PO6803 Contract Section 3

Terms of Reference

(as tendered)

Scaling up Growth: Addressing Stunting in Tanzania Early (in the under 5's) (ASTUTE)

A programme to reduce stunting in Tanzania through transforming, and sustaining, behaviours, capacity and investment around: maternal, infant and young child feeding, nutrition, early child development, hygiene and sanitation.

Introduction

1. Child stunting is associated with about 45% of all under-5 mortality[1] and (because it parallels poor brain development) leads to long-term cognitive deficits, fewer years and poorer performance in school, lower adult economic productivity, and a higher risk of growth retardation in future generations. The scale of the problem in Tanzania is significant, as it has the third highest rate of stunting in Africa with **42% of a total population of 6.6 million under-five children permanently stunted by age 5 (over 2.7 million children)[2].**

2. The last decade has been one of significant growth and change in Tanzania. Tanzania has experienced sustained macro-economic growth at around 7% for the past decade. Some health indicators have also improved and child mortality rates have declined by almost half. Between 2000 and 2010 infant mortality declined from 96 to 51 (per 1000 live births) while all under 5 mortality decreased from 143 to 81 per 1000 live births[3]. Despite this, stunting has persisted or even increased. While the causes of stunting are currently the subject of intense research, there is some evidence that can already be of help in identifying the underlying drivers of stubbornly persistent stunting in Tanzania. Income poverty has not shifted as much as national economic growth rates, for example, and 17% of the population lives below the food poverty line. Access to water and sanitation, maternal mortality rates and other outcomes dependent on good quality, consistently functional services remain challenging.

3. Stunting is high in Tanzania because of a combination of poor dietary diversity and low meal frequency (feeding practices), inadequate maternal nutrition, insufficient birth spacing, relatively low rates of exclusive breast feeding, poor sanitation and hygiene and, insufficient crop management and agriculture. These practices are shaped by culture, knowledge and practices and are underpinned by a lack of equality between men and women within the household.

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[1] Shrimpton R, Victora CG, De Onis M, Lima RC, Blossner M, Clugston G. Worldwide timing of growth faltering: implications for nutritional interventions. Pediatrics 2001; 107(5):1-7.

[2] Census 2012

[3] Tanzania Demographic and Health Survey 2010 (data compared with 1996-2000 data)

4. Tanzania has a national nutrition strategy and has a cadre of district-based nutrition officers who report upwards to a national nutrition function in the Prime Minister's office, and a nutrition budget line at district level. About 75% of 168 districts have a nutrition officer in place, however they are currently ineffective as they lack (mainly financial) support to convene multi-sectoral colleagues, build plans and implement key programmes. The President of Tanzania has also launched an initiative to support nutrition results in the context of the UN's Scaling-up Nutrition initiative (SUN) and following his participation in the 2013 Nutrition for Growth meeting held in London.

5. Within the context of this growing political commitment, the level of capacity to coordinate and deliver nutrition services on the ground has been catching up, but still lags. Services are mainly delivered through health programmes and in other nutrition-sensitive sectors such as agriculture, education, or community development. Ensuring that the district councils are increasingly able to plan and deliver critical interventions to the majority of households is vital therefore to sustainability and impact.

6. There are an increasing number of development partners becoming active in nutrition. However, despite these investments, not enough is being done at scale, especially to improve nutrition-related behaviours and strengthening the district level to ensure effective multi-sectoral collaboration to operationalise the National Nutrition Strategy. Efforts are required to collaborate amongst Government and development partners to share lessons and scale-up good practices with an evidence base.

7. In 2013, the UK Government co-hosted a high-level summit in London of developing and developed nations, businesses, scientific and civil society groups, committing them to support a reduction in "under-nutrition". Participants who signed the Global Nutrition for Growth Compact (including Tanzania) committed to improve the nutrition of 500 million pregnant women and young children, reduce the number of children under 5 who are stunted by an additional 20 million and save the lives of at least 1.7million children by preventing stunting, increasing breastfeeding and better treatment of severe and acute malnutrition.

8. As part of its commitments the UK Government is procuring a new programme to address stunting in selected regions in Tanzania. This programme consists of two lots – one for implementation in Mbeya and Njombe regions by UNICEF with a second lot to cover another five regions which together, contribute to the achievement of the results set out below. This Terms of Reference outlines the scope of work, requirements and reporting procedures for the second lot of the programme. For the second lot, DFID is expected to disburse between £18 and £23 million over the next five years.

