Section 3

TERMS OF REFERENCE (March 2016)

DFID DRC
Terms of Reference (v2) for
ASSP (Accès aux Soins de Santé Primaires) Project Consortium Lead

Contents

1. Executive Summary

The UK will provide circa £183GBP million over the next 5 years to strengthen basic health service provision in the Democratic Republic of Congo (DRC) in order to improve reproductive, maternal, neonatal and child health[1]. DFID DRC is now seeking a consortium lead for this project (and three technical consortium partners). The project will support the delivery of the Ministry of Health package of care i.e. PMA (Paquet Minimum d'Appui) and PCA (Paquet Complémentaire d'Activités) using an "appui global" approach in at least 30 health zones, whilst building capacity to strengthen the health system.

This is a design and build project (see below for further explanation). The design phase is expected to start by September 2012 and implementation of service delivery sub-contracts by January 2013 at the latest. The programme will fund service delivery support with some health system strengthening in at least 30 health zones (out of 515) in up to four of the eleven provinces in DRC, providing at least the population of those zones with access to essential primary and secondary healthcare services and provide funds for health system strengthening and capacity building. The number of zones to be supported will depend upon the model proposed by the consortium lead and this value for money element will be a significant criteria in the selection of the consortium lead. Which zones will be supported should be defined during the design phase (see paragraph on "design and build" contract below.

Approach.

This new programme builds upon DFID's existing Access to Health Programme which will end in December 2012 (in which two NGOs support twenty health zones in total). DFID will continue to work through Non-Governmental Organisations, civil society and faith based networks to implement this programme, rather than through direct assistance to the Government of DRC. DFID aims to achieve some key changes in the new programme and is looking for an agency which can demonstrate in the new programme:

- Better **value for money**. When selecting bids DFID will take into consideration the proposed number of zones for support and the package proposed. This should enable increased geographical coverage i.e. a significant increase in the number of health zones covered.
- A greater focus on **sustainability** within the programme, for example by ensuring that the approach used does not undermine capacity by providing parallel systems or substituting capacity.
- Greater emphasis on working through **Faith Based Networks** to support service delivery as an entry point into strengthening public sector provision.
- A greater focus on strengthening **empowerment and accountability** at different levels

DFID will work to strengthen public sector provision by focusing on faith based networks as an entry point of support to public sector health services as a whole. Faith based networks are likely to continue to play a central role in public sector provision and we think that this may be a more sustainable way of supporting the government to deliver services whilst achieving value for money and managing fiduciary risk. Support will be given to both government and FBO facilities and zones will be selected based on need (i.e. health zones with FBO management support will not be prioritised).

[1] This figure is inclusive of any taxes that may be payable.

In each of the health zones supported, it is anticipated that the consortium lead[2] will sub-contract to an implementing NGO/FBO or implement themselves to provide an adequate package of support through health centres and hospitals to provide universal coverage for the population in a zone, consisting of essential medicines / supplies, infrastructure / equipment, training / supervision and the provision of salary incentives for staff (if required). Implementing agencies will be expected to ensure that user fees are not a barrier to care through their removal or heavy subsidisation for vulnerable groups (such as pregnant women and children under fives). A budget will be available for solar energy for facilities to ensure that this programme is climate smart.

The project should strengthen empowerment and accountability at a number of different levels, ensuring that citizens have a greater voice and that both service providers and the government are more accountable for delivering quality basic health services.

The state has a key role to play in health in the DRC to act as an effective steward, provide an enabling environment for service delivery from a range of providers and set policy. Through a £2.8m cost extension to the original contract the delivery partner will extend the institutional and capacity building activities originally planned for provincial and health zone level to the central level in order to support improved capacity in the Ministry of Health (MSP). This forms part of the Renforcement des Capacités Institutionelles project (RCI). This support to the MSP will include technical assistance on public financial management. Work will also be done to strengthen MSP's capacity in information management by rolling out a National Health Management Information System (SNIS) and human resource management through implementation of the human resources information system (iHRIS). These were already being done at provincial and health zone level and are now being extended to the central level as well.

Additional guidance from the Ministry of Health

(i) The MSP will issue guidance to the Consortium Lead at the start of the design phase guidance on how the project should engage with faith based providers to ensure that sustainable government systems are built, that faith based networks do not compete with the Ministry of Health and that they are properly regulated by the Ministry of Health.

(ii) The Consortium Lead should allocate time and resources at central and local levels to strengthen the Health Management Information Systems i.e. SNIS.

(iii) The Consortium Lead should aim to cover a whole district/DPS where possible to ensure that a critical mass of support is provided.

[2]The term consortium lead is used to refer to the service provider.

