Jhpiego Corporation, India

REQUEST FOR PROPOSAL (RFP)

Subject: *Engagement of a Third-Party Agency for a Three-Component Assignment in Bihar*

Component 1 — Optimizing Urban Ayushman Arogya Mandirs in Patna, Bihar

Component 2 — A Coordinated and Sustainable e-Sanjeevani 2.0 System in Bihar

Component 3 — Women-Collective-Driven Family Health Care Model through AAMs in One Block of Patna District, Bihar

Issue DATE: 25th August 2026

SUBMISSION DEADLINE: 10th September,2026

SUBMISSION Mail ID: IN-Procurement4@jhpiego.org **(For submission of proposals)**

Contact Number: (For queries only): ashish.kumar@jhpiego.org

Bid opening: 11th Sept,2026

Award /start date (selection of partner)- 20th Sept 2026 (Tentative)

Introduction about Jhpiego India:

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

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 programs 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 following:

Section 1. - Instruction to bidders
Section 2 - Technical Proposal - Standard Forms
Section 3 - Scope of Work
Section 4 - Financial Proposal – Separately as excel sheet to be sent password protected)
Section 5 – Payment Schedule

Section 1- Instructions to Bidder

1. **Clarification and Amendment of RFP Documents-** Bidder may request a clarification on above contact mentioned.

2. **Proposal Validity** – must remain valid for minimum 30 days after the submission date. Should the need arise, however, the purchaser may request bidder to extend the validity period of their proposals.

3. **Preparation of bid**

3.1 Depending on the nature of the Assignment/job, bidder is required to submit a Technical Proposal (TP) in forms provided in Section-2.

3.2 **Financial Proposals:** The Financial Proposal shall be prepared as per the Guidelines given in the SOW.

3.3 All applicable taxes must be included by the bidder in the financial proposal.

3.4 Delay submitted proposal shall be rejected only Procurement committee will have the right to consider in specific situation.

3.5 Incomplete application forms are liable to be rejected. No further correspondence will be entertained from rejected applicants.

3.6 The application of the selected agency should be signed by the authorised signatory confirming that all the details furnished in the application are true and correct to the best of his/her knowledge and that in case any false information or suppression of any material information is furnished, the application shall be liable for rejection by Jhpiego Corporation.

3.7 This RFP does not commit Jhpiego to award a grant / contract or to pay any costs incurred in the preparation of a Proposal for the goods and/or services offered.

3.8 Jhpiego reserves the right to accept or reject any or all proposals received as a result of this request, to negotiate with all qualified applicant(s) 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 project 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.

4. Submission of bid

4.1 The Technical Proposal and Financial Proposal should be submitted as <u>two separate non-editable attachments via e-mail</u> to

IN-Procurement4@jhpiego.org

Both the above separate files should clearly mention the name of the file as Technical Bid or Financial Bid along with the name of the bidder. <u>Please note that the Financial Proposals should be protected by passwords</u>.

4.2 The Password needs to be disclosed/confirmed by bidder at the time of financial bid opening. Bid will be rejected if bidder will not be able to provide password of their financial bid.

4.3 <u>Please mention in Subject line of mail –</u>

GSR- Engagement of a Third-Party Agency for a Three-Component Assignment in Bihar

5. <u>Evaluation, Negotiation and Agreement:</u>

All proposals satisfying the requirements of this RFP will be evaluated to establish which of the applicant(s) best fulfils the needs of Jhpiego.

Essential Eligibility Criteria-

The organization should have valid registrations in India including PAN, GST etc.as per technical

Format

Technical Evaluation Criteria-

S.No.	Criterion	What earns them	Points
1	**Organizational experience in public health**	Depth and relevance of assignments in the last 5 years; scale, duration and demonstrated results, not just contract count	20
2	**Presence and track record in Bihar**	Functional office; prior work with SHSB, District Health Societies, municipal bodies or JEEViKA; existing relationships and staff already in state	15
3	**Component-specific technical capability**	Split evenly across the three: urban health/NUHM and facility strengthening (7); digital health/telemedicine, preferably e-Sanjeevani (7); SHG/women's collective mobilization (6)	15
4	**Technical approach and methodology**	Understanding of the assignment; quality of proposed refinements; realism about what 7 months allows; how the three components will be managed without becoming silos	20