9. In collaboration with the Government of Tanzania, DFID have identified regions with the greatest need in terms of high percentage and absolute numbers of stunted children and low coverage by development partners. Based on TDHS 2010 data, these regions include Kigoma, Rukwa, Lindi, Shinyanga, Simiyu, Tanga, Kagera and Ruvuma. However, preliminary findings from the National Nutrition survey 2014 show that there have been improvements in Shinyanga, Simiyu, Tanga and Lindi and that Geita and Mwanza have high numbers of children stunted. Five regions which have a

high burden of stunting should be selected by the contractor and agreed with the Government of Tanzania. DFID is seeking to leverage results off its other investments in water, sanitation and hygiene (WASH), Education, Family Planning and Agriculture. Implementation will be in close collaboration with the Government of Tanzania authorities at the district, regional and national levels. The programme will be implemented at scale to ensure at least 80% coverage of interventions amongst the target beneficiaries within the selected regions (i.e. across all districts in these regions).

Objective

10. To appoint a contractor to implement a large scale programme to address stunting in five regions in Tanzania. This will be via an evidence-based approach in ensuring different sectors (health, water and agriculture), communities, households and individuals are able to implement effective nutrition-relevant interventions and behaviours. District authorities will be supported to take the lead and build capacity for planning, programming, budgeting and financial management to sustainably address stunting.

Expected Results

The contractor will submit bids to achieve the expected results. Specifically, as per the log frame attached, the programme will:

11. At impact level: reduce the prevalence of stunting in Tanzanian children aged five years by at least seven percentage points in seven target regions (Mbeya and Njombe covered by UNICEF[4]), through focusing on strengthening systems and multi-sectoral collaboration at the district and regional levels and social and behaviour change at regional, district, community and household level at a regional scale (all districts in the selected regions will be covered). Through reaching over 3 million mothers and children, **over 50,000 children under five years will not be stunted and will have enhanced overall development.** There will also be a three percentage point reduction in low birth weight in the target regions. It is anticipated that the impact in both arms of the project will be similar and this component will reach over 2.2 million mothers and children.

12. By the end of the programme, it is expected that there will be improved nutrition-relevant practices for mothers, infants and young children (including feeding, care, early stimulation, hygiene and sanitation practices) in the target regions as evidenced by:

    i. 4% increase in exclusive breastfeeding at three and six months
    ii. 5% increase in children age 6 to 23 months consuming the minimum acceptable diet
    iii. Improved hand washing practices at critical points
    iv. 25% increase in positive early care and stimulation practices in the home.
    v. Enhanced capacity to deliver nutrition services through strengthened regional and district systems.

[444] UNICEF are currently being funded by Irish Aid to implement a programme to address stunting in 6 districts of Mbeya, Iringa and Njombe Regions. DFID will fund UNICEF to scale up programming in Njombe and Mbeya regions with a focus on strengthening of an evidence-based multi-sectoral response to nutrition at the district, regional and national level and enhancing nutrition-related behaviours at the household level.

These rates will be for the region as a whole, therefore if all communities are not covered, impact in those that are will be expected to be proportionately higher.

13. At the output level, the Government of Tanzania and DFID requires evidence of:

(i) Improved operational multi-sectoral response for nutrition at national and sub-national (regional and district) levels (Agriculture, WASH, Education, Community Development, Livelihoods) to establish a cycle of planning, budgeting, delivery, monitoring and reporting.
(ii) Enhanced capacity to support optimal care practices for maternal and IYCF, WASH and early childhood development in the target regions.
(iii) Increased knowledge of pregnant women, caregivers of children under-two years of age, household and community decision makers on IYCF, ECD, WASH and health practices in target regions
(iv) Continuous quality improvement and policy engagement

The Recipient:

14. The main beneficiaries are poor, rural women and children, particularly pregnant and lactating women, mothers and children *in-utero* to 2 years (focus on the first 1000 days).

Scope of work:

15. The contractor will manage overall delivery of the programme. The following principles should guide and inform all activities:

- Collaboration, transparency, openness and accountability for quality, monitoring and results (to Government, DFID and other stakeholders[5]).
- Research, analysis, evidence and expertise.
- 'Do no harm' through preventing unintended negative consequences from the programme, such as destabilising Government systems for sustainability and communities misinterpreting information resulting in unintended beliefs of practices.
- Value for money**,** sustainability and local ownership
- Leveraging from other sectors to ensure sustainable results.

16. The contractor will be responsible for identifying, sub-contracting and managing the necessary consortium of delivery partners. There should be a focus on best quality technical and local expertise, with understanding of the operating environment and socio-cultural context, ability to work with Government and implement at scale.

17. With a regional focus, the contractor is responsible for:

a. Supporting the regional and district nutrition coordinators through enhancing their capacity and transferring and monitoring use of funds (at least £3.5 million, which needs to be factored in to the total budget and is included in

[5] These stakeholders include communities, Tanzania Food and Nutrition Centre, UNICEF, as well as the High-Level Steering Committee for Nutrition and the Development Partners Group for Nutrition.

the award amount available stated above), to ensure that relevant activities can be implemented to strengthen district nutrition services, leverage better performance in key areas and ensure learning between districts within regions. Bids should be explicit regarding the costs of managing this component. Further details are in paragraph 18 below.

b. The design and delivery of an evidence-based Behaviour and Social Change Strategy (BSCS) across the regions.

c. Quality improvement and policy engagement.