Funds available

Figure 1: Revised breakdown of budget[3]

Line		2012/13 Design/ start up	2013/14 Year 1	2014/15 Year 2	2015/16 Year 3	2016/17 Year 4	2017/18 Year 5	Total
I	**Support to service delivery in health zones** (includes health zone management team strengthening)	11.36	24.67	24.76	24.76	24.76	24.76	**135.07**
Ii	**Village Assaini WASH allocation**	0.81	3.24	3.25	3.25	3.25	3.25	**17.04**
Iii	**Evaluation and operational research sub-contract**	0.25	0.99	0.87	0.87	0.87	0.87	**4.72**
Iv	**Family planning technical assistance**	0.14	0.57	0.57	0.57	0.57	0.57	**3.01**
V	**Empowerment and Accountability technical assistance/resources**	0.05	0.19	0.19	0.19	0.19	0.19	**1.00**
Vi	**Technical assistance/training and management costs**	0.80	3.20	3.21	3.21	3.21	3.21	**16.84**
Vii	**Solar or other renewable power grants**	0.10	0.38	0.38	0.38	0.38	0.38	**2.00**
Viii	**Health System strengthening Work at central level**	0	0	0	0.56	1.43	0.81	**2.80**
	ASSP Total	13.50	33.24	33.24	33.24	33.24	33.24	**182.48**

Please note that this budget is indicative only at this stage and will be confirmed when the contract is awarded. Additional funds have been donated by SIDA for the first 2 years of the programme and in September 2015 an additional £2.8 million was allocated for additional health system strengthening work. Please see contract and budget narrative for additional information.

At the design phase there will be an opportunity for the consortium lead to make minor adjustments to the allocations within these budget lines subject to approval from DFID within certain parameters.

Note that budget line F contains both the management/administration fee for the Consortium Lead and funds for training/technical assistance within the project. Bidding agencies should disaggregate and state the amount for their management fee in their bids and the amount they plan to spend on technical assistance/training within the project.

Please be advised that for the purpose of the commercial evaluation, the Pro Formas contained within ITT Volume 4 relate directly to management / administration fees only for the Consortium Lead.

Structure

The project will use a "managed programme" approach; an organisation as the consortium lead will oversee and manage other implementing partners according to a focused set of specifications determined by DFID. DFID has strategically chosen to use a more tightly specified approach based on learning from previous programmes to ensure results. This arrangement has been used effectively by other donors in the DRC (such as USAID). It facilitates a more coherent standardised approach to support and provides a mechanism for

[3] This table has been updated following DFID DRC country programme budget revision in May 2012 and in January 2016 to show the contract extension amount of £2.8m.

closer quality assurance and cost monitoring. The programme will be overseen by an Oversight Committee (OC) chaired by the Ministry of Health with DFID.

DFID is seeking an organisation to act as Consortium Lead for the programme and their proposed technical partners for three sub-projects;

i. Operational Research and Impact Evaluation (ORIE)
ii. Family planning and Reproductive Health (FP)
iii. Empowerment and Accountability (E&A)

If the consortium lead has specific technical capacity in a particular sub-project area they do not need to necessarily sub-contract this to another agency, however capacity in these specialised technical areas will be assessed as part of the selection process.

This is a "Design and Build contract". This means that DFID will contract a supplier to do the design work and then subject to satisfactory performance during the design phase and approval of the design, the same supplier will then implement the project provided DFID and the Service Provider reach agreement on the Terms of Reference for the Implementation Phase and the Financial Proposal. During the two month design phase the Consortium Lead should conduct a selection process (to international procurement standards) to identify implementing partners to provide the support for service delivery/capacity building at health zone level. This will depend upon which zones are selected in the design phase needs assessment and therefore organisations should not indicate in their bids for the Consortium Lead role their implementing partners at this stage - they should only indicate their "technical" partners i.e. for the three technical subcontracts (ORIE, FP and E&A).

Team structure

The Consortium Lead is required to propose a staffing pattern that can best achieve the desired results. Proposed candidates and any changes in key positions (i.e. Chief of party/Director and Senior Technical lead/Deputy) should be agreed by DFID.

CVs of the following post holders should be included in bids;

- Chief of Party/Director
- Senior Technical lead/Deputy)
- Finance Manager
- Key focal points (either thematic or Provincial depending on structure proposed)

Revised Timetable[4]

DFID intends to let a contract(s) until the end of March 2018. There will be two break clauses; (i) at the end of the design phase and (ii) at the end of March 2015 (the current UK government spending period).

A procurement timeline is outlined in the supplier information and instructions document. The start of this project is extremely time-sensitive since it is vital that there is no interruption in support of health facilities already receiving support from DFID. If/where there is a change in implementing partner a transition phase of at least one month will be required to ensure a smooth transition.

If DFID decides not to proceed to the Implementation Phase, the Contract will be terminated at no cost to DFID.

[4] This section has been revised following review of the DFID DRC country programme budget in May 2012.

DFID reserves the right to re-tender the Implementation Phase if it is not satisfied the selected service provider can implement the ASSP - after approval of the refined project memorandum. The revised budget for the Implementation Phase will be assessed to ensure that it still provides the most economically advantageous proposal

In this event, the service provider **will discuss and agree** close down arrangements with DFID (i.e. if not selected to implement the ASSP) **and hand over all information to DFID and the successful bidder for the Implementation Phase of the ASSP.**

The design phase should commence within 14 days of signing the contract within DFID. and is expected to last 2 months. Ideally the design phase would start in September or October 2012. Sub-contracts should be issued to implementing partners within 14 days of the CL contract being approved for implementation.

