RTI Pl. issue (69) letters

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साधारण डाक द्वारा
BY ORDINARY POST

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
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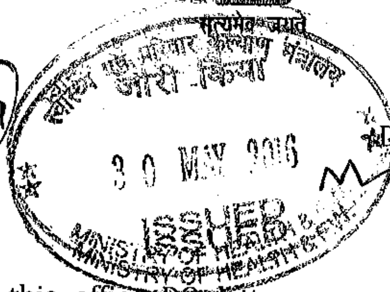
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011



D.O. No.: Z-18015/22/2015-NRHM-II
Dated the 25th May, 2016

Dear Colleague,

Please refer to this office DO letter even number dated 21 February 2016 regarding Bid Agreement and Service level Agreement, which was circulated to States/UTs. Thereafter, the said documents have been slightly revised and the same are enclosed. As you are aware, an important area of focus in NHM is enabling support for comprehensive primary health care. Provision of Primary Health Care enables providing necessary health care close to communities and reduces out of pocket expenditure and the burden on the secondary and tertiary health care facilities. NHM has supported strengthening of infrastructure and augmentation of human resources at the primary and secondary levels. Nonetheless, gaps in provision of comprehensive primary health care remain. In underserved and remote areas, as a measure of gap filling, states could partner with credible NGOs to assure that primary health care is provided to such communities. In order to enable the design of such partnerships, a Model Bid Document (Annexure 1) and a Service Level Agreement (SLA) (Annexure 2) are enclosed herewith.

These documents also draw upon the successful examples of such partnerships implemented across the country. The documents include inter alia, broad principles of the partnership, criteria and processes of selection and appraisal, and guidance for performance based incentives.

The documents are guided by the set of 12 services to be provided as part of the strengthened Health and Wellness Centres (Annexure 3).

I hope that these documents assist you in developing effective partnerships with NGOS as to enable universal and assured primary health care services, particularly for the marginalized and vulnerable.

With warm regards

Yours Sincerely

(Manoj Jhalani)

Encl.:- As above

Principal Secretary (Health) - All States/UTs

Copy to:

Mission Director (NHM) - All States/UTs

O/C

Annexure-I

No_______________

SERVICE LEVEL AGREEMENT

Between

Government of …………

(State Government)

And

…………

(Name of the Concessionaire)

To Operate and Maintain Primary Health Centre and Sub Centre Facilities.

Service Level Agreement

1. BACKGROUND

1.1 **GOVERNMENT OF <STATE>** with a view to providing competent clinical care and community outreach services including public health functions in certain areas in the State, considered it desirable to hand over the functions and responsibilities of maintaining and operating a few selected facilities in these areas to a concessionaire who would be allowed to maintain and operate such facilities in accordance with the terms and conditions laid down in this Service Level Agreement.

1.2 Government of <State> had for this purpose invited bids from eligible bidders. <Name of the Concessionaire > having submitted its bid in response to the tender enquiry and having been found technically qualified as per the conditions in the bid documents, has been awarded the concession by the competent authority in Government of <State> in respect of < Name of the PHC> and Sub Centres < Names of the Sub Centres>. <Name of the Concessionaire> has also performed required obligations after the award of agreement was communicated to it.

1.3 The Government of < State> by this agreement hereby agrees to hand over the Primary Health Centre < Name> and Sub Centres < Names> to < Name of the Concessionaire> for maintaining and operating the facilities for an initial period of five years from the effective date.

1.4 Both Government of <State> and <Name of the Concessionaire> hereby willingly enter into this agreement and agree to abide by all obligations enjoined on them by this agreement.

1.5 This Service Level Agreement would in its scope and meaning would also be treated as a concession contract.

1.6 A concession contract is a contract between the contracting authority (i.e. the Government of <State>) and the concessionaire (i.e. < Name of the Concessionaire>) that sets forth the terms and conditions for maintaining and operating the facilities.

1.7 The term "Facilities" in this agreement would mean < Name of the PHCs> and its Sub Centres <Names of the Sub Centres>. The term "Functions" would mean all clinical care functions, community outreach functions and other public health functions,

which the Central Government, State Government or any other competent authority have enjoined the PHCs and SCs to perform

1.8 The term "Concessionaire" means the legal person or entity which carries out the functions in terms of this agreement in the facilities. In this agreement, < Name of the Concessionaire> is the concessionaire.

2. PRINCIPLES OF THE ARRANGEMENT.

2.1 Both the parties agree to view the arrangements enforced by this agreement as a Public Private Partnership in the Public Health System in India. Such a partnership is seen as a step towards strengthening the Public Health System and as a measure towards facilitating and building the capacity of the state to manage such facilities by demonstrating models for comprehensive PHC, with an emphasis on active community engagement.

2.2 Both parties recognize that the Public Health System in India, despite phenomenal improvements, faces significant challenges. Both parties also recognize that the spirit of such a Public Private Partnership is essentially to share risks and rewards in such a manner so that comprehensive primary health care can be provided to those who need these services. Government of <State> recognizes that such partnerships with organizations that have competence and credibility offers the governments avenues to leverage the knowledge and expertise of such organizations to improve management and delivery of comprehensive primary health care services.

2.3 Both parties are committed to enhance the health and well-being of residents of the area covered by the facilities in this Service Level Agreement by providing high quality service, innovation and development and to meet identified needs within the resources available to both the parties.

2.4 Government of <State> commits that the facilities run by such an arrangement will be treated no differently from other PHCs managed by Government of <State> in terms of financing, training and capacity building.

2.5 The concessionaire agrees and undertakes to implement all national/States health programmes/interventions including outreach activities.

2.6 The concessionaire will, manage and maintain and ensure that the facilities are run in accordance with the Indian Public Health Standards (2012) attached to this agreement at

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Annexure A. In circumstances where IPHS standards cannot be met fully, the state government shall decide on the relaxation of the standards but ensure that facilities are in a working condition through annual inspection.

2.7 The Concessionaire will establish a Rogi Kalyan Samiti within the Primary Health Centre as mandated in the guidelines in a manner similar to that being run by government for a similar level of facility.

2.8 The concessionaire will establish a transparent and "open to public " grievance redressal system within the facility.

2.9 For certain administrative powers such as the issuance of birth and death certificates, the state government would nominate the officer in charge of the nearest government managed facility as the issuing authority.

2.10 The concessionaire agrees that the concession granted will not be treated as a business venture and will not be used to make profits.

2.11 Both parties agree that no money would be collected from the users of the facilities for any clinical consultation and service, diagnostic services or any other service provided in the facilities.

2.12 The concessionaire commits that no new building/ extension to the existing building will be undertaken without the prior written approval of Government of <State>. Failure to adhere to this provision will lead to cancellation of this agreement forthwith and Government of <State> will take over the facilities without any notice.

2.13 The concessionaire commits that any land within the premises of the facilities will not be used in any manner without the prior written approval of Government of <State>. Failure to adhere to this provision will lead to cancellation of this agreement forthwith and Government of <State> will take over the facilities without any notice.

2.14 The concessionaire agrees that by signing this Service level agreement, no rights on the property and assets of the facilities will be transferred to him now or at any future date. The concessionaire will not claim any proprietorial rights on land, buildings or any moveable or immoveable assets situated on the land pertaining to the facilities or in use in the facilities.

3. SERVICE DESCRIPTION AND RESPONSIBILITIES

3.1 The basic unit of service delivery would be the Primary Health Center and all sub centers affiliated to it. The services should include the comprehensive primary health care package encompassing all outreach, behavior change communication for promoting positive health, clinical and public health services. The conditions listed for preventive, promotive or curative action are be broadly categorised into the following groups:

(i) Care in pregnancy and child-birth. (the latter would be provided in specific facilities based on the state context).