18. Whilst over 75% of 168 districts have a nutrition officer in place, they are currently ineffective as they lack (mainly financial) support to convene multi-sectoral colleagues, build plans and implement key programmes. This is partly due to delays in the public financial management (PFM) system. In order to accelerate progress on nutrition, and whilst PFM is strengthened by other programmes in parallel, DFID has allocated funds (at least £3.5 million in total) to finance the districts directly using the existing Government financial and reporting systems. The contractor will release and monitor use of funds to the districts with regional structure supervision, coordination and oversight. These funds will be on budget and accounted for through district systems, and reported to the Ministry of Finance. The contractor will be expected to account for these funds (which are not expected to be pre-financed by the contractor – DFID will provide the forecast funds for these upfront) and ensure that they are effectively utilised by the districts for relevant activities. *This amount and the costs for managing this process should be factored into the budget submitted to DFID, which should be within the resource envelope indicated.*

19. The contractor will ensure that the BSCS materials used at regional and district levels are consistent, culturally appropriate, and technically sound and use existing materials to the extent possible; develop additional materials as needed; and, ensure a review of materials is conducted periodically;

20. The contractor will ensure a robust and well-developed monitoring and evaluation strategy is delivered that includes: a sound balance between supporting routine data collection and conducting surveys; ensures the programme contributes to evidence around effective programming to scale up stunting interventions; ensures compliance with DFID reporting; and, supports operational research where necessary. The contractor will include Government and all project partners in regular lesson learning and evidence building exercises so that experience is shared, “peer reviewed” and whenever possible, given wider exposure;

21. The contractor will be responsible for strong fiscal management and reporting.

22. The contractor will ensure excellent collaboration with DFID, Government at all levels including TFNC and other stakeholders, and participate in the Development Partners Group for Nutrition meetings, to ensure lesson learning and coordination, including with UNICEF; and,

23. Subject to negotiation with DFID, co–ordinate and manage other nutrition relevant events and activities that emerge as priorities over the life of the programme, which will support addressing stunting reduction in Tanzania. Such activities may be related to research, seminars, early child development, and food fortification regulation, amongst others.

The Requirements

24. **Performance Requirements**

[Please be aware this ToR references Logframe Outputs which should not be construed as Outputs within an Output based contract. We are expecting to see a Hybrid offer with a combination of Performance Based Milestones and expenses on a reimbursable basis]

At the output level, the contractor is expected to contribute to the achievement of the following:

24.1 Output 1: ***Improved operational multi-sectoral response to nutrition at national and sub-national levels (Health, Agriculture, WASH, ECD)***

Key deliverables:

- District nutrition officers report multi-sectoral response quarterly at regional level regarding their activities, targets and results including reports on their own budgets and expenditure in all regions (with 75% of districts within these regions starting their third budget cycle).
- Over 5000 district nutritionists, health facility workers, community health workers and non-health sector service providers trained using new/revised curricula incorporating nutrition and ECD
- All regions with a peer review process in place for districts to develop plans and budgets, discuss and approve these amongst districts and review progress
- New evidence on the barriers and facilitators of infant and young child feeding (IYCF) generated through operations research is incorporated into national nutrition policy, strategy, guidelines, standards and programmes
- Strategic linkages developed with other relevant DFID programmes in related sectors, where feasible and appropriate

24.2 Output 2: Enhanced capacity to support optimal care practices for maternal and infant and young child nutrition, WASH and early child development in the target regions

Key deliverables

- Proportion of trained health workers who report offering counselling on nutrition-relevant practices to pregnant women and mothers of children aged less than two years in the last three months increased by 70% compared to baseline.
- Number of community-based organisations who are trained engaged in nutrition-relevant activities focused on pregnant women and mothers of children aged less than 2 years in the last three months is greater than at baseline and 70% of those targeted are still active at the end of the programme.

24.3 Output 3: Increased knowledge of pregnant women and caregivers of children under two years of age, household and community decision makers on IYCN, ECD, WASH and health practices in target regions

Key deliverables

- 2.2 million women of reproductive age, pregnant women, mothers/caregivers of children under two years and decision makers reached through evidence-based social behaviour change strategy.
- BSCS reaching at least 80% of the population in the target regions (this does not necessarily mean through a mass campaign, but through any justified, evidence-based innovative approach that will bring about change in feeding practices).

