

REQUEST FOR PROPOSAL (RFP)

Subject: *Engagement of a Third-Party Agency to set up, run and document Three Learning Labs for Comprehensive Primary Health Care in Bihar*

Learning Lab 1 — Urban PHC Reliability: optimising service delivery at Urban Primary Health Centres, Patna city

Learning Lab 2 — Teleconsultation Connect and Quality: teleconsultation activation and quality, state-wide, including tele-mental health

Learning Lab 3 — Sakhi Arogya Linkage: women's collectives linked to Arogya Mandirs, one rural block of Patna district

ISSUE DATE: 24.10.2026

SUBMISSION DEADLINE: 3.11.2026

SUBMISSION MAIL ID: IN-Procurement4@jhpigo.org (for submission of proposals)

Contact for queries only: ashishKumar.SinhaAdmin@jhpigo.org

BID OPENING: 05.11.2026

AWARD / START DATE (selection of agency): 20.11.2026

ASSIGNMENT PERIOD: Work Order date through 31 March 2027

Introduction about Jhpiego India:

Jhpiego works in India across various health areas such as maternal and child health, family planning and comprehensive primary health care (CPHC) in collaboration with the Government of India.

In India, Jhpiego works across various states in close collaboration with national and state governments, providing technical assistance in the areas of family planning, maternal and child health, strengthening human resources for health, non-communicable diseases and digital health. These programmes are funded by USAID, Bill & Melinda Gates Foundation, David & Lucile Packard Foundation, Children's Investment Fund Foundation (CIFF), MSD for Mothers and other anonymous donors.

This RFP includes the following:

Section 1 — Instructions to Bidders

Section 2 — Technical Proposal: Standard Forms

Section 3 — Scope of Work

Section 4 — Financial Proposal (separately as a password-protected file)

Section 5 — Payment Schedule

Section 1 — Instructions to Bidders

1.1 General instructions

1. **Clarification and amendment of RFP documents.** A bidder may request a clarification at the contact given on the cover page, in writing, no later than the clarification deadline. Clarifications and any amendment will be issued to all bidders who have received this RFP.
2. **Proposal validity.** Proposals must remain valid for a minimum of 30 days after the submission date. Should the need arise, Jhpiego may request bidders to extend the validity period of their proposals.
3. **Preparation of the bid.**
 - a) The bidder must submit a Technical Proposal in the forms provided in Section 2, together with the documents listed under the eligibility criteria below.
 - b) The Financial Proposal must be prepared in accordance with 3.13 of the Scope of Work (Budget) and submitted in the format at Section 4.
 - c) All applicable taxes must be included by the bidder in the Financial Proposal and shown separately.
 - d) A proposal submitted after the deadline is liable to be rejected; only the Procurement Committee may consider a late proposal in a specific situation.
 - e) Incomplete application forms are liable to be rejected. No further correspondence will be entertained from rejected applicants.
 - f) The application must be signed by the authorised signatory, confirming that all details furnished are true and correct to the best of his or her knowledge, and that in case any false information or suppression of material information is furnished, the application shall be liable for rejection by Jhpiego Corporation.
 - g) This RFP does not commit Jhpiego to award a contract or to pay any costs incurred in the preparation of a proposal for the services offered.
 - h) Jhpiego reserves the right to accept or reject any or all proposals received as a result of this request, to negotiate with all qualified applicants, or to cancel this RFP if it is in the best interests of Jhpiego to do so. The decision of Jhpiego shall be final.

Disclaimer. The information provided in this RFP is intended to give bidders an overview of the assignment and its requirements. It is indicative and not exhaustive. Jhpiego reserves the right to modify, add or remove elements of the scope as deemed necessary during the tender process or subsequent stages.

1.2 Submission of the bid

4. **Two separate non-editable PDF attachments.** The Technical Proposal and the Financial Proposal must be submitted as two separate PDF attachments by e-mail to IN-Procurement4@jhpiego.org. The Financial Proposal PDF must be password protected. Each file must clearly carry the name of the file as Technical Bid or Financial Bid, together with the name of the bidder. The Financial Proposal must be password protected.
5. **Password.** The password must be disclosed or confirmed by the bidder at the time of the financial bid opening. A bid will be rejected if the bidder is unable to provide the password of its financial bid.
6. **Subject line of the e-mail.** RFP — Engagement of a Third-Party Agency for Three Learning Labs for Comprehensive Primary Health Care in Bihar.

3 Essential eligibility criteria

A bidder must satisfy every criterion below. Each is pass or fail, assessed on the documents submitted with the Technical Proposal. A proposal that fails any one of them will not be evaluated on technical merit.

#	Criterion	Evidence required with the bid
E1	Legally registered organisation in India, in existence for at least three years as at the submission date	Certificate of incorporation or registration; PAN; GST registration
E2	Audited financial statements for the last three financial years	Audited statements, signed by a chartered accountant
E3	Average annual turnover for the last three financial years (reported for information).	Chartered accountant's certificate of turnover
E4	A functional office in Patna, or a written commitment to establish one before deployment	Address proof, or a signed commitment on letterhead
E5	At least one year of experience in public health, health systems or digital health	Contracts, work orders or completion certificates
E6	Not blacklisted, debarred or under investigation by any government department, donor or development agency	Self-declaration on letterhead, signed by the authorised signatory
E7	No conflict of interest with Jhpiego, its personnel or the government counterparts named in the Scope of Work	Self-declaration on letterhead, signed by the authorised signatory

Where a required declaration is not enclosed, Jhpiego may at its discretion seek it from all bidders through a uniform clarification round rather than reject the proposals, provided that no bidder is thereby allowed to change its technical or financial offer.

1.4 Technical evaluation criteria

Proposals that pass the eligibility criteria will be scored out of 100 on the criteria below. A proposal scoring below 60 of 100 will not be considered technically qualified and its Financial Proposal will not be opened.

Criterion	Points	Assessment focus
Relevant organizational experience	15	Evidence that the bidder has delivered assignments of comparable scale, complexity or purpose. Assess the relevance of the work to reaching underserved people, strengthening services or platforms, generating and using evidence, and coordinating with communities and service providers. Experience may come from health or other development sectors.
Bihar presence and delivery capacity	25	Relevant Bihar experience and understanding; credible local deployment, partnerships and access to target communities; ability to mobilize and coordinate state, district, facility and community-level work. A Patna office may support the evidence but is not the sole way to demonstrate local capacity.
Technical and field delivery capability	15	Practical capability to understand local needs and service gaps; plan and conduct field-based work, manage information and maintain data quality; engage communities and coordinate with relevant providers, institutions or partners. Bidders may propose methods and tools suited to their experience and the assignment.
Approach and method	20	Clear response to all required activities; practical sequencing and readiness/feasibility checks; realistic coverage, volume and productivity assumptions; integrated field tools and data flows; indicator definitions, verification, safeguarding, consent and data protection; clinical and referral

Criterion	Points	Assessment focus
		boundaries; use of findings for adaptation.
Team	20	Named leadership and technical roles; relevant qualifications and assignments; availability and person-months; local deployment; field supervision and recruitment/training; community representation and continuity arrangements.
Work plan and risk	5	Complete deliverable-linked schedule, including mobilization in the first three weeks; key dependencies and assignment-specific risks with mitigations; a transparent method for prioritizing or agreeing scope within budget; handover and close-out plan.
Total	100	

1.5 Method of selection

Evaluation will be carried out on the technical evaluation criteria above. The weightage for the Technical Proposal will be 60 per cent. The price bids of only those bidders who qualify technically will be opened. The proposal with the lowest cost may be given a financial score of 100, and the other proposals a financial score inversely proportionate to their prices. The Financial Proposal shall be allocated a weight of 40 per cent.

