**TERMS OF REFERENCE**

**FOR INDIVIDUAL CONTRACT**

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| **POST TITLE:** | Consultant for the development the multicounty policy and treatment guidelines for the TB/DR-TB diagnosis, prevention, care and control in migrants and settings with refugees, Internally, displaced Populations (IDPs) and returnees |
| **AGENCY/PROJECT NAME:** | UNDP HIV, Health & Development Group |
| **COUNTRY OF ASSIGNMENT:** | Home-based |

## 1) PROJECT DESCRIPTION

This consultancy is requested by the United Nations Development Program's Regional Bureau for Asia and the Pacific (Bangkok Regional Hub) which acts as the Principal Recipient for the TB/MDR-TB interventions among Afghan refugees, returnees and mobile populations in Afghanistan, Iran and Pakistan (The Programme), funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).

The Islamic Republic of Afghanistan (Afghanistan) has one of the highest numbers of refugees, returnees and internally displaced peoples (IDPs) in the region. The existing capacity to absorb new arrivals in country is under significant strain and negative coping mechanisms such as remigration are increasingly prevalent.

Renewed insecurity and conflict inside Afghanistan continued to drive displacement in 2018, with an estimated 270,000 newly displaced people in the country. A severe drought caused the displacement of an additional 230,000 people over the course of the year. Increased support from the international community remained crucial for the Government of Afghanistan, as well as for the Governments of the Islamic Republics of Iran and Pakistan, in order to maintain their generous support for the 2.4 million Afghan refugees that they hosted[1].
In Pakistan, the Government registered nearly 880,000 undocumented Afghans providing them with Afghan Citizen Cards which regularize their temporary stay.
The Office of the United Nations High Commissioner for Refugees (UNHCR) has estimated that there are around 2.4 million registered Afghan refugees are living in the Islamic Republic of Pakistan (Pakistan) of which 1.4 million refugees hold Proof of Registration cards.

Afghanistan, Iran and Pakistan have established strong national tuberculosis (TB) programs which have to date successfully ensured appropriate TB diagnosis, care and control services to populations, including migrants, refugees, returnees and IDPs. However, some of the TB services provided are not yet fully harmonized among the three countries. Moreover, the information on migrants, refugees, returnees and IDPs with TB is not routinely collected within the National TB Program networks of the three countries, and if it is, it is fragmented and not standardized.

[1] UNHCR Annual report 2018

Although in the previous years, there were some attempts among the NTPs of Afghanistan, Iran and Pakistan to collaborate in order to strengthen TB services provision to migrants and refugees moving across national borders, there is still no formal coordination mechanism to ensure i) harmonized strategy and policy development ii) implementation of a system to exchange standardized information on TB among migrants, refugees and returnees, iii) standardized and mutually supportive capacity building approaches, iv) regional approach to advocate for sustainable TB services for migrants, refugees, IDPs and returnees, v) regional and in-country dialogue on human rights and gender issues which affect access of target population to TB services and vi) development of a regional network of partners.

There are three target **groups** important for cross-border collaboration on TB control and finding missing TB/MDR-TB cases amongst mobile Afghan populations:

- **Afghan migrants living within the general population** in Iran and Pakistan. There is a considerable number of these migrants in both Iran and Pakistan, who would receive similar levels of services as the general population of the host country.
- **Afghan refugees or returnees living in camps/villages/settlements**. This group is easier to reach out with targeted public health interventions. These camps/villages/settlements are covered by the neighboring health facilities, which need to be strengthened and equipped to handle the additional workload. No parallel structures operated by non-NTP affiliated entities should be additionally established, for the sustainability of services and capacity building of the local service providers for the long term. Existing health services within these settlements will be supported for establishing a functional referral mechanism to the nearest TB services. People living in camps are a congregated population and may need a specific algorithm for diagnosis of TB, which should be sputum examination by GeneXpert. There is also a need to develop mechanism for active case finding. The recommended options include use of digital X-rays and GeneXpert as follow-up/confirmation.
- **Afghan migrants/refugees/returnees travelling across the national borders.** Diagnostic protocols differ between the three countries and even within the same country because of the diagnostic facilities/equipment availability and the different approach needed for different target populations *(Annexes for each country's approach).* Iran has a specific lab algorithm for patient of Afghan origin.