Ideally support to health zones will be underway by 1st January 2013.

2. Objectives

The overall objective of the project is to improve reproductive, maternal, neo-natal and child health (RMNCH) in DRC whilst strengthening the health system. The project outcome will be increased coverage with essential reproductive, maternal and child health services in DFID-supported health zones.

Figure 2: Main outcomes and their key results

Outputs	Key results
Output 1: Enhanced health service delivery and quality in DFID-supported health zones.	83,760 one year olds vaccinated against measles each year. 200,000 CYPs (couple years protection) delivered by 2014/15 (pro-rata milestones for each year to be confirmed in design phase) 96,000 births per year are attended by skilled health personnel. 96,000 pregnant women receive Intermittent Presumptive Treatment (IPT) for malaria during ante-natal visits per year
Output 2: Increased empowerment and accountability in health service planning and delivery in DFID-supported health zones.	All DFID-supported health zones are completing community score cards each year by the end of the project.
Output 3: Improved access to health services in DFID-supported health zones.	50% increase in utilisation rates per capita per annum in previously unsupported health zones
Output 4: Increased and sustainable access to safe drinking water, improved sanitation, hygiene education and better environmental health in rural and peri-urban communities.	780,000 people are provided with access to clean water and sanitation by the end of the project

These outcomes may be updated during the design phase when the log-frame is finalised in light of findings from the needs assessment.

3. Recipient

The GoDRC and the people of DRC will be the recipients of the intervention

4. Scope and implementation requirements

(A) Design phase

The Consortium Lead (CL) should work closely with DFID and the Ministry of Health in the design phase to ensure that all parties are in agreement on the approach of the project.

When DFID has signed off the design phase deliverables the implementation phase can proceed. In the event that agreement cannot be reached or DFID has serious concerns about the quality of design work then the project may be terminated at the end of the design phase and retendered.

At the end of the design phase there will be an opportunity for the consortium lead to discuss/suggest to DFID if any revisions are needed to the terms of reference, which can be updated prior to the implementation phase. DFID reserves the right to not accept these suggestions.

In the design phase the consortium lead will be responsible for the following but not limited to;

1. Needs Assessment

1.1 The consortium lead should conduct a needs assessment involving field visits (with the possible involvement of DFID/MSP). Prior to the assessment process the CL should agree with DFID how need will be assessed and zones will be prioritised. The project should seek to meet the MSP's request to cluster around DFID's existing zones into districts in order to better support the health *system* rather than have a scattered approach[i]. Other parameters should also be taken into consideration, in particular;

- Zones with no external support from other donors or where a donor is withdrawing i.e. prioritise gaps in provision
- Malnutrition rates – selecting zones with the highest rates would likely result in the biggest effect on child mortality
- Poverty levels between different zones – prioritising the poorest.

1.2 The design process will need to include both analysis of political-economy and strategic conflict assessment to ensure that the programme is conflict sensitive. Implementing partners will be required to include a rapid conflict assessment in their proposals during the selection phase to ensure they "do no harm" and are fully aware of political, land or ethnic tensions in the area in which they plan to operate.

1.3 The CL should address the requirements of the guidance in sections 11 and 12 on the environment and gender in the needs assessment report.

1.4 A transition plan should be elaborated in the implementation plan for those zones which are considered outliers where expansion is not possible. These zones should

be included in the project for at least one year to allow for a safe transition out of support.

1.5 During the design phase the consortium lead should develop a guideline for implementing partners including guidance on the following

- Approach to support and cost per capita allocations
- Expectations on capacity building work including any tools to be used e.g. for leadership/management
- Targets on health outcomes/outputs for each zone
- Standards for what partners should deliver in terms of support for each health zone for each phase of support (e.g. an intensive rehabilitation phase, a maintenance phase and a transition phase).
- Standards for equipment/infrastructure (in line with DFID's environment guidance)
- Guidance on user fee tariffs and the subsidy/exemption policy for vulnerable groups. These should take into consideration elasticity of demand of vulnerable groups and ensure that fees are not a barrier to care. DFID must agree the policy of the consortium lead on user fee subsidies and exemptions before implementation starts.

2. Selection process for implementing sub-contracts

2.1 The Consortium Lead should issue a call for tender for implementing partners in potential health zones. (In the interests of time this may need to be done prior to the needs assessment and include all zones in the relevant/potential provinces). DFID wishes to prioritise where possible support through faith based networks (although where there is already an NGO which is performing well then their continued support should be prioritised. Both government and faith based facilities should be supported. The CL should not prioritise zones because they are co-managed by faith based networks – support should be directed based on need. The CL should communicate calls for proposals effectively and on a timely basis. The CL should pre-screen all full applications to ensure that proposed projects are compatible with funding criteria and principles (as outlined in annex 1 of this document).

2.2 A minimum of ten health zones should be sub-contracted by the Consortium Lead, although the expectation is that more than this will be subcontracted.

2.3 The consortium lead should outline the parameters for the appui global support package to be funded included the cost per capita to be allocated and results expected.