(ii) Neonatal and infant health care services

(iii) Childhood and adolescent health care services including immunization.

(iv) Family planning, Contraceptive services and Other Reproductive Health Care services

(v) Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments

(vi) Management of Communicable diseases: National Health Programmes

(vii) Screening and Management of Non-Communicable diseases including health education and promotion for life style related modifications.

(viii) Screening and Basic management of Mental health ailments

(ix) Care for Common Ophthalmic and ENT problems

(x) Basic Dental health care

(xi) Geriatric and palliative health care services

(xii) Trauma Care (that can be managed at this level) and Emergency Medical services

3.2 List of Services to be provided at the PHC and Sub Centre level are given at Annexure B to agreement. Both parties agree that list is an indicative list and not an exhaustive list. The concessionaire agrees to provide AYUSH related treatment for primary health care conditions, and will ensure the availability of an AYUSH provider and related drugs

3.3 The concessionaire hereby agrees that the scope of clinical, outreach and public health services to be provided by the facilities will not be less than the scope of such services to be provided by any similar institutions run by the Government.

3.4 The concessionaire hereby agrees to introduce any new clinical, outreach and public health services should Government of <State> introduce such new services in the PHCs run by it.

3.5 The concessionaire is encouraged to bring in innovative measures to improve the quality of such services.

3.6 The concessionaire is encouraged to use Information Technology to improve the quality of service as also for record management.

3.7 Government of <State> hereby commits to support innovative measures and use of Information Technology by the concessionaire and expresses its readiness to provide financial resources to the extent possible.

3.8 Government of <State> hereby commits that any measures taken across the board to improve the services of the PHCs and its Sub centres in the state would cover the PHC and Sub Centres run by the present partnership arrangement.

3.9 Government of <State> hereby commits that based on the quarterly requisition by the concessionaire, it will provide them with drugs, diagnostics, and other consumables within reasonable time. The Government further agrees that the concessionaire will be allowed to retain at any point of time at least three months' requirement of these items.

3.10 The Government further agrees that in case of emergency, the concessionaire may allow the Medical officer on duty to procure life saving drugs at reasonable prices by local purchase. Procurement of such drugs should not exceed 10 per cent of the total drugs and consumables consumed in a year in terms of value.

3.11 An indicative list of drugs and consumables to be supplied by the Government is at Annexure B to this agreement.

3.12 Both parties agree that timely availability of drugs and consumables are of greatest importance to provision of primary health care. Both parties would therefore try to resolve issues arising in this respect through mutual discussion.

4. Transitional Arrangements

4.1 Both parties agree that an effective start date for operationalizing these facilities will be fixed in mutual consultation between the authorized representatives of Government of <State> and the concessionaire. Such date will be not later than 90 calendar days from the date of signing of this agreement. Government of <State> commits that facilities will be handed over to the authorized representatives of the concessionaire on the effective date. The effective date is therefore the date of handing over the facilities to the concessionaire, after the processes of inspection and repairs have been carried out as described below.

4.2 Within 5 calendar days from the date of signing of this agreement, both the parties will inform each other in writing the names of the authorized representatives.

4.3 Within 15 calendar days from the date of signing of the agreement, the authorized representatives will complete joint inspection of the facilities and prepare list of inventories which will include buildings, plant and machineries, furniture, equipment and any other movable and immovable asset. The list will be signed by the authorized representatives.

4.4 The expenses of such joint inspection will be borne by the respective parties.

4.5 Government of <State> hereby agrees that all minor repairs to the building, plants and machineries, equipment, furniture or any other asset will be carried out at its own expenses before the effective date.

4.6 Government of <State> hereby agrees that if it is determined by both the parties that if major repairs to the building are necessary, the Government will carry out such repairs before the effective date.

4.7 Government of <State> further agrees that if it is determined by both the parties that the facilities cannot be made functional unless the necessary major repairs are carried out, Government of <State> will consider extending the effective date beyond 90 calendar days by a reasonable number of days but not exceeding 365 calendar days from the date of signing of this agreement.

4.8 If the facilities cannot be handed over within 365 calendar days from the date of signing of this agreement, the Concessionaire has a right to withdraw.

4.9 For the purpose of determining major and minor repairs, the codal provisions of the State Public Works Department will be followed.

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4.10 If the concessionaire is willing to carry out repairs on its own without any financial assistance from Government of <State>, Government of <State> will facilitate such repairs. No such repair either before handing over of the facilities or after the effective date can be carried out without written permission of the competent authority in Government of <State>. The competent authority for this purpose will be < Name of the competent authority>.

4.11 Both parties will make a list of drugs and consumables available in the facilities on the effective date. Such list will be kept on record and no financial adjustment will be carried out on account of these stores.

4.12. Notwithstanding the above provisions, the handing over and taking over will take place in the spirit of "as is where is" basis. No party will be required to financially compensate the other for any asset.

5. Financial Arrangements

5.1 Both parties hereby reiterate their commitment not to charge fee for service from any user accessing services provided in the facilities.

5.2 Government of <State> hereby commits to provide financial assistance to the concessionaire to maintain and operate the facilities. The financial assistance will have two components namely "Component X" and "Component Y". "Component X" is in the nature of fixed grant and "Component Y" is in the nature of incentive based on the patient load and performance. 50% of the component Y would be used to provide incentives to the team of service providers and facility management staff. The remainder would be used by the concessionaire for the upkeep of the facility and for further improvements in the facility.

5.3 "Component X" is the fixed sum earmarked for each PHC in the State plus 10 per cent of it. This amount will be paid in two advance instalments on 01 July and 01 January of the financial year. For the purpose of the first grant, the calculation will be done from effective date to 01 July or 01 January, whichever is earlier.

5.4 "Component Y" will be calculated annually and will be paid in two installments in a financial year. The gap between two installments will not be less than six months. The maximum amount of "Component Y" will be Rs 20 lakhs per annum for a 100% increase.

5.6 For the purpose of calculating the amount of "Component Y", the following system will be followed:

Weightage of the criteria

(i) Antenatal Care (weightage 20%) (Maximum available amount: Rs 4 lakhs per annum)

(ii) Institutional delivery: (weightage 20%) (Maximum available amount: Rs 4 lakhs per annum)

(iii) Immunization (weightage 20%) (Maximum available amount : Rs 4 lakhs per annum)

(iv) OPD footfalls (weightage 5%) (Maximum available amount: Rs 1 lakh per annum)

(v) Management of Tuberculosis; HIV, leprosy, Malaria, Kala-Azar, Filariasis, Other vector borne disease- prevention, identification, use of RDT/prompt treatment initiation, vector control measures (weightage 15%) (Maximum available amount : Rs 3 lakhs per annum)

(vi) Percentage population screened for hypertension and diabetes (weightage: 5%) (Maximum available amount: Rs 1 lakh per annum)

(vii) Percentage hypertensives/diabetics controlled (weightage: 5%) (Maximum available amount: Rs 1 lakh per annum)

(viii) Percentage population reached with at least two message for life style change to prevent chronic disease (weightage: 10%) (Maximum available amount: Rs 2 lakh per annum)

Method of calculation

Antenatal Care

$P_{anc} = (CY_{anc} - BY_{anc}) / BY_{anc} * 100$;

$Y_{anc} = P_{anc} * .04$ lakhs

Where CY_{anc} is number of pregnant women who received ante natal care services in the current year; BY_{anc} is the number of pregnant women who received ante natal care services in the base year

Institutional Delivery

$P_{Id} = (CY_{id} - BY_{id}) / BY_{Id} * 100$;

$Y_{Id} = P_{Id} * .04$ lakhs

Where CY_{id} is number of institutional deliveries in the current year; BY_{id} is the number of institutional deliveries in the base year;

