Section 3

Terms of Reference

External Technical Agency ('Technical Supplier')

Tackling Deadly Diseases in Africa Programme (TDDAP)

Contents

List of Acronyms and Definitions

Africa CDC	Africa Centres for Disease Control
AFRO	Africa Regional Office
ALMA	African Leaders Malaria Alliance
ARD	Africa Regional Department (DfID)
CVC	Core Voluntary Contributions
DHSC	Department of Health and Social Care
DHIS2	District Health Information System - 2
ECOWAS	Economic Community of West African States
ERM Fund	Emergency Response Mechanism Fund
FAO	Food and Agriculture Organisation
FTE	Full time equivalent
GDS	Government Digital Service
GHSA	Global Health Security Agenda
HEROS	Humanitarian Emergency Response Operations and Stabilisation Programme
HMG	Her Majesty's Government
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
INFORM (tool)	Information for Risk Management
JEE	Joint External Evaluation
KPI	Key Performance Indicator
LSHTM	London School of Hygiene and Tropical Medicine
OIE	Organisation for Animal Health
PHEIC	Public Health Emergencies of International Concern
PHE	Public Health England
QA	Quality Assurance
RSIS	Real-time Strategic Information System
RPP	Regional Preparedness Programme
SRO	Senior Responsible Officer (DfID)

Definition of Small and Medium Enterprises/Micro organisations:

Company category	Employees	Turnover	OR	Balance sheet total
Medium Sized	< 250	≤ € 50 m		≤ € 43 m
Small	< 50	≤ € 10 m		≤ € 10 m
Micro	< 10	≤ € 2 m		≤ € 2 m

Introduction

This document comprises the Terms of Reference for the implementation of the competitively tendered element of a new disease prevention and management programme, *Tackling Deadly Diseases in Africa Programme* (TDDAP), by the UK Department for International Development (DFID). The programme will be delivered by WHO AFRO, the Technical Supplier and a Third-Party Monitoring Supplier. These Terms of Reference relate to the requirements for the Technical Supplier (hereinafter referred to as the 'Supplier').

The Ebola crisis, and subsequent Zika and Yellow Fever epidemics, showed clearly how better preparedness could enable disease outbreaks to be picked up earlier; saving lives, saving money and protecting countries around the world. TDDAP aims to save lives and reduce the impact of disease outbreaks and epidemics on African populations.

TDDAP will strengthen African health systems and institutions, through WHO and the Supplier through supporting:

i. Reform of the World Health Organisation Africa Regional Office to deliver better on health security (WHO AFRO);
ii. countries to enhance capabilities to achieve the International Health Regulations (IHRs) based on assessment and prioritisation;
iii. better governance and accountability of public health systems for disease preparedness and health security;
iv. improved data and evidence; and
v. a contingency mechanism should a pre-crisis situation arise.

TDDAP will be the UK's main instrument, alongside a £16m Public Health England (PHE) programme[1], to prevent and respond to future disease outbreaks. It will support the reform priorities of the global health community, and Her Majesty's Government (HMG), incentivising effective coordination between partners.

Through TDDAP, the UK will provide up to £95mm over 45 months to cover all elements of the programme [WHO AFRO, the Supplier, a Third-Party Monitoring supplier and a £55m contingency fund, of which £20m is set aside for a public health preparedness pre-crisis Emergency Response Mechanism Fund (ERM Fund)].

WHO AFRO's work will build on the predecessor 'Regional Disease Preparedness Programme' in over 20 countries. The six countries which will be covered by TDDAP by the supplier will be from the following: Uganda, Cote d'Ivoire, Cameroon, Niger, Chad and Mali, to demonstrate a regional and cross-border approach. The Strategic Partnership Portal[2] should be used at the time of bids to help to prioritise country choice.

TDDAP will have some flexibility as public health emergencies emerge through triggering the use of emergency response mechanism funds of up to £20m across sub-Saharan Africa.

[1] Details on the Public Health England IHR strengthening programme is available on the DFID portal for this procurement.

2. Objective

The objective of the supplier in the focus countries is to strengthen health systems and institutions to prevent outbreaks and epidemics of deadly communicable diseases. It will achieve this by delivering the following outputs:

i. African countries have improved adherence to IHR standards (the supplier will be held accountable for its focus countries; WHO for the others and also for regional progress).
ii. Better governance and accountability of public health systems. African governments and WHO AFRO accountable for IHR and quality of public health services at all levels (the supplier is accountable for some progress on this).
iii. Improved data and evidence - Accurate data and evidence for preparedness, speedy response and accurate, contextually appropriate decision-making (the supplier in focus countries and WHO in all others)
iv. Provision of an emergency response mechanism should a pre-crisis situation arise. Rapid Response capacity to reduce the magnitude of disease outbreaks (joint responsibility with WHO). The supplier is accountable for ensuring functioning of delivery of the emergency response mechanism with contracted suppliers in case of a pre-crisis preparedness requirement.

3. Recipient

The main recipients and beneficiaries are Governments of the six focus countries and the African populations at risk of the health and socio-economic pitfalls of disease outbreaks. These include those living in poverty, women, girls and people living with disabilities and other
marginalised groups.

4. Scope

The Supplier will deliver targeted support across programme component outputs 2, 3, 4 and 5 in six focal countries that have high vulnerability to disease outbreaks and lack the investment to meet the needs. The log-frame shows how data will be collected with partner accountabilities and responsibilities. Collectively, the Supplier and WHO will contribute to the expected impact.

The six countries which will be covered by the supplier will be from the following: Uganda, Cote d'Ivoire, Cameroon, Niger, Chad, and Mali, to demonstrate a regional and cross-border approach. The Strategic Partnership Portal[3] should be used to identify and prioritise country choice.

High risk high need (select two)	Moderate risk, high need	Easier to deliver, high potential
Niger	Cameroon	Cote d'Ivoire
CAR		Uganda
Chad		
Mauritania		
Mali		

[3] https://extranet.who.int/spp/donor-focus-countries

This Contract will contribute to DFID's objectives on health security in Africa and will deliver DFID's commitment to protect the lives of the poor. It will also complement other areas of UK support on Global Health Security including that of the Fleming (antimicrobial resistance) and Ross (malaria research) Funds and the work of Public Health England on IHR.

The supplier will support countries to build IHR capabilities based on the self-assessment and joint external evaluations, focusing on priority interventions identified by the countries/WHO. Progress on these assessments is openly available on the internet.

The supplier will manage overall delivery of the contract. The following principles will guide and inform all activities:

- Collaboration, transparency, openness and accountability for quality, monitoring and results (to Government, communities, WHO, DFID and other stakeholders).
- Use of analysis including political economy, evidence and local knowledge and expertise.
- Building on existing systems and platforms.
- '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 or practices.
- Value for money**,** sustainability and local ownership.
- Leveraging from other sectors to ensure sustainable results.

4.1 ***Coordination:*** The supplier will establish effective working relationships with all stakeholders at the regional, national and sub-national levels as follows:

- Collaborate and co-ordinate with the Governments, WHO AFRO and HQ, stakeholders and local government authorities at different levels on planning, delivery and monitoring of all aspects of the programme;
- Coordinate with other development and implementing partners supporting global health security to avoid duplication of effort and enhance programme effectiveness;
- Collaborate with a (separately contracted) Third Party Monitoring supplier and participate in joint monitoring, learning and evaluation exercises on agreed aspects of programme delivery: and,
- Facilitate visits by DFID staff, and others, and respond to ad hoc requests for detailed information.

The supplier will be responsible for identifying, sub-contracting and managing partners to ensure delivery of the requirements. There should be a focus on best quality technical and local expertise, with an understanding of the operating environment and political and socio-cultural context, as well as an ability to work with host governments and implement at scale.

4.2 ***Overall results*** under the combined efforts of the programme, as detailed in the log-frame, will be:

Impact
Reduced impact of communicable disease outbreaks and epidemics on African populations.

This not only includes results in terms of lives saved, and limiting transmission to other countries, but also covers economic impacts.

Outcome

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

Outputs
The supplier is expected to contribute to the achievement of outputs 2, 3 and 4 and manage the emergency response fund contributing to output 5. The supplier can deliver on these requirements using a variety of modalities which need to be evidence-based:

- **Output 2:** African countries have improved adherence to IHR standards (the supplier will be held accountable for its focus countries; WHO for the others and also for regional progress).

- **Output 3:** Better governance and accountability of public health systems. African governments and WHO AFRO accountable for IHR and quality of public health services at all levels (the supplier is accountable for some progress on this).

- **Output 4**: Improved data and evidence - accurate data and evidence for preparedness, speedy response and accurate, contextually appropriate decision-making (the supplier in focus countries and WHO in all others).

- **Output 5:** Provision of an emergency response mechanism should a pre-crisis situation arise. Rapid Response capacity to reduce the magnitude of disease outbreaks (joint responsibility with WHO). The supplier is accountable for ensuring functioning of delivery of contingency mechanism with contracted suppliers in case of a pre-crisis preparedness requirement.

4.3 Activities under the scope of the programme:

The supplier is expected to collaborate and coordinate with WHO with the separation of responsibilities below.

Work stream	WHO HQ	WHO AFRO	Supplier
Output 1 – WHO AFRO reform	Supportive and QA functions	This is delivered through WHO AFRO's workplan for the Transformation Agenda.	-
Output 2 – IHR capacities	Quality Assurance (QA) functions, backstopping TA, coherence, ensuring different teams work together e.g. Health systems. Guidance on national action planning and costing.	Scaling up existing support to countries including on JEE (Joint External Evaluation), National Action Planning, and implementation (training, QA, and ensuring cross-sectoral working). Supporting governments to prioritise and cost plans.	Technical assistance in six focus/most vulnerable countries based on demand and needs identified by WHO AFRO, countries and INFORM tool. Assist countries in systems strengthening particularly at sub-national level and engage with communities.
Output 3 – Governance and accountability	Share best practices to support a coherent approach in the programme. Ensure support to AFRO on multi-agency	Work at regional and national levels to facilitate civil society engagement but it is not the core of their engagement as they will also be held accountable.	Strengthen Civil Society Networks and Governments, similar to African Leaders Malaria Alliance (ALMA) model to use data for accountability

	collaboration ensuring support at headquarters of relevant agencies.	Facilitate coherence, cross-border and One Health approaches and ensure various agencies/Governments work together. E.g. OIE (Organisation for Animal Health), ECOWAS (Economic Community of West African States), FAO (Food and Agriculture Organisation), Africa CDC, etc.	e.g. use of JEE scores, publicising and tracking progress; civil society networks able to engage in GHS dialogue get Governments to work better on IHR and cross-border approaches.
Output 4 – data, surveillance, evidence	TA support and coherence – as One WHO. Support to global health observatory. Capacity building of WHO AFRO/country offices. Explore links with WHO Blueprint (e.g. testing vaccines in phase 2 trials in contextually relevant settings). Ensuring linkages to other initiatives.	Build on existing work on risk mapping, ensuring country offices able to support strengthening of national integrated disease surveillance and response mechanisms, Real-time Strategic Information System (RSiS) and District Health Information System (DHIS2). Strengthen Africa and National Health Observatories. Continue risk mapping and assisting country governments and regional institutions allocate resources and interventions matched to risk.	Scaling up capacity building in focus countries to ensure evidence is translated to tangible actions. Sharing lessons across the six focus countries and the region. Work at sub-national levels to support operationalisation of data and surveillance systems including at community level, by building on existing systems Feed into operational research.
Output 5 – Rapid response	Responds at emergency levels. Backstop to regional office. No extra funding as this is through CVC and WHE funding to HQ.	Establish and strengthen emergency operations centres (Number TBC) – follow-on from Regional Preparedness Programme (RPP).	Use any intel from working on the ground to inform rapid response (links with Outputs 2, 3, 4).
3rd Party M&E			

There is a need for collaborative working between all delivery partners; this will be achieved through WHO leadership and use of the management capacity of the supplier. The Third-Party monitoring agent will support WHO and the supplier to use their data to coordinate and adapt programme delivery. Host Government health security structures will be utilised to ensure coordination. WHO will provide leadership and technical oversight in all countries, and the supplier will be responsible for delivering in the six target countries.

4.4 Geographic focus: Country Selection

Based on experiences from the Regional Disease Preparedness Programme and criteria outlined in **Annex A** the countries proposed are: **Cameroon, Cote d'Ivoire, Uganda, Niger,**

Mali and Chad. There will be flexibility, subject to approval from DFID, to alter the geographic scope as needs arise.

4.5 A Regional Approach

The supplier will work with regional and national civil society actors to hold governments and regional bodies to account for delivering quality health services. Advocacy work by civil society in a single country context is limited by the reality that the disease prevention and preparedness efforts of each country will be affected both positively and negatively by those of its neighbours.

The supplier will leverage cost and learning efficiencies by working within and across multiple countries. The supplier will be able to test and transfer best practice approaches between countries while also taking advantage of economies of scale through sharing and not duplicating resources.

The supplier needs to ensure that there is flexibility to identify and work in a wider group of core countries if specific needs and/or public health emergencies arise during the programme's lifespan as identified through WHO, the supplier, country governments and DFID. The supplier will confirm countries selected for specific support and ensure that these are clustered so that a regional and cross-border approach can be demonstrated. The supplier will avoid duplication of bilateral efforts and efforts will be made to choose countries which have limited support but high risk.

4.6 Disease focus

The supplier will focus on building the ability of our partner countries and institutions to prevent and respond to the health emergencies presented by diseases which can lead to Public Health Emergencies of International Concern (PHEIC) like haemorrhagic fevers, Zika and yellow fever. The supplier will ensure public health systems are strengthened for 'everyday' diseases that remain rife in Africa including TB and malaria. Through strengthening coordination and response, it will help to stop seasonal cholera outbreaks from escalating, amplifying the benefits of investments in water, sanitation and hygiene. It will build on the work of the malaria programme – 'Strengthening Data for Decision-making' (details here: https://devtracker.dfid.gov.uk/projects/GB-1-203155) enhancing integrated surveillance systems for a number of diseases.

5. Requirements

The Supplier will deliver targeted support across programme component outputs 2, 3, 4 and 5 in six focal countries that have high vulnerability to disease outbreaks and unmatched investment to meet the needs. For details, see scope below.

The Supplier will manage all consortium sub-contractors who will support civil society, national governments and WHO AFRO's work, by:

I. Delivering supplementary technical support on the IHR according to identified needs from the assessments and existing support;
II. Enhancing demand-side governance reform;
III. Building data, evidence and accountability at national and sub-national levels with linkages to the region; and
IV. Overseeing the delivery of an emergency preparedness response, under the contingency mechanism, through a call-down contract measures including: mobilising the requisite technical and operational skills, innovations, institutional linkages, financial and administrative management and value for money.

The programme seeks to ensure that African health systems and institutions are strengthened to prevent outbreaks and epidemics of deadly communicable diseases. The theory of change is set out in **Annex C.**

The supplier is expected to contribute to the achievement of the following outputs and achieve the key deliverables in the target countries agreed with DFID and WHO:

Outputs	**Key deliverables**
• **Output 1:** Will be managed by WHO AFRO only. • **Output 2:** Target countries have improved adherence to IHR standards The supplier will provide technical assistance in six focus/most vulnerable countries based on demand and needs identified by WHO AFRO, countries and INFORM tool. It will deliver by supporting countries in systems strengthening particularly at sub-national level and engage with communities.	• All target countries have an improvement in the IHR evaluation scorecards as verified by assessments (JEE, simulations, after action reviews). These are usually assessed every two years, but different countries are on varying timelines. The support provided by the supplier would facilitate these to happen if not planned. • All target countries working on effective cross-border approaches to strengthen health security • All target countries have evidence of human and animal health departments working jointly to tackle health security in line with the One Health Approach at national and sub-national levels including at community level. • In countries where Fleming fund is operating (e.g. Uganda), linkages must be demonstrated with the working being done by the Fleming Fund on the One Health agenda.
Output 3: Better governance and accountability of public health systems. African governments and WHO AFRO accountable for IHR and quality of public health services at all levels. The supplier will strengthen Civil Society Networks and Governments, similar to ALMA model[4] to use data for accountability e.g. use of JEE scores, publicising and tracking progress. It will build civil society networks to be able to engage in GHS dialogue compelling Governments to work better on IHR and cross-border approaches.	• All target countries have action planning that is aligned to national planning and budgeting processes. • All national and regional civil society organisations tracking and publicising investments in disease preparedness and public health systems in target countries. • Country governments supported to embed disease preparedness into public health systems strengthening planning and programming in target countries.
Output 4: Improved data and evidence. Accurate data and evidence for preparedness, speedy response and contextually appropriate decision-making. The supplier will:	• At least 80% of target countries implement IDSR (Integrated Disease Surveillance and Response) including event-based surveillance systems with at least 90% country coverage. (the indicators in the WHO framework are based on health workers but coverage should be about population/geographic areas).

[4] http://www.alma2030.org/scorecards-and-reports/map

• scale-up capacity building in focus countries to ensure evidence is translated to tangible actions. • Work at sub-national levels to support operationalisation of data and surveillance systems including at community level. • Conduct and feed into operational research.	• All target countries with national plans (technical strategies) that are evidence-based and use locally context-specific evidence of what works in their setting (including community-based approaches) relating to disease preparedness/acute public health events. • At least 80% of countries with strengthened routine health information systems and data quality and improved timeliness of reporting.
Output 5: Provision of an emergency response mechanism should a pre-crisis situation arise. Support to rapid response at community, sub-national and cross-border levels to contain and stop outbreaks from spreading (in target countries). For the supplier, this is to manage and co-ordinate an Emergency Response Mechanism with pre-approved suppliers who can provide a flexible response (should it be required and triggered) to respond quickly to new disease outbreaks in Africa to stop a public health emergency.	• Use of intel on the ground to inform contextually relevant rapid response. • Raise alerts early to country Government, WHO, DFID and others to ensure that a proportionate response is triggered. • Ability to meet ad-hoc requirements to support containment of outbreaks in the region especially at community level using an understanding of the socio-cultural aspects and can implement interventions quickly such as support on WASH and behaviour change. • Ability to ensure that funds flow to where they are needed most for on the ground delivery and prevention of outbreaks scaling up, subject to approval from DFID. • Management of extra contingency funds to meet these requirements. The ERM expenditure will be reimbursed in arrears to the Supplier via the Contract.

