Department for International Development

UKaid from the British people

CALLDOWN CONTRACT

Framework Agreement with: **Integrity**

Framework Agreement for: **DFID Global Evaluation Framework Agreement**

Framework Agreement Purchase Order Number: 7448

Call-down Contract For: **Third Party Validation, Monitoring and Research Peer Review of Delivering Accelerated Family Planning in Pakistan (DAFPAK)**

Contract Purchase Order Number: **8410**

I refer to the following:

1. The above mentioned Framework Agreement dated 12th September 2016; and

2. Your proposal of 27th November 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 **2nd September 2019** ("the Start Date") and the Services shall be completed by **30th June 2022** ("the End Date") unless the Call-down Contract is terminated earlier in accordance with the Terms and Conditions of the Framework Agreement. DFID reserves the option to extend the Call Down contract by up to 18 months.

2. Recipient

2.1 DFID requires the Supplier to provide the Services to the **Department for International Development (DFID)** ("the Recipient").

3. Financial Limit

3.1 Payments under this Call-down Contract shall not, exceed £1,874,524 ("the Financial Limit") and is inclusive of any government tax, if applicable as detailed in Annex B. For the avoidance of doubt, exercising the option to extend is at DFID's sole discretion. The total value of the contract shall not exceed £2,000,000 including all extension options.

When 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

Redacted

5. Key Personnel

Redacted

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; and

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.

Department for International Development

UKaid from the British people

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

Annex A – Terms of Reference

Terms of Reference
for
Third Party Validation, Monitoring and Research Peer Review
of
Delivering Accelerated Family Planning in Pakistan (DAFPAK)
DFID Pakistan

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LIST OF ACRONYMS

BCC	Behaviour Change Communication
CMWs	Community Midwives
CYP	Couple Year of Protection
DAFPAK	Delivering Accelerated Family Planning in Pakistan
FCO	Foreign & Commonwealth Office
FP	Family Planning
INGO	International Non-Governmental Organisation
IUD	Intrauterine device
KPI	Key Performance Indicator
LHW	Lady Health Worker
NGO	Non-Governmental Organisation
SF	Social Franchising
SM	Social Marketing
SME	Small and Medium Enterprise
SRO	Senior Responsible Owner
TORs	Terms of Reference
TPV	Third Party Validation
UNFPA	United Nations Population Fund
VfM	Value for Money

Terms of Reference

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

1. Introduction

1.1 DFID Pakistan wishes to contract a supplier to provide the services to deliver a component of its Delivering Accelerated Family Planning in Pakistan (DAFPAK) Programme. Working through both private and public sectors, this £90 million programme over 4.5 years seeks to meet unmet need for family planning (FP) services.

1.2 There are four components to the programme:

1. Behaviour change communication;
2. Service delivery a) private sector; and b) public sector;
3. Enabling environment (policy change, advocacy and coordination); and
4. Third party validation, monitoring and research peer review

1.3 This ToR relates solely to the 4th component: third party validation, monitoring and research peer review. Implementing partners for component 2a: Service Delivery (Private) and component 3: Enabling Environment have already been identified, whilst a separate procurement exercise will be used for component 1: Behaviour Change Communication and component 2b: Strengthened Quality of Public Service Delivery.

2. Context

Relevance of family planning

2.1 Family planning is a necessary condition for fertility decline. It also empowers women by freeing them to complete their education and participate in economic activity. Users are more likely to be educated, participate in economic activity, have better health and have more control over their quality of life. Additionally, while access to quality FP services is a sexual and reproductive health right, one in five married women in Pakistan want to use FP but are not doing so, resulting in an unmet need. Consequently, only 35% of married women of reproductive age in Pakistan are currently using any method of contraception[1]. Among South Asian countries, only in Afghanistan is this rate lower at 22.5%[2]. Globally, in countries without barriers to access and use of contraception and where women are free to choose, contraceptive prevalence is consistently above 60%[3].

There are high levels of unintended pregnancies, induced abortions and maternal deaths in Pakistan. Of an estimated nine million pregnancies in 2012,

[1] Pakistan Demographic and Health Survey 2012-13, National Institute of Population Studies
[2] http://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=AF
[3] https://www.unfpa.org/data/world-population-dashboard

4.2 million were unintended resulting in 2.2 million induced abortions – the majority of which were unsafe[4]. The high rates of fertility contribute to 9,700 maternal deaths each year[5]. Reducing fertility by one third alone will reduce maternal mortality by one third. Similarly, 30% of infant deaths can be averted through birth spacing intervals of two years[6]. The development benefits from fertility decline are not confined to maternal and infant mortality rates. Pakistan has had an average population growth rate of 2.4% each year between 1998 and 2017 and the total population will almost double to 400 million by 2050 if growth rates stay above 2%. The steep rise in the population is placing greater demands on the Government of Pakistan for job creation, provision of health and education, and ensuring food security. Pakistan's economy will need to grow by an estimated 8% annually in order to keep up with the need to provide jobs for the 2 million young people currently entering the job market every year.

2.2 Therefore a reduction in fertility rates will positively impact the economic burden on the state by reducing the number in need of health and education services. Every dollar invested in FP services saves almost $4 on provision of services in other sectors[7]. By reducing fertility through voluntary FP, Pakistan has the opportunity to benefit from a potential 'demographic dividend', the economic benefits of Pakistan's capacity to absorb a large, young, working age population[8].

Evidence on family planning in Pakistan

2.3 Unmet need is high in all provinces and across all age groups. Potential users face multiple barriers to using FP, although there is evidence of a positive shift in social and cultural norms. Physical access is a real challenge, especially in rural areas with rugged terrain and scattered population. For the poor, the high costs of travel and time opportunity costs can be prohibitive. Whilst most women and men are aware of FP, many lack detailed knowledge of methods and are apprehensive of side effects. Men generally are becoming more supportive of FP, and cultural barriers are diminishing, but religious and social norms remain significant obstacles[9].

2.4 A high proportion (one in four) of married women using FP are using less reliable traditional methods, such as abstinence and withdrawal[10] and could benefit from using modern contraception. Many users of traditional methods do so because of the fear of side effects, lack of information about specific methods, myths and misconceptions regarding modern methods, and limited method choice[11].

