Operational Manual
for Partnerships under National TB Elimination Programme

WORLD BANK GROUP

IQVIA

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ABBREVIATIONS

ABC	Activity-Based Costing
ACF	Active Case Finding
BMGF	Bill & Melinda Gates Foundation
CAG	Comptroller and Auditor General
CBNAAT	Cartridge-Based Nucleic Acid Amplification Test
CEO	Chief Executive Officer
CHAI	Clinton Health Access Initiative
CHC	Community Healthcare Center
CHO	Community Health Officer
CME	Continued Medical Education
CPPP	Central Public Procurement Portal
CTD	Central TB Division
CXR	Chest X-ray
DBT	Direct Benefit Transfer
DH	District Hospital
DM	Diabetes Mellitus
DMC	District Microscopy Center
DRTB	Drug-Resistant TB
DST	Drug Susceptibility Testing
DSTB	Drug-Sensitive TB
DTC	District TB Center
DTO	District TB Officer
EMD	Ernest Money Deposit
EPF	Employee Provident Fund
EPTB	Extrapulmonary TB
ESI	Employee State Insurance
FDC	Fixed Dose Combination
FFS	Fee-for-Service
FGD	Focus Group Discussion
GCC	General Contract Conditions
GeM	Government e-Marketplace
GFR	General Financial Rules
GoI	Government of India

GST	Goods and Services Tax
HR	Human Resources
HWC	Health and Wellness Center
ICTC	Integrated Counseling and Testing Center
IEC	Information, Education, and Communication
IHAT	India Health Action Trust
IHME	Institute for Health Metrics and Evaluation
IMA	Indian Medical Association
IT	Information Technology
ITB	Invitation to Bid
ITR	Income Tax Return
IVRS	Interactive Voice Response System
KII	Key Informant Interview
KPI	Key Performance Indicator
LCS	Least Cost Selection
LLP	Limited Liability Partnership
LPC	Local Purchase Committee
LWF	Labor Welfare Fund
M&E	Monitoring and Evaluation
MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MSEs	Micro and Small Enterprises
MSMEs	Micro, Small, and Medium Enterprises
NAAT	Nucleic Acid Amplification Test
NABL	National Accreditation Board for Laboratories
NCD	Noncommunicable Disease
NGO	Nongovernmental Organization
NHM	National Health Mission
NHSRC	National Health Systems Resource Center
NPY	*Ni-kshay Poshan Yojana*
NSP	National Strategic Plan for TB Elimination 2020–2025
NTEP	National TB Elimination Programme
NTSU	National Technical Support Unit
OEM	Original Equipment Manufacturer
OOPE	Out-of-Pocket Expenditure
OPD	Outpatient Department
PAC	Proprietary Article Certificate
PAN	Permanent Account Number

PBG	Performance Bank Guarantee
PF	Provident Fund
PHC	Primary Healthcare Center
PHI	Public Health Institution
PIP	Program Implementation Planning
PMDT	Programmatic Management of Drug-Resistant TB
PMJAY	*Pradhan Mantri Jan Arogya Yojana*
PPIA	Patient Provider Interface Agency
PPM	Public-Private Mix
PPP	Public-Private Partnership
PPSA	Patient Provider Support Agency
PSE	Private Sector Engagement
PSU	Public Sector Undertaking
QBS	Quality-Based Selection
QCBS	Quality- and Cost-Based Selection
RFP	Request for Proposal
SHRC	State Health Resource Center
SHSRC	State Health Systems Resource Center
SOP	Standard Operating Procedure
SoW	Scope of Work
STCI	Standards of TB Care in India
STLS	Senior TB Laboratory Supervisor
STO	State TB Officer
STS	Senior Treatment Supervisor
STSU	State Technical Support Unit
TAN	Temporary Account Number
TAT	Turnaround Time
TB	Tuberculosis
TDS	Tax Deducted at Source
ToR	Terms of Reference
TPT	TB Prevention Therapy
TSN	Technical Support Network
TSU	Technical Support Unit
TU	TB Unit
UATBC	Universal Access to TB Care
UDST	Universal Drug Susceptibility Testing
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

There are two main reasons why more targeted collaboration between the National TB Elimination Program (NTEP) and India's private health care sector has been recognized as key to India's tuberculosis (TB) elimination goals. First, collaboration is vital to ensure that the large number of people with TB who seek care in the private sector receive services in line with NTEP guidelines for TB diagnosis and treatment. Second, leveraging private sector capacity can help fulfil programmatic gaps and ensure that people seeking care from NTEP receive uninterrupted, high-quality, patient-centric services.

The Central TB Division (CTD), under the guidance of the Ministry of Health and Family Welfare (MoHFW), has developed guidelines for private sector engagements (PSEs) in 2008, 2014, and 2019. The last of these, the 'Guidance Document on Partnerships 2019', marked a major shift in NTEP's approach to private sector partnerships, demonstrating the use of output-based frameworks and market-based principles and moving away from previous 'grant-in-aid' or input-based models.

In the three years since the Guidance Document on Partnerships was published, it has formed the basis of the significant scaling-up of diverse and innovative private partnerships in the country. Building on these experiences, an operational manual has been developed to provide additional clarity on performance-based contracting and to build institutional capacity and knowledge on different modalities of service procurement to meet programmatic gaps. The manual is intended to be used as a companion document to the Guidance Document.

Implementation experiences have demonstrated that effective partnership implementation relies on seven main elements: (a) needs assessment and resource planning, (b) design of the partnership, (c) procurement of services, (d) monitoring and supervision of the partnership, (e) verifications of deliverables and payments, (f) clarity on roles and responsibilities, and (g) capacity building. The operational manual describes each of these steps in detail, along with examples from the field, key underlying principles, common challenges, and mitigation strategies.

The steps in private sector engagements are not carried out in a silo; they need to fit within existing state-specific systems and processes especially the process of program implementation planning (PIP). The first step, that is, needs assessment, should start in time with, or even a few months before, the state's PIP exercise. The step consists of a three-part cycle of service delivery planning, resource mapping, and gap analysis, which should be repeated whenever the state/district is reviewing programmatic requirements and priorities.

The second step, once needs assessment has been completed and the decision to engage the private sector has been taken, is to develop a robust and yet realistic partnership contract design. This step

consists of using inputs from the needs assessment to prioritize service delivery gaps, select the appropriate partnership design, and 'bundle' the services. Bundling can be vertical (service driven) or horizontal (geography driven) or a combination of the two. 'Overbundling' has been seen to lead to inefficiencies and delays and therefore must be avoided.

The third step, the procurement and financial management of contracts, is a highly specialized process consisting of ten stages and requires the involvement of subject experts at each stage. The 10 stages cover preparation of terms of reference (ToR), budgeting, request for proposal (RFP) preparation, technical and financial evaluation of contracts, negotiation, selection, and agreements. General Financial Rules (GFR) 2017 should be followed along with state procurement rules.

Once the contract has been signed, the next step is monitoring, which serves the dual function of ensuring that people with TB receive high-quality care and that services get delivered in an efficient manner to prevent unnecessary losses to the exchequer. For robust and effective monitoring, it needs to be concurrent and frequent, based on well-thought-out and measurable performance indicators, and implemented through mutually respectful monitoring frameworks. The focus of the monitoring process should be a supportive supervision aimed at streamlined service delivery rather than fault finding. The overall vision needs to be around improving all aspects of care being delivered through the engaged partner.

The fifth essential step in PSEs, arguably the most critical one for the health of the partnership, is verification of deliverables and payments. Important areas to focus on include structured performance matrices, clearly defined responsibilities, user-friendly processes, and – crucially - timely payments to partners.

A clear understanding of roles and responsibility and responsive capacity building are the final two elements of a successful private sector engagement. Only with these in place can states even aspire to achieve the delivery of high-quality, patient-centric care, which needs to be the core of every programmatic activity.

Private sector engagements should be designed and implemented in collaboration with all relevant stakeholders from public and private institutions, especially developmental partners providing technical assistance to NTEP at the national, state, and district levels. Implementation experiences have shown that the process of putting together a private partnership takes about four months, or about 100–120 days. It is strongly recommended that program teams approach the partnership process with ambitious frames of mind and aim to complete the engagement and onboarding processes in as short a time as possible, because delays in any step contribute to delayed service delivery to people with TB. All private partnerships need to keep three overarching principles as consistent foundations: patient centricity, shared accountability, and innovation and flexibility.

Finally, is worthwhile to underscore that the principles here described apply to any serious effort to strengthen health systems, and not just to efforts to engage the private sector for TB services. But while they are general 'good practice' principles in any program, for India's very ambitious TB elimination efforts they are especially relevant.

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Tuberculosis (TB) continues to be the 13th leading cause of death globally and the 7th leading cause of death in India; an estimated 506,000 (5.06 lakh) people died of TB in India in 2021. Furthermore, India contributed to 32 percent of the worldwide deaths due to TB and 40 percent of the global decline in TB notifications between 2019 and 2021 due to the disruption in services caused due to the COVID-19 pandemic.[1] Despite these somber realities, India has more than stepped up to the challenge—a total of 2.1 million (21 lakh) people with TB were diagnosed and notified in the country in 2021, an increase of 19 percent over the previous year. It is noteworthy that about one-third of these 2.1 million notifications were from the private sector, underscoring the importance of this sector in India's TB elimination goals.[2]

1.1. Private sector engagements: Key to India's TB elimination goals

There are at least two distinct reasons why a strategic partnership with the private sector is an important component of the country's TB elimination goals. First, about half of the people with TB (irrespective of their financial capacity) seek care from the private sector, a fact that was underscored by the recent national prevalence survey.[3] There is evidence that a significant proportion of these people seeking TB services from the private sector have less-than-desirable experiences, including high out-of-pocket payments. Patient pathways for these people can become very complicated with a wide range of unwanted components including multiple visits to different care providers, delayed (or missed) diagnosis, and variable treatment courses that are not in line with approved guidelines and that lead to significant out-of-pocket expenditure (OOPE). It is essential, therefore, that the public and private health care sectors work together to ensure that all patients accessing care in the private sector receive services in line with National TB Elimination Programme (NTEP) guidelines for diagnosis and treatment.

Second, it has been recognized that there are some programmatic gaps in services for people seeking care under the public sector also. To address these gaps, private sector capacity (including, but not limited to, diagnostic capacity, clinical expertise, human resources (HR), logistic capacity, and supply chain management expertise) can be effectively leveraged. This can ensure that people seeking care from NTEP receive uninterrupted, high-quality services at locations that are convenient for them.

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1 Global Tuberculosis Report 2022, https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2022; Institute for Health Metrics and Evaluation (IHME) (accessed October 10, 2022), https://www.healthdata.org/india.
2 India TB Report 2022, https://tbcindia.gov.in/index1.php?lang=1&level=1&sublinkid=5613&lid=3658.
3 National TB Prevalence Survey in India (2019–2021) (accessed October 14, 2022), https://tbcindia.gov.in/showfile.php?lid=3659.

1.2. Guidance Document on Partnerships 2019 – a paradigm shift in NTEP's private sector engagement strategy

Recognizing the importance of private sector particip ation in TB elimination, NTEP has been taking various steps. The first set of private sector engagements (PSEs), which were implemented between 1995 and 2011, took the form of government schemes that were rolled out with nongovernmental organizations (NGOs), medical colleges, quasi-government organizations (like the Indian Medical Association [IMA], Indian Pharmaceutical Association, and the Indian Academy of Pediatrics), and some for-profit providers. The Central TB Division (CTD), under the guidance of the Ministry of Health and Family Welfare (MoHFW), developed guidelines on partnerships for the engagement of NGOs and private providers in 2001 and 2002, respectively. The guidelines were subsequently revised in 2008, 2014, and 2019.

The early schemes were characterized by a centralized approach with fixed models and templates for contracts. The mode of financing was primarily a grant-in-aid model, with emphasis on input/process indicators rather than on output/performance. However, in 2019, there was a major shift in NTEP's approach to private sector partnerships, culminating in a recent publication, the 'Guidance Document on Partnerships 2019'. This document is a pioneering tool and represents a paradigm shift in NTEP's approach to private sector engagement:

- **It marks the movement away from the 'PPM scheme approach' to a need-based, patient-centric 'partnerships approach'.** The public sector is moving away from public-private mix (PPM) schemes, where private sector engagements were based on centrally prescribed, discrete projects at fixed rates. The current focus is on the 'partnerships approach', where the private sector is engaged with innovative and ambitious collaborations aimed at responding to programmatic gaps and providing high-quality patient-centric services to all people with TB, regardless of where they seek care. The collaborations are flexible and based on local, programmatic needs, be it outreach, diagnosis, or notification. There is scope to create innovative service delivery mechanisms responsive to local needs.

- **It demonstrates the transition from grant-in-aid mechanisms to output and performance-based mechanisms.** Early efforts to engage the private sector largely focused on grant-based mechanisms, predominantly with the not-for-profit private sector, that is, NGOs, medical colleges, and others. Deploying evidence from large-scale Patient Provider Interface Agency (PPIA) pilots,[4] the Guidance Document demonstrates how to build large-scale projects even with the for-profit sector and how to use performance metrics to produce efficient and high-impact results.

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4 PPIAs are a type of private sector engagement piloted between 2014 and 2017, launched under the Bill & Melinda Gates Foundation (BMGF) funded Universal Access to TB Care (UATBC) program. The PPIA was an intermediary agency focused on mobilizing and engaging the private sector; improving notification of TB cases by the private sector; verifying adherence to Standards of TB Care in India (STCI) regimens; and deploying innovative mechanisms to realign provider incentives. The intermediary agencies were drawn from the private sector and leading not-for-profit agencies. Through the project, which was implemented in three sites—Patna (peri-urban), Mehsana (rural), and Mumbai (urban)—NTEP was able to access data on notifications and treatment outcome and for patients managed by private providers. An assessment conducted in 2016 by NTEP and World Health Organization (WHO) demonstrated significant gains in TB case notification treatment success rates in the private sector. Source: Universal Access to TB Care Concurrent Assessment Report 2016 (accessed January 15 2023), https://www.who.int/docs/default-source/searo/india/publications/universal-access-to-tb-care-part1.pdf?sfvrsn=d7e78cd9_4

- **It provides guidance on the utilization of market-based principles.** As the for-profit sector's participation in TB care expands, it is increasingly important to use contextually appropriate, market-based principles instead of centrally prescribed guidelines. The Guidance Document, therefore, moves away from central guidelines to providing guidance on market principles relevant for TB programmatic delivery. It provides clarity on areas like using market scans and activity-based costing (ABC) for budgeting, setting key performance indicators (KPIs), negotiations, and procurement mechanisms.

The Guidance Document is a comprehensive summary of the experience of implementing various PPM partnerships under previous guidelines. It includes insights from extensive consultations with key stakeholders around successful innovations as well as on successes and failures in past and ongoing public-private partnerships (PPPs) and offers actionable guidance on how to implement mutually beneficial, performance-based partnerships based on market principles.

1.3. Need for an Operational Manual

In the three years since the Guidance Document on Partnerships was published, NTEP has continued its commitment to end TB and has demonstrated commendable resilience in adapting to the disruptions caused by the COVID-19 pandemic. It continues to fulfil programmatic commitments, including the commitments to scale up strategic private sector engagements.

During this time, the Guidance Document has formed the basis of the significant scaling-up of diverse and innovative private partnerships in the country. Over 300 partnerships have been forged across more than 250 districts along the lines of eight partnership options described in the document. The patient provider support agencies (PPSAs) model is the most commonly implemented partnership option. Further, the program has established a National Technical Support Unit (NTSU) at the central level to strengthen the private sector and inter-sectoral engagement. Multidisciplinary units for technical support have been formed in 14 states including in the nine high-priority states (that is, those that contribute to over 75 percent of the national TB notifications). The state TB offices, together with and supported by the NTSU, state technical support units (STSUs), WHO technical support network (TSN), and other technical support partners, have become fast-paced engines. They are driving innovative and patient-centric partnerships, learning, course-correcting, and expanding the programmatic understanding of harnessing market forces to strengthen TB elimination efforts.

As a result of these multipronged developments, there have been fundamental advancements among the health care systems and personnel engaged in TB elimination. Public health systems are recognized in their dual role—not just a service provider but also a purchaser of services from the private sector. There is increasing acceptance of the private sector as an equal partner and the acknowledgment that performance-based mechanisms are more effective than grant-based mechanisms. Further, there has been a significant increase in institutional knowledge: programmatic experiences have created a rich repository of lessons and learning needs, leading to the development of this operational manual.

The operational manual is a step-by-step guide to design, implement, and manage a private partnership. It is the result of observations from a wide range of experts—state leadership, implementation partners,

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and technical support partners—and experiences from implementing the new partnership guidance. These observations include the following:

- While the Guidance Document is robust on technical information, there is further need for an adjunct document that provides detailed, precise operational implementation pointers that program leadership can use to streamline and standardize processes.

- There are a few knowledge gaps that are common and recurring in implementation experiences. Those could be avoided if there was more specific operational step-by-step guidance around a few specific areas, which include needs assessments, procurement mechanisms, and protocols around verifications and payments.

- Given the increasing scale of private sector engagements, there is a need to build health system capacity for stringent due diligence processes, that is, processes that comply with appropriate government regulations—such as the General Financial Rules (GFR) of 2017 (GFR 2017), as well as state-specific procurement guidelines—that ensure efficient utilization of the finances available to local governments.

- There is a need for focused capacity building around utilization of market principles and performance-based mechanisms using real examples from implementation. Experiences from the past three years of partnership implementation projects have led to pertinent lessons that need to be shared widely so that they can help fast-track future implementation processes.

1.4. Objectives

The operational manual, which is a companion document to the Guidance Document, aims to fulfill the following three objectives:

A To provide specific operational directions for promoting and streamlining current and prospective partnership projects

B To provide additional clarity on performance-based contracting or other technical aspects of partnership guidance

C To build institutional capacity and knowledge on different modalities of service procurement to meet programmatic gaps.

1.5. Target audience

The operational manual is intended to be a useful learning and reference resource for the following:.

1 **Staff at state TB offices and state National Health Mission (NHM),** which includes officials responsible for finance, accounts, and audit at the state.

2 Staff at **district TB centers** (DTCs) and district health office.

3 **Other public health staff.** Medical officers in charge of TB Units (TUs), medical officers at primary healthcare centers (PHCs), and community health officers (CHOs) at health and wellness centers (HWCs).

4 **Technical partners.** STSUs, state health systems resource centers (SHSRCs), and other agencies supporting procurement or PPP for health departments such as medical supplies corporation limited.

5 **Private agencies.** For-profit and not-for-profit organizations already contracted for private sector engagements and organizations interested in applying for future projects.

6 Anyone interested in learning about designing and implementing performance-based mechanisms for the procurement of public services.

1.6. Structure of the manual

Implementation experiences have demonstrated that effective partnership implementation relies on the solid consideration of following seven elements:

(a) Needs assessment and resource planning

(b) Design of a partnership

(c) Procurement of services

(d) Monitoring and supervision of the partnership

(e) Verifications of deliverables and payments

(f) Clarity on roles and responsibilities

(g) Capacity building.

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The operational manual is organized in line with these elements. Chapters 2 – provide specific, detailed recommendations on each of these (Table 1). The appendix provides a list of resources, including frameworks and tools.

TABLE 1: Recommended reading

Steps in implementing a partnership	Recommended reading (operational manual)	Relevant chapter(s) in the 2019 Guidance Document
1. Needs assessment and resource planning	Chapter 2 (Needs assessment and resource planning)	Chapter 2 (Overview of partnership options) and Chapter 3 (Scope of services of available partnership options)
2. Design of a partnership	Chapter 3 (Designing a partnership - bundling of services)	
3. Procurement of services	Chapter 4 (Finance and procurement of services)	Chapter 4 (Implementing a Partnership Option)
4. Monitoring and supervision of the partnership	Chapter 5 (Monitoring and supervision)	Chapter 5 (Monitoring and evaluation)
5. Verifications of deliverables and payments	Chapter 6 (Deliverable verification and payments)	Chapter 4 (Implementing a Partnership Option)
6. Clarity on roles and responsibilities	Chapter 7 (Roles and responsibilities)	Chapter 6 (Institutional Framework Required for Implementation)
7. Capacity building	Chapter 8 (Capacity building)	Chapter 7 (Building Capacity to Implement Partnership Options)

The operational manual references the Guidance Document for Partnerships 2019 (referred to as the Guidance Document) wherever relevant. As mentioned, the manual is intended to be used as a companion document to the Guidance Document. Therefore, reading the Guidance Document before using this operational manual is strongly encouraged.

1.7. Alignment with existing process and systems

It should be noted that the steps in private sector engagements are not carried out in a silo; they need to fit within existing state-specific systems and processes (Figure 1), especially the process of program implementation planning (PIP).

Strategic alignment with the PIP process and regular updates

- Needs assessment should start a few months before the state's PIP exercise; for example, at the end of the third quarter and the beginning of the fourth quarter.

- Subsequently, the cycle of service delivery planning, resource mapping, and gap analysis can be repeated whenever the state/district is reviewing programmatic requirements and priorities. Ideally, this should be done once every quarter.

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FIGURE 1: Alignment of private sector engagements with existing systems and processes
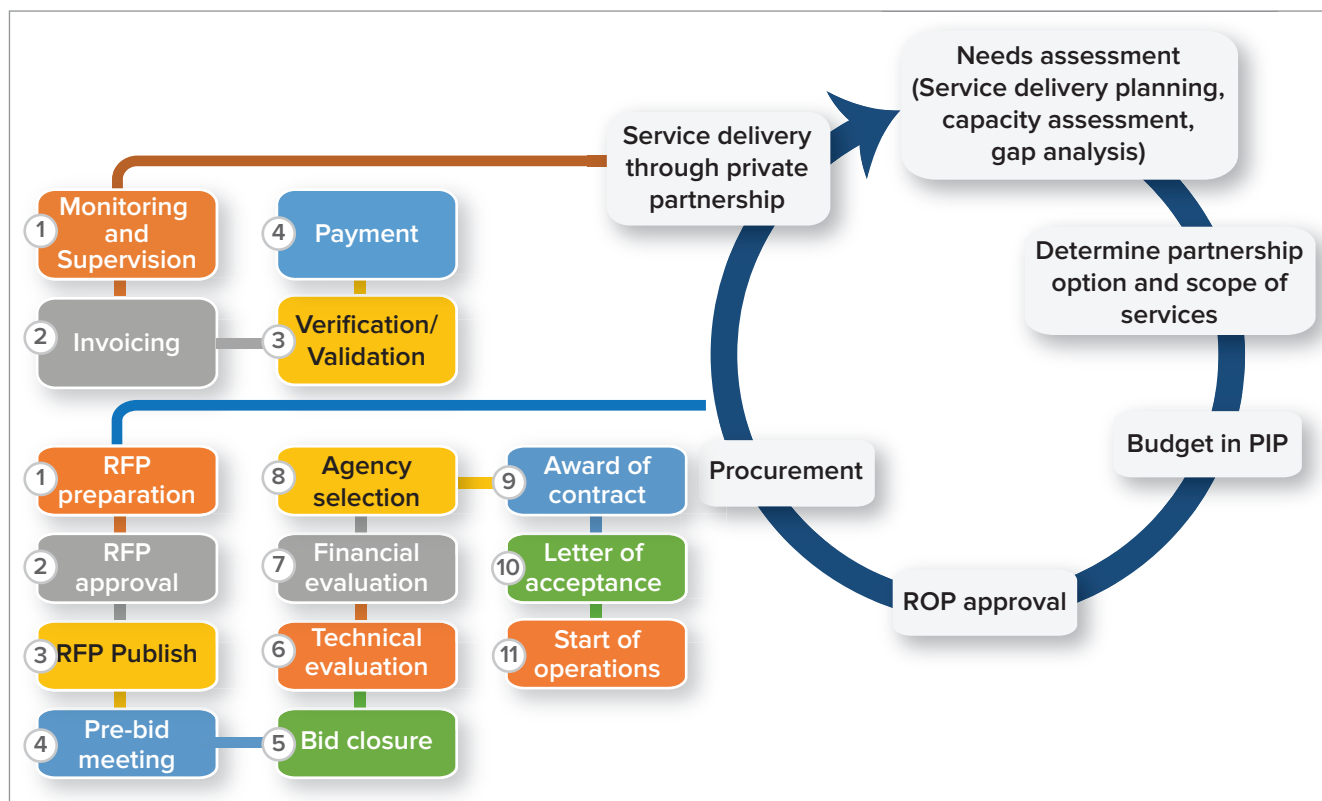
The process needs collaboration with multiple stakeholders

- **Public and private institutions:** The STO may consider coordinating with key stakeholders when carrying out needs assessment. These can include public partners (for example, NHM, state health resource center [SHRC], technical experts from the Programmatic Management of Drug-Resistant TB (PMDT) committee, TB-comorbidity committees, state noncommunicable disease (NCD) cell, medical college task force members, district monitoring and evaluation [M&E] officer, and District Health Society) as well as private partners such as local corporate bodies. Such interdepartmental collaboration can also be an important opportunity to efficiently utilize alternative funding opportunities like corporate partnerships.

- **Providers and provider groups:** Coordination with professional bodies, for example, IMA and chemists' associations, to get a view into providers who serve high volumes of TB patients (and therefore need to be engaged first).

- **Patient groups:** Stakeholder consultations with patient representatives (for example, from *Rogi Kalyan Samitis* or TB survivor groups) can help increase understanding around patient preferences, which in turn can contribute to capability assessment of facilities.

- **Existing private sector partners:** Private agencies already engaged in the state are important partners and provide deep insights for the needs assessment.

1.8. Timelines

Implementation experiences have shown that the process of putting together private sector engagements (PSEs) generally takes about four months, or about 100–120 days. See Table 2 for broadly indicative time required for each step, although ground realities may cause variable timelines in each step. This table can be used to evaluate whether timelines can be shortened at any step for faster turnaround times. It is strongly recommended that the program teams approach the PSE process with ambitious frames of mind and aim to complete the process in as short a time as possible, to carry out some steps in tandem with the others (for example, terms of reference [ToR] preparation and budget estimation can be carried out concurrently). Needless to say, delays in any step contribute to delayed service delivery to people with TB.

TABLE 2: Suggested timelines per step

Step	Sub-steps	Number of weeks	Total time
Needs assessment	Gap analysis		4 weeks | 1 month
	Resource mapping	2	
	Access planning		
Partnership design	Prioritization of needs	2	
	Packaging of services or bundling		
Procurement of services	Identification of request for proposal (RFP) requirements	1	18 weeks | 4 months
	Preparation of ToR	1	
	Budget estimation		
	Preparation of RFP documents	3	
	Approval of RFP	1	
	Pre-bid meeting	2	
	Submission and opening of RFP	3	
	Technical evaluation	3	
	Financial evaluation	2	
	Selection, negotiation & government approval	1	
	Agreement signing	1	

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BOX 1: Overarching principles for partnerships

Key principles for private sector partnerships

There are three overarching principles that, if used as a consistent foundation for private sector engagements, go a long way toward ensuring success.

(a) Patient centricity

The theme of patient-centric care or people-centric care is built on a vision in which individuals, families, and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways. People-centric health systems are designed around stakeholder needs and enable individuals and communities to collaborate with health practitioners and health care organizations in public, private, and not-for-profit sectors in driving improvements in the quality and responsiveness of health care (*source: People-centered Health Care: A policy Framework; World Health Organization 2007*). In the context of TB services, people-centric care can be seen as the provision of uninterrupted, high-quality services to all people with TB, regardless of where they seek care. This includes timely and convenient access to laboratory services, specimen transport, universal drug-sensitivity, testing, appropriate treatment with programmatic fixed dose combination (FDCs), adherence support, and socioeconomic support. The Standards for TB Care in India, published in 2014, is a comprehensive handbook facilitating patient-centric standards for TB care for all stakeholders. As private sector partnerships are scaled up, it is critical that patient centricity be at the core of all partnerships.

(b) Shared accountability

The responsibility for successful implementation lies equally with the public and private partners. Both partners need to demonstrate their commitment toward partnerships. While private agencies are expected to fulfil their contractual obligations with a high degree of commitment to quality, it is important to emphasize that public health systems have a role to play at every step—through robust needs assessments, comprehensive RFPs and contracts, transparent selection processes, concurrent monitoring and support, and perhaps, most importantly, timely verifications and payments.