Proposals will be ranked in terms of total points scored. The proposal with the highest total points (H-1) will be considered for award of contract and will be called for negotiations, if required.

1.6 Negotiations

Negotiations will be held as intimated by e-mail. Negotiations may cover the technical approach, the staffing plan, the activity assumptions and the unit rates, but will not alter the scope stated in Section 3 or the basis on which proposals were evaluated.

1.7 Award of contract

After completing negotiations, the purchaser shall issue a Letter of Intent, Technical Services Contract or Purchase Order to the selected agency.

1.8 Confidentiality

Information relating to the evaluation of proposals and recommendations concerning award shall not be disclosed to the bidders who submitted the proposals, or to other persons not officially concerned with the process, until the publication of the award of contract.

Section 2 — Technical Proposal: Standard Forms

2.1 Form 1 — Company information.

To be filled by the agency.

S. No.	Item	Agency details
1	Name and address of the agency or company, telephone number, mobile number and e-mail address	
2	Type of organisation (proprietorship, partnership, private limited, society, trust, section 8 company)	
3	Name, address, contact number and e-mail of the directors, proprietor or partners	
4	Year of formation of the agency or company	

S. No.	Item	Agency details
5	GST registration number	
6	PAN (attach copy)	
7	Total organisational experience in public health, in years	
8	List of projects undertaken in Bihar, with duration and cost of each project	
9	Address of the office in Patna, or the written commitment to establish one before deployment	
10	Average annual turnover for the last three financial years	

2.2 Form 2 — Technical approach.

To be submitted as a narrative, not exceeding fifteen pages, covering: understanding of the assignment; the proposed approach to each of the three learning labs; how the five-step sequence in 3.3 will be applied; the activity assumptions and volumes on which the Financial Proposal is built; the phase-wise workplan against the timeline in 3.10; named risks and their mitigation; and the approach to documentation and to dissemination for scale-up.

2.3 Form 3 — Team composition.

The organisation chart and staffing table required by 3.12 of the Scope of Work, with signed CVs for each of the seven key roles, stating name, qualification, relevant experience, the learning lab to which the person is assigned, location, person-months, full or part-time status, languages, and a named alternate for each key position.

2.4 Form 4 — Declarations.

The declarations required under eligibility criteria E6 and E7, each on the bidder's letterhead and signed by the authorised signatory.

2.5 Undertaking

I have read the terms and conditions of this Request for Proposal and understand that in case any of the statements furnished by the undersigned is found to be false, or if any or all of the terms and conditions are not complied with, the proposal is liable to be cancelled by Jhpiego Corporation. I agree that the decision of Jhpiego Corporation in this regard would be final and binding.

I also certify that I have understood all the terms and conditions indicated in this document and hereby accept the same completely.

Date: Signature of the authorised signatory of the agency

Place: with official seal or stamp

Section 3 — Scope of Work

3.1 What this assignment is

Bihar has invested in primary health facilities, a teleconsultation platform and community platforms. What is not yet settled is how to make each of them work reliably at the front line, at a cost the state can afford to repeat.

Jhpiego is therefore setting up three learning labs. A learning lab is a small, bounded test of one model, run in real facilities with real patients and real government staff, observed closely, and documented honestly so that the state can decide whether to adopt it more widely. The agency engaged under this Scope of Work is the third party that sets up, runs and documents all three.

The purpose is evidence, not coverage. Success is a model that has been tried, measured and costed, with a clear account of what worked, what did not and what the state would need in order to do it elsewhere. A lab that produces an honest negative finding is a useful lab. A lab that reports success without evidence is not.

Clinical assessment, diagnosis, screening procedures, prescribing, treatment and disease management shall remain the responsibility of authorised primary healthcare and referral providers in accordance with government protocols, while the agency shall support the strengthening of systems through organisation, training, mentoring, quality improvement, follow-up, documentation and liaison with relevant government departments. No clinical-service promotion, screening drive or service-day mobilisation shall commence at a facility until it meets the agreed readiness criteria, although general health awareness activities may begin earlier where approved referral information is available.

The assignment shall build on existing government platforms, registers, committees, reporting lines and service channels without creating parallel structures, focusing on strengthening underperforming systems rather than bypassing them, as outlined in 3.3.5. The agency shall not finance facility-level gaps or provide equipment, infrastructure, repairs, furniture, consumables, medicines, diagnostics, connectivity or other physical or recurring inputs. Such requirements shall be addressed through government resources, including the facility's own resources, Jan Arogya Samiti untied funds or departmental decisions, with the agency supporting the identification of needs, preparation of proposals and follow-up with the relevant authorities. Any gaps that remain unresolved shall be documented, their implications recorded and the issues escalated through appropriate channels, with implementation proceeding within the prevailing constraints and the outstanding gaps captured as findings of the learning lab.

3.2 The three labs at a glance

	Urban PHC Reliability	Teleconsultation Connect and Quality	Sakhi Arogya Linkage
The question being tested	What does it take for an Urban Primary Health Centre to deliver its full service package reliably, and what does that cost per facility?	What set of actions moves a dormant teleconsultation facility into regular use, and can government sustain it without outside support?	Can organised women's collectives reliably bring women aged 30 and above to an Arogya Mandir for priority services, and what must the facility have in place to respond?
Where	All 34 Urban Primary Health Centre catchments in Patna	State-wide. The agency works to and through the	One rural block of Patna district, and the Arogya Mandirs within

	Urban PHC Reliability	Teleconsultation Connect and Quality	Sakhi Arogya Linkage
	city are GPS-mapped. Five of those Urban Primary Health Centres form the lab itself.	State Health Society teleconsultation cell; districts are reached by the cell's own routine, not by a parallel field presence.	it.
Government counterpart	Patna City Health Society and the National Urban Health Mission, with Patna Municipal Corporation.	State Health Society Bihar teleconsultation cell, with District Health Societies.	District Health Society Patna, block health administration and JEEViKA.
Platforms used	HMIS, the NCD application, the Community Based Assessment Checklist, teleconsultation, Tele-MANAS and 102/108 referral transport.	the teleconsultation platform as primary; Tele-MANAS as the tele-mental health channel; HMIS for routine volumes.	The NCD application, the Community Based Assessment Checklist, teleconsultation, Tele-MANAS, the District Mental Health Programme and the existing village health day.
Main output	A GPS-referenced map and dataset for all 34 catchments, plus a documented, costed facility model from the five lab sites and a scale-up recommendation.	A documented, costed activation and review routine, transferred to the state cell.	A documented, costed engagement model and a replication recommendation.