[4] Pakistan Demographic and Health Survey 2006-07, National Institute of Population Studies
[5] Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2015
[6] Family Planning, An Imperative for Pakistan's Development, Population Council, 2012
[7] Family Planning, An Imperative for Pakistan's Development, Population Council, 2012
[8] Capturing the demographic dividend in Pakistan. Zeba Sathar, Rabbi Royan, John Bongaarts. Population Council. 2013
[9] Draft Meta-Analysis Report – Pakistan, UNFPA Pakistan Nov 2016
[10] Pakistan Demographic and Health Survey 2012-13. National Institute of Population Studies.
[11] Landscape analysis of the family planning situation in Pakistan, Population Council, BMGF, 2016

2.5 Pakistan's contraceptive prevalence rate has been increasing, but slowly from 12% in 1990-91 to 35% in 2012-13[12], equating to a one percentage point increase per year. Given the existing large unmet need, Pakistan has the potential for a rapid acceleration in FP uptake. Much of the growth since 2005-06 is driven by an increase in male methods: condom use has increased from 6.8% to 8.8% and withdrawal from 4.1% to 8.5%. This confirms men's more positive attitudes towards FP – but highlights growth in more unreliable methods[13].

2.6 The proportion of couples who give up using an FP method is very high. Overall 37% of couples discontinue using an FP method within 12 months of commencing its use. Reasons for stopping prematurely include side effects or other health concerns which are often associated with the quality of services and advice provided (28%), becoming pregnant because of a method failure (15%) and barriers such as cost, access and convenience (6%)[14]. There is potential to tackle some of the barriers to contraceptive use and offer greater method choice through scaling up the availability of emergency contraceptive pills, implants and new technologies such as the sub-cutaneous injectable contraceptive. Utilisation of public facilities for maternal and child health is rising, presenting an opportunity to reach an increasing client base by integrating FP into routine service delivery including pre- and post-partum care.

Policy context and enabling environment

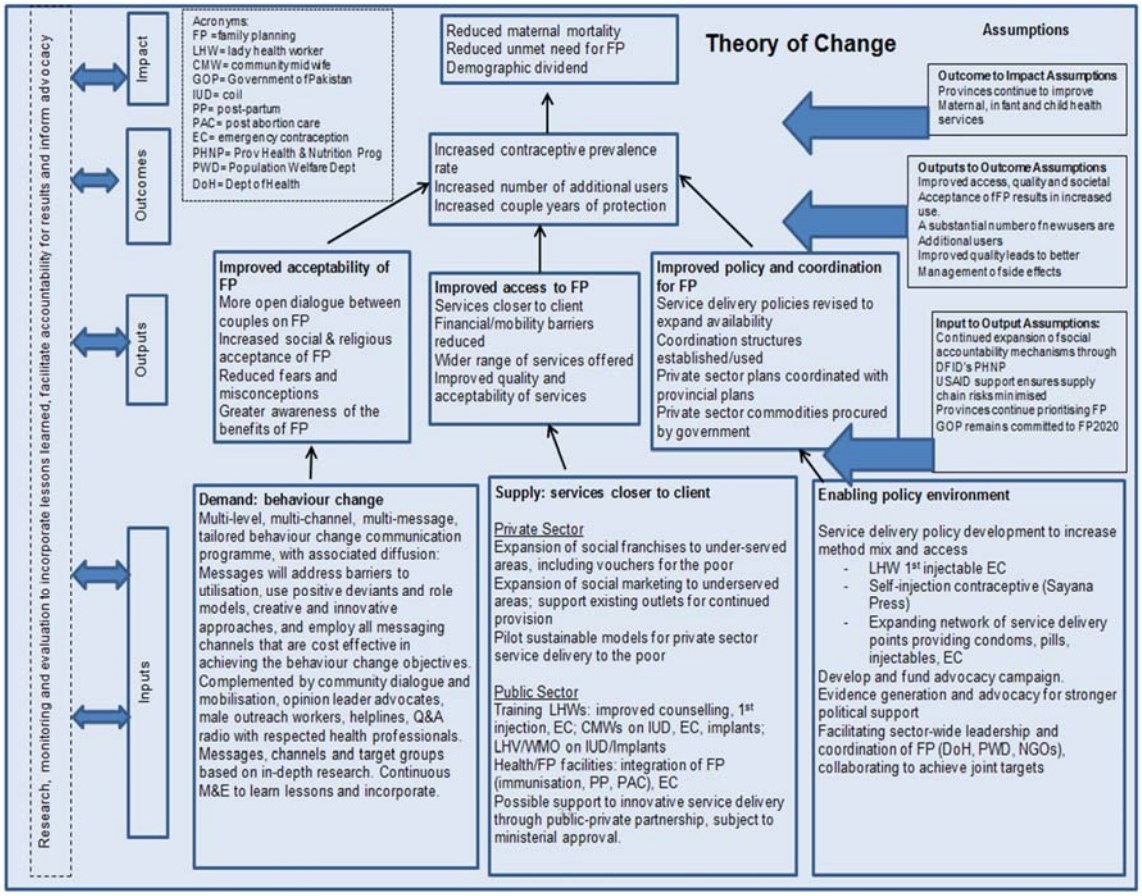
2.7 The landscaping analysis[15] conducted in 2016 and subsequent enquiries have revealed that, outside of supply chain management, much donor support is small scale and district specific. Prior to DAFPAK, one of the larger donor programmes was DFID's £39 million predecessor FP programme, Delivering Reproductive Health Results.

2.8 The Government of Pakistan's strategy 'Vision 2025' recognises the significant threat the growing population poses to Pakistan's development, stability and health and social indicators. At the July 2017 FP2020 Summit, the Government (at federal and provincial level) renewed its commitment to achieving a contraceptive prevalence rate of 50%, up from 35% in 2012. The policy context for FP has never been more favourable in Pakistan since the constitutional amendment in 2010, which devolved responsibility for development from the federal level to the provinces. The evolving plans of provincial governments present an opportunity to scale up investments in FP and better integrate the efforts of the public and private sectors for accelerated and equitable service provision.

2.9 The diagram below summarises the theory of change, showing how the

[12] Pakistan Demographic and Health Survey 2012-13. National Institute of Population Studies.
[13] Landscape analysis of the family planning situation in Pakistan, Population Council, BMGF, 2016
[14] Pakistan Demographic and Health Survey 2012-13. National Institute of Population Studies.
[15] Landscaping Analysis of the Family Planning Situation in Pakistan, Population Council, 2016

complementary programme activities are expected to increase contraceptive use. The evidence for this is strong. It is based on decades of experience and research internationally by governments, donors and specialist implementing partners, coupled with analysis and evaluation of programmes implemented in recent years funded by DFID and others in Pakistan.



3. Outline of DAFPAK

Summary of results

3.1 The DAFPAK Programme is expected to result in 2,405 fewer maternal deaths, 3.5 million fewer unintended pregnancies and 1.64 million fewer unsafe abortions. These are modelled results from estimates of couple years of protection (CYPs[16]) using the Marie Stopes International Impact Estimator (version 2.4.1). The CYP estimates were based on initial proposals from service delivery implementing partners, which, in turn, was informed by their extensive programme delivery experience.

