USAID
FROM THE AMERICAN PEOPLE

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME
TB MUKT BHARAT
TB Harega Desh Jeetega

Health Systems for
Tuberculosis (HS4TB)

# Report on Best Practices in Contract Management

JANUARY 2024 • INDIA

*This document is made possible by the generous support of the American people through the US Agency for International Development (USAID) contract no. 7200AA18D00025 task order no. 7200AA20F00009. The contents are the responsibility of Management Sciences for Health and do not necessarily reflect the views of USAID or the United States Government.*

## About HS4TB

The USAID Health Systems for Tuberculosis (HS4TB) project seeks to transform the way country leaders and health system managers understand and work toward TB control and elimination. HS4TB is a five-year USAID contract focusing on health systems priorities that most directly support achievement of TB outcomes, with a focus on health financing and governance in the USAID TB priority countries. The project helps countries increase domestic financing, use key TB resources more efficiently, build in-country technical and managerial competence and leadership, and support policy formation and dissemination. HS4TB is led by Management Sciences for Health (MSH).

### Contact Information

For more information on the HS4TB project, contact:
**Neelam Makhijani**
*Country Director, MSH India*
Email: nmakhijani@msh-india.in

**Kamiar Khajavi**
*Global Project Director, HS4TB*
Email: kkhajavi@msh.org

# TABLE OF CONTENTS


Acronym List ..... vi

Executive Summary ..... 1

1. Overview of Contracting Out in India ..... 2

1.1 Contracting Out TB Services ..... 2

1.2 NTEP Guidance on TB Partnerships ..... 3

1.3 Rules and Regulations for Public Procurement and Contracting ..... 4

2. Contracting (Input- and Output-based): Overview and Key Considerations ..... 6

2.1 Enabling Environment for Effective Contract Management ..... 6

2.2 The Contract Management Cycle ..... 7

3. Contracting Status, Challenges, and Potential Solutions in the Five HS4TB-Supported States ..... 8

3.1 Current status of contracting in HS4TB States ..... 8

3.2 Contracting challenges and solutions ..... 10

A. Pre-Contracting Phase ..... 11

B. Contracting Phase ..... 14

C. Post-Contracting Phase ..... 19

D. Human Resources and Capacity Building ..... 23

4. Summary of Key Recommendations ..... 25

Annex 1: GFR 2017 Guidance on Outsourcing Of Services ..... 29

Annex 2: Contract Tracker ..... 30

Annex 3: Needs Assessment (Methodology and Tool) ..... 31

Annex 4: Invoicing Sop and Tool ..... 34

Annex 5: Verification and Validation Sop and Tool–PPSA ..... 35

Annex 6: Challenges in Payment (Invoice Submission to Payment Release) ..... 38

Annex 7: Mapping of Fund Flow Process and Payment Process to Partners ..... 39

# ACRONYM LIST

| | |
|---|---|
| CTD | Central TB Division |
| DBT | direct benefit transfer |
| DST | drug susceptibility testing |
| DTO | District TB Office |
| EMD | earnest money deposit |
| FDC | fixed-dose combination |
| FL-LPA | first-line line probe assay |
| GeM | Government e-Marketplace |
| GFR | General Financial Rules |
| GOI | Government of India |
| HR | human resources |
| HS4TB | Health Systems for Tuberculosis |
| IGRA | Interferon gamma-release assay |
| LCS | least cost selection |
| M&E | monitoring and evaluation |
| MIS | management information system |
| MOU | memorandum of understanding |
| MPG | Manual for Procurement of Goods |
| NACO | National AIDS Control Organization |
| NGO | nongovernmental organization |
| NHM | National Health Mission |
| NSP | National Strategic Plan |
| NTEP | Indian National Tuberculosis Elimination Program |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| PFMS | Public Finance Management System |
| PIP | Project Implementation Plan |
| PIU | partnership and innovation unit |
| PLC | partnership and learning collaborative |
| PPM | public-private mix |
| PPP | public-private partnership |
| PPSA | patient provider support agency |
| QCBS | quality and cost-based selection |
| RFP | request for proposals |
| RNTCP | Revised National TB Control Program |
| ROP | record of proceedings |
| SOE | statement of expenditure report |
| SOP | standard operating procedure |
| STC | State TB Cell |
| STDC | State TB Demonstration Centre |
| STSU | State Technical Support Unit |
| TB | tuberculosis |
| TBNR | TB notification register |
| TOR | terms of reference |
| TPA | third-party administrator |
| TSU | technical support unit |
| UDST | universal drug susceptibility testing |
| USAID | US Agency for International Development |

# EXECUTIVE SUMMARY

India has made great strides in contracting tuberculosis (TB) services since 2012, but there is still sizeable untapped potential in this space. State TB units' limited capacity for contracting has been a significant factor impeding further growth. In 2019, to provide additional technical support to State TB Cells, the Government of India (GOI) launched Technical Support Units (TSUs) in nine states financed by a World Bank loan.[1] The TSUs were tasked to provide broad support, from providing expert advice on strategic purchasing and private-sector engagement to facilitating direct benefits transfers (DBT) to patients.

In 2022, the US Agency for International Development (USAID) Health Systems for Tuberculosis (HS4TB) project set up more specialized technical support units called Partnership and Innovation Units (PIUs) in five other states: Andhra Pradesh, Telangana, Gujarat, Odisha, and Delhi. The PIUs aim to support and build the capacity of the State TB Cells, specifically in contracting with the private sector— from conducting pre-contracting needs assessments to drafting requests for proposals (RFPs) and facilitating processes to ensure effective contract implementation, including timely invoice verification and payment.

The purpose of this report is to:

1. Document best practices in contract management, drawing from global literature, GOI documents, and the HS4TB team's expertise.
2. Use a problem matrix approach to diagnose problems and propose solutions based on early lessons drawn from the contracting process carried out in the five HS4TB-supported states.
3. Provide a summary of context-specific recommendations and guidance arising from these HS4TB experiences that may be relevant for both the PIU- and TSU-supported states to optimize the contracting process and ensure effective contract implementation in key process areas, such as invoicing and verification.
4. Serve as an evidence-based reference point the project can use to engage the GOI and partners such as USAID in streamlining and refining its technical support and programming needs for TB contracting in future.

This report will primarily focus on the contract management process, beginning with the "pre-contract" or pre-procurement phase, which entails the initial scoping and definition of services to contract; through the "contracting" phase, which ends with the contract signing between the government and service provider; and then the post-contracting phase.[2] The report will propose solutions addressing challenges occurring across these three phases. In-depth information related to the needs assessment and contract payment processes—including invoicing and verification—can be accessed in separate HS4TB project documents (i.e., Needs Assessment Methodology and Tool, and the Standard Operating Procedure [SOP] and Tool for Invoicing, Verification, and Validation).

This report complements the National Tuberculosis Elimination Program (NTEP) Guidance Document on Partnerships and the corresponding Operational Manual.[3,4] Although this report addresses similar subjects, it differs in its attempt to bring best practices from global experience and to address challenges identified in the HS4TB-supported states. However, the proposed solutions and recommendations apply generally to TB contracting in India.

---

1 *World Bank. (2019). Program Appraisal Document on a Proposed Loan in the Amount of $400 Million to the Republic of India for a Program Towards Elimination of Tuberculosis. February 26, 2019. Health, Nutrition & Population Global Practice, South Asia Region. Report No: PAD3185. The nine states are Assam, Bihar, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu, Uttar Pradesh, and West Bengal.*

2 *Influence of Procurement Plan on the Effectiveness of Procurement. Available from: https://www.ijebmr.com/uploads/pdf/archivepdf/2022/IJEBMR_907.pdf.*

3 *Central TB Division, Ministry of Health and Family Welfare, Government of India. (2019). Guidance Document on Partnerships: Revised National Tuberculosis Control Program. Available from: https://tbcindia.gov.in/showfile.php?lid=3456.*

4 *National TB Elimination Program. (2023). Operational Manual for Partnership under National Tuberculosis Elimination Programme. Available from: https://tbcindia.nic.in/showfile.php?lid=3705.*

# 1. OVERVIEW OF CONTRACTING OUT IN INDIA

## 1.1 Contracting Out TB Services

The GOI has contracted out health services since the 1990s as part of a broader trend of privatization and market-oriented reforms in the country. Initially, private-sector involvement in the health sector was focused on engaging organizations providing clinical services, such as hospitals and clinics, with the government continuing to provide most public health services. Over time, however, the government began contracting out a wider range of health services, including health promotion, primary care, disease prevention programs, and some specialized services, such as laboratory testing and radiology. Contracting out health services has continued, and the private sector is an increasingly important player in the country's health system.[5]

The GOI's response to HIV/AIDS has a long history of private-sector engagement. Communities have been at the center of the AIDS response, initially with prevention and testing activities (1985–1991) and then for treatment (1992–1999). Peer-led social contracting for targeted interventions is at the core of the National AIDS Control Program. India's National AIDS Control Organization (NACO)—which has a level of autonomy unlike organizations that oversee other disease areas—has been contracting out TIs to local organizations since 1996.[6] Contracting began with the distribution of condoms and has been evolving for the past three decades. Social contracting is done primarily through input-based financing, with each state publishing an expression of interest and nongovernmental organizations (NGOs) and community-based organizations submitting proposals. The government's focus progressed from pilot testing approaches that began with international development partner support to scale-up of innovations. For example, a key focus now is to provide domestic funding that supports better linkages from testing to antiretroviral therapy and counseling. Capacity strengthening has been and remains a key focus of the program, with the government providing continuous regular monitoring through the technical support units with regular site visits and formal feedback provided to NGOs/civil society organizations every six months.

India has the world's largest burden of TB, and a high volume of presumptive TB patients (estimates range from 50% to 80%) first seek care with a private provider.[7,8] Private-sector health care providers offer variable levels of quality and often inappropriate diagnostic and treatment practices, which principally affect low-income households.[9] Private-sector engagement is therefore crucial for the cascade of TB care—from case finding at private outpatient clinics/hospitals to quality-assured diagnosis, notification, treatment, and prevention.

The national TB control program (formerly the Revised National Tuberculosis Control Program [RNTCP], now the NTEP) started endorsement of public-private mix (PPM) models after the program successfully engaged Mahavir Hospital and its surrounding providers through a financial memorandum of understanding (MOU) in 1995.[10] By the mid-2000s, the RNTCP was engaging increasing numbers of private providers for TB services.[11]

In 2012, the National Strategic Plan (NSP) of India's TB program introduced the PPM model on contracting interface entities called patient provider support agencies (PPSAs), to engage private providers in the delivery

---

5 *India's flagship publicly financed health insurance scheme, PM-JAY, empanels nearly 13,000 private hospitals to provide secondary and tertiary care, with 56% of admissions in these hospitals in 2022–23. https://www.pib.gov.in/PressReleasePage.aspx?PRID=1928582#:~:text=The%20PM%2DJAY%20empanelled%20hospital,authorise d%20in%20the%20public%20hospitals.*

6 *The Lancet, Asia HIV Financing, S. Mills. See also Sustainable HIV Financing in Transition reports.*

7 *Gopinath R, Bhatia R, Khetrapal S. (2020). Tuberculosis Control Measures in Urban India: Strengthening Delivery of Comprehensive Primary Health Services. ADB South Asia Working Paper Series.*

8 *Satyanarayana S, Nair SA, Chadha SS, et al. From where are tuberculosis patients accessing treatment in India? Results from a cross-sectional community-based survey of 30 districts. PLoS One 2011; 6: e24160.*

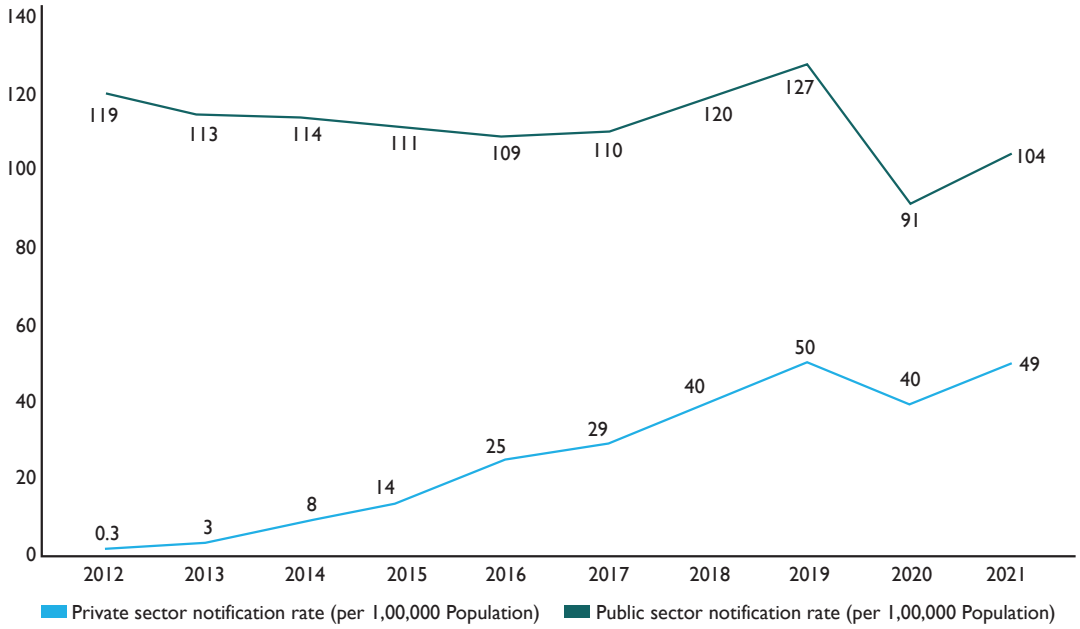
9 *Sachdeva KS, Kumar A, Dewan P, Satyanarayana S. New Vision for Revised National Tuberculosis Control Programme (RNTCP): Universal access—"Reaching the un-reached." Indian J Med Res 2012; 135: 690–4.*

10 *Mahavir Hospital and Research Centre is a large private hospital located in Hyderabad.*

11 *World Bank, 2023. Private Sector Engagement for Tuberculosis Elimination: India's Journey from Pilots to National Scale-Up (2012–2021). Available from: https://documents.worldbank.org/en/publication/documents- reports/documentdetail/099447203162313246/idu0c355d530019b80453d0b9070996ca75cbd4d. This document outlines the entire history of private provider engagement and contracting in India's TB program up until 2023. A shorter version is available as a policy brief at: https://documents.worldbank.org/en/publication/documents- reports/documentdetail/099508003162315574/idu05ac8caf90be5d04a680b59404f03c63b48b7.*

of priority TB services.[12,13] These efforts to increase private-sector engagement and the development of an online TB database (Ni-kshay) led to increased TB notifications. From 2012 to 2021, annual TB notifications from private providers grew 163 times (from 0.3 to 49 per 100,000).

This represented nearly 29% of the average total annual notification between 2018 and 2021 (figure 1), almost double the ~15% reported between 2014 and 2017.[14]




*Source: Central TB Division.*

*Source: World Bank, 2023. Private Sector Engagement for Tuberculosis Elimination: India's Journey from Pilots to National Scale-Up (2012–2021).*

**Figure 1. National private- and public-sector TB case notification (2012–2021)**

The NSP 2017–25 emphasizes the importance of private-sector engagement in part through regulation and policies to encourage adherence to TB care standards but especially through contracting. The NSP proposes that the GOI must seek ways to make contracts attractive to the private sector, stating that "program staff must understand that RNTCP needs private providers more than private providers need the RNTCP."[15]

## 1.2 NTEP Guidance on TB Partnerships

In 2019, the NTEP published a Guidance Document on Partnerships that elaborated on various mechanisms to contract out TB services to the private sector.[16] The document describes a fundamental shift in the program's approach to public-private partnerships: moving from input-based financing to an output- and results-based framework, which allows for "market discovery" instead of prescriptive costs. The document's purpose is to guide states while emphasizing the flexibility and autonomy of each state to design and establish its own approach to partnership with the private sector, based on the state's specific needs, context, and applicable laws.