The three labs run in parallel under one agency and one management structure. They are separate tests, not three projects: they share definitions, tools, data standards and a single documentation discipline so that the three sets of findings can be read together.

3.3 How a learning lab is run

Each lab follows the same five steps. The agency must apply them to all three and show them in its proposal.

1. Assess status. Establish where each site actually stands before anything is designed: what the facility has, what it does, what it reports and where it falls short. Use routine records first; observe directly where a reliable record is unavailable. This is an understanding step, not a survey — it is sized to what is needed to design the model, and no new data collection system is set up for it.
2. Design. Agree in writing, informed by the status assessment, what the model is, what is being tested, which sites are in it, what will be measured, where the data will come from, what would count as the model working or not working, and what would trigger a decision to adapt or stop it.
3. Implement. Put the model in place at the agreed sites, with government staff doing the service delivery and the agency supporting organisation, readiness, training and follow-up. Keep a dated implementation log of what was done, what changed and what obstructed it.
4. Early learnings. Track the agreed measures every month and surface what is emerging as it emerges, not at the end. Record deviations, cancellations and failures with the reason, not only the successes. Put the early learnings in front of the government counterpart while there is still time to act on them.
5. Disseminate. Produce a model description any district could follow, the cost of running it per site, an honest account of what did not work, and a recommendation on scale-up. Carry it to government through workshops and stakeholder meetings so that the state, the city and the district can decide whether to take it further.

3.3.1 Honest reporting

The agency is engaged as an independent third party. Its value to Jhpiego and to government lies in reporting what actually happened. Monthly reports must state deviations, unachieved activities and the reasons, including where the reason was a government decision, a supply gap or an access constraint. A deliverable that omits a known failure will be rejected and will not be accepted for payment.

3.3.2 Government in the room

Every lab is designed with, observed with and reported to its government counterpart. The agency supports existing meetings and routines and does not create parallel structures. By the end of the assignment the counterpart should be able to describe the model in its own words and hold the tools that run it.

3.3.3 How findings will be compared

A learning lab must be able to say what changed and against what. Each lab design must therefore state its comparison basis, which will normally combine three things: the recorded status of each site at the start; routine data from comparable facilities outside the lab — or, for the state-wide teleconsultation workstream, between districts and over time — used as a loose reference where the data exist and are of usable quality; and the dated implementation log, which explains what was done at the point any change appears.

Indicator definitions are proposed in the inception report and fixed when the design is signed off at Week 8. They may not be changed afterwards without Jhpiego's written approval, and any approved change must be recorded with the date and the reason so that the series remains readable.

3.3.4 Reporting who was reached

All person-level measures must be reported disaggregated, so that the labs say who was reached and not only how many. As a minimum, disaggregate by sex, by age band, and by settlement type for the urban lab (notified slum, unnotified settlement, other). Where social group is routinely recorded in the government source, report it as recorded; do not collect it separately for this purpose. Report whether people with disabilities were able to access the service, and what was done where they could not.

3.3.5 The systems the labs must work through

The table below lists the existing government systems, tools and channels the labs use. The agency must work through these rather than build anything alongside them. Where one of them is the obstacle, that is itself a finding and must be documented and escalated, not bypassed.

Existing system or channel	What the labs use it for
HMIS — the routine health management information system	The primary source for service volumes and facility reporting in all three labs. No parallel reporting system is created.
Community Based Assessment Checklist (CBAC)	The standard individual risk assessment. Used as issued; not redesigned.
The NCD application and register	Recording screening, diagnosis and follow-up for diabetes, hypertension and common cancers.
The teleconsultation platform	Teleconsultation from a spoke facility to a hub doctor, in all three learning labs.
Tele-MANAS — the national tele—	The tele—mental health channel. Providers are oriented to it, the number

Existing system or channel	What the labs use it for
mental health service (helpline 14416)	and route are displayed, and use is recorded. The agency does not build or run a mental health service.
District Mental Health Programme	The onward referral and follow-up route for mental health, alongside Tele-MANAS.
102 and 108 ambulance services	Referral transport, named in the referral pathway with the arrangements for using it.
Ayushman Bharat Health Account (ABHA)	Patient identity where already in use at a lab facility. The labs do not run a separate enrolment drive.
Village Health Sanitation and Nutrition Day	In the rural block, the existing monthly village health platform. The Sakhi Arogya service day aligns with or builds on it rather than competing with it.
National quality standards and the state certification route	Facility grading uses the state's own standards and feeds the state's existing certification pathway. No separate grading regime is created.
Jan Arogya Samiti untied funds	The financing route for small facility gaps. The labs test how far it can be used for this purpose, and record what it could not cover.
State drug and diagnostics supply chain	The counterpart for the medicine indent tool. The tool must produce an indent in the format the existing supply chain accepts.

3.4 Urban PHC Reliability

Optimising service delivery at Urban Primary Health Centres, Patna city.

Patna city has 34 Urban Primary Health Centre catchments, one for each Urban Primary Health Centre. Facilities see patients daily, but the full service package is not reliably available at every facility on every day, and there is no documented account of what it takes to make delivery dependable.

What this lab tests. Whether a defined, affordable set of actions at an Urban Primary Health Centre can make the full primary care service package reliably available, keep patients in follow-up, and route those who need more care through a working referral pathway — and what one facility-year of that model costs.

Where. Two scales. All 34 Urban Primary Health Centre catchments in Patna city are GPS-mapped under L1.1 — a city-wide product delivered to the Patna City Health Society in its own right. Five of those Urban Primary Health Centres, selected from the map at Week 6 under L1.2, form the lab in which the model is actually built and tested. Costs are reported per facility-year so that the model can be priced for any number of facilities.

Identifying who needs care. Identification works from the facility's own records, community health worker registers and existing community platforms. The lab tests the supply side and the link to it.

3.4.1 Activities

Activity	Required actions	Output and evidence
L1.1 GPS-map all 34 Urban PHC catchments	Produce a GPS-referenced digital map and dataset covering all 34 Urban Primary Health Centre catchments in Patna city. For each, capture the GPS coordinates of the facility itself; the catchment boundary as recognised by the City Health Society; the catchment population; the notified slums, unnotified settlements, construction sites and shelters within it; and the location and coordinates of	GPS-referenced map and dataset for all 34 catchments, with facility coordinates, catchment boundaries, settlement and referral-point layers; metadata note; delivered to