[16] CYPs are couple years of protection, the number of years a couple is 'protected' from pregnancy when using family planning

3.2 The outcome of the Programme will be more women able to safely plan their pregnancies and improve their sexual and reproductive health. A key result will be 1.6 million additional users of modern contraception, which is calculated in accordance with the methodology for additional users developed by DFID HQ[17][18]. This result will contribute to meeting the Government of Pakistan's goal to increase the modern contraceptive prevalence rate from 26% to 41% by 2020. Disaggregated data (age, sex, poverty quintile, disability status) will be collected and monitored where possible to ensure equitable service provision.

3.3 The outputs from the Programme will be (see log frame for details):

1. Improved acceptability of family planning
2. Improved access to family planning services
3. Improved quality of family planning services
4. A more conducive enabling environment for family planning

3.4 These outputs derive from the theory of change. Greater acceptability will measure progress on addressing cultural and safety barriers; access will measure progress on greater coverage; quality will measure progress on better counselling and range of methods available; and the enabling environment will measure, among other things, progress on policy change to introduce new FP methods and advocacy efforts. Coverage and quality will be the easiest to achieve as the improvements will be a direct result of service delivery implementation. Behaviour change and advocacy activities are, by their nature, less predictable and subject to greater uncertainty.

3.5 The above targets (and those in the logframe) are incomplete and provisional and will be finalised once all implementing partners have completed their inception phase. The results will be achieved through the main programme components, with the third party monitoring component providing independent verification of main programme results.

Generation and use of evidence

3.6 DAFPAK is designed to address many of the above challenges through mutually reinforcing / supporting programme components, described below. After decades of documented programme implementation around the world and within Pakistan, the evidence is strong for these components. The strength of the existing evidence base does not merit undertaking an independent evaluation of this programme. Additional evidence is required, however, to test design assumptions and to identify lessons to refine programme delivery. This evidence will be generated through both formative research and ongoing operations research. Formative research will be conducted primarily by the implementing

[17] https://www.gov.uk/government/publications/dfid-single-departmental-plan-methodology-notes

[18] The methodology was applied using UN Population Division estimates, Track20 CPR estimates (and forecasting likely impact of DAFPAK and other support on these), expected expenditure on FP in Pakistan (DFID and other sources), and then attributing DFID contribution to the expected additional users according to DFID's share of funding.

partners leading on **Component 1 and 2b**, and operations research will be undertaken by implementing partners for all implementation components. Given the importance of the research to achieving programme results, all DAFPAK research will require to be quality assured by the Component 4 (Third Party Validation, Monitoring and Research) supplier, to provide assurance of the quality of the research design and its outputs (see Scope of Work below).

Geographical scope of the programme

3.7 The scope of some BCC activities will be national. Sub-national BCC focus will support service delivery activities and will be informed by formative research findings and location of implementation of Component 2, particularly for the public sector. The location of private sector service delivery is spread out in all four provinces and has been mapped (see Annex D). The location for the public sector service delivery strengthening will be finalized with the implementing partner during their inception phase. The supplier of Component 4 should be prepared to validate results across all four provinces for all implementation components.

Component 1: Behaviour Change Communication: increasing knowledge of, demand for and continued use of modern methods of FP through attitude, norms and behavior change approaches (Integrated into all components, but led by a behaviour change specialist organisation / company.)

3.8 This component recognises the importance of increasing awareness, understanding and acceptance of modern methods of FP in order to both increase demand for FP and reduce rates of contraceptive discontinuation. It will use an integrated approach to changing attitudes and behaviours, targeting a range of stakeholders including women themselves, their partners and the wider community, and healthcare workers. It should build upon the latest evidence, including cost-effectiveness studies as well as testing out new approaches.

3.9 The broad approach under this component involves messaging being integrated into all opportunities for face-to-face communication at the household and community level to overcome remaining individual and community wide barriers where there is unmet need, linked to nearby supported service delivery points or mobile outreach. Messages will address acceptability and desired fertility, myths and misconceptions, health concerns, influence of mothers-in-law and husbands, and spousal communication, as well as access barriers through knowledge of service availability.

3.10 The specific approaches to behaviour change communication will be informed by rigorous formative research funded through this component of the programme early in its implementation. The research will seek to understand key fertility norms and decision makers, and drivers of FP use and continuation amongst different groups in Pakistan. Once research findings on the most effective forms

of communication are available, programme delivery will be adjusted to improve effectiveness. A key role for component 4 (Third Party Validation, Monitoring and Research) will be to **peer review the design, output and communication plans (for wider influence) of this research and validate that recommendations are reflected in practice**.

3.11 The supplier for component 1 will work closely with the suppliers of component 2 particularly in the early design phases, in order to inform and support effective healthcare worker interventions. Specifically, component 1 will provide recommendations / advice based on evidence generated from client-centred formative research, such as effective provider-client messaging to reinforce behavior change messages, increase service use, and limit contraceptive discontinuation across all population groups (including adolescents).

Component 2 a) Service Delivery – Private Sector

3.12 This component is designed to be implemented through private sector service delivery channels, with three main sub-components. All / some subcomponents will be informed by operations research conducted by the respective implementing partners with timing to be determined. This research will be peer reviewed through component 4. Monitoring of programme delivery results will be validated through the third party monitoring arrangements also under component 4.

3.13 Social marketing (SM) promotes the sale of branded contraceptives through retail outlets such as shops (condoms) and pharmacies (condoms, pills, injectables, emergency contraception). This provides thousands of more access points to obtain FP commodities with convenient opening hours and relative anonymity. The existing network of outlets will be consolidated and new ones will be opened. The emphasis will continue to be in rural areas. Informed by mapping of potential providers, expansion of the network will be explored to unserved areas with promotional messaging linked to the wider FP demand generation efforts to be led under component 1.

3.14 Social franchising (SF) enlists private clinics into a branded FP network to provide quality assured FP services. Typically, they are owned by a lady health visitor (paramedic) who has left government service and set up her own small private clinic. She receives training, promotional materials, commodities and basic equipment, and agrees to adhere to quality standards, price caps, and to submit records. Community midwives (CMWs, government trained and supported, stationed mostly in rural areas, eventually graduating into a private clinic) will also be part of one supported social franchise network.

3.15 The networks of social franchisees will continue to expand, with an emphasis on underserved areas. In both peri-urban and rural locations, community mobilisers will conduct community dialogue, inform and counsel clients, and refer them if an unmet need is identified. One franchise network provides vouchers for poor clients identified by the mobilisers.

