REQUEST FOR INFORMATION

TUBERCULOSIS CALL TO ACTION (TBC2A)

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. Submission shall be made electronically via IndiaRCO@usaid.gov and shall reference "TBC2A 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, point of contact (name, telephone and email address).
ii. 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. A critical element of accelerating tuberculosis (TB) control efforts to achieve a TB-free India is the convergence of stakeholders, leveraging of resources and greater public and private support.

The Government of India's (GOI) National Strategic Plan (NSP) 2012-2017 articulates a vision of a "TB-Free India". The Revised National TB Control Program (RNTCP) has a goal of "universal access by provision of quality diagnosis, and treatment for all TB patients in the community." The RNTCP emphasizes case finding among vulnerable populations, including urban slum dwellers and women, improved diagnostics, private health provider engagement, scaling up multi-drug resistant (MDR)-TB services, and better supervision, monitoring, and surveillance.

The TB Call to Action (TBC2A) will assist the GOI in launching a national movement for a Tuberculosis (TB)-free India by 2050. To launch the national movement, the successful Applicant will assist in convening a National Call to Action, drawing on lessons learned from the Global Child Survival Call to Action to End Preventable Child and Maternal Deaths. The successful Applicant will also assist national and state governments in developing road maps to achieve the National Call to Action.

Key elements of TBC2A are:

1) Identifying and leveraging Indian intellectual, financial, and material resources for TB control. (Overall Objective)
2) Assisting in the launch of the National Call to Action and the rollout of a TB road map, with associated scorecards and dashboards, at state and district levels. (Output 1)
3) Advocating to develop a broader constituency, increase understanding of TB, and reduce stigma and discrimination that prevent persons from seeking care. (Output 2)
4) Strengthening TB control through greater public and private sector collaboration. (Output 3)
5) Improving private sector delivery of TB control services. (Output 3)

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 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.

Engagement of the private sector in complying with national standards of TB care has remained elusive. This is due to the size and diversity of providers, and the assumption that when private providers report a TB case, the patient must be referred to public sector services. Providers, therefore, do not have an incentive to report cases to the national TB registry. India has a large gap in the development of practical and effective public-private mix (PPM) models for TB.

Donor Support to TB Programs

USAID/India has supported RNTCP by investing $92 million from 1998-2012, mostly through public sector healthcare services. During that period, the case detection rate increased to 58 percent and the treatment success rate increased to 87 percent.

In the past 17 years, USAID/India has directed funds for TB control through international technical partners such as WHO, CDC, and the Global Fund. Other large TB donors are the United Kingdom's Department for International Development (DFID), now UKAID, and the Bill and Melinda Gates Foundation (BMGF). The bulk of donor funds, including USAID/India's contribution to central funding mechanisms, continue to support the RNTCP and public sector TB programs.

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

The current Global Fund for AIDS, TB, and Malaria (GFATM) grants for TB address the basic goal of universal access to drug-resistant TB services through the provision of second-line anti-TB drugs and civil society involvement in TB control. The World Bank/International Development Association (WB/IDA) Program has given two TB loans to India – the first ran from 1997-2005 for $142 million and the second ran from 2006-2010 for $170 million. Both comprehensively funded RNTCP activities. The GOI has completed negotiations for a third WB/IDA loan that funds basic RNTCP activities. The GFATM grants and WB/IDA loans provide direct budgetary support to RNTCP.

Other stakeholders are the International Union Against Tuberculosis and Lung Diseases (the Union), an international organization specialized in TB control and a current Principal Recipient of India's GFATM TB grant, and the U.S. Centers for Disease Control and Prevention (CDC).

The Union is developing the National Call to Action, which has three desired results: 1) increased national leadership and commitment; 2) greater public understanding of TB; and 3) increased expertise through partnerships with academic and TB institutions and other research partners.

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 CHAMPION is an urban TB control initiative, THALI (described in a separate RFI) that establishes a holistic approach to TB control efforts in up to three or more major cities. 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 CHAMPION is TBC2A (this RFI). TBC2A 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 expertise and participation from research institutions and other organizations to energize TB control efforts.

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 TBC2A to U.S. and Indian Policies and Strategies
The proposed TBC2A 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.

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.

TBC2A Project Framework
The successful Applicant will:

- Identify and leverage Indian intellectual, financial, and material resources for TB control. (Overall Objective)
- In cooperation with the Union, facilitate the launch of the National Call to Action with key stakeholders, including the GOI; state, district, and city governments; Indian private sector resource and implementation stakeholders; civil society advocates and service providers; and international partners. The launch will be followed by the rollout of a TB road map, with associated scorecards and dashboard, to states, districts and cities. (Output 1)
- Track results and develop systems and processes to overcome heath system and other constraints, including gender barriers and stigma associated with TB. (Output 2)
- Facilitate the engagement of new partners to find ways to co-advocate, collaborate, and possibly co-design, and co-fund projects with shared interests that will improve delivery of TB control services. (Output 3)

The Applicant will be responsible for assisting the GOI in leading this effort to define clear divisions or sharing of labor according to each organization's strengths and comparative advantage. The Applicant will conduct all activities under this project with key stakeholders who are members of the partnership that include, but are not limited to:

- ***Government stakeholders*** – *TBC2A role:* Secure the GOI as the lead, driving partner as well as TB public sector leads in states and at municipal levels. National government stakeholders include the GOI and the Central TB Division of the Ministry of Health and Family Welfare (MOHFW)
- ***For-profit private sector –*** *TBC2A role:* Engage the for-profit private sector, for example in following the Standards for TB care to achieve greater impact, sharing resources, participating in surveillance and capacity building, and sharing information.