Activity	Required actions	Output and evidence
	onward referral points from Urban Arogya Mandir and Urban Primary Health Centre through polyclinic or urban community health centre to district hospital and medical college. Reconcile boundaries against Patna Municipal Corporation ward maps and health department records, and populations against anganwadi and community health worker registers. Supply the dataset in an open editable format with a metadata note describing each layer and its source. This is a city-wide deliverable for the City Health Society in its own right and stands whichever five facilities form the lab.	the City Health Society in editable form.
L1.2 Select the five lab facilities	With Jhpiego and the City Health Society, use the L1.1 map and criteria agreed at inception — facility condition, catchment vulnerability, staffing against sanction and counterpart willingness — to rank the 34 catchments and agree the five Urban Primary Health Centres that will form the lab. The number is fixed at five; only the identity of the five is decided here, and it is minuted at the Week 6 scope freeze.	Ranking note against the stated criteria; minuted joint selection of the five lab facilities.
L1.3 Assess current status at the five facilities	Assess each facility against the agreed service package: availability of screening and management for diabetes, hypertension, tuberculosis, maternal and child health, mental health and geriatric care; essential medicines and diagnostics; records; teleconsultation readiness; infection prevention; and staffing against sanction. Use routine records first and observe directly only where a reliable record is unavailable. Use a second assessor on a sample to check consistency.	Status assessment and written gap list per facility; consistency note.
L1.4 Close gaps through government routes	Sort gaps into two groups — those the facility can close from its own resources, including Jan Arogya Samiti untied funds, and those requiring a departmental decision. For the first, help the facility plan, justify and use the funds it already has. For the second, prepare the case, take it to the responsible authority with the City Health Society, and pursue it to a decision. The agency funds no gap itself. Record every gap, the route pursued, and whether it closed.	Facility plan; gap-closure tracker showing the route used for each gap; record of untied-fund use; escalation register with the authority approached, the date and the outcome; list of gaps that remained open and their effect.
L1.5 Organise the service day	Work with the facility team to organise how the service package is actually delivered: session planning, patient flow, who does what on which day, where records are kept, and how follow-up is called. This is the core of the model being tested.	A written facility routine agreed with the team; follow-up register in use; before-and-after record of service availability.
L1.6 Build the medicine indent tool	Develop a simple tool that converts caseload and screening volume into a monthly estimate of medicine and diagnostic need, producing an indent in the format the state supply chain already accepts. Agree the counterpart in the supply chain at inception. Test the tool over at least one full ordering cycle. The tool supports better indenting; it does not guarantee supply.	Working tool, short user guide and a report on one complete ordering cycle, including what the supply chain did with the indent.
L1.7 Make referral work	Prepare one Patna referral pathway covering chronic disease, tuberculosis, maternal and child health, gynaecology, cancer screening, mental health and emergencies, using the L1.1 map to locate each referral	Endorsed pathway; job aid issued city-wide; referral register at each lab facility; referral tracker with

Activity	Required actions	Output and evidence
	point. Name the contact at each step and the transport arrangements, including 102 and 108. Include Tele-MANAS and the District Mental Health Programme as the mental health routes. Have the pathway endorsed and issued to all 34 Urban Primary Health Centres. Track referrals from lab facilities to a recorded outcome or a documented reason for remaining open.	outcomes.
L1.8 Bring people in	Support community health workers and the existing Mahila Arogya Samiti and Jan Arogya Samiti to mobilise households in the catchment, using their own knowledge of who is unserved. Support outreach sessions and camps where readiness allows. Every household visit is made with a community health worker or committee member present.	Monthly outreach calendar delivered; committee meeting, attendance and decision records; coverage register disaggregated by settlement type.
L1.9 Measure and document	Track the agreed measures monthly using routine reporting, disaggregated as required by 3.3.4. Document the model, its cost per facility-year, what did not work, and what the city would need to extend it to further catchments.	Monthly measures; costed facility model; scale-up recommendation.

3.5 Teleconsultation Connect and Quality

Teleconsultation activation and quality, including tele–mental health.

Teleconsultation connects a health worker at a spoke facility to a doctor at a hub. In Bihar many facilities are registered but inactive, a share of posted providers do not hold a working login, and hub doctors are often on other duty when calls arrive. The state cell that manages the platform is very thinly staffed.

What this lab tests. Whether a defined sequence of administrative and managerial actions — issuing logins, reactivating idle facilities, rostering hub time, training providers, standardising the monthly data and running a regular review — moves facilities into sustained use, and whether the state cell can carry that routine once the agency withdraws.

Tele–mental health. The lab also tests whether providers know that Tele-MANAS exists, can reach it, and use it for the mental health presentations they encounter. Tele-MANAS is tested as a referral channel alongside teleconsultation; the agency does not build, staff or manage a mental health service.

Where. State-wide. This lab has no separate field geography. The agency is embedded with the State Health Society teleconsultation cell and works through it: the cell issues the instructions, the agency supplies the lists, the routine, the tools and the analysis that let it do so across all districts.

What the agency does and does not staff. The agency supports the state cell. It does not place staff in districts, hubs or facilities for this lab, and it does not deliver teleconsultation. Where district-level support is needed, it is given through the cell’s existing supervision and review channels and through the monthly district review, not by a parallel team.

How it is costed. Because the lab is state-wide and cell-based, this lab is priced as a support package to one state cell — named roles, review rounds, training batches, data support and analysis over the contract period — rather than per district or per facility.

3.5.1 Activities

Activity	Required actions	Output and evidence
L2.1 Agree the lab design with the state cell	With the State Health Society cell, agree what the activation and quality routine consists of, the order in which districts are taken up, the measures, the data sources and the comparison basis, and record the design in writing. The design covers the state as a whole; no separate lab geography is created.	Written lab design and sequencing plan, agreed with the cell.
L2.2 Establish the starting position	Using the state's own records, identify by name and facility the posted providers without an active login, the registered facilities recording no consultations, the eligible facilities not yet registered, and any accounts in shared use.	Dated activation lists by district; a short note on shared logins.
L2.3 Activate	Support the state in issuing logins, reactivating idle facilities, registering eligible facilities and instructing that each provider uses only their own account. Track weekly.	Weekly tracking and a monthly consolidated status, showing separately which actions remain with government.
L2.4 Make hubs available	Support the cell in getting hubs to introduce duty rosters with protected teleconsultation time and practical triage rules, so that specialist time reaches the cases that need it. Staffing directions are issued by government.	Approved rosters and triage procedure in use; hub performance visible in the restricted dashboard.
L2.5 Train and support quality	Train the agreed providers and hub doctors on the current platform workflow. Develop a teleconsultation procedure, clinical checklist and consultation register with government clinicians. Mentor, and review an agreed sample of prescriptions.	Training package and completion records with assessment; approved tools in use; mentoring and sample-review reports.
L2.6 Connect the mental health route	Through the cell and the district review, orient providers on Tele-MANAS and the District Mental Health Programme: what each is for, how to reach them, what to do while waiting and how to follow up. Ensure the cell issues instructions for the helpline number and the referral route to be displayed at facilities. Record use and outcomes, and report where the route did not work.	Orientation records; helpline and route displayed at each lab facility; recorded use with outcomes; a note on where the referral route failed and why.
L2.7 Standardise the data	Agree one monthly reporting format, tag user accounts by cadre, and reconcile facility records without deleting anything unresolved. Develop a restricted dashboard as a decision-support view on approved government data; government systems remain the systems of record. Limit access to authorised department, Jhpiego and agency users; no public dashboard is created. Document the dashboard and train named state cell users for handover.	Agreed format; reconciliation and access logs; restricted dashboard developed and in use; dashboard documentation and handover record; trained authorised users.
L2.8 Establish the review	Support a monthly district review covering volume, quality, reach, referral outcomes and feedback, and restart reporting of unanswered calls. Transfer preparation progressively: the agency prepares the first two rounds, prepares the third jointly, and observes from the fourth. Government chairs throughout.	Monthly government-chaired review with minutes; unanswered-call reports; signed note recording transfer of review preparation.
L2.9 Support the weakest districts	For the districts performing worst against the agreed measures, work out why rather than applying a uniform fix, agree a short plan with the District Health Society, conduct agreed supervision and escalate equipment and	District plans; supervision reports; a written support approach handed to the

Activity	Required actions	Output and evidence
	connectivity problems formally.	state cell.
L2.10 Measure and document	Track the agreed measures monthly, disaggregated as required by 3.3.4. Document the activation and review routine, its cost as a state-cell support package, what did not hold, and what the cell would need in order to run it unaided.	Monthly measures; costed routine; scale-up recommendation.