Immunisation

$P_{im}=(CY_{im}-BY_{im})/BY_{im}*100;$

$Y_{im}=P_{im} * .04$ lakhs

Where CY_{im} is number of immunization in the current year; BY_{im} is the number of immunization in the base year;

OPD footfalls

$P_{opd}=(CY_{opd}-BY_{opd})/BY_{opd}*100;$

$Y_{opd}=P_{opd} * .01$ lakh

Where CY_{opd} is number of OPD footfalls in the current year; BY_{opd} is the number of opd footfalls in the base year;

Vector borne Diseases

$Pvb=(CY_{vb}-BY_{vb})/BY_{vb}*100;$

$Y_{vb}= P_{vb} * .03$ lakhs

Where CY_{vb} is case load of vector borne diseases; BY_{vb} is the case load of vector borne diseases in the base year;

Diabetes and Hypertension Screening

$P_{dhs}=(CY_{dhs}-BY_{dhs})/BY_{dhs}*100;$

$Y_{dhs}= P_{dhs} * .01$ lakh

Where CY_{dhs} is number of people screened for diabetes and hypertension; BY_{dhs} is the number of people screened for diabetes and hypertension in the base year;

Diabetes and Hypertension Control

$P_{cdh}= (CY_{cdh}-BY_{cdh})/BY_{cdh}*100;$

$Y_{cdh}= P_{cdh} * .01$ lakh

Where CY_{cdh} is number of people with controlled diabetes and hypertension; BY_{cdh} is the number of people with controlled diabetes and hypertension in the base year;

Prevention of Chronic Diseases

$P_{pcd}= (CY_{pcd}-BY_{pcd})/BY_{pcd}*100;$

$Y_{pcd}= P_{pcd} * .02$ lakh

Where CY_{pcd} is number of people who received atleast two messages for life style change to prevent chronic diseases; BY_{pcd} is the number of people who received atleast two messages for life style change to prevent chronic diseases in the base year;

Component Y= $Y_{id} + Y_{opd} + Y_{im} + Y_{vb}$

5.7 For the purpose of these calculations, the base year will be counted as 12 months preceding the effective date. The current year will begin from the effective date and the first year's data will be the data of 12 months beginning the effective date. Subsequently the base year and current year will be determined on the same principle.

5.8 If reasonably reliable data is not available for the base year, the calculation will be based on the current year's data minus 20 percent of the same.

5.9 Government of <State> will provide a refundable mobilization grant of Rs 20 lakhs on the effective date. The component Y will be adjusted against the inception grant. The interest earned on this grant, if any will be treated as income of the facilities.

5.10 The concessionaire hereby agrees to maintain such books of accounts as are commonly required in a commercial enterprise in respect of the facilities. Such books of accounts will commonly include cash book/ bank book; journal and ledger. The concessionaire is encouraged to use computerized software to maintain such accounts. The concessionaire agrees to keep record of all financial transactions pertaining to all activities of the facilities in separate identifiable form.

5.11 The concessionaire further agrees to preserve all books of accounts and supporting documents in respect of the facilities for a period of five financial years following the year in which the transaction has arisen.

5.12 The concessionaire agrees to adhere to the financial year beginning 01 April of a calendar year and ending 31 March of the following calendar year.

5.13 The concessionaire hereby agrees to allow its books of accounts to any annual inspection by any authorized representative of Government of <State>. In addition, the concessionaire agrees to allow its accounts pertaining to the facilities to audit by the Comptroller and Auditor General of India.

5.14 The concessionaire agrees to open separate bank accounts to transact business of the facilities. It further agrees that such bank accounts will not be used for any other facilities.

5.15 The concessionaire agrees that it would prepare annual financial statements comprising Balance Sheet, Income and Expenditure Account and Cash Flow Statement for each financial year. Such accounts will be prepared within three months of the expiry of the financial year.

5.16 The concessionaire further agrees that such accounts will be audited and certified by a competent chartered accountant within five months of the expiry of the financial year.

5.17 The concessionaire agrees that a copy of the annual financial statements, the audit report of the chartered accountant and the concessionaire's comments on the audit report will be submitted to Government of <State> within six months of the expiry of the financial year.

5.18 The concessionaire agrees that the authorized representative of Government of <State> on submission of a written request can inspect any financial document pertaining to the facilities. The concessionaire further commits to take corrective action on any point arising out of such inspection or any audit carried out by any of the above mentioned authorities.

5.19 The concessionaire on the effective date would intimate to Government of <State> in writing the names of individuals who would be responsible for maintaining the accounts.

5.20 The concessionaire hereby agrees that it would make all efforts and put all systems in place to ensure that money received in the facilities is spent lawfully for the purpose it is received.

6. Clinical and outreach services

6.1 All clinical services will be led by a qualified medical officer.

6.2 Ailments which shall not normally require further referral/ specialist care will be treated at the facilities only. Patients will be investigated, (clinical and laboratory) treated and provided drugs free of cost. No charges of any kind will be recovered from the patients.

6.3 Services at the sub center (Health and Wellness Centers shall be provided by the Primary health Care team, supervised by the team at the Primary Health Centre. The sub center shall carry out the functions of outreach-Village Health and Nutrition Day

(VHND), community mobilization, and support and supervision of the ASHA. Ideally the Concessionaire should be able to undertake the functions of support to the Village Health, Sanitation and Nutrition Committee and community based public health functions. If the concessionaire is not equipped to undertake such tasks, the concessionaire will be eligible to tie up with reliable organizations to provide outreach services. The concessionaire however agrees that the responsibility of providing such services will always rests with it and with no other organization.

6.4 The concessionaire agrees to inform Government of <State> in writing the names of such organizations with which such tie up is arranged. The names of office bearers of such organizations as also the names of individuals providing such outreach services should also be intimated to Government of <State>.

6.5 The concessionaire agrees to provide satisfactory replies to any queries raised by Government of <State> on any aspect of such tie ups.

6.6 The concessionaire agrees to terminate such arrangements forthwith without demur on instruction from State Government.

6.7 The concessionaire agrees that under no circumstances any of the services required to be provided would be sub contracted.

7. Referral Process and Eligibility

7.1 Government of <State> hereby agrees to provide the concessionaire with an "information matrix" for nearest public health facilities or private facilities accredited by the state Government including their capacity in terms of existing Laboratory services, diagnostic services, and human resources available.

7.2 It will be the responsibility of the concessionaire to keep the Medical Officer(s) in charge informed of the information matrix. For services not available at the facilities, patients can be referred to nearest facility in accordance with the "information matrix".

7.3 Both parties hereby agree that no patient will be referred to any private medical establishment either formally or informally without specific prior approval of the authorized representative of Government of <State>. Government of <State> will inform the concessionaire the name and designation of such authorized representative for the purpose of this clause.

8. INFORMATION AND REPORTING REQUIREMENTS

8.1 The concessionaire hereby agrees to ensure that information, records and documentation necessary to monitor the agreement are maintained and are available at all times to Government of <State> or its authorised representative for a minimum period of five years. The concessionaire hereby agrees that he and all his staff shall at all times co-operate with the reasonable processes of Government of <State> for monitoring, evaluation and carrying out quality audit and financial audit by any third party authorised by Government of <State>.

8.2 The concessionaire hereby agrees to maintain all relevant data and records of all patients treated at the facilities.

8.3 The concessionaire further agrees to maintain confidentiality of these data and records and commits that such data and records will not be shared with any third party for any purpose.

8.4 The concessionaire agrees that the premises of the facilities/ walls of the buildings / or any part of any equipment will not be used for advertisement or publicity for any product or organization. The authorized messages, posters and other publicity materials authorized by the Central or State Government bodies only will be displayed.

