REQUEST FOR INFORMATION

TUBERCULOSIS HEALTH ACTION LEARNING INITIATIVE (THALI)

1. PURPOSE

The U.S. Agency for International Development's India Mission (USAID/India) is issuing this Request for Information (RFI) to solicit feedback on draft elements of a potential Request for Application (RFA). USAID/India is not seeking applications at this time, but rather feedback on key elements of its anticipated requirement. The issuance of this RFI does not constitute a commitment on the part of the United States Government (USG) to issue an RFA, nor does it commit the USG to pay for costs incurred in the preparation and submission of the RFI response. If an RFA is issued as a result of information obtained through this RFI, it will be issued via www.grants.gov.

2. INFORMATION REQUESTED

Deadline for RFI Response Submission: February 17, 2015 at 3:00 PM New Delhi Time. Submissions shall be made electronically via IndiaRCO@usaid.gov and shall reference "THALI RFI Response" in the subject line.

USAID/India is requesting the following information from interested organizations:

1. Are the requirements and expected outputs/results clear in the Draft Program Description? If not, what can USAID/India clarify or better explain?
2. Are USAID's proposed focus areas and Logical Framework an effective way to address urban tuberculosis in India?
3. Will the anticipated amount of funding and period of performance enable successful achievement of the expected outcomes?
4. Are the eligibility requirements clear? If not, what can USAID/India clarify or better explain?
5. Are the draft technical application requirements clear and reasonable?
6. Identify any other considerations for USAID/India regarding this RFI.
7. Provide one past performance summary from a program or project similar to the anticipated requirements listed in this RFI. Include the funding organization, agreement type, funding amount, period of performance and a description of the work completed.

The RFI Response format must be:

A. Written in English.
B. Submitted electronically in MS Word (version 2000 or later) or Adobe PDF format.
C. On letter size paper with 1" margins.

Interested organizations are encouraged to be concise, and must only include in their RFI responses:

i. A cover page with the organization's name and address, type of organization, contact point (name, telephone and email address).
ii. City/cities of interest to the organization for this effort.
iii. Answers to USAID/India's areas of interest above.

3. DRAFT PROGRAM DESCRIPTION

USAID/India seeks to improve the lives of people who live at the base of the economic pyramid (BOP) in India by supporting innovations at the interface of tuberculosis (TB) detection and treatment in urban communities.

The TB Health Action Learning Initiative (THALI) project will work with the Revised National TB Control Program (RNTCP), municipal governments, and private providers to improve TB control in up to three or more major cities. The successful Applicant(s) will be expected to help identify, apply, and scale up successful innovative approaches to addressing TB, especially among under- or inadequately-served urban slum dwellers and other low-income populations.

Key elements of THALI are the:
1. Identifying and scaling up of innovative approaches to improve the quality of private sector diagnosis, referral, and treatment of TB, through adherence to the recently released "Standards for TB Care in India". (Outputs 1 and 4)
2. Strengthening the utilization of TB resources of the respective municipalities. (Output 2)
3. Testing of upcoming technological innovations. (Output 3)
4. Improving data for evidence-based decision making. (Output 5)

With an emphasis on learning, improved data and the rigorous scientific testing of approaches, USAID/India expects THALI to generate documentation on lessons learned regarding the barriers to quality private sector TB services, and fundamentals for successful scale up. USAID/India anticipates that in the later years of THALI, it may be appropriate to augment learning and the sharing of information with other countries through global transfer.