(c) Innovation and flexibility

Rather than a rigid adherence to preset examples of implementation, there needs to be an openness toward innovative approaches and an attempt to reward performance. Opportunities for flexibility are available at all steps—designing partnerships with new service bundles that are responsive to local needs, utilizing regional corporates for funding local projects, including incentives that reward agencies for exceeding project targets, and so on.

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How to identify (and quantify) the unmet needs or service gaps? How to build a service delivery plan that comprehensively fulfils these unmet needs?

These questions need to be answered in a careful, data-driven manner before any partnership option can be planned. The outcome of an ideal needs assessment process is a 'service delivery plan', that is, a detailed plan on how the required services will be made accessible to everyone who needs them, regardless of whether they are seeking care in the public or private sector.

2.1. Recommended process

Needs assessment can be carried out in a three-step manner. These three steps are listed below and described further in this section:

(a) **Building a service delivery plan.** Access planning along the patient care cascade according to guidelines

(b) **Capacity analysis.** Mapping of existing resources and current capacity

(c) **Gap analysis.** Assessment of gap between service delivery plan and current capacity.

In other words, the teams working with the state TB officer (STO) (or the district TB officer [DTO]) to carry out needs assessment are advised to ask themselves the following questions:

(a) *What are the TB services that need to be provided to people in the state (or district), and how will they be provided?*

(b) *Where are the state's (or the district's) existing health care system resources (public and private)?*

(c) *What are the state's (or the district's) total needs compared to current capacity in TB service delivery?* In other words, what do the demand and the service delivery gaps look like?

A. Service Delivery Planning

As can be seen in the Guidance Document, the cascade services required by people with TB can be examined under nine headings, but states can add to this list if needed.

(a) Community mobilization

(b) Screening

(c) Specimen management

(d) Diagnostic testing

(e) Notification services

(f) Associated or pretreatment tests

(g) Treatment services

(h)   Public health actions

(i) Treatment completion and follow-up.

Target-based approach to service delivery planning

Service delivery planning can be carried out through a multipronged approach. One approach is the targets-based approach, which starts with states and districts building their vision and targets for each step in the patient care cascade. This can be done using multiple sources of information: state-level demographic data, state-level epidemiology, state-specific strategic plans, and the National Strategic Plan for TB Elimination 2020–2025 (NSP). Targets-based approach is primarily a top-down approach because it uses center or state-level inputs to build targets.

Patient-centric approach to service delivery planning

In addition to establishing targets, states should examine service delivery planning through a service delivery lens. The targets-based approach consists of asking the 'what' question, that is, what are the services that need to be provided (to all people, regardless of where they seek care). The patient-centric approach asks the 'how' question, that is,

- How are these services going to be provided to patients? What is the most optimum, most ideal way to deliver services?

- What level of decentralization is the state aspiring for? For example, a district can aspire to provide TB diagnosis and treatment initiation services at the level of a subcenter or a HWC or choose to centralize the diagnostics and treatment services and provide them at the level of a CHC or a district hospital (DH).

> **"** *Clarity on the level of decentralization in service delivery planning is crucial for robust needs assessment.* **"**

The NSP is the best source of such 'how' questions. It recommends high-quality, patient-centric care with minimal OOPE for all patients, regardless of where they seek care, and has specific recommendations for all steps in the patient care cascade. Annexure 1 (pages 81–85) in the Guidance Document provides some sample questions that can be asked to understand service needs under the different headings. The process will need to be repeated for all the steps in the care cascade to get a comprehensive assessment of programmatic needs.

Example for demonstration of service delivery planning

Figures 2 and 3 demonstrate how a state can plan service delivery for screening, diagnosis, notification, and NAAT testing in the care cascade at the level of a district X which has a 5.4 lakh population.

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FIGURE 2A: Service delivery planning for diagnostics - Scenario A

SCREENING

- District population: 5,43,210
- **Current presumptive TB examination rate: 800 per 100,000 population ("Scenario A")**
- Screening carried out in public vs private sector
  - 70% in public,
  - 30% in private sector
- **All** people undergoing screening will all receive a chest X-ray examination
- Upfront NAAT availability for:
  - 25% of people seeking care in public sector (70% on Xpert, 30% on Trunat)
  - 50% people seeking care in private sector (50% on Xpert, 50% on Trunat)
- Remaining screening to be carried out via microscopy: 75% of people seeking care in public sector, 50% people seeking care in private sector

DIAGNOSIS AND NOTIFICATION

- Estimated case positivity rate on NAAT - 15%
- Estimated case positivity rate on microscopy - 10%
- People with TB identified via clinical diagnosis - estimated at 20% of microbiologically confirmed

NAAT

NAAT will be made available to all who did not get upfront NAAT, i.e., those diagnosed clinically or via microscopy:

- Public sector: 70% on Xpert, 30% on Trunat
- Private sector: 50% on Xpert, 50% on Trunat

FIGURE 2B: Service delivery planning for diagnostics - Scenario A

District plan around steps in the care cascade in "Scenario A"
(Current presumptive TB examination rate = **800 per 100,000**)

Total presumptive TB screening in the district = 4,346

Presumptive TB screening in public sector = 3,042

Upfront NAAT (CBNAAT) = 532	Upfront NAAT (Trunat) = 228	Microscopy = 2,281

Diagnosed via CBNAAT = 80	Diagnosed via Trunat = 34	Diagnosed via microscopy = 228

Diagnosed clinically = 68

Total diagnosis in public sector = 410

NAAT for those diagnosed clinically or via microscopy (total = 297)

NAAT via CBNAAT = 208	NAAT via Trunat = 89

Presumptive TB screening in private sector = 1,304

Upfront NAAT (CBNAAT) = 326	Upfront NAAT (Trunat) = 326	Microscopy = 652

Diagnosed via CBNAAT = 49	Diagnosed via Trunat = 49	Diagnosed via microscopy = 65

Diagnosed clinically = 33

Total diagnosis in private sector = 196

NAAT for those diagnosed clinically or via microscopy (total = 98)

NAAT via CBNAAT = 49	NAAT via Trunat = 49

Service requirements

1. Chest X-RAY (CXRs) = **4,346** (3,042 in public, 1,304 in private)

2. Microscopy examinations = **2,933** (2,281 in public, 652 in private)

3. Upfront NAAT tests
Xpert tests = 858 (532 in public, 326 in private)
Trunat tests = 554 (228 for public, 326 in private)

4. Notification
No. of people with TB to be notified = 606 (410 in public, 196 in private)

5. NAAT
Xpert = 257 (208 in public, 49 for private)
Trunat = 138 (89 in public, 49 in private)

FIGURE 3A: Service delivery planning for diagnostics - Scenario B

SCREENING

- District population: 5,43,210
- **Proposed presumptive TB examination rate: 1800 per 100,000 population ("Scenario B")**
- Screening carried out in public vs private sector
  - 70% in public,
  - 30% in private sector
- **All** people undergoing screening will all receive a chest X-ray examination
- Upfront NAAT availability for:
  - 25% of people seeking care in public sector (70% on Xpert, 30% on Trunat)
  - 50% people seeking care in private sector (50% on Xpert, 50% on Trunat)
- Remaining screening to be carried out via microscopy: 75% of people seeking care in public sector, 50% people seeking care in private sector

DIAGNOSIS AND NOTIFICATION

- Estimated case positivity rate on NAAT - 15%
- Estimated case positivity rate on microscopy - 10%
- People with TB identified via clinical diagnosis - estimated at 20% of microbiologically confirmed

NAAT

NAAT will be made available to all who did not get upfront NAAT, i.e., those diagnosed clinically or via microscopy:

- public sector: 70% on Xpert, 30% on Trunat
- private sector: 50% on Xpert, 50% on Trunat

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FIGURE 3B: Service delivery planning for diagnostics - Scenario B

District plan around steps in the care cascade in "Scenario B"
(Current presumptive TB examination rate = **1800 per 100,000**)

Total presumptive TB screening in the district = 9,778

Presumptive TB screening in public sector = 6,844

Upfront NAAT (CBNAAT) = 1,198	Upfront NAAT (Trunat) = 513	Microscopy = 5,133

Diagnosed via CBNAAT = 180	Diagnosed via Trunat = 77	Diagnosed via microscopy = 513

Diagnosed clinically = 154

Total diagnosis in public sector = 924

NAAT for those diagnosed clinically or via microscopy (total = 667)

NAAT via CBNAAT = 467	NAAT via Trunat = 200

Presumptive TB screening in private sector = 2,933

Upfront NAAT (CBNAAT) = 733	Upfront NAAT (Trunat) = 733	Microscopy = 1,467

Diagnosed via CBNAAT = 110	Diagnosed via Trunat = 110	Diagnosed via microscopy = 147

Diagnosed clinically = 73

Total diagnosis in private sector = 440

NAAT for those diagnosed clinically or via microscopy (total = 220)

NAAT via CBNAAT = 110	NAAT via Trunat = 110

Service requirements

1. Chest X-RAY (CXRs) = **9,778** (6,844 in public, 2,933 in private)

2. Microscopy examinations = **6,600** (5,133 in public, 1,467 in private

3. Upfront NAAT tests
Xpert tests = 1,931 (1,198 in public, 733 in private)
Trunat tests = 1,247 (513 for public, 733 in private)

4. Notification
No. of people with TB to be notified = 1,364 (924 in public, 440 in private)

5. NAAT
Xpert = 577 (467 in public, 110 for private)
Trunat = 310 (200 in public, 110 in private)

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Notes on demonstration example (Figures 2 and 3)

- The presumptive TB examination rate, when combined with the district or state population, is the number that drives all the other downstream numbers related to service needs for this particular cascade (TB screening). In Figure 2, a presumptive TB screening target of 800 per 100,000 population has been used; this can be seen as 'scenario A'. We can also assume a 'scenario B' where the district increases the screening target from 800 to 1,800 per 100,000 population. The service needs, in such a case, will proportionately increase as can be seen in Figure 3. Both these screening targets—scenarios A and B—are hypothetical examples created to demonstrate how gap assessments can be carried out. States and districts should make their own targets in line with existing processes (annual and midterm review, PIP, and supplementary PIP) as explained previously.

- The presumptive TB examination rate, which is being used as the 'starting point' in this particular example, is only one of many possible starting points. Depending on the type of service area being examined, there can be other starting points for the needs assessment. If the focus is on notification services, the starting point for needs assessment can be the number of notifications expected from private providers. If the cascade of focus is on drug-resistant TB (DRTB) treatment, needs assessment will start from 'number of people testing positive for TB, who need to be evaluated for DRTB'.

- As mentioned, a robust service delivery plan needs to consist of 'what' questions, that is, target-based questions, which, in the example district, consist of:

  - What is the total number of people to be screened?

  - What proportion of screening is likely to be carried out in public versus the private sector?

  - What proportion of people with TB symptoms undergoing screening can be offered up-front Nucleic Acid Amplification Test (NAAT)?

  - What proportion of NAAT is to be done via GeneXpert vs via TruNat testing?

- At the same time, the service delivery planning should include the 'how' questions of the patient-centric approach:

  - How (and where) will the people with symptoms get chest X-rays (CXRs)? Possible decisions: at the PHC level/subcenter level or within 2 km radius of their residence? What proportion of these people will avail CXR services in the private sector?

  - How decentralized will the NAAT be? Possible decision: all community healthcare centers (CHCs) will have NAAT, with all PHCs having sample collection services. Alternatively, services will be even more decentralized, and NAAT services will be available even at PHCs that have heavy patient footfall.

  - How will the services be patient centric, or what are some other 'value additions' that the state aspires to add? Possible responses:

    - The state will prioritize the establishment of one 'walk-in center' per block/district where all necessary services like X-ray, co-morbidity testing and NAAT will be available under a single facility, and walk-in patients who are prescribed these tests at other facilities will be able to access them free of cost.

- An important aspect of needs assessment is the turnaround time in providing various services. The state needs to have adequate capacity to achieve optimal service delivery time if the state wants to focus on providing 'up-front packaging of TB services', that is, to ensure that rapid molecular diagnostic testing, comorbidity testing, NAAT, and provisions of programmatic FDC drugs and direct benefit transfer (DBT) will be made available to all patients in a time-bound manner (for example, within 1 week to 15 days of first point of contact).

- There will be minimal out-of-pocket spends for people accessing services.

- Services delivery will consider patient preferences (people with TB may prefer to access services in the private sector due to reasons of accessibility and perceived quality of care).

B. Capacity Assessment: Mapping of Existing Resources

After service delivery planning, the next step is resource mapping, that is, a comprehensive assessment of the healthcare resources that are currently available to provide the services described in the service delivery plan. This step can also be seen as the 'supply side assessment'. First, resources in the public sector must be examined and an understanding built around their capacity. Then, capacity in the private sector should be examined with a view to understand how much of this exists in the private sector and how much needs to be leveraged for partnerships. A wide net must be cast to include all private providers and facilities (Figure 4). There are two points to consider during resource mapping:

(i) Assessment of existing public sector capacity should be accompanied by a 'capability analysis'

It is possible that there is existing public sector capacity for some services but provision of those services is not in an ideal/patient-centric manner, and therefore, outsourcing those services may be necessary. The resource mapping should not simply focus on quantitative targets but should also focus on indicators related to quality of care such as turnaround times (TATs). In other words, there should be a 'capability assessment' of health facilities and it should consist of gathering information around the services available. This is in line with the NSP's recommendation that "*states should make an effort to reduce patient visits to health care facilities and to offer all services under one roof/single window.*"

> *Turnaround time (TAT) can be taken as a proxy indicator for service delivery quality. When TATs are high, they point to the need for increased decentralization, a need for capacity enhancement, or both.*

There may be scenarios in which laboratory infrastructure at public facility is temporarily out of order and is either under repair or being replaced by new equipment in the next round of procurement. Even though the situation is temporary, it is significant because it is leading to longer diagnostic TATs and delays in treatment initiation. Such situations should definitely be highlighted during needs assessments and feed into partnership design (leveraging of existing contracts or interim new contracts with private labs).

For example (Figure 4), resource mapping at district X revealed that public sector capacity can provide ~10,000 CXRs per year. However, when capability assessments of public health facilities were carried out, it was understood that one CHC with a capacity of ~1,500 CXRs per year was located at an inconvenient distance for a large majority of people seeking TB testing. Further, the district hospital, with a capacity of ~2,500 CXRs, has experienced an equipment malfunction; a request for a new X-ray machine was under process and this could take 8–10 months. Therefore, the CHC and district hospital cannot be included in the resource mapping, and the actual public sector capacity is only 5,808 CXRs.

(ii) Resource mapping should be universal

Given that an important objective of this exercise is to establish an accurate idea of the size of health care services available both in the public and private sectors, it is essential that the mapping covers all types of health care providers (including informal providers) and all types of health care facilities, including those run by NGOs and public sector undertakings (PSUs). As mentioned before, the goal of resource mapping is to build a clear picture of how much utilizable capacity exists (in public and private sectors) and can be utilized by NTEP to provide seamless services to all patients. For example, resource mapping may reveal that positions for key service delivery staff are 30 percent vacant at a state's public health facilities. Aligning this information with other relevant factors (like recruitment plans under NHM), the state can make a short-term bridging solution by outsourcing some of the service delivery to a private partner.

In fact, states should also use the step of resource mapping to build some assumptions around what services are likely to get disrupted during an implementation cycle and make plans to build interim contracts or rate contracts to manage these potential disruptions. For example, a state which has 100 Xpert machines may assume that 10 machines (10 percent of total) are likely to go into maintenance or stop functioning due to various reasons for a period of 15 days to one month during any year. The same is even more relevant for culture and drug susceptibility testing (DST) labs and Line Probe Assay (LPA) labs, which are, on an average, no more than 3–4 in any state and are therefore more likely to experience capacity constraints. To prepare for potential disruption in services that might occur due to this, the state may prepare contracts early on which can be leveraged as and when needed.

As mentioned, the actual mechanics of gathering this level of information should be done in collaboration between the state TB office, NHM, and other relevant partner entities and should be done in alignment with ongoing processes like the PIP process.

Given that resource mapping includes gathering private sector information, it is also a good opportunity to do some market scans which will be useful during procurement. In the example district X, the resource mapping revealed that there are 10 diagnostic centers in the district with CXR capacity, of which four can be engaged for CXR services. As this information was collected, a further set of questions was asked:

- What is the price per X-ray (inclusive of film)?
- What is the price per X-ray (not including the film)?
- What is the price of CXR including radiologist's report?
- How many of these diagnostic centers can be contracted for managing short-term service disruption?

The responses to these questions will be useful during budget estimation (see Chapter 4).

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Health facilities mapping in district X
- Primary health centres (PHCs): 16
- Community health centres (CHCs): 3
- District hospital: 1
- Medical college: 1
- Private diagnostic centres: 10
- Private clinics: 126
- Private hospitals: 8

Information to be gathered for each facility for a comprehensive capability assessment
- Location (including geo-tagging if possible)
- OPD load/patient footfall
- Type of infrastructure
- Type pf Dx capacity available
- (For private facilities)- willingness to enter into partnership with public sector

Microscopy capacity

Two (out of 16) PHCs and all three CHCs have microscope testing capacity. However, one of the CHCs (with a capacity for ~1,500 microscopy tests) will not be included in the resource mapping because it is not well-connected by public transport, and therefore has a low patient preference.
- PHC 1 = 1,320
- PHC 2 = 1,584
- CHC 1 = 1,584
- CHC 2 = 1,584
- District hospital = 1,848
- Medical college = 2,376

Total annual microscopy capacity in the district = 10,296

NAAT capacity

The district hospital has one Trunat machine, functioning at 70-% capacity; the medical college has a 2-module Xpert functioning at 50% capacity; nine (out of 10) private Dx centres have Xpert machines
- District hospital = 1,472
- Medical college = 1,056
- 9 private sector labs, each with an average capacity of 1,300 Xpert tests per year

Annual NAAT capacity (public sector): 2,528
Annual NAAT capacity (private sector): 11,700

Chest X-ray capacity

One (out of 16) PHCs and all three CHCs have CXR capacity. However, one of the CHCs (with a capacity for 500 CXRs) will not be included in the resource mapping because it is not well-connected by public transport, and therefore has a low patient preference. The CXR machine at the district hospital has been decommissioned, and a new one is budgeted for in 2024
- PHC 1 = 1,320
- CHC 1 = 1,320
- CHC 2 = 1,320
- Medical college = 1,848
- 6 private sector labs, each with an average underutilized capacity of 1,800 CXRs tests per year

Total annual CXR capacity (public sector) = 5,808
Total excess annual CXR capacity (private sector) = 10,800

How to calculate annual capacity?
- Estimate total number of tests carried out/possible to carry out in one day
- Estimate number of working days in a year
- Annual capacity = no. of tests/day X no. if working days per year

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C. Gap Analysis

The final step is to utilize the first two steps—service delivery planning and resource mapping—to develop an understanding of the gaps for which private sector engagement is required. The outcome of this can be a final list of targets for the district/state which can serve various functions: (a) comparing with past performance, (b) tracking future performance, and (c) building a service delivery plan for the district which, in turn, forms the basis of partnership designing. See Table 3 for targets set at district X.

TABLE 3: Targets for example district X (all numbers are hypothetical)

	Previous year		Next year		
Service needs	Target	Performance	Target	Public sector capacity	Gap (target - public sector capacity)
1. No. of CXRs	4,346	3300	9,778	5,808	3970
2. No. of microscopy tests	2,933	2,622	6,600	10,296	Surplus capacity of 3,696
3. Total no. of NAATs	1806	1403	4,065	2,528	1,537
3a. No. of up-front NAATs	1,412	1,202	3,178		
3b. No. of NAAT tests for people who did not get upfront NAAT	394	201	887		
4. No. of notifications	606	402	1,364	924	440
6. No. of HIV and diabetes mellitus (DM) tests	606	589	1,364	924	440

Note: Aggregate public capacity (as seen in the fourth column of Table 3) only tells part of the story. At district X, which has a CXR capacity of 5,808 X-rays per year, there are many PHCs that do not have *any* X-ray capacity. Therefore, when doing gap assessment, attention must be paid not just to gaps at the level of state (or district) but also to gaps at the level of facilities.

BOX 2: Points to note when setting targets

Target setting

A few points may be considered when targets for private sector engagements are being set as part of the needs assessment:

- **Set ambitious targets.** Since NTEP is now focused on ending TB, it is imperative that ambitious targets are set. Further, if targets are set too low, the partnership option might not be attractive enough to invite an adequate number of bids, so it may be worthwhile to make ambitious targets.
- **Revisit targets often and revise if needed.** It is important to revisit and revise targets as and when additional information comes in. Targets can (and should) change as and when more data are available. Instead of making fixed or incremental increases in targets (for example, 10 percent increase each year), targets should be revised, in a rational manner, based on new data about prevalence level or in comparison to the previous year's performance. STOs and DTOs are encouraged to conduct a realistic, data-driven approach to estimating the workload to be assigned under PSEs including missed targets of the public sector.
- **What can be done when performance exceeds the targets?** Payments to agencies should not stop when targets have been achieved—this would discourage the agency from exceeding the targets, and service delivery may get paused. In other words, payments should be linked less to targets and more to performance (explained further in Chapter 7 - Deliverable verification and payments). Further, if the performance is frequently in excess of targets, it may be an indication that higher targets need to be set.

It may be helpful to reiterate here that the purpose of needs assessment is to build a clear strategy on how to optimally utilize public sector resources, where to seek support from the private sector, and, most importantly, how to ensure a seamless continuum of services to the patients rather than making them seek one set of services from one place and another set of services from another source. See Figure 4 for a simplified summary of needs assessment process for one service (CXRs).

FIGURE 5: Summary of needs assessment for CXR services at district X

- As per service delivery planning, district requires 9,778 CXRs
- As per resource mapping, 5,808 CXRs can be provided by three public sector facilities (1,848 at medical college and 1,320 each at two CHCs and one PHC)
- As per gap analysis, there is a gap of 3,970 CXRs which can be procured from four private diagnostic centres via a private sector engagement

OUTCOME DECISION

A private sector engagement project will developed through which people with symptoms of TB will can access free CXR testing based on their location and preference.

2.2. Key principles of needs assessments

The following principles, which can markedly increase the effectiveness of the needs assessment, must form the basis of the process:

(a) Keep needs assessment outputs dynamically updated and readily available for decision-making

- Frequent and dynamic updates to service delivery planning are useful not only for early course corrections but also to ensure that inputs into the next round to PIP (and supplementary PIP) are fast-tracked and done with real-time information.

- Factsheets emerging from the needs assessments and PIP should be made publicly available—for example, published on state NHM website or the National Health Systems Resource Center (NHSRC) website—so that they can be easily accessed.

(b) Combine bottom-up and top-down approaches and build capacity for bottom-up assessments

- A good top-down/bottom-up mix would start with state-level big-picture assessments and target setting, which then get fine-tuned based on granular data from the districts.

- **Top-down flow of information:** State-level inputs can include state-level epidemiological analysis to estimate number of missing cases, annual targets, boundaries of resource allocation, approvals for private sector engagement and policy-related decisions.

- **Bottom-up flow of information:** Estimation of needs should start from the ground up—from subcenters, HWCs, TUs, or wards. Similarly, resource mapping should include granular information on available services. Such granular data can increase the robustness of the partnership design process because they can be used during tendering to mark clusters, that is, a tender can combine two clusters that have markedly different coverages of private sector services. Examples of bottom-up flow of information:

  - Previous year's patient records at local facility level should inform the assessment of sample collection needs at the level of subcenter.

  - Records of people with DRTB or people with diabetes at PHCs or CHCs should be used for calculating diagnostic requirements.

  - Resource mapping should include mapping of Xpert machines in both the public and the private sectors: number, location, capacity, current utilization, and willingness to engage with NTEP.

- **Capacity building:** There is a tendency for states to carry out gap analysis and resource mapping at the state level rather than in a decentralized manner, with contextual needs assessment data flowing in from TB units/wards to districts to states. This is due to limited capacity at the level of districts and wards to articulate gaps in an objective manner. Absence of local needs assessment is a major lost opportunity to build contextually responsive robust partnerships. States/districts can work with the NTSU, STSUs, and consultant networks in developing appropriate gap analysis tools. Figures 1 and 2 in this document can also serve as potential formats.

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(c) Intensify collaboration with other departments

- State and district TB offices often miss opportunities to collaborate with other health departments (especially the NHM) to share information and resources (including HR). For example, there may be skilled lab technicians or diagnostic capacity in other departments that can be leveraged, which when considered in resource mapping can lead to smarter access plans. Collaborations should be wider in scope to include non-health departments (for example, railways and armed forces).

(d) Build comprehensive needs assessments

- It is often seen that needs assessment covers only 5–6 indicators rather than the entire care cascade of patient needs. This can lead to a limited understanding of a state's programmatic gaps, which in turn can lead to less-than-effective partnerships. It is suggested that the diagnosis and treatment algorithm be used, as described above, to build a robust needs assessment picture.

2.3. Examples from the field

All the examples in the operational manual are anonymized descriptions of real situations and solutions.

A. Resource sharing for uninterrupted access to NAAT

When needs assessments are carried out comprehensively, they can yield valuable insights. For example, it has been observed in many states that:

- Existing public sector capacity can provide NAAT only for a subset of the patients accessing care in public health facilities due to challenges pertaining to working hours and manpower (gap assessment) and

- A private sector diagnostic partner has a functioning lab with NAAT equipment and trained laboratory staff; the NAAT equipment is used for only 2–4 hours a day and is underutilized for the rest of the time (resource mapping).

These insights have led to the creation of multiple innovative service delivery plans under which people undergoing diagnoses in the public sector are given vouchers to access free NAAT at private labs. Under this partnership, the government can opt for one of many partnership models, for example:

- The state provides cartridges to the private partner and also covers the operational costs (INR 200–500 per sample) and

- The private lab partner procures its own cartridges, and the state pays for the entire test (INR 1,800–2,200 per test).

The rates are determined through a process of negotiation with the partner. This partnership model is currently in operation at four states in the country. It allows the state to provide uninterrupted services to people with TB even when public sector capacity is limited. Some states have leveraged existing PPSA contracts to include this type of model which can be called a 'cartridge-sharing model' or a

'resource-sharing model'. An important element to note is that the resource mapping exercise revealed which private labs had excess or underutilized capacity and were therefore keen to participate in the PSE.

B. Innovative FDC delivery model in response to treatment completion needs

When an examination of ongoing PPSA implementation revealed challenges around transparent and efficient drug delivery to people undergoing treatment, a foundation developed a unique model in partnership with a private partner known for its large drugs and diagnostics network. The private partner's established network was leveraged for sample collection, drug logistics, delivery, and patient tracking to improve productivity. The project is a pilot and has not been scaled up yet but certainly has the potential to increase the uptake of programmatic FDC in the state and improve the monitoring of TB drug flow in the private sector.

C. Innovative specimen transport mechanisms in response to diagnostic delays

A deep dive into the causes of diagnostic delays often shows that the cause is long TATs (between the sample collection and the test being carried out), which in turn is caused by challenges around specimen collection and transport mechanisms. In response, a few districts have implemented innovative specimen management models in partnership with the private sector:

- A private agency was contracted to periodically collect samples from public health institutions (PHIs) in the district that did not have NAAT and transport it to the nearest NAAT facility. This served to speed up sample transport time for all people accessing care from the PHIs and served to increase patient convenience - patients could give their samples and collect reports at the PHI nearest to them. This is an example of a private partner filling a programmatic gap.

- A state uses a hub and spoke model to ensure comprehensive diagnostic coverage—facilities across the state are connected to the nearest hub in delivering free diagnostics program across the state. While both spokes and hubs are managed by the state, private agencies are used to transport samples from the former to the latter (including transport via auto-rickshaws).

D. Partnerships in response to underutilized capacity

- Needs assessment and resource mapping can provide scope for redeployment strategies. In a district hospital where the CXR machines were operational but skilled staff was not available, the machines were underutilized. This underutilized equipment was seen as a loss to the exchequer and therefore a critical challenge for which an innovative solution needed to be built. In response, the district engaged a private agency which deployed trained radiology staff for the duration of one year so that the district could meet its CXR screening targets for the year and ensured that the equipment was utilized optimally.

- A variation on 'resource sharing' can be 'HR sharing' which has been seen in cases in which a private sector partner had mobilized laboratory staff which was leveraged to manage and enhance testing in a public sector NAAT lab with staff shortage.