6. Emergency Response Mechanism (ERM)

An additional fund of up to £20m for an Emergency Response Mechanism will provide flexibility to respond quickly to disease outbreaks in Africa. The mechanism will be triggered by the cross-DFID EpiThreat group with all major responses submitted to Ministers. The EpiThreat Group is a Cross DFID Group chaired by the Chief Scientific Officer and the Director of Conflict, Humanitarian, and Security department (CHASE) which assesses disease threat and DFID's response. This funding will be awarded as small grants and DFID is not obliged to release all the funds through the life of the programme.

The Emergency Response Mechanism has been designed primarily to support community-level preparedness activities where a risk or case has been identified and activities can be supported to prevent spread of diseases at the grassroots levels. Further detail is provided in **Annex I.**

In managing the ERM, the supplier will:

- ensure that any materials used at sub-national levels are consistent, culturally appropriate, technically sound and use existing materials to the extent possible; develop

additional materials as needed; and, ensure a review of materials is conducted periodically.
- be responsible for carrying out due diligence and risk management of any partners for delivering the technical assistance and the ERM.
- ensure policy analytical capability, and ability to monitor disease threats across Africa, analyse and make sense of diseases to provide advice to DFID on responding to risks/outbreaks and/or providing analysis for related DFID work (e.g. submissions to Ministers, policy briefings).
- be responsible for strong fiscal management and reporting, including support to DFID to ensure that contingency mechanisms are triggered where appropriate. The supplier will need to have the capacity to manage additional funds for rapid response support on the ground to contain outbreaks. By nature, these are unpredictable, but capacity to manage this is important.
- ensure that there is a country presence and effective engagement; and
- Subject to negotiation with DFID, the supplier will co–ordinate and manage other GHS-relevant events and activities that emerge as priorities over the life of the programme.

7. Commitment to leaving no one behind

TDDAP will be fully compliant with the Gender Equality Act and will make concerted efforts to ensure that the poorest, people with disabilities, the elderly, children and especially adolescent girls and young women (who are among the most marginalised and at-risk populations in many public health emergencies) are incorporated into planning and delivery. Those who are most excluded and hardest to reach will be prioritised in planning to ensure that they can access and benefit from public health systems and prevention activities. The start-up phase will identify opportunities to meet the needs of the most disadvantaged; this is where community-based systems are important. Work in this area could include, but not be limited to:

- Data disaggregation and capacity of management information systems to disaggregate by gender, poverty, age, geography, environmental risks, disability and other ethnic groups who may face sociocultural barriers to access.
- Data analysis to ensure effective targeting to reduce risk and save lives.
- Capacity building of health and community members to ensure the needs of vulnerable groups are met and identified.
- Ensuring medicines and referrals for vulnerable groups are available
- Supporting public health systems to identify, track, locate and target disadvantaged populations in a given disease outbreak.

8. Ensuring Programme Quality

8.1 Key deliverables

- Continuous quality improvement and programme learning, including building on the effectiveness of preparedness and progress on IHR.
- Data is readily available and beneficiary feedback documented, shared and acted upon.
- Contextual relevance of interventions for different geographic areas.

8.2 Methodology

To achieve the results outlined above, the Supplier will carry out activities including, but not limited to, those described below:

8.2.1 Start-up:

The Contract will commence, on approval, with a start-up phase of four months for the supplier to:

- Work with WHO and TPM to set-up monitoring mechanisms and ensure access to relevant financial and programmatic files to the TPM for the duration of the programme and six-months after the end date.
- The supplier will carry out individual scoping activities in TDDAP countries and will determine the various roles and responsibilities in the governance and management structure with DFID, as well as the reporting structure between national, regional and global levels.
- Finalise the programme logframe for their components.
- Build links between technical agencies, governments and national and regional civil society actors. During the inception TDDAP country programmes will commence work on some priority activities, identified in collaboration with DFID and national government colleagues.
- Move quickly to start work on selected initiatives to demonstrate to governments and partner countries a proactive approach to prevent and respond to public health emergencies.
- Produce a high-quality country engagement strategy.
- Produce a high quality environmental and social impact assessment including consideration of safeguarding.
- Produce a finalised high-quality start-up phase report - including detailed work plan for the first year of the project and draft work plan for the duration of the contract.

8.2.2 Programme delivery:

- Provide focused support to six country governments to strengthen their capacities on the International Health Regulations through the supplier.
- Support national public health systems strengthening for universal health coverage and ensure inter-sectoral collaboration and action.
- Support strengthening of cross-border responses between countries and support a ‘One Health’ approach.
- Ensure accurate data and evidence is captured by country governments and non-state actors and disseminated for planning, action and accountability.
- Provide technical assistance and support WHO to strengthen country and regional IHR capacities and improve use of data. They will support operationalisation of systems strengthening efforts and community and district levels.
- The **supplier will support civil society** to strengthen governance and accountability within the sub-region and in countries to hold governments and international agencies to account to deliver on achieving the international health regulation capacities, preventing epidemics, and delivering quality public health services through effective allocation and management of scarce resources.
- Work closely with WHO AFRO to ensure that outcomes are achieved.
- Support a multi-sectoral approach ensuring that disease preparedness is embedded within health systems strengthening in collaboration with country governments, WHO and the African Union.
- Support strengthening of technical capacity to prevent disease outbreaks in target countries.
- Effectively engage communities and sub-national structures through culturally and contextually relevant approaches at scale.

The supplier will assume the full responsibility for delivering the areas of work under their contract. Overall the supplier will:

- Manage the relationship with the DFID core management team to report on progress, emerging issues and opportunities
- Ensure strong relationships with local actors including government at central and sub-national levels and beneficiaries
- Effectively co-ordinate activities undertaken by any sub-contracted partners/consortium members so there is coherence in countries where the programme operates.
- Manage the emergency call-down supplier and funds if this is triggered.
- DFID sees value in working with PHE on IHR especially on the regional and One Health approaches. Any technical assistance requiring support to countries not already covered by PHE (which are currently Nigeria, Ethiopia and Sierra Leone), would require the supplier to pay for these services through PHE's commercial unit.

8.2.3 Monitoring and Evaluation

The supplier 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; ensures compliance with DFID reporting; and, supports operational research where necessary. The supplier will include Governments, WHO and other stakeholders in regular lesson learning and evidence building exercises so that experience is shared, "peer reviewed" and whenever possible, given wider exposure. The supplier will ensure that data is made available to the third-party monitoring agent.

The supplier will provide timely programme and financial information to the **Third-Party Monitoring** Supplier. Terms of Reference for the Third-Party Monitoring Agent are in **Annex G.**

The supplier is responsible for managing the TDDAP programme and monitoring and evaluating progress against the agreed logframe, milestones and the Key Performance Indicators (KPIs) with any consortia and downstream partners. The Supplier will ensure the data systems used are consistent and ongoing collection of disaggregated data through the programme, and capability for real time data availability and use. Ongoing analysis and learning is expected for course correction where needed and rigorous attribution and contribution analysis and reporting. DFID will be supported by the TPM in results verification and analysis. It does not replace the suppliers own monitoring mechanisms and accountability.

The main monitoring tools for TDDAP will be against the logframe and through the third-party monitoring mechanism.

8.2.4 Innovation and flexibility

The Supplier will demonstrate how they are driving innovation through:

- engagement with new evidence and programme delivery;
- visible application of lessons learned from the changing context of global health security;
- try new innovative approaches to maximise reach and impact; and
- show flexibility to scale up and down to respond to opportunities.

8.2.5 Driving Sustainability

It is important to DFID that its investments lead to sustainable capacity and strengthened health systems. The Supplier will be expected to coordinate with existing organisations, especially WHO AFRO, national governments and civil society to build their capacity to map risk, create cultures of preparedness, track progress on IHR and ultimately ensure less outbreaks or epidemics in Africa. The Supplier will be expected to develop a work plan which incorporates the log-frame sustainability indicators.

8.2.6 Third Party Monitoring Service (TPM)

DFID is contracting a Third-Party Monitoring Service to ensure the TDDAP programme is having the intended impact and informing programme adaption as required through the life of the programme to improve overall performance by:

- Independent verification of results reported by suppliers;
- Generating additional evidence of results;
- Learning what works on key issues and sharing the evidence; and
- Providing a live audit type function (additional to the audit arrangements of the supplier).

The Third-Party Monitoring team will:

- interrogate reports,
- undertake field visits and look at areas of learning for the programme; and
- convene a peer learning process between the supplier, WHO AFRO, DFID and other key stakeholders and feed into annual assessments to allow for course correction.

Full cooperation will be expected of the Suppliers for TDDAP with the chosen Third-Party Monitoring service provider throughout the programme inception, implementation and close out period.

A suggested, but not prescribed, division of labor between implementing partners of TDDAP programme and the Third-Party contract is set out below:

Implementing Partners (WHO and the supplier) are responsible for producing:

- A clear baseline;
- Consistent and ongoing collection of disaggregated data;
- Real time data availability, analysis and use;
- Ongoing analysis and learning for course correction;
- Rigorous attribution and contribution analysis and reporting;
- Reporting against Work plan, milestones and KPI's for Quarterly and Annual Reports; and
- Active engagement with the Third-Party Monitoring Contract to facilitate verification of results, for learning and cross fertilization across wider Global Health programmes, including attending and providing input to all partner learning meetings.

Third Party Monitoring Supplier to:

- Verify results by randomly sampling TDDAP implementing countries in order to test monitoring reports;
- Assess programme performance by regular assessment of quality data produced by the programme; and

- Convene learning and cross pollination between TDDAP partners and wider stakeholders.

8.2.7 Small/Medium Enterprises (SME's) and Micro Organisations

The Supplier will effectively engage with local partnerships. This is particularly important in the interests of embedding sustainable systems in each country and region, and driving continued value for money. It is preferable that at least one key partner is categorised as SME/Micro organisation5 that works independently from the Supplier and is currently engaged in delivering services or programmes relevant to this bid. Furthermore, it is important to include southern based organisations working in the countries and regions to ensure local and contextual understanding and expertise as well as to support the wider market development of organisations in Africa promoting Global Health and Disease Preparedness.

9. Constraints and dependencies

The supplier will need to cooperate with WHO AFRO who started the programme in November 2017.

9.1 Licence to operate

The Supplier will detail country engagement strategies and must have the appropriate licence to operate in the countries selected. The engagement strategies should be clear on coordination with WHO AFRO and other coordinated programmes as well as leaving in place sustainable investments for the future.

9.2 Handover from previous DFID Programme

TDDAP will be a successor programme to the Regional Preparedness Programme (RPP) and the 'Strengthening evidence for the use of data in Malaria interventions programme'. The supplier should consider the lessons and recommendations from the above-mentioned programmes to inform their programming. Relevant documents are available on Devtracker.

9.3 Third Party Monitoring

The lead supplier and any consortia members will cooperate fully and engage constructively (participate in and respond to regular discussions) with the contracted TPM service provider and avail the evidence and data required for learning from the results for programme implementation. For further details of the TPM, refer to the TPM terms of reference on the portal.

9.4 Exit strategy

The Supplier will develop a strategy for a responsible exit leading up to the withdrawal of DFID funding at the end of the Contract and country engagement strategies should outline measures to ensure sustainability into the future.

9.5 Emergency Response Mechanism

A Global Health crisis would alert the DFID Epithreat group to trigger Emergency Response Mechanism if appropriate (up to the £20m). The Supplier is required to have a pre-approved group of suppliers/organisations who could mobilise quickly at the community level, to

[5] See definitions

respond to the crisis. DFID will decide, subject to the nature of the emergency, whether to draw upon funds from the Emergency Response Mechanism, or utilise existing mechanisms such as the Humanitarian Emergency Response Operations and Stabilisation Programme (HEROS) contract to support logistics and procurement efforts. The HEROS programme is already contracted to DFID and will allow for the provision of humanitarian emergency response and the provision of procurement, logistics, surveillance and infrastructure expertise. Further support may also be provided as appropriate to WHO AFRO's health emergencies programme.

10. Contract Management

10.1 Contract Award

DFID will award a contract to the Supplier as well as a separate contract to the supplier for the TPM service. A separate Memorandum of Understanding is in place with WHO AFRO.

The Supplier will be responsible for:

- delivering the different aspects of the contract in the geographical regions;
- ensuring the implementation and reporting of all agreed interventions;
- achievement of results targets;
- financial management; and
- carrying out due diligence and risk management of all downstream partners.

The Supplier will be required to cooperate fully with the TPM service to facilitate the verification of results and methodologies and ensure learning is shared across the different implementing partners and countries in the overall TDDAP programme. However, DFID expects to engage with all stakeholders for programme implementation, review and learning, and expects to see the programme governance and division of labour aligned to the strengths of different partners. The supplier will ensure agile management of risks including on safeguarding.

10.2 Timeframe

The Contract will start in February 2019 and run for 45 months until November 2022.

10.3 Contractual Break Points

DFID will monitor programme performance through quarterly results reporting in addition to formal annual performance reviews. DFID reserves the right to terminate the contract subject to programme performance in accordance with the Terms and Conditions of Contract.

The contract allows for formal review points at the end of the start-up phase (4 months) where progress to implementation will be subject to DFID's agreement, based on the revised implementation proposal, and at each annual review (in May/June) when DFID may withdraw support if it is not satisfied that the programme is likely to achieve its objectives. The review points will involve a substantive discussion on performance against targets, milestones, KPIs and challenges.

10.4 Scale up/Extension options

DFID reserves the right to scale back or discontinue this programme at any point in line with the Terms and Conditions. Conversely, DFID may also **scale up the programme** - for programme delivery in additional countries for example - should it prove to be having a strong impact and has the potential to yield better results, dependent on budget and ongoing effectiveness of the programme.

If DFID were to take the decision to increase the scale of the programme during its entire term (including any extensions), the increase will be up to an additional:

- £9 million over and above the £18m for Technical Assistance (50% increase) and up to £10m for the Emergency Response Mechanism Fund.

The Supplier must maintain flexibility in approach and be able to exit from high risk environments as required and with agreement from DFID.

11. Governance

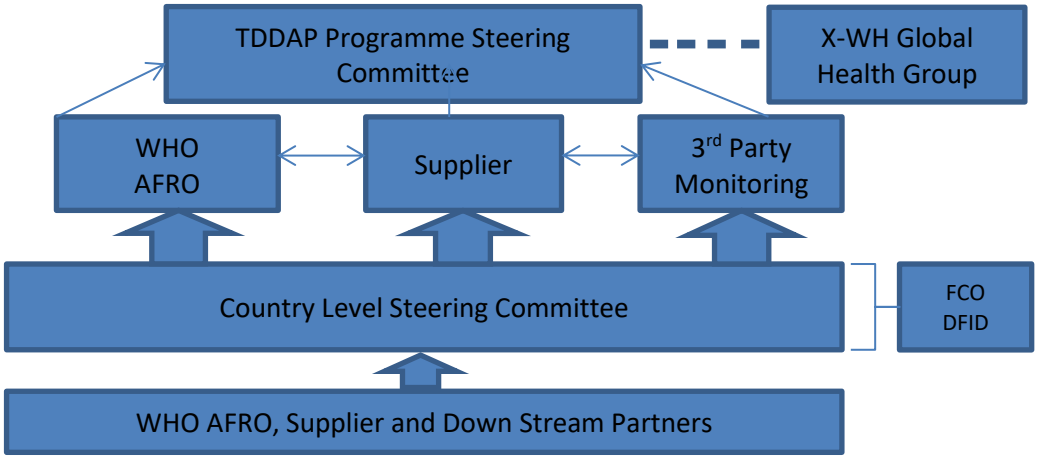
The governance of TDDAP will ensure that all aspects of the programme are coherent at the global level, and managed effectively at both regional and national levels. Overall progress on the programme will be presented to the global health oversight group to ensure alignment of HMG objectives and deliverables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

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

The Supplier will set out in their Country Engagement Strategies details of governance structures, preferably using existing host Government structures overseeing health security. These will comprise, but not be limited to, representatives from the supplier/consortium, national experts, partner country governments, key implementing partners and beneficiaries, and the UK where relevant. Views of beneficiaries collected by implementing partners and through third party monitoring will be considered in governance decisions. The committee will play a critical role in ensuring that both national and regional issues are taken forward to the TDDAP programme steering committee and raised in the Global Health Oversight Group for overall coherence on global health security. The committee will meet quarterly in the first year after which the frequency of meeting will be reviewed.

The governance process for the emergency response mechanism is in **Annex I.** The supplier will agree effective communication channels with DFID on pre-crisis situations to trigger the mechanism.

11.1 TDDAP Governance Structure



The programme will be managed in three stages:

- Start-up Phase (4 months) during which the Supplier will be asked to absorb lessons from the predecessor programmes, carry out necessary assessments and provide an updated delivery plan including division of labour between agencies in each of the geographical areas. During the inception/mobilisation phase, there will be a process of defining 'methodology notes' and each of the logframe indicators will be refined.

- Implementation (approx. 38 months) with formal annual review points;

- Closure and Learning (3 months) the supplier should aim for delivery of results by August 2022. A responsible close down/exit will be required although suppliers should be prepared to retain flexibility for scale up and expansion after this point if required. This will be reviewed between DFID and the Supplier during the programme cycle /mid-term point to allow for timely planning and implementation of close down or extension. A formal high-quality programme final report will be required, documenting overall programme results, breakdown of costs and delivery and lessons learned for future Global Health programmes.

Timelines may change if an extension to the time period is approved.

11.2 DFID Contact Points

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

12. Asset Management

The Supplier will need to set out how they will maintain, control and report on any assets purchased with DFID funds, mitigating against theft, damage or loss. A detailed asset management plan will be developed within the delivery plan for this programme.

13. Reporting

- There will be regular reporting and dialogue between the implementing partners (the supplier and WHO AFRO) and DFID.

- Documents, lessons learned, and findings will be published and shared more widely in order to be made available to a broader public audience including through the Global networks on Global Health Security Agenda, G7 and G20 fora.

- The supplier will be expected to share, discuss and meet with WHO and other stakeholders involved in disease preparedness, together with DFID.

- All data and metadata is owned by DFID and the Supplier should ensure that all data is rigorously documented and stored in an accessible format.

- The Supplier will be responsible for reporting to DFID against an agreed format.