3.16 Mobile outreach will have two variants:

a) a team in a self-contained vehicle visits many locations every month to provide the full range of non-permanent FP services; and

b) an FP 'camp' is arranged whereby a trained paramedic visits a (mobilised) rural community to provide FP services including implants at a nearby temporary venue (e.g. a local primary school).

3.17 Mobile outreach will largely operate in unserved population groups. In both cases, where and how to expand will be informed by and coordinated with component 1's formative research and implementation plans.

Component 2 b) Service Delivery – Public

3.18 This component seeks to strengthen and expand existing public sector FP services and build the capacity of local providers. As with component 2a, the findings of formative research conducted under component 1 will inform training of service providers for better client counselling, and will supplement the formative research conducted by the Component 2b supplier. Operations research will also be conducted for this component. Peer review of all the research, and validation of reported results from service delivery strengthening activities (see below) will be done through the third party monitoring elements of component 4.

3.19 In existing public health / FP facilities client centred counselling will be improved to address client concerns about side effects, provide a more empathetic approach, and offer a wider range of methods. For better integration FP will be proactively offered when delivering other services such as immunisation, childbirth and post abortion care. The range of contraceptives will be expanded to include implants and emergency contraception. Similarly, for community based workers, in partnership with the service provider for component 1, counselling skills will be improved and tailored reflecting prevailing social norms and research identifying the methodologies that work best and meet the needs of potential client groups. Lady Health Workers (LHWs) will expand the range of services and products on offer to include emergency contraceptives and will be trained to provide the first dose of injectable contraception. CMWs will provide implants, Intrauterine Devices (IUDs) and emergency contraception alongside improved counselling. Implementation will start where policies allow and commitment is demonstrated.

3.20 Training will be provided on counselling and clinical skills which will include materials, training and post training / quality assurance support. Training will be provided at public sector training facilities; involve public sector trainers and be included in government annual plans. Integration of FP with other maternal and child health services offered by the health facility may require policy change and may involve changing standard operating procedures, roles and functions.

Component 3: Enabling Environment

3.21 This component will be led by UNFPA, working closely with federal and provincial governments to integrate all components of the programme.

Technical assistance

3.22 Technical assistance will support an improving and enabling environment – a more client-centred and supportive policy framework conducive to promotion of programme outcomes. This ranges from service delivery policy change to greater resource allocation and increased open support from politicians. Specifically, it will comprise policy development, for example, to expand the range of methods offered (implants, emergency contraception, etc.), increase service delivery points in unserved areas, and task shifting (self-injection, non-doctors inserting implants, LHWs providing first dose injectable contraception). Evidence will be generated to inform policy change, by UNFPA or possibly by operations research conducted by the service delivery implementing partners in component 2. Provinces set their own service delivery policies and the extent of policy change will vary between them. Evidence based advocacy, with links to BCC and driven by local champions, will help to sustain political commitment, embed social acceptance, and increase resource allocation. In response to need identified by programme monitoring and stakeholder consultation, provincial departments of health and population welfare will be assisted to strengthen leadership and coordination mechanisms involving all partners. Again, the supplier for Component 4 will peer review all the research and validate any results reported.

Donor coordination activities

3.23 The DAFPAK enabling environment component will strengthen coordination mechanisms to optimise the effectiveness of the programme. The programme's Technical and Coordination Committee (see below) will involve key donors and will be linked to key stakeholder fora such as the Country Engagement Working Group. DAFPAK will benefit from ongoing supply chain support from USAID, particularly their support to the relevant government departments stock monitoring and procurement planning. The Bill and Melinda Gates Foundation is planning to support the introduction of two new contraceptives. DAFPAK interventions will benefit from the expanded client choice and there may be opportunities for our public sector support component to coordinate with the provider training needed for the new contraceptive introduction.

Commitment to the Paris Declaration Principles.

3.24 DAFPAK has been designed in accordance with the Paris Declaration Principles[19]. Following the commitments made at the FP2020 Summit in 2012, provinces all developed costed implementation plans. DAFPAK supports the priorities in these plans. It seeks to strengthen national capacity, particularly in components 2b and 3. Public sector service delivery will strengthen institutional management of facilities as well district quality assurance mechanisms. The enabling environment will support policy development and strengthen coordination. Rather than establishing separate project management mechanisms, government oversight will be achieved through the existing FP2020 Country Engagement Working Group.

4. Objectives of Component 4: Third Party Validation, Monitoring and Research Peer Review

Third party validation and results reporting

4.1 This contract seeks to establish a third party validation (TPV) mechanism that provides DFID with assurances around DAFPAK progress and implementation, whilst ensuring implementing partner accountability. TPV will assess whether monitoring standards are being upheld in environments where security constraints and distance prevents DFID staff having eyes on activities themselves. TPV will also provide opportunities to strengthen partner monitoring systems through capacity building, verification and feedback which will benefit both implementing agencies and DFID.

4.2 The primary focus for validation will be the suite of project results (outputs, outcomes, milestones, KPIs[20]), including those achieved directly and those the project contributes towards: scope therefore extends to the consolidation, analysis and reporting of both output and outcome level results. The programme log frame contains the full set of results. In addition, this TPV mechanism will include monitoring of inputs, activities and financial expenditure. The mechanism will also support the reporting of priority FP results[21] to central departments in DFID headquarters, through calculation of results in adherence with agreed DFID central methodology[22].

Quality assurance of formative research studies

[19] www.oecd.org/dac/effectiveness

[20] Milestones are outputs produced by a supplier and a percent of fees is paid against achievement. KPIs are more general indicators of sound implementation management that also measure supplier performance, but without linked payments. Outcomes and additional outputs are part of the logframe.

[21] See DFID's Annual Report and Accounts 2016/17 for further information on headline DFID results (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625548/DFID-Annual-Report-and-Accounts-2016-17.pdf)

[22] Through its twice yearly DFID-wide results process, departments across DFID report their contribution to DFID's Single Departmental Plan Family Planning Results commitment. The chosen methodology is based on additional users, with the aspiration to report using MSI Impact 2 methodology where possible.

4.3 A key feature of DAFPAK is the generation of context specific evidence during programme implementation. This will enable implementing partners to make adjustments to optimise programme effectiveness, as well as fill evidence gaps on FP interventions. Formative research studies will be carried out under Component 1 and 2b and operations research under all components. The TPV mechanism will perform a crucial quality assurance function in peer reviewing the design of, and outputs from, research studies to be undertaken by the implementing partners. This focus on quality assurance will therefore ensure the quality of research undertaken as part of the project, whilst dedicated consideration of dissemination and communication of research findings will maximise its potential uptake and use. Some of the researches proposed by grantees under Private Service Delivery component include:

- Conduct journey mapping, consumer insight research and solution prototyping;
- Formative research including a pilot for health insurance; and
- Small scale research like knowledge, attitude and practices survey (KAP) of Dhanak providers under DKT.

