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सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Guidance Document on Partnerships

Revised National Tuberculosis Control Programme

Central TB Division
Ministry of Health and Family Welfare
Government of India
2019

Guidance Document on Partnerships

Revised National Tuberculosis Control Programme

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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
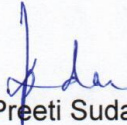**Ministry of Health and Family Welfare**

Dated : 28th October, 2019

FOREWORD

The National Strategic Plan lays specific emphasis on engaging the private sector to achieve the ambitious goal to ending tuberculosis (TB) in India by 2025. Achieving this goal will require a paradigm shift in previously followed approaches of public-private partnerships. The Ministry acknowledges that all TB patients come under the ambit of the Programme. It is essential to ensure that patients seeking care in the private sector have access to the same quality of diagnostics, drugs and community-based services as in public sector. This will also contribute towards India's goal of achieving Universal Health Care.

This guidance document is developed using lessons learnt and best practices from the recently implemented large-scale pilots to engage the private sector in detecting missing cases and ensuring high-quality care to TB patients as well as the Programme's experience in implementing various partnership options. This document is a result of a series of consultations with different stakeholders including technical experts, program managers at the national, state and district level, development partners and civil society organizations.

I am sure that states and districts, based on their specific requirement, will make full use of the options presented in this guidance document to effectively engage the private sector and take a positive step towards ending TB.

(Preeti Sudan)

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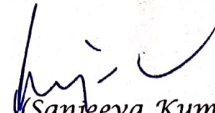**Special Secretary**
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Foreword

Ending TB is a high priority for the Government of India. This Guidance Document to Implement Partnerships with the private sector for expanding TB services is one among many steps taken by the Ministry of Health & Family Welfare, to accelerate the progress, as per the clarion call given by the Hon'ble Prime Minister, to achieve SDG goals for TB by 2025. This engagement with the private sector through partnerships has at its core the mutually shared expectation of favourable public health outcomes for Tuberculosis, while ensuring quality and a patient-centric focus.

While there is no "one size fits all" approach, there must be a shared understanding of the principles on which partnership with the private sector can be built. I am happy that this guidance document is thus not prescriptive on the method to be adopted but provides various options that can be utilized by the states and districts based on their need. The steps on contracting and procedures laid down in this document are based on the principles of the General Finance Rule, 2017.

These guidelines reflect a shift towards needs-based, output-based and ensuring that the Standards of TB Care in India reach patients in the public as well as the private sector.

(Sanjeeva Kumar)

विकास शील
संयुक्त सचिव
VIKAS SHEEL
Joint Secretary

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Foreword

India has shown considerable progress in terms of providing standards of TB care in the last decade. While this achievement has been substantial in the public sector, it has been modest for the patients seeking care in the private sector. Empirical evidence suggests that a significant number of patients still do seek private care. Taking this into consideration, the Ministry of Health and Family Welfare has released this guidance document which is will help States and Districts in expanding TB services for TB patients in private sector and also in public sector, if required.

The document provides guidance on the approaches and processes for partnering with private sector, including not-for-profit organizations, for expanding TB services. The guidance document encompasses TB-related services across eight partnership options which cover the entire cascade of care for TB patients including notification, diagnosis, treatment, and adherence. The scope of services under the partnership option can be implemented independently or bundled with other options depending on the local requirements. In result-based partnership, it is important for the program to elucidate specific and measurable expectations, for the partners, to deliver with a clear understanding of these expectations and payments to be made based on verifiable performance in a timely manner.

Contracting steps and procedures laid down in this document are based on the principles of transparency and promoting healthy competition. Rather than prescribing costing of services, an approach to arrive at the cost is suggested to enable Program Managers to arrive at a budget. Overall, this document is expected to help Program Managers execute contracts for delivery of agreed TB services by the private-sector providers according to their areas of expertise.

The presence of output-based contracts, performance indicators and verification mechanism in this document helps solidify the true spirit of partnerships. I am optimistic that the States will be able to make the most of this guidance to scale up the TB program as apart of our collective aspiration to end TB.

(VIKAS SHEEL)

Dr. K S SACHDEVA
Dy. Director General
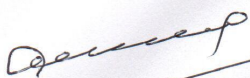*Head, Central TB Division*
Project Director, RNTCP

Foreword

The previous guidelines on partnership under RNTCP were developed in 2014. This revised document is intended to provide further clarity on partnership for services in order to scale up interventions for Tuberculosis and is in alignment with the National Strategic Plan 2017-2025 and our overall TB Elimination objectives

The experiences and evidence from some ground level, large-scale initiatives in diverse settings inform the strategic vision of the RNTCP and form the basis for development of these document as well. It focusses on building and sustaining partnerships with the private sector for delivery of TB care and prevention. Additionally, this document recommends contracting professional agencies to facilitate private provider engagement to produce desirable outcomes and strengthening the capacity of RNTCP to engage private-sector providers.

The document provides a step-by-step guide to identify the services that need to be undertaken through partnership, budgeting in the program implementation plan and subsequent options to opt for these services. Wherever needed, the document recommends bundling of services wherein the Programme Managers can combine a series of partnership options in a logical and sequential manner as it ensures better coverage. The guidance document also recommends Programme Managers to implement partnership options via an output-based approach that can be deployed using a performance evaluation matrix. Examples for the same have been shared.

I am confident that the Programme Mangers will make full use of the guidance provided in the document to ensure that high-quality services are made available in the public as well as private sector with verifiable and measurable outputs in keeping with the pay for results approach. I would like to thank the sub-group under NTWG for private-sector engagement and other stakeholders who helped put this comprehensive document together.

04.11.2019

(Dr Kuldeep Singh Sachdeva)

FOREWORD

As the head of the National Technical Working Group, it is with pride and yet humility that I present this RNTCP's Guidance Document on Implementing Partnerships. Working with the private sector (both for-profit and not-for-profit service providers), and external agencies is not new for the programme. Over the last few decades, the programme has learnt a great deal of insights in working with the private sector. Yet there still exist enormous untapped potential for collaborating with the private sector innovatively for programme effectiveness, based on the lessons of working with private sector in other social sectors. Such experiences has paved way for the Central TB Division (CTD) to consider revising its own approach towards private-sector engagement and partnerships.

At the outset, I would like to reiterate that this guidance document is merely a suggested framework and not set in stone. The CTD and NTWG recognizes and acknowledges how states with their own systems in place, could use this guidance document with flexibility and autonomy, to shape their own mechanism of partnering with the private sector in the programme. Simultaneously, the CTD is cognizant of the fact that without new and innovative approaches, the objective of TB Elimination by 2025 is not easy to achieve. This guidance document was prepared after a detailed analysis of the performance and experience of implementing various options under Public-Private Mix (PPM) guidelines and based on extensive consultations with key stakeholders on what worked and what did not. This guidance document is an attempt to embrace market principles to encourage a mutually beneficial partnership between the program and the private providers including NGOs, for better and more effective program outcomes. Under this new guidance, the program seeks to expand partnerships beyond the not-for-profit organizations and induct for-profit providers including social / health sector entrepreneurs. It also focuses on performance outcomes, and emphasises on the systems and capacity to effectively manage partnerships.

I am grateful to the leadership within the Ministry of Health and Family Welfare (MoHFW), CTD, several leading international and national experts, and various development partners who have immensely contributed in the process of developing this new guidance document. The NTWG hopes that this guidance document will promote effective partnerships between the programme and the private sector, and strengthen the health system to eliminate the scourge of TB from the country soon.

Prof Venkat Raman
Chair
National Technical Working Group on Engaging the Private Sector

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ABBREVIATIONS

ABC	Activity-Based Costing
ADR	Adverse Drug Reaction
CB-NAAT	Cartridge-Based Nucleic Acid Amplification Test
C-DST	Culture Drug Susceptibility Testing
CTD	Central TB Division
DM	Diabetes Mellitus
DBT	Direct Benefits Transfer
DR-TB	Drug Resistant-TB
DST	Drug Susceptibility Testing
EP	Extra Pulmonary
FDC	Fixed Drug Combination
GFR	General Finance Rule
LPA	Line Probe Assay
LTBI	Latent TB Infection
NAAT	Nucleic Acid Amplification Test
NGO	Non-Governmental Organization
NPY	Nikshay Poshan Yojana
NTSU	National Technical Support Unit
PFMS	Public Financial Management System
PPSA	Patient Provider Support Agency
PMDT	Programmatic Management of Drug Resistant TB
RNTCP	Revised National TB Control Programme
TB	Tuberculosis
TSU	Technical Support Unit
SOP	Standard Operating Procedures
STCI	Standard for TB Care in India
STSU	State Technical Support Unit
U-DST	Universal Drug Susceptibility Testing

GLOSSARY OF TERMS

Bid (including the term 'tender', 'offer', 'quotation' or 'proposal' in certain contexts)

an offer to supply goods, services or execution of works made in accordance with the terms and conditions set out in a document inviting such offers.

Bidder (including the term 'tenderer', 'consultant' or 'service provider' in certain contexts)

any eligible person or firm or company, including a consortium (that is an association of several firms or companies), participating in a procurement process with a procuring entity.

Bid(ding) Documents (including the term 'tender enquiry documents' or 'request for proposal' documents)

a document issued by the procuring entity, that sets out the terms and conditions of the given procurement and includes the invitation to bid, including any amendment thereto.

Consortium

association of two or more companies or firms to bid for a private sector engagement contract.

Contract

a legally binding agreement, which recognises and governs the rights and duties of the parties to the agreement. It is legally enforceable because it meets the requirements and approval of the law.

General Financial Rules 2017

compilation of rules and orders of Government of India to be followed by all while dealing with matters involving public finances.

Model Bidding Document

the standardised template to be used for preparing bidding documents after making suitable changes for specific procurement. Please refer to latest CTD guidelines.

Market Scan

market survey for determining benchmark price which comprise of available services in the private sector. These services are provided through standard rates by multiple players in private sector.

Notice Inviting Tenders (including the term 'invitation to bid' or 'request for proposals' in certain contexts)

document or any amendment thereto published or notified by the Procuring Entity, which informs the potential bidders that it intends to procure goods, services and/or works.

Private Sector Engagement

is a deliberate, systematic collaboration of the government and private sector to move national health priorities forward beyond individual interventions and programs.

Programme Managers

refers to State TB Officers, District TB Officers, City TB Officers, Public Private Mix- Coordinators.

Pro-rata

proportionate allocation or distribution of a quantity based on a common factor.

Public Financial Management System	is a financial management platform for all plan schemes, a database of all recipient agencies, integration with core banking solution of banks handling plan funds, integration with State Treasuries and efficient and effective tracking of fund flow to the lowest level of implementation for plan scheme of the government.
Registered Entity	any legal or other entity including without limitation a company registered in India under the Indian Companies Laws or incorporated outside India under relevant laws of incorporation under country of its origin, or a society registered under Societies Registration Act, 1860 or any other Indian law for registration of societies, a registered trust under Indian Trusts Act, 1882 or any other Indian law for registration of public trust or a sole proprietorship or partnership registered under the relevant laws of incorporation unless otherwise specified by the State. Bidders like NGOs and Voluntary Organizations should have registration on DARPAN portal (ngodarpan.gov.in). Health facilities / laboratories should be registered under the relevant rules and regulations of the specific State/ District/ Corporation/ Municipality. All for–profit agencies are also required to be in compliance with the legal registration.
Request for Proposal	a document that an organisation submits to one or more potential suppliers eliciting quotations for a product or service. Typically, it seeks an itemized list of prices for something that is well-defined and quantifiable.
Service	any subject matter of procurement other than goods or works, except those incidental or consequential to the service and includes physical, maintenance, professional, intellectual, training, consultancy and advisory services or any other service classified or declared as such by a Procuring Entity but does not include appointment of an individual made under any law, rules, regulations or order issued in this behalf.
Service Provider	any private (for-profit or non-profit) or public/autonomous entity that will provide the services to the RNTCP under the contract.

Partnering and
engaging with
the private sector
is imperative for
India's vision of
Universal Health
Coverage

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1. INTRODUCTION

India accounts for one-fourth of the global tuberculosis (TB) burden. More than two million people are diagnosed with the disease every year. TB kills more adults in India than any other infectious disease. As per the Global TB Report 2015, India bears the highest burden of TB and drug-resistant TB (DR-TB), and the second highest number of cases of TB-HIV.

To help eliminate TB, the Government of India (GoI) implemented the **National Strategic Plan (NSP) for 2017 to 2025** to introduce interventions to expand and improve diagnosis, treatment and care for patients with TB. It intends to extend the umbrella of high-quality TB care and control to include those treated in the private sector. The NSP highlights the need for private sector engagement as an important component to eliminate TB.

Various efforts have been invested in including the private sector in efforts to eliminate TB. In 2001, the Central TB Division (CTD) formulated the first guidelines on partnership for engagement of non-governmental organizations (NGOs) and revised them in 2008 and 2014. The objective of these guidelines was to expand the reach of the programme to all patients through NGOs and private-sector providers. Additionally, the RNTCP has engaged with medical colleges and several NGOs in the past through grant-in-aid mechanisms and with mixed outcomes. Primarily, in these interventions, a large scale, sustainable engagement of the 'for-profit' private health sector remained missing. However, evidence from the recent large-scale pilots, such as the Patient Provider Support Agency (PPSA) have shown how newer approaches to private sector engagement can produce high-impact results.

Therefore, there has been a fundamental shift in RNTCP's approach to public-private partnerships. It has moved from input-based financing to an output- and results-based framework; which allows for "market discovery" instead of prescriptive costs. This approach is referred to as "performance-based matrix" in this document, which keeps the output and results at the core of the programme.

This guidance document has been developed to help Programme Managers outline approaches, expand partnership options, revise contracting processes based on RNTCP's new approach of output-based contracting and the General Finance Rule (GFR), 2017. Engaging with the private sector has been referred to as "partnership option" in this document. This document will be helpful for Programme Managers who are willing to explore existing and new partnership options and ways to implement them successfully. In this document, private-sector providers who will be engaged in the partnership option are referred to as "Service Providers".

This document is only for guidance and should not be considered like a Standard Operating Procedure (SOP). States have the liberty and flexibility to change or adapt the design of their partnerships based on specific and contextual laws / rules / acts applicable to them. Information areas elaborated in this guidance document include overview of available partnership options; scope for innovations; scope of services under each partnership option; implementation process including contracting, costing, developing a performance-based matrix and a monitoring and evaluation (M&E) framework. It also recommends the institutional framework as well as capacity-building efforts required for the government stakeholders and the Service Providers to implement partnership options.

This document was drafted by the "Private Sector Engagement Subgroup" under the National Technical Working Group (NTWG) of RNTCP. The members of this subgroup included leading experts from Faculty of Management Studies (FMS), World Health Organization (WHO), Bill and Melinda Gates Foundation (BMGF), The World Bank, National Institution for Transforming India (NITI-AAYOG), National Health Systems Resource Centre (NHSRC), The United States Agency for International Development (USAID), development partners - PATH, CHAI, FIND, The UNION and civil society members. It is the culmination of a series of consultations with various stakeholders and has also incorporated feedback from Programme Managers and NGOs. The CTD conducted workshops in various states – Karnataka, Maharashtra, Tamil Nadu, Jharkhand, Odisha, West Bengal, Rajasthan, Bihar and Assam - in order to orient relevant staff towards new concepts like output-based contracting and performance-based payments.

2 OVERVIEW OF PARTNERSHIP OPTIONS

This chapter gives an overview of the key features of partnership options, steps to engage with a "Service Provider", importance of undertaking a Needs Assessment, types of partnership options described in this document and examples of innovative options that states and districts can propose. It also describes the concept of "Bundling".

In this guidance document, a partnership option refers to engaging with a private-sector partner to improve the availability and quality of service delivery for TB patients. Going forward, a private-sector partner will be referred to as a "Service Provider".

2.1 Key features of a partnership option

1. **Quality of Care as per Standards of TB Care in India (STCI):** RNTCP acknowledges that all TB patients, those who seek care in public or private sector, come under the ambit of the programme. It is essential to ensure that private-sector patients have access to the same quality of diagnostics, drugs and community-based services as public-sector patients. With India's goal of progressing towards Universal Health Coverage, it will be critical to ensure that everyone receives services with minimum out-of-pocket expenditure. Therefore, all Service Providers should provide services aligned as per the latest guidelines on diagnosis and treatment and STCI.

2. **Needs-based:** To be effective, partnerships have to be based on identified needs and customized to suit the local context. It is ideal that each state or district design partnership options based on the local needs, capacity of the public health system and availability of competent Service Providers. The accountability and responsibility of ensuring that services are provided remain with RNTCP even if a partnership option is leveraged. More than one partnership option can be explored based on the needs identified.

3. **Patient-centric:** Patient should be at the centre of every partnership option. All patients are eligible to receive free services at public sector facilities and with minimum out-of-pocket expenditure at private-sector facilities. When the Programme Managers propose a partnership option, they need to ensure that sufficient linkages exist in the cascade of care and the partnership option is not a standalone mechanism to address a short-term gap. The Programme Managers may use the "bundling options" described subsequently to design practical and outcome oriented partnership guidelines.

4. **Competitive and performance-based approach:** This guidance document recommends that Programme Managers must seek Service Providers who will be able to deliver high-quality services and at prices that are commensurate with market rates. It is critical to move away from the mind-set of selecting the lower cost bidder and understand what budgets are required to execute the programme. Secondly, the payment mechanism for all Service Providers are "output-based" and not merely for completion of activities.

2.2 Steps to engage a Service Provider

It is recommended that the states follow these steps (Figure 1) when partnering with a Service Provider:
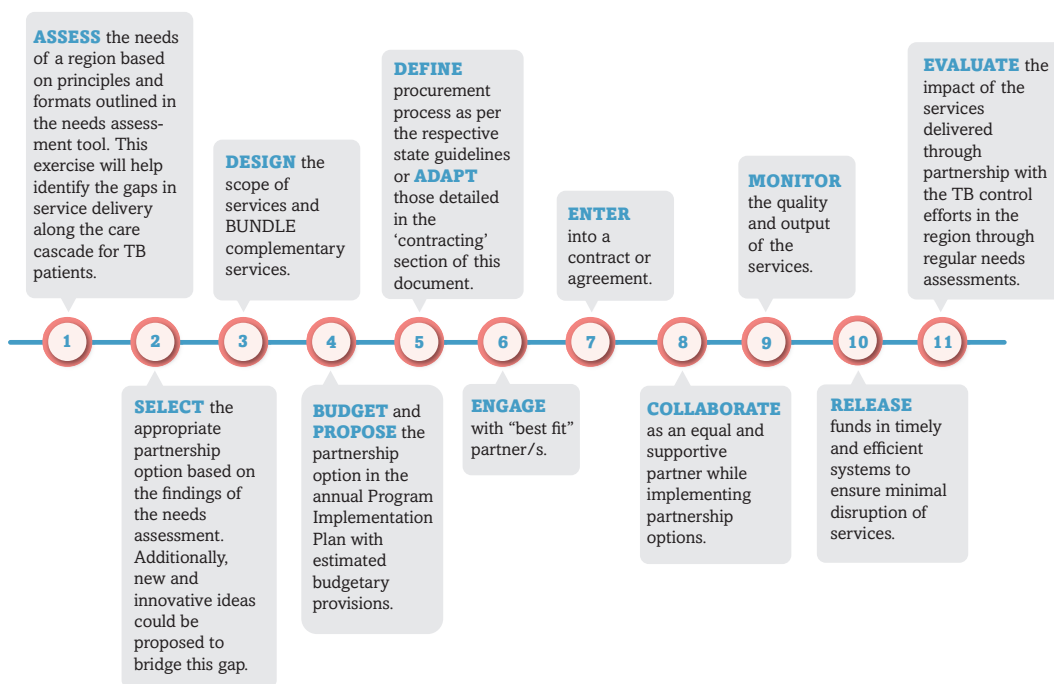

ASSESS the needs of a region based on principles and formats outlined in the needs assessment tool. This exercise will help identify the gaps in service delivery along the care cascade for TB patients.

DESIGN the scope of services and BUNDLE complementary services.

DEFINE procurement process as per the respective state guidelines or **ADAPT** those detailed in the 'contracting' section of this document.

ENTER into a contract or agreement.

MONITOR the quality and output of the services.

EVALUATE the impact of the services delivered through partnership with the TB control efforts in the region through regular needs assessments.

1 2 3 4 5 6 7 8 9 10 11

SELECT the appropriate partnership option based on the findings of the needs assessment. Additionally, new and innovative ideas could be proposed to bridge this gap.

BUDGET and **PROPOSE** the partnership option in the annual Program Implementation Plan with estimated budgetary provisions.

ENGAGE with "best fit" partner/s.

COLLABORATE as an equal and supportive partner while implementing partnership options.

RELEASE funds in timely and efficient systems to ensure minimal disruption of services.

FIGURE 1.
Steps to engage a Service Provider

2.3 Undertaking Needs Assessment

To understand which partnership options are applicable in a certain geography, it is recommended that the Programme Manager undertake a detailed "Needs Assessment" exercise. This is crucial to identify specific gaps and challenges that could be addressed either through various health systems strengthening exercises or partnering with appropriate service providers. It is recommended that this exercise is repeated on an annual basis to incorporate the changing needs of the programme.

To identify the gaps, Programme Managers may use the recommended cascade of services provided to TB patients (Figure 2) as a guidance and starting point. The thematic areas in the cascade of care are indicative of the critical gaps we see today in TB care and these are subject to evolve over time.