Background

The scope of TB as a disease in India is both wide and complex. Every day 31,500 persons are examined for TB and 6,000 are initiated on treatment. Since 1998, 60 million people were tested for TB and 16 million were treated. While an estimated 2.8 million lives have been saved during the past 15 years, India has the highest TB burden in the world (approximately 2.2 million new cases each year), accounting for 25% of the global incidence of an estimated 8.6 million. In 2012, India's health providers detected and initiated treatment for 1.3 million TB cases – 59% of the estimated case burden for the country. International and national surveys[1] estimate that there are nearly one million cases of TB each year in India that are either undetected and untreated, or diagnosed and treated by private healthcare

[1] For example, the National Tuberculosis Institute in Bangalore and World Health Organization's STOP TB unit periodically conduct estimate studies.

providers[2] with potentially sub-standard drugs and treatment regimens. These drugs and treatment regimens not only fail to fully eliminate the TB bacteria, but they also contribute to an increasing incidence of drug resistant TB (DR-TB), including both multi-drug resistant TB (MDR-TB), and extensively resistant TB (XDR-TB).[3]

In addition, gender disparities in care seeking behavior, disease prevalence, and access to health care services, stigma, and treatment adherence contribute to the complexity of India's TB burden. TB is the third leading cause of death among women of reproductive age (15-44 years). It disproportionately affects pregnant women, and the poor. Some of the greatest challenges to reducing TB rates include the following:

- Reaching urban populations.
- Measuring TB incidence and treatment with confidence.
- Engaging private health providers.
- Stemming/Curtailing Multi-Drug Resistant TB (MDR-TB).
- Engaging all health-providers, including private health providers and non-traditional partners, in TB advocacy.

USAID/India's Engagement with TB in India

Historically, USAID/India started funding TB programs in 1998, with $1.5 million in support of the RNTCP Consultant Network for much needed technical assistance to state and district-level TB control officers. As funding has steadily increased across the past 16 years (to a high of $14 million in FY 2011 and now $10.5 million in FY 2014), the USAID TB portfolio has provided critical long-term technical assistance through WHO and the U.S. Centers for Disease Control (CDC) to improve TB services according to RNTCP strategies and priorities. USAID/India's TB investment decisions to date have been intrinsic to the success in fortifying the RNTCP.

USAID CHAMPION

USAID/India is commissioning a new TB program, *Championing a Tuberculosis-Free India* (CHAMPION). CHAMPION will focus on supporting innovation and partnership, rather than the provision of traditional technical assistance. CHAMPION will emphasize development innovations that affect people at the bottom of the pyramid. The poor, especially the urban poor, are one of the groups most likely to become infected with TB, fail to be identified or treated properly, and bankrupt themselves trying to receive care from the private sector.

CHAMPION proposes to address the above challenges with the following Components:

Component 1: The first component of the CHAMPION Program is an urban TB control initiative, THALI (described in this RFI), that establishes a holistic approach to TB control

[2] Private sector healthcare providers include fully-qualified allopathic providers trained in pharmacology, also referred to as practitioners and sometimes "medical doctors," as well as non-allopathic providers, also referred to as AYUSH - Ayurveda, Yoga, Unani, Siddha, and Homoeopathy providers, and finally, less-than-fully-qualified providers, often referred to as "quacks."
[3] See later in Section 1 for an explanation of drug resistance.
[2] Davies PD, The role of DOTS in tuberculosis treatment and control, Am J Respir Med. 2003;2(3):203-9.

efforts in up to three or more major cities. As detailed in the outcomes of the Logical Framework in Annex A, THALI will strengthen urban TB control by:

1.1. Generating increased investment in urban TB control programs from government, private citizens, foundations, and other private groups;
1.2. Improving municipal management of resources, i.e. human, financial and technical;
1.3. Increasing the identification and testing of innovations for urban TB control;
1.4. Improving private sector delivery of TB services; and
1.5. Promoting evidence-based decision making.

Component 2: The second component of the CHAMPION Program is a separate activity, entitled The TB Call to Action (TBC2A). This project will leverage Indian intellectual, financial, and material resources to support TB control. TBC2A will increase participation and investment in the national TB control program by:

2.1 Promoting national leadership and outreach to leverage Indian intellectual, financial, and material resources to support TB control.
2.2 Advancing public understanding of TB, and reducing social stigma associated with TB.
2.3 Targeting forward-looking expertise.

It will be critical that both components of CHAMPION collaborate and look for opportunities to provide mutual knowledge sharing, identification of needs to be addressed, and remain calibrated to optimize performance and results.