24.4 Programme Quality

Key deliverables

- Continuous quality improvement and programme learning, including building on the effectiveness of behaviour change approaches. This could include small randomised controlled trials (RCTs) as part of the research component.
- Leveraging off multi-sectoral investments (such as water, sanitation and hygiene, education and agriculture) to ensure that they are nutrition-sensitive.
- Refer to monitoring, evaluation and research section for requirements

25. **Methodology** is to be proposed by the bidders in their technical bids agreed by DFID prior to contract award for the following components of the programme to achieve the expected results:

Institutional & Structural Support Strategy will include:

26. Tailored analysis and insight for each region, as well as national level work to promote a multi-sectoral long-term response to stunting. This long-term strand will include building capacity for district authorities to take the lead on planning, programming, budgeting and financial management in the future.

27. Support to the regional nutrition and health officers to coordinate district counterparts and build planning, budgeting and implementation capacity across their regions through the establishment of a peer review and support mechanism;

28. Support to district authorities to develop, approve and implement budgeted plans for stunting reduction that are multi-sectoral and work across key disciplines like water and sanitation, nutrition, early childhood development, health and agriculture;

29. Strengthening of health specific inputs within the health sector including district health service delivery of nutrition-specific interventions including iron-folate and Vitamin A supplementation, breastfeeding and complementary feeding counselling and other nutrition-related services.

30. Transfer, monitoring and oversight of direct funding to districts (at least £3.5 million over the five years[6]) to strengthen their nutrition response according to plans.

Behaviour & Social Change Strategy (BSCS)

[6] This should be included in the total budget which should be explicit regarding the related management costs within the total award amount.

31. The BSCS will be designed to change key behaviours to reduce stunting, and to sustain and normalize nutrition-relevant behaviours at individual, household, community, district and regional levels beyond the life-time of this programme.

32. The strategies employed should be based on formative research and robust technical analysis of behaviour. This will include identifying: key target groups; key target behaviours; key drivers, influences and barriers to change; and methods to sustain change.

33. The programme will employ innovative, multi-pronged, coordinated strategies. The partner should consider, and present, the sequencing of behaviour change through to normalizing behaviour in communities and households.

34. We do not prescribe a specific behaviour change approach; instead the BSCS should use evidence and expertise on the social and behavioural context, and drivers for change, to propose a sophisticated and tailored approach or mix of approaches, working back from behavioural outcomes.

35. However, the approach should be focused on addressing the mother and child. -It should be sensitive to gender issues. If there are any specific, significant disability issues identified, these too should be covered. Other groups will include: individuals, the family and community; teachers and health workers; influential leaders, champions, peers and religious leaders**;** and national, local, regional, district and village authorities. The approach should also include strategies to change the behaviours of district officials in addressing stunting. The BSCS will include building the capacity and capability of health practitioners to support change.

36. The BSCS should make explicit provision for cross-overs with the National Sanitation Campaign; and should explicitly position stunting within an integrated package of Early Childhood Development which includes WASH, nutrition and family planning.

37. Where there are other DFID relevant programmes (eg. in agriculture, education or family planning) in the same region, strategic linkages should be developed where feasible and appropriate.

38. The BSCS should be designed to 'do no harm'. Communities can misinterpret information resulting in unintended beliefs and practices. The BSCS should illustrate analysis to avoid harm and stigmatism.

Monitoring, research and evaluation

39. The contractor will integrate a robust Monitoring and Evaluation (M&E) plan that builds upon the latest thinking to move beyond measuring 'reach', to measuring actual change, including the step between knowledge and behaviours within the household, community and districts.

40. The contractor will engage with the project partners and the broader nutrition community, including UNICEF (who are being funded through a separate agreement) and national, regional and district authorities to ensure that:

i. The monitoring framework and tools are aligned, feeding into the overall DFID project log frame indicators.
ii. Learning and knowledge transfer is enhanced between partners and across districts within regions, through lessons learning and evidence sharing.
iii. Ensure learning is transferred across all stakeholders from community to national level (Government and development partners).

41. In addition, the contractor will:

- share M&E tools and support development of appropriate methodologies to ensure quality programming and development of the evidence-base. Where possible, the MA will ensure that any external TA for the M&E needs of the project covers all regions/partners.

- provide feedback and support to project partners on emerging issues arising from monitoring, as well as facilitate cross-fertilisation of innovative approaches to scaling up and achieving the targets across regions.

- develop mechanisms to collect, analyse and feedback relevant data from the district councils (through the partners and regions).

- ensure that DFID is kept fully engaged in the learning agenda and will provide relevant data for any special studies (e.g. operational research) that are commissioned;

- consolidate project data within the common logical framework on a quarterly basis, whilst also providing disaggregated data to allow for further analysis and identification of emerging issues with project performance.

- lead the operational research component of the project and ensure all project partners are available with the relevant data. Where requested, the contractor will provide consolidated data and analysis to respond to specific questions.

