Section 3

TERMS OF REFERENCE

RESEARCH INTO THE CAUSES OF NON-MALARIA FEVERS

Terms of Reference

Objective

1. The objective of this research is to provide evidence on:

- Most common causes of non-malaria fever
- Antibiotic susceptibility of bacterial causes
- Clinical guidelines and algorithms on how to manage non-malaria fevers

Background

2 Fever is one of the most common symptoms leading to health care and hospital admission in sub-Saharan Africa and Asia. Until recently, most febrile illness in these regions has been attributed to malaria. However, following the 2010 World Health Organization (WHO) recommendations, there has been a scale up of point-of-care testing for malaria, making clear that most febrile patients do not have malaria. Moreover, with improvements in malaria control, there has been a dramatic decline in the incidence of malaria in many settings in Arica and Asia, increasing the relative importance of other causes of fever.

3. Current guidance to clinicians for the management of non-malarial fevers often results in treatable diseases being left untreated or treated with inappropriate antimicrobials, with important implications for antimicrobial resistance. Little is known about the non-malarial causes of fever in many parts of the world. A review and mapping of the causes of fever in patients attending health facilities in sub-Saharan Africa and Southeast Asia was done. These demonstrate that it is difficult to reach general conclusions due to the heterogeneity of study designs, and that there are many regions from which no data are available.

4. The ability to differentiate between bacterial and viral infections could have a major global impact on antimicrobial resistance by limiting the unnecessary use of antimicrobials. The ability to distinguish between bacterial causes of fever requiring antibiotic treatment and self-limiting viral infections in low-income settings has been identified as a very high priority.

5. The proposed study will fill the gaps in evidence by means of a multi-centre study in regions with a high burden of infectious disease from which few or no data are available. It will focus on detecting infections that are treatable and/or preventable. The results will help design new, evidence-based algorithms for the management of febrile illness, with the potential for designing new diagnostics and rational approaches to disease surveillance. This will ultimately provide more appropriate care to patients and lead to better clinical outcomes.

Recipient

6. The contractor will work with partners in 5 countries. People involved will include researchers, clinicians, health authorities, policy makers and patients. The results will be a global public good.

Scope

7. The contractor will

- conduct a study on the causes of febrile illness and antibacterial resistance at five sites in Africa and Asia.
- generate reliable data that can be used to guide recommendations on the clinical management and prevention of febrile illnesses relevant to local contexts.
- test patients using a variety of diagnostics,
- conduct in-depth qualitative research in 4 sites following an anthropological perspective.

Methodology

8. Likely methodologies include:

- Recruit partners and set up a management system
- Obtain ethical approval. Informed consent will be sought from study participants or their caregivers at recruitment including for the future use of their biomedical samples.
- Establish a common quality management system.
- Conduct the 1 year study. This is expected to be a multi-centre study including a common design, harmonised inclusion criteria, case definitions, laboratory procedures and result interpretation. Recruitment to the study will be over a one-year period to ensure that seasonal variations in causes of fever are captured. It will use a random sample of equal numbers of children under 5, and adults and children older than 5 with fever in both outpatients and inpatients Cases will be compared to randomly selected matched community controls.
- Treat those diagnosed with a specific illness.
- Analyse and disseminate results.
- Develop algorithms for the management of febrile illness.

Inception Period.

9. There will be an Inception period of up to 8 months when the contractor will develop their workplans including for the 5 focal countries partners. These will be outlined in the inception report which the DFID programme team will review. The end of the Inception period will also act as a natural break point in the Contract and progressing to implementation phase will be subject to satisfactory review of performance to date.

Contractual and Reporting Requirements

10. The contractor will provide short progress reports on a 6 monthly basis and a more detailed Annual Report using the DFID standard template. An Inception Report will be provided at the end of the inception period, at approximately 8 months into the contract.

11. Meetings will be held quarterly in the first year and then as required, minimally annually.

12. The contractor will invoice quarterly in arrears and invoices should be accompanied by a brief narrative report showing the amount of funding allocated against key activities and any impact that this has made. This will include expenditure by downstream partners.

13. Annual Audited statements clearly showing the DFID contributions for Non-Malaria Fevers should be provided to the programme team each year following publication of the statement.

14. The contractor should disaggregate data by gender and age and any other relevant diversity indicators. The contractor will follow other DFID monitoring and reporting requirements such as assets, risks etc.