Final outputs will be assessed on the basis of the programme log frame outputs, programme activities and quality of reports. Specifically, the supplier 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. Existing data should be utilised including the Joint External Evaluation, and Self-Assessment reports, where possible. Programme data will be made available to the third-party monitoring agent.

ii. Quarterly Progress and Annual Narrative Reports (template in **Annex E)** which includes executive summary, progress of implementation of planned activities by output, progress on results against the logframe, milestones, 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, WHO and the host governments.

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 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. **Monthly, 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 to DFID quarterly in line with the narrative and financial reporting schedule.;

vii. Risk Matrix - Develop a comprehensive risk matrix setting out clear strategy for monitoring, managing and mitigating against risks which are updated at least quarterly or when a risk arises and reported to DFID quarterly in line with the narrative and financial reporting schedule. Due attention and assurances need to be made on safeguarding. Ensure contingency plans are in place.

viii. Delivery Chain mapping for funding flows and risk mitigation to downstream suppliers and reported to DFID at a minimum quarterly in line with the narrative and financial reporting schedule. (Template attached at **Annex F**).

ix. Communications products to document and disseminate useful results and lessons learned as and when required.

x. Exit Strategy - Provide and deliver an exit strategy to ensure long term sustainability of approaches.

xi. High Quality Project Completion Report: consolidating the entire programme including consolidated results, beneficiary feedback, lessons learned and recommendations for future Global Health Programmes.

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. **Templates will be provided by DFID where applicable which the Supplier may complete to provide additional relevant information to enhance the quality of the report.**

14. Value for Money (VFM)

The Supplier will be expected to drive and measure value for money throughout the programme period. They will be routinely expected to demonstrate how value for money is being accurately measured within the programme implementation.

Throughout the Contract, the supplier will document cost effectiveness determining, for every £1 invested, the return in terms of savings on future spend/investment.

Value for Money benchmarks will need to be developed during the first year of implementation. There are a number of indicators that could be used to assess VFM including:

A. Effectiveness
- Number of countries reporting IHR capacity improvements/per two years

B. Economy
- Cost/risk map/ country
- Cost of reform processes/country office/year

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

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

These measures will need to be disaggregated by country and where possible target groups, including children, women and girls.

All partners will be expected to have a VFM strategy (both commercial and programmatic) embedded into agreement and included in reporting.

15. Programme Budget, Payment by Results and Key Performance Indicators

The budget for the supplier, excluding any Emergency Response Mechanism funds, will be for the value of up to **£18m** (Exclusive of UK Government taxes if applicable).

15.1 Payment by Results

A payment by results model will be used for effective implementation of the TDDAP Contract. Key Performance Indicators (KPI's) will link delivery of targets to an agreed payment schedule. A detailed logframe will be agreed during the contract start-up phase and approved by DFID in consultation with the third-party monitoring agent. Performance will also be tracked through the progress against the logical framework and key milestones.

Payments will be made on a quarterly basis. All, or a proportion of, the payment of **fees** will be linked to the delivery of agreed Key Performance Indicators and milestones.

The Supplier will agree and be subject to the following:

- Expenses will be reimbursed to the programme implementer on the basis of actual costs incurred; however, such payment will be capped at the value of expenses as proposed in pro forma 2.

- Payment of all, or a proportion, of **fees** will be made upon successful of achievement of KPI's and milestones. Bidders are requested to propose the annual value of fees to be linked to delivery of targets. The level of payment linked to delivery of milestones and KPI's will not be below 40% of the value of fees. The remainder of fees which are not linked to KPI's (the Payment by Results mechanism) will be reimbursed to the Supplier on the basis of actual costs incurred; however, such payment will be capped at the value of the remaining fees as proposed in pro forma 1.

- As part of the Supplier's obligations to achieve the set KPI's and milestones, the Supplier will need to show progress towards milestones in the logframe on a quarterly basis.

- The Supplier also accepts that a proportion of payment of fees will be withheld according to the proposed schedule if the KPI's and milestones are not met.

The Supplier will have to be adaptive and flexible whilst working in the 6 focus countries to demonstrate progress towards milestones in the delivery plan on a quarterly basis. To ensure high quality delivery, there will be a hybrid approach to the payment mechanism:

Expenses:

- 100% paid monthly based on actuals - providing they are in line with the overall budget agreed with DFID.

Fees:

- 60% paid quarterly based on inputs - providing they are in line with the overall budget agreed with DFID, with the first payment being due at the end of the Inception Phase and, thereafter, at the end of each 3-month Implementation period.

- 20% paid quarterly based on milestones, with the first payment being due at the end of the Inception Phase and, thereafter, at the end of each 3-month Implementation period. Payment is based on satisfactory delivery of the specific outputs assigned by DFID for the Inception Phase and as agreed by the parties prior to each 3-month Implementation period.

- 20% paid quarterly based on inception performance, and subsequent implementation performance, against the KPI's with the first payment being due at the end of the Inception Phase and, thereafter, at the end of each 3-month Implementation period.

15.2 Start-up phase milestones and key performance indicators

15.2.1 Start Up Phase Milestones within 4 months

- DFID acceptance of high-quality country engagement strategy. (Delivery timeframe to be finalised)
- Completion of an Environmental and social impact assessment which includes developing safeguarding process and procedures.
- DFID acceptance of completed log frame for Supplier components. (Delivery timeframe to be finalised)
- DFID acceptance of finalised high-quality Start-Up Phase Report - including detailed work plan for the first year of the project and draft work plan for the duration of the contract. (Delivery timeframe to be finalised).

Key performance indicators

KPI's will be set to ensure rapid mobilisation and adherence to the design and outcomes of the project. This will include performance KPI's associated with performance of the core team including quality of delivery and responsiveness to requests including the ERM and evidence of problem solving. 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 Supplier. The supplier will demonstrate to DFID at specific review points, to be refined with DFID during the Inception Phase, its performance against these KPI's. Together with final agreement of the relevant KPI's, the supplier 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.

Transition from inception to implementation will be dependent on completion of milestones in the inception phase and subject to DFID approval of the start-up Phase report and detailed implementation proposal. The implementation will include a suite of specific programme outputs, programme performance measures and payment KPI's agreed between DFID and the Supplier.

15.2.2 Key Performance Indicators:

- Post Inception Phase, KPI's will be refined, agreed and used to measure Implementation Performance.

DFID Key Performance Criteria	How do you rate performance against?	Success criteria/verification	When assessed
Personnel	Performance of team	Effective management of team including quality of delivery and responsiveness to requests including the ERM and evidence of problem solving.	Quarterly report
	Robust management of performance by sub-contractors ensuring due diligence and quality assurance.	Supplier takes responsibility for managing underperformance and getting the best out of the subs to deliver effectively. Ensuring all on-board with programme strategy and implementation plans. Evidence of taking feedback from mplementers to adapt the programme (where required).	Quarterly reports
Financial and risk management	Demonstration of strong financial and risk management practices with accurate and timely submission of forecasting, invoices, audits and risk assessments/mitigation plans.	Narrative and finance reports submitted to agreed timetable.	Quarterly reporting Reports/emails
	Robust cost control in line with contract and reporting on VFM metrics	Delivery of project within agreed budget (DFID to take into consideration changes to external factors)	Quarterly reporting
Project and strategy management	Milestones and deliverables on time and budget and in line with delivery timetable and to satisfaction of DFID	Report on progress against delivery.	Quarterly milestone and financial reports
	Quality delivery against M&E strategy	M&E plan designed and delivered to effectively track step-change in strengthening health systems and behaviours around health security. Ensures no double-counting of beneficiaries and disaggregates data by gender, age, geography and disability	Quarterly report

DFID Key Performance Criteria	How do you rate performance against?	Success criteria/verification	When assessed
Customer Relationship	Strong and effective relationship management and communication with DFID, Governments, TPM and WHO.	Evidenced by appropriate level of engagement/communications with relevant stakeholders.	Quarterly reporting (Emails, phone call log, meeting minutes; feedback from relevant stakeholders)
	Demonstration of effective coordination and/or collaboration with stakeholders involved in IHR as well as TDDAP partners	Consistent participation* of relevant expertise in national and regional technical working groups, coordination fora.	Quarterly reporting - Meeting minutes; documentation of contributions in groups., feedback from stakeholders
	Engagement of local expertise for incorporating locally led solutions to support changing social norms and strengthening multi-sectoral response.	CSO's delivering response along with influencers and other outreach workers already is existing within the communities. Solutions are designed with communities, tested and adapted	Quarterly reporting
Compliance	Adherence to DFID rules and regulations to, fraud reporting management and safeguarding .rules	Supplier able to document their adherence to DFID compliance, immediate reporting of suspected cases of fraud	Check List in quarterly Reports, ad-hoc related to fraud (depends when cases arise). Section completed in quarterly report.

Key Performance Indicators

- Weightings will be applied to each KPI, which will then be scored out of 1-6 each quarter
- In line with the maximum total score of 600, the proposed payment % structure shall be as follows:

Total Score	Payment
400 and above	100%
200-399	80%
100-199	40%
99 and below	10%

15.2.3 Implementation phase

Based on completion of milestones and learning from the start-up phase, the supplier will scale-up implementation to meet the output targets as per the high-level logframe and key performance indicators.

During the implementation phase, payments will be on the basis of actual costs and payment on achievement of the set KPI's and milestones.

DFID with the support of the Third-party Monitoring Supplier will review the performance of the Supplier throughout the life of the project and at least twice yearly one of which will comprise 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 before the award of contract.

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

16. Risk

The supplier will build on the risk matrix attached at **Annex J** under the following areas: external context, delivery, operational, safeguards, fiduciary, reputational and overall risk. The supplier will discuss the Risk Mitigation matrix on a quarterly basis with DFID and flag any arising risks throughout the course of the programme.

The Supplier will be required to set out their fraud and safeguarding mitigation strategies including internal risk management and reporting systems. DFID will further require that annual financial audits include spot checks of high risk areas of programme activity (e.g. procurement), and – if any causes for concern arise – these must be reported to DFID immediately. DFID will reserve the right to conduct a full forensic audit. DFID takes a zero tolerance to fraud.

16.1 Delivery Chain Mapping

In advance of any release of funds, the supplier will be required to produce a delivery chain risk map which should, where possible, identify all partners (funding and non-funding e.g. legal/contributions in kind) involved in the delivery of a programme. Risk maps should be reviewed and updated periodically, in line with agreed programme monitoring processes and procedures. A suggested format is attached at **Annex F**. As a minimum, it should include details of:

- The name of all downstream delivery partners and their functions.
- Funding flows (e.g. amount, type) to each delivery partner
- High level risks involved in programme delivery, mitigating measures and associated controls

16.2 Risk of Fraud

The risk of fraud through downstream suppliers or with partners in country will need to be partly mitigated through the Supplier's due diligence of downstream suppliers, ensuring acceptable levels of financial control and reporting before granting funds. It will also be partly mitigated through the third-party monitoring supplier. The Supplier will be required to set out how they will monitor the performance and financial management of downstream suppliers and national partners supported through the programme.

16.3 Safeguarding

DFID maintains a zero-tolerance approach to sexual exploitation and abuse within supplier organisations, which includes their downstream supply chains. We expect DFID partners to follow our lead and robustly consider environmental and social safeguards through their own processes. The capacity of our partners to do this and their effective performance should be a key risk assessment factor in programme design, delivery and monitoring and evaluation. Some considerations include (not exhaustive):

Safe Guard	Mitigation
Third Party and down-stream partners engaged to deliver the Technical Assistance and ERM Fund components do not have adequate safeguarding policies and practices in place	Clear articulation in the ToR of Lead supplier responsibilities for assessing safeguarding policies and practices as part of the due diligence requirements for downstream and third-party suppliers. Adherence to DFID safeguarding rules built into compliance KPI which will be monitored on a quarterly basis.
Implementing partner's staff violate safeguarding rules bullying, harassment and sexual exploitation causing harm to beneficiaries and reputation.	Selected Lead Supplier will be required to demonstrate at tender evaluation stage that they have robust approaches in place to i) reduce this risk-taking place, and ii) manage instances of violations. Due diligence on WHO AFRO should demonstrate that WHO has robust safe guarding rules in place. Due Diligence and safeguarding part of tender process using new guidelines (once read). TPM will also need to support DFID to monitor. Lead supplier will need to conduct due diligence on any downstream partners.
Mistrust of communities around disease preparedness activities reduces ability to deliver programme	Programme is designed and delivered ensuring community engagement and contextually relevant with local expertise.
Accountability efforts by CSOs threaten to demotivate and demoralise providers who, with inadequate supervision and resources, will resent feeling under greater scrutiny.	TDDAP aims to avoid blame and shame approaches and use of positive deviance to highlight good practice and learning to counterbalance examples of poor performance and outcomes. Work with Africa CDC and national public health agencies. Use learning from African Leaders Malaria Alliance (ALMA)

17. UK Aid Branding

Suppliers that receive funding from DFID must follow UK Aid Branding Guidelines and use the UK aid logo on their development and humanitarian programmes to be

transparent and acknowledge that they are funded by UK taxpayers. Suppliers should also acknowledge funding from the UK government in broader communications, but no publicity is to be given without the prior written consent of DFID. A branding discussion will be held with the Supplier and the Implementing Partners and will be captured on the visibility statement and agreed prior to contract signature.

18. Digital spend

The UK government defines digital spend as 'any external-facing service provided through the internet to citizens, businesses, civil society or non-governmental organisations'. The Government Digital Service (GDS), on behalf of the Cabinet Office, monitors all digital spend across government and DFID is required to report all spend and show that what we have approved meets with GDS Digital Service Standard. In DFID, this applies to any spend on web-based or mobile information services, websites, knowledge or open data portals, transactional services such as cash transfers, web applications and mobile phone apps. Plans to spend programme funds on any form of digital service must be cleared with DFID in advance and must adhere to the following principles:

Design with the user

a. Understand the existing ecosystem
b. Design for scale
c. Build for sustainability
d. Be data driven
e. Use open standards, open data, open source & open innovation
f. Reuse & improve
g. Address privacy & security
h. Be collaborative

The Supplier will highlight any digital aspects of their approach including potential budget assigned to these interventions, licenses/permissions required and sustainability of investment.

19. Duty of care

The Supplier is responsible for the safety and well-being of their Personnel and Third Parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property**. Please see Annex D for full details of DFID's Duty of Care Policy and country risk assessments**

20. Transparency

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

21. Environmental considerations

The supplier is expected to include environmental considerations as part of the Environmental and Safeguarding Risk Assessment in the start-up phase and in the delivery of the Contract.

22. General Data Protection Regulations (GDPR)

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

Annex A: Background to country selection

The process of country selection was built on the experience and approach used through previous programmes (Ebola and Regional Disease Preparedness) where we funded a programme in 21 countries[6]. It monitored impact in seven countries selected through a joint decision with WHO using the INFORM Ebola tool[7]). This was then overlaid with WHO tracking of donor commitments to disease preparedness to ensure we were matching resources to risk. WHO AFRO has advanced their work on risk mapping to determine gaps in resources against risk.

With TDDAP, we will build on this prioritisation method with WHO, and coordinate with PHE (who are working in Ethiopia, Nigeria and Sierra Leone). **The supplier will therefore focus six high risk countries based on a number of criteria as stated above.** Approaches will be tailored to each country context, including evolving needs.

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

- Country disease risk assessments using INFORM[8]
- Health status (using indicators such as maternal and U5 mortality rates)
- Country performance against IHR and Global Health Security Agenda (GHSA) joint external evaluation assessments
- Political and institutional context (using proxy indicators such as per capita governmental expenditure on health)
- Profile of external support/DFID ability to fill funding gaps – using WHO's Strategic Partnership Portal (database of support on IHR).
- Whether it would strengthen DFID's country-level health programming
- Total country population
- Presence/absence of other development programmes.
- Policy context of ODA applicability

[6] Countries funded by the Ebola and Regional Disease Preparedness programme were: Benin, Burkina Faso, Cameroon, Central Africa Republic, Cote D'Ivoire, Guinea-Bissau, Ethiopia, Gambia, Ghana, Mali, Mauritania, Niger, Senegal, Togo, Chad, DRC, Malawi, Tanzania, Uganda, Cape Verde and Angola

[7] The INFORM Ebola tool was designed with WHO, Centres for Disease Control (CDC), EU, LSHTM (London School of Hygiene and Tropical Medicine) and DFID to rank countries at high risk on an outbreak and "weakest" in terms of preparedness systems and donor funding

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

DDAP logframe updated 17 April 2018

THIS IS THE OVERALL LOGFRAME WHICH WHO AND EXTERNAL TECHNICAL AGENCY WILL DELIVER ON: WE NEED TO BE CLEAR ON ACCOUNTABILITY FOR PIECES - INCLUDE N INDICATOR AND TARGETS WHERE RELEVANT.

