# FAQs: RFP for a cost-benefit analysis of a universal newborn hearing screening and early intervention programme in Indonesia

1. **Can Deaf Child Worldwide (DCW) confirm the expected timeline for the analysis? Pg 1 of the tender references a 30 month project, but that seems to be regarding the project that this analysis will inform, correct? Pg 3 notes six months from April 2026 and also references an update to the analysis after the programme concludes in Oct 2028.**

Yes, the programme intervention is planned to be 30 months. We (DCW and our partners) anticipate working closely with the contract recipient for data collection and evaluation tools and methods to be designed and implemented and expect this to be done within the 6-month inception phase from project start (anticipated to be from April 2026). We are also asking for 1) a rapid cost benefit analysis to be provided early on to give indicative figures, and then 2) a refreshed cost benefit analysis to be completed with final data provided by the end of the project (approx. October 2028).

2. **Can DCW clarify if there are specific local partners that it would like us to work with? For context, we work closely with many local partners across the health sector, however we are mindful this analysis may require more dedicated engagement with existing DCW partners. If there are specific partners, can you share their organization names and points of contact?**

Yes, we have a specific partner in Indonesia, that we would expect collaboration with for this analysis. We will be working with a university hospital to deliver this programme, as well as two NGO partners at community level. We are not expecting consulting agencies to have existing partnerships with our local partners, but rather we will evaluate their plan to engage and incorporate local partners into their analysis.

3. **Can you elaborate on the budget presentation requirements? For instance, does DCW prefer to see a deliverables-based budget, or will it require a line-item budget?**

DCW does not have a budget template, but would prefer a deliverables-based budget, to align with the fixed-priced contract with payment upon deliverables.

4. **What is an acceptable budget range for proposals?**

DCW is not sharing a budget range. Applicants may provide options for different budgets/outputs, including potential trade-offs or supplementary elements.

5. **Will the projected costs for a potential scale up in other LMIC countries be taken into account for the selection evaluation?**

As per the RFP, we are interested in how the cost-benefit methodology used for Indonesia could be replicated in and adapted to other LMICs. This transferable model can be costed separately in your proposal and will be assessed as per the Criteria for Selection (e.g., demonstration of good value for money and stewardship of charitable resources).

6. **Can you confirm the type of contract mechanism that will be used for this (i.e. will it be a firm fixed price contract, a subgrant, or something else)?**

This will be a fixed-priced contract, with payment dependant on deliverables.

7. **The analysis at first look appears to be a comparison between screening in the birth setting vs. no screening. There are several methods of screening newborns for PCHL, each with their own sensitivity and specificity. To maximise the relevance to an Indonesian audience we would look to represent screening as a composite of all screening methods weighted by use in the Indonesian setting- would this data be available at project outset?**

We know that each institution in East Java maintains a set of records (paper and/or digital) and can likely share their institution's screening methods. Data requirements such as these are examples of what will be helpful for us to know from the successful candidate at the start to incorporate into the Situational Assessment.

8. **What intervention scenarios does DCW envision for national scale up?**

When we deliver the costed model for national scale-up to the government, DCW expects to provide options for facility-based and hybrid (e.g., telehealth) screening.

9. **The cost and accuracy of screening would be readily apparent from both the program administration and published literature. What is less clear is the benefit of screening in the birth setting and its accrual over time. We would assume (but are happy to hear otherwise) that the earlier that PCHL support is initiated, the more comparable a PCHL child is with hearing children in terms of achievement of neurodevelopmental milestones, educational attainment, and much later, earning potential (for the individual and society) and therefore the less contact they would have with the health care system throughout their life. It is effectively a win-win for the individual and society. Is this correct, and is the program period through 2028 long enough to capture the achievement of the earliest developmental milestones such that our assumption above can be supported and modelled?**

Yes, the earlier intervention is started, the better than outcomes. But we would anticipate an increased demand on the health system, because over the first 5 years, there will need to be regular follow-up that currently isn't happening for deaf children (as they aren't identified). Deafness is a lifelong condition and deaf children need timely and regular follow-up within health services – so there will overall be an increase of demand for health services, but investment in these services is worth it because of the wider outcomes for a deaf child (development, educational attainment, earnings, etc).

We will refer identified children to the existing Resource Centres. Besides this, we will be collecting data through our two partners who work at the community level which will include indicators on some development milestones (e.g., language and pre-literacy development).

10. **The modelling of disease trajectories into the future is complex and uncertain. The modelling of developmental and achievement milestones is even more fraught. Are there Indonesian or SE Asian specific data sources such as registries that have tracked non-screened PCHL children over time (and screened PCHL children over time in SE Asia)?**

No – the LOCHI study is likely the closest (a longitudinal study of screened children in Australia). We don't believe there's data tracking non-screened children generally.

11. **The timelines are slated to run from mid-2026 into 2028. This is much longer than we would need to develop a cost-effectiveness analysis and suggest there is scope for a CEA v1.0 in 2026, and a CEA v2.0 in 2028. Is this assumption correct?**

Yes, this assumption is correct.

12. **Would DCW have any data collection abilities in Indonesia based on our recommendations and validated by Indonesian health workers/clinicians?**

Yes.

13. **Would DCW have access to pre-2026 data on e.g. age at start of PCHL support, which could be compared to post-2026 data?**

Yes.

14. **Indonesian birth setting centres and clinicians will be vital to the credibility of this project, both in terms of validating the model and its assumptions hold in the Indonesian context, but also potentially closing the evidence gaps we may have through e.g. structured expert elicitation (SEE). Would DCW have partner clinicians and health workers who can validate the model conceptualisation**

**and protocol? Would we have to locate and engage Indonesian clinicians separately?**

Yes, DCW will have partner clinicians and health workers who can validate the model. You would not have to locate and engage Indonesia clinicians separately.