8.5 Government of <State> agrees that the following display in vernacular and Hindi will be allowed in big letters so that it can read from reasonable distance in vernacular and Hindi where applicable.

Primary Health Centre < Name of the Place>

Run by

<Name of the concessionaire>

Agreement No <No of the Agreement>

Between Government of <Name of the State> and <Name of the Concessionaire>"

8.6 The Concessionaire agrees to display copies of this agreement, list of medical equipment available with the facilities, stocks of drugs and consumables at prominent places in the facilities. The names of the Medical Officer and other personnel on duty must also be displayed during duty hours.

9. STAFFING

9.1 The concessionaire will have the option to continue with the Medical Officer(s) and other staff including contractual staff serving in the facilities on a day prior to the effective date. Should the concessionaire refuse this option, the State Government agrees to make alternative arrangements for such staff. This could apply to some or all of the staff. The decision will be based on mutual agreement between the Concessionaire and the staff.

9.2 Both sides agree to make sincere efforts to resolve issues relating to service conditions of the existing staff including contractual staff.

9.3 The roles of ASHA and ANMs and other voluntary staff working under any scheme of NHM would remain unchanged in respect of such facilities run by the concessionaire.

9.4 The Concessionaire commits to ensure that at all times, sufficient suitably trained staff will be posted in the facilities to ensure that services comply with all the statutory requirements and meet patient needs.

9.5 The Concessionaire agrees that it would ensure that a minimum complement of staff mentioned at Annexure A of this Agreement would be in position in the facilities.

9.6 The Concessionaire agrees that a record of qualifications of all staff shall be maintained and it will make such records available for inspection.

9.7 The Concessionaire hereby expresses its commitment to training and staff development and the maintenance of professional knowledge and competence.

10. PERFORMANCE

10.1 An annual monitoring by a team of experts including a mix of external technical specialists shall be undertaken to review the working of the facilities

10.2 State shall use other mechanisms such as HMIS, and external monitoring to assess performance on key indicators.

10.3 A half yearly review meeting will be held and attended by appropriate levels of officials of the Government and Concessionaires to review the performance, the anticipated outcome of the agreement and future service developments and changes. Further meetings may be arranged at any time to consider significant variation in the terms or conduct of the agreement and where corrective action on either party is

indicated. Both the Government and Concessionaire agree to consider introduction of any further service in line with any new initiative of the government or in response to local demand which could not be anticipated earlier

10.4 Both the Government and the Concessionaire agree that such additional services should be provided without extra cost. However, if it is felt by both the parties that the additional services would require additional resources/manpower, the Government agrees to consider reasonable increases in amount disbursed to the Concessionaire based on the cost of additional resources. It is agreed that the Concessionaire will be under no obligation to introduce the additional service unless a commitment to reimburse additional cost has been provided to the concesionaire.

11 HEALTH AND SAFETY

11.1 The Concessionaire agrees to adequately train, instruct and supervise staff to ensure as is reasonably practicable, the health and safety of all persons who may be affected by the services provided under the agreement.

11.2 The Concessionaire agrees that he would collect feedback from all in-patients and at least 25% of out- patients through structured questionnaire at his cost. Responses to the questionnaire will be preserved at least for six months and would be available for scrutiny of the State Government or its authorized representative.

11.3 The concessionaire agrees to display telephone numbers where patients can lodge their complaints in the facilities.

12. DATA PROTECTION, CONFIDENTIALITY AND RECORD KEEPING

12.1 All Service Users have a right to privacy and therefore all information and knowledge relating to them and their circumstances must be treated as confidential. The Concessionaire must advise all staff on the importance of maintaining confidentiality and implement procedures which ensure that Service User's affairs are only discussed with relevant people and agencies.

12.2 The Concessionaire shall comply with all legislations, which otherwise would have been applicable had the services been run directly by the Government agencies.

13. VARIATION

13.1 This Service Level Agreement may not be varied unless a variation is agreed in writing and signed by all parties.

14. DISPUTES

14.1 The agreement shall be governed by and interpreted in accordance with the laws of India for the time being in force. The Court located at the place of issue of agreement shall have jurisdiction to decide any dispute arising out of in respect of the agreement. It is specifically agreed that no other Court shall have jurisdiction in the matter.

14.2 Both parties agree to make their best efforts to resolve any dispute between them by mutual consultations.

15. ARBITRATION

15.1 If the parties fail to resolve their dispute or difference by such mutual consultations within thirty days of commencement of consultations, then either the Government or the Concessionaire may give notice to the other party of its intention to commence arbitration, as hereinafter provided. The applicable arbitration procedure will be as per the Arbitration and Conciliation Act 1996 of India. In that event, the dispute or difference shall be referred to the sole arbitration of an officer as the arbitrator to be appointed by the Government. If the arbitrator to whom the matter is initially referred is transferred or vacates his office or is unable to act for any reason, he / she shall be replaced by another person appointed by the Government to act as Arbitrator.

15.2 Services under this agreement shall, notwithstanding the existence of any such dispute or difference, continue during arbitration proceedings and no payment due or payable by the Government shall be withheld on account of such proceedings unless such payments are the direct subject of the arbitration.

15.3 Reference to arbitration shall be a condition precedent to any other action at law.

15.4 Venue of Arbitration: The venue of arbitration shall be the place from where the agreement has been issued.

16. BREACH

16.1 If either Party breaches the Contract or these Terms and Conditions and fails to remedy such breach within------ days of written notice from any other Party calling

for the breach to be remedied, then the non-breaching Party shall be entitled, without prejudice to any other rights that it may have in law, whether under the Contract or otherwise, to cancel the Contract without notice or to claim immediate specific performance of all the defaulting parties.

17. PENALTY

17.1 If the concessionaire fails to provide services stipulated in the agreement, the States Government shall be entitled to, unless otherwise agreed upon, as a penalty an amount of --- or shall be entitled to deduct the amount from the payments due to the concessionaire.

18.Force Majeure

18.1 No penalty or damages shall be claimed in respect of any failure to provide services which the Concessionaire can prove to be directly due to a war, sanctions, strikes, fire, flood or tempest or Force Majeure, which could not be foreseen or overcome by the concessionaire or to any act or omission on the part of persons acting in any capacity on behalf of concessionaire provided that the concessionaire shall at the earliest bring the same to the notice of the State Government.

19. TERMINATION

19.1 Either party may terminate this agreement by giving not less than 3 months' notice in writing to the other. This notice shall include reasons as to why the agreement is proposed to be terminated. This provision will however not be applicable for violations of Clauses 2.7 and 2.8 of this agreement.

19.2 The Government may terminate the agreement, or terminate the provision of any part of the Services, by written notice to the Concessionaire with immediate effect if the Concessionaire is in default of any obligation under the agreement, where

a. the default is capable of remedy but the Concessionaire has not remedied the default to the satisfaction of the Government within 30 days of at least two written advice after service of written notice specifying the default and requiring it to be remedied; or

b. the default is not capable of remedy; or

c. the default is a fundamental breach of the agreement

19.3 If the Government terminates the agreement and then makes other arrangements for the provision of the Services, it shall be entitled to recover from the Concessionaire any loss that had to be incurred due to such sudden termination of agreement.

19.4 Both the parties agree that no further payment would be made to the Concessionaire, even if due till settlement of anticipated loss as a result of premature termination of the agreement.

19.5 The Government reserves the right to terminate the agreement without assigning any reason if services of the concessionaire create serious adverse publicity in media and prima facie evidence emerges showing negligence of the Concessionaire.

19.6 At the time of termination, the concessionaire agrees to hand over all moveable and immoveable assets to the authorized representative of the State Government on a mutually agreed date on "as is where is" basis.