PROJECT TITLE	The Tackling Deadly Diseases in Africa Programme (TDDAP)						
IMPAC	**Impact Indicator 1**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
Reduced impact of communicab e d sease outbreaks and ep dem cs on African populations	Ev dence of reduced economic shocks from catastrophic epidemic events.	**Planned**					
		Achieved					
			Source				
			Afr can Health Observa ory, Analysis by WHO AFRO and third-party mon toring agent (using sources from WB etc)				
	Impact Indicator 2		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	Reduced ep dem c-prone disease burden- annual meningit s, ye low fever, Ebola and Lassa cases and deaths in the region (as tracers) - as defined as going above spec fic thresho d for the disease.	**Planned**	**Year 2016 figures**: **Meningi is -** Cases: 7 Deaths:392 **Yellow Fever** - Cases: 7556 Deaths: 511 **Ebola** - Cases: 13 Deaths: 9 **Lassa Fever** - 22 Deaths: 208	**Compared to 2016 figures (% reduction)**: **Mening ts:** - 20 % cases/deaths **Yellow Fever:** - 50% cases/deaths **Ebola:** - 20% cases/deaths **Lasser Fever:** - 20% cases/deat s	**Compared to 2016 figures (% reduction)**: **Mening ts:** - 0 % cases/deaths **Yellow Fever:** - 70% cases/deaths **Ebola:** - 25% cases/deaths **Lasser Fever:** - 30% cases/deat s	**Compared to 2016 figures (% reduction)**: **Meningitis:** - 60 % cases/deaths **Yellow Fever:** - 80% cases/deaths **Ebola:** - 30% cases/deaths **Lasser Fever:** - 50% cases/deat s	
		Achieved					
			Source				
			Afr can Health Observa ory; AFRO outbreaks data				

OU COME	**Outcome Indicator 1**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	**Assumptions**
African hea th systems and inst tut ons strengthened to prevent outbreaks and epidemics of deadly commun cab e d seases	% of annual outbreaks transit oning to ep demics recorded in African countries. (w de geographic spread w thin country and/or interna ional spread according o d sease specific thresholds e.g for lassa, cho era, mening tis)	**Planned**	38%	20%	15%	10%	1) WHO AFRO respond positively o structural and capac ty reform in tiatives. 2) Emergency health preparedness and response to cover risks adequately financed by UK Government and other international and nat onal actors. 3) African Governments show adequa e engagement in improving capacity and qual ty of health services.) Improvemen s in disease prevention and preparedness have knock-on effects on wider welfare and growth ind ca ors (househo d income, GDP etc). 5) E fects of c imate change, drought, ood cr ses, natural d sasters and civil unrest are m tiga ed. 6) Countr es dec are outbreaks as required by IHR
		Achieved					
			Source				
			WHO AFRO da a				
	Outcome Indicator 2		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	% of countries with publ cly funded national costed act on p ans or actions embedded into other plans re ating to d sease preparedness.	**Planned**	5 (Senegal, Cote d'Ivoire, Namibia, Eritrea, Tanzan a have budgeted NAPs)	10	25	7	
		Achieved					
			Source				
			Nat onal budget analyses collated by WHO AFRO/civ l soc ety				
	Outcome Indicator 3		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	Collaborative and effective leadership: Effective coordinat on between international and regional institutions (e g. African CDC, WHO AFRO, US CDC, USAID, AU, others) - see defin tion (no es)- WHO can provide evidence of th s for speci ic outbreak examp es reaching above d sease-specific threshold levels.	**Planned**	Afr ca Health forum convened June 2017	Follow-up actions from Afr ca Health Summit completed. Coordination mechan sm for publ c health emergencies defined, established and funct onal.	Qualitative assessment		
		Achieved					
			Source				
			Benefic ary/stakeholder feedback; WHO reports; Third-party monitoring reports; Qua itative sp dergram assessment on aspects of				
INPU S (£)	**DFID (£)**		**Govt (£)**	**Other (£)**	**otal (£)**	**DFID SHARE (%)**	
	£40m						
INPU S (HR)	**DFID (F Es)**						

OU PU 1	**Performance Indicator 1 1**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	**Assumptions**
WHO's internal reform enhances ts capacity as a prem er author ty on pub ic hea th	Ev dence of effective working between WHO departmen s including health emergencies and health systems strengthening teams	**Planned**	Lim ted on d sease preparedness programme (JEE, NAPs, AMR) ac iv ties	Joint implementation reports on NAPs	Integrated health pol cies documents; Joint implementat on reports on preparedness activit es	Integrated health pol cies documents; joint implementat on reports on preparedness and response	WHO AFRO remains an important technical and policy partner in Africa. WHO AFRO reforms achieved and performance improves. WHO AFRO reforms al gn and mutually inform WHO HQ reforms.
		Achieved					
			Source				
(WHO will be held accountable on this)			Integrated health po ic es documents; joint imp ementa ion reports				
	Performance Indicator 1 2		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	% of AFRO country of ices scoring a minimum of 75% green rating KPIs over a 12 month period' (this is the same as the CVC logframe)	**Planned**	0% of the 20 ocused countr es	0%	50% of focused countries	75% of focused countries	
		Achieved					
			Source				
			WHO AFRO KPI dashboards (this indicator measures responsiveness to the WHO AFRO TA)				
IMPAC WEIGH ING (%)	**Output Indicator 1 3**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	% of DFID funding streams forecasts within 10% of actual spend every quarter - focus on TDDAP & malar a to AFRO	**Planned**	WHO: 0%; ETA: TBC	WHO: 75%; ETA: N/A (not started)	WHO: 100%; ETA: 100%	WHO: 100%; ETA: 100%	
		Achieved					
20%			**Source**				**RISK RA ING**
			Financial reporting from partners				**High**
INPU S (£)	**DFID (£)**		**Govt (£)**	**Other (£)**	**otal (£)**	**DFID SHARE (%)**	
	£3 5m						
INPU S (HR)	**DFID (F Es)**						

OU PU 2	**Performance Indicator 2 1**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	**Assumptions**
African countries have improved adherence o IHR s andards (ETA w ll be held accountab e for its focus countries; WHO for the others and also for reg onal progress).	% of countries with improvement in HR evaluat on scorecards through annual IHR repor s	**Planned**	0	0	10	25	Multi-sectoral approach e fectively operat onalises One Hea th commitments. Technical capacity to prevent disease outbreaks improves in partner countries.
		Achieved					
			Source				
			Se f assessment against IHR and independent verificat on (CSO); SPP				
	Performance Indicator 2 2		**Baseline**	**Milestone 1**	**Milestone 2**	**arget (date)**	
	Number of countr es working on effective cross-border approaches to strengthen hea th security	**Planned**	0	3	10	20	
		Achieved					
			Source				
			Programme reports; moni oring reports; A ter Action Rev ew Reports				
IMPAC WEIGH ING (%)	**Performance Indicator 2 3**		**Baseline**	**Milestone 1**	**Milestone 2**	**arget (date)**	
	Number of countr es with evidence of human, environmental and animal health departments working ointly in ine w th the One Health Approach	**Planned**	0	2	10	20	
		Achieved					
30%			**Source**				**RISK RA ING**
			Programme reports; annual reviews; monitoring repor s				**Moderate**
INPU S (£)	**DFID (£)**		**Govt (£)**	**Other (£)**	**otal (£)**	**DFID SHARE (%)**	
	£16m						
INPU S (HR)	**DFID (F Es)**						

OU PU 3	**Output Indicator 3 1**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	**Assumptions**
African governments and WHO AFRO accountab e for IHR and quality of pub ic health services at a l leve s (for the external technical agency)	Number of civil socie ies and media out ets engaged to moni or health services and report on publ c hea th ssues	**Planned**	TBC	N/A	30% over baseline	50% over baseline	Civil society and other actors show adequate wi l and capacity to engage w th holding governments and other institutions to account. Clear mechanisms es abl shed for the actors to monitor government programmes
		Achieved					
			Source				
			Analysis by Managing agent/civil society				
	Output Indicator 3 2		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	Nat onal and reg onal civ l soc ety organisations tracking and publicising investments in d sease preparedness and public health systems - th s would be spec fic to the to 6 countries receiving ex ernal techn cal assistance through TDDAP. (ETA responsib e)	**Planned**	TBC	N/A	Civil society represented in national planning processes; Civil society organ sa ions have disease preparedness on the agenda at reg onal and national levels in to 6 countries (refine)	Public expenditure reviews util sed for advocacy at national and regional levels.	
		Achieved					
			Source				
			Programme reports - civil society analysis				
IMPAC WEIGH ING (%)	**Output Indicator 3 3**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	Country governments supported to embed disease preparedness into publ c hea th systems strengthening p anning and programming (ETA and WHO responsible for areas of coverage)	**Planned**	TBC				
		Achieved					
20%			**Source**				**RISK RA ING**
			Analysis by third party monitoring/civil society				Low
INPU S (£)	**DFID (£)**		**Govt (£)**	**Other (£)**	**otal (£)**	**DFID SHARE (%)**	
	£5m						
INPU S (HR)	**DFID (F Es)**						

OU PU 4	**Performance Indicator 4 1**		**Baseline**	**Milestone 1**	**Milestone 2**	**arget (date)**	**Assumptions**
Accurate da a and evidence for preparedness, speedy response and accurate, con extua ly appropriate decision-making (ETA in focus countries and WHO in all others)	Number of countr es that are implementing IDSR (surve llance system) including event-based surveil ance systems with at east 90% country coverage. (the indicators in the WHO framework are based on health workers but coverage should be about popula ion/geograph c areas)	**Planned**	15 (Benin, Côte d Ivoire, Guinea, Mali, Senegal, S erra Leone, Togo, Angola, Burundi, Gabon, Rwanda, Lesotho, Uganda, Swazi and, South Sudan)	20 (N/A in ETA countries)	30	0	Communities and d stricts are engaged e fectively through cu tura ly and contextually relevant approaches at sca e. Data/in ormation shared by countries
		Achieved					
			Source				

			WHO repor s; KPI on IDSR				
	Performance Indicator 4 2		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	Number of countr es with national plans (technical strategies) that are evidence- based and use ocally context-specific evidence of what works in their setting (including community-based approaches) relating o d sease preparedness/acute publ c hea th events	**Planned**	0	5	15	0	
		Achieved					
			Source				
			WHO reports				
	Performance Indicator 4 3		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	Number of WHO Col aborating Centres mon toring the work on hea ths secur ty and hea th systems deve opment	**Planned**	(Institut Pasteur Dakar; C RMF Gabon; NICD South Africa; Institut Pasteur Madagascar)			5	
		Achieved					
			Source				
			WHO Repor s				
IMPAC WEIGH ING (%)	**Performance Indicator 4 4**		**Baseline**	**Milestone 1**	**Milestone 2**	**arget (date)**	
	Number of countr es with strengthened routine health information sys ems for generation of quality assured data	**Planned**	0		10	20	
		Achieved					
			Source				**RISK RA ING**
20%			WHO reports of HMIS use, WHO mon toring reports of rSiS website; reports from third-party monitoring				**Moderate**
INPU S (£)	**DFID (£)**		**Govt (£)**	**Other (£)**	**otal (£)**	**DFID SHARE (%)**	
	£13m						
INPU S (HR)	**DFID (F Es)**						

OU PU S	**Output Indicator 5 1**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	**Assumptions**
	Number of countr es with func ional public health emergency operat ons centres (or equiva ent) operating according to minimum common standard (as per regional strategy or public health security) - WHO in arget countries.	**Planned**	5 (Kenya, Senegal, Uganda, Guinea and S erra Leone)	15	25	30	Effective coordination of stakeholders in countries under Government structures.
	Rapid Response capacity to reduce the magn tude of disease outbreaks	**Achieved**					
			Source				
			WHO assessments; 3rd party monitor ver fication report				
	Output Indicator 5 2		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**	
	Number of targeted countries with multi-func ional rapid response teams (at national and distr ct evels) in place to prepare and respond o emergenc es	**Planned**	35	0	7	7	
		Achieved					
			Source				
			WHO and partners reports; documented mapping of partners				
IMPAC WEIGH ING (%)	**Output Indicator 5 3**		**Baseline**	**Milestone 1**	**Milestone 2**	**arget (date)**	
	% graded emergencies for which contingency fund requested s transferred w thin 72 hours of approval (assess WHO and DFID separa ely)	**Planned**	WHO: within 8 hours of applying; DFID: more than 72 hours for outbreak control	A l	A l	All	
		Achieved					
			Source				**RISK RA ING**
10%			WHO con ingency fund mon toring reports; Third-party monitoring reports; DFID records of own contingency fund				**Low**
INPU S (£)	**DFID (£)**		**Govt (£)**	**Other (£)**	**otal (£)**	**DFID SHARE (%)**	
	£1m (contingency up to £20m)						
INPU S (HR)	**DFID (F Es)**						

KPI s (WHO ONLY will form part of payments)	**KPI 1**		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**
	Excellence in risk and financial management: Internal Audits Assessment of the effectiveness of governance performance risk management and control processes in line with WHO compliance rules and regulations @Regional level % of internal audits issuing a "Satisfactory" or "Partially Satisfactory" assessment @Country level For audited countries only: Delays in closing audit reports (in months)	**Planned @country level Green = over 80% of audits issuing a satisfactory or partially satisfactory assessment Ye low: 50 79% of audits issuing a satisfactory or partially satisfactory assessment Red: less than 50% of audits issuing a satisfactory or partially satisfactory aud t**	TBC	TBC	TBC	TBC
WHO AFRO's transformation agenda, part of the WHO global reform programme, drives AFRO towards organisational exce lence, de ivering VFM for UK taxpayer investments		**Achieved**				
NOT TO BE NCLUDED IN IMPACT WE GHTING FOR THE OVERALL PROGRAMME			**Source**			
			WHO reporting against Transformation Agenda KPI's			
	KPI 2			**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**
	ransparent VFM budgets focussed on key priorities:WHO AFRO p ays a strong supportive ro e in WHO HQ's development of an organisation-w de VFM p an, role-modelling/ p loting new VFM ac iv ties in AFRO	**Planned**	TBC	Evidence of cost-saving init atives and reduction in general operating costs. Mee ing costs and expenses streamlined.	TBC	TBC
		Achieved				
			Source			
			WHO reports; DFID Global Funds Department annual assessment			
	KPI 3		**Baseline**	**Milestone 1**	**Milestone 2**	**arget (date)**
	Strengthened inter-cluster col aboration to address cross-cutting issues like HSS, gender, leave no one behind agenda, etc (refer to Transformat on Agenda - smart technical support)	**Planned**	Little evidence of col aboration except at HQ level between HSS and WHE clusters.	3 examples of inter-cluster col aboration	TBC	TBC
		Achieved				
			WHO reporting; DFID qualitative assessment			
	KPI 4		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**
	Qua ity bi-annual reports submit ed to agreed dead ines	**Planned**	0	Achieved	Achieved	Achieved
		Achieved				
	(Qua ity assessed against comp eteness of agreed reporting format, ol ows agreed outputs, and ut lity)		**Source**			
	KPI 5		**Baseline**	**Milestone 1 (une 2018)**	**Milestone 2 (une 2019)**	**arget (March 2020)**
	% of DFID funding streams forecasts within 10% of actual spend every quarter - focus on TDDAP & malar a to AFRO	**Planned**	0	75%	100%	100%
		Achieved				
			Financial reports variances			
INPU S (£)	**DFID (£)**		**Govt (£)**	**Other (£)**	**otal (£)**	**DFID SHARE (%)**
INPU S (HR)	**DFID (F Es)**					

KPI assessment for WHO AFRO all related to the transformation agenda:
At annual review
Assess if agreed milestone targets are achieved/not achieved
If -5/5 achieved Full payment This will change to 5 5 for year 2 after the annual rev ew.
If 3/5 achieved 10% taken off funds for the year (ca culated as the whole years budget)
If 0-2/5 achieved 30% taken off funds for the year (ca culated as the whole years budget)

Indicator	Definition (not finalised and will be with partners)
Effective coordination between international and regional institutions (e.g. African CDC, WHO AFRO, US, AU, others) - need to define this.	Evidence of MoUs; coordinated multiagency response to epidemics; multiagency exercising; programme portfolio mapping done; shared protocols; joint responses, joint training; key actor interviews by social scientists.
Number of countries with improvement in IHR evaluation scorecards (as verified by Self-assessments) annually -- JEE after two years at end line.	Reports of progress towards indicators on national JEE action plans, in line with national JEE AP monitoring processes. (JEEs are not an annual process, but annual self-assessment reports inbetween JEEs, exercises and training, and delivery of contents of post JEE National action plans will be good indicators . MINIMUM IMPROVEMENT WILL NEED TO BE DEFINED
Number of countries working on effective cross-border approaches to strengthen health security	?have made staff available for cross-border taskforces such as Africa CDC Public Health Corp
	?cross border exercises or joint training.
	?Legislation mandating cross-border collaboration.
	IHR reports to other states of specific incidents e.g. travellers with notifiable disease.
Number of countries with evidence of human and animal health departments working jointly to tackle health security in line with the One Health Approach	As per WHO JEE indicators
Country governments supported to embed disease preparedness into public health systems strengthening planning and programming - how to measure	Presence of an NPHI or other cross-govt agency with a clear legal mandate for disease preparedness.
	Multi-sectoral all-hazard emergency preparedness and response plans with system wide exercises and training might be appropriate.
	This is a JEE area.
Percentage of countries that are implementing IDSR (surveillance system) including event-based surveillance systems with at least 80-90% country coverage.	Need to consider whether to use country coverage by population or area.
Number of countries with national plans (technical strategies) that are evidence- based and use locally context-specific evidence of what works in their setting (including community-based approaches) relating to disease preparedness/acute public health events	Going one step beyond this would be to self-audit compliance with national standard operating procedures for disease response.
Number of countries with strengthened routine health information systems and data quality	Presence of an evidence-based overarching surveillance strategy and audit programme? Evidence of routine quality audits
Number of countries with functional public health emergency operations centres according to minimum common standard (as per regional strategy for public health security) - WHO in target countries	Are EOCs being activated in line with national response plans? Do they work effectively when activated? Exercises? Collaboration with WHO EOC-NET
% of target countries with multi-functional rapid response teams (at **national and district levels**) in place to investigate suspected cases for infectious disease outbreaks under the integrated disease surveillance and response (IDSR) framework	District coverage of teams with ability to respond e.g. have vehicles, fuel and mandate, right skill set, evidence of training/ exercising / action cards.
	Might not be feasible in timescale of programmes, and need to make sure baseline can be measured.

Smart Guide

Teams should use the guide below to complete the logframe template.

PROJECT TITLE

A meaningful, easily understood (plain English) Project Title.

IMPACT

Long term goal to which the project will contribute towards achieving. When drafting the impact statement, consider how your project fits with other efforts from DFID and partners to achieve the impact, ie is your project nested within a broader undertaking?

OUTCOME

The outcome of your project identifies what will change, who will benefit and how it will contribute to reducing poverty, including contributions to the Millenium Development Goals (MDGs) or Climate Change.

An assessment of whether your project achieved the Outcome will be included in the Project Completion Review (PCR). Ongoing monitoring of progress against outcome milestones should still take place as an assessment of whether you expect to achieve the Outcome by the end of the programme will be included in Annual Reviews.

OUTPUTS

Outputs are the specific, direct deliverables of your project. These will provide the conditions necessary to achieve the Outcome. The logic of the chain from Output to Outcome therefore needs to be clear.

Progress against Output milestones and results achieved will be assessed and scored during Annual Reviews and the Project Completion Review.

IMPACT WEIGHTING

Once you have defined your Outputs, assign a percentage for the contribution each is likely to make towards the achievement of the overall Outcome.

The impact weights of all the Outputs will total 100% and each are rounded to the nearest 5%.

Impact weightings for Outputs are intended to:

- Promote a more considered approach to the choice of Outputs at project design stage; and
- Provide a clearer link to how Output performance relates to project Outcome performance.

INPUTS

Clarification of inputs is a key part of results-chain thinking. Inputs are specified at the country-level in country operational plans and the project information contained in logframes should feed up into these.

