Community-based social innovations - A japan case study

Request for Proposals (RFP)

Bid Reference: CBSIJ/07/2017

Unit Name: WHO Centre for Health Development

The World Health Organization (WHO) is seeking offers for the development of a case study on community-based social innovations in Japan.
. Your institution working on public health, integrated care, long-term care, or ageing is invited to submit a proposal for the project **"Community-based social innovations "** in response to this Request for Proposals (RFP).

WHO is a public international organization, consisting of 194 Member States, and a Specialized Agency of the United Nations with the mandate to act as the directing and coordinating authority on international health work. As such, WHO is dependent on the budgetary and extra-budgetary contributions it receives for the implementation of its activities. Bidders are, therefore, requested to propose the best and most cost-effective solution to meet WHO requirements, while ensuring a high level of service.

WHO requires the successful bidder, the provider, to carry out a call for expression of interest to identify community-based social innovations, the selection of at least two social innovations, and the drafting of the case studies on each of the social innovations selected. .

The provider shall be a not for profit institution operating in the field of public health, integrated care, long-term care, or ageing, with proven expertise in empirical research into integrated care, long-term care, ageing and community based health and social care.

This research complement an ongoing research on community-based social innovations conducted by WKC since 2015, and producing 10 case studies from 10 countries in 2017.

Under this call, one proposal will be selected and funded to a value of no more than **US$25 000.**

Background and Rationale

The proportion of people in older ages is rapidly emerging across the world, particularly in low- and middle-income countries. The speed of this phenomenon is unprecedented whereby many countries will have 15-20 years to sustainably plan for older people that will reach 14% of their overall population (as compared to developed countries such as France, USA, etc. that had 100 years for this evolution). The trend coincides with a global development paradigm, the Sustainable Development Goals (SDGs), inclusive of approaches and targets for UHC, for non-communicable diseases (NCDs), and for a number of health programmes across the life-course. Health systems strengthening underpins all of these efforts. The SDGs further endorsed key principles of ensuring equity, synergy of action across sectors, and community engagement and participation (inclusive agenda).

The 2015 WHO World Report on Ageing and Health noted that the potential for healthy ageing is tempered by one of paradoxes of longer life expectancies – the fact that we must and should maintain a good quality of life and subjective well-being despite the presence of disease or loss of intrinsic and functional capacities, especially throughout oldest age. The Report reconceptualises healthy ageing away from a focus on the absence of disease and towards the building and maintenance of functional ability across the life-course. This ability is determined not just by our physical and mental capacity, but by the environments we inhabit which can enable us to still do what we value despite the presence of disease or illness.

To date, most health systems whether in the developed or developing world have responded inadequately to the changing requirements of older populations and to ever longer periods of old age. Poor physical access to clinics and hospitals, a lack of awareness of health conditions in old age and of available health and social care services are among the problems that confront an ageing population seeking a person-centred approach for their overall well-being. These issues

were further highlighted during two WHO Global Forums on Innovation for Ageing Populations organized by WKC.

In response, WKC has implemented various research programmes to identify and assess innovations in health and social service delivery. These will assist countries and communities better plan, implement, and sustain equitably-accessed services for older persons, and to craft enabling policies, financial incentives, and monitoring mechanisms. WKC is also looking into how various assistive health technologies and products can facilitate the goals of healthy ageing, as well as to capture important lessons from experiences across the health and social sectors that allow synergies for ageing populations.

WKC's preliminary work highlighted important community-based social innovations that support healthy ageing. For example, case studies suggested that improving health literacy, linked to facilitating self-care, could be an important entry point and facilitator for strengthening health systems. Similarly, "community-based care" appears to be a form of social innovation for older people to fill in crucial gaps in vertically oriented health systems through using peer-based and managed supportive networks. This can consist of older people alone or it may be inter-generational in approach. With older people, this appeared to be an important element of empowerment and of effecting inclusion by allowing for natural segmentation of those who are well-old to help the frail-old which in many instances translates into the younger-old looking after the older-old, though never exclusively.