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E. Models in response to HR issues

- When a needs assessment exercise revealed low CXR utilization even though infrastructure was in place, it was recognized that the bottleneck was a shortage of radiologists. In response, a teleradiology project was created in a public-private partnership. The partner agency collected X-ray images from the PHIs that did not have a radiologist posted, sent the images to empanelled radiologists in the nearest town, collected the reports, and sent them back to the medical officers at the PHIs.

- A DTO received a few mobile screening vans (including a CXR setup) from the district collector's funds. To utilize the vans for community-based screening, the DTO contracted a private agency for the staff necessary for the van—one driver and one X-ray technician per van and the fuel costs. This type of 'HR outsourcing' can serve to fulfil short-term to medium-term staff requirements to fulfil programmatic goals.

SUMMARY - MUST-KNOWS ON NEED ASSESSMENTS

- A thorough need assessment must precede any other action taken before proposing on planning any partnership implementation.
- The process is initiated by the STO, who should make it a collaborative and comprehensive activity by inviting key stakeholders from diverse departments to the process.
- The district teams should adopt a leading or at least an active participant role in the need assessment exercise.
- The process of resource mapping must cast a wide net and must include the private sector in all its forms.
- The ideal outcome of a comprehensive need assessment is a dynamic database that is readily available for decision-making.

Once the state has completed the needs assessment and taken the decision to engage the private sector (for-profit or not-for-profit), it is critical to develop a robust and yet realistic partnership contract design. Well-thought-out partnership designs are crucial in ensuring optimum outcomes. In the following chapter, the relevant design issues are highlighted.

Suggested reference reading and other resources

Guidance Document: The following sections in the Guidance Document provide a useful introduction and overview of the needs assessment process:

- Section 2.3 (pages 4–6)
- Annexure 1 (pages 81–85)

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CHAPTER 3
DESIGNING A PARTNERSHIP: BUNDLING OF SERVICES

3.1. Recommended process

When the needs assessment process described in the previous chapter has been completed, the result should be a detailed service delivery plan—a clear understanding of what services can and cannot be provided by existing public sector capacity (or provided optimally, as shown by capability assessments) and what services should be considered for outsourcing or procurement through private sector partnerships.

As a next step, the program team (at the central, state, or district level) should address responses to two questions:

(a) Which services do we need to prioritize for outsourcing (based on the needs assessment and service delivery planning)?

(b) Which partnership option is the right fit for the prioritized needs, and how can we best package or bundle the services that we need to procure?

The responses to these two questions form the basis of partnership design.

A. Prioritizing services for outsourcing

Using the needs assessment plan, the program team (STOs and DTOs), with support from other partners (consultant network, state technical support units [STSUs], existing private sector partners), should build a list of services that are priority needs for the state (or district) that could be delivered through private sector engagement. At this juncture, an important point to consider is the 'buy versus build' question. In other words, if existing public sector capacity is not sufficient for the service needs, district or state NTEPs need to decide whether they should build new capacity or procure services from the private sector. The decision will be based on the urgency of needs and estimates around time and resources required to build capacity. Sometimes, the decision could be to procure services from the private sector as a short-term strategy (for example, 1–3 years) while starting the process of building (or augmenting) public sector capacity. See Table 4 for an example of how service needs can be prioritized.

TABLE 4: Prioritizing services for outsourcing (sample)

District context

The following are some key observations at district X (the same hypothetical district described in the previous chapter), based on a district performance review carried out in collaboration with STSU and technical consultant network:

- **Notification:** Notification from the private sector continues to be low (55% compared to 95% notification for people under treatment at the public sector).

- **Diagnostic Delays:** Average delay in NAAT testing (calculated from *Ni-Kshay* from date of sample collection and date of test report) is 15 days; a deep dive into the causes was carried out and it was found that:
  - The sample collection at District Microscopy Center (DMC) takes place on the date of a patient's visit to the DMC, but the courier between the DMC and NAAT facility arrives only once a week, which contributes to a delay of 5 days (average) for each sample.
  - When the sample arrives at the NAAT facility, it is opened after a 5-day delay on average.

- **Patient-Centric-Services:** Indicators around NAAT testing for DM and HIV, and links to DBT are low for patients under treatment at the private sector.

- **FDC Delivery Rates:** A recent operational survey conducted by the state revealed that
  - 30% of patients received FDCs within 48 hours of treatment initiation,
  - 50% received FDCs later than 48 hours but within 7 days, and
  - 20% received FDCs later than 7 days or not at all.

- **TB prevention:** The state does have a test and treat policy but has only been able to meet 10% of the TB prevention targets.

These observations, combined with the service delivery plan, can be used to build a short list of prioritized services for which a PSE plan needs to be made.

Service delivery plan (for the public and private sectors)

The following service delivery plan was developed based on needs assessment and district-specific context at district X (it must be noted that this process needs to be carried out frequently and, at the very least, once a year):

(a) 9,778 CXRs for screening and diagnosis
  - 5,808 CXRs to be provided by public sector
  - 3,970 CXRs to be provided by outsourcing (as can be in the resource mapping carried out at this hypothetical district X—see Figure 4—there is an excess capacity of 10,800 CXRs in the private sector labs in this district).

(b) Sample transport for 4,065 sputum samples
  - 2,000 sputum samples from PHCs
  - 2,065 sputum samples from doorsteps to be collected.

(c) Sputum microscopy for 6,600 samples
  - 3,000 at district hospital
  - 3,000 at government medical college
  - 600 at the CHCs.

(d) NAAT for 4,065 samples

- 1,700 tests at the medical college (2-module Xpert machine)
- 828 tests at district hospital (TruNat machine)
- 1,537 NAATs to be procured from the private sector

(e) Private provider engagement and notification

- Line-listing, mapping, prioritization, and empanelment of the estimated 700 private providers and 600 chemists in the district
- Number who are currently notifying against the total number of providers/chemists mapped in the district)
- Notification of 440 people diagnosed with TB at private sector facilities.

(f) Follow-up NAAT

- NAAT testing for 667 patients under treatment in public sector facilities
- NAAT testing for 220 patients under treatment in the private sector.

(g) Diabetes and HIV testing

- Testing for 924 patients under treatment in public sector facilities
- Testing 440 patients under treatment in the private sector.

(h) Drug supply chain management and delivery of FDCs to people with DSTB

- Drug delivery to 924 patients under treatment in public sector facilities
- Drug delivery to 440 patients under treatment in the private sector (to facilitate access).

(i) Links to DBTs

- For 924 patients under treatment in public sector facilities
- For 440 patients under treatment in the private sector (to be linked).

(j) Adherence counseling and outcome reporting

- For 924 patients (and their families) under treatment in public sector facilities
- For 440 patients (and their families) under treatment in the private sector.

(k) TB prevention services

- Household contact testing for 1,364 households
- TB infection testing for eligible contacts and initiation of chemoprophylaxis.

(l) Community empowerment and advocacy activities (X numbers)

- Stigma alleviation campaigns
- Multi-sectoral collaboration with community leaders and corporates (Y number).

Prioritization for private sector engagement

Based on context, the district TB leadership at district X is able to prioritize services for procurement:

- Notification of people with TB getting diagnosed in the private sector (by x% increase)
- Services for people with TB receiving treatment in the private sector - NAAT, DM and HIV testing, link to DBT, adherence counseling, and treatment outcome reporting
- Outsourcing of diagnostics - 4,000 CXRs and 2,000 CBNAATs
- Supply chain management for sample transport and FDCs
- TB prevention services for all eligible contacts.

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B. Selecting appropriate partnership option and bundles

Once service needs have been prioritized, appropriate partnership option can be selected. The Guidance Document (section 2.4 | page 7) describes a total of eight types of partnerships (described as partnership options) through which private sector capacity can be leveraged to fulfil programmatic needs. The scope of services available under each option has been described in detail, along with examples of other innovative partnership options that can be considered.

The partnership options can be implemented as independent, discrete projects, or they can be combined to make one larger project; this combination is also called 'packaging of services' or 'service bundling'.

C. Bundling optimally

The program team (STOs and DTOs) can consider a combination of services or 'bundling of services' as an effective way to design partnerships. As mentioned in the Guidance Document, bundling has many advantages including reduced costs and decreased need for management and supervision. An example of optimal bundling is when all interconnected services are possibly delivered under one partner and one contract rather than multiple partners and multiple contracts. Implementation experiences have demonstrated how many states have realized cost efficiencies with service bundling through lower overhead costs. Figure 6 demonstrates how bundling was carried out at district X.

Program leads should not hesitate to think beyond the partnership options described in the Guidance Document while designing partnership projects. If a state (or a district) needs a service that has not been described so far, a new kind of partnership option can be designed. Service bundles should include at least 1–2 services that have not been prioritized previously, for example, services for extrapulmonary TB (EPTB) and pediatric TB.

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FIGURE 6: Bundling

Services required at District X

1 — **9,778 CXRs for screening and diagnosis:**
- 5,808 CXRs to be provided by public sector
- 3,970 CXRs to be provided by outsourcing

2 — **Transport for 4,065 sputum samples:**
- 2,000 sputum samples from PHCs
- 2,065 sputum samples from households

3 — **Sputum microscopy for 6,600 samples:**
- 3000 at district hospital
- 3000 at government medical college
- 600 at the community healthcare center

4 — **Upfront NAAT testing for 4,065 samples:**
- 1700 at medical college (2-module Xpert)
- 828 tests district hospital (Trunat machine)
- 1,537 CBNAAT tests for private procurement

5 — **Private provider engagement and notification:**
- Mapping and engagement of private providers
- Notification of 440 people with TB diagnosed in private sector

6 — **Follow-up NAAT:**
- For 667 public sector patients
- For 220 private sector patients

7 — **DM and HIV testing:**
- For 924 public sector patients
- For 440 private sector patients

8 — **Delivery of programmatic FDCs:**
- For 924 public sector patients
- For 440 private sector patients

9 — **Linkage to direct benefit transfers:**
- For 924 public sector patients
- For 440 private sector patients

10 — **Adherence counseling and outcome reporting:**
- For 924 public sector patients
- For 440 private sector patients

11 — **TB prevention services:**
- Household contact testing for 1,364 households
- TB infection testing and initiation of chemoprophylaxis for eligible contacts

12 — **Community empowerment and advocacy:**
- Stigma alleviation campaigns
- Multi-sectoral collaboration with corporates

Prioritization, selecting partnership options and bundling

Priority 1 [to be procured in 1st quarter]

Partnership option 1: PPSA
Bundle of 6 services

2 — Transport of 4,065 sputum samples (public + private)

4 — Upfront NAAT testing for 3,178 samples

6 — NAAT for 220 patients in private sector

7 — DM and HIV testing for 440 patients in private sector

8 — Delivery of programmatic FDCs to 440 private patients

10 — Adherence counseling and outcome reporting for 2000 private sector patients

Priority 2 [to be procured in 3rd quarter]

Partnership option 2:
Bundle of two services

1 — Outsourcing of 6,500 CXRs

5 — Private provider engagement and notification

Partnership option 3: Public Health Action
Bundle of two services

10 — Adherence counseling and outcome reporting for 440 private sector patients

9 — Linkage to DBT for 440 patients in private sector

Note: In this example, District NTEP has decided that staff will manage the service delivery of sputum smear microscopy and activities related to community empowerment, advocacy and multi-sectoral collaboration (i.e., activities #3 and #12 in the list above) directly and not outsource them.

The Guidance Document describes two types of bundles—vertical and horizontal. Both models have been implemented by states over the past three years, and these implementation experiences have yielded many useful lessons (Table 5). It is important to note that the distinction between horizontal and vertical bundles is not a simple one, and the two kinds of bundles can (and often do) overlap. For instance, a PPSA (Box 3) is by definition a vertical bundle because it includes multiple types of services (for example, notification, seeding of bank account, and treatment support services), and if a PPSA operates at a geographical cluster of 10 districts, it is also a horizontal bundle.

TABLE 5: Types of bundles

Vertical bundle (or service bundle) - a partner provides **multiple services** along the continuum of care; the 'one-stop shop'	Horizontal bundle (or geographical bundle) - a **single service** provided by a partner across a wide geographical area (like a cluster of wards/districts)
Examples	
(a) Service provider A operates in all wards of district X and provides a bundle of **six services:** Notification, NAAT, DM and HIV testing, treatment support, seeding of bank accounts for DBT, and reporting of treatment outcomes. (b) Service provider B operates in all wards of district X and provides a bundle of **four services**: sample collection, transportation, NAAT, and reporting of results. (c) Service provider C operates in all districts in one state and provides **five services** focused on TB prevention: contact tracing, testing to rule out active disease, initiation of TB prevention treatment, treatment follow-up, and reporting of treatment outcomes.	(a) Service provider P provides **sample transport services** for 10 wards in district X. (b) Service provider Q provides **sample transport services** for the remaining 15 wards in district X. (c) Service provider Z provides **treatment support services via telecounseling** to all people accessing TB care services (in public as well as private sectors) in all the districts of a state.
Advantages	
▪ More convenient from patients' perspective because they can access multiple services under one roof and do not need to visit multiple facilities.	▪ Easier to administer
Disadvantages	
▪ More complicated programmatic management and quality control (because staff for supervision and verification need to be more skilled to review the different kinds of services being delivered) ▪ The agency needs to recruit more skilled people for this kind of implementation.	▪ Appropriate only for services that do not need high technical capacity (for example, sample transport)

3.2. Key principles

Implementation experiences have revealed five guiding principles that should underlie program design and bundling strategies to maximize their effectiveness. These principles are described below:

A. Patient centricity

The goal should always be that the patient is able to access the continuum of services in an easy, comfortable manner. Therefore, service bundles (vertical bundles) should be preferred whenever appropriate because through them, people can access multiple services from the same provider. It is also important to strike a balance between minimizing out-of-pocket expenditure for the patient and providing services in the most efficient manner. For example:

- If the public NAAT facility is at an inconvenient distance for approximately 30 percent of patients, patient centricity can consist of either giving vouchers to access free testing at a private lab of the patients' choice or collecting doorstep samples collection and transport to the NAAT facility.

- Even if a public NAAT exists in the vicinity, people with TB may prefer to access services in the private sector because of inconvenient hours or TATs at the public lab. In such a case, a private lab engagement would still need to be designed because of patient preferences.

B. Rationality

Bundling choices should be logical. When making geographical clusters for horizontal/geographical bundling, it is important to select clusters in a rational, careful manner—avoiding clusters that are either too small or too large and not clustering districts that are separated by large distances or natural barriers (unless driven by strategic reasons as described in Box 4). When making vertical/service bundles, the program team should bundle services that require similar skills. For example, it is more logical to bundle sputum collection and transport and FDC delivery (because both require expertise around supply chain and logistics) rather than bundling sputum transport and advocacy.

C. Management requirements

States should avoid 'overbundling'—putting too many services in one bundle—to avoid high management costs. As bundles become larger, managing them can become inefficient, complicated, and time-consuming. As mentioned, the focus should always remain on patient centricity, efficiency for the private provider, and optimal use of public facilities.

D. Diversification

Program leadership is advised to be aware of the risk of overdependence on private partners. A good strategy is to diversify the service bundles between partner agencies and to avoid overreliance on one partner, even if this is likely to lead to slightly higher costs.

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E. Alignment with other government programs and departments

Program teams should evaluate whether there are any existing government schemes that can be added into service bundles. For example, a contract to seed bank accounts can include the task of linking people with *Pradhan Mantri Jan Arogya Yojana* (PMJAY). The two activities are related because both consist of administrative tasks—sharing of bank information (for *Ni-kshay Poshan Yojana* [NPY]) and enrollment in insurance portals (for PMJAY)—for which people from low-income communities need support. Similarly, a contract to build inter-sectoral collaboration can include the activity of scaling up enrollments in *PM TB Mukt Bharat Abhiyan*—both activities focus on increasing community participation in supporting people with TB. It must be noted that both services are recognized as separate and are budgeted for accordingly.

BOX 3: A note on PPSAs

PPSAs are a partnership option that can be seen as a type of vertical bundle because they carry out a cascade of patient services, for example,

- Private provider empanelment and engagement,
- Notification,
- Co-morbidity testing,
- Specimen transportation and diagnostics,
- Patient management (public health action, counselling, and adherence support), and
- Distribution and delivery of programmatic FDCs.

At the same time, they can also be an example of horizontal (geographical) bundling because they are often operational in multiple districts. It has been observed that PPSAs have been the most commonly utilized partnership option. Of the 300-plus partnerships currently in place, over 200 are PPSAs. While this is an interesting trend, it is hoped that going forward, other options will also be selected and implemented (as and when they respond to the prioritized needs).

BOX 4: Principles of 'clustering'

Principles of 'clustering' - building geographical clusters

There are a few points to consider when building geographical bundles (a cluster of wards, a cluster of districts, and so on) for service delivery:

- **Contiguous clusters:** Clusters that have geographical contiguity (shared borders, proximity, and easy driving distance) might be considered as a logical bundle because they can be monitored more easily. Overall operational logistics might also be more efficient in such clusters due to many reasons, for example, resources can be shared, staff recruitments and management are easier, and additional capacity in one district can be leveraged for the adjacent district.
- **Noncontiguous geographical clusters:** States may consider building geographical clusters of noncontiguous areas if they are similar in terms of operational needs. For example, two districts may have similar demographic profiles (high concentration of slums and greater proportion of migrant population) and hence may need similar active case finding (ACF) strategies.

These are different approaches to building clusters, and each has its own advantages. State and district leadership can choose either of these approaches based on the strategic needs of the area and based on past experiences of implementing partnership projects.

EXAMPLES FROM THE FIELD

A. Bundling diagnosis and treatment services

In a large district that was served by one district hospital, a few wards were located over 50 km from the hospital. The district NTEP built a partnership option with a private hospital which was located at one of these wards. The hospital had a well-staffed lab with a NAAT setup and also had a multidisciplinary specialist team. The partnership option consisted of a diagnosis and treatment bundle. The hospital was provided NAAT cartridges and programmatic FDCs so that people in the neighboring wards were able to access free diagnostic services as well as treatment from a single, convenient location.

B. Bundling sputum transport and FDC delivery

In one partnership option created in response to logistics challenges in a remote area, an agency was recruited for a combined bundle of sample transport and FDC delivery. Under this model, courier agents from the agency would travel to remote locations twice a week. In the inward trip, they would carry the FDCs and deliver them at the PHIs where they would be picked up by patients. In outward trip, they would carry the samples that the PHI staff had collected and packed for pickup.

3.3. Challenges in designing partnerships and bundling

Overbundling: A tendency to build large and complicated bundles (with a view to maximize service delivery) has been observed. Such 'overbundling' and overreliance on one partner can slow down all processes, from the RFP to verifications and payments, leading to unsatisfactory outcomes. There are examples where too many services (14 services at one state) were bundled in one contract, and the resulting complexity in management led to disruption in the entire cascade of services. Overbundling might also lead to a disruption in the logical financial spread of payment if the payment is spread across too many deliverables, and the service provider may struggle to build efficient plans to invest their effort across the multiple deliverables. For example, if a larger number of deliverables are linked to the beginning of the patient cascade, the service provider may end up investing most of their effort on services related to diagnostics and treatment initiation, and treatment outcomes may be adversely affected.

Bundling of unrelated/dissimilar services: As mentioned, activities that are related to each other (that is, require similar staff skills or similar resources) should be bundled together. When unrelated services are bundled (for example, bundling sample transport services with treatment adherence services—the former requires skills around logistics, and the latter needs expertise in counselling), it can lead to inefficient outcomes.

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- Need assessment should form the basis of partnership design and bundling.
- Bundling or packaging of services can save time and costs, but bundling choices need to be rational, guided by context and patient centricity.
- Bundling can be vertical (service-driven) or horizontal (geography-driven) or a combination of the two.
- 'Overbundling' has been seen to lead to inefficiencies and delays and therefore must be avoided.
- Consortiums—groups of agencies partnering to bid for a contract together—are called 'financial bundle' by some experts because they allow smaller agencies to bundle their financial capacity and collaboratively apply for contracts with higher finance capacity thresholds. This is a potentially useful structure and is described further in the next chapter.

Imbalance in the service bundle: A challenge seen sometimes is when, in a bundle, one set of services (for example, diagnosis and treatment initiation) is linked to payments and another service in the same bundle (for example, treatment completion) is not linked to payments. In such a case, the implementing partner will not be incentivized to invest efforts in treatment completion.

Suggested reference reading

The following sections in the Guidance Document provide a useful overview into the design process and are referred to in this chapter:
- Section 2.4 – 'Available partnership options' (pages 7–8)
- Section 2.5 – 'Using the bundling approach' (pages 9–10)
- Chapter 3 – 'Scope of services of partnership options' (pages 11–54)

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CHAPTER 4
FINANCE AND PROCUREMENT OF SERVICES

This chapter provides a high-level overview into procurement processes to aid understanding, but it must be clarified that procurement and financial management of contracts is a highly specialized area requiring involvement of subject experts at each stage. It is recommended that GFR 2017 of the Government of India (GoI) as well as state-specific procurement guidelines be read and understood thoroughly for a full comprehension of this area (see box on recommended reading).

4.1. Important terms and concepts

It would be useful to revise a few relevant concepts at this stage. A proper understanding of these concepts is essential for a comprehensive approach to service procurement.

A. Types of entities involved

Procuring entity: Procuring entity is the term for the organization that is initiating the procurement. This can include (but is not limited to) state TB office, district TB office, NHM, and program managers taking on the responsibility of procurement.

Proposer: Any eligible person, organization, or consortium (an association of several organizations) participating in a procurement process with a procuring entity. Proposers can also be called bidders, vendors, service providers, or agencies. This can include both for-profit and not-for-profit organizations. All these terms are accurate for referring to the private partners working with NTEP to provide the services according to contract; for this document, the terms 'agencies' or 'service providers' have been used. Annexures 10.4 and 10.5 (Eligibility Criteria) provide a full list of the type of entities that can be seen as proposers.

B. Contract types

Three types of contracts are relevant for procuring services from private partners: input-based contracts, fee-for-service (FFS) contracts, and performance-based contracts.

Input-based contracts: These are contracts where the 'inputs' or the services to be provided are well defined, but the results or outputs are not easy to quantify or verify. In such contracts, the calculation of contract value and payments are made based on resources deployed (inputs) or based on the number of activities. For example, in contracts for community awareness, specific services (or inputs) can be well defined and paid for—school seminar, street plays, stalls in public places, hoardings, wall painting, and social media campaigns for awareness. However, the output, that is, awareness in the community is difficult (but not impossible) to measure and verify.

Output-based contracts:[5] These are contracts where the desired results are well specified but the means of achieving the results are not prescribed. Under this type of contracting method, the focus is on outputs or outcomes that are verifiable in quantity. The service provider is expected to identify innovative, efficient, and effective ways to achieve the output. Payment is linked to the achievement of the preset outcome indicators, for example, a contract for notification and treatment outcome of TB patients in the private sector. Here, the output is verifiable and is the basis of payment (number of people with TB notified and number of treatment outcomes reported) but the activities required to achieve these outputs can be decided by the implementing agency. Output-based contracts can be target based or performance based (Box 5).

BOX 5: What are performance-based contracts?

Output-based contracts, or contracts that focus on results rather than on inputs, can be of two types:

Target-based contracts: The service provider is given a list of parameters with fixed targets to achieve and is paid according to the achievement of those targets.

Performance-based contracts: The service provider is paid according to performance, which might exceed the targets. Performance-based contracts can incentivize performance and drive agency efforts to deliver services above and beyond the targets. Performance-based payments can also be referred to as 'incentives' or 'target-plus' payments.

Example to demonstrate the difference between targets-based and performance-based contracting:
- **Service/partnership option:** Notification of people diagnosed with TB
- **KPI:** No. of people with TB notified in *Ni-kshay*
- **Target for the year:** 800 people with TB to be notified over the year
- **Payment linked to this indicator:** INR 200 per notification
- **Target achieved:** The agency is able to notify 900 people with TB.

Scenario 1: Target-based payments	Payment: 200 × 800 = INR 1,60,000
Scenario 2: Performance-based payment	Payment: 200 × 900 = INR 1,80,000

In this example, the agency was able to exceed the notification target by 100 and was given additional payment for this. The additional payment of INR 20,000 can be seen as an incentive or reward for exceeding the target. The incentive can be processed using the buffers built in the budget and the contract. As can be readily seen, **there can be little to no motivation among service providers to exceed targets in case of a targets-based contract.**

Key points to note:
- There is an increasing preference for performance-based contracts—in RFPs, procuring entities often use the term of performance-based contract than the term output-based contracts. This preference demonstrates the evolution in NTEP's approach toward private sector partnerships, especially the policy to reward the service providers' performance when the service delivery exceeds the outputs set in the contract. States are recognizing the value of incentivizing stellar performances from agencies, that is, when performance goes above and beyond the targets, payments should also increase accordingly.
- Target-based contracts and performance-based contracts may differ in terms of how they are managed or supervised, but they are the same in terms of processes around procurement and finance, that is, they are selected using the Quality- and Cost-Based Selection (QCBS) method.
- Please see Annexures 10.8 for detailed information on calculation of "pro rata payments" in performance-based contracts,

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5   Output-based contracts are now mostly called performance-based contracts. See Box 5 for an explanation.

FFS contracts: These are contracts where the scope of services can be defined up to the unit level, and the results of the service are also measurable and are of verifiable quantity and quality, so that fees can be calculated based on the unit of service provided. For example, in the purchase of specific services like CXRs and CBNAATs, the payments can be calculated on the basis of number of tests purchased.

Table 6 provides additional information on and comparison between the three types of contracts.

TABLE 6: Types of contracts

Contract type - features and examples	Payments and advantages	Selection
Input-based contract Recommended when inputs, services, or activities can be defined clearly, but outputs are difficult to quantify. For example, contracts for community empowerment through awareness sessions. In such projects, measuring the output (that is, awareness in the community) may indeed be possible but is not easy or straightforward	**Payment is linked to inputs** For example, in a contract for community empowerment, payment can be made according to the number of training sessions held.	QCBS[6] method is recommended.
Fee-for-service contract Recommended for services that have a clear-cut scope with acceptable quality, for which activities and results can be defined clearly, and the cost of service can be easily estimated through market assessments. For example: ▪ Contracts for purchase of CXR services and ▪ Contracts for CBNAAT services.	**Payment linked to specific services delivered** For example: ▪ In a contract for CXRs, the payment can be made according to the number of X-rays carried out and ▪ In a contract for CBNAAT services, payment is made according to the number of NAATs conducted.	LCS[7] method is recommended.
Performance-based contract or output-based contract Recommended for areas if work outputs or results are clearly defined, but inputs or services are not prescribed. Service provider can define their own innovative services or inputs. For example: ▪ Contracts for case notification and ▪ PPSA contracts.	**Payment linked to performance or output indicators** For example, in a contract for case notification, the payments can be made according to the number of notifications on *Ni-kshay*.	QCBS method is recommended.

Hybrid contracts

If deemed fit, states can also design and roll out 'hybrid contracts', that is, contracts that are a mix of more than one type of contract. In a contract that is a hybrid input-output contract, a state may decide to link

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6   Quality and Cost-based Selection method, also known as Quality-cum-cost based selection method, is described in detail on the next page.

7   Least Cost Selection method; described in detail on the next page.

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70 percent of the payments to outputs and 30 percent of the payments to inputs or activities. This type of structure can be useful if the state sees value in monitoring the quality of inputs/activities. For example, in a project to increase private case notification in a state, it may be decided that:

- The payment-linked indicators for 30 percent of the payment is the number of private providers notifying to NTEP, hiring of staff, and establishment of infrastructure (inputs) and

- The remaining 70 percent of the payment is linked to the increase in notifications from the private sector (outputs).

C. Types of selection processes

Least Cost Selection (LCS): This is a method of selection where the primary criterion of selection is the cost. Bidding agencies are evaluated against a minimum qualifying benchmark that they either fail or pass (no technical score is given), after which the proposal that has the lowest evaluated cost is selected. LCS is suitable specifically in situations where the requirement is highly standardized, with limited scope of technical innovation. This method is used for fee-for-services type of contracting. LCS method is more appropriate when there are more providers who can provide competitive rates for services.