The input-level boxes show the amount of money provided by DFID and any partners (£) including, where relevant, the government's own contribution. This only relates to monetary (not in kind) contributions. At Outcome level this is equal to the sum of Inputs for all Outputs. The DFID share at Outcome Level is a simple, pro rata calculation of DFID's contribution in monetary terms for all outputs.

Information should also be provided for the total number of Annual DFID Full-Time Equivalents (FTEs) allocated to this project, based on the time individual staff members will spend on the project. It is understood that this may change through the project cycle, and is intended as a management tool.

INDICATORS

Indicators are performance measures, which tell us what will be measured **not** what is to be achieved. Avoid including elements of the baseline or target.

What makes a good indicator?

- **Specific** – what will be measured? And how?
- **Measurable -** data can be collected
- **Relevant** - to the results chain
- **Useful** – for management decision making
- Does not include any element of the target
- Can be **disaggregated** if relevant
- Good mix of **qualitative** and **quantitative**
- **Already defined -** if relevant include indicators which towards the DRF / OP / ICF KPIs / MDGs.
- Consider using **standard indicators** / **best practice indicators / learning from other projects**

The basic principle is that "if you can measure it, you can manage it".
Top Tip – select indicators based on relevance to the Results Chain and the availability of data.
Best Practice suggests a maximum of three Indicators per Output.

Some example indicators for a WASH project are shown below.

IMPACT: Improved well being and rural health	•Under 5 mortality rate •Quality of water used per capita per day
OUTCOME: Increased sustainable access to and use of improved water, sanitation and hygiene facilities for the rural population	•% of rural population with access to improved water supply within 500m. •Number of additional people provided with clean water •% of rural population with access to adequate sanitation •Number of additional people with access to adequate sanitation

population	
OUTPUT: Increased and improved access to well maintained water and sanitation facilities	•Number of new (and rehabilitated) water points constructed •Number of new (and rehabilitated) small piped systems functioning •Number of improved latrines constructed

BASELINE

Baselines set the starting point and provide a measure of the situation before your project starts (could be zero if a new project).

The baseline is used to measure change and monitor progress.

Include a baseline for each of your indicators. The first 6 months of a project may exceptionally be used for assembling baseline data at output level if agreed by your SRO.

Use existing data where possible, but check reliability and seek assurances regarding the data quality eg use data from national statistical systems / MIS.

If you need to collect your own data - collect baseline data early – as soon as beneficiaries have been identified but before any results are expected.

MILESTONES

Milestones are the desired trajectory from baseline to target, helping you to track progress and make changes to underperforming areas.

Will depend on sequencing of activities and data availability.

Include REALISTIC milestones given resources and capacity.

At the output level include annual milestones for each year of the project (or monthly if short term). At outcome & impact level data may not be available annually.

TARGET (DATE)

Targets set the desired point, showing what is achievable within the timeframe available.

The target is often the last year of the project (or month if its short term).

Include realistic targets given resources and capacity, the baseline situation, funding available and country/operational context. Project targets might be informed by evidence about what has worked in the past and take into account lessons learned from other projects.

Include targets dissaggregated by sex/geography/income etc where appropriate.

Consider using government targets although if they are too ambitious then make a more realistic estimate.

Top Tip - A good Theory of Change will help you think about what is realistic and achievable as it will enable critical reflection of context, external influences & assumptions.

SOURCE

Each Indicator will have a data source to verify the results achieved.

List the specific data sources i.e. give the specific data collection e.g. named survey / report and avoid just naming the organisation.

State the frequency of the data source and ensure consistency with milestones and targets.

Check the source can provide disaggregated data as required.

Consider and specify the data collection and reporting responsibilities to ensure the results planned and forecast rows in the logframe are updated on a regular basis.

Top Tip - Before using a data source, assess its quality and seek assurances from data providers where needed ie consider its validity, reliability and availability.

ASSUMPTIONS

Define any assumptions which are linked to the realisation of your project's individual outputs, as well as those which are critical to the realisation of the outcome and impact: these will not all be the same.

RISK RATING

Risk ratings are recorded as *Low, Medium or High* and are supported by a robust analysis including a risk matrix.

VALUE FOR MONEY

Ensure the outputs and outcome projected represent good value for the invested resources, at the beginning of the project, and through its life.

Consider including VfM metrics in the logframe (or other documents such as the Delivery Plan) to allow VfM to be measured through the life of the project and to provide assurance at Annual Review.

VfM is achieved at different stages of the results chain. Thus for each result we seek to achieve we should aim to have metrics for each of the following:

Economy - Are we (or our agents) buying inputs of the appropriate quality at the right price?

Efficiency - How well are we (or our agents) converting inputs into outputs? (‘*Spending well*’)

Effectiveness - How well are the outputs produced by an intervention having the intended effect? (‘*Spending wisely*’)

Cost-effectiveness - What is the intervention’s ultimate impact on poverty reduction, relative to the inputs that we or our agents invest in it?

DFID’s Approach to Value for Money (Smart Guide) provides further advice on ensuring VfM.

Annex C – Theory of Change for overall programme with specific inputs related to this ToR underlined

INPUTS

£xm to fund WHO AFRO's Transformation Agenda

<u>£xm technical assistance to support national and cross-border IHR capacities</u>

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

<u>£xm to strengthen data and surveillance systems</u>

£xm rapid response capacity/simulation/EOC's

<u>Up to £20m potential contingency</u> mechanism

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

Inputs to Outputs: Assumptions

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

OUTPUTS

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

African countries improve adherence to IHR standards

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

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

Rapid Response capacity to reduce the magnitude of disease outbreaks enhanced

Outputs to Outcome: Assumptions

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

OUTCOME

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

Outcome to Impact: Assumptions

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

Impact

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

Annex D: Duty of Care

The supplier is responsible for the safety and well-being of their personnel and third parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

DFID will share available information with the supplier on security status and developments in-country where appropriate. DFID will provide a copy of the DFID visitor notes (and a further copy each time these are updated), which the supplier may use to brief their personnel on arrival. A named person from the contracted organisation should be responsible for being in contact with DFID to ensure information updates are obtained. There should be a process of regular updates so that information can be passed on (if necessary). This named individual should be responsible for monitoring the situation in conjunction with DFID.

Travel advice is also available on the FCO website and the supplier must ensure it (and its personnel) are aware of this. The supplier is responsible for ensuring appropriate safety and security briefings for all of its personnel working under this contract.

The supplier is responsible for ensuring that appropriate arrangements, processes and procedures are in place for its personnel, taking into account the environment they will be working in and the level of risk involved in delivery of the contract (such as working in dangerous, fragile and hostile environments etc.). The supplier must ensure its personnel receive the required level of appropriate training prior to deployment.

Suppliers must develop tenders 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 included in this Annex. They must confirm in the tender that:

- They fully accept responsibility for security and Duty of Care.
- They understand the potential risks and have the knowledge and experience to develop an effective risk plan.
- They have the capability to manage their Duty of Care responsibilities throughout the life of the contract.
- They will give responsibility to a named person in their organisation to liaise with DFID and work with DFID to monitor the security context for the evaluation.

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

Acceptance of responsibility must be supported with evidence of capability (no more than 2 A4 pages) and DFID reserves the right to clarify any aspect of this evidence. In providing evidence tenderers should consider and answer yes or no (with supporting evidence) to the following questions:

I. Have you completed an initial assessment of potential risks that demonstrates your knowledge and understanding, and are you satisfied that you understand the risk management implications (not solely relying on information provided by DFID)?

II. Have you prepared an outline plan that you consider appropriate to manage these risks at this stage (or will you do so if you are awarded the contract) and are you confident/comfortable that you can implement this effectively?

III. Have you ensured, or will you ensure that your staff are appropriately trained (including specialist training where required) before they are deployed, and will you ensure that on-going training is provided where necessary?

IV. Have you an appropriate mechanism in place to monitor risk on a live / on-going basis (or will you put one in place if you are awarded the contract)?

V. Have you ensured, or will you ensure that your staff are provided with and have access to suitable equipment and will you ensure that this is reviewed and provided on an on-going basis?

VI. Have you appropriate systems in place to manage an emergency / incident if one arises?

Country Risk Assessments

Please note: The scores were extracted from Overseas Security Threat Assessment (OSTA) dated 13 Jan 2017 version 27 by DFID's Departmental Security Department (DSU).

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

Country	City	Overall Security	Violent Crime	Civil Disorder	Terrorism	Espionage
Burkina Faso	Ouagadougou (Capital)	4	4	4	4	-
Burundi	Bujumbura (Capital)	4	4	4	4	-
Cameroon	Yaoundé (Capital)	3	3	3	3	-
Chad	N'Djamena (Capital)	4	3	3	4	-
Cote d' Ivoire	Abidjan (Capital)	3	3	3	2	-
Ethiopia	Addis Ababa (Capital)	3	2	2	3	-
Democratic Republic of the Congo	Kinshasa (Capital)	4	5	5	2	-
Mali	Bamako (Mali)	4	2	2	4	-
Mauritania	Nouakchott (Capital)	4	1	1	4	-
Niger	Niamey (Capital)	4	4	4	4	-
Senegal	Dakar (Capital)	3	2	2	3	-
Sierra Leone	Freetown (Capital)	3	3	3	2	-
Uganda	Kampala (Capital)	3	3	3	3	-

Annex E: Reporting template

DFID Quarterly, Six-monthly and Annual Narrative Reporting Template

This template must be used by partners for all narrative and financial reporting to DFID when meeting the requirements above.

Narrative Progress Reporting Format:

Narrative reports should be concise and no longer than 12 pages plus one page per output report. They must include the sections set out below:

A. Basic data sheet
B. Executive summary
C. Introduction and Context
D. Performance and Conclusions
E. Report by output
F. Value for Money and Financial Performance
G. Risk Management
H. Commercial Considerations
I. Monitoring and Evaluation
J. Management and Administration
K. Programme Governance
L. Women and Girls
M. Gender Equality
N. Climate Change
O. Due Diligence
P. Security
Q. Communications and Information
R. Financial report
S. Annual Audits

All sections in red below also form part of the DFID Annual Review template.

A. Basic data sheet (1 page)

This should give the following information:

- **Name of project** - including location;
- **Name of organisation** - with name, designation, address, telephone, fax and email of the contact point for this project. Add parent organisation and partner organisation details where applicable;
- **Project cost** – identifying separate contribution given by DFID, WB and contributions by other donors; total value of the project;
- **Project purpose** - a sentence that identifies the purpose of the project;
- **Project duration** - with start and end dates;
- **Type of agreement with DFID** (i.e. Accountable Grant, MOU, contract – Please also include DFID Component Numbers):
- **Status of report** - is this an Interim Progress Report (indicate 1st, 2nd, 3rd etc) or a Final Project Report? What dates does it cover?

B. Executive Summary (1 page)

In this part of the report, please **summarise** the main body of the report i.e.

- summary of progress, including key achievements and milestones (for last reporting period only; for entire programme if end-of-programme report);
- summary of lessons learnt; including technical and managerial lessons (e.g. personnel, financial management, partnerships, assets) Programme and management).
- summary of actions on previous recommendations
- summary of any key recommendations for the next reporting period.
- summary of operational constraints that have arisen and action taken to address them;
- summary of any issues requiring a DFID decision or urgent discussion.

N.B. Anything that might impact on timing and delivery of the project should be flagged to DFID at the earliest possible stage.

C. Introduction and Context (1 page)

- Programme outline and rationale (updated from BC)
- Expected results
- Contribution to DFID's international development objectives
- Any deviation from original programme documents (pls. explain – even if agreed with DFID); incl. any impact on DFID/UKAid objectives

D. Performance and Conclusions (1-2 pages)

Each project is different and so it is difficult to provide guidelines on length. Suggested lengths are therefore indicative and projects should use discretion to adapt to their specific context.

Progress should focus on **results and achievements** against agreed milestones and actions in the previous reporting period and should avoid elaboration of process.

D1: Assessment of achievements towards the outcome

- Progress towards the stated outcome statements and indicators (in the reporting period)
- Assessment whether the programme is on track to achieve outcome by end of the programme (explain if not)
- Move beyond just reporting of outputs and include context, policy dialogue and the changes you are seeing towards achievement of the outcome. Qualitative aspects should also be included.

D2: Key lessons learnt in the previous reporting period

- Key lessons learnt on (a) working with partners by implementing partner(s), recipients/clients, collaborators and funders; (b) project management; (c) innovative/new ways of working
- Assessment of whether assumptions (from BC and/or last AR) have changed (pls. explain); including whether the programme would be designed differently if it were to be re-designed
- Plans for sharing of lessons learnt in the team, with DFID (and other funders?) and externally (where applicable)

D3: Suggested key actions for next reporting period

- Any further information on key actions (not covered in the summary), incl. timelines and responsibilities

D4: Logframe changes

- Description of logframe changes in the reporting period and rationale
- Expected impact of these changes for the programme
- Recommendations for future changes

D5: Report against agreed annual workplan. This can be presented in matrix format (2 PAGES). This should briefly summarise:

- status of delivery against approved workplan;
- explanation if planned activity did not take place, or milestone not achieved;
- if activity did not take place, will this slip to the next reporting period. Any impact on agreed resources (staff and budgets)?
- where possible, summarise outcome of activity.
- workplan for next reporting period and any proposed changes to the current approved workplan.

E. Report by Output (max. 1 page per output)

- Summary of progress against expected milestones and results by output
- Current impact weighting; any suggestions for change of impact weighting and explanation.
- Current risk rating (also corresponding to current logframe); any suggestions for changes, including any new risks should be flagged
- Table of indicators, expected milestones and progress towards the milestones
- Key points describing progress of this output
- Response to recommendations of previous AR (where relevant) to this output
- Recommendations for future reporting period(s) to this output

Please attach the latest agreed logframe; where this is an Annual Report preceding an Annual Review or a Programme Completion Review, please complete the achievements section in the logframe.

NB: General principles:

a. **use of numbers**. Reports should quantify activities and outputs wherever possible.
b. **gender**. Where appropriate, data presented should be disaggregated by gender and impacts described for both women and men.
c. **sub grant reporting**. Where a project includes a substantial number of sub grants, then the narrative reporting should report not just on number and type of grants disbursed, but also on outputs and outcomes i.e. how the implementation of the sub-grants helps to achieve the project purpose and outputs. Sub-grants reports should be included as an annex.

F. Value for Money and Financial Performance (1 page)

F1: Key cost drivers and performance.

- Update of actual costs and cost drivers compared to BC, e.g. consultancy fees, travel and expenses.
- Changes to costs/cost drivers identified in previous ARs or BC and explanation

- Areas where the programme has achieved value for money during the reporting period.

F2: VfM performance compared to the original VfM proposition in the business case

- Performance of programme against VfM measures and trigger points
- Suggestions for any changes to the VfM measures and trigger points and rationale

F3: Assessment of whether the programme continues to represent value for money

- Following DFID metric on 3Es: Economy, Efficiency and Effectiveness (possibly with Equity as well)
- If programme is considered not to represent VfM, why not and what actions can be taken to achieve VfM

F4: Quality of Financial Management

- Best estimate of future costs against current approved budget and forecasting
- Adherence to narrative and financial reporting requirements
- Conclusions of last financial report
- Achievement of auditing requirements

G. Risk Management (½ page)

G1: Overall output risk rating (low/medium/high)

- State the documented risk for the reporting period
- Recommendations for change to overall risk based on individual output risks; explain any suggested changes

G2: Overview of Programme Risk

- Any new overall risks that DFID should be aware of
- Also highlight any potential reputational risks for DFID and other stakeholders which need to be managed.
- Suggestions for change of the overall risk environment/context and reasons
- Review of all documented and suggested risks and how they affect the programme delivery
- Review of current or suggested mitigating actions to address the risks; how are these actions affecting the identified risks
- Assessment of safeguarding and mitigation measures, including whistleblowing policies and actions.
- Requirements for additional checks and controls to ensure UK funds are not lost (e.g. but not limited to corruption and fraud)

G3: Delivery Chain Map (see Annex F)

- Update the Delivery chain map that was produced for the design report, noting any changes to funding flows and risk with downstream partners (if relevant).

G4: Outstanding actions from risk assessment

- Outstanding actions from due diligence, fiduciary risk assessment, safeguarding or programme risk matrix
- Follow-up on DFID counter-fraud and anti-corruption strategies

Please include an updated risk matrix as an annex.

H. Commercial Considerations (½ page)

H1: Delivery against planned timeframe

- Comparison of actual progress against approved timescales in the BC and follow-up documents (contract, ToR, AR)
- Explanation for any deviation to original timescales

H2: Performance of partnerships

- How well are formal partnerships/ contracts working
- Lessons learnt from partner experience and application of those lessons
- Ways for DFID to be a more effective partner

H3: Asset monitoring and control

- Description of asset management and monitoring, including spot checks
- List of assets which have been procured over the reporting period and are each valued £500 and above
- Please attach an annex with a complete asset register

I. Monitoring and Evaluation (½ page)

I1: Evidence and evaluation

- Changes in evidence and implications for the programme
- Where an evaluation is planned, update on progress
- How is the Theory of Change in the Business Case and the assumptions used in the programme design working out in practice?
- Are modifications to the programme design required?
- Is there any new evidence available which challenges the programme design or rationale? How does the evidence from the implementation of this programme contribute to the wider evidence base? How is evidence disaggregated by sex and age, and by other variables?
- Where an evaluation is planned set out what progress has been made

I2: Monitoring process throughout the review period

- Direct feedback from stakeholders, including beneficiaries
- Monitoring activities throughout review period (field visits, reviews, engagement etc)
- Including plans for the next reporting period.

J. Management and Administration (½ page)

Update on:

- Human resources and staff management
- Financial management
- Procurement and contracting
- Operational constraints (both technical and administrative), incl. how these may have impacted on programme implementation and what mitigating actions have been taken

Please include current project staff organogram as an annex.

K. Programme Governance (½ page)

- Update on changes to the Programme governance (where relevant)
- Key action points from meetings under the Governance structure.
- Key action points from programme management meetings with DFID-SA and other partners (where applicable)
- Report on action points from previous reporting period

Please include as an annex (i) current Programme Governance Structure including relevant current ToRs of any bodies (i.e. Steering Committees, Advisory Bodies, and/or Management Committees) and their membership; and (ii) minutes of any meetings during the period of report.

L. Leaving no one behind (½ page)

Update on progress made to ensure that the poorest, people with disabilities, elderly and children, most excluded and hardest to reach are prioritised to ensure that they can access and benefit from public health systems and prevention activities.