*12 PPSAs are typically NGOs and private-for-profit institutions of different sizes and capacities that are onboarded by the Government of India to engage private-sector TB providers. Previous iteration of PPSAs were called Public Private Interface Agencies (PPIAs).*

*13 Central TB Division, Ministry of Health & Family Welfare. (2023). Creating synergies to ensure quality TB care: compendium of best practices to engage the private sector providers and patients in India. Available from: https://tbcindia.gov.in/showfile.php?lid=3682*

*14 The decrease in annual notification observed in 2020 is likely due to the COVID-19 pandemic.*

*15 Revised National Tuberculosis Control Programme, Ministry of Health and Family Welfare, Government of India. (2017). National Strategic Plan for Tuberculosis: 2017–25 Elimination by 2025. p34. Available from:*

*16 Central TB Division, Ministry of Health and Family Welfare, Government of India. (2019). Guidance Document on Partnerships: Revised National Tuberculosis Control Program. https://tbcindia.gov.in/showfile.php?lid=3456.*

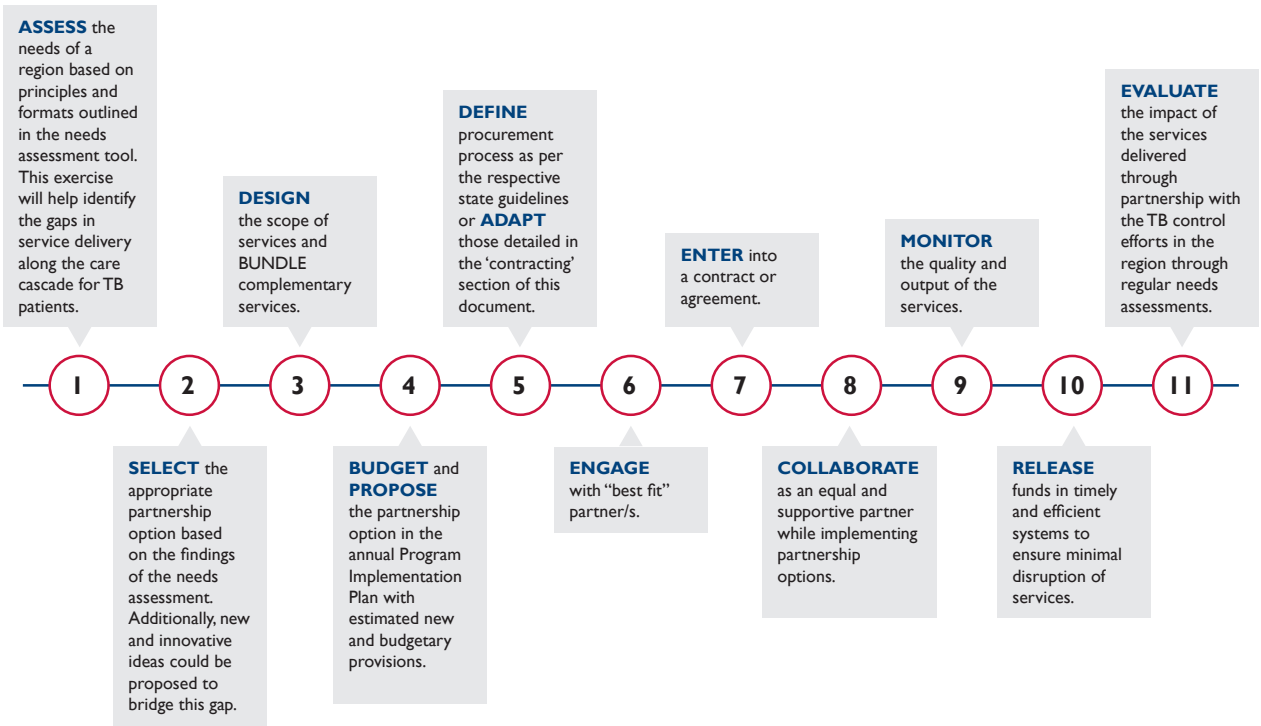
The Guidance Document covers the following topics: an overview of available partnership options; scope for innovations; scope of services under each partnership option; and the implementation process, including contracting, costing, and developing a performance-based matrix and a monitoring and evaluation (M&E) framework. The document reviews the critical steps in establishing a partnership (figure 2) but does not provide detailed SOPs for each activity.

In 2023, the NTEP released an Operational Manual on Partnerships, which serves as a companion to the original Guidance Document.[17] The Operational Manual provides step-by-step guides to the design, implementation, and management of partnerships with the private sector. The manual includes inputs from experts, implementers, and technical support partners (including HS4TB) and captures the contracting experiences since the publication of the Guidance Document in 2019.

## 1.3 Rules and Regulations for Public Procurement and Contracting

Public health is a state subject in India; hence, the rationale for and decision to outsource health care services is determined by individual state governments, and any guidance provided by the NTEP or other public health–related entities at the central government is subject to approval and adoption by the state government. However, if a state does decide to outsource health services, the contracting process must adhere to the provisions set out in India's General Financial Rules (GFRs) in addition to any relevant regulations laid down by the state.[18]

Most recently updated in 2017, the GFRs provide a comprehensive framework for the government procurement process and contract management in India, focusing on ensuring the efficient and effective execution of contracts and the protection of the interests of both the government and service providers. The rules also guide budget preparation, expenditure monitoring, and financial reporting.




*Source: 2019 NTEP Guidance Document on Partnerships.*

**Figure 2. Steps for state TB programs to establish partnership options**

17 National TB Elimination Program. (2023). Operational Manual for Partnership under National Tuberculosis Elimination Programme. https://tbcindia.nic.in/showfile.php?lid=3705.

18 1. Gujarat State (Gujarat State Purchase Policy 2016, THE FINANCIAL POWERS (DELEGATION) RULES, 1998, 2. Andhra Pradesh (The Andhra Pradesh Financial Code), 3. Guidelines for Procurement of Goods, Finance Department, Government of Odisha, 4. Bihar Financial Rules 2005.

Key provisions pertaining to contracting described in the GFR 2017 include:

- Requiring the use of the Government e-Marketplace (GeM) portal for procurement of goods and services
- Stipulating the thresholds that should be met for different procurement processes (i.e., mode of issuance of RFP, limited or open tender)
- Requiring the use of competitive bidding processes and the selection of contractors based on their technical and financial capabilities
- Providing specifications for when and how quality and cost-based selection (QCBS) should be used for the evaluation of bids
- Stipulating the requirements for contract documentation and providing details on how all contract-related documents should be maintained and kept confidential
- Requiring that the performance of contractors be regularly monitored to ensure that they are meeting obligations under the contract, including the use of performance indicators and the implementation of regular performance reviews
- Providing guidelines for the termination of contracts, including the circumstances under which a contract may be terminated and the procedures to be followed in the event of termination
- Providing guidelines for resolving disputes arising from contracts, including mediation, arbitration, and other forms of alternative dispute resolution

The GFR 2017 devotes a chapter to outsourcing services, including Rules 198–206; these rules are reproduced in Annex 1 for ease of reference. For additional contracting guidance, there are also manuals for procurement of goods, procurement of works, and procurement of consultancy or other services developed by the Department of Expenditure of the Ministry of Finance. However, these are broad and are to be taken as general guidelines. Of note, the Manual for Procurement of Goods (MPG) contained guidelines for purchasing goods (an updated version of the MPG is available as of June 2022).[19] Ministries/departments are advised to supplement these manuals to suit their local/specialized needs by issuing their own detailed manuals (including customized formats), standard bidding documents, and schedule of procurement powers to serve as detailed instructions for their procurement officials.

In India, the legal and regulatory framework for public procurement broadly comprises the following components:[20]

- Constitutional Provisions—the Constitution authorizes the Central and State Governments to contract Goods and Services and directs autonomy in public spending to states.
- Legislative Provisions—supporting central legislation derived from the Constitution exists, such as the Contract Act of 1872, Prevention of Corruption Act of 1988, Sales of Goods Act of 1930, and Arbitration and Conciliation Act of 1996. In addition, some of the states like Tamil Nadu, Karnataka, and Rajasthan have enacted state-specific legislation such as the Tamil Nadu Transparency in Tenders Act, 1998, the Karnataka Transparency in Public Procurement Act, 1999, and the Rajasthan Transparency in Public Procurement Act, 2012, which govern public procurement procedures in these states.
- Guidelines—comprehensive rules and directives on procedures for financial management and public procurement are listed in the GFR, as outlined above. In addition, the Delegation of Financial Powers Rules, 1978 (DFPR) delegates the Government's financial powers to various ministries and subordinate authorities.

Civil authorities reinforce the framework, including:

- The Central Vigilance Commission (CVC), tasked with increasing transparency and objectivity in public procurement
- The Competition Commission of India (CCI), which checks anti-competitive elements
- The Central Bureau of Investigation (CBI), which is engaged for the investigation and prosecution of criminal activities in the procurement process

*19 Unlike the GFR, departments, ministries or state authorities are not mandated to use the MPG and can develop their own manuals.*
*20 India: Public Procurement 2019—Mondaq. https://www.mondaq.com/india/government-contracts-procurement–- ppp/930884/public-procurement-2019.*

# 2. CONTRACTING (INPUT- AND OUTPUT-BASED): OVERVIEW AND KEY CONSIDERATIONS

Contracting occurs when a funding agency (such as a central or state or district government, insurance entity, or development partner), also known as a purchaser, gives resources to a nongovernment entity (such as an NGO or private-sector firm), also known as a service provider, to provide a specific set of services.[21] The service provider generally uses its own workers, facilities, equipment, and supplies to provide the service. The government may issue output-based contracts (as with PPSA contracts) or input-based contracts and/or supply the program with inputs in kind. Normative documents and guidelines, such as the 2019 Guidance Document and its supporting Operational Manual, clearly outline specific situations where the GOI should use input-based contracts (e.g., for behavior change campaigns) and fee-for-service contracts (e.g., for diagnostics) rather than output-based contracts (e.g., for most other TB services).[22]

## 2.1 Enabling environment for effective contract management

Contract management is defined as the process of actively managing contract implementation to ensure the efficient and effective delivery of the contracted outputs or outcomes.[23] Strong management can maximize the efficacy and value for money of the contracting process and is heavily influenced by upstream activities, such as those undertaken during the procurement planning, choice of contract, and contractor selection phase.

Figure 3 below, from the World Bank procurement guidance document, summarizes best practices at each contract management stage. Although engaging in good contract management throughout the process is important, the costs of remedying a defect become increasingly expensive, time-consuming, and risky the further downstream they occur. It is much better to correct an error in a bidding document before the contract has been awarded than to attempt a correction during the contract implementation. Therefore, allocating sufficient resources and time to establish the initial procurement plan is critical at the start of the contracting process.




*Source:World Bank. (2018). Procurement Guidance: Contract Management Practice.*

**Figure 3. Upstream and downstream elements of the contracting process**

21 *Loevinsohn B. (2008). Performance-Based Contracting for Health Services in Developing Countries: A Toolkit. The World Bank Institute. Available from: https://openknowledge.worldbank.org/server/api/core/bitstreams/3b1d3598-adba-5969-99bd- 74f78e43eb5b/content.*

22 *For more information on types of contracting, refer to Chapter 4 of the Operational Manual.*

23 *World Bank. (2018). Procurement Guidance: Contract Management Practice. Available from: https://thedocs.worldbank.org/en/doc/277011537214902995- 0290022018/original/ProcurementContractManagementGuidance.pdf.*

The following are some main considerations and needs of public procurement:

- Before embarking upon contracting activities, governments must **invest resources in capacity building.**
- Governments engaging in contracting need **well-developed information systems (preferably electronic)** to capture programmatic, financial, and administrative information and manage information flows and communications.
- To effectively purchase services, the government must have **payment procedures and accounting systems in place for timely disbursement of funds.**
- **Routine monitoring of contractor performance undertaken jointly by the purchaser and contracted organization** ensures that contractors are on track to achieving program objectives.
- **Performance evaluations** are a critical part of the contracting process and can be as important as the contract itself.
- Contracting requires a significant investment of time from all parties involved, and it is generally **more productive for a purchaser to develop a long-term partnership with the providers** and assist in their development and capacity building rather than switching providers at the end of each contract.[24] However, this continued partnership should be contingent on strong performance and measured by M&E indicators and acceptable managerial and operational performance. Furthermore, adequate risk mitigation measures must be considered and carefully implemented to avoid facing legal impasses with underperformers while creating unfair competition.
- **Securing political commitment to contracting,** often through the identification of champions, is essential to a sustainable contracting process.

## 2.2 The contract management cycle

Since the creation of the PIUs, states have made ongoing efforts to increase private-sector engagement, focusing on advancing the PPSA contracting procedure. Figure 4 shows the pathway from the intent to contract, through the procurement process associated with contracting, to managing the contract to closeout. This pathway, which includes activities and desired turnaround times for steps in the contract management cycle, is the organizing framework for the remainder of this document.

The suggested timeline for each step within this roughly six-month cycle is based on a combination of the established GOI process for contracting, best practices, the expertise and experience of HS4TB contract management experts, and contextual insights reflecting discussions with stakeholders, including members of the Central TB Division (CTD) and state NTEPs, donors, and partner organizations.[25] Turnaround time would vary from case to case depending on various factors, such as administrative approvals as per delegation of financial powers (i.e., district versus state), contract value (quotation versus RFP process), and complexity of the scope of services (i.e., PPSA versus X-ray services). Although there may be some state-by-state variation in some of the sub-activities required to proceed from one step to another, this cycle represents a systematic approach to contracting out health services.

*24 England R. (2000). Contracting and performance management in the health sector: a guide for low and middle income countries. The Health Systems Resource Centre at the United Kingdom Department for International Development. Available at: http://www.heart-resources.org/wp-content/uploads/2012/10/Contracting-and-performance-management-in-the-health- sector.pdf.*

*25 The steps in this diagram are aligned with table 2 of the NTEP Operational Manual; based on HS4TB experience; however, the expected time taken for the process should be longer—24 weeks compared with 16–17 weeks in the Operational Manual.*