5	**Team composition**	Fit of proposed personnel to Section 10 levels and competencies; continuity of presence at state, city/district and field level; GIS, analytics and documentation capability	20
6	**Operational plan, phasing and risk mitigation**	Phase-wise plan matched to the timeline; named risks with credible mitigation; mobilization speed	10
	Total		**100**

Method of Selection-

The Evaluation will be done based on the above technical Evaluation criteria. The weightage for Technical Proposal will be of 60 %. 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 proposal given financial score that are inversely proportionate to their prices. The financial proposal shall be allocated weight of 40%.

The 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.

Negotiations-

Negotiations will be held as per information via mail.

Award of Contract-

After completing negotiations, the purchaser shall issue a Letter of Intent/TSC/Purchase Order to the selected agency.

Confidentiality-

Information relating to evaluation of Proposals and recommendations concerning awards 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

Company Information–To be filled by Agency

S.No	Item	Agency Details
1.	Name and address of the agency/company, telephone number, fax, mobile number, email address	
2.	Type of organization (Whether Proprietorship, partnership, private proprietor/partners)	
3.	Name, address, contact no and email id of the Directors/Proprietor/Partners	
4.	Year of formation of the agency/ company	
5.	GST Registration No.	
6.	PAN. No (attach copy)	
7.	Total No of Organisational Experience in Public Health.	
8.	List of Projects undertaken in Bihar with duration and Cost of the project.	

Undertaking

I have read the terms and conditions of ToR and understand that in case of any of the statement furnished by the undersigned is found to be false OR if any / all the terms and conditions are not complied with, the ToR is liable to be cancelled by Jhpiego Corporation. I agree that the decision of the Jhpiego Corporation in this regard would be final and binding on the ToR.

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

Date :
Place :

Signature of the authorized signatory of the agency
with official seal/ stamp

Section 3

SCOPE OF WORK

Engagement of a Third-Party Agency for a Three-Component Assignment in Bihar

Component 1 — Optimizing Urban Ayushman Arogya Mandirs in Patna

Component 2 — A Coordinated and Sustainable e-Sanjeevani 2.0 System in Bihar

Component 3 — Women-Collective-Driven Family Health Care Model through AAMs in One Block of Patna District

Commissioned by: Jhpiego

Implementation Period: September 2026 – March 2027

1. The Assignment at a Glance

Jhpiego is engaging one third-party agency to deliver three distinct components between September 2026 and 31 March 2027. Each component has its own geography, anchor institution and results. They are delivered in parallel, not in sequence, and each is separately budgeted, reported and assessed. Section 7 sets out the few deliberate linkages between them.

	Component 1 — Urban AAM Optimization	Component 2 — e-Sanjeevani 2.0	Component 3 — Women-Collective Family Health
What it does	Makes urban primary healthcare vulnerability-responsive: finds the households most at risk and ensures they are screened and followed up through the UAAM.	Makes the state's teleconsultation system work at the coverage and quality its investment implies.	Demonstrates a women-led family health model in which SHG collectives drive demand for fixed-day services at AAMs.
Where	Five UPHC catchments in Patna, selected from the city's 34 (Section 4.1).	State-wide: all 38 districts of Bihar, anchored at SHSB, with intensive support to low-performing districts.	One block of Patna district and the AAMs within it (Section 6.1).
Anchor institution	Patna City Health Society / NUHM, with Patna Municipal Corporation for ward and boundary data.	State Health Society Bihar (SHSB) e-Sanjeevani / Telemedicine Cell; District Health Societies.	District Health Society Patna and JEEViKA (block project unit, VO/SHG structures).
Primary beneficiaries	High-risk households in vulnerable urban settlements, including unlisted slums, construction sites and homeless shelters.	Patients seeking teleconsultation state-wide; CHOs, ANMs and hub Medical Officers as providers.	SHG women aged 30+ and their households in the selected block.