3.6 Sakhi Arogya Linkage

Women's collectives linked to Arogya Mandirs, one rural block of Patna district.

JEEViKA has organised large numbers of women into self-help groups that meet weekly and are federated upward into Village Organisations. Arogya Mandirs operate in the same villages. The two rarely connect around women's health.

What this lab tests. Whether organised women's collectives can reliably bring women aged 30 and above to an Arogya Mandir for priority services on a predictable day, whether those women stay in follow-up, and what the facility must have in place to respond without being overwhelmed.

Where. One rural block of Patna district, selected jointly by Jhpiego, the District Health Society and JEEViKA by Week 6, on the basis of self-help group density and maturity, the number and condition of Arogya Mandirs, and the willingness of block health and JEEViKA leadership to co-own the lab.

Priority services. Reproductive and gynaecological health; anaemia awareness and iron supplementation; menopausal and mental health referral and care, routed through Tele-MANAS and the District Mental Health Programme; and screening for cervical and breast cancer. Clinical services are delivered by the facility's own providers under government protocols.

3.6.1 Activities

Activity	Required actions	Output and evidence
L3.1 Select the block and facilities	Support the joint selection of the block, then agree which Arogya Mandirs are in the lab and which self-help groups and Village Organisations are linked to each. Record the linked facility against each group.	Minuted block and facility selection; a map of groups to facilities.
L3.2 Define the cohort	With JEEViKA cadres and Village Organisations, define and record the cohort of women aged 30 and above in the catchments of the lab facilities. The cohort is sized so that it does not exceed what the service days can realistically reach.	Written cohort definition and an access-controlled register.
L3.3 Assess status and ready the facilities	Assess and grade every Arogya Mandir in the lab against the national quality standards used by the state — infrastructure, staffing, medicines and diagnostics, services, teleconsultation readiness, records and infection prevention — so that the grading feeds the state's own certification route. Agree an improvement plan per facility, help the facility use its own resources and Jan Arogya Samiti untied funds to close what it can, and take the rest to the District Health Society for a decision. The agency funds no gap itself.	Status grade and gap list per facility; improvement plan; closure and escalation registers; recorded readiness decision per site.
L3.4 Mobilise	Deliver awareness and peer education inside the weekly	Session calendar delivered;

Activity	Required actions	Output and evidence
through the groups	group meetings on chronic disease, anaemia, reproductive and gynaecological health, menopause and mental health, and cancer screening. Orient and support peer educators from within the groups. General awareness may precede readiness; invitations to a clinical service may not.	peer educator roster; session records.
L3.5 Run the service days	At facilities that have passed readiness, support one announced service day each month delivering the priority services alongside routine care, using teleconsultation for specialist advice and Tele-MANAS for mental health. Align the service day with the existing village health day where that is practical, rather than creating a competing event. Publish the calendar in advance through group and community health worker channels. Defer any session that cannot be delivered safely and record why.	Published calendar and service-specific coverage; record of alignment with the village health day; readiness and cancellation log with reasons.
L3.6 Follow up and refer	Issue a personal health record to the cohort, support the Community Based Assessment Checklist as the standard risk assessment, and track every referral to a recorded outcome or a documented reason for remaining open. Record separately how many women found positive on screening actually started treatment.	Record of diary use; access-controlled referral tracker; treatment-initiation record; follow-up arrangements at each facility.
L3.7 Build feedback and data checking into existing structures	Support consent-based exit interviews, a feedback register, group discussions and periodic dialogue with the facility team. Support the existing data validation committees to include self-help group and Village Organisation representation and to meet monthly. Provide a simple route by which a community member can raise a concern about the lab itself, and record how each was resolved.	Feedback mechanisms working; quarterly de-identified analysis of issues and actions; committee membership, minutes and a discrepancy log; grievance log with resolution.
L3.8 Measure and document	Track the agreed measures monthly, disaggregated as required by 3.3.4. Document the engagement model, its cost per block, what did not work, and what would be required to replicate it in another block.	Monthly measures; costed engagement model; replication recommendation.

3.7 Governance and the Week 18 decision

A learning lab is only useful if someone is willing to conclude that it is not working. This section sets out who decides that, and when.

3.7.1 Learning group

Each learning lab has a small learning group: Jhpiego, its government counterpart, and the agency. The agency convenes it, prepares the papers and keeps the record. It meets at three fixed points, and at any other time either Jhpiego or the counterpart asks for it:

- At design sign-off, by Week 8, to agree the model, the sites, the measures, the comparison basis, the readiness-gate criteria for each site, and the criteria that would trigger a decision to adapt or stop.
- At Week 18, to receive the early learnings and take the decision described below.
- At closure, to receive the costed model, the findings and the scale-up recommendation, and to record whether the counterpart accepts them.

3.7.2 The Week 18 decision

On the early learnings at Week 18 the group reaches one of three decisions for each learning lab, against the criteria agreed at design sign-off:

- **Continue as designed.** The model is working, or it is too early to tell and the design remains sound.
- **Adapt.** Part of the model is not working and a specific change is agreed, recorded with its reason. The lab continues on the amended design, and the change is reported as a finding.
- **Stop.** The model cannot work in these conditions, or the conditions it depends on have not materialised. The lab stops and the remaining effort is reallocated to the other labs by written change control within the accepted total price. The lab still produces its model document, recording the conditions under which the model could not work and what the state would need in order to revisit it.

A decision to adapt or to stop is a legitimate result of a learning lab and will not of itself be treated as a performance failure by the agency, provided it is evidenced, raised early and documented. Concealing an unworkable model in order to complete the activity schedule will be treated as a failure.

3.7.3 Consent and participant protection

The labs are implementation learning inside routine government service delivery. They test how existing services are organised and used; they are not a research study, and no study protocol or research ethics approval is required. Participants receive the same government services on the same terms whether or not a lab is running at their facility.

Informed consent is obtained before any interview, exit interview or group discussion, explaining the purpose and who will see the result. Separate written consent is required before any photograph, video or named case study is taken or used, and consent must cover the specific use proposed. Consent to be interviewed is not consent to be photographed or named.

3.8 What the agency is accountable for

These outputs are within the agency's control and are the basis for acceptance and payment.