Based on a first round of case studies, we have evidence that suggests that community initiatives for older people seem to function to help older people navigate vertically separated health and care systems better, through providing physical, social, economic and informational aid. Where community-based interventions exist, the most basic form of primary care seems to be tasked shifted from the local health centre to the community itself, which acts to take some of the burden off local health care resources, rendering them more sustainable. Organized groups of older people seem capable of identifying and filling in gaps in available services. These organized peer groups act to provide the first line of primary care, referring and linking to local services, such as the local health centres, which themselves then become secondary sources of primary care. This can help both the community and the clinic to manage patient flow and demand while also raising awareness and levels of health literacy on key issues affecting people in older age, such as keeping up physical activity or developing better understanding of NCDs. Scarce resources are thus rendered more sustainable, according to the first round of case studies.

The outwards engagement of a peer based network seems only to succeed and survives if it somehow engages with, innovates, renovates or reforms policy. Therefore, the case studies also articulated an idea that CBSIs must be connected up with policy innovations which will allow for intersectoral linkages with financing, legislative and resource decision making processes, otherwise they may not be sustainable.

Preliminary findings from these case studies highlighted the difficulties to create older person-centred systems of care in countries no matter what the income context. However, they suggested that CBSIs arise in many low resource environments partly because nearly all resources are committed towards curative and acute care based health systems. Implications are that existing systems do not cater to the whole spectrum of needs that older people have – the latter requiring maintenance of functional ability and attention to social problems rather than an focus on curing diseases. These case studies therefore, hinted at the need to conceptualise person-centred, management of health and well-being as a single issue which addresses both the health care and social care needs of older people simultaneously, with continuity between the different branches of care becoming a key goal for person-centred care. For some older people, particularly those with marked frailty, there will be a need for a balanced mix of both medical and social support in order to facilitate the activities that have the most meaning for them. This approach is consistent with new

WHO global strategies or frameworks on integrated, person-centred health services, for health workforce, for planning for UHC, the development of the new WHO Global Strategy and action plan on ageing and health, WHO global strategies for the prevention and control of non-communicable diseases (NCDs), for mental health, for disabilities, and WHO regional frameworks on ageing and health.

More evidence describing CBSIs is needed to better the understanding of best practices and service delivery models that engage communities and that span a spectrum of health and social services. Evidence is also needed to dissect the intersections between the community and health/social delivery systems (and referral patterns), the relationship with various types and roles of health workers in the community, and enabling policies and financing.

This is the basis for WKC's current phase of research to expand the evidence base with the identification of 10 additional case studies in middle-income countries (China, Thailand, Serbia, Ukraine, Chile, Russia, Viet Nam, Lebanon, Iran, Sri Lanka) and a systematic review of CBSI in middle- and high-income countries. This phase is being currently implemented and will provide updated evidence by end of 2017.

As the country with the world's most aged population, Japan has been at the forefront of dealing with the challenges of ensuring universal coverage of health and social services to promote healthy ageing. On one hand, it has made remarkable achievements in longevity and in establishing universal access to health care and long term care. On the other hand, it currently faces challenges to ensure equity, sustainability and effectiveness of its universally available health and long term care, challenges which could be similar to the experiences in other countries with higher proportions of ageing populations.

This third phase of the CBSI research, will focus on highlighting Japan's experiences and thus provide additional insights on how such innovations have helped Japan address the challenges posed by an ageing population in need of health and social support.

Call objective, expected outputs and outcomes

To describe, in the context of Japan, a) the core roles, services and functioning of community-based social innovations for healthy ageing that seek to support older people becoming a resource for their own health and well-being, b) their linkages with health and social services; and, c) the nature of enabling policies, programmes, and financing of CBSIs.

WKC aims to fulfil three specific objectives:

1. To complement key findings from WKC-supported case studies (in 2015 on LMICs, and in 2017 on Middle-income countries) by focusing on data from Japan, a country which has been the first to experience a significant proportion of its population over 60 years of age.

2. To complement the typology of community-based initiatives which exist globally amongst low-, middle- and high-income countries developed in 2017 both by a systematic review of literature, published and gray, and by combining vase studies implemented in 2015 and 2017.