M. Gender Equality (½ page)

Now a mandatory requirement, this should include an update on progress of specific action the programme has taken, or plans to take. Please refer to The UK's Gender Equality Act May 2014. (0.5 PAGES)

N. Climate Change (¼ page)

This should include an update on progress of specific action the programme has taken, or plans to take, so that it builds resilience against the negative impact of climate change.

O. Due Diligence (¼ page)

Progress on action points arising from any assessments carried out by your organisation on any sub-grantees. Please also provide as an annex any relevant Due Diligence assessments carried out by your organisation on sub-grantees.

P. Security (max ¼ page)

Please make DFID aware of any security issues that might directly impact on the outcomes of the project.

Q. Communications and Information (max ¼ page)

Please describe activities on communications in terms of products, events and other activities since the last report.

R. Financial report (1 page)

The financial report should show complete financial position of the programme:

- All donor commitments/spend in the same currency as the approved project budget.
- All agreed budget lines including income/spend/commitments (in the form of contracts) and unallocated.
- For reporting on upfront funding please quote the exchange rate used in the money transfer for each tranche being accounted for.
- Realistic forecast of spend for subsequent quarters.
- Narrative explaining spend variances to forecasts including any risks associated with delivery and/or identification of issues (i.e. budget virements) requiring discussion/decision.

S. Annual Audits (½ page)

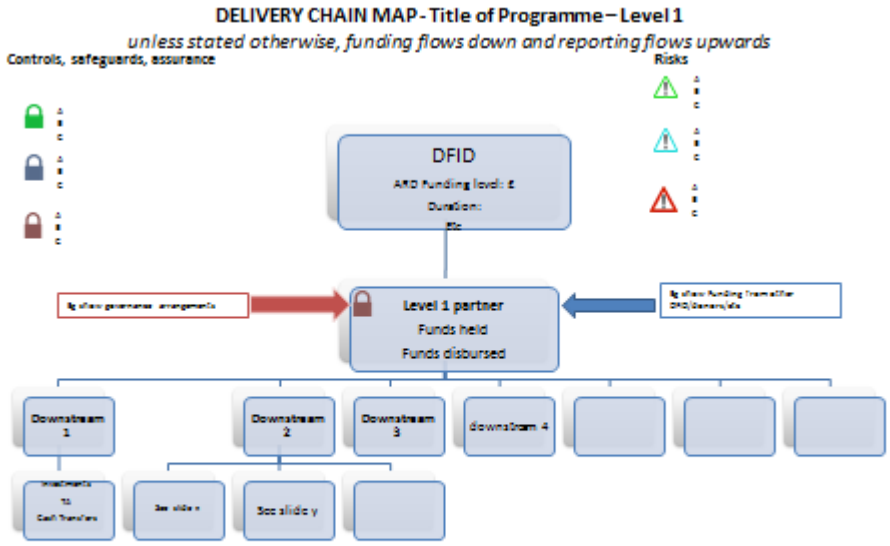
This should report on progress arising from agreed action points arising from last report. It should also provide a summary on the status of progress on arranging the next audit including the date it will be submitted to DFID. If audit reports are going to be submitted late DFID needs to know as early as possible including an explanation.

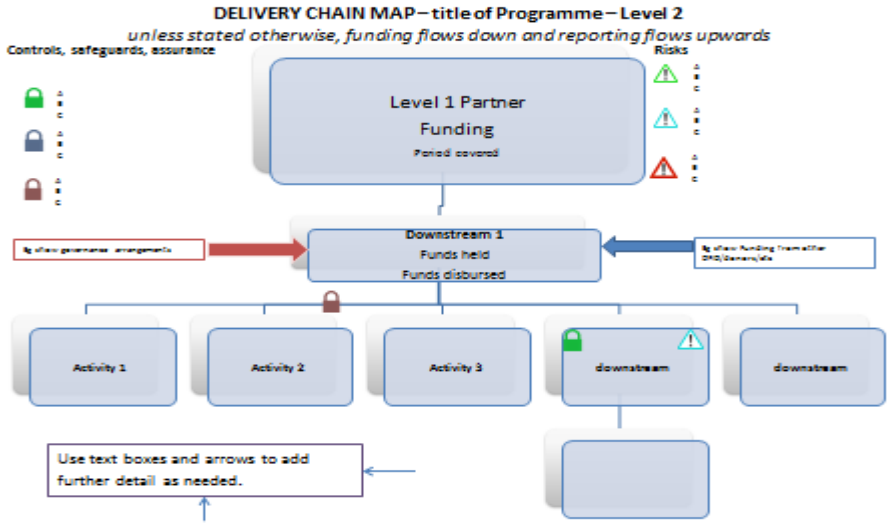
Progress against current Logical Framework

OBJECTIVES *Insert statements from original logframe.*	**INDICATORS and MILESTONES** *Insert statements from original logframe and any modifications.*	**PROGRESS** *Comment against each Indicator Milestone outlining key issues faced, and any reassessment of assumptions and risks. This should include progress since project start with changes since the last report highlighted in bold.*	**RATING *** 	**COMMENT** *Indicate actions proposed or taken to overcome problems and any recommendations*
IMPACT *(Final report only)*				
OUTCOME *NB. Under progress indicate how achievements against project purpose can be directly attributed to this project*				
OUTPUTS *NB: Please give a breakdown of each individual Log Frame indicator.*				

Description	Scale
Outputs substantially exceeded expectation	A++
Outputs moderately exceeded expectation	A+
Outputs met expectation	A
Outputs moderately did not meet expectation	B
Outputs substantially did not meet expectation	C

Annex F: Delivery chain risk map – example





Annex G: Terms of Reference for Third Party Monitoring

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

Contents

1. Introduction

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

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

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

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

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

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

2. Objective

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

a) Independent verification of activities and results as outlined in the log frame.
b) Generating additional evidence.

c) Independent verification of financial and programme management data.
d) Inform and facilitate learning.

The **purpose** is to ensure that TDDAP is having the intended impact by focusing on **assurance and accountability** and the **facilitation of learning and adaptive management** in order to improve the overall performance. Third Party monitoring will ensure independent monitoring and quality assurance of programme delivery, documentation of lessons and robust tracking of results

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

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

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

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

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

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

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

3. Recipient

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

4. Scope of Work

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

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

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

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

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

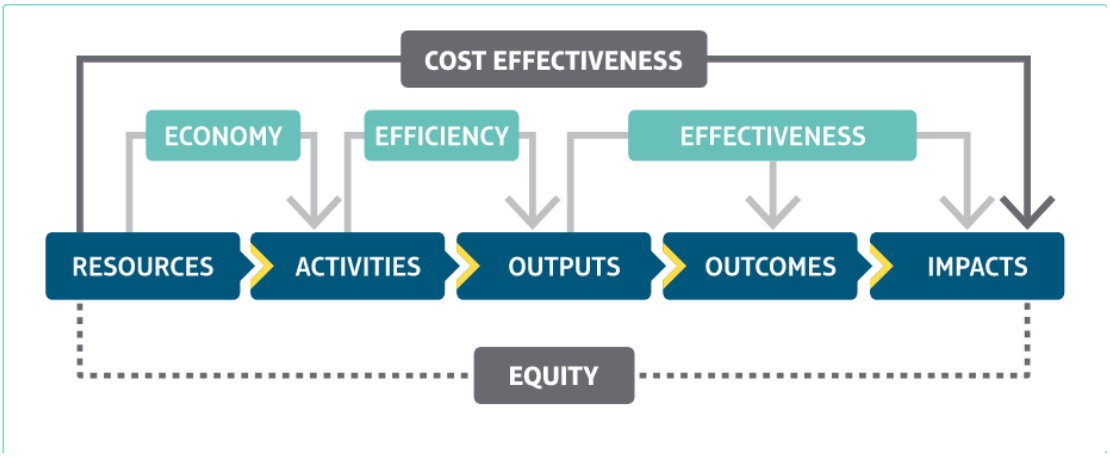
The TPM Supplier will provide the following:

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

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

b) Generating additional evidence

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



c) *Independent verification of financial and programme management data*

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

d) *Inform and facilitate learning*

- Using the findings from verification of results, activities, financial and programme management data, facilitate programme learning between implementers, WHO, DFID and relevant external stakeholders.
- Disseminating the research outputs appropriately and facilitating learning and uptake of findings. This will include to external audiences as a global good and will include theory of change workshops if the research was shaped to strengthen or test linkages within the TDDAP theory of change.
- Using the totality of the TPM supplier activities, provide insights into the implementation and progress of programme delivery. Of importance to DFID is the inclusion of beneficiary[9] feedback and evidence to inform the programme and communications (e.g. voices) (this should be collected under the verification of results and activities).
- Sharing learning from the evidence generated from the programme with DFID and key partners (convening meetings, sharing reports), promoting evidence uptake in Global Health Security Programmes. The TPM Supplier should clearly set out its lesson learning and dissemination approach in its communication plan to be agreed in consultation with DFID.
- Coordinate with the Public Health England TPM on their global health programme, particularly around research (once in place).

Geographic focus:

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

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

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

5. Methodology

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

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

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

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

6. Outputs

Proposed outputs under the scope of the programme will include:

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

- Third-party monitoring of programmes, providing robust and independent oversight of the programme's delivery [quarterly review of KPI reports]
- Provision of evidence and monitoring to support DFID reviews [at least annually]
- Assessment of monitoring systems currently used by the implementing partner to build an evidence base of which interventions are working well

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

b) Generating additional evidence of results

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

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

c) Independent verification of financial and programme management data

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

User: *DFID, Programme Steering Committee*

d) Inform and facilitate learning

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

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

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

7. Deliverables

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

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

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

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

8. Performance Management

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

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

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

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

9. Constraints and dependencies

- WHO started implementation in December 2017 and it is recognised that there will be a disconnect between the TPM, Supplier and WHO's timelines. The TPM Supplier will undertake retrospective analysis for the interim period of transition.
- The ETA will start in August/September 2018 if not sooner (subject to tender), however the TPM Supplier will review the proposed M&E plan and fiscal controls and provide recommendations once appointed.
- Work on WHO's component can start immediately.
- At the earliest time feasible, the WHO, ETA and TPM will be convened by the TPM to ensure that all parties agree on the frameworks, structures and methodologies to ensure that the TPM requirements are met.
- The TPM should have audit-type capacities as well as a good contextual understanding of the geographies and programme components with a strong practical capability of assessing data and programme quality.
- The TPM will have good relationships with country partners and ability to operate.

10. Contract Management

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

DFID Co-ordination

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

Data Ownership

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

11. Risks and Challenges

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

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

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

Finance

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

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

Assets

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

12. Expertise

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

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

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

b) Generating additional evidence

- Ability to integrate creative approaches to traditional qualitative and quantitative research methods.
- Experience of operational research, inclusive of identifying and prioritising operational research needs with other parties and disseminating findings appropriately, ensuring evidence uptake by a range of partners.
- Economic and VFM analytical skills. In particular experience of using applying the 4Es in complex developmental programmes, adapting traditional methodologies where

needed. Ability to call on a range of experts as needed to address specific requirements.

- Ability to present complex issues in a clear and accessible way.
- Ability to incorporate flexibility and innovation into M&E design and approach.
- Close understanding of political economy of each country and risks and opportunities.
- Good understanding and application of global health security and disease preparedness work as well as the ability to apply the remit of International Health Regulations (IHR) and 'One Health' to different country contexts as required.

c) Independent verification of financial and programme management data

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

d) Inform and facilitate learning

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

13. Logistics and procedures

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

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

14. Reporting

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

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

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

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

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

15. Communication:

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

16. Timeframe and Scale up/Extension options

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

17. Budget

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

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

18. Duty of care

The TPM Supplier is responsible for the safety and well-being of their Personnel and Third Parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property**. Please see Annex D for full details of DFID's Duty of Care Policy and Country Risk Assessment.**

19. Branding

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

20. Transparency

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

21. Ethical Principles

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

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

22. Safeguarding

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

own processes. The capacity of our partners to do this and their effective performance should be a key risk assessment factor in programme design, delivery and monitoring and evaluation.

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

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

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

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

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

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

Business Case

Summary Sheet

Title: Tackling Deadly Diseases in Africa Programme (TDDAP)		
Programme Summary: The Tackling Deadly Diseases in Africa Programme (TDDAP) aims to save lives and reduce the impact of disease outbreaks and epidemics on African populations. TDDAP will strengthen African health systems and institutions by supporting: (i) World Health Organisation Africa Office (WHO AFRO) reform, (ii) countries' ability to achieve the International Health Regulations (IHR), (iii) better governance and accountability of public health systems, (iv) improved data and evidence, and (v) emergency response.		
Programme Value: £40m plus up to £20m contingency mechanism		**Region:** Africa
Programme Code: 205242	**Start Date:** **July 2017**	**End Date:** **March 2020**
Overall programme risk rating:	**Moderate**	
EDRM Number:	**5759498**	

Acronyms

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

Intervention Summary

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

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

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

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

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

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

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

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

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

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

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

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

A. Strategic Case

Why is UK support required?

Background and Problem Statement

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

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

2. The weaknesses in national public health systems were exposed by the Ebola Virus Disease epidemic in West Africa; the worst in history in terms of magnitude, geographical scope and duration. The outbreak began in Guinea in late 2013, after which the disease spread rapidly to Sierra Leone and Liberia. The WHO designated the outbreak a public health emergency of international concern in August 2014. By the end of 2014, in addition to Guinea, Sierra Leone and Liberia, cases had also been reported in Nigeria, Senegal, Mali, Spain and the United States. Without interventions or changes in community behaviours, the US Centers for Disease Control and Prevention (CDC) predicted that Sierra Leone and Liberia would face up to 1.4 million cases of Ebola by January 2015.[3]

3. The response effort was a success in controlling the spread of infections. As a result of concerted action by international partners (including the UK) and African governments, these cataclysmic predictions did not become a reality: 24,802 cases were reported in Sierra Leone and Liberia, with a further 3,814 cases in Guinea.[4] In addition, a potential fourth country outbreak was averted. However, despite these successes, immense suffering and fear were experienced by communities, national health systems were brought to a halt, and hard-won social and economic gains were reversed. The World Bank estimates that the Ebola outbreak cost the economies of Sierra Leone, Liberia and Guinea $1.6 billion in 2014 and 2015.[5] The cost of dealing with the outbreak was nearly three times the annual cost of investing in building a universal health service in all three affected countries[6].

4. DFID's interventions during the Ebola crises and in other public health emergencies have contributed to a common understanding of the weaknesses in African health systems and the

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

international health architecture. The programme proposed here will address the challenges that have undermined efforts to prevent and respond to disease outbreaks:

a. **African national public health systems do not have the minimum level of core capacity to detect report and respond effectively to serious disease outbreaks.** Across Africa, investment in the health sector is below that required to establish and maintain effective services. In 2015, only eight countries had met the Abuja Declaration target of allocating at least 15% of their annual budget to improve the health sector.[7] Even before Ebola killed hundreds of health staff, the three countries at the centre of the outbreak had acute shortages: among every thousand people Guinea could count only 0.1 doctors, Liberia 0.014 and Sierra Leone 0.022.[8] Despite recent progress in the prevention and treatment of diseases like malaria, the continued prevalence of preventable disease is indicative of poor health services. For instance, a child still dies every minute from malaria in Africa.[9] All governments must take responsibility for investing in health capacity, personnel and infrastructure to meet their commitments to international frameworks such as the IHR. Investments in 'everyday' health systems must also be increased to provide the solid foundations which emergency responses can build upon. Before the West African Ebola outbreak, Uganda had the largest Ebola outbreak in history. However because of excellent technical expertise and a comparatively operational health policy and strategic plan, delivering the essential health service package at a decentralised level, it was better able to contain future outbreaks of Ebola and other diseases through strengthening disease surveillance and control capabilities[10].

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

b. **Governance failures have led to resources being diverted from health services, eroding the trust between state and citizens and making the control of disease outbreaks more difficult[11].** The long-term failure of the governments of Guinea, Sierra Leone and Liberia to provide good quality basic services for their citizens compounded the effect of the Ebola virus. Not only was health care infrastructure under-resourced and unable to deliver life-saving care, but communities displayed suspicion of healthcare workers who represented, at best, a system with which they were unfamiliar and, at worst, a system that they perceived to be illegitimate and untrustworthy[12]. Ensuring health systems are resilient to shocks from outbreaks is essential in reducing morbidity and mortality from non-communicable diseases. In this context, we can see the importance of ensuring African governments and their international partners adequately resource health systems, with a particular focus on embedding public health services in local and community-driven approaches[13]. We also need to think and work politically in our disease interventions; long before the emergency hits we must use our influence and programming to identify and remove the political and institutional barriers to investments in public health and preparedness - not just health services for the elite in urban areas. Alongside this, we must support civil society to hold their governments and international organisations to account.

c. **The incentives for timely reporting and international declaration of a serious disease outbreak have been weak[14].** During the Ebola crisis the threat of trade and travel restrictions, combined with endemic weaknesses in capacity, led to national authorities in some cases

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

seeking to downplay the severity of outbreaks. The WHO must also mobilise the required international attention and global response at the critical early stages of the epidemic.

d. **The international organisations responsible for managing effective responses to health threats require more robust capacity.** Clarity about roles, responsibilities, priority setting and accountabilities within and between international actors were delayed or absent during the Ebola epidemic. The WHO's reputation has suffered and capacity, management and governance reforms at the country, regional and global level of the organisation are needed. The WHO accepts this: its own *Report of the Ebola Interim Assessment Panel* (known as the Stocking Report) identifies a number of key reform areas for the WHO.[15] The Regional Director for WHO AFRO, Dr Moeti, has also articulated her vision for AFRO's reform.[16]

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

Figure 1: Example of malaria transmission risk map

Global Health Security and the UK National Interest

5. The events in West Africa drew global health security sharply into focus, reinforcing Her Majesty's Government's (HMG's) understanding of its international health interventions as being both an international public good and being in our national interest. Diseases and other health threats can transcend national boundaries and – as Ebola and now Zika demonstrate – have potential national, regional and international impacts. Countries with weaker health systems are less well-equipped to detect and respond to disease outbreaks, less resilient to the social and economic impacts of health emergencies, and may be unable to stop the spread of disease outside of their borders[17]. Under these shared realities, the need for a collective and coordinated response to emerging public health threats is clear.