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FIGURE 2:
Cascade of recommended services provided to TB Patients

Community Mobilization
- Community Empowerment
- Communication
- Advocacy

Specimen Management
- Specimen Transport
- Specimen Collection

Diagnosis
- Notification

Treatment
- Treatment Centre
- DR-TB Treatment Centre

Treatment Completion
- Treatment Outcome Reporting

Screening
- Vulnerability Mapping
- Active Case Finding
- X-Ray

Diagnostic Test
- Latent TB Infection
- Molecular Test
- Microscopy

Associated or Pre-Treatment Test
- Drug Suceptibility Testing
- Diabetes Testing
- HIV Testing

Public Health Actions
- Chemoprophylaxis
- Adherence Support & Follow Up
- Nikshay Poshan Yojana

STEPS TO FOLLOW WHILE UNDERTAKING A NEEDS ASSESSMENT

Programme Managers should undertake the 'needs assessment' exercise in consultation of all stakeholders, such as state-level authorities, development partners, patients' groups, community-based organizations, professional associations, academic experts. They may also include third party measurements as a "checks and balances" mechanism for the assessment of the services. While conducting the needs assessment, all Programme Managers need to consider how this process will be used to strengthen the existing health systems. Due consideration needs to be given to understand how to increase and expand the capacity of the health system in terms of capacity, skills or by investment in human resources.

Please find below (Figure 3), the steps to follow to conduct a needs assessment exercise:

STEP 1:	STEP 2:	STEP 3:	STEP 4:	STEP 5:
Identify gaps from key output and performance indicators, such as notification, microbiological confirmation, DST, HIV testing, treatment outcome etc. Data sources should include HMIS data.	Identify gaps in inputs, activities and processes carried out to get the desired output. These may include presumptive TB examination, referral, testing, linkages, adherence support etc.	Identify systemic gaps of inputs, such as infrastructure, human resource, logistics capacities.	Compile all identified issues in a logical order to understand which gaps. Prioritize areas that can be addressed through strengthening of the Public Health System and those that can be addressed through partnership options or through other innovations.	Findings of the Needs Assessment exercise as approved by a committee under the Principal Secretary (NHM), should be placed in the public domain (NHM website / Nikshay Portal).

FIGURE 3:
Steps to follow to undertake needs assessment

The states and districts, as a starting point for their needs assessments, may use the format prescribed in Annexure 1. The updated and latest version will be available on the RNTCP website.

2.4 Available partnership options

Table 1 highlights the partnership options currently available. The Programme Manager, based on the findings of the needs assessment, can identify the relevant partnership options that they can implement in their region.

TABLE 1. Available partnership options and their scope of services

PARTNERSHIP OPTION	SERVICES
Patient Provider Support Agency (PPSA)	1. Private provider empanelment and engagement 2. Linkages for specimen transportation and diagnostics 3. Patient management (public health action, counselling, adherence support) 4. Logistics of Anti-TB drugs The PPSA is an example of a "service bundle" that covers a whole range of activities for end-to-end management of private sector
Public Health Action	1. Counselling and adherence management 2. Contact tracing and chemoprophylaxis 3. HIV counselling, testing and treatment linkage 4. Drug susceptibility testing (DST) and linkage for DR-TB services 5. Blood sugar testing and linkages for diabetic care 6. Linkages for Nikshay Poshan Yojana
Specimen Management	1. Collection of sputum samples 2. Collection of respiratory (excluding sputum) and EP specimen 3. Transportation of specimen
Diagnostics	1. X-ray centres 2. Smear Microscopy (ZN/FM)/Molecular diagnostics 3. Culture (stand-alone) / Line Probe Assay / Culture and Drug Susceptibility Testing 4. Pre-treatment and follow-up investigation 5. Latent TB infection test (LTBI)
Treatment Services	1. TB management centre 2. DR-TB treatment centre (outdoor) 3. DR-TB treatment centre (indoor) 4. Specialist consultation for DR-TB patients
Drug Access and Delivery Services	1. Drug supply chain management 2. Improving access to anti-TB drugs for TB patients notified by the private sector
Active TB Case Finding and TB Prevention	1. Active TB case finding 2. TB prevention package for vulnerability mapping and LTBI management
Advocacy, Communication and Community Empowerment	1. Advocacy 2. Communication 3. Community Empowerment

The partnership options stated above are those which are currently identified and recommended. It is not an exhaustive list.

A Programme Manager can innovate new partnership options which suit the local context. Some examples of innovative options are hiring a Service Provider for airborne infection control, facility-risk assessment, rehabilitation of DR-TB patients, or alcohol de-addiction programmes for people with TB etc.

- ***Cartridge Sharing Model:*** *District A has only two CBNAAT machines and cannot cater to the increased demands of the district.They have a sufficient and steady supply of CBNAAT cartridges and have also a few selected private-sector laboratories that have CBNAAT machines. The RNTCP may consider a cartridge sharing model, under which, the RNTCP provides the cartridges to the private labs to run tests on its behalf. The purchase agreement will be per test basis to cover the overheads and maintenance charges at the labs. This may be a more cost-effective model, especially if cartridge stocks are not a challenge.*

- ***Reagent Rental Model:*** *In districts that would like to provide newer molecular diagnostics to patients but do not want to incur any additional capital costs, RNTCP may consider the Rental Model. Here, RNTCP can engage with manufacturer (who may also present as a Service Provider) to establish a purchase arrangement. A Service Provider will provide equipment, reagents on rent to a public-sector health facility and ensure the maintenance of the equipment as well. RNTCP will provide space, electricity, and a laboratory technician to run the instrument. The purchase arrangement will be per test basis to cover their overheads and maintenance charges. An agreed amount will be paid based on minimum guarantee of workload.*

- ***Mobile TB Diagnostic Van*** *: State A is considering how to make NAAT test available at the periphery. With this intention, the state proposes for an innovation – a combined X-ray unit and NAAT in a mobile van. Here the state will look to outsource the entire operations of managing the mobile testing unit to the service provider. These operations will include management of the vehicle and personnel for a defined time period in an assigned geography.*

- ***Outsourced Laboratory Operations:*** *In district A, the Programme Manager has an established lab in a public–sector facility to run services, but does not have the required human resources to run the same. In this scenario, the programme proposes that the lab is outsourced to a private agency. The costing may be proposed on a per test basis or on a consolidated monthly basis and must include various aspects like HR, reagents, overheads, consumables. The Service Provider will be responsible for undertaking a wide range of services - provision of skill personnel, cleaning, doing testing and providing result, data entry in Nikshay as per guidelines etc. This option may be used to run DMC and / or C-DST Laboratory.*

Examples of Innovation

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2.5 Using the bundling approach

In scenarios where more than multiple systemic gap have been identified during needs assessment, the Programme Manager may consider using more than one partnership option. Bundling refers to combining a series of partnership options in a logical and sequential manner to ensure that no patient is left out at any point in the care cascade.

ADVANTAGES OF BUNDLING

- **Increased coverage**: Multiple activities in the cascade of TB care from diagnosis to treatment completion can be provided to the TB patients.
- **Fewer contracts to process**: Bundling is cost effective and easy to implement as multiple contracts can be processed together.
- **Opportunities for collaboration**: Bundling allows for service providers to partner with other agencies who have the skill sets and capacities to offer support for complementary services.
- **Reduces** supervision and verification costs.

TYPES OF BUNDLING

A. Service or vertical bundles

Under this approach, the Programme Manager should consider the continuum of full range of services to patients. For example, rather than partnering for only a Microscopy Centre at a private-sector hospital, it is recommended that other allied and supportive services are made available at the same hospital so as to ensure patients have access to comprehensive care as well as easy access to services. The allied partnership options could cover the spectrum of treatment. For instance, if the Programme Manager is planning to outsource a diagnostic test such as Nucleic Acid Amplification Test (NAAT), they can also consider how to avail services from the same Service Provider for specimen collection and transportation.

It is not necessary to outsource all services, but the Programme Manager should deliberate on how this ties in with end-to-end services.

B. Geographical expansion of services or horizontal bundles

To create an impact at a large scale with more concentrated effort and focused monitoring, the Programme Manager may pick a stand-alone service and engage a Service Provider in a 'horizontal bundle' for services across clusters of TB units, cluster of districts, regional, zonal or state wide. For example, to engage a Service Provider, such as a courier, or chain laboratory or postal services or drug distributors who can be responsible for specimen transportation from public-or private-sector providers, and/or drug distribution to treatment provision sites for a cluster of districts or states.

C. Services which require similar capabilities of the partner agencies

Under this approach, the Programme Manager may consider bundling of all services which require identical skill sets of the Service Provider. For example, drug distribution and specimen transportation require agencies with similar skillsets and capability of supply chain management and logistics.

Partnership options may be implemented in isolation but it is preferable if Service Providers extend the options to ensure a continuum of care to the patients by themselves or by providing sub-contract to another Service Provider.

Here are few scenarios where bundling approach has been used to address gaps identified in the needs assessment.

1 In District A, a major gap identified during the needs assessment showed that 60% of the patients accessed private sector for TB care but there was poor participation and notifications from private-sector providers. Doctors did not use STCI practices and there was limited information available on treatment outcomes. The Programme Manager found the efforts of the Public Private Mix-Coordinator to be insufficient to engage with the private-sector providers and realized that it will be beneficial to use the Patient Provider Support Agency (PPSA) – a ready-made bundle which provides end-to-end services. PPSA, explained in detail in the subsequent section, is a recommended option which is responsible to provide end-to-end services including provider engagement, specimen transportation, notification support, drug distribution to private-sector providers, treatment adherence support for privately-treated TB patients and public health action.

2 In a tribal district, poor case detection emerged as a major challenge. This was primarily due poor health-seeking and limited access to testing facilities. While active case finding could be a good strategy to improve the detection rates, it would not be completely effective without adequate preparatory activities like awareness programmes or without linkages to appropriate diagnostic services. Hence, the Programme Manager could design a bundle to link the following partnership options – active case finding and community mobilization. To ensure closure of the service loop, the Programme Manager will also have to plan how the local RNTCP body will ensure that all the patients identified through these activities are initiated on treatment, receive public health action and are followed up till treatment completion.

3 State B has limited capacity to provide first and second line probe assays (LPA) to all patients, prior to DR-TB treatment initiation. To minimize wastage of resources and time, the Programme Manager can propose to bundle the specimen transportation partnership option with the outsourcing of first or second LPA.

4 District C has a huge influx of migrants from neighbouring states and faces the challenges for case detection and tracking treatment outcomes given the mobile and transient nature of this vulnerable group. The Programme Manager can design a "Migrant TB Project" by bundling partnership options of community engagement, active case finding, specimen management, public health actions and treatment adherence.

3 SCOPE OF SERVICES OF PARTNERSHIP OPTIONS

This chapter elaborates on the partnership options described in the previous section and provides information on the scope of work for each stakeholder for every partnership option. It describes the eligibility criteria for the Service Provider, role of the Service Provider and RNTCP, performance-based criteria and its linkage to payment, and the verification mechanism to monitor performance.

All Service Providers are expected to be registered entities as per definition in the Glossary section.

OPTION I. Patient Provider Support Agency

PPSA is an interface agency between the RNTCP and the private-sector healthcare system. PPSA acts on behalf of the RNTCP to liaise with laboratories, physicians, chemists and all other clinical / medical establishments, and ensures that all private-sector patients have access to the highest quality of services with their preferred provider and with minimum out-of-pocket expenditure. The main objectives of a PPSA is to efficiently engage with private-sector providers, ensure high-quality diagnostics, provide treatment and adherence support, ensure public health action, facilitate linkages of services and actively follow-up with patients till the completion of their treatment.

A. Eligibility criteria for Service Providers

- Service provider should be a registered entity (as defined in glossary).
- Prior experience of at least three years in implementing mid to large projects in the private sector and / or social development projects. Experience in implementing large scale health project in TB/HIV, leprosy, RCH is desirable.
- Proven track record to design and implement innovative projects in an entrepreneurial mode.
- Availability of personnel with diverse skill set familiar with performance-based approaches.

B. Role of Service Provider

PPSA covers entire an spectrum of services, as explained below:

B.1 Private Provider Empanelment & Engagement

- Conduct a mapping exercise and landscape analysis of private-sector providers in a region. This includes all types of providers included in the TB care cascade, that is, private-sector clinics, hospitals, AYUSH/ informal providers, pharmacies, laboratories etc. The Service Provider will review existing data, gather insights by interviewing professional associations, pharmacies, laboratories, patient support groups, NGOs and reviewing H1 registers.

- Prioritize providers and services for engagement, and market the package of PPSA services to them through a comprehensive approach. This includes repeated one-to-one personal communication visits with private-sector providers and engaging them for notification and referral initially, and for linkages of services, and patient support under RNTCP as a next step.

- Develop communication material to engage with the private providers, such as handouts, pamphlets etc. Adapt existing RNTCP material for private-sector patients.

- Register private-sector providers on Nikshay and facilitate the generation of Nikshay id, if not already registered, for each private-sector provider.

- Facilitate the provider's Direct Benefit Transfer (DBT) incentive for notification and reporting outcome by updating details in Nikshay.

- Sustain the relationship and build rapport with providers, to encourage, pursue and ensure that STCI is followed in their clinical practice, and to provide regular feedback to private-sector providers on notification and standards for care parameters.

- Sensitize and update all providers on the importance and updated protocols of screening of HIV services, Diabetes Mellitus (DM) testing, linkage to free drug susceptibility testing (DST) and other public health actions.

- Advocate and facilitate notification of TB patients in Nikshay directly by the providers. The Service Provider may train the health establishment to notify through Nikshay Sampark/ Call Centre on its toll-free number. Wherever required, notification will be supported by the Service Provider in Nikshay.

B.2 Diagnostic linkages and specimen transportation

- Design the specimen collection and logistics system from presumptive TB, presumptive DR-TB or follow-up patients referred from the OPD of the private-sector providers, and deliver to RNTCP laboratories.

- Coordinate the delivery of soft copy and hard copy of the test report to the doctors at the private-sector providers and update these in Nikshay.

- Liaise with NAAT/microscopy testing public-sector labs in the region.

- Plan the specimen collection route and its packaging with bio-safety precautions as per RNTCP guidelines; ensure labelling; completion of lab request form; maintain biological specimen examination, request form and laboratory register; and log books of specimen transported.

- Ensure DST for TB patients diagnosed with Rifampicin Resistance.

- Engage with private-sector labs in the assigned region to increase availability and access to free diagnostics and drugs through voucher / alternate mechanism. This may include X-ray and other laboratory tests, if needed.

B.3 Patient management (public health action, counselling, adherence support)

- Coordinate with RNTCP and private-sector provider and patient to ensure availability of anti-TB drugs.

- Ensure public health action for all privately notified patients such as verification of the diagnosed patient's residential address, screening family contacts for TB.

- Design a comprehensive strategy to sustain patients on treatment including counselling and adherence support contact investigation, chemoprophylaxis, counselling, DBT for patients, outcome reporting, etc.

- Deploy relevant digital tools for comprehensive patient adherence support including initial home visits, counselling, reminders, refill monitoring, 99 DOTS, MERM, Video DOTS

- Maintain a patient support team to support patients through the course of the treatment.

- Report treatment outcome for all notified patients.

- Update patients and contacts details on Nikshay.
- Identify adverse drug reaction (ADR) and ensure management.
- If the patient moves out to another region, the Service Provider should ensure follow-up of such patients and complete necessary public health actions.

B.4 Public health action linkages for Nikshay Poshan Yojana (NPY)

- Ensure all TB patients are aware of NPY and its components.
- Inform private-sector providers on NPY and advocate for their support to collect bank account number, **Aadhaar** details, mobile and alternate contact number.
- Facilitate bank account opening for patients who do not have one.
- Update patient bank account details on Nikshay and maintain physical/digital records of bank related information and share the same with RNTCP.

B.5 Public health action: contact investigation and chemoprophylaxis

- Screen the contacts (family members / person who co-habit the same house as the patient) of index TB case in the household with symptoms and/or X-ray and identify presumptive TB patients.
- Complete the evaluation of presumptive TB with microscopy, X-ray and molecular tests as per the diagnostic algorithm of RNTCP with adequate specimen collection and transport support.
- Facilitate the treatment initiation of person diagnosed with TB among contacts.
- Identify and initiate eligible contacts on Isoniazid Preventive Therapy for children below 6 years of age or other preventive treatment as per the prevailing guidelines of RNTCP.
- Counsel the parents and family on the importance of treatment completion.
- Coordinate with private-sector provider of TB patient and RNTCP for initiation of preventive treatment.
- Identify any ADR and address it immediately with effective linkages with appropriate private- or public-sector provider.
- Follow up of contacts through treatment completion with regular updates on Nikshay.
- Forecast drug requirements to RNTCP for chemo-prophylactic treatment.

B.6 Public health action: linkage support and services (HIV, DM, DR-TB etc.)

- Advocate with private-sector providers to ensure that all diagnosed patients are tested for HIV and DM.
- Provide support to establish linkages for TB patients to be screened for HIV and DM.
- Establish referral linkages for HIV testing at notified Facility Integrated Counselling and Testing Centres or ICTC / NACO-empanelled HIV testing centres / government dispensaries for confirmatory testing. Alternatively, the private-sector provider/ doctor may facilitate testing in a private facility and update the Service Provider accordingly.
- Establish effective linkages of patients diagnosed with Rifampicin Resistance to the designated DR-TB centres in the public sector. Additional support and linkage services for pre-treatment investigation, DR-TB - OPD and IPD Centre care may be undertaken based on local need.

B.7 Demand generation, logistics and supply chain management of public sector Anti-TB drugs

RNTCP may provide free anti-TB drugs to patients seeking care in the private sector and may leverage PPSA to undertake the following activities:

- Market public-sector drugs as part of the PPSA engagement package.
- Manage logistics of drugs from district drug store/District Tuberculosis Centre up to the consumption unit(s) i.e., private-sector providers/ doctors and chemists / pharmacies.

- Forecast and communicate the drug requirements to RNTCP.
- Liaise with the empanelled providers and chemists to facilitative dispensing of appropriate FDC to the TB patients.
- Provide standard formats of inventory management and patient's details to the chemist/pharmacies and private-sector providers.
- Coordinate updating of logistics and prescription details in Nikshay and Nikshay e-Aushadhi.
- If the patients wish to purchase drugs from the open market, the Service Provider should not force them to consume the drugs/FDCs provided by the RNTCP. The Service Provider should notify the drugs/FDCs purchased from the open market by the patient on Nikshay.

B.8 Coordination and operations management

- Use monitoring metrics, customer feedback and learnings to adjust the engagement and service provision model.

C. Role of RNTCP

- Identify the gaps and challenges with private-sector engagement through a detailed needs assessment exercise and determine targets based on results.
- Contract and train the PPSA staff on the RNTCP guidelines.
- Facilitate sensitization programmes with the private-sector providers on a regular basis to update them on the services provided as well as on STCI.
- Develop a working relationship with champion providers and major hospitals to gather feedback on services and scope for improvement.
- Send advisory to private-sector providers on engagement of Service Provider for provider engagement and the range of services that will be offered through PPSA.
- Forecast and make logistic arrangement for the supply of diagnostic consumables (including falcon tubes) and drugs through PPSA, if required.
- Design the integration and extension of universal-DST (U-DST), CB-NAAT & Culture-DST (C-DST) services, free HIV testing and any other relevant investigations to all private-sector patients from public-sector labs / private-sector collaborations.
- Collaborate with PPSA agencies to review activities and troubleshoot should a challenge arise.
- Foster a collaborative relationship between RNTCP and PPSA staff to ensure minimum disruption in services to patients and providers.
- Review performance of PPSA and provide constructive feedback to improve performance.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment as per number of notified TB patients recorded in Nikshay in the geographic areas within a defined time period.
- Deduct 10% for those notified patients who don't get at-least 1 NPY payment as documented in Nikshay.
- Deduct 20% for those notified patients whose microbiological confirmation/Drug Susceptibility Test (DST) are not documented in Nikshay.
- Deduct 30% for those notified patients whose treatment outcome are not recorded in Nikshay within 9 months of treatment start.
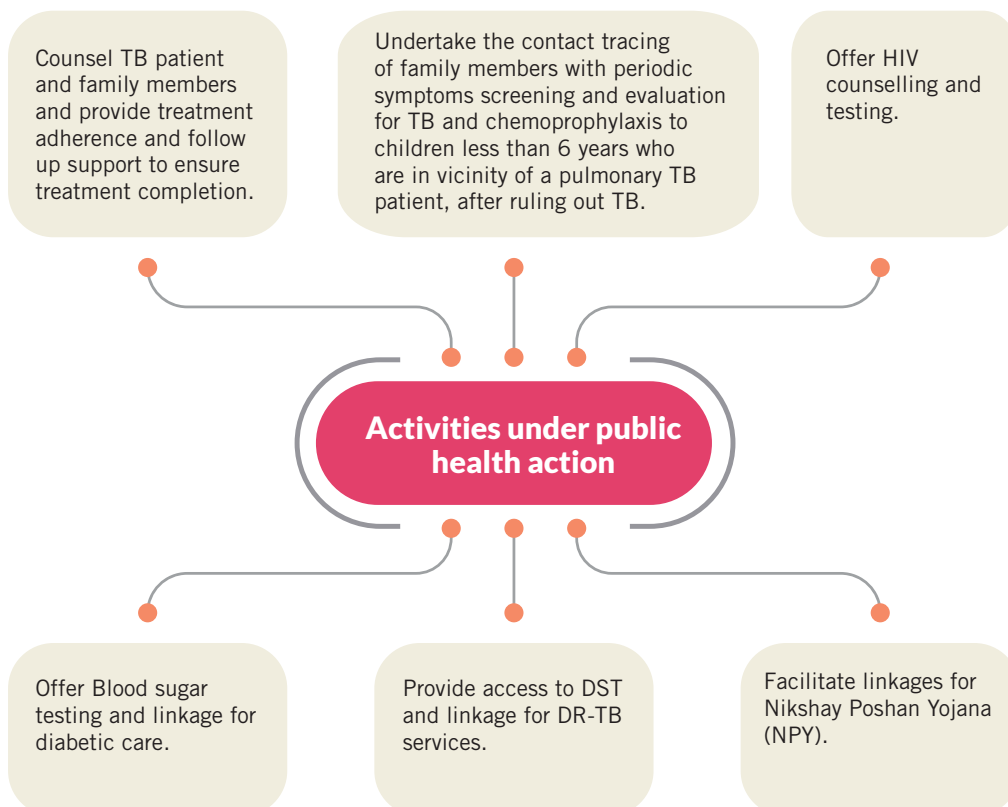
- Additional 5% incentive of overall payment under the contract for particular year, if 90% of expected notification has been achieved.
- Additional 5% incentive of overall payment under the contract for particular year, if 70% of successful treatment outcome is achieved.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interviews with 5% of TB patients who have completed intensive phase from the records of adherence score, follow-up and completion.
  - Interviews with 5% of TB patients who have completed continuation phase from the records of adherence score and completion.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarters.