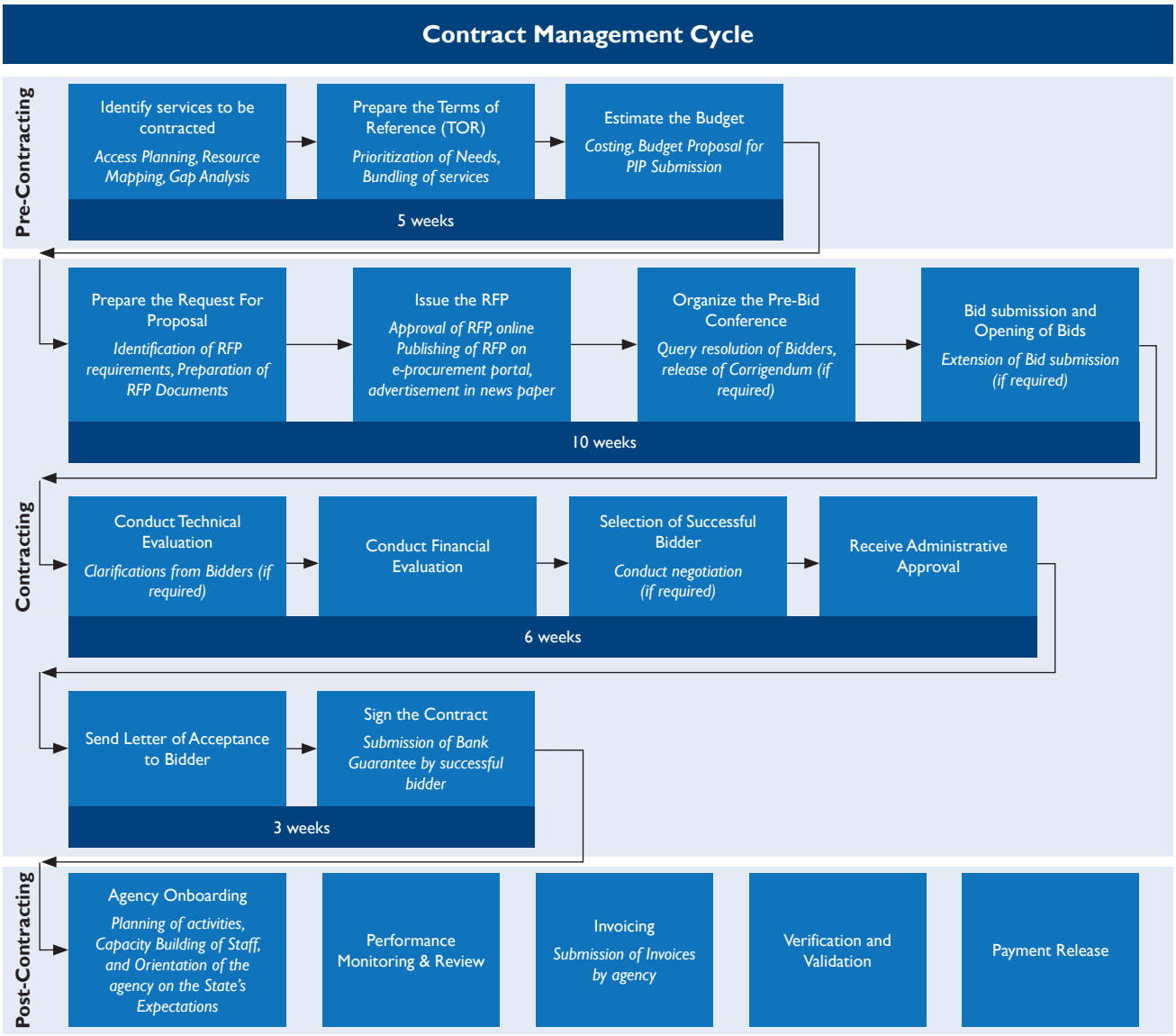


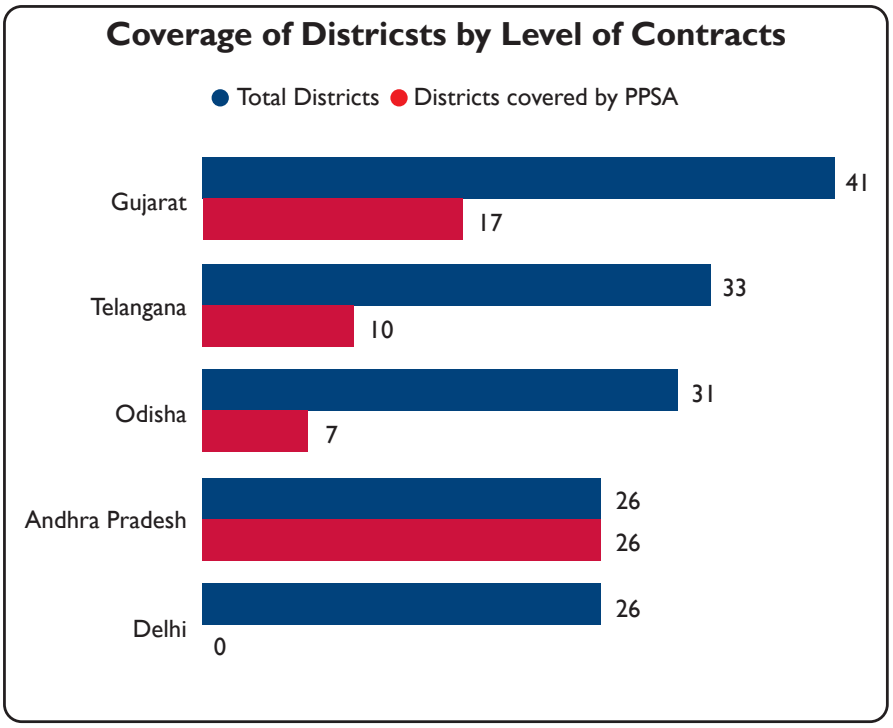

**Figure 4. Steps in the contract management process**

# 3. CONTRACTING STATUS, CHALLENGES, AND POTENTIAL SOLUTIONS IN THE FIVE HS4TB-SUPPORTED STATES

In the five high–TB-burden states of Andhra Pradesh, Telangana, Gujarat, Odisha, and Delhi, the HS4TB project has established specialized technical support units called PIUs, comprising a team of public health, contract management, public finance management, and M&E professionals. The PIUs' mission is to assist the State TB Cells (STCs) in improving their capacity for engagement with the private sector by facilitating effective contracting and contract management procedures.

## 3.1 Current status of contracting in HS4TB States

Three of the five HS4TB-supported states (Andhra Pradesh, Telangana, and Odisha) had finalized contracting for all PPSAs with supporting budgets approved in the State Record of Proceedings (ROPs) for the fiscal year 2022–2023 at the beginning of 2023 (figure 5).




| Total Districts | Districts covered by PPSA |
|---|---|
| 157 | 60 |

**Figure 5. Status of PPSA contracting in five HS4TB-supported states for fiscal year 2022–23, total districts versus districts covered**[26]

In the remaining two states, Gujarat and Delhi, the PIUs are actively supporting the procurement process at the STC to move the scheduled PPSA procurements forward. PPSA coverage in the states and plans for possible future PPSA procurements are outlined in table 1.

**Table 1. PPSA coverage in four of the HS4TB states**

| State | Total Districts | Target Districts for PPSA | Districts Covered | Remaining Districts | Comments |
|---|---|---|---|---|---|
| Gujarat | 41 | 39 | 17 | 24 | RFP for 22 districts has been published. Two districts (Tapi and The Dangs) are not included in PPSA due to negligible private- sector presence. |
| Andhra Pradesh | 26 | 26 | 26 | 0 | N/A |
| Telangana | 33 | 10 | 10 | 23 | Proposal for PPSA in remaining districts may be considered in the next program implementation program (PIP) |
| Odisha | 31 | 7 | 7 | 0 | Proposal for PPSA in remaining districts may be considered in the next PIP |
| Delhi | 25 | 25 | 0 | 25 | RFP for PPSA is under process for approval from competent authority at the state level |

The PIUs are also actively contracting non-PPSA partnerships at the state and district levels in all HS4TB states, as shown in figure 6 below.

*26 As of May 2023.*

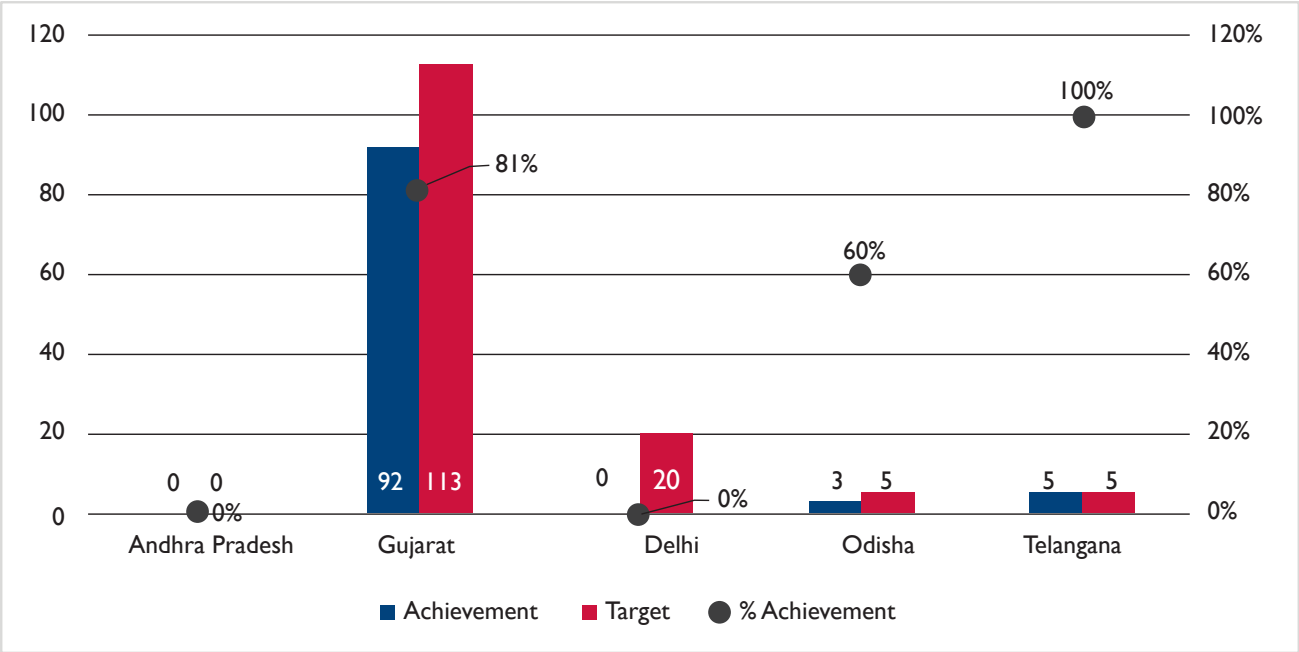



**Figure 6. Status of non-PPSA partnerships in five HS4TB-supported states for fiscal year 2022–23— target versus achievement**[27]

Currently, the target for the number and type of partnership options (i.e., the identification of services to be contracted) is proposed by the individual districts as per their local programmatic requirement and incorporated in the PIP after consultation with the NTEP team at the state level, including the State TB Officer, State TB Demonstration Centre (STDC) Officers, Intermediate Reference Laboratory Officers, other program officers, and WHO consultants. A systematic needs assessment using a defined methodology and tool will be undertaken to determine the kind and number of partnerships needed to address service delivery gaps in the districts (see details below).

### Tracking of Contracting Status

The HS4TB PMU has developed a contracts tracker, which is being used by all five states to enable each PIU and STC to track the progress on various milestones of the contracting process and support the NTEP on the engagement toward partnerships. The contracts tracker contains information on all the approved contracts under the ROP with the approved budget, status of contracting, and key dates with expected timelines. The tracker will be further developed into a contract management dashboard to monitor the contracting progress at the state and level (please refer to Annex 2: Contract Tracker).

## 3.2 Contracting challenges and solutions

The idea underpinning India's public procurement regime is to acquire specified quality products and services at the most competitive costs, transparently and non-arbitrarily. During this process, several challenges can arise from the lack of uniform implementation of comprehensive procurement rules and from the lack of clear guidelines that allow procuring agencies to alter contract structures to suit the different types of procurement (i.e., goods and services). Sometimes, procurement agencies may mandate different qualifying criteria, financial terms, selection procedures, and so on for very similar public-sector tasks (e.g., PPSA contracting for 17 districts in 2021 adopted the QCBS methodology of selection in the RFP, whereas the PPSA RFP for 22 districts in 2023 has adopted the least cost selection [LCS] method of selection). Also, given the number of stakeholders involved, it is not uncommon for decisions to be stalled at more than one level. The average time between the first release of an RFP and the final contract award could be several months or even years in some instances (e.g., PPSA contracting for 17 districts in Gujarat state took 21 months). Finally, despite the economic importance of public procurement operations and

*27 As of March 2023.*

the quantity of public money spent toward the procurement and contracting function, the staff involved with the procurement and contracting process is usually not equipped with the necessary knowledge and skills to accomplish the desired performance while adhering to the standards of good governance and professional etiquette.[28]

As a result of these gaps, there are challenges at each stage of the contract management process. The details of these challenges and the possible solutions are explored in the sections below.

## A. Pre-Contracting Phase

Although contract implementation is frequently the focus of the contract management process, upstream efforts undertaken during pre-contracting significantly impact contract success. The pre- contracting phase is crucial for ensuring efficient planning to identify service delivery gaps and to estimate budgetary resources required for effective contract implementation that will achieve the targeted outputs and outcomes. A comprehensive analysis during this phase is critical for identifying and addressing difficulties prior to contract awarding and, if done well, will save substantial time and resources for all contract stakeholders.

The HS4TB project encountered two major issues during the pre-contract phase, the first associated with identifying service delivery gaps and the second with resource estimation. A poorly implemented or absent needs assessment weakens the rationale for a particular partnership, as program managers do not have documented evidence of a gap and are therefore not confident in the added value of such a partnership. Limited partnerships resulting from a lack of systematized needs assessments also burden a resource-limited public health system, leading to limited coverage and poor quality of care. Managers who are doubtful of needs but who still decide to move forward will face increased risks of non- endorsement by relevant authorities. In addition, an absence of appropriate costing for budget planning can lead to under- and over-budgeting for partnerships in states' PIPs. This section will further explore the nature and implications of these challenges while reflecting on potential solutions.

### i. *Thematic Area—Identifying Services to Be Contracted: The Needs Assessment*

**Challenges:**

Identifying services to be contracted is a critical first step in determining specific gaps and challenges that states may be able to address by contracting with the private sector. Prior to this report, none of the five states had carried out a comprehensive needs assessment to inform the contracting process.

Instead, states and districts made decisions based on "felt need" rather than undertaking a thorough and systematic needs assessment. India's Constitution and relevant legislation confer significant autonomy to states in managing health within their borders. There are not strong incentives, e.g., from central mandates, for states to adopt/endorse and follow a more rigorous and evidence-based approach to assess their partnership-based contracting needs. Furthermore, rather than measuring the quality of contracts in addressing defined service delivery gaps, they may focus on establishing a target quantum of partnership contracts.

**Implications:**

In the absence of comprehensive needs assessments, there are gaps in procurement, which means investments cannot be prioritized to the areas of greatest need, and patients are left without essential TB care services. Also, the lack of evidence-based needs assessments weakens the credibility of the program as it seeks administrative approvals for the initiation of procurements, resulting in delays in both the approvals and in meeting the service needs of the program.

*28 The HS4TB PIUs were established in the five states based on the capacity gaps found during the PATH assessment on private- sector engagement through contracting. It is difficult to generate quantitative data for such a qualitative aspect of human resources in the absence of any system or mechanism for monitoring and capturing parameters on these inefficiencies in the government system. Therefore, HS4TB is left only with qualitative responses collected during the capacity assessment.*

**Proposed solution:**

### Needs assessment methodology and tool

HS4TB has developed a needs assessment methodology and tool, which was adapted to and piloted in the focus states to inform decisions to scale up in other states and districts.

- The assessment starts with a desk review and analysis of secondary data on the key programmatic performance indicators retrieved from the Ni-kshay portal to identify performance gaps in the NTEP program.[29] Assumptions on partnership needs are then developed.[30] Next, a blend of qualitative and quantitative methods are used to assess TB-specific needs.
- The qualitative approach uses a semi-structured interview template that covers 15 questions on programmatic performance, private-sector engagement, engagement of civil society, partnership options, organization of the services, challenges faced and redressal mechanism, and leadership.
- The quantitative approach requires primary data collection for issues and indicators not covered in Ni-kshay. This is used to validate the secondary data analysis findings, identify additional systemic and programmatic gaps not found in the desk review, and determine district-specific partnership needs.[31]

After these 3 data collection processes, the remaining steps are:

- Compiling issues and identifying those to be addressed through partnership options
- Ensuring that needs assessment findings (after the process of costing and budget estimation; see below) are reflected in the next PIP
- Ensuring that the findings of the assessment are made publicly available.

HS4TB's work on the pre-contracting needs assessments methodology described above was reworked based on feedback received from a private sector review meeting conducted by the CTD in June 2023 and complemented with actual implementation cases (i.e., the Odisha case study).

HS4TB piloted this assessment in 25 districts across the 5 supported states to assess not only the overall gaps in the NTEP but also systemic and programmatic gaps to find opportunities for private- sector partnership. Findings were shared with and validated by the STC. The process is being taken further to conduct a needs assessment for all the districts, with the involvement of the state and district officials, to be completed before the PIP process to ensure that the appropriate partnership options are budgeted for.[32] HS4TB state PIUs currently work with state and district NTEP teams to conduct this exercise in all the focused states. It should eventually be conducted in a routine and sustainable manner by the states and closely tracked by the NTEP, which similarly tracks each state's progress against specified targets, such as patient notifications. The completion of needs assessments could be included as another indicator to monitor on an annual basis.

The needs assessment results should be made available in a partnership and learning collaborative (PLC), a regular exchange between public- and private-sector stakeholders in each state. HS4TB is working with PPSAs and other partnership providers to educate them on the importance of the government conducting a needs assessment before drafting a proposal. With the development of a PLC, information on needs may be easily exchanged, and both the state government and the private sector will be better able to understand and work together to address service delivery gaps (please refer to Annex 3: Needs Assessment Methodology and Tool).

