REQUEST FOR PROPOSALS #S005434

CONSULTANT TO SUPPORT IMPLEMENTATION OF CONTINUOUS QUALITY IMPROVEMENT IN THE THIRD LINE ART PROGRAM AT THE MOH/ACP

Firm Deadline: Tuesday, December 14, 2020

The Elizabeth Glaser Pediatric AIDS Foundation, a non-profit organization, is the world leader in the fight to eliminate pediatric AIDS. Our mission is to prevent pediatric HIV infection and to eliminate pediatric AIDS through research, advocacy, and prevention and treatment programs. For more information, please visit http://www.pedaids.org.

SCOPE OF WORK AND CONTRACTOR DELIVERABLES

The Scope of Work and Contractor Deliverables for this Request for Proposals are found in Attachment A

LOGISTICS:

Kampala

KEY CONTRACT TERMS:

The anticipated contract type is Firm Fixed Price Contract. Unless stated otherwise in the statement of the work, the Contractor is responsible for providing equipment and/or supplies required to perform the services.

OPTIONAL WORK:

The Foundation also anticipates a need to potentially extend this scope of work for an additional 3 option periods. The anticipated duration of each option period is 1 month. Please indicate any pricing changes for the option periods in response to this RFP.

EVALUATION CRITERIA AND SUBMISSION REQUIREMENTS:

The Foundation will accept the proposal that presents the best value. All proposals will be evaluated against the following Evaluation Criteria. Each proposal must contain the items listed in the Submission Requirements column in the following chart. Please submit your Submission Requirements in the order that they appear below.

Evaluation Criteria Submission Requirements Weight

Evaluation criteria	Submission requirements	Weight
Past performance of similar work	Experience in the implementation of programs at regional or national level particularly in the area of viral load programming and/or HIV Drug resistance. 3 professional references from similar past projects with phone and email contact information and one or more examples of prior similar work.	25.00 %
Qualifications of proposed individuals and past performance on similar work.	CV/Resume of proposed individual to work on this project. Bachelor's degree in a medical field and a Master's Degree in Public Health. Experience in implementation of CQI programs is an added advantage.	30.00 %
Timeframe of implementation	Availability to start work as soon as possible, with flexibility to work outside normal working hours including on weekends.	25.00 %
Total fixed price	Total fixed price to complete all of the deliverables, including a breakdown by deliverable. This fixed price includes consultant time. Travel support and any other required materials are not inclusive of this pricing.	20.00 %
Total		100.00%

Attachment A

SCOPE OF WORK/TERMS OF REFERENCE

Terms of reference for the consultant to support the national HIV care and treatment program to improve drug resistance monitoring and ART optimization for patients with virological failure.

Background

The implementation of the 3rd line ART program is through a decentralized system with the regional referral hospitals taking lead at the regional level, supported by the central level team. There have been intensified efforts to build capacity among regional/health facility teams to identify patients who are at risk of HIV drug resistance (HIV DR) and may require ART optimization including third line ART. These efforts have led to an increase in the identification of clients with virological failure to 2nd line treatment through HIV drug resistance testing, and subsequent switch to 3rd line ART. However, even after capacity has been built at the regional level, there are still critical delays in decision making processes that ultimately delay identification of HIV DR and treatment optimization for the patients. These include among others;

- Delay in provision of 3 Intensive Adherence Counselling (IAC) sessions for unsuppressed children and adolescents on 2nd line ART within 3 months.
- Delay in requesting for/ taking a sample for repeat viral load (VL) test following completion of 3 IAC sessions.
- Failure to request for/ take a sample for HIV DR while taking off the sample for repeat VL test following 3 IAC sessions.
- Long turn-around-time for results of HIV DR tests following an unsuppressed repeat VL (up to 4-6 months for DBS samples and 2-4 months for plasma samples).
- Delay in receiving and transmitting of HIV DR results centrally and at the regions.
- Delay in discussing HIV DR results and taking the decision to switch the client.
- Delay in ordering for 3rd line commodities by the regional referral hospitals (following a prescription by the ART switch team).

Failure to identify and address the bottlenecks in the several processes along the cascade for identification and eventual treatment optimization may result in increased risk of the clients developing more mutations before receiving appropriate treatment leading to a risk of virological non-suppression even after switching to optimal ART.

Furthermore, there is an estimated 1500 clients aged <24 years identified between Jan and October 2020 at CPHL who continue to have unsuppressed viral loads following completion of IAC and who may have acquired HIV drug resistance. We are not reaching all the clients who are in need of HIV DR testing and could potentially need 3rd line ART. The recently updated 2020 guidelines also allow for HIV DR testing for children

The MOH through the recently concluded support supervision to the regional referral hospitals, supported the reactivation of the regional referral teams as part of the activities to strengthen the decentralized system. To build up on this, the MOH as a key strategy to improve processes in order to have better outcomes for the patients will implement a continuous quality improvement initiative. The aim will be to improve performance along the cascade of care for the virologically unsuppressed clients. The MOH with the support of a consultant will fast track this improvement. The consultant will provide catalytic support to the central team to ensure that the regional referral hospitals take up their mandate to monitor treatment optimization for clients with virological non-suppression in their regions of support. The consultant will work closely with the central MOH 3rd line team to support the start-up of the CQI activities which the MOH will then take on to completion.