**Summary of the current treatment regimens is provided in Annex 1**.
First line treatment is currently seen as being aligned. This is yet to be confirmed with involvement of the WHO-EMRO.
In April 2019 WHO introduced the latest drug management policies and all oral treatment regimens to EMR memberstates. Afghanistan, Iran and Pakistan attended the meeting and prepared transition plans. WHO EMRO is collecting update on progress which will be shared as soon as the work on the document is completed.

Second line treatment algorithms are mostly aligned[2], except for:

- A minor difference in the standard MDR-TB treatment regimen in Pakistan – one medicine on the list (Ethionamide) is different from the other two countries, but this is not seen to be a big difference by the NTPs and WHO.
- The short course regimen is similar in all countries. However, differing levels of roll-out of the short course regimen in the three countries require careful and coordinated selection of treatment for patients.

In February 2019, the Joint Program Review has been completed in Pakistan with the purpose to assess progress and constraints in reaching the targets of the NSP 2017-2020 and End TB Strategy (in particular the 2020 milestones) with particular focus on: finding missing cases; prevention, identification, care and treatment of drug resistant tuberculosis; public private partnership for TB care and prevention and community

2 All EMR member states will be oriented on the revised MDR policies and guidelines and EMRO will provide guidance in the transition planning

engagement and partnerships. Also, the National Guidelines for the TB control have been published in Pakistan in September 2019.

### 1. Purpose of the consultancy

Consultancy to develop a multi-country[3] policy and treatment guidelines for TB/DR TB prevention, care and control in migrants and settings with refugees, Internally Displaced Populations (IDPs) and returnees. The policy and referral and treatment guidelines will be aligned to the national strategies and guidelines.

## 2) SCOPE OF WORK

Consultancy to develop a multi-country [4]policy and treatment guidelines for TB/DR TB prevention, care and control in migrants and settings with refugees, Internally Displaced Populations (IDPs) and returnees. The policy and treatment guidelines will be aligned to the national strategies and guidelines.

The following activities are expected to be completed as part of this assignment:

| | November 2019 | | | | December 2019 | | | | January 2020 | | | | February 2020 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a) Develop multi-country (MC) policy document through desk work and on-line consultations | | | | | | | | | | | | | | | | |
| b) Development of a harmonized package of service, compendium) through desk work and on-line consultations | | | | | | | | | | | | | | | | |
| c) National endorsement of the TB management guidelines in the countries (the deliverables[5]) | | | | | | | | | | | | | | | | |
| d) Develop a training module for service providers on TB management in migrants, refugees, IDPs and returnees | | | | | | | | | | | | | | | | |
| e) National discussions of the project deliverables[6] within Ministries of Health and Technical Agencies and finalization of the documents | | | | | | | | | | | | | | | | |

## 3) EXPECTED OUTPUTS AND DELIVERABLES

The following are the expected outputs and deliverables:

[3] Afghanistan, Iran and Pakistan
[4] As listed in the outputs section below
[5] As listed in the outputs section below
[6] As listed in the section 5

i. A policy document on the TB services in settings with migrants, refugees, IDPs and returnees in Afghanistan, Iran and Pakistan. The document will describe the multi-country approach to the TB services for migrants, refugees, IDPs and returnees. (Expected up to 10 working days days)

ii. Updated and harmonized TB diagnosis, prevention, care and control guidelines in settings with migrants, refugees, IDPs and returnees. This will result in harmonized TB prevention, care and control services. The document will propose interventions that will also improve TB services for women and children. The development of this deliverable requires country-specific actions which includes but not limited to national consultations to review, discuss and validate the proposed guidelines. (Expected up to 15 working days)

iii. Design a minimum package of service for cross border Tuberculosis care and services and develop three guidance documents (one in each country) on active screening in refugee settings. This document will specify (Expected up to 15 working days):

   a. The criteria to select the refugee settings where the screening will be undertaken.

   b. The eligibility criteria for the refugees/IDPs/returnees who need to be screened for TB.

   c. The algorithm and standard operating procedures (SOP) to be used for active screening.

   d. The human resources that need to be involved at each step of the active screening.

   e. The information that should be collected in the process of active screening.