Data sources

4.4 Programme data will be the primary source of output level results, whilst Impact and Outcome results will be extrapolated from programme data, surveys and other data sources. The supplier will be expected to assist in analysing and tracking results and using proxy indicators to indicate results trajectories where the data is not available.

4.5 Potential data sources include:

- Implementing partner management information system
- Client records kept by providers
- Dept of Health management information systems
- Population Welfare Dept management information systems
- Roadmap independent monitoring unit data (applies to KP and Punjab)
- Health surveys eg Demograph and Health Survey, provincial health surveys
- Logistics management information systems

4.6 **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 Framework Agreement.

5. Scope of Work

5.1 The table below sets out the main activities to be conducted under this programme.

5.2 These are broken down into four components. Components 1, 2 a), 2 b) and 3 relate to implementation and are only provided here as context to inform bids. **This contract applies only to component 4: third party validation, monitoring and research peer review.**

Component 4: third party validation, monitoring and research peer review £2 million)

5.4 **Third Party Validation and Monitoring**

a) On a six monthly basis validate reported output and outcome results by implementing partners from implementing their activities (see table below). On receipt of the implementing partner reports, the supplier will have three weeks to validate and consolidate results, conduct relevant analysis, make recommendations and submit a detailed report to DFID Pakistan. The validation exercise will also include appraising a) extent to which data collection and analysis builds in-country capacity (as appropriate / relevant); and b) programme risk against the following risk categories: External Context, Delivery, Reputational, and Safeguarding. This will involve appraising existing risks and identifying new ones, and recommending any changes to the programme risk matrix. Integrated within this will be an appraisal of implementing partner risk mitigation actions. Guidance on DFID's Risk Management Framework can be found in Annex B. The report should also identify any factors that may have implications for the programme theory of change or the need for adaptive programming.

b) Quarterly, provide a detailed monitoring report focused on programme inputs, activities and financial expenditure, including analysis of DAFPAK progress, based on reports of implementing partners. The analysis of progress will be both partner specific and programme wide, and will encompass expenditure, activity implementation and results achieved. UNFPA will collate results from implementing partners and the Component 4 supplier will conduct the analysis and present to the Technical and Coordination Committee.

c) Six monthly, the scope will expand to assessment of progress at the outcome level, collating outcome level results where available or analysing proxy data to indicate progress on outcomes. All partners should be using the Marie Stopes International (MSI) Impact 2 methodology and associated definitions. A supplier role includes ensuring that a) definitions do not vary across delivery partners; (b) data collection systems are streamlined across partners / clinics / sites etc, and c) calculations follow methodology in a way that results can be easily aggregated across partners, without risk of double counting. Attribution by non-service delivery components may need to be estimated by spend related methodology, avoiding double counting. Results to be measured can be found in the log frame (see Annex C). Estimates of attribution by component may be requested of the supplier.

d) Advise DAFPAK implementing partners on monitoring and evaluation methods, formats and frameworks, including for VfM, when available. Ensure indicator definitions and method of calculation are standardised and easily aggregated, and that the indicators used are the most appropriate.

e) Upon request (usually twice yearly), advise and collate results for DFID corporate reporting, including assisting with gathering data and amending the methodology to align with that required by DFID headquarters. This may include collection and analysis of data beyond reported results from partners, such as modelled estimates of additional users and attribution based on spend.

f) Upon request (maximum twice yearly), conduct analysis of indicator trajectories to advise on feasibility of lograme milestones and targets, as well as advise on appropriateness / suitability of indicators, suggesting alternatives as needed.

5.5 **Peer review of research**

a) Peer review the design, methodology and communication / dissemination plan of proposed research to be conducted in parallel by implementing partners, ensuring recommendations are reflected in revised research designs, and explicit plans are made to maximise influence on policy and practice.

b) Peer review research outputs / reports from implementing partners' research activities, ensuring findings are robust, clear and unambiguous with the greatest potential to inform future implementation. Review recommendations should also address objectivity risks. Occasionally (probably up to twice per year), the supplier may be requested to review research / study outputs from external partners. This is likely to be a major study, or relevant research report, that may have implications for DAFPAK and the supplier could be asked to summarise and present findings of relevance to the programme.

c) Monitor whether planned communication and dissemination activities have taken place as committed. Peer review of methodology and outputs should also comment on extent to which efforts are being made to build in-country capacity of collaborating partners such as government departments.

5.6 See table below for an outline of the other DAFPAK programme components.

Main Activities	In scope for TPV	Budget allocation
Component 1: Behaviour change communication (selection through a separate tender)	Component 4 to:	£13m

Main Activities	In scope for TPV	Budget allocation
1. Formative research to understand individual, couple and community-wide drivers of, and barriers to, continued use of FP and inform a comprehensive approach to increasing awareness of, demand for and continued use of modern contraception. 2. An integrated, multi-component FP demand generation programme, the precise components of which will be informed by the formative research but which may include the use of (for example): a) Mass and social media to drive increased FP awareness at scale; b) Community sensitisation approaches to drive dialogue and challenge gender, social and religious norms which limit FP use c) Working with health workers to overcome service provider biases and improve the quality of service provision, including counselling d) The innovative use of digital technology (e.g. mobiles) to provide anonymous information and support e) Support to government to develop and scale-up approaches to provide effective "couples counselling" to newly married couples to help delay first birth and/or improve subsequent child spacing. 3. Continual lesson learning to identify and incorporate lessons learned for improved effectiveness / VfM	a) quality assure design of formative and operations research, and research reports produced, ensuring findings are integrated into programme implementation and disseminated for wider knowledge sharing, as appropriate; b) validate reported results by implementing partner; c) quality assure monitoring process; d) assess programme risks and validate partner mitigating actions.	
Component 2 a): Service delivery through the private sector providing branded products and services (delivered through NGOs with established branded services) <u>Social marketing</u>: 1. Funding INGOs to expand the retail network through: 2. Procuring contraceptives 3. Promotion of branded contraceptives (condoms, pills, emergency contraceptives), with messaging linked to component 1; 4. Encouraging new outlets to stock contraceptives 5. Visiting outlets to check contraceptives are appropriately placed on shelves, not in direct sunlight, dealing with any concerns	Component 4 to: a) quality assure design of operations research, and research reports produced, ensuring findings are integrated into programme implementation and disseminated for wider knowledge sharing, as appropriate;	£52.9m