Goal of the CQI collaborative

To improve efficiencies in optimization of clinical outcomes for patients on 2nd line ART with virological failure using the Continuous Quality Improvement collaborative approaches.

Objectives of the CQI collaborative:

1. To increase the proportion of patients with virological failure receiving 3 consecutive IAC to 100% by June 2021
2. To increase the proportion of patients with virological failure receiving a repeat viral load test after completion of 3 consecutive IAC sessions to 100% by June 2021
3. To increase the proportion of patients with virological failure on 2nd line PI/DTG based regimens following completion of IAC receiving an HIV drug resistance test to 100% by June 2021.
4. To increase the proportion of patients on 2nd line regimens with HIV drug resistance receiving an appropriate 3rd line regimen to 100% by June 2021

CQI Collaborative Approach

This CQI collaborative will be conducted over a period of 6 months, starting December 2020. It will be implemented by sites to be shared by the respective implementing partners (IPs) following the orientation meeting between MOH/ACP, the 3rd line ART national task force, and the IPs. The approach will follow the standard phases of a QI collaborative that are the basis of the collaborative activities, namely;

1. Problem identification
2. Problem analysis
3. Prioritization of the possible solutions
4. Implementation phase (using the PDSA cycle)
5. Document best practices and Change package.

Expected CQI collaborative activities:

- Meeting between MOH/ACP and IPs to introduce and understand the CQI collaborative concept, map out roles and responsibilities and develop tools for the regional entry meetings and first coaching visit.
- Regional/ District and health facility entry/ orientation meetings countrywide to introduce the national CQI collaborative to the different stakeholders for their buy in, identify clarify roles, and share the audit tools
- To undertake coaching in HIV DR to regional and district coaches.
- To collect baseline data from facilities that will be involved in the HIV DR collaborative.
- A learning session following collection of baseline data for all participating sites, and another after 3 months of implementation to share lessons and implementation experience from early adopters.
- Weekly capacity building sessions (CMEs) using the weekly virtual 3rd line ART platform.
- Monthly data collection, data validation, reporting and update of the national QI database by the implementing teams and respective IPs.
- Monthly mentorship, coaching and technical supportive supervision by central coaches to the regions, and regional coaches to district and health facilities.
- Monthly coordination meetings between the national 3rd line ART task force and the regional 3rd Line ART teams.
- Harvest meeting after 6 months of implementation to document successful practices and refine change packages for improving outcomes of clients failing on 2nd line ART.
- Scale up of the successful practices to all sites.

Role of the consultant:

The aim of having a consultant is to set up a system that will implement an intensive capacity building program based on the CQI framework to optimize clinical outcomes for patients on 2nd line treatment with virological failure targeting the Implementing Partner technical teams, regional third line ART teams and health facility teams.

Specific tasks for the consultant:

- Support the MOH 3rd line ART National committee to
    - Develop a data collection tool that will collect baseline information on
        - Patients on 2nd line ART with unsuppressed VL.
        - Patients on 2nd line ART with unsuppressed VL receiving IAC.
        - Patients receiving a repeat viral load test after completion of IAC.
        - Patients with virological failure on PI/DTG based 2nd line regimens receiving an HIV DR test after completion of IAC.
        - Patients receiving an appropriate 3rd line regimen
    - Build the technical capacity of the regional and health facility teams using the national QI initiative framework and existing QI structures to enable

the teams do baseline data collection, root cause analysis, come up with improvement objectives , implement and monitor these objectives
    - Facilitate the learning sessions and harvest meeting
- Support process improvement at regional level and facility level through working with the Implementing partners to
    - Identify the technical focal person for the collaborative who will manage and support the regional teams.
        - Select sites that account for the highest number of HIV positive children and adolescents/young adults with HIV viral non-suppression in care in their respective region.
        - Identify and allocate site QI teams and regional mentors who will participate and work with the assigned teams in the collaborative.
        - Allocate a focal person at each health facility who will bring together and prepare their respective team members to share and participate in the collaborative activities.
        - Support the selected teams to have computer and internet access and installation of the Zoom App to be able to participate in the virtual sessions.
        - Support site teams test the ability to use zoom.
        - Support MOH and site teams to collect baseline data and prioritize at least 2 improvement aims on the children and adolescents clinical care cascade.

Expected Outputs for the consultant:

- An inception report with a tentative roadmap for the QI collaborative initiative. The road map shall include a mentorship schedule to the regional referral hospitals as the team leads for the regions.
- Develop audit tools for the collection of baseline and ongoing 3rd line QI collaborative data for coaching and mentorships.
- Collect the baseline data- for the whole country based on the objectives
    - Conduct a baseline assessment with the support of the regional IP will collect regional data.
- Initiate the continued engagement of the review meetings with the RRH meetings.
- Build capacity of the 3rd line teams
- An evaluation report at the end of 3 months.

Logistical support for the consultant:

The consultant will be provided with a desk at the MOH ACP.

The consultant will be supported with facilities for conducting virtual and physical meetings/ learning sessions.

The consultant will receive a technical allowance of $150 for every day worked during the CQI collaborative.

Where travel is required, the consultant will be facilitated with transport (vehicle or fuel), accommodation, meals, and incidentals as per the current MOH rates.