Quality and cost-based selection (QCBS): This method of contract selection is used for input-based contracts and performance-based contracts. Under this method, the agencies bidding for the contract are asked to submit two separate proposals (as specified in the RFP)—one technical and one financial—and both proposals are evaluated or scored according to the criteria shared in the RFP. This selection method is an important feature of the performance-based contracting because it allows the procuring entity (central, state, or district) to thoroughly examine the technical skill of the proposers/bidders. The final selection is done based on the total combined score (technical and financial), and in the calculation, different 'weights' can be given to the technical evaluation score and financial evaluation score. To ensure high quality of work, it is recommended that the technical evaluation should be given a higher weightage than the financial evaluation. A weightage of 70 percent for technical scoring and 30 percent for financial scoring is recommended to ensure that technically stronger vendors get selected.[8] See Table 11 for demonstration of this method.

Quality-Based Selection (QBS): Under this type of selection, only technical criteria are used for evaluation; financial considerations are not factored into the process. QBS is suitable specifically in situations where the technical input required is highly specialized and the concern for technical quality dominates the concern for the lowest cost. In this process, the financial envelope is opened only for the bidder that achieves the highest technical score; the other bids are discarded at the end of the technical evaluation. There are no prominent examples of this type of selection method in TB projects.

D. Types of contractual arrangements

Subcontracting

A subcontract is when the partnership contract is given to one agency that gives further contracts to other agencies. For example, agency A takes on the services for specimen transport and testing in

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8   Manual for Procurement of Consultancy & Other Services. Government of India. Ministry of Finance Department of Expenditure. Chapter 6. Section 6.9.2.

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10 districts. After winning the contract, it gives a subcontract to agency B which has a better courier network in five of those districts. Some general considerations while allowing agencies the provision of subcontracting are listed.[9]

- Written permission for subcontracting should be taken from the procuring entity.

- The subcontracting process should not delay the initiation of operations beyond the stipulated timeline prescribed in the contract.

It must be noted that the overall responsibility of supervision, management, and operations of subcontractors would lie with the agency that has been contracted by the procuring entity, that is, the agency that is taking on the lead entity role. If executed well, subcontracts can be a win-win situation with advantages for the people seeking care and the procuring entity as well as the service provider.

Advantage for people with TB and for the procuring entity: Access to uninterrupted, high-quality services due to the combined advantages of the lead proposer and subcontracted partner.

Advantages for service providers: Subcontracting may give an opportunity for larger, financially sound agencies that have relevant experience in health-related services but do not have niche experience in certain parts of service delivery or the necessary field presence in that specific geography. Such agencies can provide the required financial pool to ensure uninterrupted operations, while their subcontracted partners have the requisite technical prowess and field presence. Eligibility criteria in RFPs must therefore be flexible to encourage participation from a broader range of agencies.

Example of subcontracting: Service provider AB is selected as a PPSA in district X to provide a bundle of six services: notification, NAAT, DM and HIV testing, treatment support, seeding of bank accounts for DBT, and reporting of treatment outcomes. It identifies a district-based medical logistics company PQ with a large courier network and proven track record in sample collection and transport. AB takes written permission from the competent authority at the state/district level as defined in the contract (for example, STO or Managing Director-NHM) to subcontract sputum collection and transport for NAAT and is able to provide doorstep sample collection, fast TATs, and reporting.

Consortiums

A consortium is an association of organizations with the objective of participating in a common activity or pooling their resources for achieving a common goal. In the consortium, one proposer takes on the role of 'lead partner' or 'lead proposer' for reporting and accountability purposes. See Annexure 10.5 for eligibility criteria for consortiums.

Example of consortiums: Agency AB, which is a chain of private hospitals, and agency CD, which is a community-based organization, have come together to bid for a contract on DRTB treatment and support services. AB provides clinical care through its DRTB clinics and clinical experts. CD will provide adherence counselling, follow-up, and outcome reporting through its wide network of community workers.

Table 7 provides a comparison between subcontracts and consortiums.

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9   GFR 2017.

TABLE 7: Subcontracts and consortiums - A comparison

	Subcontract	Consortium
Timing	A subcontract is created *after* the contract has been awarded—the successful bidder creates the subcontract with another agency.	A consortium is created *during* the proposal process. The agencies that form such an entity apply for the bid together.
Advantages for service provider	Subcontracts allow larger agencies to tap local expertise and on-ground efficient networks of other agencies rather than establishing all services from scratch.	▪ Consortiums make it possible for a wider range of organizations to participate in the bidding process; if the financial requirements of the bidding process prohibit smaller organizations from entering in the bidding, they can come together as a consortium and share their resources. ▪ Bidders can share technical resources, skills, and competencies increasing their work quality and ability to sustain operations. ▪ Bidders can share financial resources in case of delayed payments and ensure operational continuity.
Advantages for procurement entity	▪ Subcontracts and consortiums are a way to utilize the network and technical skills of more than one service provider. ▪ If the lead proposer has sound financial reserves, it ensures uninterrupted services even in the eventuality of payments getting delayed.	
Disadvantages for procurement entity	Management and supervision may be more complex because of the increased number of service providers involved in the implementation.	
Accountability	Only the lead partner is responsible for the outcomes.	

Relevant points to note

(a) Decisions to permit consortiums and subcontracts

It should be evident that there are both advantages (wider pool of resources and funding and diversification of risk) and disadvantages (complex supervision) to subcontracts and consortiums. Therefore, states need to evaluate the pros and cons in light of the local context and take a decision on a case-by-case basis in terms of whether or not they want to:

▪ Permit consortiums to apply for bids or

▪ Permit selected agencies to subcontract.

It is recommended that decision on these permissions is taken at an early stage and, if possible, mentioned in the RFP. In the case of consortiums, decisions should also be taken on the maximum number of agencies that can come together to form a consortium (for example, a maximum of three), and this should also be specifically mentioned in the RFP.

(b) Support networks

Support partners (NTSU, STSUs, and consultant networks) can help in evaluating these decisions as well as in building structures for supervising subcontracts and consortiums.

E. Types of security/guarantees

Three types of security/guarantees are relevant for service procurement: bid security (also known as Earnest Money Deposit or EMD), performance security, and bank guarantee (against advance payments).

Bid security: Also called EMDs, this is a deposit taken from all agencies bidding for the project. It is meant to safeguard against a bidder withdrawing or altering its bid during the bid validity period. The EMD serves as a 'filtering mechanism', ensuring that applications only come from bidders who have the capacity to participate in the bidding process and, once the contract is awarded, deliver the project needs according to the RFP/contract terms. See Annexure 10.2 for a sample bid security form.

Important points to note about bid security

- The amount of bid security is to be determined by the procurement entity. It is recommended that the EMD should be 2–5 percent of the estimated value of the contract or the value of the services to be procured.

- The bid security may be in any form acceptable to the procurement entity, for example, insurance surety bond, account payee demand draft, fixed deposit receipt, banker's check, bank guarantee from any commercial banks, or online payments.

- The up-front EMD payment is often a barrier to entry for smaller organizations, especially NGOs, whose cash flow reserves may not permit them to pay the EMD. To encourage such organization to apply for projects, states may consider ways to overcome such barriers. For example, bidding organizations may be exempted from EMD requirement if they are classified as micro and small enterprises (MSEs) by the Department of Micro, Small, and Medium Enterprises.

- Bid securities/EMDs of unsuccessful bidders should be returned to them at the earliest—this should not be later than the 30th day after the award of contract. For QCBS (also called two-packet or two-stage bidding), bid security/EMD of unsuccessful bidders should be returned even sooner, that is, within 30 days of declaration of result of the first stage (the technical evaluation stage).

- When a vendor has been selected, its EMD can be converted into a 'performance security' by extending the validity of the bid security (see next definition).

- The RFP should include detailed information about the EMD requirement (amount, acceptable form, and period of validity) as well as conditions for exemptions from the EMDs.

Performance security/guarantee: This is a deposit taken only from the agency that has been successful and has been awarded the contract. This is also called the Performance Bank Guarantee (PBG) and is meant to ensure due performance of the contract. It should be clearly mentioned in the RFP that

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the winning bidder will need to deposit a PBG, the value of which will be 3 percent of the value of the contract (a recent GFR amendment has reduced this from 5–10 percent to 3 percent). Performance security remains valid for a period of 60 days beyond the date of completion of all contractual obligations of the vendor including warranty obligation, if any. Please see Annexure 10.3 for a sample performance security form.

Important points to note about performance security

- Performance security is required for all types of contracts, but states can make an exception for fee-for-service contract.

- Performance security is obtained from all successful bidders who have been awarded the contract, regardless of the type of contract (input based, output based, or fee-for-service contract). It is to be obtained irrespective of the vendor's registration status (such as micro, small, and medium enterprises [MSMEs] status), unlike EMDs, for which MSMEs can be exempted.

- The EMD submitted by the selected agency can be 'converted' to become part of the performance security for the project.

Example to explain the mechanics of EMD and performance security

- For a contract worth INR 1 crore, a state has determined an EMD as INR 2 lakh (2 percent of value of contract) and performance security as INR 3 lakh (3 percent of value of contract).

- All bidders would be required to pay INR 2 lakh as EMD.

- Once an agency has been selected, EMDs of the remaining bidders are returned to them.

- The selected bidder is required to submit an additional INR 1 lakh; the EMD payment of INR 2 lakh submitted by the selected bidder is converted to part payment of performance security.

Bank guarantee (against advance payment): In most cases, payments are made only after the agency submits the invoice and deliverables are verified. However, in some cases, the agency may request the procuring entity (state or district) to give an advance payment to kickstart the operations. The state or district may consider the request if feasible and, in exchange for the advance, may request a bank guarantee, that is, a written undertaking from the agency's bank to guarantee the agency's financial viability to return the advance payment in case the services are not delivered according to satisfaction. If advance payments linked to bank guarantees are not feasible, states can consider other innovative mechanisms to provide the necessary support to service providers (Box 6).

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BOX 6: Advance payments

Ordinarily, payments to service providers are released only after services have been rendered and verified. However, documents published by the Department of Expenditure (Ministry of Finance)—specifically, GFR 2017 and Manual of Procurement of Consultancy and Other Services—do make provisions for advance payments if the state deems it necessary. The following recommendations are made:

- Advance payments should not exceed 30 percent of the contract value to private firms and 40 percent of the contract value to a PSU.
- While making any advance payment, adequate safeguards in the form of bank guarantee should be obtained from the firm.

For ease of administration, states can consider providing advance payments in the form of 'milestone payments'. For example, the payment cycle for the first year of engagement with a service provider engaged to increase private sector notification can be as follows:

- Milestone 1 - Month 1: Report on completion of HR recruitment and kick-off meeting
- Milestone 2 - Month 4: First-quarter invoices with deliverables to be verified
- Milestone 3 - Month 7: Second-quarter invoices with deliverables to be verified
- Milestone 4 - Month 10: Third-quarter invoices with deliverables to be verified
- Milestone 5 - Month 13 (year 2): Fourth-quarter invoices with deliverables to be verified.

In this example, the state can give a milestone payment to the service provider within the first month of operations by linking it to a 'low-hanging' deliverable which is crucial to effective initiation of service delivery; this can be the advance payment that allows them to sustain operations until the first-quarter invoices are submitted and processed.

> *Advance payments are a potentially life-saving approach for smaller bidders that are dealing with the financial challenges of the various securities, the wait for the first contract milestones to be reached, and the delays in milestone payments being made.*
> *- Quote from a key stakeholder*

4.2. Recommended process

Once the two initial steps—needs assessment and partnership design—have been completed, the program leadership (STO, DTOs, and their teams) have the foundation on which they can build the next step: procurement of services. As described in the Guidance Document, the procurement process consists of three steps:

(a) Contracting a service provider

(b) Budgeting for the partnership options

(c) Deriving a payment mechanism and developing a performance-based matrix.

Based on implementation experiences, it has been understood that steps (b) and (c)—budgeting for partnership options and deriving payment mechanisms—should be carried out as sub-steps in the contracting process.

Thus, the contracting process can be understood as a comprehensive 10-step process described below, along with sub-steps and recommendations derived from implementation experience.

Step 1: RFP requirements and administrative steps

Identification of RFP requirements

- Re-examine outcomes of the first two processes (needs assessment + partnership design), with a special focus on decisions taken on prioritized service needs, service bundling, and type of partnership option selected.

- Align RFP requirements with the state's PIP as well as the supplementary PIPs.

- The outcome of this step is a well-defined list of services (or service bundles) that need to be procured and the type of partnership option that will be used to procure them. For instance, a **sample RFP requirement** list can be:

  (a) Specimen transport and testing bundle (sample collection, transport, and testing on CBNAAT);

  (b) PPSA bundle for notification, public health actions, treatment adherence, and treatment outcome reporting; and

  (c) TB prevention bundle (household contact investigation, testing for infection, and treatment initiation).

Administrative steps

- Take a decision on type of contract (input-based, performance-based, or fee-for-service contract) and type of selection method (QCBS or LCS) that will be followed (Table 6).

- Take relevant administrative and financial approvals from the competent authorities (for example, Managing Director-NHM and STO).

- Select staff who will be part of the following committees:

  (a) Committee for RFP preparation

  (b) Bid opening committee (examines submitted proposals against eligibility criteria)

  (c) Proposal evaluation committee, which will evaluate the proposals that have been cleared by the bid opening committee

  (d) Negotiation committee.

- These should be four separate teams where a few members can be part of more than one committee. It must be noted, however, that the RFP team and evaluation committee should be made up of subject matter experts/procurement/finance experts from local NHM teams, members of STSU, and consultant networks.

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- As preparation, the RFP team should be asked to:

  • Examine previous partnership experiences in the state and identify potential challenges in service procurement and

  • Identify and document the capacity of existing agencies (if similar PSE projects are already ongoing) in the area. This identification of potential bidders in the area can be aligned with the 'market survey' described in step 3.

Step 2: Prepare ToR

The ToR, also known as the scope of work (SoW), is the section of the RFP that outlines the technical and geographical scope of the procurement. The preparation of the ToR and the budget estimation (step 3) should be done simultaneously because they influence each other (Figure 7):

- The ToR provides details on the type of services, their scope, volume, and geographical location requirements. These service requirements are inputs for developing budget estimates.

- The budget estimates are required to develop payment mechanisms and performance matrices. The completed ToR should include a section with detailed information on payment mechanisms.

Sections: The ToR must include the following sections, and each section should be comprehensive and detailed:

FIGURE 7: Interdependence of the processes of ToR preparation and budget estimation

Step 2: Prepare Terms of reference (ToR)
Use the budget estimates to develop payment mechanisms and performance matrix

Step 3: Budget estimation
Carry out market scans and activity-based costing (ABC) for the services listed in the ToR

TABLE 8: Sections to be included in ToR with example

1. Objectives	To provide NAAT services in a one district
2. Scope and volume of services	▪ Conduct specimen collection, transport, and testing in one district covering an estimated 4,065 samples per month. ▪ Maintain records and reports as according to formats prescribed in the contract. ▪ Provide services free of cost; ensure privacy and confidentiality. ▪ Ensure real-time reporting in *Ni-kshay*. ▪ Provide results on the same day of testing. *See Annexure 10.1 for more examples on scope of services.*
3. Eligibility criteria	▪ Service provider should be a registered entity. ▪ It should have a relevant license from National Accreditation Board for Laboratories (NABL) in the state. ▪ It should have functional molecular diagnostic facility (GeneXpert/TrueNat). ▪ It should have qualified technicians to perform specific tests. ▪ It should have adequate infrastructure and equipment. ▪ It should be willing to undergo quality assurance process according to NTEP guidelines and annual calibration exercise. ▪ It should have the facilities to ensure biomedical waste management. *See Annexure 10.5 for more information on eligibility criteria.*
4. Geographical areas	Name of districts/wards, population size, composition, and epidemiological indicators if available
Contract timelines	Duration of contract (for example, 3 years) and payment timelines (for example, monthly)
Indicators	**Payment-linked indicators:** Number of specimens collected, transported, and tested; valid result uploaded on *Ni-kshay* within 24 hours **Performance benchmarks:**[10] NAAT done within 7 days of diagnosis of TB for 70% of the notified cases. (This indicator will not be payment linked—it will be reviewed on a monthly basis for operational improvements, and its overall annual performance will be considered as a metric for contract renewal).
Verification and payment mechanisms	▪ First level of verification will be carried out monthly by cross-checking against *Ni-kshay*. ▪ Second level of verification will be carried out quarterly by physical verification of 5% of randomly selected reports. ▪ Payment will be made based on number of specimens examined and valid results reported in *Ni-kshay*. *See Annexure 10.10 and 10.11 for examples of payment mechanisms*
Penalty	Penalty will be deducted for false reporting of data.
Reporting requirements	Invoice format to be provided and index of documents to be maintained.

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10 See Box 7 for a detailed explanation of service delivery benchmarks.

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BOX 7: WHAT ARE PERFORMANCE BENCHMARKS OR SERVICE DELIVERY BENCHMARKS?

As mentioned previously, payments in performance-based or output-based contracts are linked to pre-set outputs or indicators. In addition, states can decide to attach "***minimum acceptable standards***" for the indicator to ensure that the focus is not just on achieving targets but also to provide high quality service delivery. These standards can be called service delivery benchmarks or performance benchmarks.

Examples of service delivery benchmarks

Service	NAAT	FDC delivery
Output indicator	NAAT completed for 70% of people diagnosed with TB	Provision of FDCs to 70% of people diagnosed with TB
Service delivery benchmark	NAAT completed within 7 days of diagnosis for 70% of people diagnosed with TB	Provision of FDCs within 48 hours of date of diagnosis or refill due date

How to measure: Service delivery benchmarks can be calculated either through *Ni-kshay* data (date of diagnosis and date of NAAT) or as part of field verifications. Depending on administrative convenience, the state may decide to set these benchmarks for only those indicators which can be tracked using *Ni-kshay* or other reliable data sources.

Impact: Once states have determined which service delivery benchmarks are valuable and need to be tracked, they can be used in two different ways for effective service delivery:

   (a) **Added into monitoring framework:** These benchmarks can be included as KPIs in the monitoring framework and be seen as an opportunity for driving improvements in service quality. In this regard, these benchmarks can also be useful for taking decisions around contract renewals (*See chapter 5 for details on how to use performance benchmarks in monitoring*).

   (b) **Linked to payments:** If a particular associated activity is not performed according to a pre-decided performance benchmark, then the assigned percentage of unit cost for that particular service gets forfeited or a penalty is levied on the engaged partner (see section 6.3.4 on how to calculate penalties).

Other points to note about performance delivery benchmarks

   (a) **Measure over extended periods:** Whenever service delivery benchmarks are linked to payments, they must be measured over an extended period such as quarterly, biannually, or annually so that there is scope for the service provider to average out any outlier delays.

   (b) **Consider patient factors:** The procuring entity needs to consider that service delivery benchmarks are affected by several patient-related factors (such as migration, refusal to get tested, or nonavailability for any other reason) which are beyond the control of the service provider.

   (c) **Consider dependencies on programmatic factors:** Often nonachievement of performance benchmarks is linked to programmatic gaps. For example, delays in NAAT caused by programmatic challenges like cartridge shortages should not lead to penalties for the service provider. This is another reason why measurement of benchmarks should be done over extended periods.

Objective data for patient factors and programmatic factors are likely to not be easily available, so whenever possible, penalties for nonachievement of benchmarks should be avoided, in the spirit of fair partnership with the service provider.

Step 3: Budget estimation

Timing: As mentioned, budget estimation should be done at the same time as the ToR development so that both processes can use information emerging from each other. In fact, as mentioned in the chapter on needs assessment, procuring entities can start collecting some budget-related information (market prices) during the resource mapping phase itself.

Process

- The budget estimation should be based on the scope and volume of services identified in the ToR.
- The budget estimation can be done through three different ways: – market scans, ABC, and use of prevailing prices in similar settings. See Table 9 for a comparison of these methods.
- The budgets estimates must include relevant considerations around taxability (direct and indirect taxes) under relevant acts and, as much as possible, include the applicable tax amount in the budget estimation.

TABLE 9: Budget estimation methods

Market scan	Activity based costing (ABC)	Prevailing rates
Process - Reach out to private labs in the state/district and collect information on current prices for CBNAAT package (sample collection, transport, and testing). - Using the mean (average), mode (most frequent price) and median (center of range), estimate a price that would be attractive to private partners.	**Process** - Make a simple Excel tool to calculate the cost of services. - The tool should include all inputs that would be required to complete the activity and the cost of each input based on experience.	**Process** - Use rates prescribed under any other government scheme. - Add in relevant inflation costs.
Example of services to be budgeted for: specimen collection, transport, and testing in a cluster of 4 districts covering an estimated 5,000 samples per year		
Market scan - At the 5 labs in the district, the CBNAAT package (collection, transport, and testing) costs range from INR 2,500 to INR 3,500. - The procuring entity estimates that the average price of INR 2,700 would be attractive to most private labs. - **Budget is estimated at INR 1.35 crore** (INR 2,700 per sample × 5,000 samples).	**ABC** - Inputs for the ABC include salaries of lab personnel; visits to patient homes or outpatient departments (OPDs); fuel; collection logistics; transport boxes; CBNAAT equipment; cartridges; utilities (water, electricity, and internet); information, education, and communication (IEC) material; overheads; and so on. - Unit costs for each of these inputs' costs are estimated, and a total price is calculated. - **Budget is estimated at INR 1.2 crore.**	**Prevailing prices** - A neighboring district procured the services at INR 2,500 per sample in the previous year. - An inflation factor of 4.5% is applied. - **Budget is estimated at INR 1.31 crore** (INR 2,500 per sample × 5,000 samples × (104.5%).

Selection of procurement modality

Table 10 provides an overview of how to select procurement modalities based on the results of the budget estimation. The relevant GFR 2017 are mentioned in the table next to each procurement modality and should be read for further information. It is also suggested that state-specific procurement guidelines be read for local threshold recommendations.

TABLE 10: Procurement modality based on budget estimates

Budget estimation	Procurement modality to be selected
The budget is INR 25,000 or below.	**Purchase without quotation** (GFR 2017 rule number 154). The procuring entity needs to record a certificate to confirm the quality and specification of services being procured.
The budget is between INR 25,000 and INR 2,50,000.	**Purchase by Local Purchase Committee or LPC** (GFR 2017 rule number 155). The LPC, which consists of three members of an appropriate level as decided by the procurement entity, will use the market scan to select one appropriate supplier.
The budget is between INR 2,50,000 and INR 25,00,000.	**Limited Tender Enquiry** (GFR 2017 rule number 162). Bid documents are sent directly to (more than three) registered/empanelled suppliers.
The budget is INR 25,00,000 and above.	**Advertised Tender Enquiry** (GFR 2017 rule number 161). Bids are sought from a wide range of bidders by publishing the RFP in publicly accessible sites like print media, state's e-Procurement Portal, and department website.
The market scan reveals that there is only one private organization that can provide the service required.	**Noncompetitive procurement or Single Tender Enquiry** (GFR 2017 rule number 166). Also known as 'Only Proprietor' or 'Original Equipment Manufacturer' (OEM) situation. A proprietary article certificate is obtained,4 and the services are directly purchased. This is also applicable for emergency procurement. This type of procurement is also relevant for extension of existing contracts if the procuring entity is satisfied with services in the existing contracts (for example, annual maintenance contracts for proprietary equipment like GeneXpert machines).

- In the example above, where services for specimen management and testing for 5,000 samples are being procured at a total budget of INR 1.2–1.35 crore, an **advertised tender enquiry** can be used. In general, given the large size of programmatic requirements, this is the most commonly used procurement modality.

- To extend the example, if the number of districts is reduced from 4 to 1, and the number of samples is decreased to 500 samples, the budget will decrease to about INR 12 lakh; in such a case, a **limited tender enquiry** will need to be used.

The budget thresholds in the left-hand column are according to GFR 2017, but it should be noted that state procurement rules may have different thresholds. For example, the budget threshold in Bihar Financial Rules (BFR) for 'purchase without quotation' is INR 50,000 instead of INR 25,000. Therefore, it is reiterated that state-specific rules should be consulted in all the steps, including budget estimation.

11 It is the responsibility of the procuring entity to seek a proprietary article certificate or PAC from the manufacturer/service provider and only then proceed for a single tender enquiry.

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Points to note when building budget estimations

Implementation experiences from past and ongoing partnerships have yielded some important lessons around budgeting:

- **Select the right costing approach:** The type of costing approach (market scan, ABC, or prevailing rates) can be selected according to the procuring entity's preference; when possible, the three can also be combined to arrive at the budget:
  - When the procuring entity has limited information on the component costs of an activity, market scan or prevailing rates are to be preferred. Prevailing rates are comparatively easier to follow, but such rates are sometimes outdated or unreasonable, in which case, market scan is the most useful method—not only to obtain realistic cost estimates but also to identify and understand the service delivery agencies in the area which can become potential bidders.
  - Generally speaking, ABC is preferred when the procuring entity has sufficient knowledge and experience of the activity. ABC requires accurate input cost data which are not always easy to obtain as they include both direct and indirect cost including infrastructure cost and HR cost. This estimation becomes even more challenging when HR and infrastructure are being utilized for multiple activities.

- **Specific suggestions for ABC:**
  - The costing process should include, as inputs, costs for all services and metrics (rather than only the payment-linked metrics).
  - If a comprehensive costing exercise is too time-consuming or daunting, some proxy estimates can be used. For example, it can be assumed that activities related to IEC will cost 5 percent of the diagnostic services cost, and an additional 5 percent cost can be added to the budget as buffer.

- **Seek expert help:** Costing capacity is often limited among program functionaries (this is especially true for ABC), and therefore, subject matter experts should be brought in for help. This includes finance and procurement experts from local NHM teams, members of STSUs, and consultant networks. *Recommended reading:* Section 4.2 (page 60–65) of the Guidance Document provides further examples of each type of costing.

- **Align with existing processes:** Budgets are only useful if they are based on the right assumptions on the quality and volume of services needed and are strictly aligned with the state/district's plans (diagnosis and treatment algorithm to be followed and targets to be achieved). This again underscores the importance of aligning budgets with PIP exercise and needs assessments.

- **Build buffers:** Data from market research, experiences, and inflation trends must be referred to frequently, and there should be room in the budget for annual cost increments in line with current inflation trends. There should also be an adequate buffer built into the budget to provide incentives to the agency if its performance exceeds the targets.

- **Include goods and services tax (GST) and other relevant taxes:**
  - There have been instances of delays and failure in procurement due to limited understanding around taxes, especially related to GST. It should be specified in the RFP that the bidder needs to clarify whether the bid amount is inclusive or exclusive of GST and the same needs to be incorporated in the contract.

- Generally, service providers are expected to charge GST from the procuring agency (that is, include it in their invoices). However, the exception is when the services provided by the agency fall under reverse charge mechanism (services notified by the central government. from time to time)—in such cases, GST shall be borne by the service receiver/procuring entity.

- Other taxes like tax deducted at source (TDS) are also applicable according to the existing norms, and budgets must include tax amounts as applicable from all relevant taxation acts.

EXAMPLES FROM THE FIELD

Comprehensive costing using prevailing rates to achieve better service delivery

- A state decided to include a new budget line item—'FDC delivery costs'—in its PPSA contract. This cost was estimated at INR 300 per patient using inputs from two other states. The additional budget was used by the contracted agency to invest in efficient systems for home delivery of NTEP-approved FDCs for people with TB.

- To ensure that all people with symptoms of TB get an X-ray, a state has budgeted an additional INR 250 per person for going through the TB screening cascade. The PPSA was engaged for private provider engagement and notification, but this additional budget has helped increase the CXR-based screening rates in the state.

Step 4: Preparation of RFP and bid documents

Steps

The following four steps need to be carried out by the RFP team with help from the evaluation committee:

- Develop an RFP overview document (Box 8).

- Develop a set of evaluation criteria for technical evaluation. These are in addition to the 'preliminary evaluation criteria' or eligibility criteria developed previously. See Annexures 10.4 and 10.5 for detailed information on how to make these evaluation criteria.

- Prepare the RFP document.

- Get approvals on the RFP and share it with bidders. Depending on the budget size (as mentioned in Table 10), the RFP can be:

  - Sent directly to three or more registered service providers (if the procurement size is 25 lakh or below, that is, in a limited tender enquiry) or

  - Published in open domain (if the procurement size is above INR 25 lakh, that is in an advertised tender enquiry); the advertisement should be placed on the Central Public Procurement Portal (CPPP) at www.eprocure.gov.in, on the Government e-Marketplace (GeM) portal, and also on the state/district website if available.