---

*29 The key indicators relate to: (1) notification, (2) microbiological confirmation, (3) drug sensitivity testing, (4) HIV testing, (5) diabetes testing, and (6) treatment outcome.*

*30 A high notification gap score leads to consideration of a PPSA partnership option. If a high notification gap is still observed in a PPSA district, then it leads to consideration of active case finding or ACSM activities.*

*31 Quantitative primary data is collected on systemic gaps in logistics and supply chain for drugs/diagnostics/consumables/equipment, infrastructure, HR and training, presumptive TB examination, testing, screening for latent TB infection, Ni-kshay Poshan Yojana (nutritional support), TB preventive therapy, adherence support, ACSM, and active case finding.*

*32 PPSA partnership was recommended for 12 out of the 25 districts assessed across the five HS4TB-supported states. Public health action and molecular diagnosis and SCT were the non-PPSA partnership option packages most frequently suggested with recommendations in 16 and 7 out of 25 districts, respectively. Please see Annex 3 and consult the needs assessment for partnership options document for more information.*

### Reference to the Operational Manual

The Operational Manual recommends in Chapter 2 that needs assessments be carried out comprehensively in a three-step manner:

1. Building a service delivery plan, which involves access planning along the patient care cascade according to guidelines
2. Capacity analysis, with the mapping of existing resources and current capacity
3. Gap analysis, involving an assessment of the gap between the service delivery plan and the current capacity

Chapter 2 of the Operational Manual provides several examples and recommends combining bottom-up and top-down approaches. Chapter 3 of the Operational Manual explains the follow-on process of deciding what services to bundle.

ii. *Thematic Area—Estimating the Budget*

### Challenges:

Estimating the budget for partnerships is an essential step in the pre-contracting process and should contribute to the state's PIP. The existing costing estimates are outdated, and none of the five states has done any costing exercise in the past to determine budgets for the NTEP-recommended partnerships. Because state TB cells are already overburdened and understaffed, it is difficult for them to prioritize costing investigations, especially when these are time-consuming and require specialized knowledge and a uniform approach for collecting and analyzing data. Furthermore, STCs do not see a need since NGOs and private providers will bid on the RFPs and include their cost proposals; the states can then make their selections accordingly based on the lowest cost criterion within the available budget. Because the CTD does not require states to do costing analyses to inform budgeting, this activity has received very little attention at the state level, and there is very little motivation to change.

### Implications:

Even though the team is working with new bids in which rates have been raised, the absence of market-derived costs leads to several issues. Chief among them is poor resource planning in PIPs, which results in either insufficient resources for addressing program needs through partnerships or a large amount of unutilized money due to overestimation. Further, inadequate budgeting for partnerships has downstream effects on the rest of the contracting cycle. Inaccurate cost estimates can weaken bids' viability by encouraging under-bidding and leading to selection of the wrong agency. Without the right costing approach, program managers face a lengthier contracting process and are less likely to engage agencies based on technical criteria only, use strategic purchasing, or support smaller volume contracts.

Meanwhile, depending only on previous purchase prices without modifying according to local context (see suggested process outlined below) could be risky because volume and local factors can have a significant effect.

### Proposed solution:

### Budget estimation tool for key TB care services

HS4TB intends to develop a tool allowing budget estimation at the state level after data collection for priority TB services.[33] The budget estimation tool can be developed using a market scan (market prices charged by existing organization), prevailing rates (rates prescribed under any other government scheme), and/or activity-based costing (costing each input), and must be grounded in state and district realities. HS4TB will triangulate available information from a market scan and prevailing rates for development of a budget

*33 Most currently active contracts across HS4TB priority states were already budgeted and approved in the ROP for 2022–24. Therefore, the project had no opportunity to support/conduct needs assessments or costing for these contracts.*

estimation tool, as these two approaches are simpler and easier to implement and sustain in the program. HS4TB acknowledges that activity-based costing is the most accurate estimation method, and ideally, estimates would be periodically updated using such approaches, but due to resource limitations and the time-intensive nature of costing studies, this method is not possible to implement every time.

The state-level budget estimation tool will be designed to consider detailed information about factors influencing the unit costs, such as volume, geography, local market dynamics, cost of living, demand for the service, inflation, local epidemiology, ease of delivering services, the risk involved, and other factors. HS4TB will provide this tool to assist states in estimating budgets for key TB care services and to assist the states in establishing a mechanism for utilizing these budget estimates by endorsement from a committee of experts or through an adequate administrative procedure.

### Reference to the Operational Manual

Chapter 4 of the Operational Manual recommends doing the budget estimation at the same time as the terms of reference (TOR) development, if possible, with the assistance of finance and procurement experts from local National Health Mission (NHM) teams, members of State Technical Support Units (STSUs), and consultant networks. Three possible methods are outlined: market scan, activity-based costing, and prevailing rates. It also refers to the Needs Assessment guidance in Chapter 2, which suggests collecting some budget-related information (market prices) during the resource mapping phase. HS4TB will align its budget estimation tool with the Operational Manual on market-derived costing using one or more of the suggested methods (i.e., market scan, activity-based costing, and prevailing rates) for budget estimations.

## B. Contracting Phase

During the contracting phase, program staff typically encounter three challenges when attempting to implement successful public procurement/contracting for private-sector engagement: limited knowledge and skills to develop and evaluate performance-based RFPs and bids/proposals submitted by bidders, insufficient awareness of the regulatory framework (GFR, State Financial Rules), and limited use of novel e-procurement platforms (i.e., GeM). Simultaneously, the bidders' suboptimal use of the GeM platform also limits the private players' participation in the bid.

i. *Thematic Area—Preparing the RFP*

### Challenges:

States have a Medical Services Corporation that primarily procures drugs and equipment and has set policies and processes. Still, these policies and procedures do not exist to procure services. For TB services specifically, the State and District TB Cells have limited skills in RFP development, and very few technical officials have expertise in procurement and contract management. There is a lack of availability of sample RFP formats for priority TB care services and insufficient training for NTEP staff on RFP drafting with a focus on opting for a suitable type of contract (i.e., input-based, fee-for-service, or output-based); designing a clear and specific TOR that has a logical approach to the bundling of services; and outlining terms that are clear, reasonable, internally consistent, and not overly complex or demanding in the areas of bid fees (i.e., avoiding excessively high amounts for bid fees, earnest money deposits (EMDs), and performance security), eligibility criteria (i.e., relevant work experience, financial capability), technical evaluation criteria, penalty provisions, and performance-based payment terms (which must be consistent with the TOR indicators).

In 2020, when states were gearing up for PPSA contracting through domestic budgets, the CTD shared sample RFPs with the states to start the PPSA procurement process. Most PPSA RFPs are developed at the state level with the involvement of the STC, the STDC, the WHO team, and technical experts from development partners, following the RFP templates shared by the CTD. Therefore, the structure of RFP documents was less of a concern for PPSA contracting, and the challenges in RFP development cited above are more related to the non-PPSA services than to the PPSA services.

The existing PPSA RFPs floated by the HS4TB-focused states have been assessed. In the analysis, HS4TB

compared the headings used in each RFP with the sample PPSA RFP available on the CTD website but did not analyze RFP content in-depth.[34] The general findings were that RFPs were well structured and contained the correct terms and conditions mentioned in the sample RFP. The minor variations, such as including similar clauses under different sections in the different state RFPs, may be as per the state practices. The sample RFP contains the relevant clauses and sections for PPSA contracting. However, the RFP template must be modified for non-PPSA services by revising the relevant clauses and sections (i.e., qualification criteria, technical evaluation, scope of services, payment mechanism, and penalty).

Currently, model RFPs for different non-PPSA TB care services are not available. HS4TB is supporting the states in modifying the relevant sections of the existing RFP template for different non-PPSA service procurement (e.g., first-line line probe assays [FL-LPA], X-ray, Interferon gamma-release assays [IGRA], annual maintenance contract of lab equipment, etc.).

**Implications:**

Poorly drafted terms and conditions and ambiguous specifications in the RFP may cause some bidders to submit low-priced bids. Other organizations might not submit proposals if the RFP contains insufficient information or clarity. This lack of interest could be due to concern about making little or no profit from the engagement, because unclear terms force bidders to make numerous assumptions, which increase their risk. Furthermore, when requirements are inadequately stated, bidders will perceive them differently and bid based on their subjective interpretations. Such variations in bidders' understanding of the RFP might make it difficult to compare offers and increase the risk of a poor procurement selection. For example, the NTEP in Andhra Pradesh floated an RFP for sputum transportation in April 2023. It did not receive any bidders even after extending it until May 2023. In June 2023, it went ahead with re- tendering and received bids from two bidders. During technical specification, one bidder proposed an app-based monitoring mechanism, whereas the other bidder proposed a manual model with no IT-based support system. The difference in the proposed methodologies might have been avoided by addressing the ambiguity of the RFP's terms and conditions to the bidders on this point.[35]

**Proposed solutions:**

**Capacity building of NTEP officials on public procurement and contracting**

PIU facilitates the STC in preparing RFPs by training and coaching designated officials involved in RFP preparation. However, a thorough capacity-building workshop for NTEP/NHM officials encompassing various components of RFP preparation is planned by HS4TB in targeted states between July and August 2023.

HS4TB's capacity-strengthening approach will target the following technical areas supporting RFP preparation:

- Types of tenders
- GFR 2017/State-specific financial rules[36]
- Legal compliance
- Defining the scope of work
- Eligibility criteria for bidders
- Designing the payments matrix and terms of payments
- General terms and conditions
- Special terms and conditions

---

*34 NTEP. Request for Proposal (RFP) for Selection of Patient Provider Support Agency (PPSA) for Providing Tuberculosis Related Services under NTEP for [Number of Districts] of [State Name]. https://tbcindia.gov.in/showfile.php?lid=3694*

*35 Quoting the RFP for "Sample collection & Transportation" published by Andhra Pradesh in 2023, the scope of work in contained the following text, which created ambiguity about whether an electronic solution was required or not: "Sample tracking and related records: It is expected that the records of samples transported will be always maintained by the selected Bidder. The system tracking mechanism can be in hard copy and electronic. A digital tracking software, linked to barcoding will be preferred. Reports: The Bidder must provide periodic—monthly, quarterly, annually and at the end of the contract reports of the following. These must be Excel based and can be generated manually (hard copy) or preferably electronically in an automated fashion."*

*36 https://tbcindia.gov.in/showfile.php?lid=3695 has tools for EMD and performance security calculations.*

- Financial norms for EMD and performance security
- Bid evaluation (LCS method, QCBS methodology and tool)[37]
- Negotiation
- Notification of award and signing of contract

### Development of model RFP templates

HS4TB will support the NTEP in developing standard RFP templates for Non-PPSA services.

### RFP analysis framework

An analytical framework to assess similarities, differences, and overall quality of RFPs in more depth will be conducted in future HS4TB work. This future work and an associated checklist to assess the quality of RFPs will allow the NTEP to draw some conclusions about the quality of each RFP and to provide recommendations for improvement during the design phase.

### Reference to the Operational Manual

Chapter 4 of the Operational Manual describes the types of contracts, selection/evaluation processes, contractual arrangement (i.e., subcontracting and consortiums), and securities (i.e., EMD, performance security) and in Section 4.2, it explains all the steps in the contracting process. HS4TB efforts align fully with these sections of the Operational Manual but provide a training curriculum and in-person forum to convey these concepts. In addition, many terms from the RFP become important clauses in the final contract and are therefore critical points to cover in the training, as they can greatly affect contract implementation.[38]

ii. *Thematic Area—Issuing the RFP*

### Challenges:

The GeM is an online platform where government departments and ministries can purchase goods and services.[39] The GFRs authorize procurement on GeM. GeM easily enables purchasing goods and services in specific categories already offered through the platform. For other services, the procurer on GeM must follow a specialized process of custom bidding. Most NTEP procurement of services would fall into categories unavailable on GeM (e.g., PPSAs, IGRA testing, X-ray services), necessitating training of NTEP staff in procurement management on the GeM portal. No formal training on e-procurement through GeM portals has been provided yet to NTEP personnel. Similarly, vendors' limited experience and exposure on how to participate in the custom bids through the GeM portal may lead to poor participation.

### Implications:

State governments have mandated all government departments/agencies to conduct all product and service procurements via GeM. The inadequate knowledge of NTEP personnel in drafting custom bids for services on the GeM website causes problems in initiating and managing procurement on the GeM portal, slowing down the contracting of services at the state and district levels. Similarly, service providers' limited knowledge and experience in participating in custom bids on the GeM portal makes it difficult for them to find the RFPs and participate.

### Proposed solution:

With the increased number of decentralized procurement activities at state and district levels through the GeM portal, HS4TB can support the training of NTEP officials on the portal and its different functions. Such support will help strengthen e-procurement knowledge and improve practice among the program staff. Similarly, PIUs will extend their support to the prospective bidders by sharing the correct information

37 *https://tbcindia.gov.in/showfile.php?lid=3695.*
38 *These points are covered in chapter 4 (Box 12) of the Operational Manual.*
39 *https://gem.gov.in/resources/pdf/GeM_handbook.pdf.*

related to published bids and by helping bidders to participate in the bidding process on GeM if they lack experience in adequately using the portal (i.e., bidders' registration on GeM and guidance on online participation).[40] Such support will be extended to all eligible bidders in order to avoid any bias in procurement processes.

**Reference to the Operational Manual**

Section 4.2 of the Operational manual briefly mentions the GeM, but HS4TB's hands-on training on the GeM portal is a new activity.

iii. *Thematic Area—Organizing the Pre-Bid Conference*

**Challenges:**

During pre-bid discussions, prospective bidders typically comment on criteria such as EMDs, performance guarantees, experience criteria, turnover requirements, payment timelines, and penalty provisions. The government often does not substantively respond to these bidders' comments, or responds conservatively, reflecting the limited flexibility toward specific engagements with private-sector partners. This sometimes results in conditions that are too restrictive for bidders.

**Implications:**

The government's lack of responsiveness to the bidders in pre-bid meetings leads to limited bidder involvement, reducing competitiveness.

**Proposed solution:**

HS4TB will provide a format for capturing and analyzing bidders' comments and suggestions during and after pre-bid meetings. Results from the analysis will be presented to the RFP committee, underlining the benefit/non-benefit of accepting these suggestions considering the program's interest. Based on the results of this analysis, further revisions to the RFP criteria and terms and conditions will be explored. When requested, the PIU will assist the RFP committee in formulating and documenting explanations for approvals of updated criteria and conditions by competent authorities. The more systemic potential outputs of such analysis include the identification of potential changes needed in many RFPs across multiple states, with a priority for those changes that are easier to make (e.g., a low transaction cost and ease of changing or getting exceptions to any relevant rules and guidelines), but that would bring a significant potential benefit to bidders. This feedback management approach would foster a welcoming environment for bidders and encourage their involvement.

**Reference to the Operational Manual**

Section 4.2 in the Operational Manual outlines expectations for conducting and documenting a pre-bid meeting. HS4TB's proposed solution complements the Operational Manual by supporting an evidence- based process of documented amendments and explanations to ensure that actions are taken (if required).

iv. *Thematic Area—Conducting Technical Evaluations*

**Challenges:**

The Department of Expenditure's public procurement division issued guidelines in 2021 allowing the selection of bidders for work and non-consultancy services through alternative procurement methods such as the QCBS.[41] However, reports by several statutory authorities on integrity abuses in awarding public contracts demonstrate how contracting processes might be biased by fixing arbitrarily high financial/

*40 Support was provided to Thyrocare on GeM registration and participation in FI-LPA outsourcing in Gujarat state.*

*41 In QCBS, the bidders are asked to submit two separate proposals, one technical and one financial and both proposals are scored according to the criteria shared in the RFP. The final selection is done based on the total combined score (technical and financial), and in the calculation, different "weightages" can be given to the technical evaluation score and financial evaluation score.*

experience-related criteria—enabling only entrenched agencies to bid—or by fixing narrow technical specifications of works/products, allowing only a few to bid, or by purchasing services at the higher cost even if a lower cost option is available. Therefore, to address the subjectivity factor (higher in QCBS), many states continue to prefer the LCS method over the QCBS method. Also, the lack of sufficient knowledge and experience of program staff in designing quality parameters for technical evaluation criteria is one of the constraints in adopting QCBS.

In addition, as the 2021 Economic Survey states, the LCS method for bidder selection "does not work well" but remains common due to the regulatory default problem; i.e., "No decision maker wants to exercise discretion [by taking into account scores from a technical component] for fear of future questioning."[42,43] Furthermore, it is stated that these "…criteria may appear simple and quantifiable.