19.7 The concessionaire agrees that no asset will be moved out of the premises or destroyed other than consumables used during the normal course of operation of the facilities, at any time during the period from the effective date to the date of termination without the prior written approval of the State Government.

19.8 The concessionaire agrees that the date of handing over in terms of clause 16.6 above will not be more than 15 calendar days from the date of termination.

20. Indemnity

20.1 By this agreement, the Concessionaire indemnifies the Government of <State> against damages of any kind or for any mishap/injury/accident caused to any personnel/property of the facilities.

20.2 The Concessionaire agrees that all liabilities, legal or monetary, arising in any eventuality shall be borne by the Concessionaire.

21. Compliance with existing laws

21.1 The concessionaire agrees to abide by all laws of the land as will be applicable for operation and maintenance of the facilities.

1. **Signed for and on behalf of the Government of <State>**

Signed:..

Name: ....

Designation:..

Date:..

2. Signed for and on behalf of the Concessionaire:

Signed:..

Name: ....

Designation: ....

Date: ....

Witnesses:

1) ____

2) ____

3) ____

Annexure-II

Draft

Bid Invitation Notice for "Public –Not for Profit Partnerships" in the Operation and Maintenance of Primary Health Centres and Sub Centres

Date of Issue of Invitation of Bids ____________________

Last Date for Submission of Bid: 3 P.M. on ____________________

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1. Introduction

1.1 India has made rapid progress in the past few decades in the Public Health System as reflected improvements in key parameters such as Infant, Child and Maternal Mortality Rates, Total Fertility Rate, and Crude Death Rates. There has been improvement in expanding access and coverage in much of the country. This has largely been achieved by strengthened public health systems over the years, and substantially accelerated by the National Health Mission (NHM). NHM support was largely targeted towards improving primary health care and some components of secondary care- i.e strengthening service delivery at district and sub district levels.

1.2 Despite these improvements, comprehensive primary health care in India is yet to be made fully universal. Access to primary health care remains uneven across the length and breadth of the country. The wide variations in capacity, governance and institutional structures and state investments in health have determined the extent to which the NHM support has improved health care particularly for the vulnerable, marginalized and those living in underserved areas such as remote rural geographies and urban slums.

1.3 Inadequate primary health care is reflected in the escalating demand for secondary and tertiary care services resulting in overcrowding of facilities at these levels leading to high costs and poor health care. There is enough evidence to demonstrate that quality primary health care mitigates costs and suffering.

1.4 With a view to further improving the quality of the primary health care in terms of clinical care and outreach services, **GOVERNMENT OF <STATE>**, considers it desirable to hand over the functions and responsibilities of operating and maintaining a few selected Primary Health Centres (PHCs) combined with its Sub Centres (SCs) in selected areas to a concessionaire who would be allowed to maintain and operate such facilities in accordance with the terms and conditions laid down in this Service Level Agreement. Government hopes that this would bring about considerable improvement in provision of competent clinical care and community outreach services including public health functions in these areas in the State.

1.5 Government views the arrangements as Public Private Partnership in the Public Health System in India. Such a partnership is seen as a step towards strengthening the Public Health System and as a measure towards facilitating and building the capacity of the state to manage such facilities by demonstrating models for comprehensive PHC, with emphasis on active community engagement.

1.6 The partnership will be initially for a period of five years subject to review and confirmation of the arrangement after one year. Annual performance reviews shall be undertaken. At the end of the fifth year, renewal of the partnership will be considered on the basis of the evaluation conducted by an external agency.

1.7 Such partnership should not be seen as a measure of the government, abdicating its responsibility to provide public health services, but rather as a transitional measure towards facilitating the state to be able to manage such facilities after the term of the partnership ceases. Under some circumstances- Left Wing Extremism (LWE) affected areas, remote areas, a longer term partnership over several years could be necessary, but even here ultimately the state must equip itself to provide such services.

1.8 The spirit of such a Public Private Partnership is essentially to share risks and rewards in such a manner so that comprehensive primary health care can be provided to those who need these services. Government recognizes that such partnerships with organizations that have competence and credibility offers the governments avenues to leverage the knowledge and expertise of such organizations to improve management and delivery of comprehensive primary health care services.

1.9 Government expects that the concession granted will not be treated as a business venture and will not be used to make profits. Recognizing that a reasonable surplus of income over expenditure annually will be desirable for sustainability of the PPP arrangement, the concessionaire would be allowed to retain the 10% assigned as overhead over the fixed component. (Defined in Para 5.3 of the Service level Agreement).

1.10 Bidders may note that this is an invitation for bids solely comprising of technical bid without an accompanying financial bid.

2. Definitions

2.1 Concession: Concession is the permission accorded by the Government to operate and maintain one or more "facilities" for a definite period.

(b) Concessionaire: The term "Concessionaire" means the legal person or entity which is awarded the concession to carry out the functions in terms of the Service level agreement in the facilities.

(c) Facilities: Facilities would mean a set of one Primary Health Centre and Sub Centres attached to it.

(d) Service level agreement: Service Level Agreement would in its scope and meaning would also be treated as a concession contract. A concession contract is a contract between the contracting authority and the concessionaire that sets forth the terms and conditions for maintaining and operating the facilities.

3. SERVICE DESCRIPTION AND RESPONSIBILITIES

3.1 The basic unit of service delivery would be the Primary Health Center and all sub centers affiliated to it. The services should include the comprehensive primary health care package encompassing all outreach, including behavioral change through health education and health promotion, clinical and public health services. The conditions listed for preventive, promotive or curative action is be broadly categorized into the following groups:

(i) Care in pregnancy and child-birth. (The latter would be provided in specific facilities based on the state context).
(ii) Neonatal and infant health care services and nutrition
(iii) Childhood and adolescent health care services including immunization.
(iv) Family planning, Contraceptive services and Other Reproductive Health Care services
(v) Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments
(vi) Management of Communicable diseases: National Health Programmes
(vii) Screening, and Management of Non-Communicable diseases including promotion of healthy life style
(viii) Screening and Basic management of Mental health ailments
(ix) Care for Common Ophthalmic and ENT problems
(x) Basic Dental health care

(xi) Geriatric and palliative health care services
(xii) Trauma Care (that can be managed at this level) and Emergency Medical services

3.2 List of Services to be provided at the PHC and Sub Centre level are given at Annexure A attached to this Notice. This is an indicative list and not an exhaustive list.

4. Bid Invitation

4.1 Government of <State> invites bids from organizations eligible under Clause ______ of this notice to operate and maintain the following Primary Health Centres(PHC) and the Sub Centres(SCs) attached to the PHCs. The PHCs to be covered include:

(a) PHCs in blocks with low performance indicators i.e., low coverage on immunization, OPD, and poor coverage of Village Health and Nutrition Days
(b) PHCs with high vacancies in MO/Staff nurses for over two years

c) In urban slums – organizations which have the infrastructure to provide primary health care where government infrastructure does not exist.

Sl No	District	Name of the Primary Health Centre	Sub Centres attached to the PHC

4.2 One PHC and Sub Centres attached to it will together be termed as "Facilities". Bidders are invited to bid for more than one "Facilities". Government reserves the right to decide on the number of facilities for which concession to operate and maintain will be awarded to any bidder.

4.3 Successful bidders who are granted the concession will be required to complete the formalities enjoined in this Notice and will have to sign the Service level agreement for each of the facilities. A draft Service level agreement is attached to this Notice.

4.4 Bidders are encouraged to study the draft Service level agreement and other conditions carefully.

5. Eligibility

5.1 The following Organizations are eligible to apply:

(a) Registered Society with provision of health services, health care, primary health care, or any other health related services in its memorandum of association;

(b) Trust formed to solely provide health services, health care, primary health care or any other health related services;

(c) Medical colleges including private medical colleges;

(d) Hospitals run under the aegis of Public Sector and Government Companies and Institutions;

(e) Section 8 Companies under the Companies Act 2013 (erstwhile Sector 25 Companies under Companies Act 1956) with provision of healthcare as one of the businesses in the memorandum of association.