OPTION II. Public Health Action

Public health action is a group of activities undertaken for all TB patients after notification. This partnership option may be explored with the intent of serving private-sector patients and can be proposed in regions where there are no PPSAs or where the current RNTCP staff structure is not adequate to cater to the additional patient load. This option may also be considered for augmenting the public sector in regions where required. It is desirable to deliver the entire range of services in public health action as a bundle rather than have different Service Provider for each activity.

Counsel TB patient and family members and provide treatment adherence and follow up support to ensure treatment completion.

Undertake the contact tracing of family members with periodic symptoms screening and evaluation for TB and chemoprophylaxis to children less than 6 years who are in vicinity of a pulmonary TB patient, after ruling out TB.

Offer HIV counselling and testing.

Activities under public health action

Offer Blood sugar testing and linkage for diabetic care.

Provide access to DST and linkage for DR-TB services.

Facilitate linkages for Nikshay Poshan Yojana (NPY).

ACTIVITY 1 COUNSEL TB PATIENT AND FAMILY MEMBERS AND PROVIDE TREATMENT ADHERENCE AND FOLLOW UP SUPPORT TO ENSURE TREATMENT COMPLETION

A. Eligibility criteria for Service Provider

- Service Provider should be a registered entity (as defined in glossary).
- Should have at least three years of experience in working in health-outreach or community mobilization.
- While prior TB experience is preferable, organizations with experience of working in any other allied branch like maternal and child health, leprosy, HIV etc. are eligible.
- Should have local presence in the community to be reached.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.

- Provide services free of cost to patients and ensure confidentiality of all patients.
- Ensure real-time reporting in Nikshay.
- Obtain the list of patients on treatment at least once a week from the assigned area.
- Counsel TB patients on the treatment - duration of treatment, mode of intake of drugs, frequency of drug intake, probable adverse drug events / reactions associated with treatment. Patients can be counselled at their home or workplace as per the patients' convenience during the course of treatment.
- Support patients when there is a change in their routine, such as, travel, family obligations, professional obligations etc. to ensure treatment adherence. This is also applicable if the patients change their home district or relocate elsewhere.
- Ensure assessment of adherence for patients on treatment by pill counting and monitoring refill.
- Identify ADR and ensure effective management.
- Coordinate with RNTCP / healthcare provider and patient to ensure availability of drugs with patient.
- Retrieve the patient, if treatment was interrupted or if patient is not traceable of contactable for three days or more.
- Update patient record treatment card (physically) and on Nikshay on adherence.
- Update treatment outcome of TB patients.
- Advocate with providers to use digital adherence tools for monitoring patients' treatment.
- Counsel and train patients on use of digital tools chosen by them.
- Coordinate with RNTCP for availability of digital adherence tools.
- Act as a first point-of-contact for patients facing any challenges in using digital adherence technology.
- If no digital tool is used, the Service Provider should coordinate with RNTCP to use Nikshay Sampark for weekly call and self-reporting. Service Provider will be the first escalator for Nikshay Sampark to bring patients on treatment.

C. Role of RNTCP

- Provide list of TB patients.
- Inform patients and get their consent regarding the Service Provider deployed.
- Provide letter of support to Service Provider to conduct the activities.
- Train Service Provider on technical aspects of treatment continuation and follow up.
- Provide Nikshay login credentials and digital adherence tools (application, devices other than mobile/tablet/laptop, if required).
- Provide treatment card.
- Review patient records on a regular basis.
- Facilitate availability of digital adherence technology.
- Provide support on Nikshay Sampark, as per requirement.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkages to payment (indicative)

- Payment as per number of TB patients initiated on treatment and put on adherence support for a defined time period (month/ quarter) as reported in Nikshay in the assigned area.

- Deduct 20% for those patients whose adherence score has not been reported and updated in Nikshay at the end of three months of treatment. This indicator may be reviewed and paid in the second quarter after the treatment has been initiated.

- Deduct 30% for those patients whose treatment outcomes have not been recorded in Nikshay within nine months of treatment initiation. This may be reviewed till the completion of the last cohort of patients and paid.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:

  - Interviews with 5% of TB patients who have completed intensive phase from the records of adherence score, follow up and completion.

  - Interviews with 5% of TB patients who have completed continuation phase from the records of adherence score and completion.

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarters.

ACTIVITY 2 CONTACT TRACING AND CHEMOPROPHYLAXIS

As per the RTNCP guidelines family members / close contact of diagnosed patients have to undergo screening for TB. Similarly, during the home visits, all children who are in the vicinity of a Pulmonary TB patient will receive prophylactic medication – Isoniazid Preventive Therapy (IPT).

A. Eligibility criteria

- Service Provider should be a registered entity (as defined in glossary).

- Should have at least 3 years of experience in working in the health outreach or community mobilization.

- While prior TB experience is preferable, organizations with experience of working in any other national health programmes like maternal and child health, leprosy, HIV etc. are eligible.

- Should have local presence in the community to be reached.

B. Role of Service Provider

- Recruit adequate personnel.

- Undergo training if required and adhere to RNTCP guidelines.

- Maintain records and reports as given by RNTCP.

- Provide services free of cost to patients and ensure confidentiality of all patients.

- Ensure real-time reporting in Nikshay.

- Obtain the list of patients on treatment at least weekly from concerned TB unit/ district.

- Screening of contacts (family members / person who live in the same house as the patient) of index TB case in the household with symptoms and/or X-ray and identify presumptive TB patients. Children should be screened by a Medical Officer.

- Complete evaluation of presumptive TB with microscopy, X-ray and molecular tests as per the diagnostic algorithm of RNTCP.

- Linkage to be established to free diagnostic services at public-sector laboratory or engaged private-sector laboratory.
- Ensure collection and examination of appropriate sample for children and for EP presumptive TB.
- Facilitate initiation of treatment of person diagnosed with TB among contacts.Refer TB patients for treatment and provide contact details to concerned TU for patient follow-up as needed.
- Identify eligible contacts for preventive treatment.
- Coordinate with RNTCP for initiation of preventive treatment and regular provision of drugs.
- Counsel the family on the importance of treatment completion.
- Support completion of preventive treatment.
- Identify any ADR and address it immediately.
- Ensure regular drug provision of drugs of preventive treatment.
- Forecast and demand drugs for chemoprophylaxis.

C. Role of RNTCP

- Provide list of patients with address and contact number.
- Train Service Provider on guidelines of RNTCP and procedures to be followed for contact investigation and chemoprophylaxis.
- Provide preventive treatment drugs.
- Provide containers to collect specimen, e.g., falcon tubes, for transport to testing sites.
- Provide list of laboratories and health facilities to strengthen referral linkages.
- Forecast and make provisions for chemoprophylaxis drugs to be made available to the Service Provider, if required.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment as per number of notified TB patients whose contacts were screened and recorded in Nikshay in the assigned geographic area for a defined time period.
- Deduct 20% for those patients whose contacts were not evaluated and documented in Nikshay.
- Deduct 30% if eligible contacts did not complete preventive treatment, as recorded in Nikshay, within the stipulated time period of treatment mentioned in the guidelines.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interviews with 5% of contacts/ presumptive persons who have been examined.
  - Interviews with 5% of patients completed the chemoprophylaxis treatment.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarters.

ACTIVITY 3 OFFER HIV COUNSELLING, TESTING AND TREATMENT LINKAGE

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have at least three years of experience in working in the health outreach or community mobilization.
- While prior TB experience is preferable, organizations with experience of working in any other national health programmes like maternal and child health, leprosy, HIV etc. are eligible.
- Should have local presence in the community to be reached.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure confidentiality of all patients.
- Ensure real-time reporting in Nikshay.
- Collaborate and design the appropriate model of referral linkage and testing service at private hospitals and clinics based on RNTCP and NACO guidelines.
- Advocate with private-sector providers who need HIV testing facilities.
- Facilitate patient testing, preferably at free testing centre, such as F-ICTC/ICTC or NACO-empanelled HIV testing centres.
- Establish effective linkages between patient and nearest ICTC for confirmatory test. Post linkage, the ICTC will be responsible for treatment initiation of HIV patient and other ART-related services.
- Liaise with RNTCP and the National AIDS Control Programme at the district and coordinate for kits logistics and data sharing.
- Update HIV status of TB patients in Nikshay.

C. Role of RNTCP

- Provide list of providers whose TB patients are to be tested for HIV.
- Train Service Provider on HIV-TB collaboration.
- Coordinate with District AIDS Prevention and Control Unit or a similar unit to support referral linkage and providing care of patients, if found HIV reactive.
- Provide Nikshay user credentials.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment as per number of notified TB patients who were recorded in Nikshay and tested for HIV with results for a defined time period (month/ quarter) as reported in Nikshay in the assigned area.

E. Verification Mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interviews with 5% of TB patients whose HIV status is updated.

- Interviews with 5% of TB-HIV con-infected patients who have been linked to ICTC centres.

▪ If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

ACTIVITY 4 BLOOD SUGAR TESTING AND LINKAGES FOR DIABETES MELLITUS

A. Eligibility criteria for Service Provider

▪ Service provider should be a registered entity (as defined in glossary).

▪ Should have at least three years of experience in working in the health outreach or community mobilization.

▪ While prior TB experience is preferable, organizations with experience of working in any other national health programmes like maternal and child health, leprosy, HIV etc. are eligible.

▪ Should have local presence in the community to be reached.

B. Role of Service Provider

▪ Recruit adequate personnel.

▪ Undergo training if required and adhere to RNTCP guidelines.

▪ Maintain records and reports as given by RNTCP.

▪ Provide services free of cost to patients and ensure confidentiality of all patients.

▪ Ensure real-time reporting in Nikshay.

▪ Collaborate and design the appropriate model of referral linkage and testing service at private-sector hospitals and clinics based on RNTCP and NPCDCS guidelines.

▪ Advocate with private-sector providers on the need of DM testing.

▪ Patients who have not been tested for DM should be followed up with in concurrence with the treating doctor.

▪ Patients with TB-diabetes need to be linked to a facility for proper management for diabetes.

▪ Update DM status of TB patients in Nikshay.

C. Role of RNTCP

▪ Provide list of providers whose TB patients need to be tested for DM.

▪ Train Service Provider on DM-TB collaboration.

▪ Coordinate with District NCD Control Unit to support referral linkage and provide care to patients, if found to have DM.

▪ Provide Nikshay user credentials.

▪ Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

▪ Payment as per number of notified TB patients whose DM status is updated in Nikshay within a defined time period in the assigned area.

E. Verification Mechanism

▪ The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

▪ The second level – physical verification may be undertake by the District assigned personnel / agency and could include:

- Interviews with 5% of TB patients who DM Status has been updated in Nikshay.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

ACTIVITY 5. DRUG SUSCEPTIBILITY TESTING AND LINKAGE FOR DR-TB SERVICES

A. Eligibility criteria for Service Provider
- Service provider should be a registered entity (as defined in glossary).
- Should have at least three years of experience in working in the health outreach or community mobilization.
- While prior TB experience is preferable, organizations with experience of working in any other national health programmes like maternal and child health, leprosy, HIV etc. are eligible.
- Should have local presence in the community to be reached.

B. Role of Service Provider
- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure confidentiality of all patients.
- Ensure real-time reporting in Nikshay.
- Ensure DST for all TB patients with a biological specimen.
- Advocate with the provider to prescribe DST for all TB patients and share the latest government protocol of DST.
- Establish specimen collection centre at private-sector facility and establish a transport system to transport specimen to designated laboratory.
- Coordinate with laboratory for results and communicate it to the provider.
- Establish linkage of TB patients diagnosed with Rifampicin Resistance by referring patients to the DR-TB centre.
- Liaise with RNCTP to ensure all patients go through to pre-treatment Evaluation and are initiated on treatment.

C. Role of RNTCP
- Provide list of TB patients and their private-sector providers to be tested for drug susceptibility.
- Train Service Provider on DR-TB testing and treatment.
- Provide formats for recording information of DST and initiation of treatment.
- Provide containers for specimen collection, e.g., falcon tubes.
- Provide Nikshay user credentials.
- Coordinate with the molecular laboratory and C-DST laboratory for referral of patients expected.
- Ensure all patients complete their Pre-treatment Evaluation.
- Coordinate with the DR-TB centre regarding treatment initiation of patients.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkages to payment (indicative)
- Payment as per number of privately notified TB patients as reported in Nikshay for a defined time period (month/ quarter) in the assigned area.The Nikshay records needs

to reflect the patients DST results.

- Deduct 10% for the notified patients who get tested for drug susceptibility beyond 15 days of notification, as documented in Nikshay.

- Deduct 20% for those patients diagnosed as DR-TB and who are not initiated on treatment within 15 days of diagnosis as documented in Nikshay.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:

  - Interviews with 5% of TB patients who DST Status has been updated in Nikshay.

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

ACTIVITY 6. LINKAGES FOR NIKSHAY POSHAN YOJANA (NPY)

NPY has been rolled as a supplementary nutritional support to patients. Under the programme, all TB patients notified in Nikshay are provided financial assistance of ₹ 500/- per month till completion of treatment.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).

- Should have at least three years of experience in working in the health outreach or community mobilization.

- While prior TB experience is preferable, organizations with experience of working in any other national health programmes like maternal and child health, leprosy, HIV etc. are eligible.

- Should have local presence in the community to be reached.

B. Role of Service Provider

- Recruit adequate personnel.

- Undergo training if required and adhere to RNTCP guidelines.

- Maintain records and reports as given by RNTCP.

- Provide services free of cost to patients and ensure confidentiality of all patients.

- Ensure real-time reporting in Nikshay.

- Inform eligible people about NPY benefits, provide support in opening bank accounts, if required, collect accurate and complete bank account details, update in Nikshay within 15 days since notification and take corrective action if the account is not validated by the Public Financial Management System (PFMS).

- Advocate with private-sector providers to counsel and give information to patients on NPY and to motivate them to provide their bank account number and *Aadhaar* number (if required).

- Support private-sector providers in collecting accurate bank account details of patients, verifying them and entering in Nikshay.

- Follow-up with the provider and the patient to ensure receipt of payments.

- Support the RNTCP to verify and process the payments.

C. Role of RNTCP

- Authorise the Service Provider to collect bank account details and *Aadhaar* details, if required.
- Train the Service Provider on NPY process.
- Ensure timely payments to eligible patients.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment as per number of notified TB patients with recorded validated bank account in Nikshay.
- Deduct 10% for those patients whose bank account details are recorded in Nikshay more than one month of notification.
- Deduct 20% for those patients whose first payment was rejected due to incorrect bank account details.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interviews with 5% of TB patients who have received NPY as per Nikshay records.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

OPTION III. Specimen management

This partnership options explores the processes to collect all types of specimen including sputum, other respiratory specimen, EP samples etc. It also elaborates on the logistics and linkages to the designated laboratory facilities.

ACTIVITY 1. COLLECTION OF SPUTUM SAMPLES

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have experience of at least two to three years in similar work.
- Should have staff to conduct outreach activity.
- Should have local presence in the community intended to be reached.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure their privacy and confidentiality.
- Ensure real-time reporting in Nikshay.
- Ensure and establish a sample collection centre in private-sector healthcare facility / community.
- Identify designated areas as well as nodal persons for specimen collection and packaging.
- Counsel and coach the patient on expectorating to produce a good specimen.
- Ensure accurate packaging and labelling of collected specimen as per the RNTCP guidelines.
- Ensure appropriate specimen storage facility as per the RNTCP guidelines in case of delays in transport.
- Coordinate with corresponding laboratories for on-time delivery of result.
- Maintain biological specimen examination request form and sputum collection register.
- Ensure on-time delivery of results to the specimen collection centre and/or patients.

C. Role of RNTCP

- Provide the SOPs, RNTCP formats for specimen collection and packaging as well as access to Nikshay user credentials to the Service Provider.
- Train Service Provider on specimen collection, packaging and transportation with requisite safety precautions as per RNTCP guidelines.
- Identify and specify laboratory linkages.
- Provide a prototype of sputum specimen container and specification for procurement of specimen collection containers.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be based on number of specimens collected, accepted at laboratory and entries updated in Nikshay.
- Deduct 20% if fewer than 70% of diagnostic sputum sample are of mucopurulent quality as recorded in Nikshay.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Verification of records from lab registers.
  - Interviews with staff from facilities where samples are collected.
  - Interviews with 5% of TB patients who have availed services under this option.

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Bundling options to consider: The partnership option could be bundled with specimen transportation.

ACTIVITY 2. COLLECTION OF RESPIRATORY (EXCLUDING SPUTUM) AND EP SPECIMEN

A. Eligibility criteria

- The Service Provider should be a registered entity (as defined in glossary) - **essentially a health facility**.

- Since the specimen retrieval process is either invasive or surgical, it is preferable if the Service Provider has a clinical setup. The Service Provider must ensure the ready availability of specialist expert who can perform fine needle aspiration and cytology, biopsy, gastric aspirate, gastric lavage, broncho-alveolar lavage, drainage of abscess, surgical excision from presumptive EP or paediatric TB patients from a healthcare facility based on the needs of the programme.

- Should have instruments, consumables and infrastructure for the required procedures.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure their privacy and confidentiality.
- Ensure real-time reporting in Nikshay.
- Ensure availability of specialists, infrastructure, instruments and consumables for the required procedure (specimen collection).
- Collect and pack specimen as per RNTCP guidelines.
- Maintain documents and registers.
- Enter details in Nikshay.
- Ensure appropriate facility to store specimen as per RNTCP guidelines in case of delays in transport.

C. Role of RNTCP

- Provide SOP, documents, formats for specimen collection and packaging as well as access to Nikshay user credentials.
- Provide prototype specimen collection and transportation box and technical specification for procurement.

- Provide prototype of records to be maintained.
- Train Service Provider on the SOP, if necessary.
- Identify and ensure linkage to logistics Service Provider and laboratory.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be based on number of specimens collected, accepted at laboratory and entry of specimen made in Nikshay.
- Deduct 20% if fewer than 70% of specimen are of acceptable quality (cross-verify with Nikshay).

E. Verification Mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Verification of records from lab registers.
  - Interviews with staff from facilities where samples are collected.
  - Interviews with 5% of TB patients who have availed services under this option.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

ACTIVITY 3. TRANSPORTATION OF SPECIMEN

This partnership option is to ensure transportation of all pulmonary and EP specimens to linked laboratories so as to avoid or reduce travel time for patients as well as and minimize loss in referral.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have an existing network or capacity to make adequate arrangements for logistics and transportation.
- Should have experience in managing a logistics network for at least two to three years.
- Should have staff to conduct outreach activity.
- Should have local presence in the community intended to be reached.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure their privacy and confidentiality.
- Ensure real-time reporting in Nikshay.
- Transport specimen from identified collection centres (either in public or private setting or from community) to the linked TB laboratory as per RNTCP guidelines.
- Ensure on-time delivery of test results to collection centres.
- Maintain specimen transportation record and getting it signed every day from a representative of RNTCP.

C. Role of RNTCP

- Identify centres for sputum collection and specify laboratory linkages.
- Train Service Provider on the government's health and safety guidelines for staff involved in sputum transportation.
- Provide prototype sample transportation box and technical specification for procurement of the boxes.
- Provide prototype of records to be maintained.
- Ensure timely payments to Service Provider

D. Performance parameters and linkages to payment (indicative)

- Payment will be based per number of pick up visits from number of specimen collection sites to the laboratory.
- Deduct 20%, if samples are received at the linked laboratories 72 hours after the time of collection.

E. Verification Mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Verification of records from lab registers.
  - Interviews with staff from facilities where samples are collected and transported.
  - Interviews with 5% of TB patients who have availed services under this option.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Bundling options to consider: *This partnership option could be bundled with specimen collection and laboratory services. The skill set of agencies should also include drug delivery and supply chain management.*

OPTION IV. Diagnostics

Under this partnership option, the RNTCP may outsource essential diagnostic tests that the public sector may not be able to provide fully due to operational challenges such as paucity of time and resources, workload capacity, access and other administrative issues. Essential diagnostic tests should be provided to all patients free of cost. The Programme Managers are responsible for ensuring that only diagnostic tests approved by the Government of India are offered to patients.

DIAGNOSTIC 1. X-RAY UNITS

This partnership option may be explored to ensure that all patients have access to high-quality X-ray services in private-sector labs, irrespective if care is sought in public or private sector.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have a relevant license from state bodies/other relevant authorities.
- Should have qualified technicians to perform specific tests.
- Should have adequate infrastructure and equipment.
- Should be willing to undergo quality assurance process as per RNTCP guidelines.
- Should have the facilities to ensure proper biomedical waste management.
- Should have a licence from Atomic Energy Regulatory Board and should follow all safety measures as prescribed by the Board and fulfil the Original Equipment Manufacturer recommendations.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide chest X-ray (free of cost) for all presumptive TB cases referred by the programme or from identified private-sector healthcare providers.
- Ensure real-time reporting in Nikshay.

