Consolidated Responses to pre-bid Queries

RFA: Scaling Intensified TB Screening in Tertiary Hospital Ecosystems Bridging the Detection Gap through Intensified OPD/Inpatient Screening and AI-Driven Triage in Medical Colleges and District Hospitals

S.No	Questions / Clarification sought	Response of TIFA
1.	It is requested to kindly provide the bibliography link to number 1,2,3,and 4 in the paragraph header “About the subject”	● Lahiri, A., Bandyopadhyay, S., Ghosh, A., Bhakta, I., Ramteke, S. A., & Dey, A. (2023). Outpatient-department-based intensified tuberculosis case-finding activity in the tertiary care hospitals in West Bengal, India.: An observational study on the yields and outputs. Clinical Epidemiology and Global Health, 25, 101463. https://doi.org/10.1016/j.cegh.2023.101463 ● Sharath, B. N., Sangeetha, M. D., Menon, S., Gokul Santhosh, Darshan, H. S., R Manukrishnan, R Nandhini, Katakdhond, S. S., Nair, A. S., M Indu, M Spuriti Sushma, & Rakesh Mudhol. (2025). Opportunistic Screening for Enhanced TB Case Detection among Inpatients in a Tertiary Care Hospital, Bengaluru. Indian Journal of Community Medicine. https://doi.org/10.4103/ijcm.ijcm_498_23 ● Sharma, S. K., Mohan, A., Chauhan, L., Narain, J., Kumar, P., D Behera, Sachdeva, K., Kumar, A., & in. (2013). Contribution of medical colleges to tuberculosis control in India under the Revised National Tuberculosis Control Programme (RNTCP): Lessons learnt & challenges ahead. The Indian Journal of Medical Research, 137(2), 283. https://pmc.ncbi.nlm.nih.gov/articles/PMC3657851/ Please note that one citation has been referenced twice in the document
2.	The request for application mentions 10 high-burden or low-burden medical colleges and/or district hospitals across 5 targeted states. Are these five states already identified, or the state selection is entirely left to the applicant?	The Central TB Division will suggest five intervention states during the co-design phase. Within these states, the implementing partner is expected to finalise the intervention sites in consultation with the state NTEP.
3.	Can a single award cover a mix of medical colleges and district hospitals, or does TIFA prefer sites from one category only?	TIFA expects the implementing partner to execute its activities at a mix of medical colleges and district hospitals, amounting to a total of 10 sites under a single award.
4.	The NNS data cited suggests a different yield between OPD and IPD. Does TIFA have a preference on the OPD/IPD balance of effort?	Since the referenced evidence cannot be generalized, TIFA would like the applicant to incorporate both OPD and IPD screening activities across all intervention sites. For OPD intervention in medical colleges, selected

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		specialised OPDs (Medicine, Respiratory, Diabetic, Cancer, Rheumatology, etc) can be targeted
5.	The RFP specifies Deep CXR equipped handheld X-rays but asks applicants to 'map and ensure operational availability'. Does this mean that the X-rays are already procured and deployed by NTEP, or that for this intervention, its procurement will be the applicant's responsibility within the budget?	If hand-held X-rays/fixed X-ray machines, and DeepCXR areneeded for grant implementation, applicants will engage with the respective state TB program for access to their inventory. TIFA/CTD will facilitate this process. If required, radiographers can be recruited for the activity period. Procurement of equipment is not allowed under TIFA.
6.	The TB Mukt Bharat app's pre-screening registration form is described as in development. What is the confirmed deployment timeline and what is the fallback screening tool if it isn't ready at project launch?	The pre-screening registration module is likely to be developed before this project is planned to commence its facility-based screening activities. The fallback strategy would be to align with the existing case finding strategy under the NTEP, unless specified otherwise by the state NTEP team.
7.	The call requires 100% real-time Ni-kshay logging and ABHA linkage with duplicate-CXR blocking algorithms. The technical integration responsibility will be the implementing partners responsibility or the NTEP ICT team? Will API access be granted to the implementing partner from Nikshay?	The implementing agency must ensure timely entries within Ni-kshay, and build a concept that flags if a patient has already undergone a CXR for TB screening within the past six months (de-duplication). No additional technology integration in Ni-kshay is expected by implementing agencies beyond the existing ABHA-compliant level of Ni-kshay.
8.	There will be a requirement for the baseline Ni-kshay data completeness at the target facility types. This affects how much of the budget need to go toward data quality remediation versus the new screening activity. Will the baseline Ni-kshay data completeness of the target facility types be provided?	This will be discussed and agreed upon during co-design. Project activity efforts should focus on enrolling all individuals screened for TB within Ni-kshay. However, decisions on approach and investment will be taken in consultation with the state NTEP, with the overall aim of ensuring sustainability of the project activities.
9.	The budget range of $120,000–$250,000 across ten sites over 6 months is roughly $12,000–$25,000 per site. Given that the scope includes workflow redesign, staff training, data system	The implementing partner should propose covering a total of ten implementation sites, with optimal representation of medical colleges and district hospitals.