5.2 To be eligible to apply, an organization must be in existence for at least 5 years as on 31 December 2015. Organizations established after 31 December 2010 are not eligible to apply.

5.3 One person Companies are not eligible to apply.

5.4 The Organizations must produce demonstrable and verifiable evidence of providing clinical, outreach and public health services at the primary healthcare level for a minimum period of five years continuously.

5.5 The Organization must have must have medical (MBBS), paramedical and community health staff on the rolls for more than three years in the last five years.

5.6 The Organization must have an annual expenditure /turnover of at least Rs 25 lakhs per annum for the last five financial years preceding the current year.

5.7 The Organization must be willing to sign the service level agreement.

6. Bid Proposal

6.1 The Organizations fulfilling the above conditions may submit the following information/ documents along with a covering letter on its letterhead (Page 1) indicating clearly the facilities that they would seek concession to operate and maintain.

(i) Name, Address, Registration details of the Organization (Information) (Page 2);

(ii) Copy of the Registration Certificate or equivalent certificate (Document 1);

(iii) Copy of the Memorandum of Association or equivalent document (Document 2);

(ii) Names of the Office Bearers along with their addresses for the last five years (in case of Trusts and Registered Societies) / Names of the key Personnel along with their addresses for Other Organizations for the last five years / Names of the key personnel for the last five years (Information)(Page 3-7);

(iv) Annual Reports of last three years (Documents 3-5) (In case of hospitals run by the PSUs, annual reports of the PSUs; (Organizations not preparing annual reports should provide legitimate reasons for not preparing the same.)

(v) Copy of the resolution of the competent authority in the Organization authorizing the signatory to respond to this invitation (Document 6);

(vi) Annual Financial Statements duly audited with audit report attached for the last 5 years preceding the current year (Documents 7-11)

(vii) A document containing the vision, mission and organizational structure of the Organization (Document 12);

(viii) A document containing details of the activities undertaken by the Organization during the last five years (Document 13);

(ix) A document containing the details, which inter alia must include the names, addresses and educational qualifications, of key personnel employed by the Organization during the last five years including those employed at the time of submission of this bid (Document 14).

(x) A short document containing a maximum of ten achievements of the Organization during its lifetime clearly indicating outputs and outcome (Document 15).

(xi) A short document containing descriptions of activities of the Organization in the primary health care system in any parts of India emphasizing (a) geographical area (b) outputs (c) manpower dedicated to projects (d) outcome (Document 16).

(xii) A document containing the IT capacity of the Organization indicating capacities in terms of (a) hardware (b) application software (c) usage (Document 17).

(xiii) Income Tax and Other Tax registration certificates (Document 18).

(xiv) An undertaking that the Organization is willing to sign the service level agreement. (Document 19).

(xv) A certificate that no criminal/civil case is pending against the Organization or any of its office bearers in any Court (Document 20).

(xvi) A document containing details of any past criminal or civil case against the Organization or any of the Office bearers. A NIL certificate will be required. (Document 21).

(xvii) A certificate that the bidder has never been "blacklisted"/ debarred from participating in any tendering process by any State Government/ Central Government institutions. The bidder may provide details of circumstances of the cases.

6.2 The bid proposals will have to be accompanied by Earnest Money Deposits submitted separately. Registered Societies and Trusts will have to pay an EMD of Rs 10,000 (Rupees Ten Thousand only) in the form of a Demand Draft or Banker's Cheque. Others will have to pay an EMD of Rs 100,000 in the form of a Demand Draft or Banker's Cheque. The EMD will be refunded after selection of the successful bidder. No interest will be paid on the EMD.

6.3 Bid proposals not accompanied by EMD will not be opened. EMD of the bidder will be forfeited if it is discovered that the bidder has submitted false or forged or incorrect or misleading documents or information.

6.4 All these information and documents must be submitted with clear indication of the Page Number/ Document Number as per above. In case the document contains more than one page, it should be properly bound and identified with clear heading on the first page. All pages must be signed by the authorized signatory.

6.5 The bid proposals shall be valid for a minimum of 180 days. Government may should the circumstances so require request the bidders to extend the validity beyond 180 days.

7. Financial Bid

7.1 No financial bid is required to be submitted. The proposed financial arrangements may be seen in the draft service level agreement.

8. Methodology of selection

8.1 The State Government will form a technical committee of experts with 5 members comprising both internal and external experts. The number of external experts will be at least two. The internal and external experts will provide a signed certificate that they are not and were not associated during the last 10 years, either directly or indirectly, with any of the organizations that will be considered by the Committee for last ten years.

8.2 A list of the key criteria that could be used to appraise and rank proposals is attached at Annexure 2. States could add additional criteria, but would retain the key criteria. Each criterion would be assigned a weightage to be decided by the technical committee, since this could vary between states and depends on the context. The technical committee must meet

once before the opening of bids to review the criteria and assign weightage based on which the proposals would be ranked. The bids will not be opened unless the criteria and weightage for ranking the proposals have been finalized.

8.3 The technical bids will be opened on a pre-decided date, venue and time that will be communicated to all bidders at least 10 days in advance. The bidders will be allowed to be present during the opening of the bids.

8.4 All technical proposals will be placed before the technical committee. The committee will rank the proposals based on the criteria decided beforehand by awarding score for each criteria. The first three ranked proposals would be shortlisted for field appraisal.

8.5 The technical committee will also devise scoring system for field appraisal.

8.6 A team to be formed by the State Government will undertake field appraisal of the bidders within 45 days of the date of finalization of ranking. It is desirable that at least one member of the technical committee would be an observer for the field appraisal process. The report of the appraisal team will be placed before the Committee.

8.7 Final ranking of the bidders will be done by the technical committee by adding rank scores and field appraisal scores.

8.8 The bidder with the highest score will be ranked No 1 and will be offered the concession.

9. Post Selection Procedures

9.1 The State Government will conduct the required enquiries about the Organization selected.

9.2 After approval of the competent authority in the State Government, the Organization will be informed in writing of its selection for the concession. This will be the letter of award of the concession.

9.3 Within 15 days of the issue of the letter of award of the concession, the Organization will be required to inform the State Government in writing of its acceptance or otherwise of the award failing which, the Government will be free to offer the concession to the 2nd rank holder.

9.4 The Organization on acceptance must provide the State Government a bank guarantee for Rs 200,000 (Rs Two lakhs only) from a nationalised bank valid for a period of minimum six years.

9.5 On completion of these formalities, the State Government will inform the Organization the date of signing the service level agreement.

10. Other Conditions

10.1 The State Government at its discretion may hold a pre-bid meeting.

10.2 Once the bid is submitted, no additions/ alterations will be allowed or entertained.

10.3 If any bidder submits additional documents after the last date of submission of bid is over, such documents will not be considered and will not be placed before the technical committee.

10.4 Any effort of any bidder to bring in extraneous influence on the selection process will lead to summary rejection of the bid.