- A written design for each lab, agreed before implementation starts, stating the model, the sites, the measures, the data sources, the comparison basis, the readiness-gate criteria, and what would count as the model working, needing adaptation, or failing.
- A GPS-referenced map and dataset for all 34 Patna Urban Primary Health Centre catchments, handed over to the City Health Society in editable form with a metadata note.
- A minuted joint selection of the five Urban Primary Health Centres that form the Urban PHC Reliability, ranked against the stated criteria.
- A recorded status assessment at every site, drawn from routine records first and from direct observation only where a reliable record is unavailable.
- Facility plans, gap-closure tracking showing the government route used for each gap, documented escalations with the authority approached and the outcome, and a closing status assessment at every facility.
- A recorded readiness decision for each site before any demand is created there.
- A dated implementation log per lab, including deviations, cancellations and the reasons.
- Monthly measures against the agreed indicators, reported by lab and disaggregated as required by 3.3.4.

- An endorsed Patna referral pathway issued to all 34 Urban Primary Health Centres, covering mental health through Tele-MANAS and the District Mental Health Programme, with referral tracked to outcome at lab facilities.
- Named, state-wide activation lists and weekly tracking supplied to the State Health Society teleconsultation cell, with government-owned actions shown separately.
- A restricted dashboard developed by the agency using approved government data, with role-based access, documentation and user training; a monthly government-chaired review operating, with preparation transferred to the state cell; and the dashboard handed over in usable form to named government users.
- A convened learning group for each learning lab, with early learnings presented and a minuted Week 18 decision to continue, adapt or stop.
- A documented, costed model for each of the three labs, with honest findings and a scale-up or replication recommendation, plus a cross-model learning note. Where a lab is stopped under 3.7.2, its model document records why the model could not work in these conditions.
- Dissemination workshops and stakeholder meetings at state, city and district level at which the findings and the scale-up recommendation are put to the counterparts and to districts that might adopt the model.
- A signed transfer record and transfer of every tool and dataset in open, editable form to the named counterpart.

3.8.1 What the labs are expected to move

Starting values and targets are agreed once the status assessment is complete and the Week 6 scope freeze is recorded. These outcomes guide implementation; they are not standalone payment conditions.

- Urban PHC Reliability: availability of the service package on a given day, patients kept in follow-up, referrals closed, and stock-outs of tracer items.
- Teleconsultation Connect and Quality: providers holding and using an active login, facilities moving from no use to regular use, calls answered at hub, consultation quality, and mental health referrals reaching Tele-MANAS or the District Mental Health Programme.
- Sakhi Arogya Linkage: women from the cohort attending on service days, screening coverage across the four priority services, treatment started where indicated, and referrals closed.
- All three: reviews held on time and chaired by government, data checks completed, and actions arising from community feedback recorded as closed.

3.9 Counterpart coordination and dependencies

Jhpiego will provide technical guidance and implementation support, coordinate with government counterparts, and facilitate access to agreed records, facilities and counterpart teams. The contracted agency remains accountable for planning and delivering the agreed activities, managing its team, maintaining the access and dependency log, and producing complete and accurate deliverables. The agency will coordinate requests through Jhpiego and plan them early. Government retains authority over staffing, supplies, platform accounts, facility operations, clinical decisions and government instructions.

Input	Agency action	Record and escalation
State and district platform, provider and facility	Submit a minimum-data request by Week 1 and validate it with the state cell.	Log the request, what was received, what is missing and the follow-up;

Input	Agency action	Record and escalation
records		escalate through Jhpiego.
Municipal ward maps and catchment boundary records	Request from Patna Municipal Corporation and the City Health Society by Week 1; reconcile against health department records.	Record discrepancies between municipal and health boundaries and how each was resolved.
Teleconsultation account administration — issuing logins, reactivating and registering facilities	Prepare named, verified action lists by district and submit them to the State Health Society cell; track weekly what has been actioned.	Show government-owned actions separately from agency actions; escalate unactioned lists through Jhpiego.
Facility, hub and staff access	Agree visit and training calendars; record attendance and cancellations.	Document access constraints and their effect on milestones; propose recovery.
Government decisions on staffing, supplies, connectivity or registration	Prepare an issue note with evidence, the responsible authority and the decision requested.	Maintain an escalation register that distinguishes agency action from government action.
Drug and diagnostics supply chain counterpart	Agree the counterpart and the accepted indent format at inception.	Record what the supply chain did with each test indent.
JEEViKA and self-help group participation	Coordinate calendars and consent-based cohort definition through the block unit.	Record counterpart, date, participation and constraints.

3.10 Timeline

The assignment begins on the Work Order date, which will be no earlier than 7 November 2026. The weekly sequence assumes a 7 November 2026 start; bidders shall show both weeks from the actual Work Order date and corresponding calendar dates. If the Work Order is later, compress the weekly sequence to preserve the fixed calendar deadlines. Operational implementation and closing assessments must be complete by 15 March 2027, approximately two weeks before the final contract close. Final documentation, transfer and financial closure are due by 31 March 2027.

Phase	Weeks	What must be complete
1. Assess status and design	1–8	Team deployed; inception approved by Week 3; GPS mapping of all 34 Urban PHC catchments complete and the Week 6 scope freeze recorded by Week 6, including the minuted selection of the five Urban PHC facilities, the teleconsultation activation sequence agreed with the state cell, and the Sakhi Arogya block and facilities; status assessment and facility grading complete by Week 7; all three designs signed off by Week 8, including the readiness-gate criteria and the adapt-or-stop criteria; activation lists produced and activation begun.
2. Readiness and set-up	9–12	Facility gaps closed through government routes or formally escalated; facility routines in place at the five Urban PHC Reliability sites; referral pathway endorsed and issued; medicine indent tool built and in use by Week 12; training delivered and mental health routes displayed; data format, restricted dashboard and review routine operating; cohort defined and peer educators active; service days begun only at facilities that passed readiness.
3. Implementation	13–16	Each lab running at the agreed scale; follow-up and referral tracked to outcome; state cell preparing the monthly review;

Phase	Weeks	What must be complete
		support to the weakest districts under way through the cell; feedback cycles completed and acted on.
4. Early learnings and dissemination	17–18; operational close by 15 March 2027	Week 18 early learning decisions taken; closing status assessment and facility re-grading complete by 15 March; costed models, findings and scale-up recommendations completed; dissemination workshops and stakeholder meetings held at state, city and district level; tools and datasets transferred in editable form against a signed record; final report and accounts by 31 March.

If the Work Order is issued after 7 November 2026, submit a compressed recovery plan within five working days and retain the 15 March 2027 operational close. Within the accepted budget, protect the status assessment, designs, facility readiness, safe referral and dissemination before reducing the scale at which the models run. No demand may be created before readiness. Reallocation requires written approval and cannot increase the accepted price.

3.10.1 Week 6 scope freeze within the accepted budget

The bid must state unit assumptions and rates for mapping, assessment, training, outreach and service days. The Urban PHC Reliability is fixed at five facilities and the city-wide map at 34 catchments, so only their identity is settled at the freeze. By Week 6 the agency must confirm in writing the five Urban PHC lab facilities, the teleconsultation activation sequence agreed with the state cell, the Sakhi Arogya block and its lab facilities, and the estimated volumes for each lab. The accepted total price does not increase because of the scope freeze.