15. DFID will use reports and their judgement of the Suppliers' performance to take a formal decision whether or not to proceed with the study or terminate the contract, or reduce budget or scope. If judged inadequate, concerns will be shared in writing and formally discussed.

16. DFID reserves the right to scale back or discontinue this study at any point (in line with our Terms and Conditions) if it is not achieving the results anticipated. Conversely, we may also scale up and/or extend the programme by up to 2 years (subject to internal DFID approvals) should it prove to be having a strong impact and have the potential to yield better results

17. The Supplier will maintain regular dialogue with DFID's programme management team to ensure compliance with all terms and conditions set out in the contract, as guided by DFID's Procurement and Commercial Department; best practice financial management, including timely and accurate financial forecasting and invoicing and cost control; and effective contract management, including early notification on any proposed changes to the contract, before formal agreement is sought from DFID's contract office.

Timeframe

18. The programme is expected to start in early 2017 and will end in March 2021.

DFID Coordination

19. The Senior Responsible Owner (SRO) will be a member of DFID's Health Research team and the programme team will include an adviser, a research manager and a deputy programme manager, together with other team members as required. The SRO and team will provide the lead technical and project management roles, overseeing the relationship with LSHTM and be responsible for the day to day administration of the grant including financial tracking, compliance and other administrative functions.

20. Environmental Considerations

20.1 The Supplier should ensure due consideration is given to the environmental impact of all work undertaken to deliver this component, both in terms of minimising any direct negative impact, and the extent to which research findings contribute to positive environmental management.

20.2 Specific attention to minimising operational impacts on the environment and global climate of those undertaking the research should include ensuring individuals travel by economy class, and reducing carbon footprint through for example, using recycled paper and minimising printing waste.

UK Aid Branding

21. Partners that receive funding from DFID must use the UK aid logo on their development and humanitarian programmes to be transparent and acknowledge that they are funded by UK taxpayers. Partners should also acknowledge funding from the UK government in broader communications but no publicity is to be given to this Contract without the prior written consent of DFID.

22. **Transparency**

22.1 DFID has transformed its approach to transparency, reshaping our own working practices and pressuring others across the world to do the same. DFID requires Suppliers receiving and managing funds, to release open data on how this money is spent, in a common, standard, re-usable format and to require this level of information from immediate sub-contractors, sub-agencies and partners.

22.2 It is a contractual requirement for all Suppliers to comply with this, and to ensure they have the appropriate tools to enable routine financial reporting, publishing of accurate data and providing evidence of this DFID – further IATI information is available from; http://www.aidtransparency.net/

23. **Digital Principles for Partners and Suppliers**

23.1 DFID expects all partners and suppliers who manage aid programmes with a digital element to adhere to the global Principles for Digital Development. If any proposal contains a digital element this must be costed separately within the proformas and are subject to approval by DFID's digital team.

24. **Ethical Principles**

24.1 It is a requirement that all partners DFID commission and fund comply with the Ethics Principles. Partners will be required to include consideration of ethical issues and a statement that they will comply with the ethics principles.

25. Duty of Care.

25.1 The Supplier must set out in their bid documentation, how they will respond to Duty of Care and Security requirements. DFID has assessed country and project risks and includes a summary assessment against the various risk factors.

25.2 The Supplier is responsible for the safety and well-being of their Personnel (as defined in Section 2 of the Contract) and Third Parties affected by their activities under the contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

25.3 DFID will share available information with the Supplier on security status and developments in-country where appropriate.

25.4 The Supplier is responsible for ensuring appropriate safety and security briefings for all of their Personnel working under this contract. Travel advice is available on the FCO website and the Supplier must ensure they (and their Personnel) are up to date with the latest position.

25.5 The Supplier must have developed their response to the tender on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix prepared by DFID. They must confirm in their Tender that:

- They fully accept responsibility for Security and Duty of Care;
- They understand the potential risks and have the knowledge and experience to develop an effective risk plan;
- They have the capability to manage their Duty of Care responsibilities throughout the life of the contract.

25.6 If you are unwilling or unable to accept responsibility for Security and Duty of Care as detailed above, your bid will have been viewed as non-compliant and excluded from further evaluation.

25.7 Acceptance of responsibility must be supported with evidence of Duty of Care capability and DFID reserves the right to clarify any aspect of this evidence

Annex 1 – Duty of Care

[REDACTED]