Main Activities	In scope for TPV	Budget allocation
6. Monitoring supply chain through wholesaler 7. Training and funding volunteers to conduct group and individual counselling on FP and provide branded contraceptives 8. Funding trained health workers to periodically visit rural communities where no health facility exists to provide long acting methods <u>Social franchising</u>: 1. Procuring contraceptives 2. Identifying new potential private clinics 3. Training new providers on quality service provision 4. Providing contraceptives and equipment (eg autoclaves for sterilisation) 5. Monitoring existing providers for quality, ensuring they submit client data, offering affordable services to clients 6. Training and funding mobilisation/counselling volunteers in the clinic catchment areas 7. Managing the voucher programme (checking integrity of the system, reimbursing providers on redemption of vouchers) 8. Fund running costs of mobile FP clinics in unserved areas where there are no potential franchisees 9. Continual lesson learning to identify and incorporate lessons learned for improved effectiveness/VfM	b) validate reported results by implementing partner; c) quality assure monitoring process; d) assess programme risks and validate partner mitigating actions.	
Component 2 b): Strengthened quality of public service provision (selection through separate tender) 1. Training government health/FP facility staff on integration of services, improving quality, expanding the range of contraceptives offered 2. Training community workers on better counselling and to expand the FP services that they offer 3. Establishing new procedures in health facilities to better integrate services 4. Improving quality assurance systems involving district health management teams 5. Monitoring and post-training follow up 6. Technical assistance in related areas to improve supportive management systems	Component 4 to: a) quality assure design of formative and operations research, and research reports produced, ensuring findings are integrated into programme implementation and disseminated for wider knowledge sharing, as appropriate; b) validate reported results by implementing partner; c) quality assure monitoring process;	£17m

Main Activities	In scope for TPV	Budget allocation
	d) assess programme risks and validate partner mitigating actions.	
Component 3: Enabling environment and programme coordination (to be led by UNFPA) 1. Research on the safety of allowing lower level health workers to provide FP services (eg nurses to insert implants, lady health workers to provide first injectable) 2. Research on the political economy and stakeholder analysis related to FP 3. Development of advocacy strategy, including theory of change, and implementing the strategy – which is likely to include: 4. Coalition for FP mobilised, champions identified, trained and supported 5. Provide secretariat function to DAFPAK Technical Coordination Committee 6. Technical assistance to / on: a) FP2020 Country Engagement Working Groups and parliamentarians to monitor progress towards commitments and conduct budget analysis; b) Mapping of funding from all sources to FP and tracking over time; c) Capitalise on the census results: analyse population projections, quantify national savings and other benefits from lower population growth; coordination of the donor community on messaging on the census results eg for population policy, and what more needs to be done on FP d) Coordination of FP activities at subnational level e) Ensuring lessons learned are maximised from successful innovative service delivery models through the Punjab Population Innovation Fund f) Conducting analysis, scoping out and promoting an expanded role of the health insurance market to subsidise FP services by policy holders	Component 4 to: a) quality assure design of formative and operations research, and research reports produced, ensuring findings are integrated into programme implementation and disseminated for wider knowledge sharing, as appropriate; b) validate reported results by implementing partner; c) quality assure monitoring process; d) assess programme risks and validate partner mitigating actions; e) support analysis of DAFPAK programme-wide progress in preparation for quarterly and annual reviews.	£4.7m

5.7 The Supplier will develop, monitor and update a risk matrix to deliver on these ToR, using the same format as programme's matrix. See Duty of Care and the

Summary Risk Assessment Matrix below, as well as Annex B for DAFPAK's risk matrix.

5.8 Since validation will be the Supplier's primary role, the data sets being used will be provided by DAFPAK implementing partners, all of whom are/will be contractually required by DFID to submit programme results quarterly and avail records to the Supplier. Much of the data to be validated will be from implementing partner management information systems, such as names of facilities, activities conducted there, client records and the services they received, including their background characteristics where appropriate. Part of the role of the Supplier will be to appraise and advise on monitoring frameworks and research designs and will be in a position to influence and uphold the quality of data produced. Third party validation was used during a predecessor FP programme for DFID in Pakistan and the data was consistently of sufficient quality for successful validation.

6. Recipients

6.1 The primary recipients of these deliverables will be DFID Pakistan and its implementing partners.

7. Expected achievements

7.1 The Supplier's contribution to DAFPAK will not directly influence delivery of logframe milestones and targets, however robust assessments of progress will strengthen project implementation and therefore support the achievement of programme results. The Supplier's contribution will also ensure that reported logframe results are accurate and correctly calculated according to appropriate, standardised formulas. Specific deliverables will be agreed during the Supplier's inception phase.

8. Value for Money

8.1 The purpose of VfM is to develop a better understanding and articulation of costs and results so that we can make more informed, evidence based choices. This is a process of continuous improvement. The Supplier, alongside any subcontractors, will agree a priority set of VfM indicators which are monitored on a regular basis. The implementation of VfM principles will be assessed by DFID through the Supplier's quarterly reports and programme annual reviews. VfM indicators will be based on DFID's four Es strategy, including but not limited to following proposed indicators:

Economy	Unit costs of consultants in project design and management and surveyors in implementation phase
	Operational and expenses costs (as % of total project costs)

Efficiency	Cost per validation (i.e. per site visit, breakdown of rural / urban)
	Cost per results report (total costs per verification period)
Effectiveness	TPV reports accepted by DFID (and IPs) and used to make programming decisions
	Cost per FP result verified (i.e. per number of IUDs fitted) – will require attribution of costs across methods
Equity	Validation samples are statistically significant for all areas of equity focus (e.g. rural/urban, disabilities, gender, socio-economic status)

8.2 Justifying, monitoring, and continually striving for better VfM should be integrated into all the supplier's activities.

9. Duration and break clause

9.1 The contract duration will be from the contract start date until June 2022, the end of the DAFPAK programme. The contract will consist of 2 phases i.e. an inception and implementation phase. DFID will have the option to invoke a break clause after the inception phase and at the midpoint of overall contract duration. The break clause is the opportunity to respond to initial performance and adapt the design of the programme based on the first few years of implementation. Programme inception will be completed within 3 months of the contract start date, including finalising the contractual arrangements with any downstream partners, finalisation of work plans and budgets aligned to the DAFPAK reporting cycle, finalised roles and relationships with other DAFPAK implementing partners, and detailed methodology of validation approaches.

10. Budget

10.1 The budget for DAFPAK is £90 million. The total budget including tax if applicable must not exceed £2 million for this procurement.

11. Inception Period

11.1 **This contract will have an Inception Phase of 3 months**. Immediately after signing of the contract, the Supplier will develop an Inception Plan, defining activities and clear milestones for the Inception period.