Relationship of THALI to U.S. and Indian Policies and Strategies

The proposed THALI project dovetails with the long-term vision of a "TB-Free India" in India's National Strategic Plan (NSP) 2012-2017. The RNTCP developed the NSP with the central goal of universal access to quality TB diagnosis and treatment for all TB patients, by building on India's achievements to date, identifying TB cases before those infected can infect others, and developing more effective treatment adherence strategies to prevent the further spread of MDR-TB. The NSP places importance on improving the involvement of private healthcare providers in TB diagnosis and treatment, a key element of the USAID CHAMPION Program.

The five-year NSP delineates activities in every area of TB control that will lead India towards "universal access." An excerpt from the NSP highlights the activities:

- Ensuring early and improved diagnosis of all TB patients, through improving outreach, vigorously expanding case-finding efforts among vulnerable populations, deploying better diagnostics, and by extending services to patients diagnosed and treated in the private sector.
- Improving patient-friendly access to high-quality treatment for all diagnosed cases of TB, including scaling-up treatment for MDR-TB nationwide.
- Re-engineering program systems for optimal alignment with NORM at block level, and human resource development for all health staff.
- Involvement of the private sector at a scale commensurate with their dominant presence in healthcare in India. New and innovative approaches for involvement of sectors not involved in RNTCP will be piloted and successful models will be scaled up in order to move towards universal access to TB cure and control.

- Enhancing supervision, monitoring, surveillance, and program operations for continuous quality improvement and accountability for each TB case, with program-based research for development, and incorporation of innovations into effective program practice.

If the RNTCP is successful at achieving its objectives by the end of five years, modeling has indicated that compared to today, TB incidence should decline by 40% over the next 15 years and MDR-TB should be reduced by 50%. This translates to between 750,000 and 1.7 million Indian lives saved over 15 years, and 100,000 MDR-TB cases averted.

THALI Project Framework

The successful Applicant(s) will design and implement an urban TB control initiative that:

- Develops and implements strategies to engage non-traditional partners (i.e., the private sector, commercial entities, associations, etc.) in investing in TB control. (Output 1)
- Accelerates the scale up of proven solutions and develops innovative strategies to address specific issues that can help transform TB control efforts in India. (Output 2)
- Identifies and tests innovative interventions to address challenges in case finding and treatment adherence in urban populations, and seeks ways to prevent and treat MDR-TB. THALI will generate important research questions for either project partners or other research platforms and organizations to undertake. THALI may also be used as the setting to test key new technology innovations developed through the IKP Knowledge Park Grand Challenges for TB control or other innovation partnerships. (Output 3)
- Fosters the generation of new ideas and the formation of new approaches to improve private sector delivery of urban TB services. (Output 4)
- Provides rigorous scientific evidence for the GOI to improve its quality and learning as it scales up key urban TB innovative interventions. THALI will implement communications efforts, compliant with USAID branding and marking guidelines and rules[4], which may include products such as a website, fact sheets, brochures, activity briefs, media advisories and press releases, speeches, newsletters, presentations, photos and graphics, maps and geospatial data. (Output 5)

Note: The role of THALI is not to support basic TB control services.

The successful Applicant will be responsible for achieving stated results in collaboration with the municipal corporations, anticipated private sector and civil society partners, and other donors.

THALI's Geographic Target Area

THALI shall focus on urban slums in up to three or more major cities, and create systems through innovation to engage with the private healthcare sector in general and private practitioners in particular. Applicants may propose to work in up to three or more major cities while ensuring feasibility of proposed coverage.