C. Role of RNTCP

- Prescribe the specification for infrastructure and equipments (if required).
- Provide formats for records and reports.
- Ensure timely payments to Service Provider.

D. Performance indicator and its linkage to payment

- This is a fee for service contract i.e., payment will be based on the number of X-rays completed as per authorized doctors' prescriptions with results (and images, as feasible) updated in Nikshay.
- Deduct 20% from payment if time from the X-ray examination to reporting results in Nikshay is more than 24 hours.

E. Verification Mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification

- The second level – physical verification may be undertake by the District assigned personnel / agency and could include :
  - Verification of records from lab registers.
  - Interview with 5% of TB patients who have availed services under this option.
  - Random checking of at least 5% of the X-rays images, where feasible.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Note for consideration: Based on the local context, the partnership option could also account for report endorsement by a radiologist. It is desirable that all designated microscopy centres are co-located with X-ray centres to minimize patient inconvenience. Depending on the scale and number of X-ray laboratories engaged, RNTCP may budget for an additional Service Provider to set up a voucher system and manage reimbursements.

DIAGNOSTIC 2. MICROSCOPY CENTRES

This partnership option may be explored to universalize free and quality assured microscopy services for TB diagnosis and/ or for follow-up examination

A. Eligibility criteria for Service Provider
- The Service Provider should have a relevant license from state bodies/other relevant authorities.
- Should have adequate infrastructure and diagnostic equipment as per RNTCP's technical specifications.
- Should be willing to undergo quality assurance process as per RNTCP guidelines.
- Should have the facilities to ensure biomedical waste management.
- Should have qualified laboratory technician/s and functional microscopes.

B. Role of Service Provider
- Recruit adequate personnel.
- Undergo training if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Ensure quality of reagents as per RNTCP specifications
- Provide quality assured and free smear microscopy -by ZN stain or fluorescent stain (free of cost to patients) for TB diagnosis and follow-up.
- Ensure real-time reporting in Nikshay.
- Provide test results within 24 hours.
- Ensure regular upkeep and maintenance as per RNTCP norms.
- Participate in quality assurance protocols as recommended by RNTCP.

C. Role of RNTCP
- Provide SOP, RNCTP formats/registers and access to Nikshay credentials.
- Train laboratory technician on microscopy and other programmatic guidelines, if required.
- Provide specifications for laboratory reagents and container to collect specimen.
- Ensure quality assurance protocol as per programme guidelines.
- Ensure coordination between laboratory and field staff to initiate treatment for patients who are diagnosed at this centre.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment

- Payment will be based on the number of specimens examined and results reported in Nikshay.

- Deduct 10% from the payments of the specimens if time from test result to reporting of result in Nikshay is more than 24 hours.

- Deduct 10% from payments if error rate on quality assurance is more than 5%.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:

  - Verification of records from lab registers.

  - Interview with 5% of TB patients and referring providers who have availed services under this option.

  - Review (verification and validity of results) as per the latest RNTCP quality assurance protocols.

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Bundling options to consider: *It is desirable that all microscopy centres should have co-located X-rays and access to molecular diagnostics. Specimen management including collection and transportation may be bundled with this partnership option. If initiating microscopy centre at private hospital, this could be bundled with partnership options under treatment centres.*

DIAGNOSTIC 3. MOLECULAR DIAGNOSTICS

RNTCP recommends universal access to molecular tests for TB diagnosis and early identification of Rifampicin Resistance. If the demand for tests are higher than the capacity of the existing public system infrastructure, the programme can outsource the test to a private-sector laboratory.

A. Eligibility criteria for Service Provider

- Service Provider should be a registered entity (as defined in glossary).

- Should have a relevant license from state bodies/other relevant authorities.

- Should have qualified technicians to perform specific tests.

- Should have adequate infrastructure and equipment.

- Should be willing to undergo quality assurance process as per RNTCP guidelines.

- Should have the facilities to ensure biomedical waste management.

- Should have functional molecular diagnostic facility (GeneXpert/Truenat). It is mandatory to undergo an annual calibration exercise.

The minimum infrastructure that lab is expected to have for GenExpert is an air conditioned room, back-up electricity services and steady supply of cartridges. For TrueNat, there should be a steady supply of chips.

B. Role of Service Provider

- Recruit adequate personnel.

- Undergo training if required and adhere to RNTCP guidelines.

- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure their privacy and confidentiality.
- Ensure real-time reporting in Nikshay.
- Provide results on the same day of testing.
- Recording and reporting using standard RNTCP laboratory register, notification register, stock register, specimen examination request form.
- Submit monthly abstracts.
- Ensure timely calibration / maintenance of equipment.

C. Role of RNTCP

- Provide SOP for molecular testing.
- Provide biological specimen examination request form, laboratory register, notification register, reporting format and Nikshay user credentials.
- Organize training for Service Provider on molecular testing and other programmatic guidelines, if needed.
- Provide prototype specimen collection container and specification for procurement.
- Cover the lab under the quality assurance protocol.
- Coordinate with field staff for timely collection and transport of specimen from patients in the catchment area.
- Ensure that treatment for patients diagnosed with molecular tests is initiated
- Ensure timely payments to the Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be paid based on number of specimens examined and valid results reported in Nikshay.
- Deduct 10% if time from test result to reporting of result in Nikshay is more than 24 hours.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Verification of records from lab registers.
  - Interview with 5% of TB patients and referring providers who have availed services under this option.
  - Review (verification and validity of results) as per the latest RNTCP quality assurance protocols.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

DIAGNOSTIC 4. CULTURE (STANDALONE) / LINE PROBE ASSAY (LPA)/ CULTURE AND DRUG SUSCEPTIBILITY TESTING (C-DST)

A. Eligibility criteria

- Service provider should be a registered entity (as defined in glossary).
- Should have a relevant license from state bodies/other relevant authorities.
- Should have qualified technicians to perform specific tests.
- Should have adequate infrastructure and equipment.
- Should be willing to undergo quality assurance process as per RNTCP guidelines.
- Should have the facilities to ensure biomedical waste management.
- Should be accredited under RNTCP / have NABL accreditation / assessed and recommended by National Reference Laboratory.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training, if required, and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure their privacy and confidentiality.
- Ensure real-time reporting in Nikshay.
- Offer quality assured and free TB Culture / C-DST services for patients referred under the programme.
- Perform liquid culture DST through BACTEC MGIT system and Hain LPA 1st line and 2nd line drug resistance testing.
- Report results within 42 days for liquid culture, 3 days for LPA and 60 days for solid culture.
- Effectively coordinate with the respective NRL, IRL and Programme Manager for routine external quality assurance and annual proficiency testing.
- Maintain adequate infrastructure, personnel, equipment and consumables (as assessed by the NRL) for the laboratory to be fully functional at all times.
- Recording and reporting using RNTCP C-DST laboratory register and update Nikshay.
- Submit quarterly laboratory performance reports including indicators for Culture and DST laboratories as per RNTCP guidelines.
- Report contamination of the samples to the concerned Programme Manager on time and request for recollection of specimen for repeat culture from patients whose prior samples were reported to be contaminated.
- For laboratories engaged in culture only, culture isolates that are positive at month during follow-up in multi-drug resistance treatment are to be sent to the linked C-DST laboratory for DST. For laboratories engaged for 1st line C-DST alone, culture isolates should be sent to the linked C-DST laboratory for 2nd line DST as per RNTCP guidelines.
- Report test result to IRL and concerned DR-TB centre and Programme Manager in a timely manner through email.

C. Role of RNTCP

- Coordinate with the laboratory and field staff in the catchment area for timely collection and transportation of specimen and linkage to diagnostic services.
- Provide updated SOPs and guidelines for TB culture.
- Provide culture and DST laboratory register, specimen examination request form and Nikshay credentials.

- Coordinate for repeat collection of specimen from patients whenever required by the laboratory (in case of contamination; loss of specimen during transit; breakage/ leakage etc.).
- Organize training for the laboratory staff based on need.
- Ensure timely payments to the laboratories engaged through the partnership options.
- Monitor, review performance and provide timely feedback.
- Ensure quality assurance as per RNTCP protocol.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be based on number of specimen examined and valid results reported in Nikshay.
- Deduct 10% if time from test result to reporting of result in Nikshay is more than 24 hours.
- Deduct 10% from payments if error rate on quality assurance is more the RNTCP prescribed limits.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Verification of records from lab registers.
  - Interview with 5% of TB patients and referring providers who have availed services under this option.
  - Review (verification and validity of results) as per the latest RNTCP quality assurance protocols.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

DIAGNOSTIC 5. PRE-TREATMENT EVALUATION AND FOLLOW-UP INVESTIGATIONS

RNTCP can explore this partnership option to ensure free and quality assured investigation for pre-treatment evaluation and any follow-up tests of DR-TB patients with minimal inconvenience to the patient.

A. Eligibility criteria

- Service provider should be a registered entity (as defined in glossary).
- Should have a relevant license from state bodies/other relevant authorities.
- Should have qualified technicians to perform specific tests.
- Should have adequate infrastructure and equipment.
- Should be willing to undergo quality assurance process as per RNTCP guidelines.
- Should have the facilities to ensure biomedical waste management.
- Should have facility for investigations for DR-TB patients' pre-treatment investigations or follow up, as per requirement, such as CBC, liver function, TSH, kidney function, pregnancy, S. proteins, S. electrolytes (Na, K, Mg, Ca), blood sugar, urine (R & M), audiometry, ophthalmoscopy and ECG. The Service Provider should

also have participated in quality assurance protocols such as external Proficiency Testing or ILC exercise on every year.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training, if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- To provide services free of cost to patients and ensure their privacy and confidentiality.
- Ensure real-time reporting in Nikshay.
- Provide quality assured services for CBC, LFT, TFT, RFT, pregnancy test, serum magnesium, calcium, amylase, lipase, potassium, blood sugar, urine (R&M), audiometry, ophthalmoscopy, ECG for pre-treatment evaluation of DR-TB patients.
- On-site blood collection and report to the concerned DR-TB centres within 24 hours.
- Maintain adequate infrastructure, equipment, consumables for adequate functioning.
- Maintain records and submits reports in prescribed formats.

C. Role of RNTCP

- Provide necessary formats for records and reports under RNTCP.
- Coordinate with the field staff and doctors for referral of patients in the catchment area.
- Ensure timely payments to the Service Provider.
- Monitor and review performance, and provide appropriate feedback.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be based on the number of test done and valid result reported in Nikshay.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Verification of records from lab registers.
  - Interview with 5% of TB patients and referring providers who have availed services under this option.
  - Review (verification and validity of results) as per the latest RNTCP quality assurance protocols – if applicable.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

DIAGNOSTIC 6. LATENT TB INFECTION TEST (LTBI)

A. Eligibility criteria for the Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have a relevant license from state bodies/other relevant authorities.
- Should have qualified technicians to perform specific tests.
- Should have adequate infrastructure and equipment.
- Should be willing to undergo quality assurance process/ accreditation as per RNTCP guidelines.
- Should have the facilities to ensure biomedical waste management.

B. Role of Service Provider

- Recruit adequate personnel.
- Undergo training, if required and adhere to RNTCP guidelines.
- Maintain records and reports as given by RNTCP.
- Provide services free of cost to patients and ensure their privacy and confidentiality.
- Ensure real-time reporting in Nikshay.
- Conduct test as per prescribed SOP.
- Coordinate with RNTCP staff to ask patients to return within 72 hours in case of skin test.
- Maintain adequate infrastructure, equipment and consumables for effective functioning.
- Maintain records and submits reports in prescribed formats.

C. Role of RNTCP

- Provide necessary formats for records and reports under RNTCP.
- Coordinate with the field staff for referral of patients in the catchment area.
- Monitor and review performance, and provide appropriate feedback.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment

- Payment will be based on the number of LTBI test conducted and valid results reported in Nikshay.
- Deduct 10% if time from test result to reporting result in Nikshay is less than 72 hours for 95% of specimens.

E. Verification Mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Verification of records from lab registers.
  - Interview with 5% of patients who have availed services under this option.
  - Review (verification and validity of results) as per the latest RNTCP quality assurance protocols – if applicable.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Bundling options to consider: The partnership option should be bundled with vulnerability mapping with LTBI diagnosis, LTBI treatment and adherence support.

OPTION V. Treatment services

RNTCP envisions that every patient receives care as per STCI at a facility of his/her choice. Private-sector health facilities are an asset in terms of availability of experts and infrastructure to manage TB. There are many private-sector health facilities which provide TB services which can be engaged directly by the Programme Manager to ensure that standards of TB care reach all the patients in that facility. This partnership options explores direct engagement with private-sector health facilities. The Programme Manager may also consider engaging with the private-sector healthcare facilities to manage DR-TB patients as per need.

The Programme Manager can also explore the possibility of bundling treatment services with public health action by engaging facilities which can do both directly or can engage another Service Provider to ensure complete coverage of public health actions for patients treated in their facility.

CENTRE 1. TB MANAGEMENT CENTRE

In a region where there is no dedicated PPSA, the RNCTP can directly empanel and engage a private / corporate / trust hospital and designate them as "TB Treatment Centres". This will ensure that all the patients who get diagnosed and treated will have access to high-quality care and will also receive public health action services.

A. Eligibility criteria for Service Providers

- Service Provider should be a registered entity (as defined in glossary) - essentially a Health facility.
- Should be a private-sector hospital / clinic that is willing to provide clinical services for treatment initiation, follow-up care, and ADR management. The facility can provide all services related to Drug Sensitive (DS) TB and DR-TB management.

B. Role of Service Provider

- Follow RNTCP diagnostics and treatment protocols.
- Nominate nodal staff/s for coordinating activities and establishing a single window mechanism in the hospital for all TB related services.
- Prescribe microbiological testing for all presumptive patients
- Ensure access to free testing services.
- Notify all TB cases diagnosed in the facility in Nikshay.
- Guide, support and arrange for U-DST, RNTCP drugs, DBT data collection.
- Initiate treatment as per RNTCP protocol.
- Referral for HIV counselling and testing.
- Educate patient on TB, and counsel the patient and family members on the importance of completing the treatment on airborne infection control, ADR and smoking cessation. Support the patients with the uptake of an appropriate digital adherence support tools.
- Follow up with the patient periodically (at least monthly basis) to motivate them to continue treatment, detect any ADR, remind about follow-up investigations and scheduled clinical visits.
- Update details of bank account, U-DST, treatment initiation, co-morbidity and outcome in Nikshay.
- Fast tracking patients with infectious TB to ensure air borne infection control in health facility.

- Ensure other public health actions either directly or by linking patients willing to be followed up by the government field staff and referred to local primary health care team.
- Ensure that all clinicians and nodal staff addressing TB undergo formal training on STCI and RNTCP.

C. Role of RNTCP

- Provide linkages to free tests like microscopy, NAAT, LPA and C-DST including mechanism for specimen collection and transportation.
- Stock FDC, loose drugs and drugs for prophylaxis daily.
- Provide public health actions and retrieve those lost to follow up if requested by the nodal officers of private-sector treatment centres.
- Build capacity of Service Provider on STCI, RNTCP and Nikshay.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be based on the number of privately notified TB patients treated with RNTCP provided drugs, as recorded in Nikshay.
- Deduct 10% for those patients whose DST results are not updated in Nikshay.
- Deduct 30% for those patients who have not been provided RNTCP drugs for full course.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interview with 5% of TB patients who were notified from this facility to understand what the types and quality of free services availed.
  - Interview with 5% of the patients who have completed their treatment at the facility and are assigned an outcome of "Treatment Success".
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

CENTRE 2. DR-TB CENTRE (OUTDOOR)

This partnership option can be used to extend out-patient services to DR-TB patients when the public health system may need an additional facility to manage DR-TB patients or for DR-TB patients who seek care in the private sector.

A. Eligibility criteria for the Service Provider

- Service provider should be a registered entity (as defined in glossary)- essentially a Health facility.
- Should be a tertiary / secondary care hospital, a nursing home or a poly-clinic with a physician / pulmonologist available round the clock.
- Should comply to the National Guidelines for Air-Borne Infection Control for Out-Patient Settings.

- Should institute a DR-TB Committee in the facility as per the national DR-TB guidelines.
- Should have relevant specialties like pulmonologist, physician, paediatrician, psychiatrist, dermatologist, cardiologist, ENT, ophthalmologist, gastroenterologist & gynaecologist etc. to whom patients can be linked for second opinions.
- Should have in-house laboratory services (or adequate linkages) required for pre-treatment and follow-up investigations to ensure that patient does not have to be referred elsewhere.

B. Role of Service Provider

- Initiate treatment with appropriate regimen as per Programmatic Management of Drug Resistant TB (PMDT) guidelines including counselling support, ensure necessary steps for organizing treatment support, including NPY.
- Provide follow-up care and manage ADR.
- Make provisions for access to free drugs from RNTCP for DR-TB management.
- Make provisions of ancillary drugs.
- Maintain relevant RNTCP records (DR-TB treatment register, laboratory request form, referral forms, treatment card, treatment booklet, a-DSM forms etc.).
- Update patient records in Nikshay and Nikshay Aushadhi.
- Ensure coordination with the Programme Manager as well as with laboratory for follow-up of patients till outcome.
- Extend support to the local RNTCP efforts to increase access of newer drugs like Bedaquiline, Delamanid for private-sector patients.

C. Role of RNTCP

- Train Service Provider on PMDT guidelines and provide regular updates.
- Provide forms for request of examination of biological specimen, DR-TB treatment register and referral forms and provide Nikshay and Nikshay Aushadhi user credentials.
- Coordinate the supply and availability of DR-TB treatment drugs to the facility.
- Manage the linkage with RNTCP field staff to manage patients at the community level (if the facility is not providing community level services).
- Coordinate with the field staff to manage patients in the catchment area.
- Ensure timely payments to Service Provider.

D. Performance parameters and linkages for payment

- Payment will be based on the number of patient visits for DR-TB treatment initiation (based on drug resistance pattern), follow up / ADR management as per RNTCP protocol and recorded in Nikshay.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interview with 5% of TB patients who were notified from this facility to understand what the types and quality of free services availed.
  - Interview with 5% of the patients who have completed their treatment at the facility and are assigned an outcome of "Treatment Success".

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Bundling option to consider: Please note that the Service Provider may also tie up with another similar entity to provide field services for public health action, treatment adherence services etc. It is also suggested that Service Provider has a service arrangement to provide lab services as well.

CENTRE 3. DR-TB TREATMENT CENTRE (INDOOR)

This partnership option can be used to extend in-patient services to DR-TB patients when the public health system may not have dedicated indoor patient facility or need an additional facility to manage DR-TB patients or for DR-TB patients who seek care in the private sector.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary)- essentially a Health facility.
- Should comply to the National Guidelines for Air-Borne Infection Control for Out and In-Patient Settings.
- Should institute a DR-TB Committee in the facility as per the national DR-TB guidelines.
- Should have relevant specialties like pulmonologist, physician, paediatrician, psychiatrist, dermatologist, cardiologist, ENT, ophthalmologist, gastroenterologist & gynaecologist etc. to whom patients can be linked for second opinions.
- Should have in-house laboratory services (or adequate linkages) required for pre-treatment and follow-up investigations to ensure that patient does not have to be referred elsewhere.
- Should have dedicated DR-TB indoor management facility.

B. Role of Service Provider

- Undergo periodic trainings on the PMDT guidelines and updates.
- Constitute DR-TB Committee as per PMDT guidelines.
- Designate in-patient ward/s (compliant with national guidelines) and a specific number of beds as per the National PMDT guidelines.
- Make laboratory investigation available for pre-treatment evaluation and follow up.
- Provide services for treatment initiation, follow-up care and ADR management.
- Provide referral facilities for expert opinion of other medical specialties, if required.
- Liaise and consult with the local RNTCP Programme Manager in case the in-patient stay has to be extended beyond 5 days.
- Coordinate with the RNTCP to ensure a steady supply of DR-TB drugs.
- Provide commodities, services and drugs to the patients free of cost.
- Update and maintain records and registers as per PMDT in Nikshay and Nikshay Aushadhi.
- Coordinate with RNTCP / designated labs / assigned DR-TB OPD to update patient records and share relevant information related to patients.

C. Role of RNTCP

- Train the Service Provider on the latest PMDT guidelines and provide regular updates.

- Assess the centre for Air Borne Infection Control measures.

- Provide forms for request of biological specimen, PMDT treatment register and transfer forms and share used credentials of Nikshay and Nikshay Aushadhi.

- Coordinate the supply and availability of DR-TB drugs to the Service Provider.

- Manage the linkage with RNTCP field staff to manage patients at the community level.

- Ensure timely payments to Service Provider.

D. Performance Parameter and linkages to payment

- Payment will be based on the number of days that the patient stayed for treatment initiation, follow up / ADR management as per RNTCP guidelines and recorded in Nikshay.

- Deduct payments for admissions beyond five days of stay if the extension is without the requisite approval from RNCTP.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:

  - Interview with 5% of TB patients registered at this this facility to understand what the types and quality of free services availed.

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Please note that the Service Provider facility may also tie up with another Service Provider to provide field services for public health action and treatment adherence services. It is also suggested that the Service Provider has a service arrangement to provide lab services.

CENTRE 4. SPECIALIST CONSULTANTS FOR DR-TB PATIENTS

This partnership option may be availed when the RNTCP does not have sufficient number of specialist doctors to manage DR-TB patients or required additional specialist doctors.