11.2 The Inception Phase will include but not be limited to the following:

a) Establishment of an office in Islamabad, if needed, and recruitment of qualified staff;
b) Co-ordination, reporting timelines, partner monitoring, evaluation and research plans and procedures agreed with all DAFPAK implementing partners;

c) Development of detailed workplans and budgets, including identified advisory support, plans for analysis of reports, format for feedback on peer review of partner research products, and detailed validation methodology;
d) Defined roles and responsibilities and communication mechanisms with other DAFPAK partners – it is important that the supplier does not actively collaborate with other partners to avoid conflict of interest;
e) Finalisation of the costed work plan for the Implementation Phase, disaggregated by quarters;
f) Finalisation of the detailed budget for the full Implementation period, disaggregated by quarters; including breakdown of inputs, fees, and expenses in a format that will enable VfM analysis;
g) Development of the detailed operating procedures and systems necessary for the management of activities and disbursement of funds;
h) Finalisation of contractual arrangements with any downstream partners;
i) Training for any subcontractors in financial systems and reporting, and in monitoring and technical reporting; and
j) Finalisation of implementation responsibilities, deliverables and annual work-plans with any subcontractors.

11.3 The Supplier will produce an inception report by the end of the Inception Period, to be approved by DFID.

12. Management Arrangements

12.1 To implement the programme, the Supplier will be responsible for the financial, administrative and logistical arrangements for the monitoring and evaluation component. This will include all activities under the Inception period and ongoing implementation including:

a) Managing the disbursement of and accountability for DFID funds, including through financial reporting and annual audits; and

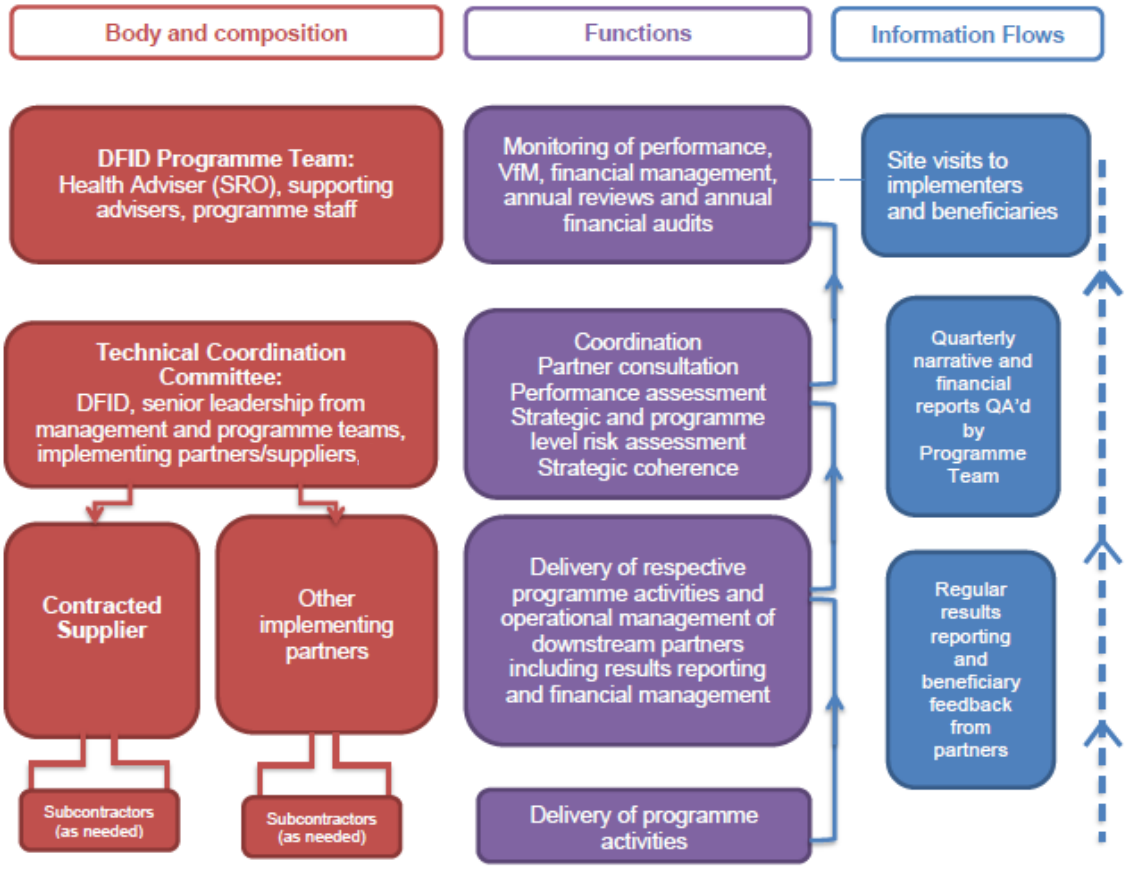
b) Development of close and effective working relationships with other DAFPAK component implementers, particularly UNFPA who will lead on overall reporting and co-ordination.

12.2 The performance of the Supplier and Programme will be formally monitored through semi-annual financial and narrative reports and as part of the DFID Annual Review process. Payments to the supplier will be linked to performance and delivery of key deliverables (see below).

12.3 The diagram in Annex D sets out the **management arrangements for DAFPAK.** Served by a secretariat (UNFPA) the Technical Coordination Committee is the main management mechanism. Meeting quarterly, it will ensure coordination and facilitate quality assurance. Plans will be shared, reports presented and reviewed, risks assessed and revised, and reviews arranged. Key external stakeholders may be invited to these meetings. The Supplier will be contracted

solely by DFID but will be required to submit plans and reports timely according to a common coordinated format, following UNFPA's lead. This will facilitate the analysis of progress by the TPV supplier. The management diagram indicates the partner inter-relationships and provides examples of the overlapping issues between components.

13. DFID Coordination



13.1 The Senior Responsible Owner (SRO) of DAFPAK will be the designated DFID Health Adviser, supported by other advisers and programme staff as needed. A diagram setting out the governance structure for the programme is below.

13.2 **The expected timeline for mobilisation and implementation is as follows:**

Activity	**Tentative Start Date**
Contract start date	2 September 2019
Inception period	2 September to 1 December 2019 To be completed within 3 months of the contract start date, including finalising the contractual arrangements with any downstream partners, finalisation of work plans and budgets aligned to the DAFPAK reporting cycle, finalised roles and

	relationships with other DAFPAK implementing partners, and detailed methodology of validation approaches.
Implementation period	2 December 2019 (subject to inception sign off from DFID)

14. Contract Model

14.1 DFID will procure the services of the Supplier, using the Global Evaluation Framework Agreement (GEFA), to implement the monitoring and evaluation component of the DAFPAK programme.