- ensure that there is robust analysis of DHS and other national nutritional surveys for the revelant regions

- report to DFID and Government on a quarterly basis, aligned to the PMO-RALG's quarterly reporting cycle for districts to ensure that timely, accurate data is available to provide the evidence base for management decisions.

- engage with DFID in informal dialogue as needed based on emerging issues.

- Submit formal quarterly progress reports to include:

  a. A consolidated narrative report;
  b. Analysis of progress against logical framework outputs and key performance indicators; and,
  c. An expenditure report, work plan and budget for the next six months.

  These reports will feed into the meetings of the Project Steering Committee.

There will be break-points at the end of the Inception Period where progress to implementation will be subject to DFID's agreement based on the revised implementation proposal and at each annual review, when DFID may withdraw support if it is not satisfied that the programme is likely to achieve its objectives.

The Contractor shall commit to being fully prepared in the event any decision is made to scale up (increase) or scale down (decrease) the scope of the Programme (i.e. in relation to the Programme's inputs, outputs, deliverables, outcomes and fund element) during the course of the contract.

Reporting

42. Final outputs will be assessed on the basis of the programme log frame outputs, programme activities and quality of reports. Specifically, the Contractors will be expected to produce:

i. Monitoring and Evaluation Plan which captures disaggregated data according to the log frame. This will either incorporate baseline data, or set a plan as to how this data will be collected and used. The TDHS 2015 will provide baseline data for the overall project and by region, followed by the TDHS 2020 for end-line data. The programme will encourage partners to undertake on- going monitoring through community-based monitoring approaches being developed in Tanzania, to avoid sampling bias of clinic attendees and overburdening the health system. Biannual national nutrition surveys (UNICEF) should also be utilized.
ii. Quarterly Progress and Annual Narrative Reports which includes executive summary, progress of implementation of planned activities by output, progress on results against the logframe and key performance indicators, constraints and lessons learned, information on programme quality and action plan for the next period. The reports will be shared with DFID, the Government (including PM Office, PMO-RALG and TFNC), the Project Steering Committee, relevant Technical Working Groups (TWG) and DPs. This will include Government regional level reports;
iii. Annual reviews: Annual reviews with full progress against the log frame, lessons learned and recommendations for adjustments going forward. The review will be discussed with stakeholders with a report submitted by DFID Tanzania to DFID Headquarters which will be publicly available.
iv. Financial Reports- Quarterly and Annual financial reports to be submitted to DFID. This will include expenditure against approved budget and forecasts by output. Quarterly and annual financial forecasts to ensure strong financial management; and a certified annual audit statement showing funds received and expended .
v. Annual budget identifying cost efficiencies. Demonstrate value for money across all activities;
vi. Asset Register - Develop and maintain an assets register and report against it annually;
vii. Risk Matrix - Develop a comprehensive risk matrix setting out clear strategy for monitoring, managing and mitigating against risks. Ensure contingency plans in place;
viii. Communications products to document and disseminate useful results and lessons learned as and when required

ix. Exit Strategy - Provide and deliver an exit strategy to ensure long term sustainability of approaches (where relevant) to be provided not less than 6 months before the end of the contract;
x. Project completion report: consolidating the entire programme including consolidated results, lessons learned and recommendations.

All reports should be of a length and level of detail appropriate to the purpose, and generally be as concise as possible. The writing and presentation of data must be written in plain English.

In addition the Contractor is expected to support external annual and project completion reviews to monitor impact, outcome and output indicators. These reviews will also examine the evidence of effectiveness, efficiency and equity.

Constraints and dependencies

43. Commodity procurement remains a challenge in Tanzania and it is understood that iron folate and vitamin A will be procured and distributed through other mechanisms, but could be covered through the district budgets if needed.

44. With regard to any commodity purchases, the Contractor is authorised to procure goods and equipment up to £111k, providing they are able to demonstrate procurement capability and good value for money. Any procurement by the Contractor must be carried out in accordance with DFID Procurement Group guidance and in liaison with the local Divisional Procurement Officer. The budget for goods and equipment must be calculated on an aggregated figure, the allowance for a budget of £111k does not mean that Contractor can spend the first £111k and then revert to the Procurement Agent. Any goods and equipment purchased must be reported to DFID and will be managed by separated invoices.

45. This programme aims to strengthen government systems and capacity to address stunting, particularly at the district level. The success of the project will depend upon the government's willingness to engage, particularly at district levels.

46. It is required that the contractor works closely with relevant stakeholders to ensure effective use of resources, leveraging, sharing of lessons and data. This includes Government, UNICEF other DFID projects and programmes in relevant sectors notably WASH, education and agriculture, NGO's and other programmes such as Mwanzo Bora.

Risks

47. The risk of financial fraud or the misuse of funds is judged to be medium overall in this programme, due to the high value of the contract, disbursement and management of direct funds to local government and the complexities of the project. Tanzania has moderately high levels of corruption. The contractor will be responsible for the funds in the programme and will take all necessary measures to ensure funds are tracked and managed to a high standard.