3. To disseminate knowledge of the diversity of CBSI in Japan through peer reviewed publications

Bidders should follow the instructions set forth below in the submission of their proposal to WHO.

The proposal and all correspondence and documents relating thereto shall be prepared and submitted in the English language.

The proposal should be concisely presented and structured to include the following information:

- Proposed solution

The deliverables are noted above.

- Approach/methodology
  - A description of the approach to designing a research protocol for the two to four case studies; this will include the adaptation of existing survey instruments to the Japanese context (the survey instruments will be provide to the bidder by WKC)
  - A description of the fieldwork coordination and of the authoring of the case study reports according to a standardized framework that will be provided by WKC
  - An analytical report containing policy option and suggestions to strengthen CBSI in Japan and globally based on case study lessons learned
  - A description of the production and dissemination of peer-reviewed articles on the findings of the case studies
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- Proposed time line (The contract period will be from 20 September 2017 – 20 March 2018)

- Financial proposal.

  Proposals should be a maximum of 6 pages (excluding the financial proposal) with font size no smaller than 10 points.

  CVs of the Principal Investigator and partners should be supplied alongside listings of relevant publications

Evaluation Criteria

A two-stage procedure will be utilized in evaluating the proposals, with technical evaluation of the proposal being completed prior to any focus on or comparison of price.

Technical evaluation

Proposals will be reviewed and evaluated by an ad hoc committee according to the following criteria:

Evaluation criterion	**Range of possible points**	**Weight applied to the points**
Extent to which WHO's requirements and expectations have been satisfactorily addressed	0-5	2
Quality of the overall proposal	0-5	2
Technical merit of the proposed approach and methodology	0-5	2
Capacity of the base institution	0-5	2
Relevant qualifications and experience of the project personnel	0-5	2
Feasibility of the proposed timeframe for the project	0-5	1
Quality of correspondence with WKC (clarity, timeliness)	0-5	1

The maximum possible value for the total Technical Score is **60**.

Financial evaluation

The financial evaluation will be based on the following scoring system:

Evaluation criterion	Assigned points
Financial Proposal is reasonable and sufficiently justified.	Yes = 10; No = 0
Proposed budget amount is acceptable to WKC.	Yes = 15; No = 0

The maximum possible value for the total Financial Score is **25**.

The proposals will be evaluated based on the sum of the Technical and Financial scores. Selection between proposals with tied scores shall be resolved based on further qualitative evaluations of the technical and financial aspects of the proposals by WHO staff.

Selection process

Only one proposal will be selected up to a maximum total funding of US$ 25 000. The proposal will be selected by the external ad hoc review group in collaboration with WHO staff, following an open competitive call for applications.

Information which the bidder considers confidential, if any, should be clearly marked as such. The bidder shall submit the complete proposal to WHO in writing no later than **[Tuesday, 5 September 2017] at 23:00 hours Japan time** ("the closing date"), by email at the following.

Address to: garconl@who.int
Mr Loic Garcon, Technical Officer
World Health Organization Centre for Health Development

With a copy to: ongpa@who.int
Dr. Paul Ong, Technical Officer
World Health Organization Centre for Health Development

Each proposal shall be marked Ref: **CBSIJ/07/2017** and be signed by a person or persons duly authorized to represent the bidder, to submit a proposal and to bind the bidder to the terms of this RFP.

WHO may, at its own discretion, extend the closing date for the submission of proposals by notifying all bidders thereof in writing.

Any proposal received by WHO after the closing date for submission of proposals may be rejected.

The offer outlined in the proposal must be valid for a minimum period of 90 calendar days after the closing date. A proposal valid for a shorter period may be rejected by WHO. In exceptional circumstances, WHO may solicit the bidder's consent to an extension of the period of validity. The request and the responses thereto shall be made in writing. Any bidder granting such an extension will not, however, be permitted to otherwise modify its proposal.

The bidder may withdraw its proposal any time after the proposal's submission and before the above mentioned closing date, provided that written notice of the withdrawal is received by WHO via by email as provided above, before the closing date.

No proposal may be modified after its submission, unless WHO has issued an amendment to the RFP allowing such modifications.