Anticipated Funding, Period of Performance and Cost-Share

[4] Graphic Standards Manual for the U.S. Agency for International Development (USAID) is available at http://www.usaid.gov/branding/gsm

USAID/India anticipates that up to three (3) awards may be made with a total maximum funding across awards of U.S. $22.5 million over a four-year period of performance. A minimum cost-share of 10% is anticipated. USAID defines cost share as, "contributions, both cash and in-kind, which are necessary and reasonable to achieve project objectives and which are verifiable from the recipient's records." Further information about cost-share and eligibility of contributions can be found in the mandatory standard provision RAA14 "Cost Share (June 2012)" found in the mandatory standard provisions at: http://www.usaid.gov/sites/default/files/documents/1868/303mab.pdf

5. ANTICIPATED ELIGIBILITY

Eligibility is anticipated to be restricted to local Indian organizations that are private, non-profit organizations, including private voluntary organizations, universities, research organizations, professional associations, and relevant special interest associations. Local Indian for-profit companies are eligible provided they are willing to forego profit under the award.

a) "Local Indian organization" is defined as one that:
   i. is organized under the laws of India;
   ii. has its principal place of business in India;
   iii. is majority owned by individuals who are citizens or lawful permanent residents of India or is managed by a governing body, the majority of whom are citizens or lawful permanent residents of India; and
   iv. is not controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of India.
      1. The term "controlled by" means a majority ownership or beneficiary interest as defined above, or the power, either directly or indirectly, whether exercised or exercisable, to control the election, appointment, or tenure of the organization's managers or a majority of the organization's governing body by any means, e.g., ownership, contract, or operation of law.
      2. "Foreign entity" means an organization that fails to meet any part of the "local organization" definition.

b) Government-controlled and government-owned organizations in which the Indian government owns a majority interest or in which the majority of a governing body are Indian government employees, are included in the above definition of local organization.

6. DRAFT TECHNICAL APPLICATION REQUIREMENTS

Depending on interest and responses to this RFI, USAID/India may conduct a single or two-step application and review process. Under a two-step process, concept notes will first be requested. USAID/India will review concept notes, and those organizations most highly rated will be requested to submit full applications. Under the single-step process or the full application step of the two-step process, USAID/India anticipates the following Technical Application requirements. USAID/India is providing this information to help interested organizations understand Technical Application requirements. **Applications are not being**

accepted at this time. Please only provide the information requested in 2., Information Requested, above.

Excluding the cover page, table of contents, past performance references and annexes, Technical Applications must not exceed 20 pages. The Applicant should paginate pages (except for the cover page) at the bottom.

1. Cover page (not included in 20-page limit)
   - Concise title of project;
   - Identification of City/Cities for the submission;
   - Solicitation Number of this APS;
   - Name and address of the Applicant organization;
   - Type of organization (such as for-profit, non-profit, university, network, etc.);
   - Contact point (name, telephone, and e-mail);
   - Names of major sub-applicants and types or organizations, including noting local India organizations sub-applicants (if any)
   - Signature of authorized representative of the Applicant.
2. Table of Contents (not included in 20-page limit)
3. Executive Summary (not included in 20-page limit, but limited to two pages)
4. Body of Application (up to 10 pages) – In this section, the Applicant must:
   - Demonstrate an in-depth understanding of the health sector in India, especially the TB field, and a comprehensive knowledge of the past interventions in the field, particularly as it pertains to private sector engagement and the reasons for their success/failure.
   - Justify the city or cities where the project activities will occur, identify existing TB activities and partners in the city/cities, and demonstrate how the Applicant and those entities will collaborate and complement actions to achieve a TB-free India.
   - Detail the proposed approach/methodology and demonstrate how its proposed project ties to outputs. The Applicant must articulate how its proposed project will achieve results under the priority area(s). This should include the purpose, output(s) input(s) and the feasibility of proposed coverage of cities.
   - Include an approach for significant private sector engagement, with a focus on innovative and practical approaches to use such resources, and highlight the usefulness, innovativeness and likelihood that partnerships will contribute to project sustainability beyond the performance period and funding received from USAID. Signed letters of commitment from private sector partners must be included in Annex C.
   - Describe a plan that will enable the activities to continue after the project is completed.
5. Monitoring and Evaluation (M&E) (up to two pages) – The Applicant must provide a project specific monitoring and evaluation plan that articulates how it will monitor and manage the project. The plan should have a clear logarithmic framework demonstrating linkages to program objectives results, indicators, data sources, and data gathering methods, as well as estimated baseline data and indicator targets. The Applicant must also explain how it will use lessons learned during implementation to make needed adjustments to the program in order to maximize impact. Monitoring and evaluation

methods must be specific, measurable, realistic, and applicable to the project objectives and results. Plans must also include gender sensitive indicators and sex-disaggregated data as appropriate.