However, in a complex world where it may not be possible to define everything in the pre-procurement process, it is advisable to leave some discretion in the hands of administrators along with maintaining enough transparency and active supervision." Therefore, evaluation using QCBS is sometimes challenging to explain in the public procurement environment, where the more traditional and straightforward LCS method holds sway and is the preferred method for risk-averse officials when approving procurements on file or in the case of an audit. QCBS selections are harder to justify, and officials are often reluctant to risk having their decisions questioned and investigated.

However, QCBS is an essential tool, especially when:

- The scope of work/TOR cannot be precisely stated, e.g., when the task is complex and highly specialized.
- Buyers expect bidders to develop innovative solutions to challenges and need out-of-the-box thinking and approaches that they might not necessarily have the capacity or enough guidance to provide to bidders.
- Projects can be carried out in different ways, leading to proposals not being comparable through the LCS method without considering and evaluating the quality of their unique technical aspects.

**Implications:**

Avoiding using QCBS may lead to the selection of low-cost but low-quality bidders, who will then fail to meet the quality required by the NTEP.

**Proposed solution:**

HS4TB will advocate for adopting QCBS to contract services where quality and innovative approaches are necessary to address the program challenges and service delivery gap.[44] HS4TB's support will focus on helping states develop more objective technical evaluation criteria (see the RFP Analysis Framework) and processes to gain confidence in this method and thus maximize the likelihood of a fair selection process and minimize any subjectivity factor. Specifically, the project will address knowledge gaps on the QCBS methodology identified at the NTEP and NHM levels through sensitization and capacity-building workshops in each state

42 *Economic Survey 2020–21, Chapter 6: Process Reforms, page 188, The Problems of Regulatory Effectiveness. Available from: https://www.indiabudget.gov.in/budget2021-22/economicsurvey/doc/vol1chapter/echap06_vol1.pdf.*

43 *Big Bang Reform, Quietly Done: "L1" Will No Longer Be Default Way To Select Contractors For Government Projects. Available from: https://swarajyamag.com/ideas/modi-government-executes-one-of-the-biggest-reforms-quietly-five-major- changes-explained.*

44 *Previously, under the General Financial Rules, 2017, which government agencies and ministries had to follow while dealing with matters involving public finances, QCBS was used only for procurement in cases where the quality of consultancy services is of prime concern. The need to revise the public procurement strategy was felt after different agencies including the Central Vigilance Commission (CVC), Comptroller and Auditor General (CAG), and NITI Aayog flagged concerns that the L1 system is not the most effective when it comes to selecting bidders for products or services that require a high level of technical expertise. In Oct 2021, the guidelines issued by the Department of Expenditure's Public Procurement division allowed the selection of bidders for works and non-consultancy services through alternative procurement methods like the Quality-cum- Cost Based Selection (QCBS).*

from August to September 2023.[45] HS4TB will also advocate to government officials at the senior leadership level to adopt the QCBS approach wherever applicable.

**Reference to the Operational Manual**

Table 6 in Section 4.1 of the Operational Manual recommends QCBS for input- and output-based contracts. HS4TB will support efforts toward sensitizing and creating awareness among government officials for adopting QCBS as the preferred selection methodology for input-based and output-based contracts in line with the Operational Manual.

## C. Post-Contracting Phase

i. *Thematic Area—Agency Onboarding*

**Challenges:**

Output-based contracts do not have any input requirements such as for human resource (HR) or management and reporting processes. This gap has led to several operational challenges at the PPSA level, hampering efficient contract management. These operational issues include:

- Lack of minimum suggested staffing in the RFP (i.e., Technical Evaluation), possibly leading to insufficient staffing, causing excessive multitasking among service delivery staff
- Poor HR management with issues in hiring, high turnover rates, and delays in payment of salary, allowances, and incentives
- Poor inception planning and co-designing of activities with the state/district program team
- Limited training and capacity building of staff
- Lack of appropriate reporting processes, forms, and management information systems
- Poor communication and coordination with the government, and infrequent and poor-quality performance and progress updates

**Implications:**

Lack of emphasis on a minimum HR structure in the RFP results in PPSAs under-investing in HR, hiring staff with suboptimal qualifications, skill mismatch relative to the required work, low pay, understaffing, and high turnover. Similarly, poorly designed program management (e.g., state/district level coordination), financial management (e.g., reimbursements to field staff), and data reporting processes create inefficiencies and compromise performance.

**Proposed solutions:**

- The HS4TB team proposes a hybrid model—an input- and output-based RFP—mainly for PPSA contracts during the preparation of the TOR and RFP. This would ensure minimum HR availability to manage workload difficulties and to eliminate excessive multitasking, thereby optimizing PPSA operations. This hybrid RFP will be proposed.[46] Based on experience, HS4TB will strongly advocate for addressing the issue of insufficient HR at the time of PPSA extension/renewal (e.g., Gujarat state shared feedback with the PPSA to add the additional position of Cluster Coordinator in the contract extension). HS4TB also proposed a prequalification assessment (i.e., an organizational assessment and a costing study to establish benchmarks and ensure that the firms are adequately budgeting for HR) and a shortlisting of only those organizations that pass that assessment, followed by capacity building once selected firms are onboarded. This approach's impact will be evaluated by analyzing the pre- and post-status of program indicators and the experience of districts/state officials (i.e., qualitative interviews).

*45 Such as the use of an Excel file recently added by the NTEP at https://tbcindia.gov.in/showfile.php?lid=3696, which is for QCBS calculations.*

*46 Exact information (i.e., RFP development timeline, month, year and state-level locations of procurement trials) is difficult to forecast as of now because wherever PPSA contracts are active, states may opt for extension of contracts with the same terms and conditions without going into the new RFP process.*

- Following onboarding, HS4TB might additionally assist with the capacity building of PPSA staff using standard training materials on private-sector engagement activities such as provider mapping, linkages for diagnostic services, the orientation of DBT schemes for private patients and private providers, data management, and management information system (MIS) development. HS4TB will be careful to ensure that this is technical assistance and not the HS4TB project doing the work of the contracted PPSA.
- HS4TB proposes a platform (the PLC) to facilitate discourse between private-sector partners and the government to hear out their operational difficulties and facilitate the support needed to overcome them.

**Reference to the Operational Manual**

Chapter 4 of the Operational Manual recommends using hybrid input- and output-based contracts, where the state may decide to link 70%of the payments to outputs and 30% to inputs or activities. HS4TB's proposed solution focuses on operationalizing this concept.

ii. *Thematic Area—Invoicing*

**Challenges:**

The NTEP lacks a standard format for PPSA invoicing. On the PPSA side, most states have observed delays in PPSA invoice submission due to a lack of a robust data validation system within the PPSA, which generates a proper format for invoice production. This delay is exacerbated by the emphasis on submitting physical records alongside bills and by the lack of an interlinking mechanism between Ni- kshay and invoicing formats.

**Implications:**

Delay in invoice submission is one of the major contributors in the chain of factors delaying payment to the service provider.

**Proposed solutions:**

**Tool for invoicing**

The HS4TB team has created Excel-based tools and SOPs for invoice submission (which calculate the invoice amount after data entry), developed standard formats, and assisted PPSAs with invoice calculation and submission. Further efforts to digitize invoicing, including integration with Ni-kshay as a data source, will standardize the process and significantly eliminate errors and delays (please refer to Annex 4: Invoicing Tool).

**Tool for internal data validation by PPSA**[47]

HS4TB will develop a data quality assurance checklist for internal data quality checks by PPSAs to streamline internal data validation in a timely manner and to enhance their credibility by timely submission of invoices with minimal errors. The desired result will be almost zero penalty charges from the program due to data quality issues.

**Reference to the Operational Manual**

Chapter 6 of the Operational Manual suggests an invoice format to be used by PPSAs or other partners for raising their invoices, but a ready-made tool has not been available. HS4TB has developed an Excel- based invoicing tool, which will complement the Operational Manual by providing a ready-to-adopt platform for calculating invoices with minimum effort and maximum accuracy.

iii. *Thematic Area—Verification and Validation*[48]

47 *In the Operational Manual, the term verification is used for the first level of verification, that is, the Ni-kshay-based verification, and the term validation is used for the second level, that is, the physical cross-checking of information.*

48 *In the Operational Manual, the term verification is used for the first level of verification, that is, the Ni-kshay-based verification, and the term validation is used for the second level, that is, the physical cross-checking of information.*

**Challenges:**

The verification and validation clause in contracts lacks uniformity in several states. As outlined in the operational manual, verification via Ni-kshay is for 100% of patients. Subsequently, only 5% of patient records or results should be subject to physical validation processes, but in practice, this can go up to 100% validation in some states. Moreover, the lack of HR or role assignment of existing NTEP HR and the absence of a standard protocol (i.e., ready-to-use tools and SOPs) for verification and validation makes it even more challenging to complete the verification and validation efficiently and in a timely manner.

**Implications:**

Given the overburdened TB program team, the cumbersome verification and validation process leads to prolonged delays in payment to PPSAs.

**Proposed solutions:**

**SOPs and tool for verification and validation**

HS4TB developed an Excel-based tool and prepared SOPs for verification and validation. The tool facilitates first-level verification at the state level with Ni-kshay data, and every district is given a set of patient IDs (to use during physical validation) along with services provided that are extracted through random sampling from the data submitted by the PPSA agency. The HS4TB team has built the capacity of PPSA staff on critical TB indicators and beneficiary-level data and facilitated PPSAs' access to Ni-kshay through the creation of PPSA logins. Furthermore, the project proposes to train the district NTEP team on verification and validation processes and the supporting tool (please refer to Annex 5: Verification and Validation Tool).

**Deploy a third-party administrator (TPA) and introduce digital tools for verification and validation processes.**

HS4TB proposes hiring a TPA to conduct invoice verification and validation. The TPA could also develop and pilot an algorithm-based digital tool, should one be needed, for optimizing the sampling approach to support automated verification and validation processes and to create evidence and learning on the effectiveness of technology-enabled solutions in reducing delays due to manual processes.

Support the rollout of the Contract Management Dashboard

The Ni-kshay team is currently working on the Contract Management Dashboard.[49] HS4TB will support the rollout of the Contract Management Dashboard created in Ni-kshay with the experience garnered from field-level implementation in the five focused states.

**Reference to the Operational Manual**

Chapter 6 of the Operational Manual outlines the verification and validation process with timelines. HS4TB has developed an Excel-based verification and validation tool, which provides a quick process at the state level for 100% data verification and generates a sheet for sample validation at the district level. After the responses are received from the districts, they can easily be copied to the tool to calculate the penalty (if any) and final amount payable to the PPSA. This Excel tool aligns with the process described in the Operational Manual. It can be a ready-to-adopt verification and validation tool requiring minimum manual effort.

The Operational Manual suggests that "digital solutions like call centers, interactive voice response system, or SMS follow-up can be used. Such digital media can also be built into the contractual requirements" to address validation challenges. HS4TB's proposed digital tool for verification and validation is one example of these next-level solutions that the Operational Manual suggests exploring.

iv. *Thematic Area—Payment Release*

*49 The CTD team presented a demonstration of a Contract Management Dashboard and Module on PPSA Invoice Verification and Validation being developed under Ni-kshay during the "National Review of private sector engagement & Orientation on Operational Manual for Partnership" held in Hyderabad (June 27–28, 2023).*

**Challenges:**

Further payment delays have arisen because the NTEP and NHM finance teams lack awareness and experience in payment mechanisms for output-based service contracts using performance-based indicators. Payment release requires a series of steps, starting from invoice processing by the NTEP Account Officer appointed at the state or district level (for state- or district-level contracts, respectively); this officer should document all the findings of the verification and validation process, explain the penalty calculation, add a "satisfactory certificate" from district authorities that confirms that the services provided met standards (in case of invoice processing done at the state level), and explain the final payment amount for the approval from multiple signatories.

If a service contract is negotiated at the state level but the payment clause mentions decentralized payment at the district level, then this will create multiple potentially unnecessary authorization points (i.e., District TB Officer [DTO], District NTEP Account Officer, District Finance Officer, Chief District Health Officer/ Chief Medical Health Officer), further delaying the payment processing (please refer to Annex 6: Challenges in Payment [invoice submission to payment release]).

**Implications:**

A delay in payment release has significant implications for the organization's operations and may lead to delayed payment to staff, leading to staff attrition. If contract payments are not made on time after implementation, it could force the service provider to shoulder long periods of operational expenditures on their own. Payment delays have a significant financial impact on the service provider and impact both program quality and employee motivation.[50] Prospective bidders may be put off responding to RFPs for fear of financial exposure and disagreements with government over payments down the line.

**Proposed solutions:**

HS4TB mapped the funds flow mechanism from Centre to State and the process flow from invoice submission to payment release (please refer to Annex 7: Mapping of Fund Flow Process and Payment Process to Partners). HS4TB proposes the following solutions to address the triggering factors of delays at every level of the process (the first four of these steps are all noted in the SOPs for invoicing, verification and validation; see sections C. ii and iii above, and Annexes 4 and 5):

- Advocate for the inclusion of an Accounts Officer (NTEP) in the following stages:
    - RFP drafting—for an understanding of payment-linked indicators and payment calculation
    - Invoicing, verification, and validation process—for understanding penalty deductions and calculating the final payment amount
- Advocate to the program for adopting centralized payment at the state level to reduce bureaucratic layers and the number of signatories
- Orient the Finance Division (State Finance Management Group, State Finance Manager, State Account Manager, District Accounts Manager) on payment-linked indicators and payment calculation in PPSA contracts, calculation of penalty, and pro-rata calculation of payments in case of achievement of less than the full given targets.
- Frequently interact and follow-up with the Finance Division for resolution of queries and release of payment.
- Roll out a state-level payments tracker developed and maintained by HS4TB for monitoring the turnaround time of payments and capturing the status of meeting various milestones in the payment process. In some cases, there may be multiple sign-off authorities for invoices and the sequence of signatures may vary from state to state which may require capturing additional information with some

*50 Operational Manual, Chapter 6, Deliverable verification and payments, Section 6.2, Payment Delays.*

slight customization of the trackers. In the states where PPSA contracts are at the district level (i.e., Odisha), a cloud-based payment tracker has been developed for monitoring district-level payments, and the district NTEP teams have been oriented on a tracker for regular payment tracking.

- Pilot a revolving fund, loan guarantee structure, or other financing mechanism to temporarily cover the financial shortfalls of organizations waiting to receive payment.

### Reference to the Operational Manual

Chapter 6 of the Operational Manual highlights challenges in payment, such as delays in invoice submission and incomplete documentation on the PPSA side, multiple verification tiers, and the complexity of penalty clauses as some of the challenges on the procurer's side. The solutions above constitute multiple approaches to address these challenges and include a new tool (the tracker) to monitor progress.

## D. Human Resources and Capacity Building

### Challenges:

The vacancy rate of PPM coordinators is currently 33% on average across the 5 states. There are many

vacancies for state and district PPM coordinator positions because the NHM oversees recruitment but may not prioritize TB PPM positions, particularly where states have been slow to engage in PPSA contracts and other partnership options. The State TB Officers also have many competing priorities and may not prioritize hiring PPM coordinators. They are primarily concerned with the public sector being the most significant part of their program portfolio and prioritize filling those positions if they become empty.

With most of the health spending determined at the state level, CTD has limited ability to issue directives about hiring and transfer of the staff at the state level and can provide guidance on contract management but not significant supportive supervision to ensure that best practices are undertaken.[51] Also, most procurement so far has been of goods and not the services for private-sector engagement, although the latter has picked up after the launch of the Guidance Document on Partnerships 2019.

Moreover, most states provided State TB Officers, DTOs, and PPM coordinators with very limited or no training on contract management in the past two years, leading to knowledge and skill gaps among the program staff. The most recent training was conducted in 2020 on PPSA planning after the launch of the Guidance Document on Partnerships 2019 and was provided by the CTD to various states. Overall, "program managers under the national TB program were already overstretched with the demands of the program; they had limited bandwidth to organize the large and dispersed private sector and to manage relationships, organize contracts, and make timely financial reimbursements through archaic administrative structures."[52] Finally, allowing multiple signatories (NTEP and non-NTEP)—with little or no orientation on output-based contracting—to be involved at different stages of the contract cycle has been identified as the biggest driver of ineffective management and process delays, ranging from administrative approval of the RFP to payment release to the agency.