   f. The indicators needed for evaluation: e.g.: prevalence of TB among active screened refugees, number of refugees that needed to be screened to identify 1 TB case (NNS) and contribution of active screening to TB detection (ex.: number of TB cases identified through active screening divided by the total number of notified TB patients

iv. Compile a compendium of the developed strategies, tools and processes for use by the National Tuberculosis Program and national stakeholders for achieving universal access to TB services for migrants, refugees and returnees. (Expected up to 10 working days)

v. Develop a training module for service providers on TB management in migrants, refugees, IDPs and returnees. This module will be adopted by each country to include gender, childhood and data confidentiality aspects in each country based on the relevant national policies. The module should include a component of the respective recording and reporting tools for data on TB/MDR-TB and related services for migrants, refugees, IDPs and returnees. After its adoption, the training module should be endorsed by each NTP and incorporated in the general training packages of NTPs; reproductive, maternal, newborn, child and adolescent health (RMNCHA) programs and civil society organizations dealing with the target populations in order to ensure its sustainability. (Expected up to 15 working days days)

## 4) INSTITUTIONAL ARRANGEMENTS

The Consultant shall report to the Team Leader for the Asia and the Pacific Health team at UNDP Bangkok Regional Hub. The work will be facilitated in close coordination with the GF HIST team in Geneva, WHO Regional Office for the Eastern Mediterranean (EMRO) and the Stop TB partnership

## 5) DURATION OF ASSIGNMENT, DUTY STATION AND EXPECTED PLACES OF TRAVEL

The duration of the assignment is for 65 working days, 18 November 2019 to 15 February 2020.

The position is home based, with no travel.

(i) In the event of authorized travel, payment of travel costs including tickets, lodging and terminal expenses should be agreed upon, between the respective business unit and the Individual Consultant, prior to travel and will be reimbursed by UNDP.

The fare will always be "most direct, most economical" and any difference in price with the preferred route will be paid for by the expert. Travel costs shall be reimbursed at actual but not exceeding the quotation from UNDP approved travel agent

## 6) DEGREE OF EXPERTISE AND QUALIFICATIONS

**Education:**

- Advanced university degree in public health or medicine.

**Experience:**

- At least 7-year experience working with TB programs in developing countries,
- Experience in development of tools and strategies for TB control.
- Experience with projects undertaken with governments of similar nature and magnitude
- And preferably, experience in working for TB program in refugee/migratory settings.

**Skills/Technical skills and knowledge:**

- Sound knowledge of organization, processes and challenges in Tuberculosis management.

**Language**

- Fluent in English

**Competencies**

Proven experience in designing/developing policies;
Proven experience in designing/developing tuberculosis guidelines.
Proven experience in designing/developing training materials and educational tools;
Proven experience on supporting countries implement the Stop TB strategy;
Excellent organizational, communication, interpersonal and writing skills

## 7) REQUIRED DOCUMENTS

Interested individual consultants must submit the following documents/information to demonstrate their qualifications. Please group them into **one (1) single PDF document** as the application only allows to upload maximum one document:

1- **Letter of Confirmation of Interest and Availability** using the template provided in Annex III.
2- **CV ,** indicating all past experience from similar projects, as well as the contact details (email and telephone number) of the Candidate and at least three (3) professional references.
3- **Technical proposal which includes the following**

a) The proposed assignment work plan;
b) the proposed framework for the MC policy;
c) the proposed process to update the national TB management guidelines for refugees, IDPs, migrant and returnees

4- **Financial Proposal** that indicates the all-inclusive fixed total contract price supported by a breakdown of costs, as per template provided. IF an Offeror is employed by an organization/company/institution, and he/she expects his/her employer to charge a management fee in the process of releasing him/her to UNDP under Reimbursable Loan Agreement (RLA), the

Offeror must indicate at this point, and ensure that all such costs are duly incorporated in the financial proposal submitted to UNDP.

Incomplete proposals **will not be considered**. The shortlisted candidates may be contacted, and the successful candidate will be notified

## 8) CRITERIA FOR SELECTION OF THE BEST OFFER

Applicants will be evaluated based on the following methodology. The award of the contract shall be made to the individual consultant whose offer has been evaluated and determined as a) responsive/compliant/acceptable; and b) having received the highest score out of set of weighted technical criteria (70%). and financial criteria (30%). Financial score shall be computed as a ratio of the proposal being evaluated and the lowest priced proposal received by UNDP for the assignment.