A. Eligibility criteria for Service Provider

- Should be a Specialist doctor with the required registration and qualification.

- Willingness to entire directly work with the program or through a recruitment agency.

- Willingness to attend OPD hours as per RNTCP requirements.

B. Role of Service Provider

- Undergo periodic training on PMDT guidelines and updates.

- Provide OPD consultancy services during designated hours.

- Update patient records.

C. Role of RNTCP

- Provide designated space for consultation services for DR-TB patients.

- Coordinate with clinical and field teams to ensure that all designated staff prepare the required documents/ patient case history.

- Liaise with field teams for updating details in Nikshay.

- Collaborate with the Service Provider to discuss changes in treatment regimen.

- Ensure the availability of lab reports / investigations to support the Service Provider to take clinical decisions.
- Ensure timely payments to Service Provider.

D. Performance parameters and linkages to payment

- Payment will be based on the number of consultations.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interview with 5% of TB patients who were put under treatment under this consultant to understand what the types and quality of free services availed.
  - Interview with providers engaged under the option.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

OPTION VI. Drug access and delivery services

These partnership options may be explored to strengthen the supply chain management and last mile delivery of drugs (FDCs, ancillary drugs, DR-TB drugs etc.). This option may be used for supply chain management in the public sector, private sector- clinics/ hospitals/ chemists, as per the need of the region.

SERVICE DELIVERY 1. DRUG SUPPLY CHAIN MANAGEMENT

The partnership option will ensure uninterrupted supply of anti-TB drugs at the state / district / sub-district and facility level for both public and private sector facilities.

A. Eligibility criteria

- Service Provider should be a registered entity (as defined in glossary).
- Should have prior experience in supply chain management.

B. Role of Service Provider

- Design and undertake the supply chain management and logistics arrangements of RNTCP drugs from the state / district drug store to the public / private health facilities.
- Leverage Nikshay Aushidi to set up and manage the inventory system to record the opening, utilization and closing balances.

C. Role of RNTCP

- Forecast the drug requirements at all levels in consultation with the state authorities and ensure regular supply of drugs to identified drug delivery points.
- Define the frequency of delivery to stocking points (ideally not more than twice a month).
- Provide list of drug dispensing units or drug stores for ensuring availability of RNTCP drugs.
- Provide drug stock register, documentation and formats.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment

- Payment will based on the number of deliveries to the drug stocking points in a particular period and as reported to RNTCP.
- Deduct 20% of the payment for each delivery for which there is either a discrepancy in stock balances or a stock-out caused by delay in distribution.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interview with 20% of the drug stores managers who have received RNTCP drugs through this mechanism.
  - Review of drug inventory records.
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

SERVICE DELIVERY 2. IMPROVING ACCESS TO FDCS FOR TB PATIENTS NOTIFIED BY THE PRIVATE SECTOR

If there is no PPSA in the region, RNTCP can explore this partnership option to engage a Service Provider who will be responsible for communicating, marketing and increasing the accessibility to government supplied FDCs for patients in the private sector.

A. Eligibility criteria for Service Provider

- Service Provider should be a registered entity (as defined in glossary).
- Should have prior experience in supply chain management in promoting and marketing of drugs as well as in supply chain/ logistics management.

B. Role of Service Provider

- Ensure and enable accurate and real time reporting of stocks in Nikshay Aushadhi under the relevant TB Centre.
- Market RNTCP FDCs to the private-sector providers.
- Identify FDC stocking points / dispensing points either at clinic or hospital or chemist or supply through online pharmacy system (directly from dispensation point / District TB Centre / TB unit to patient's home). The stocking points can be decided in consultation with private-sector providers and should prioritize patient's convenience.
- Set up the inventory system to record opening, utilization and closing balances.
- Design and implement the supply chain and logistics arrangements of drugs from District / TB unit drug store to designated retail chemists or stocking points.
- Establish mechanisms to process incentives for chemists to stock and disburse government drugs. This incentive should be designed to compensate the loss of profits from sales of private-sector drug supplies.
- Train the private chemist / stocking point staff to maintain the required records as per RNTCP mandates.
- Make arrangements for interim storage to maintain sufficient inventory and regular supply.
- Deploy innovative digital platforms to manage the logistics.
- Liaise with the relevant PPSA (if applicable) to ensure patients are connected to chemists in designated area.
- Build awareness among private-sector providers in the network on the accessibility and availability of free drugs from the public sector.

C. Role of RNTCP

- Forecast the drug requirement and ensure regular supply of drugs at the private-sector drug dispensing points.
- Undertake a market price discovery exercise to cover the overhead margins for chemists and design the chemist incentive accordingly. The state is at liberty to establish the norms for this incentive.
- Provide drug stock register, documentation and formats.
- Training service provider in Nikshay Aushadhi and provide user credentials.
- Liaise with the State Food and Drug Administration to ensure adherence to regulatory measures and reinforce H1 surveillance.
- Set up coordination with PPSA (if applicable) to ensure all private sector patients get access to the free drug programme.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment

- Payment will be made based on the number of patients initiated on FDC.

- Deduct 20% for stock-outs due to delay in distribution.

- Add an incentive of 20% if more than 50% of the TB patients have six months or more of free anti-TB medicines.

E. Verification Mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:

  - Interview with 20% of the drug stores managers who have received RNTCP drugs through this mechanism.

  - Review of drug inventory records.

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

OPTION VII. Active case finding and TB prevention

The partnership option can be explored to facilitate active search of TB cases among the identified vulnerable populations or individuals. This is essential for early diagnosis of TB and for treatment of TB.

ACTIVITY 1. ACTIVE CASE FINDING

Active case finding is a strategy that cuts down transmission of TB through early case-finding especially in the high-risk and vulnerable population like prisoners, slum dwellers, workers in the informal sector and similar such. Programme Managers can identify areas for active case-finding among vulnerable groups or in settings with lower presumptive case testing due to accessibility issues, such as in hard to reach areas.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have two to three years of experience in community screening and active case finding activities.
- Should have local presence in the community to be reached.

B. Role of Service Provider

- Undergo necessary training and ensure adherence to RNTCP guidelines.
- Maintain records and reports as provided by RNTCP.
- Update details in Nikshay in real-time.
- Ensure confidentiality / privacy of every case.
- Identify, assess and refine mapping of high-risk population, wherever available.
- Conduct active case finding at a pre-defined frequency as per the programme guidelines.
- Screen all high-risk population by household or workplace screening activities.
- Ensure complete evaluation of identified TB symptomatic as per RNTCP diagnostic protocol.
- Establish linkages for specimen collection and transport of specimens.
- Refer diagnosed patients to most convenient TB Treatment centre as selected by patient.
- Print reporting formats as per requirement.
- Maintain records and reports of active case finding as per the recording and reporting system used by RNTCP.

C. Role of RNTCP

- Facilitate the identification and sharing of data on high-risk and vulnerable groups to be covered under the active case finding with the Service Provider.
- Train the Service Provider on active TB case finding methodology and SOPs.
- Develop linkages between the identified areas with vulnerable population and the diagnostic services. This will ensure that all presumptive TB patients have access to appropriate tests.
- Provide consumables such as sputum specimen collection cups / tubes, specimen transportation boxes, packaging material (if required).
- Ensure that presumptive and diagnosed patients are linked to appropriate diagnostic and treatment centres.

- Provide the Service Provider with standard formats used for active case finding under RNTCP and access to Nikshay credentials.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be based on the number of TB patients diagnosed under the ACF and recorded in Nikshay.
- Deduct 10% if coverage of screening of population is below 75% of the agreed targets.
- Deduct 15% if coverage of complete examination of presumptive TB is 75% below the agreed targets.

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with Nikshay records and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
  - Interviews with at least 10% patients diagnosed through ACF as identified from the notification register.
  - Interview with at least 5% of presumptive patients examined through ACF as identified from the lab register.
  - Interview with at least 1-2% of at least households screened as recorded from ACF surveys
- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

Bundling options to consider: This partnership option can be bundled with a "Advocacy, Communication and Community Empowerment" partnership option to improve community level awareness. Another bundling option can be with vulnerability mapping described below. This will be particularly useful in settings with low TB notification despite high presumptive TB examination rate.

ACTIVITY 2. TB PREVENTION PACKAGE FOR VULNERABILITY MAPPING AND LTBI MANAGEMENT

A. Eligibility Criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have two to three years of experience in community screening and active case finding activities.
- Should have local presence in the community to be reached.

B. Role of Service Provider

- Undergo necessary training and ensure adherence to RNTCP guidelines.
- Maintain records and reports as provided by RNTCP.
- Update details in Nikshay in real-time.
- Ensure confidentiality / privacy of every case.
- Map the vulnerable population:
  - Capture the individual's vulnerability to develop TB. This should be done among the entire population in an assigned geographical area.

- Visit all households, workplace and other settings to take a census of the population and assign vulnerability scores to all individuals in the prescribed format.
- Identify vulnerability for TB in the local context. Vulnerability refers to capturing information like household contact with TB in family, past history of TB, diabetes, tobacco user, chronic respiratory disease, alcoholism, chronic liver/kidney disease, bedridden, miner/quarry worker, health care worker, tribal, coastal, urban slums, malnutrition or any other contextual vulnerability etc.
- Weighted score could be given for individual vulnerability based on local epidemiology and individuals above a particular vulnerability score could be targeted for periodic active case finding.
- Digitalize the data and identify individuals with high vulnerability to develop TB.

- Screen all identified individuals (based on the vulnerability score) eligible for LTBI testing in a population for active TB disease based on TB symptoms, X-ray, clinical examination and testing for TB disease if required.

- Test for LTBI using the RNTCP recommended test (IGRA/skin test):
  - Specimen collection and transportation for LTBI testing and outsourcing of LTBI tests can be done based on local needs.
  - *In case of a skin test*, the Service Provider will be responsible for recruitment of personnel, training them in administering the test and deploying them at necessary facilities for continuous service.

- Link to facility for decision to start LTBI treatment.

- Obtain the list of patients eligible for LTBI treatment on a weekly basis from concerned RNTCP unit.

- Counsel patients regarding LTBI and support patient for completion of LTBI treatment.

- Provide treatment support for the individuals, without causing inconvenience.

- Identify and address any Adverse Drug Reactions (ADR) events at the earliest to ensure that all patients initiated on treatment complete their course unless medically contraindicated and within the time period defined by RNTCP.

- Ensure assessment of adherence of all persons on LTBI treatment through pill count and refill monitoring.

- Maintain records and reports as per RNTCP recommendation.

- Develop vulnerability reduction strategies like control of diabetes, tobacco cessation and management of chronic respiratory diseases which precede the development of disease.

C. Role of RNTCP

- Provide data and information to aid the planning and execution of this surveillance exercise.

- Train Service Provider on vulnerability mapping tools, LTBI management protocols, adverse events and adherence support mechanisms.

- Make arrangements in clinical setting for ruling out active TB (including X-rays and NAAT tests) and for confirmation for LTBI testing.

- Linkages for clinical decision to start LTBI treatment.

- Establish systems for two-way communication with the Service Provider about treatment follow up of each individual initiated on treatment.

- Provide drugs for LTBI to the Service Provider or at the concerned health institution, whichever feasible.

- Establish linkage with health facility nearest to the patient for management of adverse events.

- Ensure timely payments to Service Provider.

D. Performance Parameters and linkages to payment (indicative)

- Payment will be based on the number of people with LTBI treated and recorded in Nikshay.

- Deduct 10% if coverage of population under vulnerability mapping is below 80%.

- Deduct 10% if coverage of testing with LTBI is less than 90%.

- Deduct 30% for those patients whose treatment outcome were not reported within one month of completion of treatment (treatment duration will be as per latest RNTCP protocol).

E. Verification mechanism

- The first level of verification will be completed by reviewing and cross-checking with all the community empowerment related documentation and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:

  • Interview with at least 5 % persons who were identified and treated for LTBI under this option.

- If discordance is found during the verification mechanism, the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

OPTION VIII. Advocacy, Communication and Community Empowerment

Mobilization of administrators, politicians, key influencers in the community, corporations and the media is essential to bring more accountability, and commitment for TB elimination. Community awareness is an ongoing process to keep the community prepared to detect cases early, prevent the spread of disease and deliver services more effectively. A community-led response makes the TB elimination effort more patient-centric, helps in addressing issues of the stigma and discrimination, treatment literacy and bring about positive change in the community for prevention. All three activities demand different skill sets. However, a Programme Manager may engage a Service Provider who could in all the required skill-sets and provides relevant services.

Note that the Programme Manager will finalize the group to be targeted for advocacy (Political, Media, Corporates etc.).

ACTIVITY 1. ADVOCACY

Partnership options may be considered to increase political and administrative commitment for TB elimination at the local level.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have three years' experience of undertaking similar work in past.
- Should have local presence in the community to be reached.

B. Role of Service Provider

- Prepare an advocacy strategy with the activities, outputs, expected coverage area, target participants and expected outcomes.
- Sensitize relevant stakeholders on TB.
- Organize meetings with the district / block and *panchayat* officials to advocate for TB-free block and motivate *panchayat* to generate ownership of the cause.
- Advocacy with *panchayat*, corporates, any other stakeholders identified, for resource mobilization for local support to TB-free activities.
- Bring together all key stakeholders such as government representatives, TB champions, business leaders, religious leaders and RNTCP officials for integrated response.

C. Roles of RNTCP

- Train Service Provider on TB and all its components.
- Verify and approve the tools developed by the Service Provider for consistency and accuracy of the messaging materials/ content.
- Define number of participants for each meeting /program.
- Guide the agency on the local requirements of advocacy.
- Ensure timely payments to Service Provider.

D. Performance indicators and its linkage to payment (indicative)

- Payment will be based on the number of activities conducted and on the coverage area of each activity to reach out to stakeholders.
- Deduct 25% if the stakeholder participation is less than 80% of an agreed target.

- Incentivize 20% of the payment if there are successful results/ end-goals as agreed upon at the beginning of the contract. For e.g. if a proportion of Panchayati Raj Institutions with whom the Service Provider advoacated with have committed to fund a TB Elimination project in their region.

E. Verification mechanism

- RNCTP should participate in the Advocacy events organized by the Service Provider.
- The first level of verification will be completed by reviewing and cross-checking with all the community empowerment related documentation and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
    - Interviews with at least 5% of defined target group/s who have been covered under the advocacy campaigns.
- If discordance is found during the verification mechanism, there the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

RNTCP should conduct an impact assessment/ qualitative survey at the end of advocacy campaign to assess the effectiveness

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ACTIVITY 2. COMMUNICATION

The partnership option may be explored by RNTCP to hire a service provider to prepare a detailed communication strategy, content and dissemination activities for an assigned geography. RNTCP will need to brief the agency on the core groups (these could be specific target groups / general public/ vulnerable groups) they want to reach out to and the specific areas they need communication support e.g., campaign for TB awareness or anti-stigma drive.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have three years' experience of undertaking similar work in past.
- Should have local presence in the community to be reached.

B. Role of Service Provider

- Prepare a communication strategy with a detailed plan with description and number of activities, outputs and expected outcomes.
- Develop and implement high-impact media campaign on TB.
- Develop and implement standardised and customised content for communication material in local languages (standardised content for specific population groups) for interpersonal communication, mass media, mid-media and social media.
- Identify strategic locations (including non-traditional outlets like tea/*paan* stalls) for dissemination and display of communication material and implementation.
- Identify popular platforms (like *gram sabha, palli sabha, yatras, panchayat bhawan* etc). for behavioural change communication and implementation.
- Develop and implement plan to use print media for disseminating key messages related to TB.
- Develop and implement plan to use community radio platforms for dissemination of messages related to TB.
- Develop and implement plan to use of social media platforms for dissemination of messages related to TB in relevant setting and audience.

- Develop and implement plan for production of street plays.
- Mobilise and train local artistes, theatre groups etc. for creating innovative and fresh messages.
- Document activities, time, participants attended, or activity reach (in terms of viewers, listeners, likes etc.).

C. Role of RNTCP

- Give authorization letter to Service Provider for facilitating local mass campaign activity.
- Support efforts to acquire the permissions to conduct to conduct campaign activities.
- Orient the Service Provider on TB which in turn helps them in content development.
- Review content developed by the Service Provider for consistency with updates and practices.
- Communicate with staff and health facility in-charge about activities and the Service Provider in their respective areas.
- Attend field activities regularly.
- Ensure timely payments to Service Provider.

D. Performance parameters and linkages with payment (indicative)

- Payment will be based on the number of activities conducted and on the coverage area of each activity to reach out to stakeholders.
- Deduct 20% if the stakeholder participation is less than 80% of an agreed target.
- Incentivize 20% of the payment if there are successful results/ end-goals as agreed upon at the beginning of the contract.

E. Verification mechanism

- RNCTP should attend the events organized by the Service Provider.
- The first level of verification will be completed by reviewing and cross-checking with all the community empowerment related documentation and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.
- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:
    - Interviews with at least 5% of defined target group/s who have been covered under the communication campaigns.
- If discordance is found during the verification mechanism, there the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

RNTCP should conduct an impact assessment/ qualitative survey at the end of communications campaign to assess the effectiveness.

ACTIVITY 3. COMMUNITY EMPOWERMENT

This partnership option may be explored by RNTCP to engage a Service Provider who will be responsible for designing and implementing activities such as TB Champions, peer group activities etc. The objective is this option is for the engagement and empowerment of communities affected by TB.

A. Eligibility criteria for Service Provider

- Service provider should be a registered entity (as defined in glossary).
- Should have 3 years' experience of undertaking similar work in past.
- Should have local presence in the community to be reached.

B. Role of Service Provider

- If applicable, undertake a baseline to assess the community knowledge, attitudes and awareness on the defined and specific areas of empowerment.
- Design a community engagement strategy.
- Identify and build capacity of TB survivors/ champions, and orientation on their roles and responsibilities.
- Facilitate for their inclusion in TB forums/TB networks.
- Facilitate meeting with the district officials on a quarterly basis.
- Coordinate with the RNTCP to jointly create opportunities for TB survivors to speak at public meetings, patient-provider meetings and various local forums.
- Involve local survivor-led networks (if any) in various activities.
- Facilitate anti-stigma campaigns led by TB survivors.

C. Roles of RNTCP

- Orient the Service Provider on essentials of TB which in turn helps them in designing a community engagement strategy.
- Provide the list of TB survivors and help in linking with them.
- Approve the scientific content/ messaging content in any of the materials developed by the Service Provider.
- Ensure timely payments to Service Provider.

D. Performance parameters and linkages with payment (indicative)

- Payment will be based on the number of activities conducted to reach out to community against the plan.
- 25% of the payment will be linked to evidence of impact within of the community. The impact may be defined by designing a set of appropriate monitoring indicators at the start of the program. e.g. patients awareness of benefits under the TB programme, change in knowledge levels of peer–groups on TB treatment etc. The indicators should demonstrate tangible and measurable indicators of community empowerment and in terms of increase in TB champions working as social mobilizers.
- Deduct 20% payment if number of TB champions/ peer groups formed are less than 80% of the agreed numbers.

E. Verification mechanism

RNCTP should attend the Community Empowerment events organized by the Service Provider.

- The first level of verification will be completed by reviewing and cross-checking with all the community empowerment related documentation and/ or any other RNTCP reports submitted for a defined period. Payments will be as per this verification.

- The second level – physical verification may be undertaken by the District assigned personnel / agency and could include:

  - Interviews with at least 5% of defined target group/s who have been covered under the empowerment campaigns.

- If discordance is found during the verification mechanism, there the assigned penalties may be applied and may be adjusted in payments of subsequent quarter.

RNTCP should conduct an impact assessment/ qualitative survey at the end of empowerment campaign to assess the effectiveness.

4 IMPLEMENTING A PARTNERSHIP OPTION

This chapter elaborates on the steps to follow to implement a partnership option in a region. There are three steps involved in implementation –

| 1. Contracting a Service Provider | 2. Budgeting for Partnership Option | 3. Deriving a payment mechanism and developing a performance-based matrix |
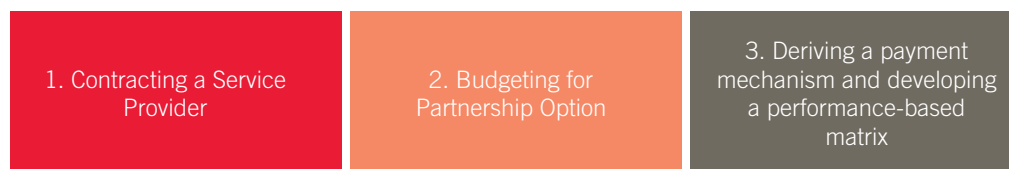
4.1 Contracting a Service Provider

Contracting a Service Provider involves multiple steps, such as identifying the types of contracting and the steps to follow while developing a contract etc. However, the first step that a Programme Manager should take is to consider the following questions when developing a financial arrangement with a Service Provider:

- Is the amount to be paid to the Service Provider be determined by resources deployed (input), activities implemented, services provided or outputs produced?
- Is the amount is pre-determined by the programme or proposed by the Service Provider?
- Will there be more than one Service Provider in the region who will be offering similar services?
- Is the Service Provider going to be selected through a competitive process or sole-sourced?
- Does the value of the financial arrangements exceed thresholds defined by the rules prescribed in GFR 2017 or relevant regulations laid down by the state?