### Implications:

Significant vacancies of PPM coordinators at the state level and redesignation of them at the district level, in some instances, have weakened support for private-sector engagement activities, including contracting services in the program. Furthermore, the lack of contract management capacity and shortage of training directed at program officials (i.e., State TB Officers, DTOs, and PPM coordinators) is affecting the overall capability of already-burdened NTEP staff at state and district levels in developing and managing partnerships.

---

*51 In Gujarat, the entire PPM coordinator cadre for all the districts has been redesignated as Social and Behavior Change Communication (SBCC) coordinators, shifted from NTEP, and placed at the respective district panchayats.*

*52 World Bank. 2023. Private Sector Engagement for Tuberculosis Elimination: India's Journey from Pilots to National Scale-Up (2012–2021). Washington DC. http://hdl.handle.net/10986/39623, Shortage of human resources and inadequate capacity, pg. 17.*

**Proposed solutions:**

- The CTD recently organized a training on the operational manual for state and TSU participants (i.e., State TB Officers, WHO Consultants, TSU leads, etc.) from all states from June 27 to 28, although this did not include training on the new tools developed by HS4TB. Meanwhile, HS4TB has conducted a capacity assessment of NTEP and NHM staff in each state and, on that basis, will use the Operational Manual and other guidelines and/or manuals (i.e., GFR 2017, Manual for Procurement of Goods, Works, Consultancy & Other services, and this document) to develop an evidence-based curriculum and training to enhance the capacity of NTEP and NHM staff in public procurement and contract management. Directives are then expected to be communicated on presenting any new (HS4TB-related) material while not duplicating or contradicting the recent operational manual training, and HS4TB will then conduct capacity building of NTEP program staff at the state and district levels (DTOs, District Project Coordinators, PPM Coordinators, and Accountants) on contract management in focused states in alignment with the Operational Manual.

- Beyond the competency-based training, the project will provide continuous supportive supervision and seek opportunities to integrate the training and skills into the collaborative learning process, forming a partnership model between the state government and contractors.

- HS4TB will also advocate to the NHM and other key stakeholders to fill the vacant positions and provide the NHM with supporting resources, including job descriptions and job aids that provide role clarity relative to the contract management cycle, as suggested in the Operational Manual.

- HS4TB will support the rollout of the Contract Management Dashboard, currently under development, in Ni-kshay with key performance indicators for monitoring as with other dashboards. This module will help to digitize the data on contracts to make them readily available for monitoring and necessary decision making by the program staff.

- HS4TB will leverage the PLC to provide an opportunity for consultative exchange on program components, goals, and objectives with the private sector for addressing NTEP needs.

**Reference to the Operational Manual**

Chapter 8 in the Operational Manual recommends capacity building for both program staff (at the state and district levels) and service providers engaged in private-sector partnerships (e.g., PPSAs). The manual further recommends areas where knowledge gaps have been identified and suggested for capacity building, including needs assessments, partnership design, finance and procurement, and monitoring, and it points back to information in the 2019 Guidance Document on Partnerships and how to assess the capacity and competencies of program staff (at state and district levels) to initiate, manage, and implement the new partnership options at the state, and district levels.[53] HS4TB's efforts on capacity assessments, curriculum development, and then capacity development of NTEP/NHM align with the Operational Manual's recommendations.[54] Furthermore, HS4TB's assistance in PPSA capacity building

---

*53 The Guidance Document on Partnerships suggested the following areas for competency assessment: partnership fundamentals; contract design and management; administrative procedures; procurement processes, including RFP drafting, performance review and management of the payment system, M&E of program performance, stakeholder coordination, and financial management of partnerships.*

*54 HS4TB covered the following areas for capacity assessment which broadly covered the suggestions of the Guidance Document and expanded the areas to capture more details wherever it was needed:*

- ***Section 1: Knowledge/Awareness***

1. *Understanding the Private Health Sector Characteristics*
2. *Importance of Engaging the Private Sector*
3. *TB PPM in India—Past and the Present*
4. *Guidance Document on Partnership, 2019*
5. *Types of Contracts*

- ***Section 2: Behavioral and Soft Skills***

1. *Building Relationships with Private-Sector Providers*
2. *Managing Relationship with Vendors/Agencies/Contractors*
3. *Negotiation and Persuasion*

- ***Section 3: Technical***

on private-sector engagement activities, data management, MIS creation, and invoicing ensures that all stakeholders, both program personnel and service providers, align with the capacity-building guidance in the Operational Manual.

# 4. SUMMARY OF KEY RECOMMENDATIONS

In the previous section, HS4TB reviewed challenges and discussed proposed solutions for the individual steps of the contract management cycle. Some overarching themes emerged (summarized below), in addition to some reflections on critical enabling factors for sustaining HS4TB's efforts in the focused states for successful contracting.

Successful contract management requires a holistic approach and strengthening at all phases of the contract cycle (i.e., pre-contracting, contracting, and post-contracting) to ensure the expected outcomes. Under HS4TB, this holistic approach includes:

- Implementation of key HR-strengthening initiatives (i.e., capacity assessment, standard job descriptions and job aids for role clarity, curriculum development, and capacity building of NTEP/NHM staff on the contract management cycle covering all aspects, from needs assessments to payment release)
- The rollout of methodology and tools (i.e., the needs assessment methodology and tool, budget estimation tool, model RFP templates for non-PPSA services and for combined input- and output-based contracting), RFP analysis framework (i.e., list of objective technical evaluation criteria, feedback format for pre-bid meetings plus a prequalification capacity assessment for agencies), SOPs for capacity building and onboarding PPSAs, data quality assurance checklist for PPSAs, invoicing tool, verification and validation tool, model MOUs/Contracts with guidance on payments and outcome calculations, and introduction of TPA services and/or digital tool for invoicing, verification and validation[55]
- Increased availability of and access to data for decision making (i.e., pre-contract tracker—including contract details, pre-contracting timeline, and pre-contracting turnaround times as well as post- contract tracker—tracking payment turnaround time and including a contract management dashboard)
- Creating a platform for dialogue and information sharing between the private sector and government (i.e., PLC)[56]

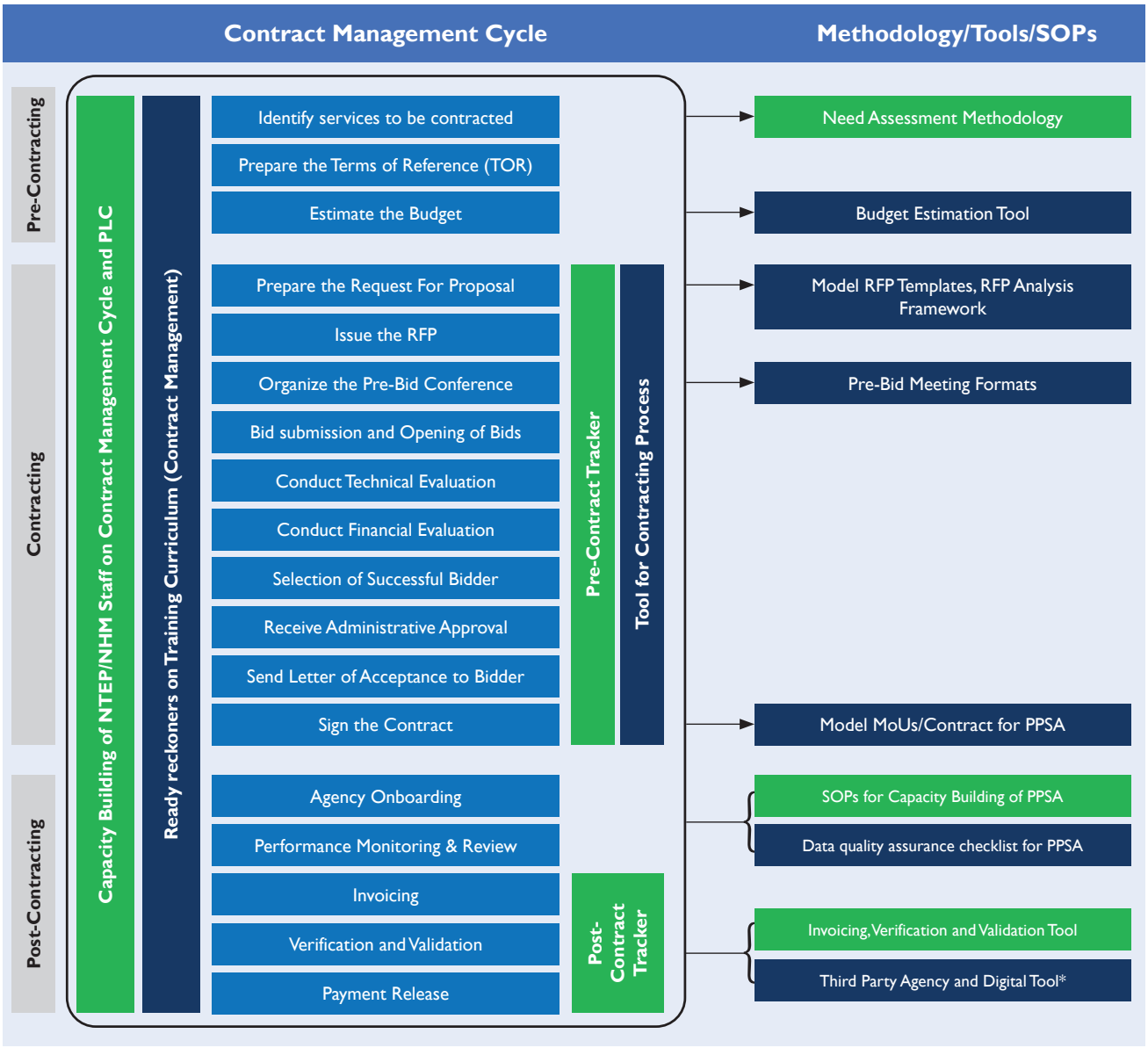
Figure 7 outlines how these processes and tools (those completed are in green; those in development are in dark blue) range across the contract management cycle (in light blue). After the full suite of tools has been finalized (expected by September 2024), this document will be updated to include details on the new tools and accompanying SOPs. Hyperlinks to the new tools will also be added to the revised document.

---

1. *General Profile (Procurement and Contracting)*
2. *Conducting PSE Needs Assessments*
3. *Costing of Services*
4. *Designing Technical Specifications (Scope of Services for PSE/ PPSA, Terms of Reference)*
5. *Preparing EoI, RFP, RFQ, Bid Document*
6. *Compliance and due diligence*
7. *Estimating Bid Value*
8. *Holding Pre-Bid Consultation and Addressing Queries*
9. *Bid/RFP Evaluation Principles (QCBS, Lowest Quote, etc.)*
10. *Award of Contract (Letter of Intent, Performance Guarantee, and Preparing a Service Contract)*
11. *Procurement/GFR or State Financial Rules*
12. *Taxation (e.g. GST, Income Tax)*
13. *Procuring Services through GeM*
14. *Understanding the Key Performance Indicators (Metrics)*
15. *Performance Monitoring and Evaluation*
16. *Use of an IT-Based Interface in Monitoring and When Using Performance Benchmarks*
17. *PFMS (including digital approval)*
18. *Invoicing, Verification and Validation*
19. *Payment Processes*

55 *TPA services subject to approval from Central TB Division.*

56 *The concept of the PLC in each state as a forum for dialogue and information sharing has been endorsed by CTD and the draft PLC guidance document is being developed by HS4TB.*




*Legend: Green = Completed tools that are available; Blue = Tools in development for PY3 (2024).*

**subject to approval from the Central TB Division*

**Figure 7. The contract management cycle and associated quality-improvement approaches**

This activity in the focus states will support an increase in the number and productivity of NTEP's private-sector partnership projects, with ultimate impacts of higher-quality services for TB patients that bring India's efforts closer to TB elimination.

As HS4TB finalizes these multiple tools, SOPs, guidance, and processes described in figure 7, it will discuss with CTD how to make them available online to all states in India as an organized and easy-to- navigate package, along with existing NTEP materials on PPM and contracting.

These tools are packaged as Series on Pre-Contracting, Contracting, and Post-Contracting, and align/add the tools as different volumes, such as:

- Pre-Contracting Series, vol. 1 (developed in 2023)—Pre-Contract Tracker and Needs Assessment Methodology and Tool, and vol. 2 (to be developed in 2024) - Budget Estimation Tool
- Contracting Series, vol. 2 (to be developed in 2024)—Model RFP templates for non-PPSA and hybrid contracts, RFP Analysis Framework, Tool for Contracting Process, and Meeting Formats for pre-bid meeting

- Post-Contracting Series, vol. 1 (developed in 2023)—Invoicing Verification and Validation Tool, Post-Contract Tracker Tool, and SOPs for Capacity Building of PPSAs, and vol. 2 (to be developed in 2024)—Data Quality Assurance Checklist for PPSA to promote more accurate data entry by PPSA staff, and model MOUs/contract that include guidance on payment (i.e. invoicing dates, payment timelines, provision for early partial payment, and outcome calculations)

This suite of tools is included in the curriculum developed for capacity building of NTEP/NHM staff on the contract management cycle. Job aids/"ready reckoners" will be developed as quick reference guides on key concepts from training modules for users at the district and state levels.

While working on expanding the states' existing contract management capabilities, HS4TB must also consider the approach to sustainability, which is discussed below.

### A. Sustainability of the work post-HS4TB: Appointment of contract management team/ program management unit for contracting

HS4TB hopes that the work of the PIUs will result in a mindset shift which recognizes the need to approach contracts deliberately and holistically. Currently, a typical public-private partnership (PPP) contract outlines in some detail the private partner's varied responsibilities for managing and reporting on its achievements in relation to the project scope of work or specifications.[57] Because the government's obligations under the PPP contract may be quite limited, it is usual for the purchasing authority to believe that the PPP contract will be self-regulating and self-reporting. This assumption frequently leads to the procurement authority establishing an inadequate governance and contract management structure, which can frequently lead to a decline in the overall advantages of PPPs.

- For TB contracting in India, nine states have STSUs, and the five HS4TB-supported states have PIUs to strengthen this governance function. For HIV contracting in India, there are similar state co-implementing bodies that oversee contracting called State AIDS Control Societies.[58] However, the absence of a centralized and organized contract management system can lead to a lack of oversight and coordination of contract management, including missed deadlines for contract renewals, and an increased risk of errors, disputes, penalties, or litigation due to noncompliant or poorly drafted contracts. To mitigate these risks, as the PIUs phase out of their role in assisting TB contracting, states could manage their ongoing TB procurements and portfolio of TB contracts with the staff already present in the NHM. This would require these existing NHM staff to take on the additional responsibilities of various roles and activities currently supported by HS4TB PIU staff. Another option is involvement of the medical services corporation (state government enterprises that exist in most states) for contracting of TB care services through the capacity building of existing staff of the medical corporation. However, these corporations generally procure commodities, so the procurement of services may be a considerable change. A second and related alternative would be to assemble a formal procurement unit of existing and/or new NHM staff modeled on the structure of the PIU at the state level, including key technical experts (e.g., contract management expert, finance expert, M&E expert). Finally, these contract management services could be outsourced to a TPA, which would require states to run a procurement to identify the necessary service provider. In either the second or third option, the use of a more formal procurement unit would lead to numerous benefits, some of which are summarized below:

- Allowing the government to develop an in-depth understanding of and structured approach to procurement, resulting in clear and specific TORs, well-structured RFP development with all the relevant terms and conditions, strong technical evaluations and skilled negotiation during procurement, and well-defined MOUs/contracts covering the roles and responsibilities of both parties

*57 PPM is very specific to NTEP; elsewhere in government, the more usual term is PPP (see, for example, the discussion by NITI Aayog at https://www.niti.gov.in/verticals/ppp). As the discussion on the appointment of a contract management team or project management unit will go beyond the NTEP, here we have used the term PPP.*

*58 India case study in: USAID, PEPFAR, Linkages and FHI360 (2019). Improving social contracting to end HIV in Thailand: experiences from selected countries and implications for the national response.*

- Supporting the development of performance metrics to review and monitor intended services regularly
- Facilitating coordination and integration of all stakeholders and activities to discuss the learnings, challenges, and support required—during both the pre-contracting and post-contracting stages—to minimize identified issues in the future for improved performance[59]

As the initial phase of the project concludes and HS4TB has a better sense of state contracting needs and capacity, it will work with the states to choose the suitable option out of those highlighted above to make these contracting programs more sustainable. Lessons can also be learned from the experience of the NACO and the US President's Emergency Plan for AIDS Relief (PEPFAR) India in contracting with NGOs to provide outreach and community-based HIV interventions that serve key population groups. The success that the HIV program has achieved in contracting can be attributed to putting in place strong and transparent mechanisms for tendering, contract management, monitoring of service quality, and reporting of and fund use.