No proposal may be withdrawn in the interval between the closing date and the expiration of the period of proposal validity specified by the bidder in the proposal (subject always to the minimum period of validity referred to above).

WHO may, at any time before the closing date, for any reason, whether on its own initiative or in response to a clarification requested by a (prospective) bidder, modify the RFP by written amendment. Amendments could, *inter alia*, include modification of the project scope or requirements, the project timeline expectations and/or extension of the closing date for submission.

All prospective bidders that have received the RFP will be notified in writing of all amendments to the RFP and will, where applicable, be invited to amend their proposal accordingly.

Before conducting the technical and financial evaluation of the proposals it has received, WHO will perform a preliminary examination of these proposals to determine whether they are complete, whether any computational errors have been made, whether the documents have been properly signed, and whether the proposals are generally in order. Proposals which are not in order as aforesaid may be rejected.

Please note that WHO is not bound to select any bidder and may reject all proposals. Furthermore, since a contract would be awarded in respect of the proposal which is considered most responsive to the needs of the project concerned, due consideration being given to WHO's general principles, including economy and efficiency, WHO does not bind itself in any way to select the bidder offering the lowest price.

WHO may, at its discretion, ask any bidder for clarification of any part of its proposal. The request for clarification and the response shall be in writing. No change in price or substance of the proposal shall be sought, offered or permitted during this exchange.

WHO reserves the right to:

a) Award the contract to a bidder of its choice, even if its bid is not the lowest;
b) Award separate contracts for parts of the work, components or items, to one or more bidders of its choice, even if their bids are not the lowest;
c) Accept or reject any proposal, and to annul the solicitation process and reject all proposals at any time prior to award of contract, without thereby incurring any liability to the affected bidder or bidders and without any obligation to inform the affected bidder or bidders of the grounds for WHO's action;
d) Award the contract on the basis of the Organization's particular objectives to a bidder whose proposal is considered to be the most responsive to the needs of the Organization and the activity concerned;
e) Not award any contract at all.

WHO has the right to eliminate bids for technical or other reasons throughout the evaluation/selection process. WHO shall not in any way be obliged to reveal, or discuss with any bidder, how a proposal was assessed, or to provide any other information relating to the evaluation/selection process or to state the reasons for elimination to any bidder.

NOTE: WHO is acting in good faith by issuing this RFP. However, this document does not oblige WHO to contract for the performance of any work, nor for the supply of any products or services.

At any time during the evaluation/selection process, WHO reserves the right to modify the scope of the work, services and/or goods called for under this RFP. WHO shall notify the change to only those bidders who have not been officially eliminated due to technical reasons at that point in time.

WHO reserves the right at the time of award of contract to extend, reduce or otherwise revise the scope of the work, services and/or goods called for under this RFP without any change in the base price or other terms and conditions offered by the selected bidder.

WHO also reserves the right to enter into negotiations with one or more bidders of its choice, including but not limited to negotiation of the terms of the proposal(s), the price quoted in such proposal(s) and/or the deletion of certain parts of the work, components or items called for under this RFP.

Within 30 days of receipt of the contract, the successful bidder shall sign and date the contract provided to it by WHO, and return it to WHO according to the instructions provided at that time. If the bidder does not accept the contract terms without changes, then WHO has the right not to proceed with the selected bidder and instead contract with another bidder of its choice.

All bidders must adhere to the UN Supplier Code of Conduct, which is available at the following link: https://www.un.org/Depts/ptd/sites/www.un.org.Depts.ptd/files/files/attachment/page/2014/February%202014/conduct_english.pdf

WHO reserves the right to publish (e.g. on the procurement page of its internet site) or otherwise make public the contractor's name and address, information regarding the contract, including a description of the goods or services provided under the contract and the contract value.

Any and all of the contractor's (general and/or special) conditions of contract are hereby explicitly excluded from the contract, i.e., regardless of whether such conditions are included in the contractor's offer, or printed or referred to on the contractor's letterhead, invoices and/or other material, documentation or communications.

We look forward to receiving your response to this RFP.

Yours sincerely,
Loic Garcon, Technical Officer