KEY FEATURES OF A CONTRACT

- All contracts, regardless of type, should include detailed and clear information on the scope of services (as described in Chapter 3) and costing (as described in subsequent section). Scope of services will help define the services required from the Service Provider and in defining the payment mechanism. The details on costing included in the contract will depend on whether the inputs and activities are standardized (inputs-based contract) and available in the market, or whether flexibility and innovation is expected (output-based contract).
- The estimated value of the contract (regardless of type) for a given period (say, one year) may vary considerably and impact the procurement process.
- The contract can also be either sole-sourced (to be used for strategic purchasing arrangement) or awarded through a competitive process. Although, the latter is the preferred approach as far as possible.

TYPES OF CONTRACTING

There are three main types to contracting. The Programme Manager may decide on the type of contract based on various components, such as services to be provided, partnership options used etc.

1. Input-based contracts

What are input-based contracts?

- These are contracts in which the nature of the services is clear, direct and easy to define but the results or output are not easy to quantify / verify.

How to plan for an input-based contract?

- Should be used for a well-established process and activities for specified services, (e.g. training, empowerment, education) that may not vary during implementation, but whose measurement of outputs are difficult to quantify.

- Here the calculation of contract value and payments are made based on resources deployed (input) or based on the number of activities. Payment schedules should be drawn up well in time and should be followed. Providing advance payment can be considered for more effective deployment of resources by Service Provider towards service delivery.

- To develop these contracts, the Programme Manager may develop indicators to measure processes and activities.

- RNTCP may negotiate scope of services in terms of inputs, approach, methodology and work plan with the Service Provider.

- A Request for Proposal (RFP) should be used for input-based contract which defines the expected activities/processes and process indicators, including methodology, proposed cost / bid value with justification/break up to deliver services in a defined area.

What are the advantages of an input-based contract?

- This mode of contract opens the market to Service Providers who have limited means, such as, NGOs to provide services but are able to work in specific, often challenging environments.

- These contracts can help Service Providers become more activity/process oriented. But it is recommended that Programme Managers consider performance goals or outcomes in the long term.

What types of partnership options can covered be under this?

- This contract type may be considered for partnership options like advocacy , communication and community empowerment.

2. Fee-for-service contracts or Purchasing of Services contract

What is a fee for service contract?

These are contracts in which the activities, processes and results are quantifiable and are available at a specified value / fee.

How to plan for a fee for service contracts?

- In this contract, the scope of services is well defined up to the unit level. The results of the service are measurable and of verifiable quantity and quality.

- The fee is based on the unit of service provided. The payment is based on the number of services provided to patients and adjusted, if needed, to assure quality parameters. Payment should be made monthly after services are provided.

Under this contract, the Programme Manager will pay for predefined units of services from Service Provider in order to address existing gaps in services.

- Quality indicators should be defined before engaging the Service Providers and should be included in the agreement.

- In a scenario where a combination of fee-for-service contracts are to be developed, the Programme Manager may use the rationale of the scenarios described below, whichever applicable.

  - In scenarios where the Service Provider is procured through a non-competitive process with a fixed rate, the same service cannot be procured with a different method like input or out-put based contracting or cost for the same set of patients (e.g. patients from private health facility) in the same geography (e.g. TB unit).

  - *In a geographical area where only one Service Provider is available for the provision of particular service*. In this case, ask for quotation from the single Service Provider, negotiate, if possible and sign the agreement.

  - *In a geographical area, there are multiple Service Providers. However, after the bid process, only one Service Provider bids for service delivery*. In this case, negotiate if possible and sign the contract.

  - *In a geographical area, there are multiple Service Providers and RNTCP wishes to engage with more than one Service Provider for service delivery.* In this case, based on a market survey of tariffs for a specific service in the geographical area to administratively determine price of the service. Seek application from the Service Providers willing to deliver services at the price prescribed by RNTCP and sign an agreement.

  - *In a geographical area, there are multiple Service Providers for a specific service and RNTCP wishes to choose the Service Provider competitively.* In this case, ask for open quotation and choose the Service Provider through a competitive process and sign the agreement with the selected Service Provider.

What are the advantages of a fee for service contract?

- This contract can be useful when it is more efficient to pay per service rather than the government establishing the infrastructure and running operations. Alternatively, it can be used in an attempt to reach the patients who are using services of the private sector and paying from their pocket.

What types of partnership options can be covered under this?

- This contract type may be considered for partnership options like specimen management, diagnostics,   treatment centres and drug supply and delivery services.

3. Output-based contract

What are output-based contracts?

- These are contracts in which the desired results are well specified but means of achieving the results are not prescribed.

- It is a performance-based contracting method which focuses on the output, quality, or outcomes which are verifiable in quantity and quality.

- In these contracts, a part of the Service Provider's payment is linked to the achievement of the pre-set performance indicators. The Service Provider is expected to identify innovative, efficient and effective ways to achieve the outputs.

What are the advantages of output-based contracts?

- These contracts allow flexibility, innovation and efficiency (for example case notification, treatment success etc.).

How to plan for an output-based contract?

- The Service Provider should be identified through a Request for Proposal (RFP) process. Selection may combine quality and cost assessment of the proposal (QCBS, described in the subsequent section on costing).

- The Programme Manager issues a contract which includes the performance indicators identified by RNTCP and a clause on performance-based payment matrix (largely based on Nikshay). Payment schedules should be finalized in advance and strictly followed. Provision of advance payment should be considered for more effective implementation of services.
- The work plan in contract should clearly define the indicators to be measured. This will enable the Programme Manager to effectively monitor the services being provided.

What are the advantages of output-based contracts?

- These contracts allow flexibility, innovation and efficiency (for example case notification, treatment success etc.).

What types of partnership options can be covered under this?

- This contract type may be considered for partnership options like PPSA , Public Health Actions, active case finding and TB prevention package.

STEPS FOR CONTRACTING

As the Programme Manager decides the method of contracting, s/he need to follow the below listed steps (Box below) to complete the process.

Steps for Contracting

Step 1. Identify service(s) to be procured from the Service Provider
- Services to be procured should be based on the Needs Assessment, as described in Chapter 2. Identified services should be proposed in the government's annual Program Implementation Plan (PIP).

Step 2. Prepare a Terms of Reference (ToR) including scope and volume of services, and quality/performance/output indicators
- Prepare a ToR defining the service objectives and the scope of the services. The TOR should include a schedule to complete the tasks as well as the support or inputs required from the Programme Manager to facilitate service provision.
- Define the eligibility criteria to be fulfilled by the Service Provider.
- Define the volume of services and geographical area where the services are to be procured.
- Define the quality/process/performance/output indicators.

Step 3. Estimate the budget
- Based on the scope and volume of services, the Programme Manager should estimate the budgetary requirement.

Step 4. Prepare and issue a request for proposal
- The request for proposal should include*:
- A letter of invitation
- Information to potential Service Provider on the procedure for submission of proposal
- Terms of Reference
- Eligibility and qualification criteria
- Bid evaluation criteria and selection procedure
- Standard formats for technical and financial proposal.
- Proposed contract terms including contract management and payment mechanism
- Based on the regulations laid down by the State or as per GFR 2017, the Programme Manager may decide the mode of issuance of RFP through limited or open tender.
- The Programme Manager should publish RFP through advertisement in print media and on state's e-Procurement Portal and on department website.

- The Program Manager should disseminate the RFP through workshops, stakeholder consultations or through professional outreach in the defined geographical area.

The latest version of "Model RFP" will be available on CTD website.

Step 5. Organize a pre-bidding conference

- A pre-bid meeting should be prescribed in the RFP along with the date and time.

- In this meeting, the scope of services, responsibilities of either parties or other details should be explained to the prospective Service Providers to avoid any ambiguity at the time of submission of bids.

- If significant changes are made in the terms/scope of the RFP after the pre-bid meeting or otherwise considered necessary by the Programme Manager, a formal corrigendum to the RFP may be issued to all bidders. In such cases, it should be ensured that after issue of the corrigendum, reasonable time is available to the bidders to prepare/submit their bids. If required, the time for preparation and submission of bids may be extended.

Step 6. Submission and opening of RFP

- Submission of the proposals should be as per the rules for procurement process followed in the state.

- Bidding process should follow the two-stage bid process of quality and cost-based selection (QCBS) for input- and output-based contracts and for fee-for-service contracts only commercial bids are sought.

- Submission of technical and financial proposal should be separate and be kept confidential. The technical bids should be opened immediately after closing hours of receipt of bids by competent authority. The financial proposals shall be opened at a designated time by a competent authority only for those Service Providers who have qualified technical bids.

- All rules pertaining to procurement including conflict of interest of individuals/entities should be followed.

Step 7. Technical evaluation

- Technical bids should be analysed and evaluated by a Technical Evaluation Committee (TEC) constituted by the competent authority. The TEC should evaluate the technical bids using the technical evaluation criteria defined in the RFP.

Step 8. Financial evaluation

- The Financial Evaluation Committee appointed by a competent authority should open the financial bids of only those bidders who have been declared qualified by the TEC. Bids should be opened at a designated time known to all those technically qualified.

- In case of fee-for-services contracting, commercial bids of only those who meet minimum eligibility criteria will be opened.

Step 9. Select the proposal

- QCBS will be used for procurement of services, where quality of service is the primary concern. This method is recommended for input- and output-based contracts.

- Under QCBS system, the quality of technical proposals is scored as per criteria shared in the RFP. Only those proposals that have achieved specified qualifying score are considered further.

- After opening and scoring the financial proposals of the responsive technically qualified bidders, the authority arrives at a final combined score by giving predefined relative weightages for the score of quality of the technical proposal and the score of financial proposal.

- The competent authority can decide the relative weightage of technical and financial components, however, weightage of the technical parameters i.e. non- financial parameters

in no case should exceed 80%. The proposal with the highest weighted combined score, based on QCBS, is selected.

- Least Cost Selection (LCS) shall be used for fee-for-services contracting. This method will be used for purchase arrangement. Unlike QCBS, there is no weightage for technical score in the final evaluation and the responsive technically qualified proposal with the lowest evaluated cost will be selected.

- The competent authority should consider any representation/appeal against selection decision. Usually, the time period for such appeals is not more than 15 days after the date of announcement of selection.

Step 10. Letter of acceptance and signing the agreement

- The competent authority will issue a letter of acceptance to the selected Service Provider. The letter should contain the contracted value, duration of the contract, details on adjudicator and performance security, wherever applicable.

- The competent authority should also seek a reply to letter of acceptance within a stipulated period. After receiving a positive response from the selected service provider with submission of performance securities, wherever applicable, the competent authority should proceed for the signing of agreement. The states are advised to take legal consultation on the terms of the contract by involving their respective legal departments and institutions.

4.2 Budgeting for partnership options

Once the Programme Manager identifies the partnership option to be implemented, the next step is to arrive at an estimated cost. This costing is critical, as it will form a part of the Annual Programme Implementation Plan (PIP)of the region.

This chapter provides guidance on the approaches as well as tools to determine and benchmark costs for various partnership options. It is envisaged that the document will support the Programme Managers to estimate the budget for all possible partnership options as well as provide guidance to invite competitive bids.

This guidance document moves away from the traditional approach of prescribing pre-defined costs for each service and recommends that costs remain dynamic. The primary factors that influence cost of services are volume, geography (urban, rural, tribal etc.), local market dynamics, cost of living, demand of the service, inflation, local epidemiology, ease of delivering services, importance of service, risk involved, and delay in payment. Most Service Providers will have to invest costs up-front and in the initial phase to start field operations. Local factors, such as delay in payment, risk of non-achievement should be factored into the cost. Any additional costs that will affect or improve the outputs also needs to be factored in for example, awareness generation activities, capacity building and establishing feedback systems.

If costs are pre-defined by the CTD, it may not attract bids from a wide variety of Service Providers. It could also restrict competition, limit innovation or design of interventions suitable to the local context. This may lead to non-achievement of the goal to expand services for TB patients.

A costing exercise can help the Programme Manager in the following areas:

- Budgeting for services in the PIP.
- Estimating the value of the procurement.
- Engaging Service Providers to contribute towards wider coverage of services.
- Evaluating the RFP.

Costing can be done at the state or district using one or more approaches described below. It will depend on the need, available capacity and technical guidance from Technical Support Unit (TSU) / expert group/ other local level institutions.

The state can have varying rates for "difficult to reach" districts, metro and urban towns and may be revised at a regular interval of usually two to three years based on the changes in the market and inflation.

Accurate cost estimates are important because lower cost estimates may make approval challenging for selected competitive bids.

A market survey is always a preferred tool used to understand the prevailing rates for similar services in the private sector in a given geography or market. Information on the price for specific services defined under the selected partnership options can be sought from the Service Providers available in a particular geographical area. In addition to acquiring prevailing costs in the private sector, the Programme Manager can also seek information on the prevailing rates of similar services in government or non-governmental programmes, such as PM-JAY, Free Diagnostic Schemes which are implemented in the state, ESI, CGHS, etc. Moreover, insurance schemes can also be collected to derive the cost.

APPROACHES TO COSTING

1. Market scan

Under this approach, the Programme Managers must compile data on the market price of a particular service. They may send a letter to the Service Providers in the region, which should clearly mention the scope of services required, and request for unit price for the given scope of services. Information is collected through post or email. This information is used to arrive at mean/median/mode of prices so as to derive the unit cost.

This approach can be used in various partnership options, such as diagnostics.

Using market scan is explained through the following scenario:

Let us assume that the Programme Manager wants to do a market scan for a partnership option to undertake X-ray servicea. As a first step, the Programme Manager will send a letter to the private-sector X-ray labs available in the region to collect the required information from the providers. Here is what the collated information will look like:

Centre no. →	1	2	3	4	5	6	7	8	9	10
Cost of chest X-ray - digital with print out and report (in INR)	270	200	250	250	200	400	350	300	300	200
Cost of chest X-ray - digital with film and report (in INR)	410	250	250	250	200	400	350	300	300	200

The market scan analysis for the above centres is as follows:

	Range	Mean	Median	Mode
Cost of chest X-ray - digital without film and report (in INR)	200-400	272.00	260	200
Cost of chest X-ray - digital with film and report (in INR)	200-410	291.00	275	250

The analysed data indicates that the price range for the given service is between Rs. 200 to 400, and average price for two types of services are Rs. 272 and Rs. 291. Since the average price is more than mode, the market scan shows that the estimated cost is around Rs. 270 per X-ray without film and Rs. 290 per X-ray with film. It indicates that a large share of the Service Providers may agree to participate in the bid at these prices. If mode price is more than the mean price (average price), then it indicates that the mode price may be agreeable to the majority of Service Providers. This price is for the base year and a suitable inflation factor will be applied if the price is fixed for three years.

2. Activity-based costing

Activity-based costing (ABC) is used when the Programme Manager wants to establish an output-based cost estimate. ABC can be used for costing partnership options which have a wide set of services and a large number of activities within them, such as PPSA. While using this approach, all the activities are included to arrive at an estimate. All the resources, such as personnel, equipment, reagents and material, transport, communication, establishment cost etc. required for each of the activity have to be identified and quantified. The unit cost of each resource is estimated based on multiple components, such as local context, stakeholder consultations, market price etc.

The approach follows the principles of cost-accounting, under which, any event, unit of work, or task with a specific goal, such as visiting a patient, transporting sputum specimen, on-boarding doctors etc. is estimated in the form of an expense. The cost of each activity is driven by underlying cost drivers such as staff, transportation, communication, administration, incentives, other contingent cost etc.

This approach can be used in various partnership options, such as PPSA, Active TB Case Finding, LTBI Management, Specimen Management, Public Health Action, Advocacy, Communication and Community Mobilization, and Drug Access Methods.

Using ABC is explained through the following scenarios:

Let us cost for a partnership option which has a single activity of "patient visits", which includes time taken for a visit and distance travelled per visit. Thus, the cost drivers for the activity are the resource cost for time and the transportation cost. For example, the programme needs to cover 1000 patients per month under this partnership option. Here is how the estimate will be prepared:

TABLE 2.
Estimate to prepare a budget.

Average time for a single visit	2 hours
Number of visits	1000
Total time spent on visits	= 1000*2 hours = 2000 hours
Possible effort by one person per month	= 22 days*8 hours = 176 hours
Number of person required per month	= 2000 / 176 ~ 12
Salary of person per month	Approximately INR 10000 per month
Total resource cost	**= 10000*12 = INR 1,20,000**
Distance travelled per visit	5 kms
Total distance travelled	=1000*5 = 5000 kms
Cost of travel per km	INR 10
Total transportation cost	**= 5000*10 = INR 50,000**
Total cost of input	**= 1,20,000 + 50000 = INR 1,70,000**
Overhead cost (administrative, management, etc.)	Approximately 10% = INR 17,000/-
Total estimated cost of the partnership option	INR 1,87,000

Figure 6 shows the breakdown of the costing exercise.
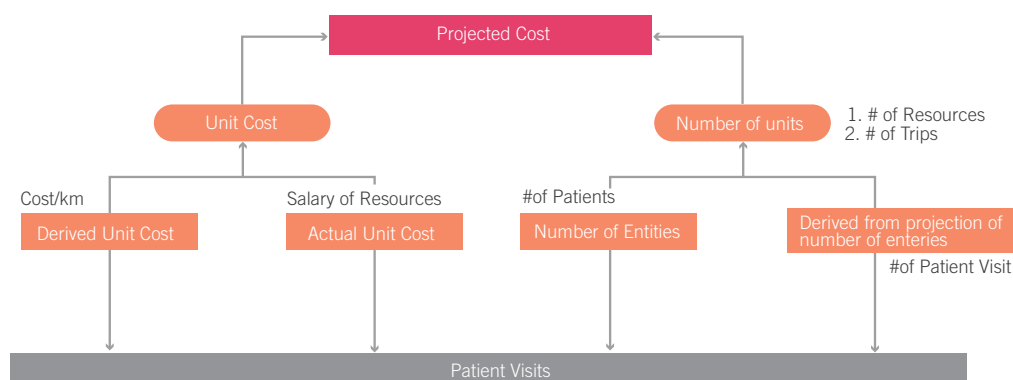
FIGURE 6.
Step-wise understanding of costing for a partnership option.

Please note that this example is basic as it only has two cost drivers. Usually, ABC is used for partnership options which have many activities. Breaking each activity into its cost drivers and determining the cost for each activity will help to derive the cost of the entire partnership option or bundled services.

3. Use of Prevailing unit price as used in other government programs /similar settings

In a scenario where similar services are not available in the market and if ABC is also not possible, the rates prescribed under the Partnership Guidelines 2014 or rates prescribed under any other government scheme may be considered as reference unit price. In such situations, the inflation factor should be applied to estimate the cost of a specific service for the year of procurement. The inflation rate information is available on the online (http://www.mospi.gov.in/).

Using this approach is explained through the following scenario:

For example, a region procured a service at Rs.100 in January 2015 and now wants to use this method to estimate the cost for 2020. From the website, the Programme Manager will get the information on the CPI inflation rates for general index to calculate the annual inflation rate as demonstrated in Table 3.

Table 3. Combined-CPI Inflation Rates Current Series (Base 2012=100).			
Year	**State**	**Description**	**Annual inflation rate**
2015	ALL India	General Index (All Groups)	4.91
2016	ALL India	General Index (All Groups)	4.96
2017	ALL India	General Index (All Groups)	3.33
2018	ALL India	General Index (All Groups)	3.96

Compounding average inflation rate is 4.5722 and is applied to the initial price of Rs.100 as of January 2015 by multiplying 5 for deriving the cost for 2020. Therefore, the estimated cost for January 2020 is Rs.100 + (100 x 4.5722% x 5), that is, Rs.122.86. The formula used is base cost + (base cost x compounded annual inflation factor x number of years from base cost).

Please note that inflation factor should be applied to estimate the unit cost for future years for all three approaches.

APPROPRIATE APPROACHES FOR AVAILABLE PARTNERSHIP OPTIONS

A region implementing a partnership option can use any of the three approaches (or any other approach which a state might be using for estimating cost) for costing the various services. As

costing needs to be approved, the table below highlights the indicative level at which approvals can be obtained for any partnership option.

TABLE 3. Appropriate approach for available partnership options.

Partnership option	Services	Level of approval for contracting and cost estimates – Centre (C), State (S), District (D)
Active Case Finding and TB Prevention	Active case finding	S
	TB prevention package for vulnerability mapping and LTBI management	S
Specimen Management	Collection of sputum samples	D/S
	Collection of respiratory (excluding sputum) and EP specimen	D/S
	Transportation of specimen	D/S
Diagnostics	Designated X-ray units	D/S
	Designated microscopy centres	D/S
	Molecular diagnostics	S
	Culture (standalone) / Line Probe Assay/ Culture and Drug Susceptibility Testing	S
	Pre-treatment and follow-up investigation	S
	Latent TB Infection Test	S
Treatment	Treatment centre	D
	DR-TB Treatment Centre (outdoor)	S
	DR-TB Treatment Centre (indoor)	S
	Specialist consultation for DR-TB patients	D/S
Public Health Action	Counsel TB patient and family members and provide treatment adherence and follow up support to ensure treatment completion	D/S
	Contact tracing of family members with periodic symptoms screening and evaluation for TB and Chemoprophylaxis to children less than six years old who are in the vicinity of a pulmonary TB patient, after ruling out TB.	D/S D/S
	Offer HIV counselling, testing and treatment linkage	D/S
	Drug susceptibility testing and linkage for DR-TB services	D/S
	Blood sugar testing and linkages for diabetic care	D/S
	Linkages for Nikshay Poshan Yojana	D/S
Patient Provider Support Agency	Private Provider Empanelment & Engagement	S
	Patient Management	S
	Diagnostic Linkages and sample transportation	S
	Public Health Action	S
Drug Access and Delivery Services	Drug supply chain management	S
	Improving access to FDCs for TB patients notified by the private sector	S S
Advocacy, Communication and Community Empowerment	Advocacy	D/S
	Communication	D/S
	Community Empowerment	D/S
Innovation/Other options		*S/C*

State may decide whether this activity needs to be approved at a state/district level.