Beyond this day-to-day management work for contracting, an oversight governance function is also important. A good governance structure for contracting should operate across the different health sector vertical programs and include strategic, management, and operational levels. This is necessary for several reasons: to monitor and review performance against agreed-upon service-level indicators, to ensure a change management procedure is in place to respond to operational challenges, and to perform regular contract assessments to revisit the initial objectives in light of changes in the program strategy and to ensure the contract is modified as required.

*59 Pre-contracting challenges related to the RFP process (i.e., Terms and Conditions) also have a designated forum, the "Pre-Bid Meeting," for bidders to discuss their concerns and suggestions in front of the relevant authorities (i.e., RFP Committee), although this will typically only surface issues related to a specific RFP, and may not be a productive venue for issues that cut across multiple RFPs and that have come to be seen as standard procedure.*

# ANNEX 1: GFR 2017 GUIDANCE ON OUTSOURCING OF SERVICES[60]

## Outsourcing of Services

Rule 197: Non-Consulting Service means any subject matter of procurement (which is distinguished from "Consultancy Services") involves physical, measurable deliverables/outcomes, where performance standards can be clearly identified and consistently applied, other than goods or works, except those incidental or consequential to the service, and includes maintenance, hiring of vehicle, outsourcing of building facilities management, security, photocopier service, janitor, office errand services, drilling, aerial photography, satellite imagery, mapping, etc.

Rule 198: Procurement of Non-Consulting Services. A Ministry or Department may procure certain non-consulting services in the interest of economy and efficiency, and it may prescribe detailed instructions and procedures for this purpose without, however, contravening the following basic guidelines.

Rule 199: Identification of Likely Contractors. The Ministry or Department should prepare a list of likely and potential contractors on the basis of formal or informal inquiries from other Ministries or Departments and Organizations involved in similar activities, scrutiny of Yellow Pages and trade journals, if available, website, etc.

Rule 200: Preparation of Tender Inquiry. The Ministry or Department should prepare a tender inquiry containing, inter alia: (i) the details of the work or service to be performed by the contractor, (ii) the facilities and the inputs which will be provided to the contractor by the Ministry or Department, (iii) eligibility and qualification criteria to be met by the contractor for performing the required work/service, and (iv) the statutory and contractual obligations to be complied with by the contractor.

Rule 201: Invitation of Bids. (i) For estimated value of the non-consulting service up to Rupees 10lakhs or less: The Ministry or Department should scrutinize the preliminary list of likely contractors as identified as per Rule 199 above, decide the prima facie Eligible and capable contractors and issue limited tender inquiry to them asking for their offers by a specified date and time, etc., as per standard practice. The number of contractors so identified for issuing limited tender inquiries should be more than three.

(ii) For estimated value of the non-consulting service above Rs.10 lakhs: The Ministry or Department should issue advertisement in such case should be given on Central Public Procurement Portal at **www.eprocure.gov.in** and on GeM. An organization having its own website should also publish all its advertised tender inquiries on the website. The advertisements for invitation of tenders should give the complete web address from where the bidding documents can be downloaded.

Rule 202: Late Bids. Late bids, i.e., bids received after the specified date and time of receipt, should not be considered.

Rule 203: Evaluation of Bids Received. The Ministry or Department should evaluate, segregate, rank the responsive bids, and select the successful bidder for placement of the contract.

Rule 204: Procurement of Non-Consulting Services by Nomination. Should it become necessary, in an exceptional situation, to procure a non-consulting service from a specifically chosen contractor, the Competent Authority in the Ministry or Department may do so in consultation with the Financial Adviser. In such cases the detailed justification, the circumstances leading to such procurement by choice and the special interest or purpose it shall serve, shall form an integral part of the proposal.

Rule 205: Monitoring the Contract. The Ministry or Department should be involved throughout in the conduct of the contract and continuously monitor the performance of the contractor.

Rule 206: For any circumstances which are not covered in Rule 198 to Rule 205 for procurement of non-consulting services, the procuring entity may refer Rule 135 to Rule 176 pertaining to procurement of goods and not to the procurement of consulting services.

60 *https://cga.nic.in/DownloadPDF.aspx?filenameid=1626.*

# ANNEX 2: CONTRACT TRACKER

This contract tracker is currently implemented in HS4TB's five focus states. After further implementation, the project will discuss with CTD a system integration plan outlining an approach to identify the appropriate web-based platform to host these trackers and the resources needed (technical and ICT infrastructure) to support this transition.

### Table A2-1. Pre-contract tracker (part 1)

HS4TB PROJECT - CONTRACT TRACKING TOOL

| SN | State Name | District Name | Category | Operational status | Thematic Area 1 | Thematic Area 2 | Thematic Area 3 | Type of contract | Date of operationalization (DD/MMM/YY) | Contract End date (DD/MMM/YY) |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Andhra Pradesh | 10 districts | PPSA | Operational | PPSA | | | Output based | 01-Aug-21 | 31-Jul-24 |
| 2 | Telangana | 10 districts | PPSA | Operational | PPSA | | | Output based | 24-Dec-22 | 23-Dec-25 |
| 3 | Telangana | Hyderabad | Other | Operational | Diagnostics | Specimen Management | Treatment Services | Grant-In-Aid | 01-Apr-22 | 31-Mar-23 |
| 4 | Telangana | Hyderabad | Other | Operational | Diagnostics | Specimen Management | Treatment Services | Grant-In-Aid | 01-Apr-22 | 31-Mar-23 |
| 5 | Telangana | Hyderabad | Other | Operational | Diagnostics | Specimen Management | Treatment Services | Grant-In-Aid | 01-Apr-22 | 31-Mar-23 |
| 6 | Telangana | Hyderabad | Other | Operational | Diagnostics | Specimen Management | Treatment Services | Grant-In-Aid | 01-Apr-22 | 31-Mar-23 |
| 7 | Telangana | Medchal-Malkajgiri | Other | Operational | Diagnostics | Specimen Management | Treatment Services | Grant-In-Aid | 01-Apr-22 | 31-Mar-23 |
| 8 | Telangana | Medchal-Malkajgiri | Other | Operational | Diagnostics | Specimen Management | eatment Services | Grant-In-Aid | 01-Apr-22 | 31-Mar-23 |
| 9 | Gujarat | 17 Districts | PPSA | Operational | PPSA | | | Output based | 09-Jun-22 | 08-Jun-23 |
| 10 | Gujarat | 22 Districts | PPSA | Non operational | PPSA | | | Output based | | |
| 11 | Gujarat | All | Other | Non operational | Diagnostics | | | Fee for service | | |
| 12 | Gujarat | All | Other | Non operational | Diagnostics | | | Fee for service | | |
| 13 | Gujarat | All | Other | Non operational | Diagnostics | | | Fee for service | | |

### Table A2-2. Contract tracker (part 2)

| Contract value INR (if not operational then approvedamount) | If Not operational, current status | If not operational, expected date to be operational (DD/MMM/YY) | Budget Source | Remarks | Delayed | Where | RoP Approval date | RFP Publish date | Bid Closing |
|---|---|---|---|---|---|---|---|---|---|
| 7,80,36,000 | Operational | | NHM | 10 districts. | No | | 16-04-2020 | 04-09-2020 | 15-03-2021 |
| 3,56,35,320 | Operational | | NHM | 10 districts. | No | | 28-04-2020 | 15-08-2022 | 15-09-2022 |
| 3,20,000 | Operational | | NHM | TU Scheme | No | | | | |
| 3,20,000 | Operational | | NHM | TU Scheme | No | | | | |
| 1,50,000 | Operational | | NHM | DMC Scheme | No | | | | |
| 1,50,000 | Operational | | NHM | DMC Scheme | No | | | | |
| 1,50,000 | Operational | | NHM | DMC Scheme | No | | | | |
| 1,50,000 | Operational | | NHM | DMC Scheme | No | | | | |
| 7,25,85,000 | Operational | | NHM | Annexure 1.1 | No | | 22-02-2019 | 24-09-2020 | 14-10-2020 |
| 12,00,00,000 | RFP preparation | 01-06-2023 | NHM | Annexure 1.2 | Yes | Delayed approval, frequent deli | 05-08-2022 | 20-01-2023 | |
| 4,00,00,000 | Financial Evaluation | 01-04-2023 | NHM | FL-LPA Testing | Yes | Delayed approval, frequent deliberations | | | |
| 18,00,00,000 | RFP preparation | 01-06-2023 | NHM | IGRA Testing | Yes | Delayed approval, frequent deliberations | | | |
| | | | | State has decided to shelve the RFP for | | | | | |

### Table A2-3. Contract tracker (part 3)

| Tech Bid opening and evaluation | Financial Evaluation | Contract signing | TAT between RoP approval to RFP Publish | TAT between RFP Publish to Bid Closing | TAT between Bid Closing to Tech Bid open | TAT between Tech Bid open to Financial Evaluation | TAT between Financial Evaluation to Contract Sign |
|---|---|---|---|---|---|---|---|
| 15-04-2021 | 15-05-2021 | 28-07-2021 | 141 | 192 | 31 | 30 | 74 |
| 15-10-2022 | 31-10-2022 | 24-12-2022 | 839 | 31 | 30 | 16 | 54 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 17-10-2020 | 15-02-2021 | 09-06-2022 | 580 | 20 | 3 | 121 | 479 |
| | | | 168 | | | | |
| | | | | | | | |

### Table A2-4. Contract tracker (part 4)[61]

| Contract renewal-1 date | No of changes in the *contracting terms* during renewal-1 | Contract value after renewal-1 | Current status of contract | Contract End date (DD/MMM/YY) | Remarks | TAT between RoP approval to RFP Publish | TAT between RFP Publish to Bid Closing (4 weeks) | TAT between Bid Closing to Tech Bid opening (1 week) | TAT between Tech Bid open to Financial Evaluation (4 weeks) | TAT between Financial Evaluation to Contract Sign (5 weeks) | TAT between ROP approval to Contract sign | RFP Publish to vendor selection | TAT between RFP publish to Contract sign | TAT between RFP drafting to Contract sign |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01-Sep-22 | | 7,32,60,000 | Ongoing | | | 148 | 13 | 13 | 130 | 177 | 468 | | 320 | |
| | | | Ongoing | | | | 0 | | | | | | | |
| | | | Ongoing | | | | 0 | | | | | | | |

*61 The recommended timeline is included in parentheses in the column headers.*

# ANNEX 3: NEEDS ASSESSMENT (METHODOLOGY AND TOOL)

The Guidance Document on Partnerships, RNTCP 2019, outlines the steps for conducting a needs assessment as shown below:

- Identify gaps in key output and performance indicators such as notification, microbiological confirmation, drug susceptibility testing (DST), HIV testing, treatment outcome, etc. Data sources should include Health Management Information System data.
- Identify systemic input gaps, such as infrastructure, HR, and logistics capacities.
- Compile all identified issues in a logical order to understand the gaps. Prioritize areas that can be addressed through strengthening the Public Health System and those that can be addressed through partnership options or other innovations.
- Findings of the Needs Assessment exercise should be placed in the public domain, such as the NHM website/Ni-kshay Portal.

Since the needs assessment process started before the Operational Manual for Partnerships under NTEP 2023 was released, the methodology used was adopted from the Guidance Document on Partnerships 2019, as described above.

### 1. Design

The assessment would start with a desk review of secondary data retrieved from the Ni-kshay portal and then adopt a blended method combining qualitative and quantitative assessment methods.

### 2. Data collection

a) District-level data on key performance, input, activities, and process indicators was collected using an MS Excel-based tool.

   i. Key performance indicators were collected from the Ni-kshay Government of India portal. These indicators included but are not limited to: (1) notification, (2) microbiological confirmation, (3) drug sensitivity testing, (4) HIV testing, (5) diabetes testing, (6) treatment outcome, and others.

   ii. Information not available on Ni-kshay, such as details on HR, training status, NAAT, and others, was collected from state and district-level program records.

b) The list of indicators selected for analysis and the systemic data collected is summarized below:

**Table A3-1. List of indicators selected for analysis and data collected**

| Desk review: Review of performance indicators (Source: Nikshay) | Primary Data Collection: Analysis and Gap Identification: | | |
|---|---|---|---|
| | Systemic Gaps | Program Gaps (Inputs/ Processes) | Other Support Services/ Systems |
| • Notification<br>• Microbiological confirmation of TB<br>• Drug Sensitivity Testing (DST) Coverage<br>• HIV Testing Coverage<br>• Diabetes Testing Coverage<br>• Treatment Outcomes | • Logistics and Supply chain of drugs/ diagnostics/ consumables/ equipment<br>• Infrastructure<br>• Human Resources (HR Status, Training, Working Analysis) | • Presumptive TB Examination<br>• Testing (LTBI, Microscopy. Molecular Tests, Chest X-rays, Extrapulmonary TB)<br>• Screening (Interferon-Gamma Release Assays -IGRA)<br>• Nikshay Poshan Yojana (NPY)<br>• TB Preventive Therapy (TPT)<br>• Adherence Support | • Advocacy Communication Social Mobilization (ACSM)<br>• Active Case Finding (ACF) |

c) An open-ended, semi-structured questionnaire would be used by HS4TB staff to conduct in- depth interviews of stakeholders at different health system levels, such as the state, district, block, and primary health care level; civil society or partners and community. Such interviews aim to validate the gaps identified from the secondary data analysis to inform prioritization decision making.

d) The questionnaire consists of a number of questions under thematic areas of programmatic performance, such as service coverage, quality, and community feedback on the perception of services. Furthermore, other focus areas would address some of the means to address the gaps including private-sector engagement, engagement of civil society, partnership options, organization of the services, challenges faced, redressal mechanism, and leadership. The in-depth interviews will be conducted among NTEP program officers.

### 3. Data analysis

Data for the performance indicators was compiled from Ni-kshay; the performance gap for these indicators (target vs. actuals) for the last 5 years was calculated. The indicators used were:

- Total notification gap score
- Total diabetes testing gap score
- Total HIV testing gap score
- Microbiological confirmation gap score
- Universal DST (UDST) gap score
- Treatment outcome gap score

The indicator gaps were used to identify the type of partnership option needed for each district. For the pilot, in states where a small sample of districts was selected, an overall gap score was also calculated to rank the districts from worst to best performing (ranking/priority). The desk analysis was followed by the primary data collection, using a questionnaire, from a few selected districts in the state through interviews with NTEP and health care staff. The findings from interviews/focus group discussions with key stakeholders were used to inform/verify the priority partnership options identified during the desk review.

### 4. Selection of partnership options

Based on the analysis of the desk review as well as the primary data collection, an indicative list of possible partnership options was presented to the state officials for further approvals and inclusion into the PIP for the year 2024. The table below illustrates the identification of partnership options with the possible justification. This list is indicative.

**Table A3-2. Partnership options identified**

| Partnership Option Suggested | Justification for Partnership Option |
|---|---|
| PPSA | • High notification gap between public and private sector in last 5 years<br>• PPSA financially viable as private sector TB notifications are high<br>• High TB notification target given population of district<br>• Support required in UDST<br>• Availability of large number of private providers and urban conglomerations |
| ACSM | • Innovative ACSM required in tribal region<br>• Lack of availability of adequate quantity of IEC material<br>• Lack of availability of appropriate human resources<br>• Tribal and/or extremist (specific to Odisha) blocks in district |

| Partnership Option Suggested | Justification for Partnership Option |
|---|---|
| Public Health Action | • HIV testing, diabetes screening and UDST most lagging indicators in private sector,<br>• In regions where there are no PPSAs or where current NTEP staff structure is not adequate to cater to additional patient load<br>• Augmenting public sector in regions where required<br>• Desirable to deliver entire range of services in public health action as a bundle rather than have a different service provider for each activity |
| ACF | • High case load<br>• Tribal/ Hard to reach blocks<br>• Unavailability of appropriate human resources (STS) |
| Diagnostic Services | • Diagnostic support required in tribal and hard-to-reach areas<br>• No agency outsourced currently<br>• Appropriate human resources not available |

## 5. Framework of needs assessment




**Figure A3-1. Framework of needs assessment**

For more details, please refer to the Partnership Needs Assessment Guide.[62]

62 *This document will be updated with the hyperlink to the tool when it is made available on the CTD website.*

# ANNEX 4: INVOICING SOP AND TOOL

This SOP and tool are intended to standardize the process of invoicing by PPSAs. This will help the PPSA agency to prepare the invoice using Ni-kshay reports and submit it to the NTEP within the prescribed timeline, along with supporting documents.