48. The contractor is expected to complete a risk matrix and implement mitigation measures. This will be reviewed, updated and discussed with DFID on a quarterly basis as part of the quarterly review process. Any risks or incidents requiring immediate attention will be communicated to DFID when necessary.

Bids are expected to articulate clear inception and implementation methodologies.

Inception phase:

49. During the 6 months inception, the contractor will develop the strategy including detailed plans, outputs and budgets for the implementing phase.

50. By the end of inception phase the establishment of the delivery teams should be complete, with all staff in place.

51. Agreements signed (where relevant) with other partners, and plans developed through engaging with the regional and district Governments, in line with the Government planning and budgeting cycle.

52. The contractor will support regional coordination of district nutrition officers through setting-up/re-establishing a peer coordination and monitoring group, which will continue through the life of the programme.

53. Agree coordination strategies and areas for collaboration with stakeholders including Government (national and local levels), UNICEF, Mwanzo Bora, highly relevant DFID projects operating in the same regions and DFID.

54. During the inception phase, the lead agency will develop a detailed Monitoring and Evaluation Framework with specific deliverables and milestones. The M&E Framework should go beyond measuring 'reach'. It should focus on tangible outcomes.

55. DFID and the Government of Tanzania will expect regular progress updates from the contractor. At the mid-point of the inception, the contractor will provide a concise mid-inception report ahead of a meeting with the DFID programme team to assess progress and direction. There will be break-points at the end of the Inception Period where progress to implementation will be subject to DFID's agreement based on the revised implementation proposal and at each annual review, when DFID may withdraw support if it is not satisfied that the programme is likely to achieve its objectives.

56. Key Performance Indicators (KPI's) will be set to ensure rapid mobilisation and adherence to the design and outcomes of the project. The KPI's to be identified by DFID will be based on consultation with Government of Tanzania. This will include performance milestones associated with the stability of the core team including retention of the team leader for the first two years. The exact wording of the sub-criterion for the first year will be agreed between DFID and the contractor by the end of the Inception phase. KPIs will ensure that management of the contract is

undertaken as transparently as possible and to ensure that there is clarity of roles and responsibilities between DFID and the agency. The contractor will need to demonstrate to DFID at specific review points, to be agreed with DFID prior to contract award, its performance against these KPI's. Together with final agreement of the relevant KPI's, the contractor and DFID will also agree an effective system to monitor their achievement over time and provide appropriate management information for both parties in respect of such. This system will include a process whereby any disputes concerning achievement of the KPI's or otherwise can be dealt with effectively.

57. Transition from inception to implementation will be subject to DFID approval of the Inception Phase report and detailed implementation proposal. The implementation proposal will include a suite of specific programme outputs, programme performance measures and payment milestones agreed between DFID and the lead agency.

Implementation phase

58. Based on learning from the inception phase, the contractor will scale-up implementation to meet the output targets and key performance indicators.

59. During the implementation phase, payments will be on the basis of milestones achieved. The tender submitted to DFID should include quarterly payment milestones. These can be refined during inception.

60. DFID will review the performance of the contractor throughout the life of the project and at least twice yearly one of which be part of DFID standard Annual Review of the programme. A suite of key performance indicators will be developed and agreed as part of the contract management process during the inception period.

61. The contractor will ensure robust and transparent assessment, supervision and reporting of work delivered.

62. The contractor will be responsible for support to Regions/ Districts to build plans and budgets to address stunting through multidisciplinary cooperation.

63. The contractor will develop a disbursement plan for district financial support and inform DFID Tanzania and Ministry of Finance on disbursement of funds

64. The contractor will ensure funds are monitored and support implementation, working with districts to account for funds

Programme Management

65. The contractor will need to combine project management skills with expertise in facilitating relations between multiple stakeholders. They will report to DFID Tanzania's Health Adviser.

66. The contractor will deliver effective financial management demonstrating: value for money; administrative costs savings; timely and accurate financial forecasting, invoicing and cost control; and effective contract management.

67. The contractor will deliver quarterly and annual reports in formats that will be agreed with DFID during the Inception Phase. Monitoring reports will be concise, evidence based and focused on results, together with specific measurable outputs and activities.

68. The contractor will engage with all programme stakeholders, including UNICEF (who are being funded through a separate agreement) and national, regional and district authorities to ensure that, the monitoring framework and tools are aligned, feeding into the overall DFID project logframe indicators, learning and knowledge transfer is enhanced between partners and across districts within regions, through lessons learning and evidence sharing, and ensure learning is transferred across all stakeholders from community to national level (Government and development partners).

Environmental considerations

69. The contractor is expected to include environmental considerations in the bid, and explain how any approaches have a negative or positive impact on the environment.