4.3 Costing for new partnership options

Costing for partnership options (except for the ones which are already available) can also be undertaken by the Programme Manager. Usually, these are services applicable in a local context or can be a result of new developments (e.g. new diagnostic test for LTBI) in the region. The cost can be estimated by following any of the three approaches. If the cost of this service in other regions is available, it can be adapted to the local context. However, if the service is not widely available in the market, the costing should be undertaken in coordination with the experts at the TSU and Central TB Division. The assumptions considered for costing for new options should be documented, reviewed regularly and updated accordingly.

Costing for a new partnership option is explained below:

> Scenario 1: State A with a mobile X-ray unit and NAAT testing intends to outsource the mechanism of operationalization. Here, a new partnership option can be designed wherein the operations and personnel (driver, POL, maintenance of vehicle based on distance travelled, driver, technician etc.) is outsourced. The cost can be derived considering all the expenses of the mobile van in the last one year (cost of camps, distance travelled, human resource deputed etc.). Further, ABC method can be used to derive the cost estimates as the activities under the service have been identified and a cost can be attributed.
>
> Scenario 2: A Programme Manager is working towards operationalizing a government NAAT lab and ensuring that the lab can manage the large number of specimens. However, the laboratory technician is not available due to various reasons; in this case, the Programme Manager can derive the estimated cost for outsourcing the laboratory operations by recruiting a Service Provider to run the operations of the laboratory. To estimate the cost, the Programme Manager will need to mention the items / activities / consumables that will be provided. (e.g. space, equipment, consumables, electricity including backup, etc.). Moreover, the Service Provider should clearly understand the scope of service (e.g. provision of skill personnel, cleaning, doing testing and providing result, entry in Nikshay as per guidelines etc.) and mention the rate for per specimen tested or per day / month operations cost. Thereafter, ABC can be used where the Programme Manager can derive the cost based on the expenditure on various activities as per scope of service and average number of specimen processed per day / month in the laboratory during last quarter or year when the laboratory was optimally functional.

This is a classic example of a "Operations Expenses "model scheme. Other options that may be budgeted under this method include innovative models like cartridge sharing model, reagent rental, Op-Ex cost of running Mobile Medical Units

> **All partnership options should have the required programmatic and budgetary approvals through the PIP process and / or other relevant approval processes of the state.**

4.4 Deriving a payment mechanism and developing a performance-based matrix

Once the Programme Manager derives the estimated cost and prepares the budget, the next step is to arrive at a payment mechanism based on the estimates. A well-defined payment mechanism is critical for the implementation of partnership options to succeed. Based on the previous experience of implementing partnership options, most third party partners / NGOs / vendors have raised concerns on how delays in payments affects their ability to deliver services. This in turn hampers implementation, quality of services, satisfaction levels and perception levels of government programmes. In this new phase, the district and state RNTCP need to ensure timely payments as per the contract and as per payment timelines norms that are applicable within specific states. The ideal turn-around time for payment is fifteen working days after the first level of verification as explained in the partnership options above. Any adjustments can be made in subsequent quarters based on physical verifications.

PAYMENT MECHANISM

There are a few broad guidelines that a Programme Manager can follow while deriving the payment mechanism for the Service Provider.

- The payment mechanism should clearly mention the frequency, linked deliverables and mode of payment.
- The frequency can be monthly or quarterly as per State norms on deliverable linked payments. The earliest payment is desirable.
- The deliverable should be clearly defined and the documents which are to be submitted along with invoice / payment request should be mentioned with in the contract.
- Preferred mode of payment should be electronic and should follow the state norms of National Health Mission.
- Advance payment may be considered by state and district based on the local need and if it ensures that high-quality and timely services are provided to the patients.
- With respect to output-based contracting, regularity and timely payment should be followed.
- Invoices / payment request should be processed based on documentation of the performance in Nikshay.
- Deliverable will be verified / validated in the subsequent month or quarter and discrepancy or discordance can lead to recovery, if any, in the next invoice. Extent and reason of discordance should be considered in renewal/extension of the contract.

PERFORMANCE-BASED PAYMENT MATRIX

Under the proposed partnership options, payments are linked to specific outputs, which should be measurable and verifiable. Indicators / outputs existing in Nikshay can be selected. For partnership options where output indicators are not readily available in Nikshay, the Programme Manager should develop an alternate mechanism to record and report.

For each partnership option, one key output should be identified and the unit cost will be invited against this key output. In addition, performance of associated important activities or milestones are also linked to payments with pre-decided performance benchmark as percentage of the unit cost. Payments are linked pre-set indicators, primarily to cohort of patients / services. A cohort can be a month (e.g. diagnostic services) or a quarter (e.g. PPSA). Key outputs linked to these cohorts will be used to calculate the payment and performance in associated activities will be monitored to honour or withhold a particular percentage of unit cost for these associated activities. If a particular associated activity could not be performed

within the prescribed time, then the assigned percentage of unit cost for that particular service gets forfeited and is not paid to the Service Provider.

The percentage of unit cost to specific activity / benchmark is decided based on its importance in the geography and level of effort required to perform the activity.

The first invoice should be raised against the key output. If the associated activities are yet to be implemented, then appropriate amount will be withheld for that cohort of patients until the activities are complete. Upon completion, an invoice will be provided at a later time. Separate invoices have to be raised for each associated activity, for example, under PPSA, three invoices for same cohort are expected - one for notification, one for public health action and one for treatment outcome, whereas for a NAAT diagnostic test partnership option, the Service Provider can submit one invoice for the month / quarter with all the information on the test results.

It is advisable to give incentives in case of over-achievement. Achievements should be evaluated annually. It is recommended to provide maximum 10% incentive (overall) on the annual payment made to the Service Provider. The Programme Manager can select the activities and indicators against which incentives will be given. Please refer to example below to understand how the Programme Manager can derive incentives. This scenario provides an illustrative example of how a Payment Mechanism can be set up for a PPSA using a performance based matrix.

In District A, a contract for PPSA partnership option has been awarded to a Service Provider for 5000 patients over three years (Jan 2019 to Jan 2022) with agreed targets of 1000 patients in first year, 1800 patients in second year and 2200 patients in third year. The unit cost agreed in the contract is Rs.4000 per notified TB patient from the private sector for the project period.

The end-to-end patient management includes the key activities like notification, public health action and treatment completion. Here the Programme Manager proposes the key outputs and payments to be linked to each of the key areas for e.g., 30% for notification, 30% for public health action and 40% for outcome reporting.

Activity	Key output	Payment Allocation
Notification	Number of patients notified from private sector	**30%**
Public health action	• Comprehensive Public Health Action • Microbiological / DST test result • HIV testing result • DM test result • Correct bank details for DBT available in Nikshay as evident with at least one DBT	**30%** **DST – 10%** **HIV &DM Testing-10%** **DBT Details- 10%**
Outcome reporting	Proportion of notified TB patients who have successfully completed the treatment. Payment will be linked to the proportionate achievement of treatment completion for the notified patients.	**40%**

While payments may be attached to the above matrix, the Programme Manager should also develop a comprehensive set of indicators to monitor the monthly and quarterly performance of the PPSA. These indicators may be developed in line with the detailed Scope of Work developed for the PPSA. In an output-based contracting systems, payments are made on achieving specific milestones. All of which must be reported and verified through Nikshay to the best extent possible.

Considering the above, the following performance-based matrix may be proposed:

In Q1 (from January to March 2019), if the Service Providers notifies 300 patients (proportion of achievement is 100% against the target). then the Service Provider is eligible to raise an invoice for 300 patients, ie. A unit cost of 30% - @ Rs. 1200 (i.e. 30% of the unit cost of Rs. 4000 per patient) will be submitted on 1st April 2019. Verification and validation of the notification will be done in the Q2. The Programme Manager will verify the number and details of patients notified in Nikshay and process the invoice.

Since the Service Provider is yet to complete the public health action and treatment outcome for this cohort of patients, the next 30% (Rs.1200) of the unit cost for public health action and 40% (Rs.1600) of the treatment outcome will be withheld for this cohort. For public health action, information on the same cohort of 300 patients is expected and he Service Provider may report the following achievements against their performance targets by the next quarter and they raise the invoice every quarter.

For Outcome Reporting component, the Service Provider will submit the invoice for the cohort of the patients only after successful treatment completion (as verified by Nikshay). The invoice could be raised either on a monthly or quarterly basis. If the Service Provider reports that 230 patients (>70%) have successfully completed treatment and accordingly raises the invoice, the payment will be calculated as follows:

The matrix may also include incentives to encourage good performance. For example, the Service Provider is expected to notify 1000 patients in Year 1 and notifies 1100 patients that they could be eligible for an incentive of 5% of the annual payment which will be calculated in Q1 2020. The total amount received by the Service Provider to deliver all services to the 300 notified patients in the first quarter as per actual performance will be along these lines:

- Notifications: 300 patients x Rs. 1200 = Rs. 3,60,000
- Microbiological / DST: 180 patients x Rs. 400 = Rs. 72,000
- HIV testing result: 250 patients x Rs. 400 = Rs. 10,000
- Correct bank details for DBT: 280 patients x Rs. 400 = Rs. 1,12,000
- Successful treatment outcome: 230 patients x Rs. 1600 = Rs. 3,68,000

Total Payments of Rs. 9, 22,000 (i.e. 77% of the total Rs. 12,00,000 that the Service Provider could be the maximum received for the 100% completion of notifications, public health action and successful treatment outcome for the 300 notified patients).The actual payments will be made in the quarter when invoices are submitted.

Please note:

A Programme Manger may select two to three 3 key indicators as suitable to the local context and the payment will be linked to the achievement of the performance.

All output indicators are linked to each other, for example, non-performance in one indicator (inaccurate bank details) will impact other indicators such as treatment outcome because the patient may discontinue the treatment if they do not receive the incentives.

VERIFICATION AND VALIDATION

Verification and validation of the key output is required specifically in output-based contracting as the payments are linked to the activities. It is suggested that verification and validation of outputs is done by the District TB team which includes the District TB Officer (DTO), District PPM-Coordinator and all the key staff at the DTC including the STS, STLS and SDPS.

State / District should conduct a field verification and validation for these indicators / key output periodically among a sample of at least 5% service users. Verification and validation can be done using record review (e.g. valid test results of NAAT), contacting the patients (e.g. notification of TB patient, result of HIV testing, successful treatment outcome), verifications from healthcare service provider - a combination or any other method which might be useful in the context of the partnership option. Validation and verification should be completed within a quarter of performance of activities. It is advisable that indicators are combined for verification and validation, for example, a patient contacted for verification and validation of notification can also help in verification and validation of a public health action activity.

Observations made during verification and validation should be communicated to the Service Provider and be given an opportunity to respond to the observations and discordance, if any, within a deadline. The Programme Manager will review the response and finalize the report.

In case of discordance, a pre-finalized penalty can be applied on the payments for the concerned patient cohort. The rate of penalty for discordance can be the deduction of two times the unit cost for the number of patients with discordance or can be applied on pro-rata basis, as decided by the Programme Manager. The penalty clause should be a part of the bid and contract.

In the example shared for performance-based matrix in the above case, verification and validation for the cohort of patients registered in Q1 2019 should be conducted periodically within Q2 2019. The list of the patients with the required information on the three indicators is taken and at least 5% of the notified patients from the private sector (i.e. 15 out of 300 patient cohort) should be randomly selected for field verification. This random sample should have gone through DST test, HIV test, and verified bank details. After validation and verification, the following is noted:

▪ Out of 15 patients notified, information on 1 patient was not correct (patient notified as TB in NIKSHAY, but on field found that the patient was not TB as per patients' report) with discordance of 6.67% [1/15]

▪ Out of information on HIV test result for 12 patients, there was mis-match in 1 patients report with discordance of 8.33% [1/12]

▪ Out of information on DST test result for 10 patients, there was mis-match in 1 patient report with a discordance of 10% [1/10]

The Service Provider may be asked to explain the discordance and give them 30 days to respond. If the invoice information submitted by the Service Provider on HIV and DST results is verified to be correct by the concerned laboratory, and further verification from the randomly chosen patients is also found to be correct, the Programme Manager need not ask the Service Provider to submit a report. However, if the Service Provider is unable to justify the discordance in the various indicators as described in the table below.

Treatment outcome report for the same cohort (Q1 2019) will be available after nine months, i.e., by January 2020. Verification and validation of a sample of patients will be done by review of the records and interview of the patients. From a list of the 11 patients (5% of 230 patients reported with successful treatment outcome) that are selected randomly from the list, information on one patient was not correct (patient reported with successful treatment

outcome in NIKSHAY, but on field found that the patient hasn't completed his/her treatment as per patients' report), with a discordance of 9% [1/11].

Based on the discordance reported and confirmed, the Programme Manager may proceed to calculate the penalties along the following lines:

Indicator	Discordance	Total Patients on the Indicator	Patients for Penalty
Notification	6.67%	300	6.67%*300 = 20
HIV	8.33%	180	8.33%*180 = 14
DST	10%	250	10%*250 = 25
Outcome	9%	230	9%*230 = 20

*lower number is assumed in cases of decimals in patients for penalty.

For the value of the penalty imposed, the payment must be linked to that particular indicator. Hence the total penalty payment would be:

Indicator	Payment linked	Patients for Penalty	Penalty Value
Notification	1200	20	1200*20 = 24000
HIV	400	14	400*14 = 7600
DST	400	25	400*25 = 10000
Outcome	1600	20	1600*20 = 32000
Total			73,600

The penalty amount will be not paid or be deducted from any future payment, if the payment of the previous quarter has been made. The penalty will be applied depending upon the number of discordant results as per a specific indicator variable.

5 MONITORING AND EVALUATION

As the process of contracting is complete and Service Provider begins to implement the expected activities, the next step is monitor and supervise these activities. In order to do that, a monitoring and evaluation (M&E) plan has to be prepared and implemented.

Overview

WHY HAVE A M&E PLAN?

A M&E system is essential to ensure the efficiency of the contracts established between a Service Provider and the RNTCP. A system of periodic reporting, review, supportive supervision and ongoing monitoring will be instituted to track contract performance. An effective M&E system will enable the Programme Manager to make mid-course corrections, if required, based on the findings of the review. It will also ensure that the state's priorities and the goals of the project are met.

HOW TO DEVELOP AND IMPLEMENT A M&E FRAMEWORK?

- The Programme Manager must decide on a set of indicators during the design of the partnership option. The performance of the Service Provider will be monitored based of agreed indicators, which should be clearly mentioned in the contract.
- The TOR for M&E should be developed and shared with the Service Providers prior to the launch of field operations. The Service Provider should have the opportunity to provide feedback to M&E processes.
- The Service Provider will submit a detailed report of its activities every month in the format prescribed by RNTCP. The RNTCP will give suggestions and guidance after reviewing the report.
- The Programme Manger will conduct review meetings at the state and district level on a monthly/ quarterly basis (as required and applicable). At the meeting, the Service Provider will report the progress and challenges faced. These meetings will serve as a forum to discuss and propose solutions to the challenges faced by the Service Provider in project implementation.
- At the state level, State TB Officer (STO) and Mission Director will chair the meeting.
- At the district level, Chief Medical Officer (CMO) and DTO will chair the meeting.

TABLE 4. Example of performance monitoring time-table.

Activity	Frequency of reviews (# of months)												Monitoring Committee
	1	2	3	4	5	6	7	8	9	10	11	12	
Review by DTO													DTO, DHS team, Implementation agencied (IAs)
Review by District Collector													DCs, STO, all DTOs. All IAs, CTD/ CTD nominated members (representatives)
Review by STO													STO, DTOs. All IAs, CTD/ CTD nominated members (representatives)
Review by MD-NHM													MD-NHM, STO, all DTOs. All IAs, CTD/ CTD nominated members (representatives)
Review by AS/JS - MoHFW													AS/JS, MD-NHM of all States. All IAs, CTD/ CTD nominated members (representatives)

EXTERNAL EVALUATIONS

- The state should preferably commission external evaluations as per requirements, to study and improve the programme.

- The State TB Cell may conduct these evaluations at state and district-level Service Provider of up to 10% of contracts. The partnership options to be evaluated may be selected randomly or as per the state's preferences.

- These evaluations could include a review of contract management, payment timelines, performance of the agencies, coordination with agencies, fulfilment of objectives of engagement, etc. However, it should be ensured that the same Service Providers are not evaluates multiple times unless there is a specific reason.

Reporting of uptake of partnership options

The states and districts are expected to report the number and type of partnership options deployed in the field. The CTD recommends that the PPM details are updated on a regular basis on the NHM website / Nikshay Portal and CTD's website. The details of all the partnership options in terms of funds allocated, utilized and beneficiaries covered should all be made available for public viewing. Every quarter, the Programme Managers are expected to update and report the number and type of contracts that are being implemented. The formats in **Annexure 2** may be used to report on the various partnership options deployed.

6 INSTITUTIONAL FRAMEWORK REQUIRED FOR IMPLEMENTATION

To ensure success of the partnership options, it is key that the state has sufficient capacity in technical areas such as contract deployment and management, capacity building, monitoring and payments processing on completion of services. An institutional mechanism such as a Technical Support Unit (TSU) at the state level may be considered as a framework to take on these tasks especially like large scale- contract management. These TSUs could also function within a states existing TSU systems and augment the state's current capacity for managing large-scale partnerships with private entities.

Guiding principles of an institutional mechanism

▪ Focus on contracting, ensuring prompt payment for services, and providing strategic guidance to the National and State TB programme to effectively scale up interventions.

▪ Develop an online performance and contract tracking system to optimally monitor empanelment and payments for services.

▪ Acquire adequate support and ownership of interventions from the National Health Mission, State Health Societies or State TB programme for its effective functioning.

▪ Ensure periodic meetings of the management and governance bodies both of which are critical for oversight and review of partnership options. It is recommended that management bodies meet quarterly and governance bodies meet yearly; the frequency can be increased, if required.

A TSU may be formed at the state level as an interim arrangement to implement the newer principles of partnership guidelines. Once the state acquire the required level of competencies and skills to handle the contracting, monitoring and other critical tasks, it may be transitioned into the appropriate frameworks of the health system. The structure, responsibilities and governing mechanisms of a TSU are discussed below:

B.1 ROLES AND RESPONSIBILITIES

▪ Support the state in implementing the engagement of Service Providers. These Service Providers could be utilized to contract state–level PPSA and any other partnership option as required by the state to provide various services in the TB care cascade for e.g., private sector engagement, community mobilization, etc

▪ Support the State TB Cell to manage the complete cycle of engaging Service Providers:
  • Finalize state-specific terms of reference.
  • Define results-based performance indicators.
  • Develop contracts.
  • Undertake costing based on the terms of reference.
  • Identify a suitable procurement process.
  • Facilitate the procurement process for to select Service Providers.

- Support the State TB Cell with the on-boarding of the Service Providers, operational management of the contract through its duration, periodic performance reviews against indicators, validation of achievements, accuracy of claims, submission of documentation, etc.
- Undertake M&E activities:
  - Monitor the progress of the Service Provider on results-based outputs.
  - Facilitate third party dipsticks of results (quantitative and qualitative) to avoid fraud and ensure transparency.
  - Coordinate the use of Nikshay to review data for action.
  - Obtain specified outcomes.
  - Work with the state to recommend payments to Service Providers timely based on the outcomes.
- Undertake capacity building and technical assistance activities:
  - Provide technical assistance to Service Providers, especially in the initial phase of engagement.
  - Make recommendations for payments to Service providers including PPSAs, laboratory networks, pharmacy chains, pharmacies etc. based on outcomes.
  - Provide technical support to public sector on process improvement.
- Facilitate support via innovative financing for implementation/ technical support etc. that are made available to the state from any donor or through philanthropic institutions.
- Support and facilitate the tabling and review of grievances received from parties. The TSU shall be responsible to execute due process. The state-level governing committee / managing committee will review and resolve grievances.

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B.2 RECOMMENDED STRUCTURES

TSU in existing government structure

State Governing Committee		Principal Secretary
State Managing Committee		Commissioner/MD-NHM
		Directorate of Health Services
		State TB Cell
		State TSU
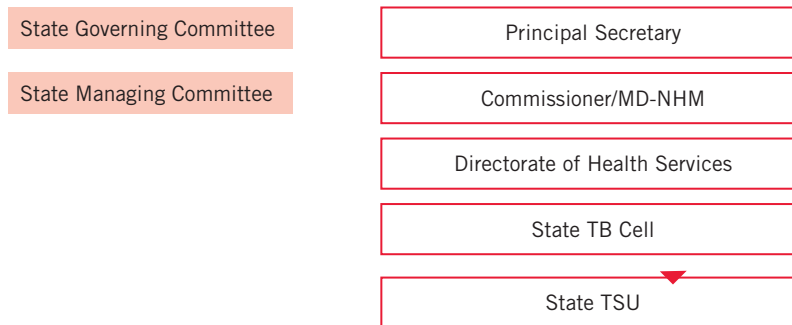
FIGURE 9.
Structure of the TSU within the MoHFW

Governing Committee to oversee the overall performance of the TSU and ensure speedy resolution of escalations / challenges /issues face by TSU.

Governing Committee – State level

Chairperson	Principle Secretary, Health and Family Welfare
Vice Chairperson	Mission Director, NHM
Member Secretary	State TB Officer

| Member 1 | Member 2 | Member 3 | Member 4 | Member 5 | Member 6 |
| Director, Public Health | Team Lead, State Technical Support Unit | JD-NHM/ SPM-NHM | Representative, Civil society | Representative, TB expert | TB Survivor |

FIGURE 10.
Structure of the TSU governance committee

This is a proposed governance structure but given that there are larger state needs beyond TB for contracting, it is up to the states to see how they can subsume it under the broader public-private partnership umbrella while maintaining ownership and accountability.