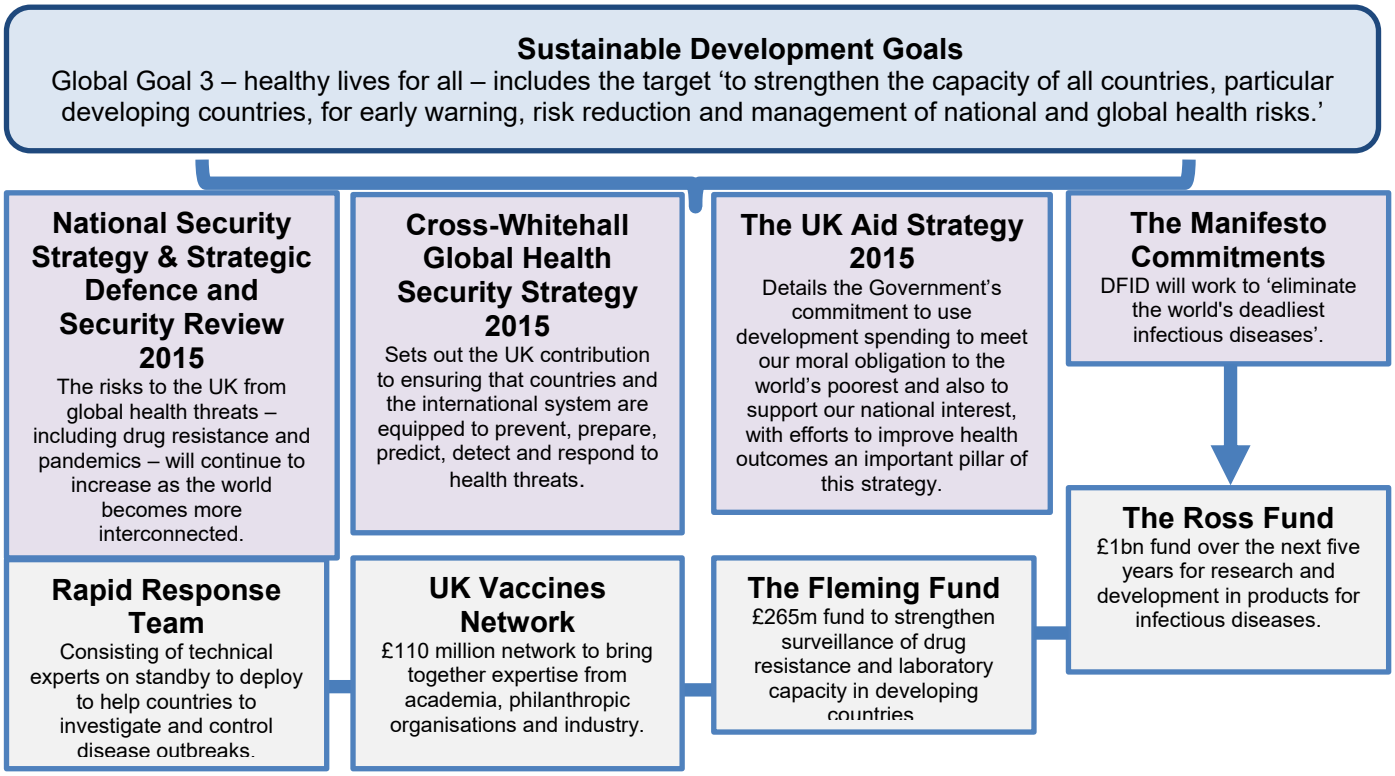
[15] WHO, *Report of the Ebola Interim Assessment Panel,* 2016 http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf
[16] WHO Africa, *The Africa Health Transformation Programme 2015-2020: A Vision for Universal Health Coverage,* http://apps.who.int/iris/bitstream/10665/206535/1/9789290233022.pdf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

6. However, it is important that political attention and financial resources are not drawn away from the 'everyday' health emergencies posed by diseases like malaria, tuberculosis and respiratory tract infections to focus only on the most recent, attention-grabbing disaster. DFID, international organisations and African governments also need to take into consideration the demands placed on African health systems by multiple lower level outbreaks each year, such as 2016's yellow fever outbreak in Angola and Democratic Republic of the Congo (DRC). These lower level outbreaks showed the importance of political and technical commitment with adequate systems. This programme acknowledges this by mainstreaming across its interventions an approach that integrates prevention, preparedness and response capacities for both the extreme emergency outbreaks like the 2013 Ebola epidemic and the more routine and long-term challenges presented by diseases like malaria and HIV/AIDS.

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

Figure 2: Links to HMG strategic priorities and global commitments

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



DFID's Leadership in Africa Health Programming

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

tackling Ebola in West Africa. The UK is also the third largest contributor to the Global Fund to Fight AIDS, TB and Malaria.

9. DFID's ARD has implemented a significant portfolio of health programmes to address the health challenges in Africa that occur both during emergencies like Ebola and Zika and also in the longer-term. See Table 1 for a summary of recent interventions. At country level, the majority of DFID's offices also implement health programmes focusing on, *inter alia*, health systems strengthening. These programmes and lessons learnt from them directly inform the design of the TDDAP.

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

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

Evidence for the Intervention

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

Leave no one behind

11. TDDAP will make concerted efforts to ensure that the poorest, people with disabilities, elderly and children, most excluded and hardest to reach are prioritised to ensure that they can access and benefit from public health systems and prevention activities. The programme start-up phase

will identify opportunities to meet the needs of the most disadvantaged. One of the criteria for country selection is vulnerability, and while this focuses on risks of outbreaks and epidemics, decisions will also be made according to poverty levels. TDDAP will hold governments and institutions to account, and the emphasis on increasing health budgets and involving civil society will ensure that there is equitable allocation and use of resources.

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

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

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

Gender Equality

14. Gender inequalities affect the ability of women and girls to access health care and determine social positioning and familial care roles that expose women to more risk, ultimately affecting patterns of disease among women and girls. The Ebola outbreak pulled into focus the gendered nature of many epidemic and non-epidemic prone diseases in Africa. For example, women make up 57% of all adults living with HIV in sub-Saharan Africa, and in the high prevalence countries of Southern Africa, HIV infection rates among 15-19 year old females are sometimes five times higher compared to their male peer groups. In Africa, an estimated 10,000 women and 200,000 of their infants die annually as a result of malaria infection during pregnancy.[18] Epidemiological statistics on the Ebola outbreak indicate that the disease slowly became a female epidemic. By September 2014, authorities in Liberia were estimating that as many as 75% of their Ebola fatalities were women, and UN sources in Sierra Leone reported that women represented around 59 per cent of the deceased.[19] While there seems to be no biological sex difference regarding vulnerability to Ebola, many sociocultural and health-care-related factors increased the risks for women in the Ebola outbreak in West Africa.[20]

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

a. **We will analyse the gender context in each of our focus countries and in relation to our target diseases.** This will take into consideration the ways in which the different genders are

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

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

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

differently affected by diseases and health emergencies within the prevailing social, economic and cultural norms of each focus country.

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

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

Counter Terrorist Financing

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

Risk

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

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

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

Working with Partners

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

21. TDDAP will be implemented through three main partners:

- **WHO AFRO** will be responsible for directly supporting countries and the region to build IHR capacity, strengthening governance and accountability through direct engagement with governments and building data and evidence at the Africa Regional level. It has been chosen because of its remit to support country Governments and strengthen national health

systems, whilst also working regionally and internationally. It has been delivering on our existing regional preparedness programme post-Ebola and has made promising strides in increasing its capacity to prevent, detect and respond to outbreaks. However, we are also mindful that AFRO is in the process of reform following weaknesses exposed during the Ebola crisis. For this reason TDDAP will in itself help to drive forward AFRO's reform efforts as a separate output and our support will be carefully calibrated against delivery. Progress and further payments will be contingent upon delivery of agreed outputs.

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

Programme Impact and Outcomes

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

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

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

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

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

What do we mean by 'preparedness'?

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

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

B. Appraisal Case

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

Option 1: Core Contributions to WHO only

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28. This is a hybrid of options 2 and 3. Learning from the Ebola crisis and our existing programmes in regional preparedness and data for malaria has demonstrated that initiatives to strengthen governance and accountability are required which are supported by strong data, surveillance and evidence. This option will support non-state actors to strengthen governance and accountability at national and regional levels as well as strengthen data, surveillance and evidence. The rapid response component is also included. This option would require a Memorandum of Understanding (MOU) with WHO and a contract with an ETA. The programme will incentivise collaboration between WHO AFRO and the ETA consortium as they will need to jointly work on the components of the programme. This option ensures that:

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

Option 5: Do nothing.

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

Option 6: Set up a vertical disease response mechanism

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

Multi-Criteria Decision Analysis of decision options

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

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

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

This programme is seeking to tackle a number of complex and inter-related issues in order to tackle deadly diseases in Africa. Through the provision of broad-ranging support to a number of critical areas Option 4 scores the highest on maximising public health impact and minimising global

health security risk. Option 4 entails strengthening the supply of health services (WHO AFRO and health systems strengthening) and the demand for health services (improving governance and accountability and the provision of data and evidence). The other options receive lower scores against this criterion as they are insufficiently broad-ranging to sufficiently maximise the public health impact and minimise the global health security risk.

b. Support health systems strengthening across Africa

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

c. Strengthen accountability for service delivery

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

d. Provide data and evidence to inform decisions

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

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

e. Strengthen capacity of WHO AFRO

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

f. Maximising UK's influence and leverage Cross Whitehall working to strengthen disease preparedness

With its cross-cutting focus and ability to bring in Whitehall colleagues, Option 4 scores the highest against this criterion. DFID has worked with PHE and DH on the design of this programme to

ensure that efforts are coordinated and that expertise is utilised effectively. There are possibilities for PHE to provide technical assistance to WHO AFRO through secondments and provide regional assistance especially in underserved areas where PHE do not already have a bilateral presence. This fits with PHE's remit to be a technical agency for the region and utilised according to demand. The business case being developed by PHE for DH approval is for £16m of ODA for five years, and is insufficient to meet the requirements as shown by the scoping mission.

Preferred Option

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

Evidence for the theory of change

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

Country Selection

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

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

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

- Country risk assessments using INFORM[21]
- Health status (using indicators such as maternal and U5 mortality rates)
- Country performance against IHR and Global Health Security Agenda (GHSA) joint external evaluation assessments
- Political and institutional context (using proxy indicators such as per capita governmental expenditure on health)
- Profile of external support/DFID ability to fill funding gaps – using WHO's Strategic Partnership Portal (database of support on IHR).
- Supports and strengthens DFID's country-level health programming
- Total country population

A Regional Approach

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

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

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

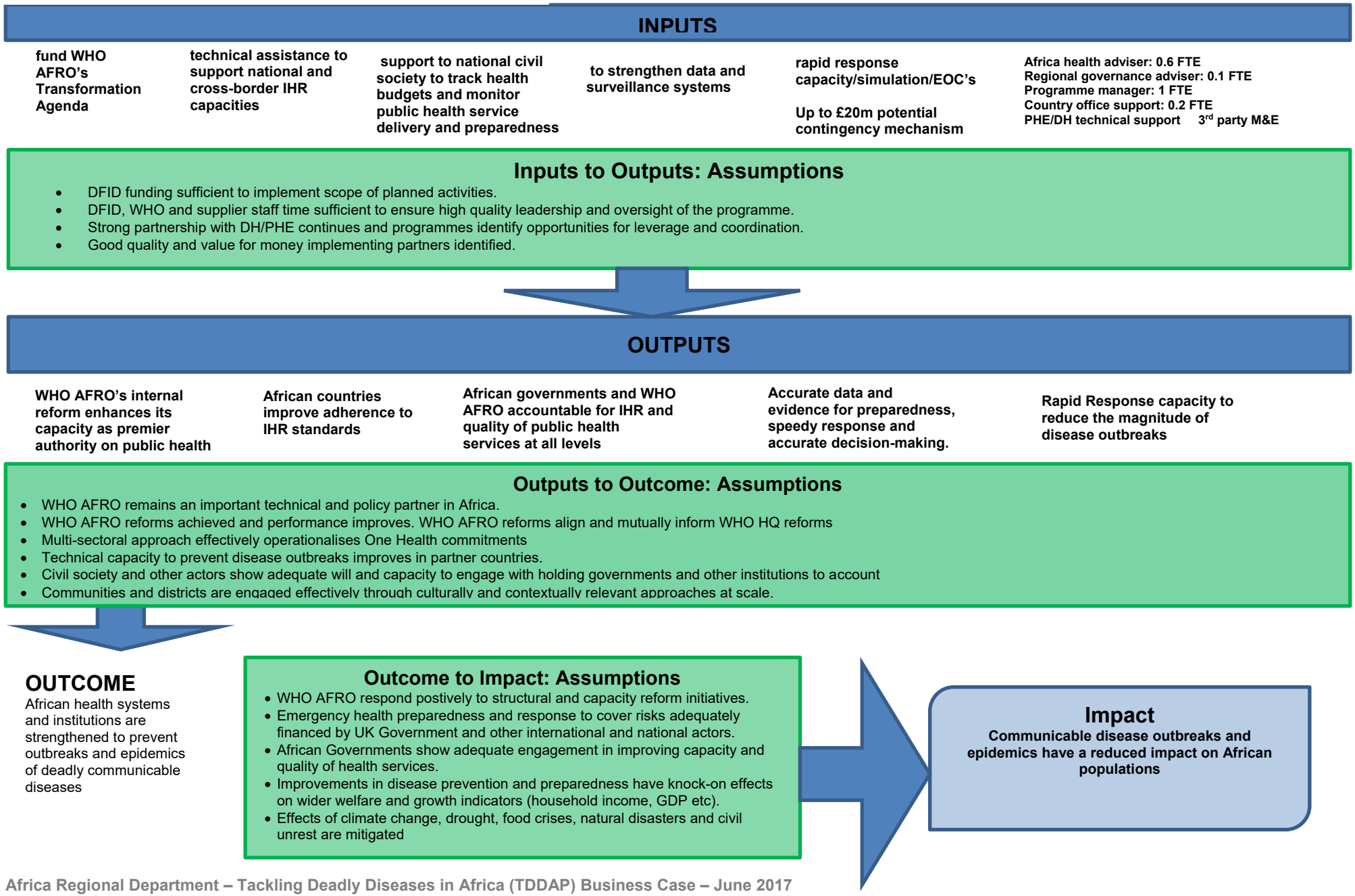
40. The programme's design will retain the flexibility to identify and work in a wider group of core countries if specific needs and/or public health emergencies arise during the programme's lifespan. The countries selected for specific support will be clustered so that a regional and cross-border approach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

Disease focus

41. The TDDAP will focus on building the ability of our partner countries and institutions to prevent and respond to the health emergencies presented by diseases which can lead to public health emergencies of international concern (PHEIC) like Ebola, Zika and yellow fever. However, the programme also recognises that health systems – and populations themselves – are weakened by 'everyday' diseases that remain rife in Africa. Although significant progress has been made in combatting a number of diseases – for example, an estimated 60% reduction in malaria deaths since 2000 – malaria, HIV/AIDS and other infectious diseases continue to extract a high human and financial cost from Africa. Some estimates put the economic cost of malaria to the African continent at a minimum of $12 billion a year in lost productivity, accounting in some high burden countries for 40% of public health expenditure.[22]

[21] INFORM is a global, open-source risk assessment for humanitarian crises and disasters supported by DFID (among other international partners) http://www.inform-index.org/.
[22] UK Government, 'The UK's role in cutting malaria deaths since 2000', https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461358/Facsheet-The-UK-role-in-cutting-malaria-deaths-by-60-percent-since-2000.pdf

Figure 3: Theory of change for the preferred option



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

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

Sustainability

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

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

Importance of civil society and community engagement

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

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

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

Economic Appraisal and Value for Money

49. The estimated cost has been set out above and in the Financial Case below. The financial cost has been estimated using learning from the existing programmes. With the economic losses of $1.6 billion from the Ebola outbreak in the countries it affected, and morbidity in the tens of thousands, preparedness actions increase the value for money of investments made with early responses. The regional impact is expected to rise to USD 4.7 billion in 2017 due to the negative fallout of such crises. If such preparedness investments are strategic, benefit cost ratios can be as high as 7:1[23]. Costs and mitigation measures should be seen as variable and part of a spectrum along the scale of outbreaks, epidemics and pandemics. Responding to the Ebola crisis cost three times what is estimated to be required annually for health systems strengthening in the three countries affected. Through investing in the health systems building blocks, the results of investments are multiplied as the capacities can be transferred to a variety of infectious diseases and benefit non-communicable diseases as well as maternal, newborn and child health services. This was a key recommendation from the Ebola lessons learned report commissioned by Africa Regional Department in response to the Public Accounts Committee.

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

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

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

53. The evidence above suggests that the approach represents strong value for money (VFM). VFM indicators have been developed, and due to a **lack of data availability**, benchmarks will be

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

[1] UNICEF/WFP Return on Investment for Emergency Preparedness Study, January 2015

[2] A ROI (return on investment) above 1 indicates a higher cost saving than the original investment.

developed during the first Annual Review. We have consulted with experts including WHO, and this would require huge assumptions and modelling which would not provide the evidence required. There are a number of indicators which could be used to assess VFM, with the following prioritised, as they are feasible to measure by analysing data available through the programme:

Effectiveness

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

Economy

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

Efficiency

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

Equity

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

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

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

C. Management Case

Management arrangements

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

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

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

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

Contingency Mechanism

86. The purpose of the contingency mechanism is to provide flexibility to respond either to new/emerging needs identified through adaptive programming or to respond to disease outbreaks in Africa where ARD assistance is sought. Recent examples include a request for additional help on Yellow Fever, and during the Ebola crisis where DFID needed to provide support to NGOs to help with the preparedness at community and national levels mainly focused on WASH as well as burial practices. The contingency mechanism will mean that in the event of additional funding requirements, we have business case approval and contracts in place with high quality suppliers

ready to provide assistance as needed. This mechanism should not duplicate other mechanisms and it will not provide funding for UK medical experts to mobilise and attend medical emergencies (currently covered by the UK Public Health Rapid Response Team through the Conflict, Humanitarian and Security department (CHASE) Operations Team). The TDDAP contingency mechanism would provide funding for specialist suppliers who could fill essential gaps and help sustainable responses (e.g. working at community levels contracting local staff or building local capacity). It could also provide funding to institutions, such as WHO AFRO for targeted emergency responses.