6. Implementation Schedule (up to two pages) – The Applicant must include a chart indicating when project activities will occur. The chart should be broken down into 3-month quarters and cover all four years of the project. Key milestones should be clearly articulated, with specific deliverables and expected dates defined. The Applicant is encouraged to propose innovative implementation mechanisms to reach the desired results and an ambitious but realistic schedule of performance milestones as steps toward achieving proposed results.
7. Institutional Capacity (up to four pages) – The Applicant must describe the roles, responsibilities, and contributions of the proposed organization(s) who will deliver the project. The Applicant must briefly describe the systems, policies, procedures, and technical expertise of the organization(s) to manage and implement the proposed project and to comply with award terms. The Applicant must describe if and how the organizations have worked together previously, citing specific projects and specific roles on those projects. The Applicant must include a staffing plan that describes the types of technical positions and the level of effort of those positions on an annual basis.
8. Key Personnel (up to two pages) - The Applicant must describe its Key Personnel proposed for the project. Applicants are limited to proposing two Key Personnel, the Project Director and Deputy Project Director. The Applicant must include brief descriptions of the positions, roles, and responsibilities for each Key Personnel position, and articulate how the qualifications and abilities of the selected individuals meet the descriptions and how both meet the needs of the program.

   The minimum requirements for Key Personnel are:

   - Ten years of professional experience in fields related to the successful implementation of this project, with at least one of the Key Personnel demonstrating experience engaging the private sector or non-traditional resource partners and one Key Personnel with experience in the field of TB.
   - A professional medical degree for either the Project Director or Deputy Project Director, with at least a graduate degree for the other person (Master's Degree or higher professional degree preferred) in a similarly related field of study.
   - Proven, exceptional leadership in the design, management, implementation, monitoring, and evaluation of similar-sized international donor support projects.
   - Skills and experience in strategic planning, management, supervision, and budgeting, and managing complex activities involving coordination with multiple program partner institutions.
   - Ability to develop and communicate a common vision among diverse partners and the ability to coalesce and lead multi-disciplinary teams, with a bias towards experience with innovative solutions to TB challenges.
   - Strong communication skills, both interpersonal and written, to fulfill the diverse technical and managerial requirements of the project.

- Knowledge of USAID policies and procedures as related to program management.
- Proven ability to bring together a diversity of partners from different interest bases and create a business case that benefits all parties. For example, the ability to bring together the interests of diagnostics labs, private practitioners, non-traditional resource partners and pharmaceutical companies, etc. in a business model that addresses the public health problem of TB.

9. Annexes (not included in page count but limited to no more than 25 pages total across annexes)

   Annex A - Past Performance References – The Applicant must provide three past performance references for itself. Past performance references shall be for contracts, grants, and cooperative agreements for recent and relevant projects carried out by the Applicant. If sub-awardees are proposed, one past performance reference is required for each proposed sub-awardee. Sub-awardee past performance references do not count as part of the three required past performances for the Applicant.

   Recent is defined as the last three years. Relevant is defined as programs of similar size and scope funded by international donors in India and the surrounding region. Reference information must include the award number, period of performance, dollar value, brief description of award activities, location, and point of contact for the award (name(s), current telephone number(s), and e-mail address(es)).

   Annex B – CVs and Letters of Commitment of Key Personnel – The Applicant must provide CVs of all proposed key personnel. Though USAID/India is not imposing a page limit, the Applicant is encouraged to limit each CV to three pages maximum. The Applicant must also provide contact information for up to three references per Key Personnel. The Applicant must all submit signed letters of commitment from the proposed Key Personnel.