- ***Not-for-profit private sector --*** *TBC2A role:* Engage civil society organizations, which mobilize community support.
- ***Academia*** *– TBC2A role:* Engage medical colleges and research institutes to develop pre- and in-service curricula, carry out research, perform evaluations, and advise on project initiatives.
- ***Bilateral and multilateral donors and technical partners*** *– TBC2A role:* ensure coordination among donors and technical partners to maximize impact of investments and facilitate the sharing of tools, materials, approaches, and lessons learned. The partnerships will seek innovative solutions for TB control, while focusing on results and impact.

Key stakeholders must coordinate, share information and learning and work with the other implementing partners in TB activities, particularly those under the anticipated THALI activity.

The results of the project will be measured through key TB indicators, such as the case detection rate, TB treatment success rate, and percentage of drug-resistant TB cases successfully treated. The Applicant must track and report on these indicators. In turn, success with the TB Call to Action will increase multi-stakeholder participation in national TB control efforts. This will be measured by increased public and private sector investment in TB control, the scaling up of PPM initiatives and an increased number of private sector groups and organizations working on TB control.

Project communications will be governed by the Applicant's Branding and Marking strategy, which must comply with USAID branding and marking guidelines and rules[4]. Communications 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.

See Annex A, Logical Framework, at the end of this RFI for additional results information.

Anticipated Funding, Period of Performance and Cost-Share
USAID/India anticipates that a single award of up to U.S. $6 million may be available 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

4. 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

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

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.

5. DRAFT TECHNICAL APPLICATION REQUIREMENTS

Depending on interest and responses to this RFI, USAID/India may conduct a single or two-step process. Under a two-step process, concept notes will first be requested. Concept papers will be evaluated, 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, Technical Applications are anticipated to include the following requirements. This information is being provided 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;
    - 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 its understanding of the health sector in India, particularly related to TB, and of successes and failures of past TB control interventions and private sector engagement activities.
   - Identify target area(s) where it proposes to focus project activities. Selection of target project area(s) should be justified by the Applicant.
   - Articulate how its proposed project will achieve the results in the Program Description. Specifically, the Applicant must describe its proposed methodologies and "theory of change" for achieving the proposed outputs. Simply put, a theory of change is a hypothesis that outlines an if-then statement underlying the proposed intervention. It states the expected (changed) result that will follow from a particular set of actions.
   - Identify potential risks related to its proposed project activities and ways to mitigate those risks.
   - Describe how its proposed project is sustainable and how it will promote sustainability in project activities.
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 project 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 project 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.
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 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 four Key Personnel, one of which must be the 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 project.

The minimum requirements for Key Personnel are:

- Ten years of professional experience in fields related to the project results, particularly advocacy and engaging the private sector.
- A Master's Degree in management, public health degree, communications, or related field.
- Proven exceptional leadership in the design, management, implementation, monitoring, and evaluation of similar-size international-donor supported programs.
- Skills and experience in strategic planning, management, supervision, and budgeting, managing complex activities, coordinating with multiple program partner institutions.
- Ability to develop and communicate a common vision among diverse partners (government, NGOs, development partners, private sector, and other stakeholders) and the ability to lead a diverse and multi-disciplinary team in translating policy and vision into action.
- Strong communication and influencing skills, both interpersonal and written, to fulfill the diverse technical and managerial requirements of the project.
- Knowledge of USAID program management policies and procedures.

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 anticipated, 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 projects 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 Letters of Intent – The Applicant must provide a signed letter of intent from each sub-applicant proposed (if any). The letter must commit the organization to participation in the project, and briefly state that the sub-applicant

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

Results	Objectively verifiable indicators[5]	Means of verification	Important Assumptions
Objective Increased multi-stakeholder participation in national TB control program.	1. Amount of public resources allocated to TB control: 10% increase in national and state TB control budgets. 2. Private Sector Contributions to TB Control: Private sector investment (TBD). 3. Number of private sector groups and organizations with substantial involvement in TB Control (20).	• TB India Annual reports • Project data • Project data	The GOI will wish to mobilize increased investment and support for public and private sector. GOI will work with the private sector. The will to control TB exists in both the public and private sector.
Outputs			
1. Increased national leadership and outreach to leverage Indian intellectual, financial, and material resources for TB control.	1. National Call to Action launched and rolled out to states and cities. 2. Strategic Roadmap toward a TB-free India developed. 3. Increased media coverage (# of stories in print media and air time increased by 20%). 4. Public commitment by senior policy makers and officials, opinion makers and private citizens and groups (25 statements).	• Project data • Project data • Analysis of press coverage • Project Data	• Mechanisms that allow for co-funding can be developed and approved in a timely manner. • Media determine that TB is an issue of public interest. • The will to act on TB-free India exists.
2. Greater Public Understanding of TB	1. Government develops and implements a comprehensive TB SBCC strategy and campaign. 2. Percent of population who know how TB is transmitted (20% increase). 3. Percent who know TB is curable (15% increase). 4. Percent who know TB can infect anyone (10% increase).	• TB India Annual reports • Project data • Project data • Project data	• Acceptability of out-of-the-box ideas for the campaign. • Media and other informational campaigns can reach key hard to reach populations
3. Technical collaboration expertise and	1. Number of technical partners collaborating with GOI including research institutions (10).	• Project data	Engagement with CTD and identified institutions crucial to

	TB control efforts (5).	• Project data	support
Inputs			
<<If an RFA is issued, the Applicant must define the inputs.>>		•	