2.4 Coverage: the Consortium Lead should elaborate standards for implementing partners on the number of health facilities to be supported in each health zone, taking into consideration Ministry of Health guidance. Adequate facilities should be supported to allow the whole population of the health zone to have access to care and where possible, one hospital per health zone should be supported.

2.5 DFID and the MSP / other relevant local authorities should be either consulted during the selection process or invited to participate in the selection panel. The CL should work with the Direction of Primary Health to provide technical advice on proposals.

2.6 The selected implementing partners, respective health zones, budgets and summary statistics on supported health facilities should be presented to the ASSP Oversight Committee.

2.7 The CL should inform applicants whether their proposal has been successful or not (using a standard formatfor responses) as soon as possible. Contracts should be issued to implementing partners within 14 days of the implementing phase starting.

3. Implementation plan

- By the end of the design phase the CL should produce a detailed implementation plan, including annual milestones outlining
  - which zones will be supported by which implementing partners,
  - planned length of phases for each zone,
  - which facilities will be supported in each zone,
  - which villages will be targeted for Village Assaini
  - targets for each zone and budget allocated[5]
  - An outline of plan for ensuring that user fees are not a barrier to care i.e. the planned approach for targeted vulnerable groups. Other demand side barriers of access to care should also be considered in the plan e.g. gender.
  - Detailed work plan for capacity building and technical assistance to (i) the MSP centrally (ii) at provincial/district/DPS level and (iii) for implementing partners i.e. local NGOs/FBOs and faith based networks.
  - Detailed work plans for the three technical sub-contracts including targets (in the form of a log-frame for each sub-contract)
  - A revised detailed budget for the whole programme
  - A revised log-frame agreed with DFID for the whole programme

4. Other preparatory work

4.1 The CL should liaise with UNICEF to set up a nutrition Programme Cooperation Agreement with UNICEF for support to deliver the nutrition results in the project. DFID may have funding to support UNICEF to deliver this support through its humanitarian budget. (DFID may also negotiate to include some support for EPI into this given the recent problems with vaccine supply chains in project areas). The CL should lead on setting up the PCA ideally on behalf of the implementing partners – the PCA could cover technical assistance, nutrition commodities and supplies to facilitate IMAM or CMAM in the relevant health zones.

4.2 The CL should also liaise with UNICEF and the Directorate of Hygiene on quality assurance arrangements for the Village Assaini component of the programme.

4.3 The programme should be designed to be flexible to adapt to a changing context and respond to humanitarian needs within reason. In the event that there is a general shift towards more humanitarian programming (for either political or humanitarian reasons), the programme should be able to re-focus resources more heavily to service delivery from capacity building / developmental elements. The project should be designed to have the capability to respond to increased humanitarian need through surge capacity of existing supported health services (for example through the CL maintaining emergency drug stocks and emergency response expertise centrally to assist the MSP).

4.4 Ensuring some locally added value and promoting sustainability in procurement is an important principle. The CL should procure commodities locally where possible to strengthen supply chains and enhance local skills. Where possible the CL should

[5] Budget allocation should take into consideration the fact that some DFID supported health zones have a bank account with funds from user fees in situ.

procure pharmaceuticals as much as possible in country e.g. from Centres d'Achats - quality assurance issues and availability permitting. The CL should avoid *where possible* procuring in Europe/USA as this is not likely to be something the MSP will continue in future. The CL should outline a procurement plan in the design phase and agree this in principle with DFID.

4.5 The CL should also undertake other preparatory work as required by DFID if feasible within available resources.

4.6 The service provider will be required to demonstrate clear value for money at each stage of the implementation process. This will include demonstrating that administrative costs can be minimised; that management processes (including procurement procedures) are designed to maximise cost effectiveness; and that funds can be allocated based on evidence of results to ensure the greatest possible impact is achieved. A clear process for measuring value for money should be included within the monitoring framework.

Design phase deliverables

The consortium lead should deliver the following by the end of the design phase;

i. A needs assessment report of at least ten pages outlining assessment findings and rationale for why zones were selected.
ii. A detailed implementation plan including details of proposed implementing sub-contracts and mechanisms for achieving seamless transition from the existing Access to Healthcare programme into this Programme with no interruption of health service delivery.
iii. Revised budget – the overall envelope will be the same but individual budget lines may be reviewed in light of the design work findings.
iv. Revised log-frame – targets to be agreed with DFID. Revision of the log frame should include *disaggregation of by gender and possibly age/vulnerability group as appropriate.*
v. A suggested format for quarterly reports and reporting timetable – agreed by DFID.

(B) Implementation phase

5. Management responsibilities of the Consortium Lead

Including but not limited to;

5.1 Take the lead on monitoring and evaluation of the programme, including assessing and synthesising project reports/data to provide oversight on whether the project is delivering on its key targets (as outlined in the log frame). Produce a clear action plan when required for rectifying problems identified at the M&E stage and lessons learned stage.

5.2 Disburse funds to approved implementing partners when required. DFID has permission from H.M. Treasury to pre-finance the Consortium Lead quarterly if the Consortium Lead can demonstrate that they do not have the capacity to prefinance themselves..