Timeframe

70. The indicative duration of the contract is expected to be five years from 2015 to 2020. The UNICEF component will run from October 2014 to Mar 2019. (Timings may be subject to change dependent on contract award date). The contractor is expected to submit a work plan as part of the bid.

Duty of Care

71. The risk assessment for this programme has been assessed as medium. The Contractor is responsible for the safety and well-being of their Personnel (as defined in Section 7 of the Contract) and Third Parties affected by their activities under this contract, including appropriate security arrangements.

72. DFID will share available information with the Contractor on security status and developments in-country where appropriate. For expatriate staff, DFID will provide the following:
    - Contractor Personnel will be offered a security briefing by the British High Commission/DFID on arrival. All such Personnel must register with their respective Embassies to ensure that they are included in emergency procedures.
    - A copy of the DFID visitor notes (and a further copy each time these are updated), which the Contractor may use to brief their Personnel on arrival.

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

74. Tenderers must develop their PQQ Response and Tender (if Invited to Tender) on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix prepared by DFID. They must confirm in their PQQ Response that:

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

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

76. Acceptance of responsibility must be supported with evidence of Duty of Care capability and DFID reserves the right to clarify any aspect of this evidence.

UKAid Communications and branding

77. The contractor and DFID will agree the appropriate level of communications and branding to acknowledge DFID's support. This will include contributions from the field for external communications such as text, photographs, video and audio interviews.

78. Further to our terms and conditions, any working papers, reports, including guidance and training material produced by the contractor or used by the contractor during the term of this contract, and the associated Intellectual Property Rights thereof, will become the property of DFID, on acceptance by DFID.

Background:

79. This programme contributes to DFID Tanzania's and UK global development priorities including the UK Nutrition Strategy and the commitments made at the 2013 *Nutrition for Growth – Beating Hunger through Business and Science,* summit. Participants who signed the Global Nutrition for Growth Compact (including Tanzania) committed to improve the nutrition of 500 million pregnant women and young children, reduce the number of children under 5 who are stunted by an additional 20 million and save the lives of at least 1.7million children by preventing stunting, increasing breastfeeding and better treatment of severe and acute malnutrition.

80. UK development objectives in Tanzania focus on poverty reduction, economic growth and wealth creation amongst the poorest households, the achievement of the Millennium Development Goals (especially water and sanitation, education, women's access to reproductive health and malaria control), and helping build accountable, responsive governance[7]. Hence this programme addresses an important impediment to economic growth and poverty reduction and one of the critical drivers of health and education.

[7] DFID-Tanzania Operational Plan 2011-2015, updated 2012. UK Government.

81. Child stunting is associated with about 45% of all under-5 mortality[8] and (because it parallels poor brain development) leads to long-term cognitive deficits, fewer years and poorer performance in school, lower adult economic productivity, and a higher risk of growth retardation in future generations. The scale of the problem in Tanzania is significant, as it has the third highest rate of stunting in Africa with 42% of a total population of 6.6 million under-five children permanently stunted by age 5 (over 2.7 million children)[9].

82. Stunting is high in Tanzania because of a combination of poor dietary diversity and low meal frequency (feeding practices), inadequate maternal nutrition, insufficient birth spacing, low rates of exclusive breast feeding, poor sanitation and hygiene and, insufficient crop management and agriculture. These practices are shaped by culture, knowledge and practices and are underpinned by a lack of equality between men and women within the household.

83. Without purposeful programmes to address stunting, economic growth alone is unlikely to have much impact considering that even 26% of the wealthiest children are stunted and there has been little decrease in stunting in the last ten years despite sustained economic growth. This programme will work with partners (Local and National Government, NGO's, CBO's) to that add to the evidence about what works best in practice at scale, to change the behaviours and social norms that contribute to stunting.

84. The goal of this programme is to reduce the prevalence of stunting in Tanzanian children aged under 5 years by 7% in 6 to 8 of the regions with greatest need. The programme will support interventions to build knowledge, change attitudes, strengthen practice and expand services in order to prevent low birth weight and stunting in newborns, to increase health and nutrition in the poorest households, and to increase height for age in young children. It will do this through:

(a) opening up a national debate about the care of young children (in the first 1,000 days from conception to two years), the causes of stunting and its consequences, make stunting something that is widely recognized: (i) as a problem, and (ii) one that can be addressed in the household;
(b) transforming attitudes, knowledge and practices related to women's empowerment and control over household budgets, maternal and young child feeding, nutrition, hygiene, sanitation and early childhood development/ care practices in the worst affected regions of the country;
(c) getting professionals who have the scope to make significant impact on stunting as part of their jobs (in particular health workers) to do these parts of their jobs better; and
(d) Strengthening the institutional, planning, budgeting and programme implementation capacity of local government authorities (LGAs) especially in the targeted regions.