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RFP overview document

It is recommended that the RFP team create an overview document and use it to track the progress of the procurement process. The document can cover the following milestones:

(a) RFP launch date

(b) Last date and time for receipt of request for clarifications/queries

(c) Prebid meeting: date, time and venue/mode

(d) Date of clarification on queries/amendment

(e) Last date, time, and place for submission of bids

(f) Last date and time for submission of EMD in hard (physical) copies and validity of EMD

(g) Date, time, and mode of opening of technical bid

(h) Date, time, and mode/place of technical presentations

(i) Date of completion of technical evaluation

(j) Date, time, and mode of opening of financial bid

(k) Date of completion of financial evaluation

(l) Award of contract (tentative).

Sections in the RFP document

The following sections are essential for ensuring (a) comprehensive vendors response and (b) appropriate technical scoring:

- Purpose of the RFP

- Scope of services including clear roles and responsibilities of both parties (bidder and procuring agency)

- **Evaluation criteria**
  - Eligibility criteria or preliminary qualification criteria (see Annexure 10.5)
  - Technical evaluation criteria (see Annexure 10.6)

- **Guidelines for submitting the proposal**, including clarity on
  - Security deposits (see section 4.1 for detailed information on security deposits),
  - Detailed specifications/ToR of product/service,
  - Documents required for submission,
  - Information on how and where to send queries requests for clarification on RFP, and
  - Information on pre-bid meeting.

- **Partnership management plan**
  - Project deadlines with precise dates and milestones—review processes, invoice submission, and payment timelines.

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- Verification mechanisms and timelines

- Monitoring frameworks

- Insurance requirements

- Expected contract duration - three-year contracts are recommended for maximum effectiveness of partnerships but should be reviewed annually and considered for renewal based on performance.

- **Programmatic responsibilities:** It is important to include a section on the responsibilities that will be fulfilled by the procuring entity. In the example of a contract for specimen transport, NTEP responsibilities include (but are not limited to) the following:

  - Ensure availability of free tests according to estimated patient load.

  - Identify and specify laboratory links.

  - Provide a prototype/sufficient supply of sputum sample container and specification for procurement of sample collection containers.

Please see Chapter 7 for a more detailed list of responsibilities that should be taken on by the procuring entity.

Lessons from the field

- **Language:** The language in all these documents (ToR and RFP) should be simple and easy to understand and should not be open to subjective interpretations.

- **Published widely:** The RFP should be published on a variety of national and local platforms so that it can attract a wide range of bidders.

- **Expert inputs:** The RFP team must seek support from subject area experts in the state/district.

- **Room for innovation:** The RFP should have flexible requirements rather than highly specific ones to encourage more participation for competitive bidding.

- **Costing recommendations:** To ensure competitive bidding, the RFP cannot recommend any base rates or budget ranges. However, in the section on financial evaluation, it can include a pricing template and advise bidders to:

  - Provide a detailed cost breakup or component-wise pricing (fees, charges, salaries, incidental expenses, and so on) and

  - Align with existing government guidelines around minimum wages.

BOX 9: Government e-marketplace (GeM)

- The GeM is an online platform for public procurement in India.
- Thresholds for procurement through the GeM are different from other routine procurement and are prescribed under rule 149 of GFR 2017.

Step 5: Organize a pre-bid meeting

Steps to be taken

- Receive written queries/clarifications from bidders, review them, and develop a response to them. As mentioned in step 4, the RFP should include information on how to send requests for clarifications and should also include information around the date, time, and place of a pre-bid meeting.

- Organize a pre-bid meeting. Suggestions:
  - Ideally, the pre-bid meeting should be within 7–10 days of the RFP being published.
  - All the written queries received should be discussed at the pre-bid meeting.
  - These meetings are important opportunities to provide clarity on expectations and therefore should be comprehensive and detailed (see Box 10 for a sample agenda).
  - Nonattendance is not a cause for disqualification.

- Actions to be taken after the pre-bid meeting:
  - If there are any changes in ToR or RFP terms after the pre-bid meeting, an amendment to the RFP must be published at the same source where the RFP was published.
  - Minutes of meeting from the pre-bid meeting should be published at the same source where the RFP was published along with response to queries of the pre-bid meeting.

BOX 10: Sample agenda for pre-bid meeting

- Discussion on queries received
- Scope of services covered in ToR and RFP:
  - Types of services—volume, geography, and details of services—and roles and responsibilities of agency and state/district partners
  - Metrics—payment linked and nonpayment linked
  - Duration of contract
  - Timeline of deliverables
- Cost implications of services being procured
  - Need to cost both payment-linked as well as nonpayment-linked metrics
  - Impact of inflation on costs in future
- Requisite documents
- EMDs
- Performance security.

Step 6: Submission and opening of RFP

Submission

- Proposals are submitted through online mode to the online procurement portal mentioned in the RFP and/or in offline mode by submitting sealed hard copy of the bid document.

- Submission of technical and financial proposal is kept separate, encrypted, confidential (password-protected), or in a sealed envelope (in case of offline mode).

- Proposals should be rejected if any information related to financial proposal is provided in the technical proposal.

Bid opening

- The technical bids should ideally be opened immediately after closing hours of bid submission deadline, or latest by next working day.

- Invitation to bidders (or their representatives) is mandatory at bid opening; however, bidders' attendance in not mandatory. Nonattendance is not a cause for disqualification.

Preliminary evaluation against eligibility criteria

- The bid opening committee examines the submitted proposals against eligibility criteria (see Annexure 10.4 for eligibility criteria).

- Any bid that does not meet the eligibility criteria is rejected and allowed to proceed for the next step in evaluation.

- Although weightage of technical evaluation is not included in the LCS process, the procuring entity must ensure that the service providers fulfil the minimum eligible criteria so that services to be provided are according to the programmatic guidelines or previously agreed-upon minimum acceptable standards. For example, in a contract to outsource CXRs, the bid opening team can evaluate bidders through preset criteria such as:

  - Technical specifications of the X-ray equipment,

  - Qualifications of the staff, and

  - Location of X-ray facilities in convenient locations.

In other words, LCS contracts also undergo a 'technical assessment', but it is passed/failed evaluation against minimum eligibility criteria rather than a full scoring. This step can be carried out along with preliminary evaluation.

Step 7: Technical evaluation

- A detailed technical evaluation is required for those procurements where QCBS method is used, that is, for input- and performance-based contracts.

- The technical evaluation committee should carry out the evaluation using a scoring matrix. A sample technical scoring matrix has been provided in Annexure 10.6. The sample is indicative, and states can modify it according to their needs.

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- **Recommendations:**
  - The technical evaluation process should be very stringent, with strong technical parameters that have greater weightage than financial parameters (for example, 70 percent weightage to technical and 30 percent to financial as recommended by the Department of Expenditure).
  - Adequate weightage may be accorded in the technical scoring on the basis of concept, approach, and methodology. The evaluation committee must thoroughly examine the bidder's proposed approach including elements like HR plans, proposed service delivery under specific personnel, and ratio of staff to patients.
  - Further, the evaluation committee may consider fixing 'minimum marks' for technical quality of the proposal and reject anyone who scores below this.
- During the technical review, the committee may ask the bidder for clarifications or request the bidder to submit additional documents related to past work or administrative documents for Permanent Account Number (PAN), Temporary Account Number (TAN), GST, and income tax return (ITR) (nonsubmission of such historical documents during the bid submission process will not disqualify any bidders).

Step 8: Financial evaluation

- Financial bids (also known as commercial bids) should be opened at a designated time by the bid opening committee in the presence of bidders' representatives (whose nonattendance cannot be the cause of disqualification)
- For input-based and performance-based contracts, financial bids are opened for only those agencies whose technical bids have passed the technical evaluation.
- In case of fee-for-services (FFS) contracting, where LCS method is used, the financial bids are opened for all those bidders who have met the minimum eligibility criteria.
- No change/amendment is acceptable in the financial proposal.

Step 9: Negotiation and selection

Fee-for-service contracts

For Fee-for-service contracts, where LCS selection is carried out, the process is straightforward—the lowest bid is selected.

However, if the lowest bid (called L-1 bid) is higher than the estimated procurement value (for example, if the budget estimate was INR 1 lakh, and the lowest bid was INR 1.05 lakh), the following steps can be followed progressively:

- **Negotiation:** The bidder with the lowest bid (called the L-1 bidder) is called for negotiation and asked to reduce the price to bring it within the estimated budget. If this negotiation fails, the procurement entity may proceed further for negotiation with the bidders with the second-lowest bid (L-2 bidder). In general, Central Vigilance Commission (CVC), which is an independent body appointed by the GoI to address corruption, discourages interactions with L-2 or L-3 bidders, so procuring entities need to take well-considered decisions around negotiations.

- **Approvals for budget increase:** If the procuring entity (STO/DTO) decides not to negotiate with the bidders, or if the negotiation is not successful, the procuring entity can seek financial approvals (from the competent authority) to increase the budget to meet the lowest bid. There are existing processes through which NHM budgets can be reappropriated to increase the available budget, provided adequate justification is submitted in writing by the procuring entity.

- **Rebidding:** If the request to increase budget is not approved, the procuring entity needs to restart the bidding process.

Input- and output-based contracts

For input-based and performance-based contracts, where QCBS is carried out, financial evaluation is done after the technical evaluation, and the combined scores are used for selection. See Table 11 for an example of how to do the combined scoring.

In the example in Table 11, three proposers A, B and C have applied for a particular assignment. Their technical and financial evaluations have been completed.

- **Technical evaluation:** Proposer C received the highest marks in technical evaluation (91 points out of 100), and proposers A and B received 79 and 85 marks, respectively.

- **Financial evaluation:** Proposer A has the quoted the lowest bid with a per-patient cost of INR 2,300 per patient, and proposers B and C have quoted INR 2,417 and INR 2,576, respectively.

TABLE 11: Demonstration of QCBS scoring

Bidder	Technical scoring			Financial scoring			Combined score
	Technical marks	**Technical score**	**Technical weightage**	**Quoted value**	**Financial score**	**Financial weightage**	
	Marks scored in technical evaluation	*Bidder's/ marks of the highest scorer × 100*	*Fixed as 70%*	*In INR*	*Cost of L-1 bidder/cost quoted by bidder × 100)*	*Fixed as 30%*	*Technical weightage + financial weightage*
A	79	(79/91) × 100 = 86.81	86.81 × 70/100 = 60.76	2,300	(2300/2300) × 100 = 100	100 × 30/100 = 30	90.76
B	85	(85/91) × 100 = 93.41	93.40 × 70/100 = 65.38	2,417	(2300/2417) × 100 = 95.15	95.15 × 30/100 = 28.54	93.92
C	**91**	(91/91) × 100 = 100	100 × 70/100 = 70.00	2,576	(2300/2576) × 100 = 89.28	89.28 × 30/100 = 26.78	96.78

The final scoring and selection is done in three steps:

(a) **Technical scoring:** To calculate the technical score, the highest marks achieved in the technical evaluation are used as a denominator as follows:

- A's technical score = A's marks in technical evaluation (that is, 79)/marks of the highest scorer (that is, 91) × 100 = 86.81
- Similarly, B's technical score = B's marks in technical evaluation (that is, 85)/marks of the highest scorer (that is, 91) × 100 = 93.41
- C's technical score = 91/91 × 100 = 100.

(b) **Financial scoring:** To calculate the financial score, the lowest bid (L-1) is used as the denominator:
- A's financial score = A's bid (that is, 2,300)/lowest bid (that is, 2,300) × 100 = 100
- B's financial score = B's bid (that is, 2,417)/lowest bid (that is, 2300) × 100 = 95.15
- C's financial score = C's bid (that is, 2,576)/lowest bid (that is, 2,300) × 100 = 89.28.

(c) **Combined scoring:** As a final step, the technical and financial scores are combined. In this example, the procuring entity has decided to use a weightage distribution of 70 percent and 30 percent for technical and financial scoring, respectively. Therefore, the combined final score was calculated as follows:

Final score (S) = (T/T High × 70) + (C Low/C × 30),
where,
T = Technical evaluation score of the proposer,
T High = Highest technical score among the proposers,
C Low = Lowest quote of financial proposal among the proposers, and
C = Quote of financial proposal by the proposer.

Given the higher weightage to technical scoring, proposer C wins the bid in the example, even though its financial bid was higher than the other two. This makes it clear that QCBS method gives an opportunity to procuring entities to select agencies with better technical capacity.

BOX 11: The process of negotiations in contracting

Negotiations in partnership contracting

Negotiation, contrary to general understanding, does not primarily focus on pricing. While procuring services from a private sector partner, the procuring entity should invest time in a broader process of negotiation with the successful bidder. This should consist of detailed communication around all necessary points, for example,
- Alignment on the ToR, especially if an activity that was not mentioned in the RFP has been added into the contract,
- Clarity on quality of services required,
- Examination of HR planning for the activities,
- Examination of pricing assumptions made in the proposal, and
- Clarity on timelines for invoicing and payment.

If a consensus is built on these vital issues at an early stage, it helps protect both parties from many kinds of challenges including service disruptions and financial and legal ramifications.

Note: Negotiation with unsuccessful bidders is discouraged by the CVC.

In case two or more proposers quote the same value, the one having the higher annual average turnover according to the eligibility criterion can be given preference.

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FIGURE 8: Summary of selection steps - QCBS and LCS
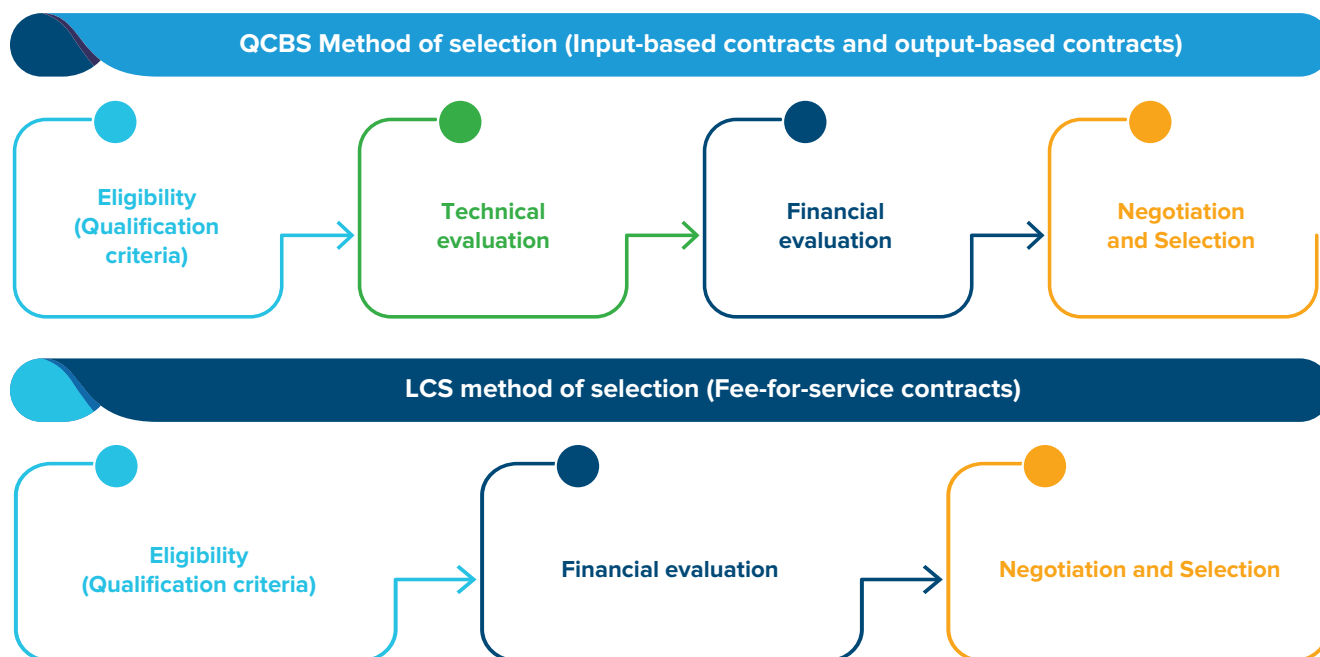
Step 10: Agreement signing

The procurement entity should award the contract to the proposer whose proposal has secured the highest total combined score during evaluation of proposals and which has been agreed and approved by the relevant approving authority.

- **PBG:** When the contract is awarded/signed, the selected vendor is required to pay a PBG which is advised to be 3 percent of the size of the contract—this is ideally done within 28 days of receipt of the letter of acceptance from the procurement entity. The vendor's EMD (deposited at the time of bid submission) can be converted into PBGs as long as they are the same size or the vendor is required to pay the difference.

- **Advance payments:** The vendor may request the state partner for an advance payment to kickstart operations. Advance payments can be given if:

  - Advance payments are permissible by state procurement guidelines/rules and will be repaid or adjusted against the deliverable-linked payments or

  - The vendor submits the 'bank guarantee' against the advance.

See Box 6 for additional information on advance payments

- **Comprehensive contracts:** The contract should be comprehensive and cover all necessary areas (Box 12). The clauses, especially those related to the SoW, should remain, as much as possible, the same as the clauses in the RFP— any proposed changes should be discussed with the bidder and should be added only if mutually agreeable.

- **Taxes:** Tax component/amount as applicable by the relevant act should be clearly mentioned.

- **Payment buffers for payments:** As mentioned under Step 3, budgets for private sector contracts should include buffers to accommodate cost increases due to inflation and incentives if the service provider exceeds the targets. These buffers should be explicitly mentioned in the contracts. On a related note, if the cost of services (or products) decreases drastically due to any factor such as currency fluctuations, the contract payment terms may be reduced accordingly but only if there is bilateral agreement. For example, if the cost of computer tomography (CT) scans reduces from INR 2,000 during the time of signing of the contract to INR 1,000 in the second year of the contract, there may be a need to discuss a possible reduction in per-patient payment to the agency.

BOX 12: Points to be covered in contracts

Important points to be covered in a contract

- **Deliverables:** Clearly define the milestone of all deliverables (including nonpayment-linked metrics) with timeline of completion of the same, including clear reporting requirements and period of reporting.
- **Responsibilities:** Define the details of documentation to be maintained and responsibility metrics of officers for reviewing the same.
- **Payment mechanisms and documentation:** Clearly mention the frequency (monthly or quarterly) that should be linked to deliverable as above as well as documentation inclusive of invoice formats and so on and details of relevant authority to whom all these details and documentations are to be submitted for release of payments.
- **Advance payment:** In case of any provisions for advance payments, details of frequency, documentation, and adjustment-related terms and conditions need to be clearly mentioned.
- **Deductions and taxation:** Relevant deductions for taxation as well as penalties should be clearly mentioned.
- **Verification and validation process:** To be processed based on documentation of the performance in *Ni-kshay* or predefined reports. See Chapter 7 for a complete list of verification-related details that need to be included in the contract.
- **Penalty clause:** Penalty clauses should be clearly linked with milestones, and the process of deduction needs to be clearly mentioned.
- **PBG:** Receipts of PBG, release of PBG, and forfeiture of PBG need to be mentioned.
- **Timelines:** Timelines for invoicing, verification, and payments need to be mentioned.

Other contract-related tasks

Three additional contract-related tasks are described: contract addenda, contract extensions, and contract renewals.

Addenda: If the state/district sees the need to add additional services to the contract—expanding the scope of existing services or adding new services/service bundles—the contract can be modified by adding a new section called addendum (plural: addenda) to the contract with mutual consent.

- This needs to be done only after detailed discussion with the selected vendor on implementation modalities and its cost implications.

- Financial implications of the additional requirements need to be considered, and additional budget needs to be added in (after receiving approvals from the competent authority.

> **EXAMPLES FROM THE FIELD**
>
> ### Addendum to existing contracts
>
> A DTO, after discussion with the PPSA in the state, added in a new service in the third year of an existing contract with a service provider engaged to provide sample transport services for 5,000 people with the symptom suggestive of TB. The cost of the original contract was INR 200 per sample, for a total cost of INR 10,00,000 (10 lakh). The additional services were for FDC delivery services for an estimated 250 people diagnosed with TB in the same geography. Using ABC, a unit cost of INR 600 was arrived at for FDC delivery services, for a total additional cost of INR 1,50,000 or INR 1.5 lakh. The DTO collaborated with the district collector to get approval for the additional 1.5 lakh. The addendum was added to the final year of the contract.

Contract renewals

- At the end of the contract period, the state/district may either float a new RFP for the next round of service procurement or consider renewing the contract with the existing agency after taking approvals.

- To ensure service continuity, it is suggested that the process of contract renewal or floating a new RFP should start 6–8 months before the end date of the current contract.

If both these processes are taking time (contract renewal and new RFP process) and the existing contract is ending, the state/district can consider extending the contract with the existing agency for the interim period so the service delivery to patients can continue without a break.

Contract extensions

Building on insights from the latest cycle of the needs assessment and from the performance review of the agency, the state/district might need to take a decision to extend an existing contract. Below are some example scenarios when this might be done:

- The agency's performance has been satisfactory, but due to extenuating circumstances, the service delivery targets will only be partially met by the end of the contract period, for example, the agency carried out sample collection and transport for 1,500 people with TB over 12 months against a target of 2,000 for the same period. The procuring entity may agree to give the agency an additional 3 months to achieve the outcomes and ask the agency to submit the final invoice at the end of the period of extension. **In this scenario, the agency is receiving a no-cost extension**.

- The agency's performance has been satisfactory, they have achieved the targets set out in the contract, and there is the continued need for the services, for example, the agency achieved the sample collection and transport target of 2,000 people with TB. In this scenario, there is no mechanism in place for sample transport and collection services after the contract with the agency ends (because the next cycle PIP and budgeting is in process), and the state can decide

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to extend the contract by 3 months so that there is no interruption in services. The agency will need to be paid for the services they provide in this extension period, and approvals from the competent authority will be required for the additional payment. **In this scenario, the agency is receiving a costed extension**.

Contracts can be extended for a period of about 1 year based on approvals received. As explained earlier, the timing of the new RFP should align with the next round of PIP or supplementary PIP (Figure 1). In other words, the process of contract renewals and/or extensions should be initiated only if the most recent cycle of needs assessment indicates that services are still a priority requirement and the contract fits under the budget planning.

4.3. Challenges related to procurement

Two challenges, which can derail or at least significantly delay the procurement processes, are described below: limited response to RFPs and irrationally low financial quotations.

A. Limited responses to RFPs

There can be situations where an RFP is published and gets very few responses. In such situations, the procuring entity can do the following, according to the new GFR.

If two or more bids are received, the selection process is carried out as described. It should be noted here that although a large number of bids to select from would be ideal, the procuring entity can make a selection even if only two bids are received. If neither of them passes the eligibility criteria, technical and financial evaluation, rebidding will have to be done.

If only one bid is received, the procuring entity can go ahead with the selection as long as the following conditions are satisfied:

- The procurement was satisfactorily advertised, and sufficient time was given for submission of these.
- The qualification criteria were not unduly restrictive.
- Prices are reasonable in comparison to market values.

In other words, as long as the bidder meets the eligibility criteria and passes the technical evaluation and the financial quotes are aligned with the budget estimates, it can get selected. If the bid does not pass the eligibility criteria and technical and financial evaluation, rebidding will have to be done.

If no bids are received, the procuring entity should deliberate on the reasons for the lack of response and take the next step accordingly.

TABLE 12: Possible causes and solutions to no responses to RFPs

Possible cause of no bids being received in response to RFP	Possible solution
(a) The publicity was inadequate, and information about the RFP did not reach potential bidders.	The deadline should be extended and the RFP should be published in a wider range of publications.
(b) The Scope of Work (SoW) in the RFP was less than clear, and potential bidders were unable to understand the type/scope of services required.	The procuring entity should request the RFP committee to make the required changes in the SoW. The changes will need to be approved by the competent authority, after which the RFP can be published again with an extended deadline. If the RFP needs major changes or if the competent authorities do not approve of the changes, the RFP will need to be cancelled and go for rebidding.
(c) The eligibility criteria were too stringent, and no bidders could meet all the criteria.	The procuring entity should request the RFP committee to make the required changes in the eligibility criteria or consider permitting consortiums to apply. The changes will need to be approved by the competent authority, after which the RFP can be published again with an extended deadline. If the RFP needs major changes or if the competent authorities do not approve of the changes, the RFP will need to be cancelled and go for rebidding.

Prevention: How to avoid situations with limited bid responses

Based on the three contributory causes listed, the following are some ways to ensure that an adequate number of diverse bids are received in response to RFPs, giving procuring entities an opportunity to select the most suitable private sector partner:

- When the SoW is being made, attention should be paid that it is adequately detailed and easy to understand.

- As much as possible, eligibility criteria (especially related to size, financial capacity, and experience of organizations) should be flexible so that a wider range of agencies are able to apply.

- The RFP should not be limited to state-specific procurement portals. States may consider publishing the RFPs in national-level newspapers, CTD website, and central procurement portals.

B. Irrationally low financial quotes from bidders

There have been a few instances where some agencies have quoted extremely low financial quotes to get selected. At times, such vendors may get selected due to overall high score due to very low financial quotations, even though their technical capacity is lower than other more qualified vendors. This can lead to situations where the vendor gets the contract and starts the project but fails within a few months because of financial nonviability of their resource planning and operations. For example, a recent PPSA project had to be halted because the vendor's inappropriately low staff costs made implementation challenging.

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Prevention: How to prevent irrationally low financial bids

As mentioned, irrationally low bids lead to situations in which states have to either reject the lowest quote or proceed for rebidding, and neither option is ideal. Therefore, it is essential to put in place some systems that can prevent bidders from submitting such irrational bids. States may be tempted to fix some base rates to protect themselves from such situations, but that would be against the spirit of innovation and performance-based contracting. Instead, there are a few other ways to avoid these challenges:

- Use the QCBS method of vendor selection and accord higher weightages to technical evaluations (weightage commonly used is 70–30 percent or higher weightage for technical bid).
- Evaluate the technical plan in detail to identify areas of inadequate planning; the following areas are examples of details to focus on:
  - Operational workflow
  - HR deployment
  - Business model.
- Carry out a thorough market scan and costing during the budgeting phase of the RFP—this will allow the program to build some internal benchmark costs.
- Request agencies to provide comprehensive costing, including component-wise breakups of staff costs, indirect costs, and so on. A suggested template for costing can be added in the RFP.
- Request agencies to comply with local state laws around minimum wages.

What to do when irrationally low bids are received

The following steps are recommended when irrationally low financial quotes are received:

- **Assess financial viability:** At the time of evaluation, financial viability of the bidder's proposal should be assessed critically by the evaluation committee, which can come to the conclusion that the proposal is not financially viable, for example, if the budget set aside for services is significantly lower than the budget estimates emerging from the market scan conducted by the state. If the committee comes to such a conclusion, the following steps are recommended by GFR 2017:
  - **Invite the bidder for review:** The L-1 bidder is called to explain why the prices are misaligned with the market scan. For example, if the bidder's explanation for the low quotes is that they are planning to leverage other resources, the evaluation committee can ask for a detailed written undertaking on the plan to leverage other resources (including documentary evidence of the quantum and duration of availability of any alternative funding source). If the evaluation committee is satisfied with the explanation, the contract award can proceed.
  - **Seek approval to reject the bid:** If the evaluation committee is not satisfied with the bidder's explanation, they should submit a letter to the approving authority that at these prices, the expected service outcomes cannot be achieved, seeking approval to reject the L-1 bid and proceed with the L-2 bid. If approval is received from competent authority, the L-1 bidder is informed of the decision, and the state can select the L-2 bidder.
  - **Re-tender:** If the competent authority does not approve of the decision to reject the L-1 bid, the entire bid will need to be cancelled and the state will need to go for rebidding. The entire RFP process needs to be repeated from scratch, which is a massive loss of time and resources.

4.4. Post-award contract management

Once the contract agreement has been signed, the state/district team needs to carry out a series of key tasks to manage the private partnership:

- Monitoring and supportive supervision of the engaged private entity—implementation of robustly designed monitoring frameworks, regular meetings, and assessments.

- Timely and transparent verification of deliverables and prompt processing of invoices.

- Activities around capacity assessments and enhancements—not only for the engaged agency but also for the public sector staff responsible for managing the contracts.

The chapters ahead provide further clarity on these areas.