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Annexure A: List of services to be provided

	Health Condition: Numbers / 1000/yr	Care in the Community/Household visits/Community level meetings/School health Delivered by ASHA/AWW/School teacher	Care at the Sub Center outreach sessions Delivered by ANM/Mid el service provider	Care at the first referral site- PHC
1.	Care In Pregnancy-Maternal Health. 20 to 30/1000 population	Early diagnosis of pregnancy, Counselling, support throughout pregnancy and delivery and motivation for institutional delivery, Nutritional information, Hygiene, Nutrition, Enabling Take Home Rations (THR) for pregnant woman through Anganwadi Worker, Identifying high risk births, facilitating referrals, helping birth planning, post partum complication identification/support	Early registration, Regular Ante-natal check-ups; includes Screening for Hypertension, Diabetes, Anaemia, Immunization for mother - TT, Iron-folic Acid & Calcium Supplementation , MCH cards, Identification of High Risk Pregnancy and referral Antenatal High Risk Cases. Post Natal Cases High Risk, Abortions, ***Normal Vaginal Delivery in specified delivery sites where Mid level provider or ANM is trained as a Skilled Birth Attendant***	Stabilization Antenatal in High Risk Cases. Post Natal Cases High Risk, Normal Vaginal Delivery, Complicated Deliveries Ante-Partum & Post-Partum Haemorrhage, Ecclampsia, Puerperal Sepsis,
2	Neonatal and Infant Health (0 to 1 years of age) 20/1000 population	:6 house hold visits in neo-natal period for improved newborn care practices, identification and care of low birth weight/preterm newborn (with referral as required) , counselling and support for early Breast Feeding, improved weaning Practices, Identification of Birth Asphyxia, sepsis, . Identification of congenital anomalies and appropriate referral Family/community education of Prevention of infections -ARI/Diarrhoea- identification and initiation of treatment- ORS/	Complete Immunization, Vitamin A Supplementation, Monitoring and assisting VHND : Care of Common illnesses of new born, AGE with mild dehydration, pneumonia case management, Treat, stabilize and refer sever cases. Where deliveries take place: asphyxia management, newborn screening;	Birth Asphyxia, severe ARI, Diarrhoea management, treat,
3	Child health,	Growth Monitoring, Prevention	Detection & Treatment	Management of

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	Health Condition: Numbers / 1000/yr	Care in the Community/Household visits/Community level meetings/School health Delivered by ASHA/AWW/School teacher	Care at the Sub Center outreach sessions Delivered by ANM/Mid el service provider	Care at the first referral site- PHC
	Adolescent health 234 children/1-10 Years of age 143adol./11-18 years of age	through IYCF counselling, access to food supplementation- all linked to ICDS Detection of SAM, referral and follow up care for SAM. Prevention of Anaemia, use of iodised salt; de-worming Prevention of diarrhoea, prompt and appropriate treatment of diarrhoea/ARI, referral where needed. Pre-school and School Child: Biannual Screening, School Health Records, Eye care, De-worming; Adolescent Health services: peer counselling, life skills education, personal hygiene,	of Anaemia and other deficiencies in children and adolescents Early detection of growth abnormalities, delays in development and disability Prompt Management of ARI and fever, Skin Infection, acute Diarrhoeas, Adolescent health-counselling, referral as per need	SAM children, severe anaemia, or persistent malnutrition, Severe Diarrhoea, & ARI management, Diagnosis and follow up plan for disability and delays in development
4	Reproductive health and Contraceptive Services 170 eligible couples-	Preventive education for early marriage, Identifying eligible couples, and motivating for Family Planning- delaying first child, spacing between two children, Access to spacing methods- OCP, ECP, condoms. Education and mobilizing for action against gender based violence Knowledge of and referral for RTI/STI, recognition of gender based violence	Counselling for Family Planning. Access to all spacing methods including IUCD Medical abortion RTI treatment-Syndromic First aid for GBV- link to referral centre and legal support centre.	IUCD, Vasectomy, Tubectomy, RTI/STI diagnosis and treatment, Manual vacuum aspiration, Hormonal & menstrual disorders tract infections and
5	Management of Chronic Communicable Diseases- Approx. 6 to 20 cases. – plus 1000	Tuberculosis; HIV, leprosy, Malaria, Kala-Azar, Filariasis, Other vector borne disease- prevention, identification, use of RDT/prompt treatment initiation, vector control measures examination, follow up medication compliance- - Prevention – mass drug administration in filariasis, immunization for Jap B, RDK testing and treatment for	Tuberculosis; HIV, leprosy, Malaria, Kala-Azar, Filariasis, Other vector borne disease Diagnosis treatment plan, follow up diagnostics, RDK + Lab testing and treatment for all vector borne disease	Confirmation of diagnosis, Management of Complications, Treatment Plan

	Health Condition: Numbers / 1000/yr	Care in the Community/Household visits/Community level meetings/School health Delivered by ASHA/AWW/School teacher	Care at the Sub Center outreach sessions Delivered by ANM/Mid el service provider	Care at the first referral site- PHC
		malaria		
6	Management of Common Communicable Diseases & Basic OPD care- (acute simple illness)	Symptomatic care for fevers, URIs, LRIs, diarrhoeas, Skin infections/Abscesses- identify/refer Symptomatic care for aches and pains	Diagnosis and management of common fevers, ARIs and diarrhoeas, and skin infections. (scabies, abscess) Management of common aches, joint pains, common skin conditions, (rash/urticaria) Indigestions, gastritis Acute febrile illness,	Diagnosis and Management of all fevers, gastroenteritis and skin infections,
7	Management of Common Non-Communicable Diseases	1. Hypertension- Screening, Primary and Secondary Prevention 2. Diabetes mellitus – Screening , Primary and Secondary Prevention 3. Silicosis, Fluorosis – Preventive action, early case identification, 4. Chronic Obstructive Pulmonary disease (COPD), and Asthma: Early detection, prevention- primary and secondary, 6. Epilepsy- early case identification, Mobilize +35 age group for NCDs for screening at Village Level	Hypertension- Medication, enable specialist consultation, Follow up measurements, Diabetes mellitus – Medication, follow up diagnostics, enable specialist consultation early referral for complications Cancers - Cervical, Breast, Oral- Screening, early referral. Silicosis, Fluorosis – follow up care Chronic Obstructive Pulmonary disease (COPD), and Asthma- Medication, follow up care	Hypertension- Medical management Diabetes mellitus – Medical management including complications Diagnosis, part of treatment and follow up- Cervical, Breast, Oral Silicosis, Fluorosis – diagnosis, Chronic Obstructive Pulmonary disease (COPD), and Asthma- diagnosis, treatment plan Epilepsy- diagnosis, treatment plan

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	Health Condition: Numbers / 1000/yr	Care in the Community/Household visits/Community level meetings/School health Delivered by ASHA/AWW/School teacher	Care at the Sub Center outreach sessions Delivered by ANM/Mid el service provider	Care at the first referral site- PHC
			Epilepsy- Medication, early referral for complications.	
8	Management of Mental Illness	Screening for mental illness- using screening questionnaires/tools Community education and Preventive measures against Tobacco use and Substance Abuse, Identification of people for De-Addiction Centres,	Detection and referral of mental illness, follow up medication, counselling/support Confirmation and referral for de-addiction Management of Violence related concerns	Diagnosis and Treatment Plan for mental illness.
9	Dental Care	Education on Oral Hygiene & Substance Abuse, in community and schools- dental fluorosis- recognition	Dental hygiene - Screening for gingivitis, dental caries, oral cancers Treatment for glossitis, candidiasis (look for underlying disease), fever blisters, aphthous ulcers;	Tooth abscess, dental caries, scaling, extraction,
10	Eye Care/ENT care	School : Screening for blindness and refractive errors, Community screening for congenital disorders and referral, Counselling and support for care seeking for blindness, other eye disorders -first aid for nosebleeds, screening for congenital deafness, recognizing acute suppurative otitis media, other common ENT conditions, referral	Eye care in newborn, Screening for visual acuity, cataract and for Refractive Errors, Identification & Treatment of common eye problems- conjunctivitis; spring catarrh, xerophthalmia, first aid for injuries, referral Management of common colds, ASOM, injuries, pharyngitis, laryngitis, rhinitis,URI, sinusitis	Cataract Blindness, Glaucoma, Trachoma,

	Health Condition: Numbers / 1000/yr	Care in the Community/Household visits/Community level meetings/School health Delivered by ASHA/AWW/School teacher	Care at the Sub Center outreach sessions Delivered by ANM/Mid el service provider	Care at the first referral site- PHC
11	Geriatric Care	Support to family in palliative care	Management of common geriatric ailments; counselling, supportive treatment, Pain Management and Provision of palliative care with support of ASHA	Referral care, diagnosis and treatment plans
12	Emergency Medicine	First Aid and First responder training for school teachers, Anganwadi workers and ASHAs.	Snake bites, scorpion stings, insect bites, dog bites Stabilization care in poisonings, trauma of any cause Minor injury, abscess management	Treatment of poisoning, management of simple fractures, basic surgery and surgical emergencies.