85. This will be achieved through an evidence-based approach to social behaviour change communication which is delivered by supervised, retrained facility and community resource persons whilst ensuring a range of sectors (such as WASH) are

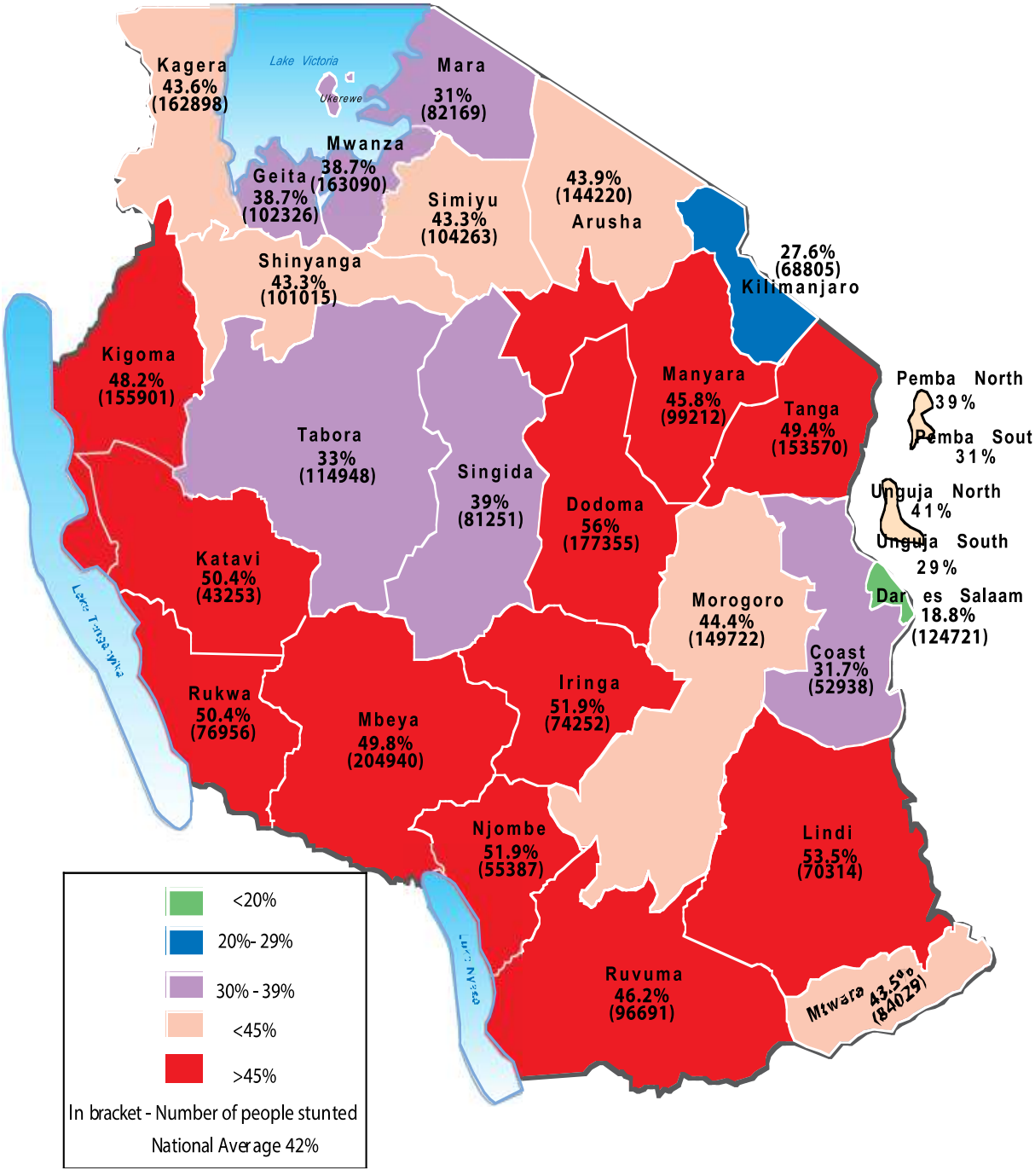
[8] Shrimpton R, Victora CG, De Onis M, Lima RC, Blossner M, Clugston G. Worldwide timing of growth faltering: implications for nutritional interventions. Pediatrics 2001; 107(5):1-7.
[9] Census 2012

optimally engaged and delivering on nutrition outcomes. District authorities will be supported to take the lead and build capacity for planning, programming, budgeting and financial management to sustainably address stunting.

86. UNICEF will expand their existing programme in two where they are currently working (Mbeya and Njombe) and another contractor will deliver an innovative programme in up to five regions.

Annex A: Map and distribution of stunting in Tanzania

Map1: Percentage (%) and Absolute Numbers of Stunted Children in Tanzania



Source: TDHS 2012 and Consensus 2012