SUMMARY: MUST-KNOWS ON PROCUREMENT PROCESSES

- Procurement is a highly specialized area; state and district TB staff may not have the capacity to lead this work on their own. It is therefore essential that procurement experts at NHM, NTSU, STSU, and consultant networks be brought in as partners for this work.
- GFR 2017 and state procurement rules should be followed.
- Procurement of all private sector engagements should be based on the principles of transparency, economy, equal opportunity, competitive bidding, confidentiality, and accountability.
- All procurement-related documents (ToR, RFPs, and contracts) should be detailed and should include inputs from domain experts.
- At the same time, it is recommended that every attempt be made to make the documents easy to understand.
- RFP should be compliant with all applicable program requirements and local regulations.
- QCBS method of selection should be preferred wherever possible because it provides scope for greater weightage to technical criteria and thus allows selection of technically stronger vendors.
- Procurement of service for partnerships is a complex, resource-intensive 10-step process, but it should be carried out in a time-bound manner: 3–4 months or 100–120 days can be considered ideal.

Suggested reference reading

- The following section in the Guidance Document provides a useful introduction and overview into the processes around procurement and finance: Chapter 4 - 'Implementing a Partnership Option' (pages 55–68).
- The CTD team has created a document called 'Standard Document for Selection of PPSAs' that can be accessed at the CTD website. This is an extremely valuable resource that provides guidance on the correct language and formats for all documentation related to service procurement.
- Two documents published by the Department of Expenditure (Ministry of Finance) are useful sources for more detailed information on the topics in this chapter:
  - GFR 2017
  - Manual for procurement of consultancy and other services 2020–22.

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CHAPTER 5
MONITORING AND SUPERVISION

5.1. The value of monitoring

Engaging private partners to augment TB services is one of the core strategies toward bridging programmatic gaps, and it represents the allocation of significant amount of funding. Therefore, monitoring the engagements is important for two reasons:

(a) To ensure that people with TB receive high-quality care

(b) To ensure that services are being delivered in an efficient manner to prevent unnecessary losses to the exchequer.

The essence of partnership projects is the timely delivery of patient-centric services. In practical terms, patient-centric care can include aspects such as the following:

- Samples collected on day 1 of facility visit

- Up-front NAAT to all presumptive TB cases

- Fast-tracked testing and reporting of test results

- Timely notification, treatment initiation, and up-front delivery of programmatic FDCs

- Free and timely comorbidity testing and second-line testing

- Timely and frequent counseling for adherence for people with TB

- Minimal out-of-pocket expenditure by patients for accessing NTEP services

- Minimal facility visits by patients

- Timely and complete DBT payments (NPY and provider incentives).

5.2. Principles underlying monitoring

- **Shared ownership:** In a nonideal scenario, there is a tendency to see private sector engagements in the light of 'outsourcing' rather than as 'partnerships'. It should be understood that successful partnership outcomes, in addition to efforts from the service provider, need oversight and monitoring from the NTEP leadership, that is, the STOs and DTOs, with support from the TSNs.

- **Supportive supervision:** The focus of the process should be on analysis of how to streamline service delivery, and it should consist of a deep stock-taking of the functionality of services being

provided, measurement (quantitative and qualitative) of the performance along agreed-upon service delivery elements, identification of contingent factors, and development of responsive solutions. Rather than fault-finding, the objective should be to improve service delivery, and therefore, the process of monitoring should not lead to requiring the engaged partner to submit additional reports. Rather than generating more data, the focus should be on improving quality and generating insights.

- **Structured, concurrent process:** Instead of a situation where the DTO conducts a performance review six months into the implementation of a PSE and uncovers issues in the service delivery quality, a robust monitoring process needs to be developed and implemented as early as the first month of operations, so that issues can be identified and addressed as soon as possible.

- **Multiple points of communication:** Monitoring can be done through a mixture of modalities— from check-in meetings and document examination to random field visits. Procuring entities should build their monitoring plans creatively and based on project needs.

5.3. Monitoring vs verification

At this point, it may be useful to understand the difference between verification and monitoring. The two processes are different in terms of purpose and content. As can be seen in Table 13, monitoring should always be concurrent with the project processes, and it should precede (and be more frequent in comparison to) the verification and payment cycle. This is because successful achievement of deliverables or outputs is dependent on many factors, some contingent on the state and some on the service delivery partners. Monitoring can help identify these contingencies early on and create opportunities for collaborative problem solving. If there are deliverables that are unlikely to be met due to any liabilities or challenges, early identification can lead to early solutions or better streamlining of patient care processes in the field. Thus, a structured monitoring plan can contribute to programmatic success in all respects and especially contribute to timely deliverable verification and payments.

TABLE 13: Difference between monitoring and verification

Monitoring and supervision	Verification
Definition	
Monitoring can be defined as a process of systematically examining the quality of operations/activities being carried out by the partner.	Verification can be defined as the process of confirming that the outputs reported by the partner agency are correct and can be used for processing the invoice payments.
Timing	
Monitoring should be done concurrently or in real time, that is, states/districts should have fortnightly or monthly monitoring cycles.	Verification is done in line with the payment cycle, or post facto, that is, whenever the partner agency submits the invoice, which can be at the end of a month or at the end of a quarter (depending on the contract-determined timelines).

Monitoring and supervision	Verification
Purpose	
The purpose of monitoring is to: • Identify challenges early and suggest timely course corrections, • Improve the quality of services, and • Ensure that the work is patient -centric and in line with the state's vision and goals.	The purpose of verification is for the state to be able to pay the partner agency according to the outputs in the contract. According to financial norms, verification of deliverables is a prerequisite for payment.
Metrics	
In this process, all the KPIs that affect the quality of services available to patients are examined. These include, but are not limited to, payment-linked metrics.	In this process, a smaller subset of metrics, called payment metrics, are verified.
Process	
• The program team reviews metrics on *Ni-kshay* or on other data dashboards where the partner agency is sharing data on service delivery and also carries out periodic field visits and monitoring meetings. • Observations made during monitoring should be communicated in real time to the partner agency and should lead to concerted efforts to improve the program.	• The partner agency submits the invoices along with deliverables. The program team examines the invoices and verifies the deliverables.
Impact	
• A robust monitoring plan can lead to a high achievement of program targets and can have a positive impact on the deliverables examined during the verification cycle.	• Based on the results of the verification, the program team can calculate payments and penalties.

5.4. Factors involved in monitoring and supervision

There are four key factors that should be clearly defined, included in the contracts, and discussed in detail with the service delivery partner at the beginning of the implementation:

- Metrics - what are the indicators that will be monitored?

- Frameworks and documents - how will the agreed-upon metrics be monitored?

- Systems - how will the process of monitoring be structured?

- Frequency - how often will the monitoring interactions be carried out?

A. Metrics

To build robust monitoring frameworks, program managers need to build a set of KPIs or metrics that need to be tracked to ensure optimum performance. Monitoring should cover both types of metrics (Table 14):

Payment-linked metrics: These can also be called 'deliverables or 'outputs' in the contract. These indicators are used for building verification protocols, that is, they are submitted as part of the invoice

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submission process and are verified by NTEP. Payments to the service provider are made on the basis of these indicators.

Nonpayment-linked metrics: These are indicators that may get deprioritized (because they are not linked to any payments) but are very important for ensuring the quality of service delivery and can be important considerations for contract renewals. Nonpayment-linked metrics can be of multiple kinds depending on the type of project, covering programmatic aspects, management aspects, quality of service, or data quality.

TABLE 14: Payment-linked indicators and nonpayment-linked indicators

		Examples
Payment-linked	Output Indicators	- No. of people with TB notified in *Ni-kshay* % of diagnosed people with TB who received NAAT testing - Number of notified TB patients with validated bank accounts % of people with TB who underwent HIV and DM testing % of people with TB who successfully completed their treatment
Non-payment-linked	Programmatic indicators	% change in number of providers registered on *Ni-kshay* % increase in the engaged private sector providers (mapped and notifying to *Ni-kshay*) % change in number of active providers % change in number of providers with FDC available at their clinic % private notified patients initiated on programmatic FDCs % patients who received the comorbidity testing within the agreed TAT
	Management-related indicators	- Number of continuous medical education (CME) trainings done with the private providers % of HR positions vacant for more than a month - Program management unit has set their office up at an accessible location - All the patient's records are being maintained according to the program guidelines
	Quality-of-service indicators	- Quality of sample collection - Management and disposal of biomedical waste according to regulations - NAAT test carried out within 7 days of diagnosis - Second-line DST carried out within timelines prescribed by the PMDT guidelines - Frequency and quality of adherence counseling - Basis of diagnosis (microbiological vs clinical)
	Data quality indicators	- Consistencies and logic in dates (dates of enrollment, diagnosis, treatment initiation, NAAT, DBT, and treatment outcomes should follow each other and should have a logical distance) - Consistency between age of person with TB with treatment protocols (pediatric vs adult) - Consistency between results of diagnosis and DST result with treatment protocol (DSTB vs DRTB) - No inappropriate/outlier values

Points to note about KPIs

- **Nonpayment-linked metrics are valuable:** They are essential to ensure quality of care and hence need to be defined and regularly monitored.

- **KPIs should be simple and easily measurable:** It is suggested that between five and seven indicators should be linked to payments, and an additional five to seven indicators can be selected as nonpayment-linked indicators.

- **Determine service delivery benchmarks:** A subset of the nonpayment-linked indicators can be earmarked as service delivery benchmarks and receive additional attention (described previously in Box 7).

- **Determine indicators early:** It is important to reiterate that all KPIs should be determined early in the RFP process and published along with the RFP.

- **Utilize past experiences:** While determining KPIs, the RFP team can examine previous contracts of existing/past PSEs and reduce the emphasis on indicators that have not been easily achieved in the past and increase the emphasis on indicators and technical areas that require greater effort to achieve improvements in the future.

- **Contingencies:** Generally speaking, payment-linked indicators should be the ones that have minimal dependencies on patient-related factors and programmatic factors. For example, getting NAAT done may be a payment-linked indicator, whereas TAT for NAAT, which is contingent on various factors like programmatic systems and patient factors (availability and consent), should be a nonpayment-linked indicator. TAT would be, in fact, an ideal nonpayment-linked service delivery benchmark.

B. Monitoring frameworks

For each indicator, there needs to be clarity in terms of frequency, responsibility, and reporting formats. Tables 15–18 provide examples of monitoring frameworks for four types of partnerships. States may consider building such a framework during the RFP process and including it in the RFP and contract.

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TABLE 15: Monitoring framework - PPSA (example framework)

Indicator	Numerator	Denominator	Frequency — How often will it be measured?			Data source — How will it be measured?
			State level	District level	Sub-district level	
PPSA: Suggested payment-linked indicators						
No. of people with TB notified in *Ni-kshay*	—	—	Monthly	Weekly	Weekly	*Ni-kshay*/field visit
% of diagnosed people with TB who received NAAT testing	Number of private sector who patients received NAAT testing	Total number of private sector patients notified	Monthly	Weekly	Weekly	*Ni-kshay*/field visit
% of private sector patient initiated on FDC	Number of private sector patients initiated on FDC	Total number of private sector patients notified	Monthly	Weekly	Weekly	*Ni-kshay*/field visit
PPSA: Suggested nonpayment-linked indicators						
% increase in the engaged private sector providers	Number of private providers engaged in current year	Private providers engaged in last year	Quarterly	Monthly	Monthly	*Ni-kshay*/field visit
% increase in number of active providers	Private providers who notified at least 1 notification in current year – Private providers who notified at least 1 notification in last year	Private providers who notified at least 1 notification last year	Quarterly	Monthly	Monthly	*Ni-kshay*/field visit
% of providers with FDC available at their clinic	Number of providers that have FDC available at their clinic	Total private provider engaged in current year	Quarterly	Monthly	Fortnightly	PPSA reporting/field visit
% of HR positions vacant for more than a month	Total number of positions that are vacant for more than a month	Total number of vacant positions	Quarterly	Monthly	n.a.	PPSA reporting/field visit
PPSA office is at an accessible location and is operational	Yes/no	—	Quarterly	Quarterly	n.a.	PPSA reporting/field visit
Patient records maintained according to contract terms/NTEP guidelines	Yes/no	—	Monthly	Weekly	Weekly	PPSA reporting
Training of PPSA staff	Yes/no	—	Quarterly	Quarterly	Quarterly	PPSA reporting
CME conducted with private doctors	Yes/no	—	Quarterly	Quarterly	N/A	PPSA reporting

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TABLE 16: Monitoring framework - NAAT services (example framework)

Indicator	Numerator	Denominator	Frequency How often will it be measured?	Data source How will it be measured?
NAAT services: Suggested payment-linked indicator				
Number of people tested via NAAT	—		Monthly	*NI-Kshay* data
NAAT services: Suggested nonpayment-linked indicator				
Average TAT for the patients to get the NAAT report	Sum of the TAT of all the patients	Total number of patients	Monthly	PPSA reporting
% of patients who received report with valid result	Total number of patients who received confirmed report	Total number of patients tested	Monthly	PPSA reporting

TABLE 17: Monitoring framework - X-ray services (example framework)

Indicator	Numerator	Denominator	Frequency How often will it be measured?		Data source How will it be measured?
			State level	District level	
X-ray: Suggested payment-linked indicators					
% of patients who availed X-ray services	No. of patients who availed X-ray service (as per eligibility criteria)	Total number of patients registered for x-ray services at the facility	Monthly	Weekly	Facility registers, prescription/ vouchers from referring provider
% of patients who received their X-ray report	Total number of patients who received X-ray report	Total number of patients who availed X-ray services	Quarterly	Weekly	Facility registers/ records
X-ray: Suggested nonpayment-linked indicators					
Average waiting time for patients to get X-ray services	Sum of the waiting time of all the patients	Total number of patients who availed X-ray services	Quarterly	Monthly	Facility registers
X-ray providers have Atomic Energy Regulatory board (AERB) Registration, and have adequate space and arrangements, in line with bio-safety norms	Yes/no	—	Quarterly	Monthly	Field visit

TABLE 18: Monitoring framework - sample collection and transport services (example framework)

Indicator	Numerator	Denominator	Frequency How often will it be measured?	Data source How will it be measured?
Sample collection and transport: suggested payment-linked indicator				
Number of samples collected and transported in defined period (disaggregated by collection center/facility)	Number of samples collected and transported in defined period	n.a.	Monthly	Facility records
Sample collection and transport: suggested nonpayment-linked indicators				
Average time (in days) between sample collection and pickup by courier/transporter (disaggregated by collection center/facility)	Average pickup time (in days)	No. of samples	Monthly	
Average TAT of sample collected and transported	Sum of TAT of all samples collected and transported	Total number of samples collected and transported	Monthly	PPSA reporting
Average TAT for the sputum samples to reach the testing center since collection (disaggregated by collection center and facility)	Sum of the TAT of all the patient samples collected at centers	Total number of samples collected at centers	Monthly	PPSA reporting
Number of days with no falcon tubes available for sputum collection and transport in a month	Total number of days in a month where no falcon tubes were available for sputum collection and transport	—	Monthly	PPSA reporting
% of samples spilled during transportation	Total number of sample containers discarded	Total number of sample containers collected	Weekly	Lab reporting

C. Document index

0The program team should provide a 'document index'—that is, a comprehensive, well-defined list of documents that the service provider is required to maintain as part of the monitoring process (see Table 19 for example). As much as possible, the same document index (or part of it) may be used for the verification process to ensure ease of operations for the service delivery partner.

Standardized formats

- Wherever possible, the program team should prescribe standardized formats for the documents that need to be maintained.

- Documents maintained in electronic formats should be accepted by the program teams.

TABLE 19: Example of document indices for verification

Partnership option	Document index	Frequency	Responsibility
PPSA	▪ Summary line-list with details of person with TB and checklist for all the supporting documents ▪ Doctor's prescription/diagnosis ▪ X-ray report and/or laboratory investigation reports ▪ NTEP treatment card ▪ Annexure 14B (FDC stocks record at district level) ▪ CBNAAT/TruNat report ▪ Bank passbook copy ▪ Aadhar card (optional)		
Public health action	▪ Summary page: details of person with TB and checklist for all the supporting documents ▪ Bank passbook copy ▪ Aadhar card (optional) ▪ NTEP treatment card or adherence card (format accepted by NTEP) ▪ TB Prevention Therapy (TPT) information booklet		

D. Systems for monitoring and supervision

The following points are recommended for a systematic monitoring review process:

- **Develop a 'performance review meetings timetable':** In addition to the concurrent monitoring described earlier, states/districts should set up review meetings with the objectives of collaborative problem solving and best practice sharing. A performance review timetable can be developed and shared with the partner agency at the time of contract signing. Table 20 provides an example timetable, which can be used to make a customized performance monitoring table based on the project needs.

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TABLE 20: Sample timetable for monitoring meetings

Meeting title	Frequency	Purpose and focus	Attendees
Joint review meeting	Monthly/ fortnightly	Review payment-linked and nonpayment-linked metrics, provide feedback, identify challenges, and respond to issues raised by agency and grievance redressal	Partner agency, NTEP, and STSU
Consolidated committee review	Once every quarter	Feedback from partners on challenges, payment-related issues, requests on changes in SoW, and sharing of lessons and best practices	Partner agency, NTEP, NTSU, STSU, SHRC, and medical college advisors
Field visits	Monthly/as required	Examination of service delivery quality through indicators defined above	Partner agency, NTEP, and STSU

- **Include random monitoring visits:** The DTO or STO can also make a few random monitoring visits to the areas of implementation. As a best practice, NTEP field and supervisory staff are encouraged to regularly interact with TB patients from both public and private sectors to take feedback on quality of services to further streamline patient care.

- **Make the process collaborative:** Rather than being directive, monitoring interactions should be seen as opportunities to provide 'supportive supervision' and as platforms for knowledge sharing and cross-learning. As and when issues are identified, they should lead to co-creation of solutions with a patient-centric lens and with the goal of improving service delivery to the people seeking care.

- **Incorporate capacity building:** Lessons from the monitoring interactions should feed into capacity-building plans to improve performance (see Chapter 8).

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EXAMPLES FROM THE FIELD

Example 1: Monitoring NAAT in the section turnaround at a PPSA

A PPSA had been contracted for a bundle of five services in one district—notification, NAAT, comorbidity testing, bank account seeding, and treatment outcome reporting. When the DTO carried out a review at the end of the third month of operations, it was found that the TAT for NAAT was 11 days on average. This was measured by calculating the difference between the date of sample collection for NAAT and the date of reporting of test results. The DTO requested the service provider to work with the STSU and consultant network to identify the causes for the high TAT and learned that the bottleneck was at an overburdened NAAT facility where samples were kept for an average of 7 days before being tested. The team developed a more efficient batching mechanism by redirecting samples from an overutilized NAAT facility to a second underutilized facility and was able to reduce the TAT from 11 days to 4 days by the fifth month of operations.

Example 2: monitoring laboratory utilization at a district cluster

In a large district, a service provider engaged to provide specimen transport was unable to meet sample collection targets in the first month of operations. A joint monitoring meeting between the DTO, the service provider lead, and members of the STSU examined possible causes of the sample collection delays. They were able to identify two specific PHIs, which were located in high-incidence neighborhoods, where sample collection was lower than expected. This was because of the laboratory hours—the sample collection window was from 10 am to 12 noon, which was inconvenient for most patients. The monitoring team ideated together and decided to increase the laboratory timings to include an evening window and to add additional staff for receiving samples beyond working hours. This allowed the service provider to meet the specimen transport targets before the first set of deliverables and invoices was submitted for verification.

Suggested reference reading

The following section in the Guidance Document provides a useful introduction and overview into monitoring frameworks relevant for partnerships:

- Chapter 5 – 'Monitoring and Evaluation' (pages 71–72).

> 66
> *Monitoring: To observe and check the progress or quality of (something) over a period of time; keep under systematic review (Oxford dictionary)*
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CHAPTER 6
DELIVERABLE VERIFICATION AND PAYMENTS

Verification of deliverables may be considered the most important programmatic responsibility in the post contracting phase of partnership implementation because without verification, partner agencies cannot be paid on time, and without timely payments, agencies cannot sustain their operations. Unsurprisingly, this area of work has been the greatest source of questions and challenges for both sets of contracting partners (NTEP and agencies). As a result, it has yielded a large repository of lessons, which are summarized in this chapter. It may be noted that the terms verification and validation are often used interchangeably or together (as verification and validation). For this document, the term verification will be used for the first level of verification, that is, the *Ni-kshay*-based verification, and the term validation will be used for the second level, that is, the physical cross-checking of information.

Engaging partners in output-based contracts can only work if there is timely verification of deliverables and release of funds, or else it will not be sustainable for any partner. Multiple instances of delays in payment will, inevitably, discourage service providers from engaging in performance-based contracting.

6.1. Overview – process of deliverable verification and payments

Below is a step-by-step summary of how the deliverable verification and payment process should be carried out.

A. Step 1: Generation of reports based on *Ni-kshay*

- The agency generates and submits reports on services completed during the previous month/quarter (according to the frequency defined in the contract).

- The formats for the reports should be according to the type of partnership option and should provide information on the services delivered by the agency, for example, number of samples collected and transported, number of CBNAATs done, line-list of people identified with TB, and so on. The formats for the reports should be included in the contract.

- The reports must be accompanied with supporting documents as prescribed in the contract—these can include organization-specific reports and *Ni-kshay*-generated reports.

- The reports must be generated on a designated day of the month (mentioned in the contract), to avoid discrepancy in the patient cohorts during verification process.

B. Step 2: Raising of invoices

- The partner agency raises invoices (in the format prescribed under the contract) on completion of services of the previous month/quarter.

- The invoices must be submitted on a designated day of the month. The template of the invoice should be provided in the contract (see Annexure 10.7 for a sample)

- The agency submits the invoices to designated state/district NHM department personnel (defined clearly in the contract).

- The invoices must be accompanied with supporting documents according to a predetermined 'document index' (see Table 19 for a sample document index).

Steps 1 and 2 can be carried out simultaneously.

C. Step 3: Verification

- **First level of verification:** The invoices and supporting documents are received and examined by the NTEP team. The first level of verification is 100 percent, that is, 100 percent of the metrics submitted for payment are cross-checked against data in *Ni-kshay* or any other NTEP database. Payments are processed on this level of verification, so it should be completed within 10 days of invoice submission.

- **Validation:** Physical or field verification of data needs to be done on a much smaller proportion of the data—5 percent is recommended. To do the physical validation, a combination of various modalities can be used, for example:

  - Interview (in-person or telephonic) of randomly selected TB patients whose invoices have been submitted by the agency/partner as achieved deliverables to cross-check deliverables like NAAT and bank seeding for DB;

  - Validation of randomly selected patient reports/supporting documents for the given deliverables, for example, for validating a deliverable on NAAT, the NAAT report copy can be checked from the private lab or primary lab record from *Ni-kshay* in case the test was done at an NTEP lab. For verifying DBT seeding verification, bank passbook or check copy can be cross-checked;

  - Interactions with randomly selected health care providers to cross-check availability of FDCs and *Ni-kshay* login details.

- **Discrepancies:** If any discrepancies are found (in *Ni-kshay*-based verification or in physical validation), the following steps can be followed:

  - A communication is sent to the agency within 3 working days of the discrepancy being found, and the agency gets 7 days to provide an explanation.

  - If no explanation is made, or the explanation is not acceptable, penalties are calculated and deducted from payment due at the end of the year (see section 6.3.4).

  - Additionally, the designated NTEP staff increases the quantum of verification from 5 percent to 10 percent or 20 percent of the deliverables (also selected randomly) to identify further discrepancies.

- If there are continued discrepancies, the state may further expand the quantum of verification or may also consider getting an independent audit from a third-party organization.

- States may also consider building a consensus on 'the tolerance rate for discrepancy in verification' (for example, discrepancies of less than 0.5 percent magnitude may be data entry errors) and include this in the RFP and contract.

- **Reporting:** A report of the verification is shared with the competent authority who gives approval for the payment to be released.

The above steps are indicative, and states should use them as guiding principles to build their own 'verification and payment protocol' with detailed instructions and clear assignment of responsibilities (see Box 13 for a sample). It must be noted that in the example in Box 13, the verification and payments are being made at the district level, and the district is following a monthly verification cycle.

BOX 13: Sample verification and payment protocol

(a) Generation of *Ni-kshay* report and invoice submission

- Between the 1st and 5th of every month, the agency will submit the previous month's invoices along with supporting documents mentioned in the 'Document Index' according to instructions in the contract (see Table 19 and Annexure 10.7 document index and invoice format, respectively).
- The documents will be submitted to the district senior treatment supervisor (STS).

(b) Verification

- The STS will verify the invoices and forward the verification report to DTO by the 10th of the month.
- If any discrepancy is found, the STS will inform the agency within 3 working days and ask for clarification.

(c) Payments

- DTO will review and approve the validation report and submit to the finance team at NHM for release of funds by the 15th.
- The Finance Department will release funds before the 30th; if verification is getting delayed, ad hoc payment, that is, 75 percent of the eligible payments may be released according to the notification issued by Department of Expenditure (DEA).

(d) Field validation

- Data from the previous 3 months will be collated and 5 percent of the patients will be contacted and interviewed.
- Based on the results of the physical validation, one or more of the following steps will be taken:
  - Any remaining payments that have been kept in balance are paid.
  - Any discrepancies that have been found are shared with the agency.

D. Step 4: Payments

- Payment to be made is calculated on the basis of a predetermined 'performance-linked payment plan' (see Table 21 for an example). *Additional examples of performance-linked payment plans can be seen in Annexure 10.8.*

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- An ad hoc payment of 75 percent is to be made within 10 days of submission of invoices, and the remaining 25 percent is to be made within 28 working days of submission of invoice.[12]

- The remaining 25 percent payment can be held back until the verification process is completed, until discrepancies have been satisfactorily addressed. It can also be used to make adjustments for calculations of penalties, if any.

- In case the payment has not been released as prescribed, it should be done as soon as possible, and after payment, a written explanation for the delay needs to be submitted to the next higher authority within three working days.

- All payments are subject to TDS according to Income Tax Rules/GST Act (if applicable) and other deductions according to applicable laws.

These decisions—to make verification process monthly versus quarterly and to make payments at a district versus at a state level—will need to be made by the state based on administrative feasibility. This type of detailed verification and payment protocol should be part of the RFP and the contract.

TABLE 21: Performance-linked payment mechanism (for a PPSA)

Services provided	KPIs (payment-linked indicators)	Payment proportion (%)	Target[13]
Notification of diagnosed patients	No. of people with TB notified in *Ni-kshay*	25	At least 80% of TB notification target set in the contract
Drug sensitivity testing	% of diagnosed people with TB who received NAAT testing	15	At least 70% of notified people with TB undergo NAAT testing
Linkages to NPY	Number of validated bank accounts	20	At least 80% validated account details for notified people with TB
Counseling and HIV and DM testing of notified patients	% of people with TB who underwent HIV and DM testing	15	At least 80% of notified people with TB undergo HIV and DM testing
Adherence counseling and outcome reporting	% of people with TB who successfully completed their treatment	25	At least 85% of the notified people with TB should have successful treatment outcomes

6.2. Payment delays

If the contract payments are made late, months into the implementation, it might lead to a situation where the service provider has to cover operational costs on its own for a long time. This puts a large financial burden on the service provider and affects not only staff motivation but also program quality.

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12 Revised GFR 2017. Rule 172 (2). Clauses 12.1 and 12.3.

13 The service providers' performance against targets can be examined (and linked payments can be calculated) at monthly, quarterly, or annual intervals, based on administrative convenience. However, for the calculation of penalties and incentives, the performance against targets should only be examined at annual intervals. These time intervals should be decided upon at the RFP stage and mentioned clearly in the contract.