If verified volumes exceed what can be delivered in budget and time, prioritise: first the status assessment and the designs; second readiness at the facilities where the models will actually run; third referral tracking and safe transfer; and last the pace of the teleconsultation activation sequence. The 34-catchment map, the five Urban PHC lab facilities and the support to the state cell are not reduced. Reallocation requires written approval, stays within the accepted total price, and must not silently reduce a committed output or breach the readiness gate.

3.11 Deliverables and acceptance

Payment depends on Jhpiego's written acceptance. Deliverables must meet the stated evidence and format requirements.

#	Deliverable	Due
1	Inception report: workplan and chart, proposed indicator definitions, mapping and status-assessment approach, site selection criteria, staffing and person-months, activity assumptions, clinical, consent and data safeguards, risks and dependencies.	Week 3
2	Monthly progress report for each learning lab, with disaggregated measures, implementation log, deviations and reasons, risks, dependencies and expenditure.	By the 5th of the following month
3	GPS-referenced map and dataset for all 34 Patna Urban PHC catchments, with metadata note, delivered to the City Health Society; plus the ranking note and minuted selection of the five facilities.	Week 6
4	Status assessment reports: the five Urban PHC Reliability facility	Week 7

#	Deliverable	Due
	assessments, Sakhi Arogya Linkage facility grading with improvement plans, and teleconsultation activation lists — each stating which findings came from routine records and which from direct observation.	
5	Written design for all three learning labs — model, sites, measures, data sources, comparison basis, readiness-gate criteria, success criteria and adapt-or-stop criteria — signed off by each learning group.	Week 8
6	Teleconsultation activation status and evidence that the agreed monthly reporting format is in use.	Week 12
7	Endorsed Patna referral pathway, issued city-wide, with registers in use at the five facilities and mental health routes displayed.	Week 14
8	Training package, facilitator pack, and completion records with assessment.	Week 16
9	Early learning note and presentation to Jhpiego and the three counterparts, with what is emerging, what is not working, and the minuted Week 18 decision for each learning lab.	Week 18
10	Medicine indent tool, user guide and report on one full ordering cycle, including what the supply chain did with the indent.	Week 14
11	Sakhi Arogya Linkage service-day operations and coverage report, with the first community feedback analysis and the grievance log.	Week 16
12	Teleconsultation support approach for the weakest districts, with district plans and the record of support given through the state cell, handed to the cell.	Week 16 (by 28 February 2027)
13	Closing status assessment and facility re-grading across all three learning labs, set against the opening assessment.	By 15 March 2027
14	Three costed model documents with findings and a scale-up recommendation — Urban PHC Reliability to the City and State Health Societies, Teleconsultation Connect and Quality to the State Health Society, Sakhi Arogya Linkage to the District Health Society and JEEViKA — plus a cross-model learning note, taken to government through dissemination workshops and stakeholder meetings at state, city and district level. A model stopped under 3.7.2 still produces its document, recording why.	By 31 March 2027
15	Final report, signed transfer record, transfer of all datasets and tools in editable form to the named counterparts, and final accounts.	By 31 March 2027

Drafts of Deliverables 4, 5, 7, 12 and 14 are due at least two weeks before the final date. Deliverable 3 is exempt: the map and the selection it informs are both due at Week 6.

3.12 Team and staffing

Propose a team sized to the three labs and to the activity assumptions. Seven named key roles with signed CVs are mandatory. At least three of the seven must reside in Bihar or commit to relocate before deployment; the State Team Leader must be one of them and must be full-time in Patna.

Role	Minimum profile and responsibility
State Team Leader	Full-time in Patna; accountable across all three labs; postgraduate in public health, health management or health informatics; 7+ years in health systems including

Role	Minimum profile and responsibility
	urban and digital health or telemedicine; experience of working with a State Health Society.
Clinical quality lead	Registered doctor, or nurse with a public health qualification. Responsible for procedures, training, mentoring, prescription sample review and facility grading alongside government clinicians. Does not replace primary care providers.
GIS and mapping specialist	Demonstrated previous GPS-referenced mapping of health facility catchments or settlements, described in the CV with the product named. Responsible for the 34-catchment map and dataset, the ranking that informs site selection, and transfer in editable form.
Digital health and teleconsultation lead	Demonstrated experience of running or supporting a teleconsultation or health information platform with a government counterpart, described in the CV with the platform named. Responsible for the Teleconsultation Connect and Quality: activation, hub rostering, the monthly data format and the transfer of the review routine to the state cell.
Data and measurement analyst	Health data and dashboard experience; responsible for indicator definitions, data quality, disaggregated analysis and restricted-access reporting across the three labs.
Community mobilisation specialist	Experience with self-help groups under a state rural livelihoods mission or an equivalent women's collective structure.
Documentation and learning lead	Responsible for the implementation logs, the early learning notes, the three costed model documents, the cross-model learning note, the dissemination workshops and the transfer record.

3.12.1 Staffing plan

Provide an organisation chart and a staffing table giving name, qualification, relevant experience, lab, location, person-months, full or part-time status, languages and a named alternate for each key position. Show capacity separately for each lab. Where field staff are required, state numbers and the productivity assumptions behind them. CVs require Jhpiego's written approval before deployment. Replacements require prior approval and an equal or better fit.

3.12.2 Single contracting agency

One eligible organisation will contract. Joint bids, consortia and partnerships are not accepted. Named individual consultants may be engaged under the agency's responsibility. No lab, geography or substantial part of the scope may be subcontracted to another organisation. Eligibility and institutional experience must be the bidder's own; individual experience is assessed under the team criterion.

3.13 Budget

Submit a fixed total price in Indian Rupees, built from unit cost, quantity, frequency and total for each line, with the volume assumptions stated. Allocate staff costs across the activities they deliver rather than as a separate salary head. Show goods and services, and GST, separately. The price covers the agency's own people, materials, travel and tools only: no facility equipment, infrastructure, repairs, consumables, medicines, diagnostics or connectivity may be priced in any head. Cost each lab separately as well as in total, so that the cost of each model can be read on its own.

Budget head	Unit examples	Coverage
GPS mapping and catchment	Per catchment mapped	Field verification, GPS capture, software,

Budget head	Unit examples	Coverage
dataset		boundary reconciliation, dataset preparation and metadata.
Status assessment	Per facility assessed	Assessment teams drawing on routine records first, supervision, data and analysis. Direct observation only where a reliable record is unavailable.
Facility readiness and liaison	Per facility per improvement cycle	Support visits, grading and re-grading, facility planning, and preparing and pursuing cases with the department. No facility goods, equipment or works are priced here.
Training and capacity building	Per module; per batch; per participant	Content development, trainers, platform costs, materials, logistics and assessment.
Outreach, mobilisation and service days	Per session; per camp; per service day	Mobilisation, logistics, materials and field time.
Information materials, health records and community tools	Per package or unit	Design, printing, personal health records, registers, feedback and grievance tools.
Digital, data and measurement support	Per tool or dashboard; per month of data support	Reporting on government systems, the medicine indent tool, data cleaning, analysis and hosting during the period.
Governance and counterpart coordination	Per round; per workshop; per learning group meeting	Venue, materials, coordination and facilitation.
Support to the state cell and to weak districts	Per named role per month; per district plan	Embedded support to the teleconsultation cell, diagnosis of weak districts, and reporting.
Closing assessment, documentation, model costing and dissemination	Per product; per assessment; per workshop or meeting	Closing status assessment, re-grading, the three model documents, the cross-model learning note, production, and the dissemination workshops and stakeholder meetings.
Travel not priced above	Actuals, capped at a percentage stated by the bidder	Only travel not already built into the heads above, with approval and evidence.
Management fee and overheads	Percentage or amount	Institutional overhead, statutory compliance and insurance.
GST	At the applicable rate	Shown separately by head and in the total.