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

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

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

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

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

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

Roles, Responsibilities and Coordination

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

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

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

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

Coordination

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

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

External Technical Agency responsibility

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

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

DFID staff capacity

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

99. TDDAP will be led by a Health Adviser who will also be the SRO and based in ARD. The SRO will have the overall responsibility for ensuring that the programme delivers the agreed outputs and outcome, ensuring compliance with Smart Rules and provide direction to the core programme team. The programme team will comprise:

- Two programme managers (0.5 FTE each) who will be jointly responsible for sound financial management throughout the life cycle of the programme, management of the funding agreements with the consortium and the independent verification body, timely monitoring and lesson learning;
- One senior programme manager (0.2 FTE) who will be responsible for oversight and challenge of programme management
- Senior health adviser, ARD – 0.2 FTE for technical support and challenge
- Two advisory staff – governance and economist who will provide technical oversight (each 0.1 FTE);
- Health and governance adviser support in country offices – potentially 0.2 FTE X 6 (depending on countries chosen and negotiated with Heads of Office);
- Technical health advisory support from Global Health Security leads in Policy Division;
- Commercial support through the Africa Regional Commercial Adviser;
- Results support through the Africa Regional Statistics Adviser; and,
- PHE/DH advisory support as part of x-HMG working.

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

101. Our support to non-bilateral countries needs to be balanced with the capacity to be able to support Francophone countries and the Sahel, but now that the FCO has two staff based in the region, and the Department's family planning programme is operational, resources could be combined to support engagement and monitoring.

Programme Implementation

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

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

Governance

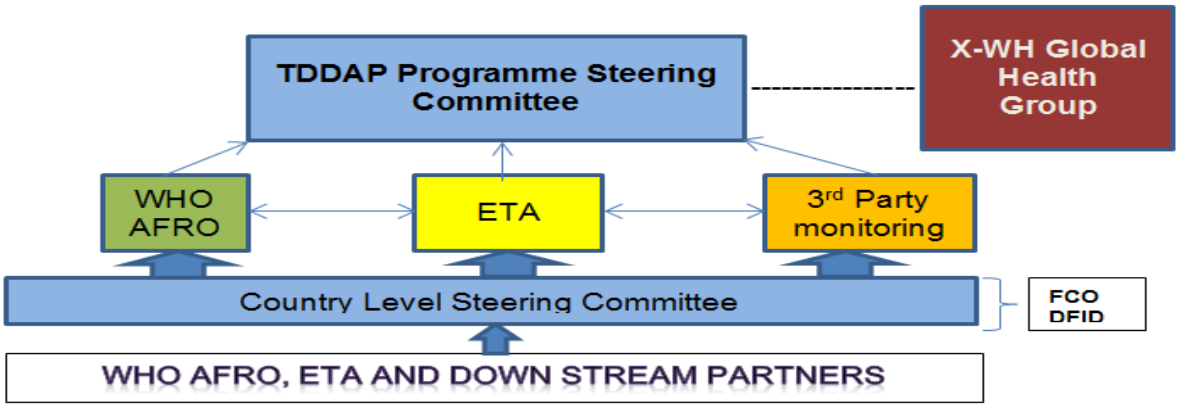
104. The governance of TDDAP will ensure that the programme is coherent at the global level, and managed effectively at both regional and national levels. Overall progress on the programme will

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

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

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

Figure 4: Proposed governance structure



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

Monitoring and Evaluation

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

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

Independent results verification

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

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

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

Annual Reviews and Reporting

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

Risk management

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

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

Table 5: Overall Risk

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

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

Process, Publication, Event	*Outline*
WHO Interim Assessment (the Stocking Report)	Considers the roles and responsibilities of WHO during the outbreak and assesses the strengths and weaknesses of those actions. Makes recommendations to guide the Ebola response and inform future responses, including strengthening organisational capacity and establishing a

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

Annex B: Multi Criteria Decision Analysis

Option **Criteria**	Option 1: Core Contributions to WHO	Option 2: Support WHO AFRO and national health systems	Option 3: Support strengthening governance and accountability, data and evidence and rapid response	Option 4: Support to WHO AFRO, national health systems, governance and accountability, data and evidence and rapid response
a.Maximising the public health impact and minimising global health security risk	2	3	3	5
b. Support health systems strengthening across Africa	2	4	1	4
c.Strengthen accountability for service delivery	1	1	4	4
d.Provide data and evidence to inform decisions	1	1	4	4
e.Strengthen capacity of WHO AFRO	2	4	1	4
f.Maximising UK's influence and leverage Cross Whitehall working to strengthen disease preparedness	1	2	2	5
Weighted Total	**1.5**	**2.5**	**2.5**	**4.3**

Annex C: Roles, Responsibilities and Coordination

Work stream	WHO HQ	WHO AFRO	External Technical Agency
Output 1 – WHO AFRO reform	Supportive and QA functions	This is delivered through WHO AFRO's workplan for the Transformation Agenda.	-
Output 2 – IHR capacities	QA functions, backstopping TA, coherence, ensuring	Scaling up existing support to countries including on JEE,	Technical assistance in four to six focus/most vulnerable

	different teams work together e.g. health systems. Guidance on national action planning and costing.	National Action Planning, and implementation (training, QA, and ensuring cross-sectoral working). Supporting governments to prioritise and cost plans.	countries based on demand and needs identified by WHO AFRO, countries and INFORM tool. Assist countries in systems strengthening particularly at sub-national level and engage with communities.
Output 3 – Governance and accountability	Share best practices to support a coherent approach in the programme. Ensure support to AFRO on multi-agency collaboration ensuring support at headquarters of relevant agencies.	Work at regional and national levels to facilitate civil society engagement but it is not the core of their engagement as they will also be held accountable. Facilitate coherence, cross-border and One Health approaches and ensure various agencies/Governments work together. E.g. World Organisation for Animal Health (OIE), Economic Community of West African States (ECOWAS), Food and Agriculture Organisation (FAO), Africa CDC, etc.	Strengthen Civil Society Networks and Governments, similar to ALMA model to use data for accountability e.g. use of JEE scores, publicising and tracking progress; civil society networks able to engage in GHS dialogue get Governments to work better on IHR and cross-border approaches.
Output 4 – data, surveillance, evidence	TA support and coherence – as One WHO. Support to global health observatory. Capacity building of WHO AFRO/country offices. Explore links with WHO Blueprint (e.g. testing vaccines in phase 2 trials in contextually relevant settings). Ensuring linkages to other initiatives.	Build on existing work on risk mapping, ensuring country offices able to support strengthening of national integrated disease surveillance and response mechanisms, RSiS and DHIS2. Strengthen Africa and National Health Observatories. Continue risk mapping and assisting country governments and regional institutions allocate resources and interventions matched to risk.	Scaling up capacity building in focus countries to ensure evidence is translated to tangible actions. Work at sub-national levels to support operationalisation of data and surveillance systems including at community level. Feed into operational research.
Output 5 – Rapid response	Responds at emergency levels. Backstop to regional office. No extra funding as this is through Core Voluntary Contribution and WHE funding to HQ.	Establish and strengthen emergency operations centres (Number to be confirmed) – follow-on from regional preparedness programme.	Use any intel from working on the ground to inform rapid response (links with Outputs 2, 3, 4).
3rd Party M&E			

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

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

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

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

- GFD representatives sit on the TDDAP and UK-WHO AFRO Framework Board

- TDDAP SRO attends the quarterly DFID meeting chaired by GFD and attended by all SROs for DFID funded WHO programmes and projects. This group ensures coherence of approach across DFID.
- WHO AFRO – as a key reform priority – already has KPIs included in GFD's core voluntary contribution log frame. This represents real cross-DFID integration of WHO programmes
- TDDAP's log frame will align with the CVC log frame, specifically reinforcing for the African context top UK asks. E.g. the CVC log frame requests the WHO HQ produces an organisation-wide new VFM plan. TDDAP's logframe will direct WHO AFRO to support the creation of this plan and pioneer new VFM approaches in AFRO to support the plan's implementation.
- Led by the CMO, the UK has now instigated annual UK-WHO Strategic Dialogues with WHO HQ where a deep-dive is performed with senior WHO management (including the DG) on four top UK priorities. At the upcoming Dialogue (18-19 October 2017) one priority will be effective working between AFRO and HQ. Clear actions to improve performance will flow from this and be included in a revised and re-published second edition of the UK-WHO Performance Agreement.
- The election for the new DG of WHO takes place in May 2017. In our direct advocacy with the new DG we will press the vital importance to the UK of AFRO reform and a "one WHO" approach
- Feedback and concerns on TDDAP performance will be directly fed into GFD's advocacy and interventions at the WHO's supreme governing body, the World Health Assembly
- Additionally, the UK has now secured observer status at WHO AFRO's Regional Committee. GFD and the TDDAP SRO will jointly prepare our advocacy for the Regional Committee, prioritising reform and the need for a "one WHO" approach and alignment with WHO HQ
- WHO HQ has identified a senior accountable person within WHO HQ who will be responsible for liaising with WHO AFRO on TDDAP and maintaining coherence
- The UK's support for WHO's Health Emergencies Programme (WHE) likewise sits under the UK-WHO Performance Agreement. Expected funding through CHASE to WHE supports WHO HQ's global leadership role. Support through TDDAP builds WHO AFRO's emergencies capabilities, and more importantly preparedness. The two are aligned and mutually reinforcing.

Annex F: Risk assessment matrix

Risks: (Minor, Moderate, Major and Severe)	Probability	Impact	Mitigation	Residual risk
External Context				
Country governments do not sustain the programme	Major	Severe	A central focus of the programme is to establish the right approaches in countries, working closely with the national Government, and strengthening health and other systems through a multi-sector approach. It will also compel Governments to increase funding for preparedness and health systems.	Moderate
Political economy around disease preparedness is complex and context specific, and needs to be worked with to ensure outcomes are achieved	Major	Severe	WHO well established in countries of support and will use their understanding and relationships to deliver the programme effectively. ETA will need to have local technical expertise with strong relationships and understanding in focus countries. Partners will ensure political economy analysis used to adapt the programme in different contexts.	Moderate

Political unrest/conflict destabilises efforts	Severe	Severe	The project maintains information channels with security networks and emergency procedures to minimise the disruption to activities, and apply Duty of Care. This is challenging to mitigate.	Major
Investment on health security decreases as donor landscape changes	Major	Major	Policy Division and DH working to influence the international architecture and to coordinate efforts. Investments are forthcoming from World Bank and influence on G7.	Moderate.
Deadly diseases resistance to drugs undermines current strategies.	Severe	Severe	The programme will play an important role in monitoring the future challenges to tackling deadly disease. This will contribute to regional responses to contain resistance linking with the work on AMR, although will not guarantee that strategies will be successful.	Major
Delivery				
Breakdown of relationship between ETA partners	Moderate	Major	Management capacity will be tested during evaluation of commercial tenders and during inception phase.	Moderate
Planned efficiency gains are not achieved within the project lifespan	Moderate	Minor	WHO and the ETA will be responsible for keeping control over the costs and demonstrating credible outcomes and VfM by end of programme, although full realisation of efficiency gains may take longer than 3 years.	Moderate
High staff turnover for WHO and ETA slows down planned activities.	Major	Major	Procurement of ETA ensures adequate capacity. Incentivise staff retention. Ensure good transition between existing programme with WHO and TDDAP. Support to WHO HQ allows for backstopping regional office.	Moderate
Over-reliance of countries on donor funding resulting in lack of exit strategy and sustainability	Major	Major	WHO programme is strengthening the system and ETA will accelerate actions in underserved countries. We need to recognise what is feasible in this timeframe and ensure that strengthened national and sub-national capacities are being used by country governments for longer-term change.	Moderate.
Ineffective coordination and collaboration to achieve outcomes	Severe	Major	Incentivise collaboration and coordination amongst all partners and agree ways of working.	Moderate
Operational				
Country health systems and governments not effective or strong enough to deliver	Major	Major	ETA a) builds partnership with relevant others early to support uptake needs b) has links to global/regional/national and other relevant policy actors and c) support joined up implementation research to inform and underpin evidence and identify risk areas and gaps.	Moderate
National and sub-national capacities weak especially at community level where good surveillance and responses need to start	Major	Major	Programme strengthens sub-national capacities. ETA provides local expertise to ensure accelerated capacity building efforts in high risk, low resource settings. Programme strengthens rapid response and surveillance at all levels.	Moderate
One Health and cross-border approach	Moderate	Major	Programme focus is to ensure that this works through strengthening IHR capacities. WHO have been defining One Health and cross-	Minor

dependent on effective multi-sectoral working, which varies by context.			border approaches with country governments and other stakeholders in the existing programme.	
WHO lack capacity to effectively lead, co-ordinate and adapt reform process	Moderate	Moderate	Coordinate dialogue with WHO through GFD. WHO are undergoing a reform process and this programme will support it. WHO have evaluated the first phase of their reform process and results are positive.	Minor
High burden of humanitarian emergencies and outbreaks detracts efforts from longer term system strengthening efforts	Major	Major	WHO and ETA will ensure they are resourced to ensure capacity available for preparedness systems strengthening and emergencies (WHO through existing WHE funding).	Moderate
Safeguards				
Mistrust of communities around disease preparedness activities	Major	Severe	Programme is designed and delivered ensuring community engagement and contextually relevant with local expertise.	Moderate
Accountability efforts by CSOs threaten to demotivate and demoralise providers who, with inadequate supervision and resources, will resent feeling under greater scrutiny.	Moderate	Moderate	TDDAP aims to avoid blame and shame approaches and use of positive deviance to highlight good practice and learning to counterbalance examples of poor performance and outcomes.	Minor
Fiduciary				
Fraud involving DFID funds	Moderate	Moderate	ETA has strong fraud and financial management practices, rigorous due diligence, annual reviews, financial audits and open ongoing dialogue with partners. WHO have strong systems in place which is monitored through GFD. DFID ensure delivery chain mapping is completed and monitored. The third party monitoring agent will also provide fiduciary verification.	Minor
Reputational				
TDDAP unable to deliver on results.	Moderate	Severe	DFID will engage in dialogue and harmonisation x-HMG and apply learning and best practice from Ebola and Zika to maintain a faster approach through improved evidence sharing. DFID will remain flexible in its ability to partner and respond as new diseases emerge. It is designed to ensure lives are saved, systems are strengthened and protects UK nationals.	Minor

Annex I: Emergency Response Mechanism

The purpose of the Emergency Response Mechanism is to provide **flexibility** to respond to disease outbreaks in Africa.

Requirements

- Respond quickly to new disease outbreaks in Africa at the community level to stop a public health emergency.
- Use on the ground intelligence to inform a contextually relevant response.
- Raise the flag early to country Government, WHO, DFID and others to ensure that a proportionate response is triggered.
- Support containment of outbreaks in the target countries at community level using an understanding of the socio-cultural aspects.
- Ensure timely implementation of interventions such as support on water, sanitation and hygiene, safe burial practices, local communications and behaviour change to help contain outbreaks.
- Work in coordination with the country Government and WHO leads on outbreak response. Close working relationships with local governments to ensure community responses work, are essential.
- Ensure that funds flow to where they are needed most for on the ground delivery and to prevent escalation of outbreaks, subject to approval from DFID.
- Provide quality delivery and value for money through joined up working with other components of the programme.

Geography

- The Emergency Response Mechanism would be required to work in any country in sub-Saharan Africa as required.

Timeframes:

- Depending on the nature of the outbreak a response may be required between 1 week and 1 month following DFID approval.

Funding

- Funding will be approved from the Africa crisis/DFID contingency reserve as required and is not allocated to the programme upfront. Depending on the need, funding may be channelled via the MOU or Supplier contract.

Spending controls

- Robust and efficient spending control process will be put in place to ensure the required approvals are received before funding is released.

Approval Mechanism

- Identification of need for additional DFID response by Cross Whitehall Global Health Oversight Group and / or DFID EpiThreats group
- Decision by DG's to task ARD with leading response
- ARD to obtain approval from TDDAP Programme Steering Committee and then submit recommendation to appropriate level of Delegated Authority (likely to be Ministers)
- Additional funding to be released from within Africa Division or from DFID Crisis Reserve (depending on scale of need)
- ARD to provide funding to most appropriate delivery partner (either International Institution or consortium partner).

For new (non-urgent) needs identified through adaptive programming the process would be:

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

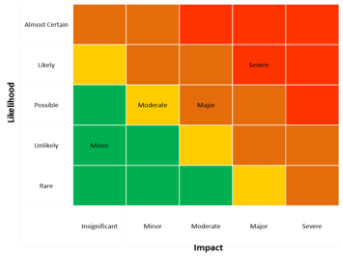
Last updated

PROGRAMME: Tackling Deadly Diseases in Africa Programme
Overall risk rating:

R sk Number	Risk	Potent al Impact Insignificant, Minor, Moderate, Ma or or Severe)	Likelihood	Gross Risk	M tigation measures	Potential Impact after mitigation	Likelihood after mitigation	Net Risk	Has the r sk been realised? Please give details of when and how	Direction of Travel (increasing, decreasing, or stable)	How and how often wi l this be monitored?	Risk Owner
Contextual Risks												
Delivery Risks												
Safeguarding Risks												
Operational Risks												
Fiduciary Risks												
Reputational Risks												

Individual risk	Definitions
Minor	Th s s an ssue / sk that could have a m no effect on the ach evement of one o many of the Depa tment s st ateg c object ves, o could have a m no effect on the effect veness o e f c ency of the Depa tment s act v t es o p ocesses.
Moderate	Th s s an ssue / sk that could have a mode ate e fect on the ach evement of one o many of the Depa tment s st ateg c object ves, o could have a mode ate effect on the effect veness o eff c ency of the Depa tment s act v t es o p ocesses.
Major	Th s s an ssue / sk that could have a majo effect on the ach evement of one o many of the Depa tment s st ateg c object ves, o could have a majo effect on the effect veness o eff c ency of the Depa tment s act v t es o p ocesses.
Severe	Th s s an ssue / sk that could seve ely affect the ach evement of one o many of the Depa tment s st ateg c object ves, o could seve ely affect the effect veness o eff c ency of the Depa tment s act v t es o p ocesses.

How to calculate gross/net risk



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

This schedule must be completed by the Parties in collaboration with each-other before the processing of Personal Data under the Contract.

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

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