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Annexure B: Criteria for screening and ranking proposals

All eligibility conditions detailed in the Bid document must be met. For technical screening the reviewer will assess the bid against the five major criteria listed below. Each of the five criteria is allocated twenty points. Within each criteria there are suggestions for additional weightage which states can modify based on their specific contextual challenges.

1. **Organization's work in inaccessible areas (Twenty points):**
   Experience of five years or more,
   - working **in** remote, rural areas
   - high priority districts/blocks or urban slums (if agency is being selected for urban PHC).
   - Left Wing extremism affected districts
   - Areas where there are no facilities for primary health care within a half hour walking distance
   - Working with vulnerable populations such as SC/ST, Minorities, Homeless, Migrants
   - Experience in establishing a referral network for secondary care - Experience in using public sector facilities for referrals would be preferred.
   - Experience in making available basic drugs and diagnostics/linkages for such services that are sensitive to poor and marginalized groups.

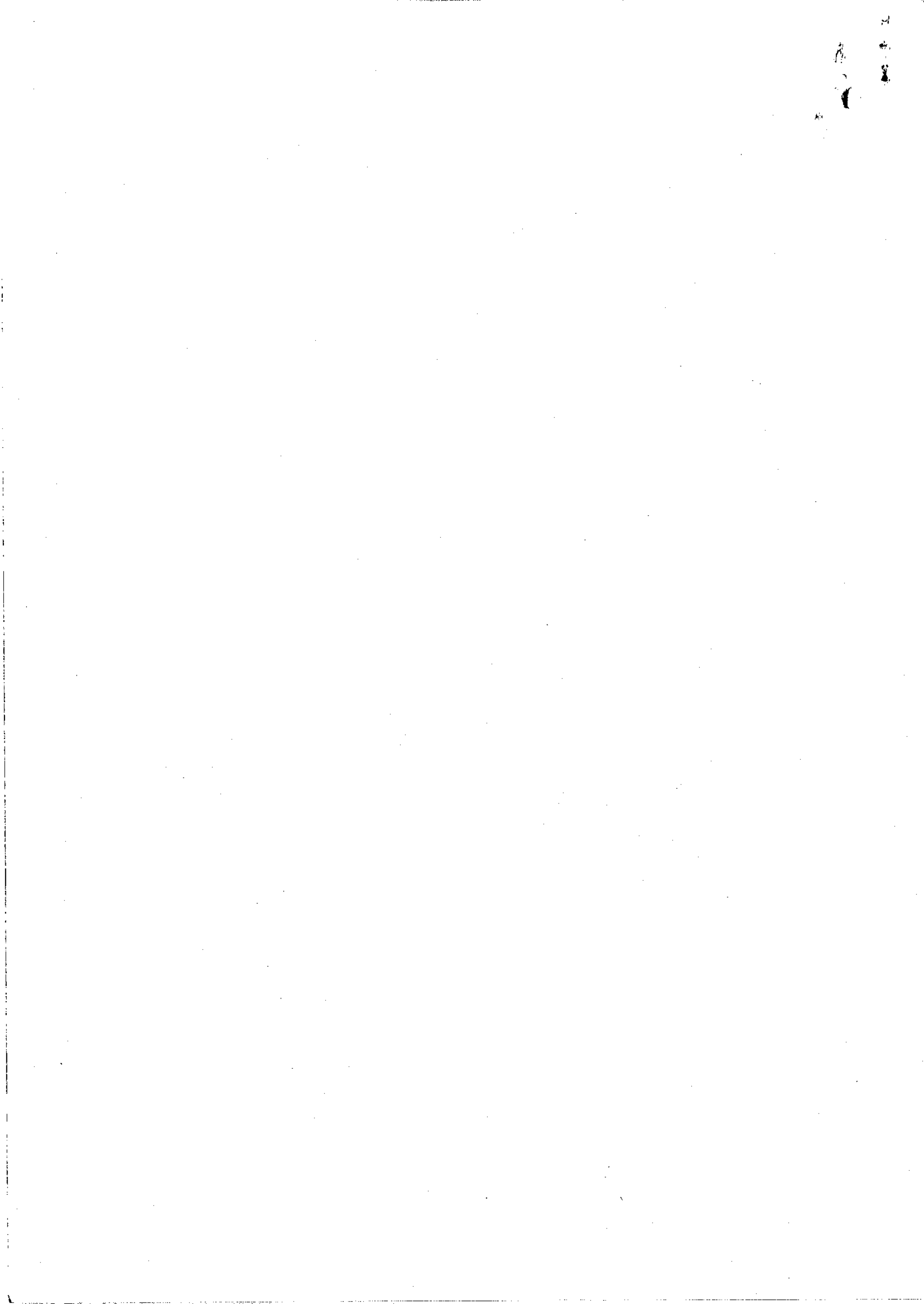
2. **Range of Services provided: (Twenty Points)**
   - Experience in providing comprehensive primary health care services **would be preferred over single, vertical interventions-** such as eye care, or TB control alone, or HIV/AIDS alone.
   - Experience of providing reproductive and child health services
   - Experience in service delivery for marginalized populations through the use of Mobile Medical Units, or innovative combinations of clinic and referral services
   - Evidence of robust monitoring and information systems for data collection and feedback.

3. **Outreach/Community Based services: (Twenty Points)**
   - Experience in community based health education and promotion would be preferred over those agencies that have clinical care experience alone.
   - Experience of providing community level outreach services- through camps or clinics,
   - Experience in building or strengthening community collectives (village committees, Self Help Groups - SHGs, Panchayati Raj Institutions- PRIs) for health related interventions

4. **Staffing: (Twenty Points)**
   - Has appropriate number of staff with an optimum skill mix to deliver primary health care services for at least three years

- Has demonstrated ability to undertake skill based training
- All staff have received regular, in service training.
- Agencies who demonstrate a core staff of an optimum number of medical officers (allopathy and AYUSH), Staff nurses and ANMs in position for over three years would be given added weightage.

5. **Undertaking community level public health interventions: (Twenty Points)**
   - Experience of undertaking water and sanitation activities and vector borne control interventions,
   - For those that do not have this experience, demonstration of partnership with such agencies to provide such services in their intervention areas.



Annexure-III

Health and Wellness Centre

The set of 12 services to be provided are as under:

1. Comprehensive maternal health care services-delivery services to be provided in those sites equipped to serve as "delivery points".
2. Comprehensive neonatal and infant health care services.
3. Comprehensive childhood and adolescent health care services.
4. Comprehensive contraceptive services.
5. Comprehensive reproductive health care services.
6. Comprehensive management of communicable diseases.
7. Comprehensive management of non communicable diseases.
8. Basic ophthalmic care services.
9. Basic ENT care services
10. Screening and basic management of mental health ailments.
11. Basic dental health care
12. Basic geriatric health care services.