To prevent such delays, it may be useful to understand (and therefore avoid) the reasons that lead to payment delays (Table 22):

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TABLE 22: Understanding payment delays

Possible cause of payment delay	Responsibility
Delays in invoice submission: If invoices are submitted late, the staff in charge of verification will have challenges in verifying the outputs (for example, the people with TB may have migrated and may not be traceable).	Service provider
Incomplete documentation: If supporting documents submitted with invoices are incomplete and/or have errors or internal contradictions, it may lead to back and forth between the service provider and procuring entity, taking up time.	Service provider
Backlogs: When agencies submit long lists of deliverables for verification, including deliverables from previous reporting period that need to be reconciled, it can contribute to longer verification processes.	Service provider
Multiple tiers of review: The payment mechanisms are based on too many levels of verification (from STS to DTO to STO).	Procuring entity
Poorly defined contract terms and ambiguous verification and payment mechanisms: If contract terms are not well defined and the payment mechanisms described in the contract are not objective and easily verifiable, it can lead to unnecessary back and forth.	Procuring entity
High quantum of verification: Some procuring entities continue to carry out as much as 100% of the physical verification	Procuring entity
Complex penalty clauses: The payment terms include complex calculations for penalties and pro rata deductions, which need the verifying team to invest time in cross-checking and calculations.	Procuring entity
Paper-based invoices: Following up and cross-checking paper-based invoices and supporting documents is time-consuming.	Procuring entity
Communication issues: The team in charge of verifications may take too long in sharing information on discrepancy or the service provider might take too long to provide explanations.	Both service provider and procuring entity

6.3. Key points to note in verification of deliverables

As mentioned earlier, it is very important that timelines for verification and payments are adhered to as this affects the service delivery to the patients. Having considered the causes that can contribute to payment delays (Table 22), it is evident that there are a few necessary decisions that can be taken upfront to prevent payment delays. These must be deliberated upon during the RFP stage and included in the contract. These are described below.

A. Levels of verification and responsibilities

- **Clarity on tiers of review:** It is up to the states to select centralized or decentralized verification mechanisms (see Table 23 for a comparison). This is a strategic choice and needs to be made

according to the local needs. Whichever approach is selected, there should be an attempt to avoid duplication of efforts. Instead of multiple rounds of verification, mechanisms can be structured such that one level does the actual verification of deliverables and the higher levels only carry out cross-checking of a smaller, randomly selected subset.

TABLE 23: Centralized versus decentralized verification structures

	Description	Advantages	Disadvantages
Centralized invoice submission and decentralized verification	The service provider collates invoices and submits them at the state level. The first level of verification (*Ni-kshay* verification) takes place at the state level. The state requests the district to carry out physical verification of randomly selected (5%) deliverables.	▪ Since most contracts are signed at the state level, it is effective that the state has overall control of the verification process. ▪ This is a transparent process because the deliverables for physical verification are randomly selected by the state and communicated to the district.	▪ It can be administratively challenging to collate the large volume of invoices (however, to mitigate this challenge, STSUs have been provided in 14 states).
Decentralized invoice submission and verification	Invoices collated and submitted at the level of respective districts, with both levels of verification carried out at the level of the district.	▪ Any discrepancy found in the invoice can be corrected and reconciled sooner. ▪ There is more ownership of the district on the entire process of verification. ▪ Field verification can be easier.	▪ Invoices for different districts will get submitted and verified at different points—the state has limited view into the process, limiting control and transparency. ▪ Since both types of verification are taking place at the district, it can be time-consuming. ▪ Any clauses open to subjective interpretation will get interpreted in different ways in different districts. ▪ STSUs can only a play limited role in streamlining the verification process. ▪ In large states, when a partner is engaged in larger districts, it can be very time-consuming to track and follow up.

Payment levels can also be centralized or decentralized, and the decision can be made by state authorities based on local considerations of efficiency and timelines.

▪ **Clarity on responsibilities:** At the district level, verification can be done by the district TB team which includes DTO, District PPM Coordinator, and all the key staff at the DTC including the STS and Senior TB laboratory Supervisor (STLS). At the state level, the responsibilities need to be borne by STO and their staff. The contract should include a clear delineation of responsibilities for each of these personnel with regard to verification and validation.

B. Clarity on frequency and metrics

- Verification can be done on a monthly or a quarterly basis as determined by the state or district TB leadership. The frequency of verification should be decided at the time of contract signing and be strictly adhered to by all parties.

- When the contracts (and RFPs) are drafted, they should have clear instructions around KPIs, payment metrics, and supporting documents.

C. Quantum of verification

Some states carry out physical verification of 100 percent of the data submitted. This increases the workload and slows down payments and should be discouraged. In a situation in which public sector HR are already constrained, adding a large amount of verification-related work might defeat the entire purpose of a partnership. Some ways to address this are suggested:

- **Use a staged approach:** States can take a decision to carry out physical verification of 25 percent deliverables for the first 6 months of implementation. If no discrepancies are found, they can reduce the physical verification to 5 percent of deliverables.

- **Use tech-solutions for second level of verification:** Digital solutions like call centers, interactive voice response system (IVRS), or SMS follow-up can be used. Such digital media can also be built into the contractual requirements.

D. Clarity on penalties

The decision to impose penalties is fraught with complexity—on the one hand, penalties can help increase the focus on service delivery quality, but on the other hand, they can be an administrative challenge for the procuring entity and a source of challenging financial losses for the agency. Below are two scenarios where penalties can be used (Table 24):

- If the agency has not been able to meet its annual targets

- If discrepancies are found during the physical verification.

Key points to note in the calculation of penalties

- Penalties should be aggregated and imposed annually; imposing them at each payment cycle (monthly or quarterly) is not helpful—first, it can become a time-consuming activity, and second, it may not give enough time for the agency to provide an adequate explanation.

- When the contracts (and RFPs) are drafted, they should have simple, user-friendly, and detailed directives on penalty calculations. Penalty clauses should be based on easily measurable KPIs (see Table 24 for example).

- As mentioned under the discussion on performance benchmarks (Box 7), nonachievement of targets or performance benchmarks can be caused by programmatic gaps (for example, delays in NAAT caused by programmatic challenges like cartridge shortages) or patient factors (unwillingness to get tested). Such instances should not lead to penalties to the service provider. Therefore, in the spirit of fair partnership with the service provider, penalties should only be calculated if there is objectively clear information about nonperformance on the part of the service provider.

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- The decisions for calculation of penalties should be taken at an early stage and should be described in clear and unambiguous terms in the RFP as well as in the contract signed with the private sector partner. The language used in the documents, especially pertaining to assessment of performance, calculations of payments should be very specific and free from subjective interpretations. The spirit of these documents should be clear and transparent, with no hidden clauses for penalty. There should be clear articulation of pro-rata reduction in unit cost, if planned, as well as of any other penalty clauses which the State would like to incorporate in the partnership, preferably with hypothetical examples elaborating how the payments and penalties would be calculated.

- Clarity in RFPs and contracts is also crucial because, very often, contracts are signed at the state level and execution & verification and sometimes even payments is at district level. The RFPs and contract should therefore be articulated in such manner that all levels of stakeholders on same page can arrive at common understanding.

- In spite of the efforts to provide clarity in the RFP and contract, issues around subjective or variable interpretation of contract terms can emerge during the implementation of a partnership. In such cases, the issues should be addressed with mutual consensus and subsequently incorporated in the contract by means of an addendum or amendment. This is necessary not only from a legal perspective but also from the perspective of building institutional memory at both parties in the contract because private sector contracts often extend over several years, during which there can be multiple changes of personnel dealing with different aspects of the contract.

TABLE 24: Calculating penalties - an example

Service/partnership option: Notification of diagnosed patients

KPI: No. of people with TB notified in *Ni-kshay*

Target for the quarter: 800 people with TB to be notified over one year

Payment linked to this indicator: INR 200 per notification

Decision on penalties (hypothetical example):
- INR 100 to be deducted per unit on targets not achieved
- INR 400 to be deducted per unit KPI for false reporting.

(Please note these are all arbitrary penalties for demonstrating the example)

Scenario	Calculation of payment and penalty
Scenario 1: Targets not achieved: The agency was able to notify 600 people with TB to *Ni-kshay*.	Payment: 200 × 600 = INR 1,20,000 Penalty: 100 × 200 = INR 20,000 Net payment = INR 100,000
Scenario 2: False reporting: The agency submitted an invoice and report confirming that 600 people with TB were notified. Upon verification, it was found that only **550** people were notified.	Payment: 200 × 550 = INR 1,10,000 Penalty for nonachievement: 100 × 250 = INR 25,000 Penalty for false reporting: 400 × 50 = INR 20,000 Net payment = INR 65,000

Note: It is very important to confirm that the false reporting is indeed false and not a data entry error.

E. Use of technology for invoice verification and payments

What are the tools that can be used?

- It is strongly recommended that verification and validation processes be migrated away from paper-based to information technology (IT)-based systems.

- Although a few states are already using their own tech-based processes (Excel files and Google Sheets are the tools that are most commonly used by most states and serve the purpose well), a new tool is under development at CTD and is likely to be rolled out soon for national uptake.

- Automated verification and payment processes are valuable for three reasons:

  - First, they have a positive impact on verification timelines and release of payments, ensuring transactions are completed quickly and efficiently. Such tools can reduce the time taken in the first level of verification (against *Ni-Kshay* data) from current average of 20 days to as low as 1 day.

  - Secondly, technology-based systems can lead to transparent systems that function seamlessly, are not person dependent, and help expand mutual trust between partners. Automated tools can remove all possibility of subjectivity in physical verification (validation) by randomly selecting the 5 percent quantum of deliverables that need to be validated.

  - Third, in developing technology tools, attempts should be made to automate even the validation (for example, automated IVRS calls to validate patient information).

6.4. Additional information

- **Management costs:** All costs related to verification and validation are to be borne by the procuring entity.

- **Managing service delivery challenges related to factors beyond the agency's control:** There can be situations in which there are service losses and missed targets that are contingent on issues at the state level (for example, cartridge shortages leading to losses in NAAT indicators). It would not be appropriate to penalize the agency in such situations. Alternative methods for verification and payments have been tested by states and are suggested as follows:

  - Use other indicators as proxy indicators for payments (like specimen transportation).

  - Carry out pro rata reduction in targets given to the agency with mutual agreement.

  - Use the budget buffers to purchase the services or products that are causing delivery challenges (for example, the Xpert cartridges).

As mentioned in the section on comprehensive contracting, there should be clarity around which specific indicators have dependencies on NTEP processes and what the contingency management measures are.

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Suggested reference reading

The following section in the Guidance Document provides a useful introduction and overview into the processes around verifications and payments:

- Chapter 4 – 'Implementing a Partnership Option': Verification and validation (pages 69–70).

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ROLES AND RESPONSIBILITIES

7.1. Responsibilities of procuring entity

It is crucial to understand the role that the program team and their partners play in ensuring the success of a partnership. These entities include:

- STOs (and their staff),
- DTOs (and their staff),
- NHM team, and
- Technical partners such as the NTSU, STSUs, and the consultant network.

The responsibilities that need to be fulfilled by these institutions are listed in this chapter. Inevitably, the accountability for the completion of the activities listed lie with the STO. It is suggested that the STO develop a 'responsibility framework' as suggested in Table 25 at an early stage, ideally around the same time that the PIP process and needs assessment are being done. The third column of the table, 'assigned to person' (which can be representatives from any of the institutions listed above), should have names and designations of the people that the STO deems fit for taking on the accountability for the tasks listed in column 2, as well as timelines assigned for each task.

TABLE 25: **Responsibility framework - general (for procuring entity)**

Sl. No.	Task	Assigned to person | Deadline
	Responsibilities in the pre-contracting phase	
1	Complete needs assessments and sharing results database widely.	
2	Constitute the RFP committee, bid opening committee, and technical evaluation committee and assign tasks to them.	
3	Get approvals for the evaluation committees from the district/state administration (the approvals should include the committee members names and the tasks assigned to them).	
4	Supervise RFP development, approval, and publishing.	
5	Organize the pre-bid meeting.	
6	Conduct proposal evaluation and selection.	

Sl. No.	Task	Assigned to person | Deadline
	Orientation and training of agency at the beginning of contract	
1	Technical operations and expectations	
2	Process of procurement and supply management of project associated supplies (for example, reagents and consumables)	
3	Reporting on NTEP formats and other relevant formats	
4	*Ni-kshay* and data management	
5	Invoicing, verification, and payment process	
6	Review and monitoring process	
	Post contractual management - responsibilities related to verifications and payments	
1	Provide checklist for voucher submission.	
2	Complete validation/verification within 30 days of voucher submission.	
3	Provide details in case of penalty.	
4	Ensure timely payment to agency according to provisions in the contract.	
5	Introduce relevant stakeholders for better liaison (for example, with IMA and local NGOs).	
6	Provide *Ni-kshay* login credentials to agency with access according to services under agreement.	

In addition to the general responsibilities mentioned, STOs can also make partnership-specific responsibility frameworks. Table 26 provides a sample framework for six types of partnership options. These process frameworks can also be used to track progress during monitoring and supervision meetings. It must be noted that Tables 25 and 26 should be seen as highly customizable templates.

TABLE 26: Responsibility framework - specific to type of partnership (for procuring entity)

Sl. No.	Task	Assigned to person | Deadline
	Private provider engagement and notification	
1	Issue authority letter to agency for reaching out to private providers to facilitate NTEP services.	
2	Provide *Ni-kshay* login credentials (to agency and to providers) with access according to services under agreement.	
3	Share data of existing registered health facilities and their activities.	
4	Provide communication to private health care providers and professional associations on project arrangements.	
5	Ensure regular payment of eligible incentives (for providers as well as patients) according to NTEP guidelines.	

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Sl. No.	Task	Assigned to person | Deadline
	Sample management and diagnostic testing	
1	Ensure availability of free tests according to estimated patient load.	
2	Provide the agency with standard operating procedures (SOPs) and NTEP formats for sample collection and packaging as well as access to *Ni-kshay* user credentials.	
3	Train concerned staff on specimen collection, packaging, and transportation with requisite safety precautions according to NTEP guidelines.	
4	Identify and specify laboratory links.	
5	Provide a prototype and specification or sufficient supply of sputum sample containers and other related logistics.	
6	Provide results of the sample transported by agency according to TAT recommended under NTEP.	
	Treatment support	
1	Include private sector patients in forecasting of drugs.	
2	Ensure regular supply of drugs to agency for further distribution to patients.	
	Public health action - HIV and DM testing	
1	Support links with Integrated Counseling and Testing Centers (ICTCs) at facilities identified by agency for HIV testing.	
2	Support diabetes testing at appropriate public health facilities.	
3	Provide SOPs, training, and reference material to the agency.	

7.2. Responsibilities of service providers

The scope of services to be provided by the service provider is well understood (see Annexure 10.1 for scope of services). In addition, there are some other responsibilities that are relevant to all types of services. These are listed below:

- **Building team capacity:** Field staff should have a clear understanding of the project, the deliverables, and the role they play in the big picture. This may require frequent orientation sessions, on-job training sessions, and guidance as needed.

- **Task management:** It is suggested that the service provider should review performance data in both aggregate and disaggregate ways (by breaking it down at peripheral levels) to identify bottlenecks and potential areas for improvement. Having an internal M&E system can aid in efficient processes.

- **Timely invoice submissions:** Invoices should be completed with all necessary details, submitted according to timelines and formats agreed upon in the contract.

- **Documentation:** All activities carried out should be documented in detail to aid review and verification.

- **Timely communication:**

  - Any challenges should be shared with the NTEP leadership (STO/DTO) on time, along with supporting documents (for example, if the agency is unable to meet targets due to any issues, they should communicate with NTEP early and try and co-create solutions).

  - Relevant support systems (NTSU, STSUs, and consultant networks) should be engaged with frequently to get technical support and guidance.

Suggested reference reading

The following section in the Guidance Document provides a useful introduction and overview of the monitoring frameworks relevant for partnerships:

- Chapter 6 – 'Institutional framework required for implementation' (pages 73–74).

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CAPACITY BUILDING

Objective of capacity building

Similar to monitoring processes, the objective of capacity building is to improve programmatic performance and to ensure that people with TB get access to high-quality services and that services are being delivered in a cost-efficient manner. More specifically, capacity-building efforts can:

- Allow the sharing of best practices from one area of operation to another,
- Correct any areas that are adversely affecting service delivery, and
- Help teams and organizations achieve their targets.

Focus of capacity building

In the context of private sector partnerships, capacity building is required for two sets of stakeholders:[14]

(a) **Program staff:** This includes all relevant NTEP staff:

- At the state level - staff at STO office and procurement and finance team (NTEP/NHM).
- At the district level - staff at district TB center, District PPM Coordinator, procurement and finance teams, STS and STLS.

(b) **Service providers engaged for private sector partnerships.** This includes:

- PPSA staff, organizations working under other PPP schemes, and private providers/AYUSH providers.
- Potential partners/local NGOs/not-for-profit organizations/other ministries-departments.

Capacity assessments

The Guidance Document describes how to assess the capacity and competencies of program staff (at state and district levels) and of the service providers to initiate, manage, and implement the new partnership options at the national, state, and district levels. These capacity assessments are essential and must be carried out periodically, for example:

- Before any partnership options are planned, that is, in the needs assessment phase.
- Any time a new program staff joins the team, the district TB team, or the state TB team.

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14   For a more complete list, see section 1.5 on 'Target Audience'.

- Whenever a new service provider is contracted for partnership options.
- Periodically (quarterly or annual) (should ideally be aligned with the monitoring and supportive review sessions).

How can capacity be assessed?

The monitoring frameworks and systems described in Chapter 5 are ideal opportunities to assess capacity. Field monitoring visits and performance review meetings can serve to be platforms where capacity needs get identified. If additional insights are required, and if feasible, further capacity assessments can be done through focus group discussions (FGDs) or key informant interviews (KIIs) with stakeholders from NTEP, service providers, and perhaps also with the people accessing TB services.

Areas that require capacity building

This operational manual has been structured around the key areas for which knowledge gaps have been identified in the past—needs assessments, partnership design, finance and procurement, monitoring processes, verification, and payments. States and districts can add to this list based on their observations of implementation and based on capacity assessments.

Capacity building models

CMEs for private providers

States may consider organizing CMEs for private providers that can fulfil the dual aim of increasing competency among private providers and building interest among private providers to participate in partnerships with the public health sectors. Such CMEs can be organized in collaboration with the contracted agencies and also be included in their scope of services. The CMEs should cover subjects of interest to private providers—for example, programmatic FDCs, TB prevention, and STCI.

Training calendars for program staff as well as service provider staff

States may consider building state-specific training calendars; the following are indicative examples:

- All team members can be required to complete a mandatory number of hours of focused training on private sector partnerships in one calendar year.
- Designated state and district staff can be required to complete mandatory biannual refresher workshops.
- Service provider partner should build their own training calendars with support from NTEP partners.
- These trainings can be planned and organized by the state TB leadership with help from the consultant networks in the state.

Other suggestions are provided as follows:

- Lectures/experience sharing by health experts.

- Links with local research and training institutions.

- Creation of demonstration or model site that can function as knowledge and resource hub for advocacy and capacity building.

- Organization of exposure visits to sites where PSEs have been successful (and/or can yield useful lessons) for cross-learning.

- Organization of annual conferences and seminars on partnership engagement.

Existing capacity-building models

Workshops conducted by NTSU, STSUs, and other support partners

CTD, in partnership with NTSU and WHO, frequently conducts capacity-building workshops aimed at increasing the competency necessary for implementing private sector partnerships. These workshops can be included among the mandatory training requirements for relevant program staff. Workshop topics for recent workshops have included:

- Process of procurement of services (GFR and state-specific rules).

- Compliance with GST and other tax rules.

- Use of programmatic FDCs.

- Key programmatic aspects including monitoring frameworks.

Requests for future technical capacity-building needs can be sent to CTD via the following email address: tsu@rntcp.org.

Existing capacity-building platforms

Existing capacity-building platforms like *Swasthya e-gurukul* can also provide information on areas relevant for private sector partnerships.

Budgets for capacity building

Both partners should include budgets for capacity enhancements:

- State/districts should include training budgets in PIP.

- Service providers should also budget for them in their project costing plans.

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> *Capacity building is the process by which individuals, groups, and organizations increase their ability to understand and solve problems in a sustainable manner.*

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Eliminating TB continues to remain a priority for India, and in recent years, the country has made encouraging progress. The COVID-19 pandemic did put the progress at risk—not only by increasing the health risks among people with TB but also by causing severe disruption to services. However, the country's health care personnel have doubled down and managed to regain much of the lost ground. With the same ambition, determination, and innovative tools that were used to defeat TB, India is back in the race to end TB.
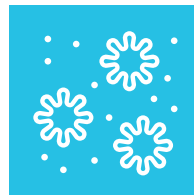
At present, India is better prepared to address TB than ever before. It possesses advanced and effective interventions and technologies for diagnosis, treatment, and care of TB. Equally importantly, it is prioritizing the construction of an innovations-driven health system aimed at providing comprehensive, integrated, patient-centric care. Functional PPPs are a key part of this new ecosystem, and learning to build these partnerships is critical for those who are responsible for providing essential services.

There are variations in the strengths and gaps at the health systems across the country. The partnership approach has proven to be an appropriate response to health system gaps. Through the implementation of such partnerships, the country has seen an expansion in the provision of timely, high-quality people-centric care to people with TB. From being primarily focused on service delivery, NTEP has been able to move into a role of supervising and guiding the delivery of care through all types of systems, implemented according to local needs.

As observed by the Comptroller and Auditor General (CAG) at the recent workshop on procurement, "post facto wisdom is easy, and cost of indecision is high." In other words, it is in the best interest of public agencies to keep themselves well-informed and take decisions based on accurate information and right principles. This operational manual is an attempt to provide an easy-to-understand resource that provides the main information necessary for partnerships.

The next few years are critical for TB elimination. As the deadline for elimination draws close, the opportunity cost for building new systems (which might not even remain relevant a few years down the line) is high—partnering with and leveraging the underutilized capacity in the private sector therefore makes sense from the efficiency point of view. It is rational to expect a steady increase in the partnership-driven TB implementation projects across the country which not only serve people with TB in a respectful and high-quality manner but also take India close to the finish line in the race toward TB elimination.

It is hoped that these operational guidelines will be used extensively in building such partnerships which, in future, can become the basis for care delivery for other disease areas as well.

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10.1 Scope of services

The following subsections provide a description on the scope of services that can be written under different types of partnership options:

A. Partnership option: Private provider engagement

(a) The agency will carry out mapping of private providers in the district(s). This includes all types of private providers—private hospitals, clinics, nursing homes, charitable/trust hospitals, chemists/pharmacists, laboratories (government/NABL accredited/NTEP approved), *AYUSH* providers, informal providers, and so on. The agency can build on the existing list of private health facilities available with district, professional associations, or any other source.

(b) The agency will build a prioritization list of providers for targeted engagement based on the existing data (from already existing database at the district and *Ni-kshay*) and insights gathered by interviewing professional associations, pharmacies, laboratories, patient support groups, and NGOs working in the area. The H1 register may also help identify key providers.

(c) The agency will engage private providers through in-person visits and through workshops/CMEs on a regular basis. To supplement this further, sharing of relevant reference materials will also be facilitated. The agency shall design the private provider engagement package and put appropriate resources to ensure effective and long-term relationship is built between private providers and NTEP.

B. Partnership option: Notification

(a) The agency shall register private providers on *Ni-kshay* and facilitate generation of *Ni-kshay* health establishment ID (if not already registered on *Ni-kshay*) for each private provider. These credentials shall be used by the private providers to enroll/notify the TB cases, as well as to update other patient details, for example, follow-up, FDC prescriptions, and treatment adherence. Wherever required, notification on *Ni-kshay* will be supported by the agency. In any case, it shall be the responsibility of the agency to ensure that the patient gets notified on *Ni-kshay*.

(b) The agency shall encourage, advocate, and facilitate enrollment/notification of TB patients in *Ni-kshay* directly by the providers. It shall train and handhold private health establishments on notification of TB patients on *Ni-kshay* in the prescribed format with complete information. It may train the private providers to notify through *Ni-kshay Sampark*/Call Center on the Toll-Free No. 1800116666.

C. Partnership option: Sample collection and transportation

(a) The agency shall be responsible for specimen collection from private providers/collection centers and delivery to the NTEP laboratories (government/private labs, as applicable).

(b) The agency shall be responsible for collection and packaging of samples with bio-safety precautions according to NTEP guidelines, ensuring labelling and completion of lab request form and maintaining records such as laboratory register and logbooks of samples transported.

(c) The agency shall be responsible for coordinating the delivery of soft copy and hard copy of the test report to the private providers and for entering the report in *Ni-kshay*.

(d) The agency shall coordinate with NAAT/microscopy/culture and DST labs/intermediate reference labs/national reference labs in notified public sector labs/linked private labs (as applicable) in the concerned state(s)/union territories.

(e) Logistics and supplies shall be procured by the agency or provided by NTEP, as mutually agreed.

(f) For EPTB and pediatric TB samples, the agency will provide links for sample collection and facilitate transportation.

(g) The agency shall facilitate sample collection and transportation services for pretreatment evaluation of DR-TB patients according to the latest NTEP guidelines.

(h) The agency shall facilitate sample collection and transportation services for testing of TB infection according to the latest NTEP guidelines.

D. Partnership option: Linkages for free diagnostic and drugs

(a) The agency will establish links for free diagnostic services (sputum microscopy, molecular diagnostics, line probe assay, culture and DST, pretreatment evaluation of DRTB, tests for TB infections, and any other tests according to NTEP guidelines) from notified public sector labs/linked private labs (as applicable).

(b) The agency will establish links for free radiology services for private sector patients from public/private empanelled radiology centers. The agency shall support in managing vouchers for these services (where applicable) as well as track and follow up on patients who do not turn up for X-ray services after voucher issuance.

(c) The agency will facilitate supply of free NTEP anti-TB drugs to private patients ensuring convenience of patients and providers.

(d) The agency shall also be responsible for demand generation among private providers and patients for use of NTEP-supplied free anti-TB drugs.

(e) The agency shall collect the drugs from district drug store/DTC/TU and deliver to the consumption unit(s), that is, private providers/chemists/pharmacies/doorstep delivery to the patient.

(f) The agency shall be responsible for inventory management for opening balance, stock, consumption, and closing balance and reporting the same regularly to DTC.

(g) The agency shall coordinate with NTEP for forecasting and regular supply of free drugs for private sector patients.

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(h) The agency shall be responsible for providing standard formats of inventory management/stock registers to private providers and ensure the same is updated on *Ni-kshay Aushadhi*/any other software or format as communicated by NTEP.

(i) In cases where the patient is willing to purchase drugs from open market, the agency shall not force to consume only the NTEP-provided FDCs. In such cases, the agency shall update the prescription on *Ni-kshay*.

(j) The agency shall be responsible for updating prescription for all patients on *Ni-kshay*.

E. Partnership option: Public health action - comorbidity testing

HIV testing

(a) The agency shall ensure all TB patients diagnosed in the private sector are with known HIV status. For this, the agency shall establish referral links for HIV testing at a public/private facility.

(b) For patients with the test result as reactive on screening, the agency shall be responsible to establish effective links between patients and the nearest ICTC for confirmatory testing. If found HIV positive, the patient shall be linked to the nearest anti-retroviral therapy center for TB HIV management.

Blood sugar testing for DM

(a) The agency shall ensure all TB patients diagnosed in the private sector are tested for diabetes. For this, the agency shall establish links for testing at a public/private facility.

(b) For patients who are found diabetic, the agency shall establish effective links for diabetes management.

F. Partnership option: NAAT

(a) The agency will establish links for NAAT services—NAAT, line probe assay, and culture and DST at notified public sector labs/linked private labs (as applicable) according to the prevailing algorithm.

(b) This will include both first- and second-lined DST.

G. Partnership option: Drug resistant TB management

(a) Counselling of DRTB patients for treatment initiation.

(b) Linkages for investigations for pretreatment evaluation.

(c) Linkages for free treatment at a private or public health facility, according to convenience of patients.

(d) Contacts' investigation and TB preventive treatment according to the NTEP guidelines.

(e) Identification, referral, and linkages for management of adverse drug reaction.

(f) Treatment adherence support.

(g) Follow-up for clinical examination and sputum examination.

(h) Reporting of treatment outcomes.

H. Partnership option: Patient and provider incentive

(a) The agency shall generate awareness on incentives to patients (NPY, tribal support scheme, treatment supporter's honorarium, and incentives for notification and outcomes) and collect the bank account details with necessary supporting documents according to NTEP guidelines from patients and update on *Ni-kshay*.

(b) The agency shall inform private providers on various incentives (informant, notification, treatment support, and outcome) and collect the bank account details with necessary supporting documents according to NTEP guidelines and update on *Ni-kshay*.

(c) The agency may assist NTEP in releasing incentives to patients and private providers on time.

10.2. Bid Security Bank Guarantee Form

Bid Security Bank Guarantee Form

Date   : _____

Bid Ref. No.   : _____

Contract: : _____

To: _____

WHEREAS _____ (hereinafter called 'the Bidder') has submitted its bid dated _____ for the performance of the above-named Contract (hereinafter called 'the Bid')

KNOW ALL PERSONS by these present that WE _____ of _____ (hereinafter called 'the Bank') are bound unto _____ (hereinafter called 'the Purchaser') in the sum of: _____, for which payment well and truly to be made to the said Purchaser, the Bank binds itself, its successors and assigns by these presents.