   Annex C – Sub-Applicant and Private Sector Partnership Letters of Intent – The Applicant must provide a signed letter of intent from each sub-applicant proposed (if any) and any private sector partners. The letter must commit the organization to participation in the program, and briefly state that the sub-applicant and/or private sector partner understands its role on the project. Though USAID/India is not imposing a page limit, the Applicant is encouraged to limit each letter to one page maximum.

   Annex D – Completed Logical Framework – The Applicant must complete the Logical Framework by inserting the inputs that complete the design and adding indicators, means of verification and assumptions to support the inputs. The Applicant may also add indicators and assumptions to the Output section as necessary to support its proposed project.

Annex A: Logical Framework

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Goal: Improved TB Control	1. National case detection rates (10% improvement from 2014 to 2019[5]). 2. National case treatment success rates (does not fall below 85% even with increases in numbers detected and patients initiated on treatment).	• GOI Annual TB Reports	• TB remains priority for GOI with commensurate budgets. • Treatment can keep up with improved detection • USAID project funding levels realized
Project Activity 1	**THALI**		
Objective 1: Improved Urban TB Control in Selected Cities	1. City case detection rates (10% increase from baseline). 2. City private practitioner case notification (20% increase in number of cases notified). 3. City treatment success rates (do not fall below 85% even with increases in numbers of cases detected and patients initiated on treatment). 4. Number MDR-TB cases diagnosed (30% increase). 5. MDR Treatment Success Rate (50%). 6. TB patients with known HIV status (90%).	• TB India Annual Reports • City records • Project data • NIKSHAY records	• City specific data available, by gender • Selected cities remain engaged in TB control • City and local partners buy-in to the project
Outputs			
O1. Increased investment in urban TB control	1. City TB control budgets (10% annual increase). 2. Private sector financial investment in urban TB ($10 million/city). 3. Private sector organizations participating substantially in urban TB control e.g. companies foundations, and associations (25/city). 4. Co-funding from other donors and international organizations for urban TB control ($5 million/city).	• City records • Project data	• City and private groups are willing and able to invest more in TB control • Central government continues to support urban TB control in selected cities
O2. Improved city management of resources (human, financial	1. Percent of key RNTCP city staff trained and in position (80%). 2. Improvement in disbursements to private sector	• RNTCP records • Project data	• Non-GOI Actors able to influence employment levels in cities

technical)	(final indicator TBD). 3. Newer technical approaches and/or technologies introduced and scaled up (no less than 4/city). 4. Improved integration of data analytic systems in city TB management decisions (final indicator TBD).	• City records	
O3. Innovations for urban TB control catalyzed	1. Number of innovations identified (No less than 4/city). 2. Number of innovations tested and proven effective (No less than 3/city). 3. Evidence base of proven solutions shared with the GOI, other municipalities, and key private health care providers.	• Project data	• Targets for scaling receptive to ultimate findings • Effective sharing mechanisms across GOI, cities, and private sector exist • Regulatory environment conducive to TB innovations
O4. Improved Private sector delivery of urban TB services	1. Percent of formal providers practicing "Standards for TB Care in India" and notification (30% in each city). 2. Percent of informal providers practicing "Standards for TB Care in India" and notification (10% in each city). 3. Number of DR-TB chest symptomatic tested (10% increase). 4. Day Delays in diagnosis and initiation of treatment (50% reduction).	• Project data • Surveys • Nikshay data	Requirement of best practices and research in identified geographies
O5. Increased evidence-based decision making	1. Routine data collection and reporting on private sector TB activities (quarterly/annual reports). 2. Strategies developed for vulnerable populations, including urban slum inhabitants and women. 3. Presentations or briefings on data findings to public and private sector. 4. Increased use of data in city policy and program decisions (30%).	• RNTCP records • Project data	
Inputs			
<<Inputs to be completed			

by Applicants>>			