5.3 Maintain effective and regular communication with implementing partners, MSP and DFID.

5.4 Ensure all implementing partner reports are timely and of a high quality, and that financial audits and fiduciary arrangements are satisfactory. (This is outlined in further detail in the section on management of fiduciary risk)

5.5 DFID will conduct an Annual Review in collaboration with the CL each year. After this the project may be subject to amendment and review where possible.

5.6 Develop and implement an approved transition strategy for the programme. This should be developed by the end of year one and updated in the middle of year three.

5.7 Provide a secretariat function to the ASSP Oversight Committee (which will be chaired by MSP with DFID). The CL should:

- Set, facilitate, support and fund quarterly OC meetings and OC functions.
- Provide regular updates on project achievement against outputs to the OC
- Provide regular disbursement and financial forecasting updates to the OC
- Provide any other information as required to the OC if requested.

5.8 The lead will ensure that all meetings, workshops, training etc conform to the donor group guidance on daily subsistence allowances and that they have clear terms of references, deliverables and outcomes that are followed up.

6. Technical responsibilities of the Consortium Lead

Including but not limited to;

6.1 Provide policy and technical guidance to implementing partners to ensure quality of service provision, alignment of priorities with both MSP and project objectives and development of mechanisms to allow social accountability.

6.2 Set up and implement a monitoring system so that key data on project indicators as outlined in the log-frame are available, together with other data routinely collected through the SNIS/GeSNIS. The CL should ensure that implementing partners do not need complex parallel systems outside of the MSPSNIS to collect project data. The CL should suggest changes to the log-frame as required to facilitate this.

6.3 Gather, synthesise and disseminate lessons learned from projects, particularly those related to gender and empowerment and accountability. Identify and disseminate between implementing partners ways of cross-sectoral links and innovative approaches to delivery.

6.4 Contract or deliver technical assistance for the MSP centrally as budget permits. This may include support for SNIS (the health management information system) for example or the use of technical focal points within the CL to improve engagement with the MSP. The CL should work closely with the RCI institutional strengthening project lead to maximise synergies between the two projects.

6.5 Other support to the MSP as identified by the CL – for example allocation of funding for training health personnel (pre-service or in-service), support for workshops etc.

6.6 Develop an annual plan of technical assistance and capacity building for Provincial and district/DPS health management teams. Technical assistance should seek to strengthen human resource and administrative capacity, reinforcing linkages between the different levels of administration and ensuring adequate surveillance. As a minimum the CL should assist the provinces/districts supported by the project to produce an annual operational plan.

6.7 Engage in policy dialogue with the MSP centrally, in conjunction with DFID on key issues relevant to service delivery within the DRC. The CL and implementing partners should actively engage the MSP in discussions to register clinic staff on the MSP payroll.

6.8 Deliver parts of the RCI institutional capacity building project including technical assistance on public financial management, implementation of a National Health Management Information System (SNIS) and a human resources information system (iHRIS).

6.9 Seek to strengthen links between the MSP and Faith Based Networks – this may be in the form of information exchange, coordination or regulation.

6.10 Ensure that any procurement of drugs or medical supplies follows international best practice standards to ensure quality. Gifts in kind of pharmaceuticals should be avoided unless the items are on the national essential drug list and have a reasonable expiry date. The Consortium Lead may choose to provide some capacity building/technical assistance to strengthen local centres d'achats and drug procurement systems.

6.11 The Consortium Lead should develop a programme of capacity building for partner local NGOs/FBOs and faith based networks to build their capacity both organisationally and in terms of management skills to support service delivery and their ability to engage with the government. Improving systems to reduce fiduciary risk will be a key area to support.

The annex contains suggested ToR for implementing sub-contracted implementing and technical partners at health zone level. These terms should be revised and finalised by the Consortium Lead in the design phase and used by the CL to performance manage the sub-contracts.

Implementation phase deliverables

i. An LQAS (Lot Quality Assurance Sampling) survey of the health zones in the project should be undertaken at the beginning, middle and end of the project. This should be undertaken using the expertise and funds within the Operational Research and Evaluation sub-contract.
ii. Quarterly narrative and financial report to DFID including updated progress work-sheet and activity report for the log-frame[6].
iii. Quarterly forecast of funds required for the next quarter.
iv. Submission of annual audited accounts of consortium lead (and implementing partners if identified as a need in a fiduciary risk assessment)
v. A transition strategy for the programme. This should be developed by the end of year one and updated in the middle of year three. It should outline the plan of how/when each health zone will transition through the phases (from intensive rehabilitation to transition phase) and milestones to monitor progress. Capacity in health zones should be measured annually according to milestones set and a short summary table included in the last quarterly report each year comparing achievement against targets.

[6] The format for reports will be agreed in the design phase.

7. Performance management arrangements

If DFID decides to proceed to the Implementation Phase, a Contract Amendment will be issued to include details of the services to be provided in the form of updated Terms of Reference and detailed costs with provision for expanded reviews to be undertaken at the end of Year 3. This review will recommend whether activities should be scaled up or down or refocused or the contract terminated in the event that the SP has failed to perform satisfactorily.

Failure to perform would typically be defined as two consecutive Annual Review scores of C "outputs significantly not meeting objectives"[7].