Sealed with the Common Seal of the said Bank this _____ day of _____, _____.

THE CONDITIONS of this obligation are the following:

1. **If, after the bid submission deadline, the Bidder**
    - withdraws its bid during the period of bid validity specified by the Bidder in the Bid Form, or
    - does not accept the Purchaser's corrections of arithmetic errors in accordance with the Instructions to Bidders; or

2. **If the Bidder, having been notified of the acceptance of its bid by the Purchaser during the period of bid validity**
    - fails or refuses to sign the Contract Agreement when required; or
    - fails or refuses to issue the performance security in accordance with the Instructions to Bidders.
    - In case of any false, incorrect or misleading information provided in the bid.

We undertake to pay to the Purchaser up to the above amount upon receipt of its first written demand, without the Purchaser having to substantiate its demand, provided that in its demand the Purchaser will note that the amount claimed by it is due to it, owing to the occurrence of any one of the two above-named CONDITIONS, and specifying the occurred condition or conditions.

This guarantee will remain in full force up to and including _____, and any demand in respect thereof must reach the Bank not later than the above date.

For and on behalf of the Bank

Signed : _____

Date   : _____

in the capacity of: [_____]
Common Seal of the Bank

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10.3. Performance Security Bank Guarantee

Performance Security Bank Guarantee
(Unconditional)

Date: _____

Bid Ref. No.   : _____

Contract   : _____

To   : _____

Dear Sir or Madam:

We refer to the Contract Agreement ('the Contract') signed on _____ between you and _____ ('the Supplier') concerning the supply and delivery of _____. By this letter we, the undersigned, _____, a bank (or company) organized under the laws of _____ and having its registered/principal office at _____ _____, (hereinafter, 'the Bank') do hereby jointly and severally with the Supplier irrevocably guarantee payment owed to you by the Supplier, pursuant to the Contract, up to the sum of _____. This guarantee shall be reduced or expire as provided for by GCC Sub-Clause 8.4.

We undertake to make payment under this Letter of Guarantee upon receipt by us of your first written demand signed by your duly authorized officer declaring the Supplier to be in default under the Contract and without cavil or argument any sum or sums within the above-named limits, without your need to prove or show grounds or reasons for your demand and without the right of the Supplier to dispute or question such demand. Our liability under this Letter of Guarantee shall be to pay to you whichever is the lesser of the sum so requested or the amount then guaranteed under this Letter in respect of any demand duly made under this Letter prior to expiry of this Letter of Guarantee, without being entitled to inquire whether or not this payment is lawfully demanded.

This Letter of Guarantee shall be valid from the date of issue until the date of expiration of the guarantee, as governed by the Contract. Except for the documents herein specified, no other documents or other action shall be required, notwithstanding any applicable law or regulation. Our liability under this Letter of Guarantee shall become null and void immediately upon its expiry, whether it is returned or not, and no claim may be made under this Letter after such expiry or after the aggregate of the sums paid by us to you shall equal the sums guaranteed under this Letter, whichever is the earlier. All notices to be given under this Letter shall be given by registered (airmail) post to the addressee at the address herein set out or as otherwise advised by and between the parties hereto.

This guarantee shall expire no later than the _____ day of _____ 2 _____, and any demand for payment under it must be received by us at this office on or before that date.

We hereby agree that any part of the Contract may be amended, renewed, extended, modified, compromised, released, or discharged by mutual agreement between you and the Supplier, and this security may be exchanged or surrendered without in any way impairing or affecting our liabilities hereunder without notice to us and without the necessity for any additional endorsement, consent, or guarantee by us, provided, however, that the sum guaranteed shall not be increased or decreased.

No action, event, or condition that by any applicable law should operate to discharge us from liability hereunder shall have any effect, and we hereby waive any right we may have to apply such law, so that in all respects our liability hereunder shall be irrevocable and, except as stated herein, unconditional in all respects.

For and on behalf of the Bank in the capacity of: _____
Common Seal of the Bank

Signed : _____

Date   : _____

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10.4. Eligibility criteria

The Guidance Document mentions under the description of each partnership option (for example, Chapter 3|page11) that there are certain eligibility criteria that must be considered for evaluating a service provider that wants to bid for any service delivery contracts. Of these criteria, an important one is that the "service provider should be a registered entity." Further, the glossary (page xiii) defines a registered entity as follows:

"any legal or other entity including without limitation a company registered in India under the Indian Companies Laws or incorporated outside India under relevant laws of incorporation under country of its origin, or a society registered under Societies Registration Act, 1860 or any other Indian law for registration of societies, a registered trust under Indian Trusts Act, 1882 or any other Indian law for registration of public trust or a sole proprietorship or partnership registered under the relevant laws of incorporation unless otherwise specified by the State. Bidders like NGOs and Voluntary Organizations should have registration on DARPAN portal (ngodarpan.gov.in). Health facilities/ laboratories should be registered under the relevant rules and regulations of the specific State/ District/Corporation/Municipality. All for-profit agencies are also required to be in compliance with the legal registration."

Table 27 provides additional clarity around the eligibility criteria.

TABLE 27: Eligibility criteria for organizations responding to RFPs (proposer)

A. Eligibility criteria	Mandatory documents as evidence
1 The organization needs to be registered as one of the following: (a) A single business entity under the Companies Act 2013 (as amended from time to time) or an incorporated entity under equivalent acts of the parent country (in case of foreign entities) (b) An organization registered under the Societies Registration Act 1860 or any relevant act of a state or union territory in India (c) A public trust registered under the Indian Trusts Act 1882 or any other equivalent act of a state or union territory in India (d) A charitable company registered under Section 25 of the Companies Act, 2013 (as amended from time to time) (e) A firm registered under Limited Liability Partnership (LLP) Act 2008 (f) A partnership firm (g) Any combination of (a) to (f) with a formal intent to enter into an agreement or under an existing agreement to form a consortium (h) A firm registered under any other act of India.	Self-attested copy of registration certificate
2 In case of nonprofit entity, the organization should be registered on the GoI's portal, DARPAN, https://ngodarpan.gov.in/maintained by *NITI Aayog*, *GoI*.	Proof of registration on NGO - DARPAN portal
3 The organization must not be (a) blacklisted/banned/convicted by any court of law for any criminal or civil offenses/declared ineligible by any entity of any state government or GoI or any local self-government body or PSU in India for participation in future proposals for unsatisfactory performance, corrupt, fraudulent or any other unethical business practices or for any other reason, as on date of submission (upload) of online proposal document.	Affidavit attested by Notary Public or sworn before Executive Magistrate

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A. Eligibility criteria		Mandatory documents as evidence
4	The organization shall inform the procurement entity of any such pending suits/enquiry/investigation against the proposer in any court of law, legal authority, or paralegal authority which may hamper the execution of works under this RFP.	Undertaking to be submitted on a nonjudicial stamp paper
5	The organization shall declare all ongoing litigations, if any.	Self-declaration on company letter head

B. Experience and financial criteria		Mandatory documents as evidence
1	Proposer should have 3 (three) years of experience—both completed and ongoing projects/contracts (projects with experience and contract period less than 1 [one] year would not be considered for eligibility matrix)—in health and/or social sector with public and/or private agencies in the state/country in the last 5 years as on due date for submission of proposal. Proposer should submit the following documents in support of fulfilment of proposer's qualification, along with its proposal. *Preference will be given to the organization that has experience of working in TB program and will be considered for evaluation.*	▪ Registration document showing incorporation of the proposer and self-declaration by the director/partner/chief executive officer (CEO) or authorized signatory of the proposer, ▪ Copy of agreement/ work order/letter of notification of award, and ▪ Client's certificate on satisfactory completion and/or satisfactory progress report of project.
2	The proposer should have a positive net worth in the last three (3) financial years (that is, 2018–19, 2019–20, and 2020–21). However, nonprofit organizations may have negative net worth.	Certificate from Statutory Auditor and Audited financial statements shall be submitted by the Proposer for the stated financial years.
3	The proposer must have average annual turnover of (a) INR 50,00,000 (fifty lakh rupees) if proposal is for 1 cluster/district and (b) Additional INR 50,00,000 (fifty lakh rupees) for every additional cluster/district will be required.	Audited balance sheet and (a) Statement of Income and Expenditure account (if the proposer is a nonprofit entity) or (b) Statement of Profit and Loss (if the Proposer is a for-profit entity).

	C. General documents required
1	Self-attested copy of certificate issued by the appropriate authority valid as on date of submission of RFP documents
	Self-attested copies of:
	(a) PAN card,
	(b) GST registration certificate (if applicable),
	(c) GST exemption certificate (if any),
	(d) Copy of Income Tax Return (with computation) filed and submitted by the proposer for three financial years FY 2018–19, 2019–20, and 2020–21,
	(e) Employee state insurance (ESI) and employee provident fund (EPF) registration certificate, and
	(f) MSME registration certificate (if applicable).
2	Copy of policies and procedures of the proposer:
	(a) Accounting/financial policies
	(b) Internal control policies, risk matrix, and procedures
	(c) Procurement guidelines
	(d) HR and administrative policies.
3	Valid certificate of 12A and/or 80G registration (submit documented proof), if applicable, in case of nonprofit entity
4	Self-attested copy of the MoA/deeds/bylaws or such other document evidencing vision, mission, objective, and rules and regulations
5	Copy of last three years annual reports
6	Proof of annual documents submission to registrar of societies/trusts/companies/registrar of companies
7	Evidence of local office premises or declaration for establishment of local office premise in the district of the state where it wants to operate once contract is awarded
8	Any other relevant detail, statutory requirements, and compliance - provident fund (PF), income tax/GST, ESI and labor welfare fund (LWF)
9	Such other document/s as may be relevant at the point of assessment

Note: States/districts can use these evaluation criteria to make a preliminary evaluation matrix (Figure 9) to examine the eligibility of bidding organizations. The technical bids should be opened only for those organizations that fulfil the conditions in the preliminary evaluation matrix.

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FIGURE 9: Preliminary evaluation matrix

Sl. No.	Required Document	Name of Bidder		
		Bidder-1	**Bidder-2**	**Bidder-3**
	For Profit Entities			
1	Copy of certificate of registration under companies Act 1956/2013			
	For Non-profit Entities			
2	Copy of certificate of registration under Indian Societies Registration Act 1860 (register firms as non-profit agency/NGO under Firms and Society Act rule 27 of the state) or registered trust under Indian Trust Act 1882			
3	Proof of registration on the Government of India portal, DARPAN (https://ngodarpan.gov.in)			
4	Certified copy of the MoA/Deeds/byelaws or such other document evidencing vision, mission, objective and rules and regulations			
5	Certification of 12 A/80G Registration, if applicable			
	General Documents			
6	Audited Balance sheet confirming Annual turnover of at least Rs. 50 lakhs			
7	Undertaking for nonblack listing/banning by any entity of any State Government or Government of India or any local Self Government body or public sector			
8	Undertaking regarding any pending suits/enquiry/investigation against the Bidder			
9	**Self-attested copies of** 1) PAN Registration 2) TAN Registration 3) GST Registration (if applicable) 4) Income Tax Return for last 3 financial years 5) MSME Registration (if registered) 6) ESI & EPF Registration			
10	**Policies and Procedures** 1) Accounting/Financial policies 2) Internal control policies 3) Procurement guidelines 4) HR and Administrative Policies			

10.5. Eligibility criteria for consortiums

Table 28 provides a sample list of criteria that can be used to assess consortiums.

TABLE 28: Eligibility criteria for consortiums

A. Eligibility criteria	Mandatory documents as evidence
Same as eligibility criteria mentioned above for proposers—all organizations that are part of the consortium must independently fulfil the eligibility criteria.	Same as above
B. Experience and financial criteria - the consortium partners need to fulfil these criteria as a combined entity.	**Mandatory documents as evidence**
1 Lead proposer and consortium partner should each have 3 (three) years of combined experience—both completed and ongoing projects/contracts (projects with experience and contract period less than 1 [one] year would not be considered for eligibility matrix)— in health and/or social sector with public and/or private agencies in the state/country in the last 5 years as on due date for submission of proposal. Proposer should submit the following documents in support of fulfilment of proposer's qualification, along with its proposal. **Preference will be given to the organization that has experience of working in TB program and will be considered for evaluation**.	▪ Registration document showing incorporation of the proposer and self-declaration by the director/ partner or authorized signatory of the proposer, ▪ Copy of agreement/work order/ letter of notification of award, and ▪ Client's certificate on satisfactory completion and/or satisfactory progress report of project.
2 Lead proposer and consortium partner should have a combined positive net worth in the last three (3) financial years (that is, 2018–19, 2019–20, and 2020–21). **However, nonprofit organizations may have negative net worth.**	Certificate from statutory auditor and audited financial statements shall be submitted by the proposer for the stated financial years.

3   Lead proposer and consortium partner must have *combined* average annual turnover of
      (a) INR _____ (_____ _____) if proposal for 1 cluster/district and
      (b) Additional INR _____ for every additional cluster/district will be required.
 	
 These amounts can be derived from market scans or costing tools.
	Audited balance sheet and
	      (a) Statement of Income and Expenditure account (if the proposer is nonprofit entity) or
	      (b) Statement of Profit and Loss (if the proposer is a for-profit entity).

C. Additional documents required	
Same as the documents mentioned above for proposers—all organizations that are part of the consortium must independently submit the additional documents mentioned in Table 27.	

Specific terms and conditions relevant for consortiums

(a) With regard to establishment of relation of lead proposer and consortium partner(s), procurement entity would require a declaration/memorandum of understanding (MoU) between the parties, clearly defining lead proposer and consortium partner(s) and their roles and responsibilities. The declaration or MoU needs to be signed by authorized signatories from all partners.

(b) For procurement entity, the lead proposer will be liable for satisfactory performance of all services mentioned in the SoW as well as legal/financial implication of the contract.

(c) Lead proposer will be responsible for monitoring the performance of consortium partner(s).

(d) Any proposer (including consortium partner, as the case may be) participating in the procurement process shall:

(i) Not have a conflict of interest, which materially affects fair competition.

(ii) Have fulfilled his/her obligation to pay tax payable to the Central Government or the state government or any local authority.

(iii) Not be insolvent, in receivership, bankrupt or being wound up, not have its affairs administered by a court or a judicial officer, not have its business activities suspended, and not be the subject of legal proceedings for any of the foregoing reasons.

(iv) Ensure its directors and officers have not been convicted of any criminal offense related to their professional conduct or the making of false statements or misrepresentations as to their qualifications to enter into a procurement contract within a period of three years preceding the commencement of the procurement process, or not have been otherwise disqualified pursuant to debarment proceedings.

(v) Not be debarred by any procurement entity under the state government, the Central Government, autonomous body, or authority by whatever name called under them.

10.6. Technical evaluation

It must be reiterated that technical evaluation is carried out only for those organizations that fulfil the conditions in the preliminary evaluation (Annexures 10.4 and 10.5). Table 29 provides a sample technical evaluation criteria.

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TABLE 29: Technical evaluation criteria

Particulars	Allocation of marks		Weightage
1. Experience of implementing health and/or social sector program with public and/or private agencies in any three years of the last five financial years (*2016–21*).	(a) Minimum 3 years	5 marks	**15 marks**
	(b) > 3 years and <= 5 years	10 marks	
	(c) > 5 years	15 marks	
2. Experience of working in TB program with public and/or private agencies in any two years of the last five financial years (2016–21)	(a) Minimum 2 years	5 marks	**15 marks**
	(b) > 2 years and <= 5 years	10 marks	
	(c) > 5 years	15 marks	
3. Average annual financial turnover INR 50 lakhs (rupees fifty lakhs) per cluster/district in the last three (3) financial years (2018–21)	(a) INR 50 Lakhs - 10 marks (b) Additional one (1) mark for every additional INR 10 lakhs average annual financial turnover above INR 50 lakhs	20 marks	**20 marks**
Concept plan for executing the project in the concerned cluster/district with technical presentation *(one hard copy of technical presentation to be submitted along with proposal)*	**1.1 Provider/patient management plan/ operational plan** ▪ Provider mapping and engagement ▪ Notification support ▪ Links for free diagnostics (X-ray, sputum microscopy, molecular testing, and DST services) ▪ Links and drug distribution models for NTEP-provided FDC ▪ Links for comorbidity testing ▪ Patient support, treatment adherence, and follow-up till treatment outcome reporting ▪ Contact Investigation and TB preventive treatment - links for DR-TB patients ▪ Facilitation of incentives.	20 marks	**30 marks**
	1.2 Creativity and innovations	10 marks	
Implementation plan	(Proposed HR structure with organogram for project implementation, M&E, data management, operational model with timelines, analysis, and reporting)	20 marks	**20 marks**
Total marks			**100 marks**

Note: While the scoring for the first part of technical evaluation (related to experience and financial turnover) is straightforward, there can be subjectivity when evaluating the remaining sections, especially those related to concept planning and implementation plan. Therefore, the procuring entity must ensure that the evaluation committee is made up of subject matter experts/procurement/finance experts from local NHM teams, members of STSUs, and consultant networks, to ensure that technical evaluation is stringent and transparent.

10.7. Invoice Format

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Letter head of the Organization (STSU)

INVOICE	
Ministry of Health & Family Welfare Room No. 551A, Nirman Bhawan, New Delhi - 110011 GSTN: _____ State: Delhi State Code: 97	**Date** : **Invoices No** : **Contract Agreement No** : **Date of Agreement** :
Particulars	**Amount (Rupees)**
Payables as per agreed contract agreement	
Total	
Add-CGST @ 9%	
Add- SGST @ 9%	
Grand Total	
Rupees:	
Details of Billing Organization:	
Pan Number:	
GSTIN:	
SAC Code:	

Payment Instructions for Payer Organization:

Please issue a cheque in favour of "**VENDOR NAME**" or transfer to our Bank Account, the details for which are as under.

Bank Name   : _____

Bank Account No   : _____

Bank IFSC Code   : _____

E-mail ID   : _____

(Signature)

Name of authorized signatory

Address:

Stamp/seal of organization

10.8. Performance-linked payment plans - example scenarios

Full clarity should be provided in both RFP and the contract to be signed by State with PPSA/other partner, in clear and unambiguous terms. The language used in the documents, especially pertaining to assessment of performance, calculations of payments should be very specific and free from subjective interpretations. The spirit of these documents is that there should be no hidden clauses for penalty. Reduction in unit cost as well as other penalty clauses which the State would like to incorporate in any partnership should be clearly articulated, preferably with hypothetical examples elaborating how the payments and penalties would be calculated.

Also, during the implementation of ongoing contracts & partnerships whenever such issues emerge demonstrating subjective/variable interpretation of terms of contract, such issues should be addressed with mutual consensus and subsequently incorporated in the contract by means of an addendum/ amendment etc.

This is very crucial both from legal perspective and from the perspective of institutional memory of both parties as often these contracts extend over several years and there is change of officials dealing with different aspects of the contract.

Further, very often these contracts are signed at the State level and execution & verification and sometimes even payments is at district level, therefore to bring all on same page, the RFP/contract should be articulated in such manner that it would be easy to understand and same interpretation would come by its reading by different stakeholders.

Below is a sample scenario on how to calculate performance-linked payments. This is an example only and states are requested to use following in accordance with state needs.

Project type: PPSA

Cycle of payment: Monthly/quarterly/Yearly

Assumptions:

(a) Target no. of patients (from private sector): **1,000 (**may be Monthly/quarterly/Yearly)

(b) Price quoted by the bidder for the complete services till the treatment: **INR 2400**

(c) Total expected payment from the project: **INR 24,00,000 (twelve lakh rupees)—**_multiplied (a) with (b)_

(d) In this example, we have not considered any penalties or taxes in the calculations.

Sl. No.	Parameters	Weight		Targets
1	Number of people with TB notified	**25%**	**80%**	Of private sector notification target
2	Validated bank account details	**15%**	**80%**	Of the people notified with TB
3	NAAT	**20%**	**70%**	Of the people notified with TB
4	HIV and DM Testing	**10%**	**80%**	Of the people notified with TB
5	Successful Outcome	**30%**	**85%**	Of the people notified with TB

Methodology of pro rata calculations

Sl. No.	Parameters	Weightage	Unit cost value in INR
1	Number of TB patients notified	25%	600
2	Validated bank account details	15%	360
3	NAAT	20%	480
4	HIV and DM Testing	10%	240
5	Successful Outcome	30%	720
Total (INR)			**2400**

With respect to above scenario, we illustrate below how the payment should be calculated on a pro-rata basis in accordance with the above specified weightage:

In the case of notifications, the target is kept at 80 percent of the private sector target notified, that is, 1,000 × 80% = 800. Therefore, if the agency less than 800 notifications & for example the private sector notification is 500, then the pro rata payment would be calculated as **unit cost for specified parameter × notification achievement, that is, [600 × 500] = 300000**.

Example outcome: Achieved notification targets but did not meet other targets (for bank details, DST, HIV + DM, TPT, and outcome)

Sl. No.	Parameters	Patients notified	Achievement	Performance
1	Notification	1,000	100%	Over-achieved
2	Bank details	700	70%	Shortfall
3	NAAT	400	40%	Shortfall
4	HIV + DM	700	70%	Shortfall
5	Outcome	700	70%	Shortfall

Payment calculation

Parameters	Achievement as shown in above table	Unit cost value in INR	Total eligible payment
Notification	100%	600	1,000 × 600 = 6,00,000
Bank details	70%	360	700 × 360 = 2,52,000
NAAT	40%	480	400 × 480 = 1,92,000
HIV + DM	70%	240	700 × 240 = 1,68,000
Outcome	70%	720	700 × 720 = 5,04,000
Total			**17,16,000**

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FINANCE AND PROCUREMENT OF SERVICES

MONITORING AND SUPERVISION

DELIVERABLE VERIFICATION AND PAYMENTS

ROLES AND RESPONSIBILITIES

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However, a State might like to introduce a penalty clause for non-achievement of targets, by means of prorating the unit cost of payment for each deliverable in line with the achieved performance. In this case, the State must include a clause in the RFP & the Contract specifying the same, for better understanding and transparency with all stakeholders. If state wants to use this "pro rata" term for differential performance-based unit cost, it is suggested that in addition the states needs to specifically mention following clarity with clear examples to impose reduction in "unit cost" by using the term "pro rata".

In the case we elaborate below how the payment calculation should be made and the below or similar relevant example be included in RFP & Contract documents:

- In the case of notifications, the target is kept at 80 percent of the private sector target notified, that is, 1,000 × 80% = 800. Therefore, if the agency achieves 800 or more notifications in the year, then the calculated payment would be 25% × 2400 = INR 600 per patient notified.

- However, if the agency achieves less than 800 notifications (that is, 80 percent of the private sector target; 500 notifications for example), then the pro rata weightage may be calculated as [(initial weightage/notification target%) × notification achievement%], that is, [(25%/80%) × 50%] = 15.62%. Hence the amount paid per patient may be 15.62% × 2400 = INR 374.88 per patient. (Note the calculations may be rounded up to maximum of 2 decimal places.)

Example outcome: Achieved notification targets but did not meet other targets (for bank details, DST, HIV + DM, TPT, and outcome)

Sl. No.	Parameters	Patients notified	Achievement	Performance
1	Notification	1,000	100%	Over-achieved
2	Bank details	700	70%	Shortfall
3	NAAT	400	40%	Shortfall
4	HIV + DM	700	70%	Shortfall
5	Outcome	700	70%	Shortfall

Payment calculation

Parameters	Achievement as shown in above table	Calculation	Total eligible payment
Notification	100%	25/100 × 100 = 25	1,000 × 2400 × 25% = 6,00,000
Bank details	70%	15/80 × 70 = 13.13	700 × 2400 × 13.13% = 2,20,584
NAAT	40%	20/70 × 40 = 11.43	400 × 2400 × 11.43% = 1,09,728
HIV + DM	70%	10/80 × 70 = 8.75	700 × 2400 × 8.75% = 1,47,000
Outcome	70%	30/85 × 70 = 24.70	700 × 2400 × 24.70% = 4,14,960
Total			**14,92,326**

Targets or payment frequency may be monthly, quarterly or bi-annual. However, it is suggested that the performance assessment for the calculation of penalties or reduction in unit costs should only be done on an annual basis. If a more frequent performance assessment is planned, it should be specifically mentioned in the RFP and the contract.

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10.9. Committee and other experts who contributed to the development of the operational manual

Committee for development of Operational Manual for Partnerships

Committee Chair: PROF. A. VENKAT RAMAN, Chairperson, NTWG on Pvt Sector Engagement in TB Elimination and Professor, Faculty of Management Sciences

DR. B.K. MISHRA, State TB Officer Bihar

DR. VINOD GARG, State TB Officer Rajasthan

DR. SANTOSH ROY, State TB Officer West Bengal

DR. ADEKEKAR, State TB Officer Maharashtra

DR. RAJESH RAJU, State TB Officer, Haryana

DR. VARSHA PURI, City TB Officer, Mumbai

DR. NEERAJ RAIZADA, Team Lead, National Technical Support Unit, IQVIA

DR. KIRAN RADE, NPO TB Epidemiologist, World Health Organization

DR. SAMEER KUMTA, Senior Program Officer, Bill and Melinda Gates Foundation

DR. SAPNA SURENDRAN, Health Specialist, Health Nutrition and Population, South Asia Region, The World Bank Group

DR. BHAVIN VADERA, Project Management Specialist, USAID

DR. SHAMIM MANNAN, Deputy Director - Tuberculosis, William J Clinton Foundation

MR. VENKATESH RODDAWAR, Project Director, JSI India

DR. VIJAYASHREE YELLAPPA, Lead, TBPPM Learning Network India

DR. SWATI IYER, National Consultant PPM, World Health Organization

DR. VAISHALI VENU, Director, Health Services, Doctors For you

DR. SANGITA PANDEY, National Lead – HIV/AIDS and TB, HLFPPT

DR. PRACHI SHUKLA, Country Director, World Health Partners

MS. NEELAM MAKHIJANI, Country Director, Management Sciences for Health

MS PRABHA MAHESH, Director - Projects Health, ALERT India

DR. SANDEEP BHARASWADKAR, Consultant, Bill and Melinda Gates Foundation

DR. MANJOT KAUR, Consultant, The World Bank Group

DR. SANDHYA GUPTA, National Technical Support Unit - Public Health Expert, IQVIA

CA VIJAY KR GUPTA, National Technical Support Unit – Finance & Accounts Expert, IQVIA

MR. AMIT SHRIVASTAVA, Former- Contract Management Expert, NTSU

MR. ARUN SINGH RANA, National Technical Support Unit - Monitoring & Evaluation Expert, IQVIA

MR. SHASHANK MALVIYA, National Technical Support Unit - Public Private Partnership Expert, IQVIA

MR. DEVASHISH SARKAR, National Technical Support Unit – DBT Expert, IQVIA

DR. SHANOO MISHRA, National Technical Support Unit - Multi-Sectoral Engagement Expert, IQVIA

MR. RITESH TYAGI, National Technical Support Unit - ICT Expert, IQVIA

DR. PRARTHANA B. S., Team Lead, State Technical Support Unit, Karnataka

MR. AKBAR HUSSAIN, Team Lead, State Technical Support Unit, Bihar

MR. BHARATESH K. SHETTY, Team Lead, State Technical Support Unit, Uttar Pradesh

DR. RAJABHAU D. YEOLE, Team Lead, State Technical Support Unit, Maharashtra

DR. DEEPIKA KHALADKAR, Program Officer – Tuberculosis, PATH

DR. MAYANK SHARMA, Senior Program Officer, Health Systems Strengthening at PATH

MR. SATYA VERMA, Procurement consultant

DR. DI DONG, Senior Health Economist, Health Nutrition and Population, South Asia Region, The World Bank Group

DR. LUNG VU, Health Specialist, Health Nutrition and Population, South Asia Region, The World Bank Group

DR. GYÖRGY BÈLA FRITSCHE, Senior Health Specialist, Health Nutrition and Population, South Asia Region, The World Bank Group

DR. GODELIEVE VAN HETEREN, Senior International Consultant, The World Bank Group

DR. VAIBHAV GHULE, Consultant, The World Bank Group

DR. DEEPAK SANTHANAKRISHNAN, Consultant, The World Bank Group