14.2 The Supplier will be responsible for any sub-contracting of organisations to implement the specified components. The Supplier will be responsible for its performance and for managing the performance of its sub-contractors in line with the DFID supply partner Code of Conduct. Performance of the Supplier and its contractors will be managed through clear contracts with robust and appropriate implementation plans, including agreed outputs and payments based on performance. There will be a break clause after the inception phase and also at 2 years from the contract start date. The break clause provides DFID with an opportunity to assess supplier performance and progress and may result in the adaptation of the design of the programme or termination of the contract.

15. Accounting / Auditing

15.1 Payments to the Supplier will be made in arrears by DFID on the basis of approved work plans and budgets, and agreed milestones. This will be a payment by results contract, the Supplier must set out on a semi-annual basis the progress made towards achieving agreed milestones with recommendations for corrective action, if required. This information must be provided within three weeks of receipt of implementing partner's progress reports and end of each assigned period through a narrative and financial progress report, as agreed during programme inception.

15.2 To ensure financial forecasting is highly accurate for this contract, the Supplier should clearly set out in their work plan when they expect deliverables to be submitted in line with ToR, and an updated work plan will be agreed on a yearly basis and continuously updated to ensure it takes into account any programmatic changes.

15.3 To ensure strong management oversight and quality control, Supplier should also propose financial plan that links payment to key deliverables:

a) Linking costs to specific TPV activities (key component output); and

b) Linking payments to the submittal of evaluation deliverables (e.g. robust report of peer review of programme funded research related outputs) to DFID.

15.4 The Supplier will appoint a State Bank of Pakistan approved international audit firm acceptable to DFID to conduct annual audits of its accounts and those of downstream partners. The Supplier will share all audit reports with DFID within 2 weeks of receiving a completed audit report.

16. Monitoring, Reporting and Performance Management

16.1 The Supplier will be responsible for:

a) Developing and submitting an inception report within 3 months of contract signing that describes detailed methodology for TPV, criteria, timing and regularity of verification visits, depth versus breadth of coverage and sampling strategy, tools to be used for different types of data, feasibility of spot check, how data problems will be identified and reported. The report will also include how data will be stored and accessed, coded, and detail any triangulation or other analysis proposed for verification reports (see below on other requirements for the inception period);

b) Submitting 6 monthly validation reports within three weeks of receipt from implementing partners that include data collection methods, analysis and findings of TPV of DAFPAK partner reported results. The report will include recommendations to DFID on a) validation of every reported result within the parameters of the agreed methodology; b) disbursements to partners within the framework of their DFID performance based financing agreements; c) the VfM achieved; and d) any other implications for future implementation;

c) Quarterly progress reports on DAFPAK programme performance including inputs, activities and financial expenditure (validation reports and progress reports will inform annual and project completion reviews; analysing proxy data, triangulation, etc, mentioned above under Scope will be particularly important for these reviews to guide assessment of trajectory towards targets, eg for KPIs, outputs, outcomes, VfM). This will also involve a) advising on all monitoring and evaluation processes, indicators and frameworks, as needed; and b) ensuring DAFPAK partners have the correct format and are using the correct standardised methodology, indicators, VfM frameworks, etc, for results reporting;

d) With 10 days of receipt, produce comments on DAFPAK partner draft research design, methodology and related products, including recommendations to address identified shortcomings in design and narrative around the clarity and rigour of research conclusions and findings, with a view to strengthening all research approaches as well as dissemination efforts and influence on policy and practice (consolidated research plans will

not be complete until all partner inception reports are complete but will probably number more than 10);

e) Programme wide and implementing partner specific risk matrices updated;

f) Upon request (usually twice yearly), advise and collate results for DFID corporate reporting; and

g) Consulting, coordinating and collaborating with DFID and DAFPAK partners as needed for optimal execution of the supplier's responsibilities.

17. Registration

17.1 The Supplier, whether a for-profit or not-for-profit organization i.e. private sector / INGO / NGO / CSO (or its local affiliate in Pakistan) or in any other form recognised by law, must be registered under the relevant department as laid out by rules of the Government of Pakistan. The organisation must be in full compliance with the rules and regulations specified by the body under which it is required to be registered.

18. Duty of Care

18.1 **The Supplier is responsible for the safety and well-being of its personnel and Third Parties affected by the supplier's activities under this contract, including appropriate security and safeguarding arrangements.** It will also be responsible for the provision of suitable security arrangements for its domestic and business property.

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

a) Supplier will be offered a copy of the latest British High Commission Security awareness document on arrival. All such personnel must register with their respective High Commissions / Embassies to ensure that they are included in emergency procedures.

18.3 The Supplier is responsible for ensuring appropriate safety and security briefings for all of its personnel working under this contract and ensuring that the personnel receive briefing as outlined above and a personnel register is kept. Travel advice is also available on the FCO website and the supplier must ensure all its personnel are up to date with the latest position.

18.4 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).

18.5 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.

DFID Overall Programme/Intervention Summary Risk Assessment Matrix

Theme	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score	DFID Risk Score
Province	Islamabad Capital Territory & Rawalpindi	Punjab (north) including Lahore	Punjab (south)	Sindh (north)	Sindh (south) including Karachi	Balochistan	FATA	Khyber Pakhtunkhwa (south) including Peshawar	Khyber Pakhtunkhwa (north and east)	Karakorum Highway (KKH)	Gilgit-Baltistan (except KKH)
Overall Rating*	3	3	4	4	4	4	4	4	3	3	2
FCO Travel Advice	2	2	2	3	2	4	4	4	3	4	2
Host Nation Travel Advice	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Transportation	3	3	4	4	4	4	4	4	4	4	4
Security	4	4	4	4	4	4	4	4	4	4	4
Civil Unrest	3	3	3	3	4	5	5	4	2	2	2
Violence / Crime	2	3	4	4	5	4	4	4	3	3	2
Terrorism	5	5	5	5	5	5	5	5	5	5	5
Conflict (war)	2	2	2	2	2	4	5	3	2	2	2
Hurricane	2	2	2	2	2	2	2	2	2	2	2
Earthquake	4	3	3	3	3	4	3	4	4	4	4
Flood / Tsunami	2	4	4	4	4	3	2	2	2	2	2
Medical Services	1	2	3	3	2	4	4	3	3	3	3
Nature of Programme Intervention	1	2	3	3	2	4	4	3	4	2	1

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

*As assessed by DFID Risk Manager

Updated: 26/04/2018

Appendix A: of Contract Section 2 (Terms of Reference) Schedule of Processing, Personal Data and Data Subjects

The completed schedule must be agreed formally as part of the contract with DFID and any changes to the content of this schedule must be agreed formally with DFID under a Contract Variation.

Description	Details
Identity of the **Data Controller** and **Data 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 Framework Agreement) 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 B

SCHEDULE OF PRICES

REDACTED