The list of reports to be used for invoice calculation is mentioned below (based on agreed indicators in the MOU):

**Table A5-1. Reports to be used for invoice calculation, by indicator**

| Indicator/s | Reports |
|---|---|
| Notification | TB notification register (TBNR) (enrollment facility) |
| Validated Bank Accounts, HIV, DM Testing, Contract Tracing, and Successful Outcome | TBNR (Current facility) |
| Fixed-Dose Combination (FDC) Uptake | Dispensation register |
| UDST | Lab register |

**Table A5-2. Snapshot of invoicing tool**

| | Q3 | PPSA Invoice Calculation Sheet | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rate Quoted (INR) | 2305 | | | | | | | |
| Indicators | TB Patients | Bank Details Available | TB Patients with HIV testing | TB patients with DM testing | TB patients contacted during visit | Outcome Status | FDC | UDST |
| Payment Linked | 10% | 5% | 5% | 5% | 5% | 25% | 25% | 20% |
| Rate Quoted by Agency (INR ) | 230.5 | 115.3 | 115.3 | 115.3 | 115.3 | 576.3 | 576.3 | 461.0 |
| Achivements based on TBNR for current period | 2743 | 8364 | 9929 | 9792 | 9347 | 6880 | 38 | 180 |
| Achievements after verification | | | | | | | | |
| Amount (INR) for current period | 632262 | 963951 | 1144317 | 1128528 | 1077242 | 3964600 | 21898 | 82980 |
| GST (18%) | | | | | | | | |
| Total Amount Claimed (INR) in Invoice | | | | | | | | |
| Amount (INR) paid in previous quarters | | | | | | | | |
| Payable Amount (INR) for current Period | 632262 | 963951 | 1144317 | 1128528 | 1077242 | 3964600 | 21898 | 82980 |

For more details, please refer to the Verification and Validation SOP and Tool–PPSA (Annex 5).

# ANNEX 5:VERIFICATION AND VALIDATION SOP AND TOOL– PPSA

This SOP and tool intend to standardize submitted vouchers' verification and validation stages to process the PPSA payouts. This document lists steps for verification and validation. It provides guidance on means of verification to the districts and state NTEP teams to complete the process in a timebound manner and disburse the payment.

- Verification of all patient IDs and eight performance-linked indicators, claimed by the PPSA agency, is to be done at the STC/STDC through Ni-kshay reports, including the Enrollment register, TBNR- current facility, dispensation register, and lab register.
- In the state, STDC will produce a certificate of the said verification exercise and its findings with necessary recommendations for claim approvals.
- After verification, 5% of patient IDs will be selected through random sampling from the TBNR (current facility) submitted by the PPSA agency along with the invoice.[63] This sample will represent every district proportionately to the actual number of district notifications.

**Table A6-1. List of documents to be verified for each indicator**

| Sl. | Indicators | Documents to be verified |
|---|---|---|
| 1 | Notification | Prescription of a treating doctor or NTEP treatment card |
| 2 | Validated bank account details | Bank passbook/checkbook |
| 3 | UDST | Lab registers or Annex 15 or treatment cards, etc. |
| 4 | HIV testing | Lab registers or treatment cards, etc. |
| 5 | DM testing | Lab registers or treatment cards, etc. |
| 6 | NTEP FDC | Prescription of treating doctor or physical verification of FDC blisters or stock register |
| 7 | Successful outcome | Prescription of treating doctor/patient's statement of discontinuation of medicine asked by treating doctor/physical verification with treating doctor/treatment card |
| 8 | Contact tracing and chemoprophylaxis | Physical verification/TB Preventative Therapy card |

*63 As noted in the NTEP Operational Manual, there is some flexibility around this number, particularly for newly onboarded agencies, although for well-established contracts, 5% is the recommended sample size.*

**Table A6-2. District validation sheet**

| Details of Notified Patients for validation (TBNR-Current facility) | | | | | | | | | | | | | Validation details by NTEP | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SN | Month/ Quarter | Patient ID | Patient Name | District | Bank detail | UDST | HIV | DM | Successful Outcome | Contact Tracing | FDC | | Notifica-tion | Bank detail | UDST | HIV | DM | Successful Outcome | Contact Tracing | FDC | Remarks (If any) |
| 1 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 2 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 3 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 4 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 5 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 6 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 7 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 8 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 9 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 10 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |
| 11 | | | | Banaskantha | | | | | | | | | YES | NO | NA | NA | NA | NA | NA | NA | |

This validation sheet provides a way to keep data outcomes organized, but still leaves a challenge of organizing all of the primary data sources (either physical paperwork or digital data sources). The verification and validation module that is under development in Ni-kshay will help to address the need to automate many of the processes of this existing Excel tool, including linking to the primary digital data.

**Table A6-3. District validation scoring**

| | | Documents not found (NO) | | | | | | | | | Documents found (YES) | | | | | | | | | % | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SN | District | Notifi-cation | Bank detail | UDST | HIV | DM | Suc-cessful Out-come | Con-tact Trac-ing | FDC | | Notifi-cation | Bank detail | UDST | HIV | DM | Suc-cessful Out-come | Con-tact Trac-ing | FDC | | Notifi-cation | Bank detail | UDST | HIV | DM | Suc-cessful Out-come | Con-tact Trac-ing | FDC |
| 1 | Arvalli | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 | Banaskantha | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3 | Gandhinagar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 | GMC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 | Mehsana | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6 | Sabarkantha | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Compiled** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |

For more details, please refer to the SOP on Invoicing, Verification & Validation of Claims for PPSA Payment.[64]



64 *This document will be updated with the hyperlink to the tool when it is made available on the CTD website.*

# ANNEX 6: CHALLENGES IN PAYMENT (INVOICE SUBMISSION TO PAYMENT RELEASE)

Challenges at various levels of the payment process have been summarized below, highlighting the proposed solution and state-wise implementation status (see also Table 22 in the operational guidance). These solutions are a mixture of interventions by HS4TB staff (which would transition to national staff by project end) and system-based fixes (using new tools etc). The project is supporting tool development and initial training and roll-out, but ongoing support and improvements of these tools will gradually be transitioned over to the states.

**Table A7-1. Payment challenges and solutions**

| Area of concern | Challenges | Proposed solution | Implementation of solutions |
|---|---|---|---|
| Delay in invoice submission by PPSA | Lack of clarity on performance assessment and payment calculation | Capacity building of PPSA staff on usage of the invoicing tool | All HS4TB states (except Delhi) |
| | Delayed data entry in Ni-kshay by PPSA | Follow-up with PPSA | |
| | Emphasis on submission of physical records along with invoice | Digital tools for verification processes | To be designed |
| Delay in verification and validation by state/district | Non-adherence to verification criteria mentioned in the agreement | Design SOP and tool for verification and validation | Andhra Pradesh, Telangana, and Delhi |
| | | Rollout of SOP and Tool for verification and validation | All HS4TB states (except Delhi) |
| | Lack of HR at the state level for verification of data | Project support on data verification at the state level | Gujarat |
| | Lack of HR at the district level for verification and validation | Digital tools for verification processes | To be designed |
| Delay in payment release by state/district | Decentralized payments | 1. Design and rollout of Payment Turnaround Time Tracker<br>2. Advocacy with NHM Finance Division<br>3. Follow-up with PPSA | All HS4TB states |
| | Multiple approval levels | | |
| | Timely availability of funds | | |
| | Lack of follow-ups with NHM Finance | | |
| | Administrative delay | | |
| | Change in leadership | | |
| | Delayed response by PPSA on finance-related queries | | |

# ANNEX 7: MAPPING OF FUND FLOW PROCESS AND PAYMENT PROCESS TO PARTNERS

The PIUs analyzed the flow of funds from central to state (and district) and of the payment processes to understand the points where funds could get stuck, thus delaying payment.

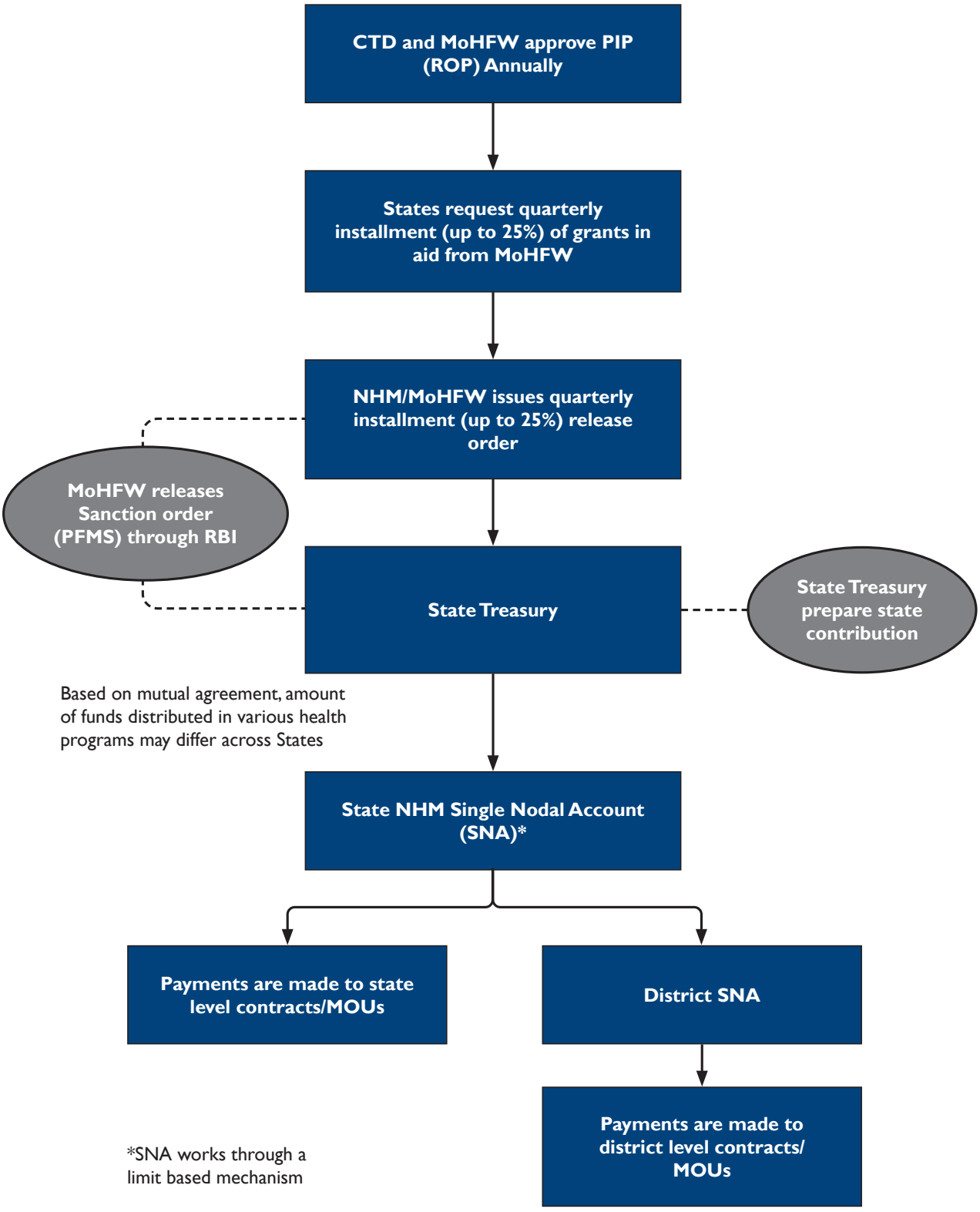


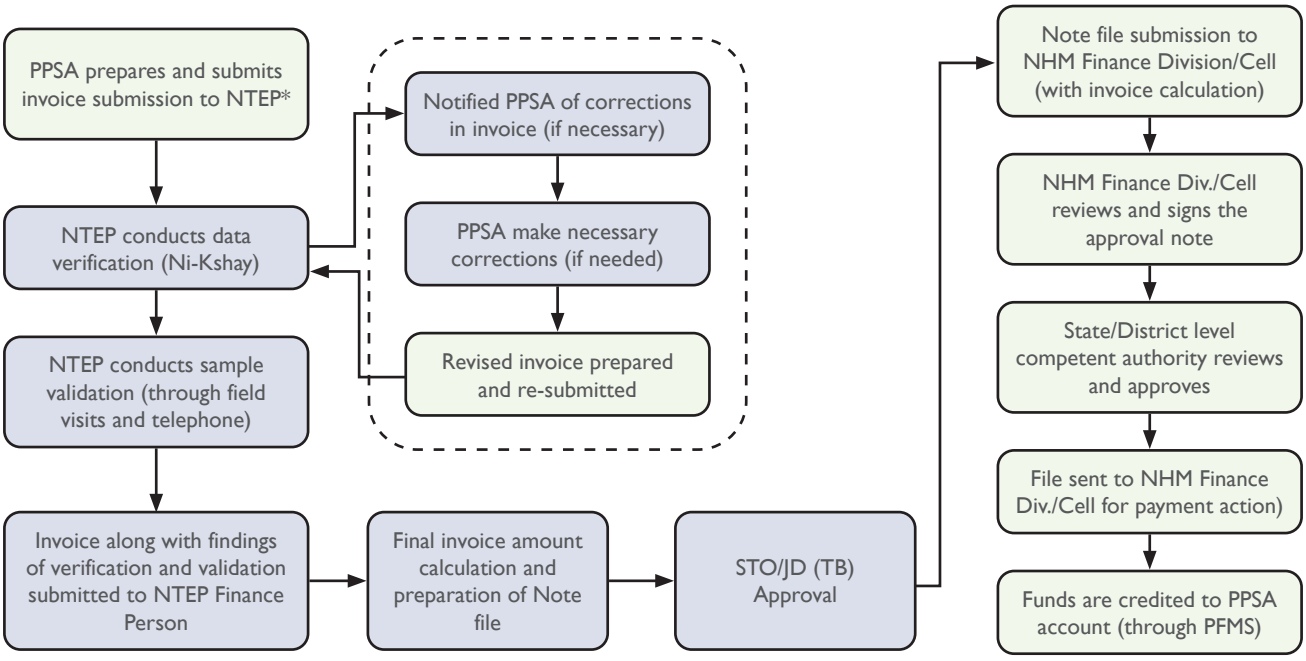

**Figure A8-1. Central government to state government—fund flow process**

The table below highlights the activities and the timeline, from the needs assessment to the ROP approval to the further release of funds under NTEP.

**Table A8-1. Fund flow activities and timeline**

| Activities | Timeline |
|---|---|
| Using the needs assessment as an input, the PIP, which incorporates the planned partnerships and the budget for the upcoming financial year, is prepared. | Sep-Oct |
| The discussion on the PIP is held between the state and central government | Nov-March |
| Based on discussion, ROP are shared with the state governments as budget approval. | April-May |
| Release initiated by central to state government: Based on requests received from state governments, and after adjusting their unspent balance, the central government releases the money to state governments. The amount released is based on the State government's expenditures, Audited Utilization Certificates , statement of expenditures (SOE), and state share portion. | Oct-Sep |

Generally, a PPSA submits its invoice quarterly or as agreed in the terms and conditions of their contract. The next step is verifying the invoice and data (at the state or district level depending on the level that the invoice is submitted) and validation of the sample size at district levels. If this is successful, the invoice is submitted to the finance division for payment. Figure A8-2 below maps the generic PPSA payment process.[65]




*Invoice submission to District/State authority as per MoU

**Figure A8-2. Mapping of generic PPSA payment process**

*65 May differ from state to state and as per the contract terms and conditions*