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	integration, fast-track coupon systems, and monthly DTO review meetings, is there a flexibility to propose fewer sites with deeper implementation quality?	
10.	The 15-day mobilization requirement is ambitious for sites requiring institutional permissions from Medical College Deans and Medical Superintendents. Does the clock start from agreement signing, or from the date institutional permissions are secured?	The implementing partner should be in a position to initiate activities within 15 days of signing the agreement. This requires the implementing partner to undertake preparatory activities (such as consultations with the Central TB Division and state TB programs etc. during co-design, anticipate the team structure and tentative role requirements) well in advance. This will be done during the co-design process with the TIFA team. This is to ensure that the organization can swiftly onboard the existing/new team members in order to execute this short duration project.
11.	TPT eligibility assessment is listed as a deliverable. Is the expectation to assess and Initiate TPT within project scope or it is only to assess and refer to existing NTEP services?	Once individuals are screened for TB, they must additionally be assessed for their eligibility for TPT. All TPT-eligible must be advised for TPT, and referred to the existing NTEP TPT provisions.
12.	Selection of States Has TIFA already identified the five states for implementation, or should applicants propose states based on predefined selection criteria?	The Central TB Division will suggest five intervention states during the co-design phase in consultation with the successful applicant.
13.	Selection of Intervention Facilities ● Is the preferred model one Medical College and one District Hospital per state, or is an alternative distribution acceptable? ● Are private medical colleges eligible, or must Medical Colleges be government institutions?	TIFA expects the implementing partner to work with a mix of medical colleges and district hospitals, amounting to a total of 10 sites under a single award. Partners are free to propose an equitable split between these two categories, provided that there is no large skew in representation. Government institutions are preferred; however, partners may propose a mix of private and government institutions if required. Selection will be deliberated and agreed during the co-design process.
14.	Use of Handheld X-Ray (HHX) and Existing Radiology Infrastructure ● Is HHX mandatory at all intervention sites, or can existing digital X-ray infrastructure be leveraged?	Both handheld and fixed digital X-Ray infrastructure can be used under this project. However, the overall aim should be to ensure that clients are not inconvenienced by being required to move from one facility/building to another for TB screening), which may lead to pre-screening attrition, or non-

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	● If existing infrastructure is used, will integration of Deep CXR AI software with current systems be acceptable for AI-assisted screening reports?	compliance. Implementing partners are expected to account for this within their workflow, and when selecting X-ray facilities. Yes, integrating Deep CXR AI, or any other NTEP-approved AI software for this purpose is acceptable.
15.	Provision and Operation of HHX Equipment ● If HHX devices are required, will these be provided under the project/NTEP, or should applicants budget for procurement? ● Is dedicated manpower required for HHX operation, and if so, should this be provided by the implementing organization or by the health facility/NTEP?	The implementing partner is expected to liaise with the state NTEP to gain access to the NTEP HHX. In case the machines are determined to be not available by the state NTEP, then TIFA will work with the implementing partner to determine if the selected facility's fixed X-Ray can be used, or if a modest and appropriate amount can be budgeted for renting HHX.
16.	Scope of Universal Screening Does "100% screening coverage" mean all OPD/IPD patients across departments, or can screening be strategically targeted to high-yield departments/patient groups based on TB risk?	The aim of this intervention is to demonstrate a lightweight workflow, which allows for 100% screening across all OPD and IPD settings (similar to front desks enquiring about COVID symptoms at the registration desk), without significant incremental efforts needing to be undertaken by hospitals in order to achieve this end goal. The implementing partner will incorporate high-yield departments/patient groups within their intervention, but that should not be the only strategy.
17.	Digital Screening and Workflow Platform Integration ● If a new platform is developed, are interoperability mechanisms/APIs currently available within Ni-kshay, Deep CXR, and related systems for automated data exchange? ● What approvals, permissions, and technical clearances would be required for such integrations, and will NTEP/TIFA facilitate support in obtaining them?	Interoperability mechanisms/APIs will be determined during co-design. TIFA can support the implementing partner in consulting the Central TB Division on this subject relative to the approach proposed by the applicant.

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18.	Partnership structure: We intend to partner with a public-health organization that holds the required tertiary-hospital track record, while we lead on the technology. Since consortium proposals with subawards are not permitted, how may a two-organization partnership be structured? Can one entity serve as the lead applicant and the other as a formal partner, and which should hold the prime role?	The implementing partner can engage a vendor with a clearly defined scope of work with an estimated resource requirement. Sub-awards are not allowed under TIFA.
19.	Government system access: Will the selected organization be granted the API access and CTD/NTEP technical support required to integrate with Ni-kshay, ABHA, and DeepCXR? Or is securing such access the applicant's responsibility?	Please refer to response 7.
20.	Build vs. integrate: Which digital components are expected to be developed new by the awardee, and which already exist for the awardee to integrate with or enhance (e.g., the TB Mukt Bharat app, Ni-kshay)?	This will be determined at the time of co-design, in consultation with the Central TB Division and the implementation sites.
21.	Hosting and data: Where must the system and screening data be hosted — on government cloud (e.g., NIC/MeghRaj), within India, or is commercial cloud permitted? Are there specific data security or compliance requirements we must meet?	All screened cases are to be registered on Ni-kshay. Any further development, if agreed by the Central TB Division, will also be hosted on the same platform.
22.	Scale: What is the expected patient footfall per site (daily/monthly OPD and IPD), and approximately how many staff will use the system concurrently (registration, ward nurses, laboratory, pharmacy)? This will help us correctly size the system for load and data volume.	This information will be determined as a part of or following site selection during co-design.

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23.	Budget and hardware: For sites that lack a working handheld X-ray (HHX) machine, is procurement out of scope, or should the budget include any machine costs, maintenance, or last-mile logistics?	The duration and value of this award do not support procurement. The implementer will engage state NTEPs to utilize existing HHXs, or will utilize digital X-Ray facilities at the medical college or hospital. In case this is not available, HHX rental may be discussed with the state NTEP and medical college/hospital leadership. This will be agreed during co-design.
24.	Maintenance: Who is responsible for maintaining the software and digital tools after the six-month project concludes in March 2027? Is post-project support expected from the awardee?	Refer to response 21. Anything built additionally will also be hosted within Ni-kshay, and managed by the Ni-kshay management team.
25.	Number of sites: Will a single award cover all 10 sites, or can an award cover fewer sites if multiple organizations are selected?	See answer to questions 3 and 9.