Managing Committee – State level

Mission Director, NHM	Chairperson	Co-Chair	Director, Health Services
	Vice Chairperson	State TB Officer
	Member Secretary	Team Lead, State Technical Support Unit

| Member 1 | Member 2 | Member 3 | Member 4 | Member 5 |
| Director, Finance / State Finance Manager | Principle STDC | PPM coordinator | Representative, Civil society | Representative, TB Expert |

FIGURE 11.
Structure of the TSU governance committee

MANAGING COMMITTEE

The Committee will:

- Review, redress and resolve complaints that are raised pertaining to services and contracts.
- Ensure prompt payment for services after reviewing Nikshay data.

Role	Competencies and Roles
Team leader	Leads the TSU
Deputy Lead	Manages the overall TSU operations
Contract management expert	Design contract, costing, procurement and operations to ensure timely engagement and deployment of quality implementation partners

Role	Competencies and Roles
Monitoring and evaluation expert	Leads the monitoring and evaluation of contracted agencies (define mechanisms and studies to verify qualitative and quantitative aspects of results)
Knowledge Management expert	Documents learnings from one site and disseminate knowledge to others
Information Communication Technology (ICT) specialist	Facilitates the ICT engagement and address grievances and strengthening interface with Nikshay, online empanelment process and privately contracted agencies
Finance manager	Provides guidance and implementation support for results-based payments
DBT specialist	Provies guidance on DBT payments /schemes and PFMS
Public Private Partnership expert	Provides guiding on strategy to involve PPs/chest specialists.
Inter-Sectoral Coordination Expert	Facilitates inter-sectoral coordination
Communication Specialist	Provides guidance on any overarching communications pertaining to engaging private sector (Advocacy and communications) Bring uniformity on the messaging pertaining to various interventions
Capacity Building Expert	Facilitates capacity development at State/District and among partners in private sector engagement, DBT and system strengthening

Roles/ positions indicative for discussion and inputs. Regional/ specific location positions may be considered for states with larger burden.

Roles/ positions indicative for discussion and inputs. Regional/ specific location positions may be considered for states with larger burden.

SELECTING A TSU

- An organization must fulfil the following eligibility criteria to be selected as a TSU:
- A proven record of technical assistance in the areas of strategic planning and result-based performance and demonstrate healthcare innovations.
- Documented evidence that demonstrates appropriate technical capacity. These may include:
    - Published article,
    - Appreciation/Recognition letter
    - Agreement/work order
    - Client certificate
- Have organizational capacity and disease area expertise related to the projects with prior experience of working in relevant public health programs. Previous experience may include projects on patient and provider management, innovations in service delivery, health system strengthening including experience in relevant geography etc.
- Have an average annual turnover that should be pre-determined based on the workload and scope of service.

When evaluating potential organizations, the CTD should review the following parameters in the project proposal - adequacy, quality, and operational feasibility of the proposed methodology and work plan in response to the TORs, staffing pattern and hiring plan, timelines of the project rollout; and innovations.

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7 BUILDING CAPACITY TO IMPLEMENT PARTNERSHIP OPTIONS

There is a need to enhance the technical and managerial capacity of Programme Manager and Service Providers to implement these partnership options. The first step is to assess the capacity and competencies of these two key stakeholders to initiate, manage and implement the new partnership options at the national, state and district levels.

This chapter elaborates on the capacity assessment and capacity building needs of the Programme Managers as well as the Service Providers.

Stakeholder 1: Programme Manager

1.1 UNDERTAKING CAPACITY ASSESSMENT

Why assess?
- To measure overall capacity of the state and district team to effectively manage Service Providers in different domains of partnership management and identifying areas that need strengthening or further development.

Whom to assess?
- The various government stakeholders who will play a critical role in partnership management.
- RNTCP Officers (STO/DTO), RNTCP staff, DHS / CMO and their officers in general health services, faculty and staff of medical colleges, State Health Society, District Health Society, PFMS, partnership / NGO cell etc.

This list is not exhaustive and may be expanded to include any relevant stakeholders within the government, as per the local context.

Who will conduct the assessment?
- The assessment can be conducted by Programme Managers or through an independent agency (e.g. academic or public health institutions). For example, the NTSU may be engaged to support the states in this exercise. Where applicable, STSU may assess the capacity at the district level.
- The role of the Programme Officers is of utmost importance in leading and organizing the assessments.

What will the assessment cover?

The Capacity Assessment has to be conducted at national, state, district, block and health facility levels. An illustrative list of capacities and competencies highlighted below could be assessed:

- Partnership fundamentals
- Contract design and management
- Administrative procedures
- Procurement processes – RFP
- Performance review and management of payment system
- M&E of programme performance
- Stakeholder co-ordination
- Financial management of partnerships

The assessment may also include capacities of the current infrastructure around contracting, for example, local policy and context, availability of local resources including manpower, infrastructure, etc.

When to assess?

An initial detailed assessment can be conducted at the time of adoption of this guidance document and a subsequent assessment can be conducted either annually or a needs basis.

1.2 UNDERTAKING CAPACITY BUILDING

- An agency with relevant experience and expertise can be contracted for capacity-building activities.
- On completion of the assessment exercise, the agency will prepare a detailed capacity-building plan with a timeline and budget. The agency shall identify partner institutions (e.g. TISS / IIHMR/NIFM etc.) to develop a curriculum addressing the gaps identified in the needs assessment for relevant government stakeholders.
- At the onset, the agency should look to build the capacity of Programme Managers who in turn can become resource persons for future trainings. The agency will recruit these resource persons to conduct various training at state/district level.
- Training may be conducted in different ways such as, face-to-face training, virtual-based, on-the-job training, coaching and mentorship etc. and using methods such as case study analysis, group work and experiential learnings.

Stakeholder 2: Service Provider

2.1 UNDERTAKING CAPACITY ASSESSMENT

Why assess?

To identify the gaps in desired capacities vs. existing capacities of Service Providers. The insights gathered to develop capacity- building modules for Service Providers to implement the partnership options effectively.

Whom to assess?

- Any private sector agency/ registered agency who has enlisted and accepted to become a Service Provider and enter into a contract with RNTCP to implement partnership options

Who will conduct the assessment?

- The assessment can be conducted by an agency in collaboration with Central TB Division and the State TB Cell. Areas of competencies necessary for effective implementation of the partnership options will be assessed by an agency in collaboration with Central TB Division and State TB Cell.

What will the assessment cover?

An illustrative list of capacities and competencies highlighted below could be assessed

- Organizational profile / policy
- Area of operation
- Human resource management
- Area of expertise
- Management of information system
- Commodity and logistics management
- Accounting and financial management

When to assess?

- An assessment should be carried out prior to contracting the Service Provider and subsequent assessments may be carried out either annually or when needed.

2.2 UNDERTAKING CAPACITY BUILDING

After contracting a Service Provider under partnership options, the training of all relevant staff of the Service Provider/s needs should be prioritized and be based on the type of partnership option that they will be implementing.

- The agency shall identify partner institutions (e.g. TISS / IIHMR/NIFM etc.) to develop a curriculum addressing the gaps identified in the needs assessment for relevant government stakeholders.
- At the onset, the agency should look to build the capacity of key personnel within the Service Providers who in turn can become resource persons for future trainings at state/district level.
- Training may be conducted in different ways such as, face-to-face training, virtual-based, on-the-job training, coaching and mentorship etc. and using methods such case study analysis, group work, virtual-based and experiential learnings.

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Annexure 1: Needs Assessment Tool

TB notification

- What is the TB notification rate in the geography in a year?
- Is the TB notification low as compared to the estimated/expected rate in the geography? If Yes
  - What is the gap in TB notification?
  - What is the presumptive TB examination rate?
    - Is the presumptive TB examination rate low? If Yes
      - How much is the gap in presumptive TB examination rate?
        What is the referral rate of presumptive TB among patients attending public health sector OPD? Is it low? If Yes
        - Identify health facilities referring less presumptive patients
        - What are the reasons for low referrals?
          - Is required health staff available? If No, ensure availability
          - If a trained medical doctor available? If No, conduct relevant training
      - What is the proportion of referrals being <u>examined</u>? Is there any gap in referral and examination?
        - If Yes,
          - Does the patient have to pay for travel? If yes
            - Establish specimen transport from peripheral health facility to microbiological testing facility.
            - Is the free test (microbiological or X-ray) available? If No,
          - Engage service provider and provide free test
  - Has the district conducted active TB case finding?
    - If No, is the staff: key population ratio adequate? If No, engage agency to conduct active TB case finding
    - If Yes, is there is a gap in coverage and quality of screening, identification of presumptive TB and examination
      - Is the staff key population ratio adequate?
        - If No --- Engage agency to conduct ACF.
      - Is the staff trained adequately?
        - If No --- Train the staff.
      - Is screening activity monitored?
        - If No --- increase monitoring to improve quality.
      - What is the coverage of complete examination of presumptive TB patients identified?
        - If low,
          - Establish specimen transport system.
          - Purchase free examination test.

TB notification from the private sector

- How many TB patients were notified from private health care providers?
- Is TB notification low from private health care providers as compared to estimation?
- If low,
    - How many private health providers are there in the geographical area?
    - How many of these providers   prioritize diagnosis and treating TB patients?
    - Are all priority providers notifying TB patients?
    - If No,
        - How many priority providers are not notifying?
        - Are there adequate staff to contact and engage private providers?
        - If No,
            - Engage an agency for provider engagement.
        - If adequate,
            - Does the staff make efforts for engagement?
                - If No, make engagement efforts.
                - If yes,
                    - Is the skill of the staff adequate?
                        - If no, train staff on skills of engagement of providers.
                        - Even after skill-building efforts, if provider coverage is low, engage agency for provider engagement.

Paediatric TB notification

- How many notifications of paediatric TB have been done?
- Is there any gap in detection of paediatric TB?
- If Yes,
    - Are public-sector healthcare providers screening children for symptoms of TB? Are health providers able to identify presumptive TB in children and referring them for diagnostic tests?
    - If No,
        - Are health care providers available?
        - If No, make health care providers at required places.
        - If Yes,
            - Are health care providers trained in screening of children with TB?
                - If No,
                    - Train health care providers on screening of children for TB.
- Do presumptive TB patients receive appropriate tests?
    - If No,
        - What is the proportion of patients not tested?
        - Is sputum specimen available for testing?
            - If No, is staff available to get non-sputum specimen?
                - If No, is it possible to train existing staff to get non-sputum samples?
                    - If No, engage paediatrician services for specimen collection.

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Extra-pulmonary TB

- How many notifications of extra-pulmonary(EP) TB have been done?
- Is there any gap in detection of EP TB?
- If Yes,
  - Are health providers able to identify presumptive EP TB and refer for diagnostic tests?
  - If No,
    - Are public sector health care providers trained in identifying EPTB?
      - If no,
        - Train health care providers on identifying EP TB.
- Are presumptive TB patients tested with appropriate tests?
  - If No,
    - What is the proportion of patients not tested?
    - Do the facilities in the local area have the facility for EP sample collection?
      - If No, engage facilities for sample collection.
    - Is staff available to get samples?
      - If No, is it possible to train existing staff to get alternate samples?
        - If No, engage private providers /health facilities services for sample collection.

Microbiological confirmation

- What proportion of privately notified TB patients are microbiologically confirmed?
- Is there any gap in microbiological confirmation?
  - Are providers prescribing microbiological testing?
    - If No, advocate with providers for increasing microbiological testing.
    - If Yes, establish sample collection and transport systems to public laboratory.
      - Is there adequate capacity of laboratory service available?
        - If No, purchase laboratory service from a private and make available to patients.

Drug Susceptibility Testing (DST)

- What proportion of all notified TB patients are tested for DST?
- Is there any gap in DST?
  - Are providers prescribing DST for all TB patients?
    - If No, advocate with providers for increasing DST and counselling patients for the same
    - If Yes,
      - Establish sample collection and transport system to public laboratory.
        - Is there adequate capacity of laboratory service available?
          - If No, purchase laboratory service from private and make available to patient

HIV testing

- What proportion of private notified TB patients are tested for HIV? Is there any gap in HIV testing? If yes,
  - Are private providers prescribing HIV testing for all TB patients?
    - If No, advocate with providers for increasing HIV testing and counsel patients
    - If Yes,
      - Establish blood collection and transportation to nearest NACO-affiliated HIV testing/screening facility.
        - Is there adequate HIV testing/screening available?
          - If No, Engage private laboratory for HIV testing/screening facility.

Diabetes testing

- What proportion of notified TB patients are tested for blood sugar? Is there any gap in blood sugar testing? If yes,
  - o Are providers prescribing blood sugar testing to all TB patients?
    - If No, advocate with providers for increasing blood sugar testing and Counsel TB patient.
    - If Yes,
      - Establish blood collection and transportation to nearest free blood sugar testing facility.
        - o Is there adequate blood sugar testing facility available?
          - If No, engage private laboratory for blood sugar testing facility.

Contact investigation and preventive treatment

What proportion of patients' contacts are investigated? Is there a gap in coverage of contact investigation or identification of symptomatic or examination of symptomatic? If Yes,

- Is the staff:patient ratio adequate for contact investigation?
  - If No, engage agency for contact investigation and preventive treatment.
- Are free tests available nearby?
  - If No, establish sample transport system from community.
  - If No, purchase tests.
- Is there a gap in initiating and completion of preventive treatment? If Yes?
  - o Are drugs available? If Yes,
    - Is there a drug supply system available to reach the patient? If No, Establish a drug supply system.
    - Is the staff:patient ratio adequate to reach out to all contacts for preventive treatment? If No, engage agency for preventive treatment.

Treatment adherence support and outcome reporting

- What is the proportion of treatment success rate? Is there a gap in treatment success rate?If Yes,
  - o Is there a treatment adherence monitoring system? If No,
    - Advocate with providers to establish adherence monitoring systems and counsel patient.
    - Establish treatment adherence monitoring system through refill/DAT/DOT.
    - Is there adequate staff:patient ratio to track patients back on treatment?
      - If No, engage agency for adherence support system.

Nikshay Poshan Yojana

- What proportion of patients have received benefits of Nikshay Poshan Yojana? Is there a gap? If Yes,
  - o What is the proportion of bank account details available?
  - o Is there a gap in collecting bank account details? If Yes,
    - Advocate with providers to get bank account details and explain NPY to the patient.
    - Is there adequate staff:patient ratio to get bank account details, verification?
      - If No, engage agency for patient support.

Initiation of treatment

- What proportion of notified TB patients have been initiated on treatment? Is there a gap in treatment initiated or delay in any particular group of patients? If Yes,
  - o Are patients the residents of the same district/TB unit?
    - If No, does the district have a system to track such patients and put on treatment with existing staff?
      - If No, engage agency to track patients and initiate on treatment in moving migrant population.

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DR-TB

- What proportion of diagnosed DRTB patients have been initiated on treatment? Is there a gap or delay in treatment initiation? If Yes,
    - Does the district have OPD treatment initiation facility?
        - If No, engage hospital for DRTB centre.
    - Does the district have IPD treatment initiation facility?
        - If No, engage hospital for DRTB centre.
    - Does the district have required experts?
        - If No, specialist doctor on consultation.
    - Does the district have required free lab services?
        - If No, engage with laboratory for free lab services required for pre-treatment investigation and follow-up.

LTBI

- What is the incidence of TB in an area? Is it low?
- Is the district planning to introduce LTBI management?
    - If Yes, is the staff:population ratio adequate ?
    - If No, engage agency for LTBI management

Hospital engagement

- Does the district have hospitals with high TB notification rates? If yes
    - Is there a gap in STCI and a capacity issue to undertake public health action
      Engage hospital directly for patient management, linkage and public health action.

Drug supply

- Does the district have sustainable efficient drug supply?
    - If No, engage agency for supply of drugs.
- What is the proportion of TB patients in private sector who have been treated with free FDC? Is there a gap in coverage of FDC?
    - If Yes, are private providers prescribing FDC?
        - If Yes, is adequate quantity of FDC available in the district?
            - If Yes, have private providers agreed to dispense FDC?
                - If Yes, is the staff: dispensing point ratio adequate to supply drugs?
                    - If No, engage agency for supply of drug.
    - If either providers are not prescribing or not agreeing to dispense FDC
        - Engage agency for marketing, and distributing FDC.

Communication

- What is the awareness level of TB in the population?
    - If low,
    - If Yes, engage agency to reach out to community through communication campaign

Advocacy

- What is the awareness level of TB among leaders, decision makers?
    - If low, had the district/state conducted advocacy efforts with leaders on TB?
        - If Yes, engage agency to reach out to leaders, decision makers through advocacy campaign.

Community empowerment

- How much is the community involved in advocacy?
    - If low, what is the discrimination and stigma level in the community?
        - If high, does the district have adequate staff:community ratio?
            - If No, engage agency for community engagement.

Annexure 2 : Reporting formats

2A. GUIDANCE REPORTING FOR CONTRACTS

A Reporting Unit is a RNTCP state / district who has deployed at least one contract under the partnership guidelines. States need to compile the data from all districts with regards to the various PPM options. Critical information on every partnership option signed must be maintained at the state level. All PPM reports need to be prepared and updated at least once every quarter. Districts and states are expected to complete the report preparation by the 7th and 15th of the month following the reporting quarter.

Name of PPM Option	**GUIDANCE:** *As per partnership guidelines*	
Name of agency	*As per the contract*	
Contract duration	From	*As per contract*
	To	*As per contract*
Coverage	Date of initiating the activity	*As per launch date*
	Geography coverage	*As per contract*
	Population coverage	*As per contract*
	Key activities	*As per contract, preferably four major key activities to be mentioned, usually having highest linkages with payments. Should remain same for the complete reporting year.*
Physical performance	Expected target	*As per target*
	Achieved during the reporting period (Quarter)	*As reported by agency / TU / District*
	Achieved during the year	*Progressive figures*
	Remarks	*Mention regarding factors for over / under achievements*
Financial performance till reporting period	Expected for the year	*As per contract*
	Planned till reporting period	*As per contract*
	Eligible Amount (invoices) submitted till date for the year	*As per finance section*
	Approved Amount among submitted invoices for the year	*As per finance section*
	Disbursed Amount for the year	*As per finance section*
	Remarks	*Mention regarding the progress on performance*

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Name of PPM Option	GUIDANCE: *As per partnership guidelines*	
Verification details (if applicable)	Date of last verification	*Mention as per verification report, if done by reporting unit. Otherwise mention not-applicable*
	Discordance (if any)	*As per verification report*
	Remarks	*Mention reasons / factors associated for discordance (e.g. typo-error, mis-classification, de-duplication etc)*

2B. QUARTERLY / ANNUAL REPORT ON PARTNERSHIP UNDER RNTCP FROM REPORTING UNIT :

Name of Reporting district

Reporting Period : April- June 2020   Date of reporting: 15th July 2020

(Information on all the agencies who have signed the contract with the reporting unit needs to be included; Agencies who have signed contract at State level need not be included).

Name of PPM Option	Name of agency	Contract duration		Coverage				Physical performance				Financial performance till reporting period						Verification details (if applicable)		
		From	To	Date of initiating the activity	Geography coverage	Population coverage	Key activities	Expected target	Achieved during the reporting period (Quarter)	Achieved during the year	Remarks	Expected for the year	Planned till reporting period	Eligible Amount (invoices) submitted till date for the year	Approved Amount among submitted invoices for the year	Disbursed Amount for the year	Remarks	Date of last verification	Discordance (if any)	Remarks
GUIDANCE: As per partnership guidelines	As per the contract	As per contract	As per contract	As per launch date	As per contract	As per contract	As per contract, preferably four major key activities to be mentioned, usually having highest linkages with payments. Should remain same for the complete reporting year.	As per target	As reported by agency / TU / District	Progressive figures	Mention regarding factors for over / under achievements	As per contract	As per contract	As per finance section	As per finance section	As per finance section	Mention regarding the progress on performance	Mention as per verification report, if done by reporting unit. Otherwise mention not-applicable	As per verification report	Mentions reasons / factors associated for discordance (e.g. typo-error, mis-classification, de-duplication etc)

EXAMPLE:

Name of PPM Option	Name of agency	Contract duration		Coverage				Physical performance				Financial performance till reporting period						Verification details (if applicable)		
		From	To	Date of initiating the activity	Geography coverage	Population coverage	Key activities	Expected target	Achieved during the reporting period (Quarter)	Achieved during the year	Remarks	Expected for the year	Planned till reporting period	Eligible Amount (invoices) submitted till date for the year	Approved Amount among submitted invoices for the year	Disbursed Amount for the year	Remarks			
PPSA	Danesh Consultancy	4/1/2020	3/31/2022	5/1/2020	Urban TU (3)	1450242	Privates sector coordination - PPs to be engaged	238	32	32		5400000	1350000	240000		0	Invoices under process of payment			
							Notification	1800	340	340											
							Public health action	1620	280	280											
							Treatment outcome	360	0	9											

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2C. SUMMARY OF PARTNERSHIPS

Name of Reporting State :

Reporting Period : April-June 2020   Date of reporting:15th July 2020

(Information on all the agencies who have signed the contract within state)

Name of PPM options	Coverage			Physical performance					Financial performance till reporting period						Verification details (if applicable)		
	Number of agencies engaged / contracted	Number of districts covered	Population covered under the PPM option	Key indicator	Expected target	Achieved during the reporting period (Quarter)	Achieved during the year	Remarks	Expected for the year	Planned till reporting period	Eligible (invoices) submitted till date for the year	Approved for the year	Disbursed for the year	Remarks	Date of last verification	Discordance (if any)	Remarks