Key Performance Indicators

10% of the management/technical assistance budget line allocation will be contingent on satisfactory attainment of a set of key performance indicators. These will be assessed during the Annual Review process using data from routine quarterly reports of the CL to DFID.

The targets are;

1. Vaccinate 83,760 one year olds against measles each year.
2. 200,000 CYPs (couple years protection) cumulatively by 2014/15 (pro-rata milestones for each year to be confirmed in design phase)–at least 10% of these to be in 19 year olds and under.
3. Ensure that 96,000 births per year are attended by skilled health personnel.
4. Provide 96,000 pregnant women with Intermittent Presumptive Treatment (IPT) for malaria during ante-natal visits per year
5. Provide 780,000 people with access to clean water and sanitation by the end of the project (pro-rata milestone for each year – to be confirmed in design phase)

Independent evaluation

Since the operational research and evaluation work will be contracted as a sub-contract to the consortium lead, this will mean that it will be unable to provide a completely independent evaluation of the project overall. DFID may therefore contract one or more independent evaluations during the project to review whether the project has delivered the key outcomes as outlined in the log-frame. This evaluation would be outcome level rather than an impact evaluation and DFID using its own funds.

8. Constraints and dependencies

Security:

Parts of DRC are relatively insecure and the consortium lead and sub-partners need to consider how to ensure the security of their workforce.

Interface and recipient:

[7] Defined according to the guidelines DFID How to Note November 2011 Reviewing and Scoring Projects.

The CL should seek to maintain good working relationships and keep updated all stakeholders concerned including the MSP centrally, at provincial, district/DPS health management teams and relevant local authorities.

The CL (and sub-contracted partners where appropriate) should sign Memoranda of Understanding with their MSP counterparts at zonal, provincial and central level.

The CL should ensure that the project builds synergies with other DFID project including in particular;

- The RCI institutional strengthening project in the central Ministry of Health
- The Tuungane community reconstruction project or any follow on project where there is geographical overlap (as this programme builds clinics).
- The proposed Education programme where there is geographical overlap (to be confirmed).

9. Reporting

Quarterly presentations to the Oversight Committee.

The programme will be overseen by the ASSP Oversight Committee which will include representation from the central level Ministry of Health, relevant provincial Ministries of Health, DFID DRC, relevant development partners, and beneficiary associations. The CL will be responsible for the secretariat function as outlined in detail above and will present an update at each meeting.

Narrative reports

The consortium lead on the contract will produce quarterly narrative reports. Reporting should include progress updates on the three technical sub-projects including any findings e.g. community monitoring of the programme through community scorecards.

The format for quarterly reports and reporting timetable should be suggested by the consortium lead during the design phase and agreed by DFID. In general, DFID would like to avoid reports with a lot of narrative. The CL should focus on;

- Ensuring that the progress work-sheet and activity work-sheet on the log-frame excel file are updated accurately.
- Focusing on exception reporting i.e. highlighting where the project is off-track, reasons for this and an action plan of how things will be rectified.
- Identifying clearly problems where either external intervention from DFID /MSP/Oversight Committee input or support are required e.g. policy bottle-necks.

Financial reports

The reporting will include full details of expenditure against agreed budget lines. There should be a clear link between expenditure and results achieved. To facilitate accurate forecasting and tracking of the work, forward looking quarterly plans would be reconciled with quarterly financial reports. The lead agency would be responsible for checking and compiling the plans and reports for its own work and that of NGOs/partners involved in programme delivery. DFID would be able to access full data on request.

It is envisaged that substantial sums would be spent on equipment and fixed assets such as building renovation or improvement. Quarterly reports should include a section on assets and their management and condition.

See also the later section on responsibilities of the Consortium Lead on managing fiduciary risk.

Audited accounts

Annual audited accounts for the DFID contribution would be required from the Consortium Lead.
Annual audit reports will be required and analysed by DFID'sHSS Deputy Programme Manager or DFID may engage external support for this at DFID's expense.

If the audit of the consortium lead is carried out by a local audit company, it should be done in partnership with an international audit firm (though not necessarily one of the large four) to ensure that the audit is independent and done to international standards. The audit should include an audit of the accounts plus process (i.e. in respect of procedures) through the analysis of a sample of expenditure and reconciliation with bank statements. DFID will require both the audited accounts and a copy of the audit conclusions and recommendations. The Consortium Lead should outline progress made against audit recommendations in quarterly financial reports. This will be reviewed as part of the Annual Review process.

Facilitation of field visits

Regular monitoring and reporting of the programme is anticipated through field visits by DFID staff at least twice a year. These routine field visits by DFID staff will focus in particular on value for money (comparing prices for key items), and fiduciary management (including progress made on recommendations to reduce fiduciary risk of sub-contracting). One of the monitoring visits would form part of the mandatory Annual Review. DFID will use the annual review process to monitor both programme delivery and financial management. This will include a full interrogation of full financial statements of partners at each annual review.

The CL should suggest a timetable for field visits involving DFID annually each year – ideally these should be planned in conjunction with DFID's timetable for annual and mid-term reviews.