Summary	Urban PHC Reliability	Teleconsultation Connect and Quality	Sakhi Arogya Linkage	Shared	Total (INR)
A. Activity-cost subtotal					
B. Management fee and overheads					
C. Total before tax (A+B)					
D. GST, if applicable					

Summary	Urban PHC Reliability	Teleconsultation Connect and Quality	Sakhi Arogya Linkage	Shared	Total (INR)
E. Grand total (C+D)					

Costs that cannot sensibly be assigned to one lab — the State Team Leader, the measurement analyst, the dissemination workshops — go in the shared column, with the basis of apportionment stated. The accepted total price does not increase at the Week 6 scope freeze. Any approved reallocation stays within that total and follows written change control.

3.14 Data protection, safeguarding and consent

Assignment data are for Jhpiego and the Government of Bihar. Access is limited to authorised department, Jhpiego and agency personnel according to role and need. No public dashboard will be created, and identifiable personal health data will not be published or used for unrelated purposes.

- Use approved fields and tools; obtain informed consent before interviews, explaining the purpose and the users in a language the participant understands.
- Obtain separate written consent before any photograph, video or named case study is taken or used, covering the specific use proposed.
- Collect the minimum necessary data; use role-based access and secure transfer and storage approved by Jhpiego; prohibit shared accounts.
- Maintain access logs and confidentiality undertakings for personnel handling personal data. Use de-identified or aggregated data in shared reports, and suppress small cells or location detail that could identify a person. This applies to the GPS dataset: settlement-level location may be shared, household-level location may not.
- Report any suspected loss, unauthorised access or disclosure promptly through the route agreed at inception, and cooperate with the response.
- Transfer data securely to named authorised recipients, and return or delete agency copies at close as instructed, subject to applicable retention obligations.
- Follow Jhpiego policies on safeguarding, prevention of sexual exploitation and abuse, anti-fraud and conflict of interest, and government protocols. Obtain written approval before any public communication, including any publication of lab findings.

The inception report will set out data flows, roles and permissions, consent, retention and deletion, incident contacts, and the consent arrangements set out in 3.7.3.

3.15 Working arrangements and transfer for scale-up

- The agency reports to Jhpiego. Jhpiego provides technical guidance, facilitates counterpart access, coordinates review and issues written acceptance.
- The Urban PHC Reliability is anchored in the Patna City Health Society and the National Urban Health Mission, with Patna Municipal Corporation; the Teleconsultation Connect and Quality in the State Health Society cell, working state-wide through it; the Sakhi Arogya Linkage with the District Health Society Patna, the block administration and JEEVIKA.
- Government chairs and minutes its own meetings. The agency supports existing routines and does not substitute for government or create parallel structures.

- The agency will develop and operate the restricted teleconsultation dashboard using approved government data and role-based access. By 31 March 2027 every map, dataset, referral format, dashboard, routine, training module, procedure, grading tool, roster and tracker must be handed over in usable form to a named government or JEEViKA counterpart, with documentation, access arrangements and user training, and must work without the agency's continued involvement. Government systems remain the systems of record.
- Transfer in open, editable formats against a signed record naming the item and version, its format, where it sits, the recipient, access rights and the training given. Contract terms will define intellectual property and licence rights, pre-existing tools and third-party materials.

3.16 General contract conditions

The expected contract is activity-based and deliverable-linked. Salaries are not separately reimbursed, and prices are firm for the contract period. The agency is not a financier of facility gaps: no part of the contract price may be applied to equipment, infrastructure, works, consumables or other physical inputs at a government facility. Maintain auditable activity and expenditure records and permit field verification by Jhpiego or its representatives, subject to safeguarding and privacy.

Failure to meet milestones may lead to a recovery plan, proportionate withholding of a disputed deliverable amount, suspension or termination under the signed contract. The final contract must specify notice and cure periods, payment for accepted work, transition and transfer, force majeure, insurance, liability, indemnity, confidentiality, intellectual property, change control and dispute resolution.

Section 4 — Financial Proposal

The Financial Proposal must be prepared in accordance with 3.13 of the Scope of Work (Budget) and submitted on the format issued with this RFP.

Form of submission. The Technical Proposal must be submitted as a non-editable PDF. The Financial Proposal must be submitted as a separate, non-editable PDF protected by a password. The password must be disclosed at the time of financial bid opening. The password must be disclosed at the time of financial bid opening.

The Financial Proposal must state:

- A fixed total price in Indian Rupees, built from unit cost, quantity, frequency and total for each line, with the volume assumptions stated against each.
- The cost of each learning lab separately, as well as the total, so that the cost of each model can be read on its own, with shared costs shown in a separate column and the basis of apportionment stated.
- Staff costs allocated across the activities they deliver. No separate salary head is permitted and salaries are not separately reimbursed.
- Goods and services, and GST, shown separately by head and in the total.
- The percentage quoted for the agency management fee and overheads, and the percentage cap quoted for travel not already built into the other heads.
- No facility equipment, infrastructure, works, consumables, medicines, diagnostics or connectivity in any head. Those inputs are met from government sources, as set out in the Scope of Work.

A Financial Proposal that prices facility goods or works, or that shows a separate salary head, will be treated as non-responsive on that head and the amount will be excluded from the comparison.

Section 5 — Payment Schedule

Payments are milestone-based and linked to Jhpiego's written acceptance of the deliverables listed in 3.11 of the Scope of Work, on the following indicative schedule.

Tranche	Payable on	Share
1	Approval of the inception report (Deliverable 1)	25%
2	Acceptance of the 34-catchment map and the minuted selection of the five lab facilities, the status assessment reports, and the written design for all three learning labs (Deliverables 3, 4 and 5)	25%
3	Acceptance of the teleconsultation activation status, the endorsed referral pathway, the training package, and the early learning note with the minuted Week 18 decision (Deliverables 6, 7, 8 and 9)	25%
4	Acceptance of the remaining deliverables, including the three costed model documents and the dissemination workshops, the signed transfer record and financial closure (Deliverables 10 to 15)	25%

Monthly progress reports (Deliverable 2) are a condition of payment in each tranche but do not themselves carry a payment share. All payments are subject to satisfactory performance, to the deliverable meeting the stated evidence and format requirements, and to statutory deductions.