**Technical Criteria for Evaluation (Maximum 70 points)**

- Criteria 1 Relevance of Education – Max 5 points
- Criteria 2 Relevance of work experience with TB programs in developing countries - Max 15 points
- Criteria 3 Proven experience in development tools and strategies for TB control. Max 20 points
- Criteria 4 Effectiveness of the proposed process for completing the assignment -Max 20 points
- Criteria 5 Relevance of the proposed policy framework – Max 10 points

Only candidates obtaining a minimum of 49 points (70% of the total technical points) would be considered for the Financial Evaluation.

## 9) CONSULTANT PRESENCE REQUIRED ON DUTY STATION/UNDP PREMISES

NONE PARTIAL INTERMITTENT FULL TIME

## 10) PAYMENT TERMS

The Consultant must send a financial proposal based on the lump sum amount.

The total amount quoted shall be all-inclusive and include all costs components required to perform the deliverables identified in the TOR, including professional fee, travel costs, living allowance (if any work is to be done outside the IC's duty station) and any other applicable cost to be incurred by the IC in completing the assignment. The contract price will be fixed out-put based price regardless of extension of the herein specified duration. Payments will be done upon completion of the deliverables/outputs and as per below percentages:

| **Deliverables/ Outputs** | **Payment** |
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|---|---|
| First payment of 15% shall be made upon the successful receipt of the multi-country (MC) policy document | 15% |
| Second payment of 20% shall be made upon the successful receipt of an updated and harmonized TB diagnosis, prevention, care and control guidelines in settings with migrants, refugees, IDPs and returnees. | 20% |
| Third payment of 20% shall be made upon the successful receipt of a 1) minimum package of service for cross border Tuberculosis care and services and 2) three guidance documents (one in each country) on active screening in refugee settings | 20% |
| Forth payment of 20% shall be made upon the successful receipt of a compendium of the developed strategies, tools and processes for use by the National Tuberculosis Program and national stakeholders for achieving universal access to TB services for migrants, refugees and returnees | 20% |
| Fifth payment of 25% shall be made upon the successful receipt of a standardized training module for service providers on TB management in migrants, refugees, IDPs and returnees. | 25% |

In general, UNDP shall not accept travel costs exceeding those of an economy class ticket. Should the IC wish to travel on a higher class, he/she should do so using their own resources.

In the event of unforeseeable travel not anticipated in this TOR, payment of travel costs including tickets, lodging and terminal expenses should be agreed upon between the respective business unit and the Individual Consultant, prior to travel and will be reimbursed.

Travel costs shall be reimbursed at actual but not exceeding the quotation from UNDP approved travel agent. The provided living allowance will not be exceeding UNDP Living Allowance rates.

## 11) ANNEXES TO THE TOR

ANNEX 1- INDIVIDUAL CONSULTANT GENERAL TERMS AND CONDITIONS is provided here:
http://www.undp.org/content/dam/undp/documents/procurement/documents/IC%20-%20General%20Conditions.pdf

**Annex 2 - TB treatment regimens**

| Country | DS-TB Cat 1 | DS-TB Cat 2 | MDR-TB | Comments |
|---|---|---|---|---|
| | | | 24 months regimens are | • TB treatment regimens for children generally follow current international recommendations, except for TB meningitis, where the currently used regimen is no |

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| Afghanistan | 2RHZE/4RH | 2SRHZE/1RHZE/5RHE | used.<br>Short regimens are piloted in Kabul | longer recommended by WHO. There is a plan for introducing the newly developed FDCs for children through the MSH-managed Challenge-TB project. |
| Pakistan | 2RHZE/4RH | 2SRHZE/1RHZE/5RHE | 24 months regimens are used.<br><br>One medicine on the list (Ethionamide) is different from the other two countries, but this is not seen to be a big difference by the NTPs and WHO.<br><br>It is planned that up to 30% of new MDR-TB cases will be treated with the shorter regimens by 2020. | • TB treatment regimens for children follow current international recommendations. The NTP already uses the newly developed FDCs for children as standard medication. |
| Iran | 2RHZE/4RH | 2SRHZE/1RHZE/5RHE | Standardized MDR-TB regimen: Am+Lfx+Cs+Pto+Z+E (=/-H) | • FDCs are purchased and imported from WHO pre-qualified companies<br><br>• Cat 2 will be deleted before 2020, If GX and LPA will be available sufficiently<br><br>• Pediatric FDCs are not applied |
| | | | Short course regimen is going to be applied in the frame of an interventional study in 2019 | |