Verification of asset registers

It is envisaged that substantial sums would be spent on equipment and fixed assets such as building renovation or improvement. Quarterly reports would include a section on assets and their management and condition. A physical check would be carried out during field visits. Assets from the programme should be signed over to the health zones or a follow on project implementing agency at the end of the programme as appropriate.

Quarterly forecasting of funds from DFID

DFID has approval from HM Treasury to pre-finance the project if required. The CL should submit quarterly pre-financing forecasts to the DFID programme officer according to a pre-agreed schedule (see section below).

In the event that the Consortium Lead submits three consecutive forecasts which are more than 40% over-estimated, DFID will suspend the pre-financing facility and the CL will be required to submits claims one quarter in arrears and find another source of pre-financing.

Timing of reports:

Report	Timing
Design phase deliverables	2 months after the start of the design phase
Quarterly financial and narrative reports from CL	Every 3 months after start of implementation contract.
Quarterly pre-finance requests	At least one month in advance.
Steering committee presentation	Quarterly
Annual review supplementary reporting	Every 12 months – ideally July to enable review implementation of previous financial year.
Annual audited accounts and reports	Every 12 months
Final report	Within 3 months of end of project

All reports should be provided in English (with the exception of the community monitoring reports which may be in French) and in electronic format compatible with MS Word or Excel.

They should be submitted through the HSS team health Programme Officer, Ccing the Health Adviser and Deputy Programme Manager, in accordance with the timetable outlined above.

A summary reports/financial report should be also presented to the Oversight Committee quarterly.

DFID may share reports with other stakeholders e.g. the MSP and other donors.

10. Additional information that the suppliers should refer to

Suppliers submitting a pre-qualification questionnaire should refer to

- Annex 1 of these terms of reference – this outlines the minimum specifications for the three technical subcontracts and the implementing partners.

Suppliers reaching the invitation to tender stage should refer closely to additional documentation that will be made available at that stage;

- A background information note for suppliers invited to tender.

11. Climate and environment guidance

Issues that the consortium lead will need to consider and plan to manage in the design phase will include (i) disposal of clinical waste/sharps/expired drugs, (ii) impact of rehabilitated and new infrastructure and choices in design, and (iii) implications of access to water. Building materials will need to be locally sourced wherever possible, consistent with avoiding land and forest degradation. Water supply will need to be considered for all new

and rehabilitated clinics and hospitals. Wherever possible, collection and treatment of rainwater should be considered.

The CL should ensure that clinics and hospitals are climate resilient and have a minimal impact on the climate and the local environment, and that power sources have low lifetime costs and can be locally maintained, will safeguard the physical sustainability of health services. DFID DRC's Climate and Environment Adviser will provide ongoing support and advice to ensure that the consortium lead and other partners are minimising climate and environment risks and maximising opportunities.

Implementing partners' management systems will need to include mechanisms to ensure that their operations are low carbon and that climate and environment issues around construction are taken into account. Implementing partners will need to have access to appropriate environmental expertise for judgements on, for example, procurement of building materials and design of buildings to be climate resilient (to extreme weather, for example) and to have minimal impact on the climate and the local environment. Strategies for capacity building in government agencies will also need to include planning for environment and climate risks and opportunities.

12. Gender guidance

The detailed programme design should ensure that the priorities of women and girls are prominent in all key programmes by systematically taking account of gender inequalities and of the different roles that men and women play. The programme should be designed in a way that helps address the disadvantages faced by women and girls, by empowering them and ensuring that results are disaggregated by gender wherever possible. The programme should be designed to focus on;

- Building a positive enabling environment for girls and women. This requires the cultural constraints and barriers for girls and women in accessing health services to be addressed. The design should be informed by DFID's strategic vision for girls and women to examine opportunities in the health programme to strengthen the four pillars: delay first pregnancy and support safe childbirth; get economic assets directly to girls and women; get girls through secondary school; prevent violence against girls and women. An important priority will be to ensure that behaviour change communication works to address social/cultural barriers which act as a barrier to accessing healthcare.
- Addressing the different needs of girls and women. DRC statistics show high pregnancy rates for adolescent girls. The family planning sub-project will need to focus on ensuring that they are able to access contraception and ante-natal/obstetric care. The cultural constraints and barriers for unmarried women need to be explored. There may be an opportunity link to DFID'sGirlhub work on providing an enabling environment for adolescent girls.
- Violence against girls & women. An analysis of the situation in the health zones selected will be helpful in building a nuanced picture of the problem, causes, and what can be done through health service provision. The CL should explore opportunities to address prevention and link with other sectors/programmes, as well as just providing care and post-exposure prophylaxis against HIV.

13. Consortium Lead responsibilities in the management of fiduciary risk

DFID has a zero tolerance on corruption and the consortium lead will need to invest time and resources in ensuring that fiduciary risk is well managed within this large programme.

Consortium Lead responsibilities include but are not limited to;

13.1 Actively participate and cooperate in a fiduciary risk assessment (FRA) of the ASSP project which DFID will commission in late 2012/early 2013 using either an external consultant or expertise within DFID. (This will assess both DFID DRC's capacity to manage fiduciary risk and also the fiduciary risks of the consortium lead and their sub-contracts).

The assessment will consider risks at each stage, provide risk ratings for the CL and sub-contracted partners (to categorise them into three risk categories i.e. high, medium, low risk) and provide a set of recommendations in the form of an action plan. The action plan will outline what changes need to be made both within DFID DRC, the consortium lead and the sub-contracting partners. The FRA action plan will include annual milestones on improving systems – progress on these will be reviewed by DFID at each annual review. The CL should ensure that funds are allocated within the project budget to cover any financial implications of the FRA recommendations (and also to meet routine audit requirements of DFID).

As part of this process DFID DRC will define an appropriate strategy for what to do should misappropriation of funds happen and share this with the consortium lead. Where fraud is detected DFID will demand repayment of the amount involved in the fraud and carry out an investigation which will come up with a set of recommendations. Continued disbursement of funds will be contingent upon adequate financial oversight mechanisms.

13.2 The Consortium Lead should follow international best practice standards for the selection of implementing sub-contract partners. DFID will take an active role in overseeing this selection process. Within the selection process the CL will be required to undertake an analysis of fiduciary risk and financial management capacity and systems of sub-contracted partners (categorising them into low, medium and high risk). The CL should make recommendations to sub-contracted partners on how their systems should be strengthened to meet requirements and ensure that monitoring and oversight is tailored to check that these recommendations are met during implementation.

DFID DRC is seeking to contract an agency to support suppliers strengthen their financial and procurement systems so some additional support may be available for the CL in this area.

13.3 The CL should use community monitoring of projects for example using community scorecards, where beneficiaries are able to rate and report on the goods and services they receive. This will function as an additional check that resources are reaching the poorest. One option under the empowerment and accountability sub-contract is to explore setting up a "transparency/anti-corruption hotline" that beneficiaries could call to blow the whistle on alleged misappropriation of funds.

Annex 1 – see separate attachment

Annex 1 contains minimum specifications for sub-contracts to the Consortium Lead (the three technical sub-contracts and also for implementing sub-contracts) and is available as a separate attachment.

Abbreviations

ACT	Artemesinin Combination Therapy for malaria
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASSP	Accès aux Soins de Santé Primaires (Access to Primary Health Care)
BAR	Bilateral Aid Review
CL	Consortium Lead
CMAM	Community Based Management of Acute Malnutrition
CSO	Civil Society Organisation
CYP	Couple Years Protection
DALY	Disability Adjusted Life Year
DHS	Demographic and Health Survey
DPS	Direction Provinciale de la Santé (Provincial Health Office)
DRC	Democratic Republic of Congo
DTP3	Diphtheria, Tetanus and Pertussis - third vaccination
ECZS	Equipe Cadre de la Zones de Santé (Zonal Health Office)
EmONC	Emergency Obstetric and Neonatal Care
FBN	Faith Based Network
FBO	Faith Based Organisation
FRA	Fiduciary Risk Assessment
GBP	Great British Pound
GIBS	Groupe Inter-Bailleur Santé (health donor group)
GoDRC	Government of DRC
HDI	Human Development Index
HMIS	Health Management Information System
ICCM	Integrated Community Case Management
IMAM	Integrated Management of Acute Nutrition
IP	Implementing Partner
IPTP	Intermittent Presumptive Treatment of Malaria
ITN	Insecticide Treated bed Net
IYCF	Improvement of infant and young child feeding
LLINS	Long Lasting Insecticide Treated bed Nets
LQAS	Lot Quality Assurance Sampling survey
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
M&E	Monitoring and evaluation
MSP	Ministry of Health
MOU	Memorandum Understanding
MSP	Ministère de la Santé (Ministry of Health)
NGO	Non-Governmental Organisation
OJEU	Official Journal European Union
ORIE	Operational Research and Impact Evaluation
PCA	Paquet Complémentaire d'Activités (complementary package for hospital care)
PCIMA.	Prise en Charge Intégrée Communautaire de la Malnutrition Aiguë (IMAM)
PHC	Primary Health Care
PMA	Paquet Minimum d'Appui (minimum package for primary care)
PMTCT	Prevention of Mother to Child Transmission of HIV
PNDS	Plan National de Développement Sanitaire (National HealthSector Plan)
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SGBV	Sexual and Gender Based Violence
SNIS	Health Management Information System

SRP	Structural Reform Plan
SSA	Sub Saharan Africa
STAREC	Stabilisation and Reconstruction in Eastern Congo
TA	Technical Assistance
VCL	Value for Money
WHO	World Health Organisation
ZDS	Zone de Santé (Health Zone)

[i] **Zones receiving existing support from DFID;**

MANIEMA

- Kindu
- Kailo
- Alunguli
- Kalima
- Kampene
- Pangi
- Pubia
- Ferekeni
- Lubuto
- Obokote

PROVINCE ORIENTALE

- Banalia
- Bengamisa
- Ubundu

SOUTH KIVU

- Kalehe
- Kabare
- Itombwe
- Minembwe

KASAI OCCIDENTALE

- Demba
- Mutoto
- Lukonga