	Component 1 — Urban AAM Optimization	Component 2 — e-Sanjeevani 2.0	Component 3 — Women-Collective Family Health
Headline result by Mar 2027	≥70% of line-listed high-risk individuals screened and followed up; a costed scale-up playbook.	CHO login coverage ≥70%; active spokes ≥8,500/month; ≥90% hub call acceptance; institutionalized monthly review.	All selected AAMs graded and improved; SHG women screened across four priority interventions; replication framework.
Scale of effort	Field-intensive; the largest share of household-level work.	State- and district-level systems work; largely virtual and data-driven.	Block-level demonstration; deep rather than wide.

Throughout this document, activities are numbered by component: C1.1, C1.2 … for Component 1; C2.1 … for Component 2; C3.1 … for Component 3.

2. Rationale and Background

2.1 Why urban primary healthcare in Patna needs a vulnerability lens

Bihar is urbanizing rapidly, and Patna is witnessing the growth of diverse urban settlements — slums, informal habitations and migrant-dominated residential areas — characterized by high population density, occupational mobility and varied living environments. Under the National Urban Health Mission (NUHM), the Government of Bihar has invested substantially in Urban Ayushman Arogya Mandirs (UAAMs) and Urban Primary Health Centres (UPHCs) to deliver Comprehensive Primary Health Care (CPHC). The city today has 34 Urban PHC catchments, but their service boundaries, catchment populations and vulnerability profiles are not consistently mapped, which limits the city's ability to plan and target services.

NFHS-5 data for urban Bihar shows a significant burden of anaemia (58% among women), child undernutrition (36% stunting), hypertension (22%) and diabetes (10%), concentrated in high-density, resource-constrained settings. These risks are not evenly distributed: certain slums and migrant settlements carry a disproportionate burden, and populations in unlisted slums, construction sites and homeless shelters sit largely outside routine service reach. UAAMs record steady OPD attendance, but attendance is not the same as coverage of those most at risk. Closing that gap requires proactive outreach, household-level risk stratification, working referral pathways and structured follow-up of people needing long-term care — for tuberculosis, diabetes, hypertension, maternal anaemia and childhood undernutrition. This is the work of Component 1.

2.2 Why e-Sanjeevani needs coordinated support now

e-Sanjeevani is a critical enabler of CPHC across Bihar's 38 districts, generating over 8 million consultations annually. A recent state-wide assessment combining secondary data analysis with primary field verification found substantial headroom: only 57.4% of posted CHOs have active logins, leaving 2,720 without accounts; roughly half of spoke facilities record no consultation in a given month; only 57% of eligible AAM facilities are onboarded on the portal; measured hub call loss averaged 22–25%, reaching 35% in some districts, and call-loss reporting was discontinued in September 2025; half of CHOs and nearly two-thirds of hub providers have not been trained on version 2.0; and the SHSB e-Sanjeevani Cell operates with a single officer and no dedicated support staff. Modelled estimates indicate that activating dormant spokes alone could add roughly 2.75 lakh consultations per month at near-zero marginal cost. Most of these are administrative and managerial gaps rather than structural ones, which is precisely why time-

bound external support can convert them into rapid, measurable gains — and then hand the system back. This is the work of Component 2.

2.3 Why a women-collective model, and why demonstrate it in one block

Self-Help Groups under the JEEViKA network are among Bihar's most powerful platforms for social empowerment and community mobilization. The Swasthya Nari Shashakt Parivaar approach seeks to demonstrate a sustainable, women-led model of family health care through AAMs — SHG women aged 30 and above driving screening and treatment for reproductive tract infections and gynaecological conditions, anemia awareness and supplementation, referral and care for menopausal and mental health concerns, and cervical and breast cancer screening. Predictable fixed-day ("Pink Day") delivery at AAMs, NCD diaries, structured referral and follow-up, and coordination among CHOs, ASHAs, Community Mobilizers and Community Nutrition Resource Persons make the model accessible and replicable.

This is a model to be proven before it is spread, which is why it is scoped to a single block rather than thinly across a district. Demonstration also imposes a discipline: demand generated by women's collectives must meet a facility able to answer it, so the component begins with grading and strengthening the AAMs themselves and ends with a documented, costed replication framework. This is the work of Component 3.

2.4 Why a third-party agency

Jhpiego intends to engage a competent third-party agency to provide dedicated, field-based facilitation and programme management support across all three components. The agency will work under Jhpiego's technical guidance and in close coordination with the State Health Society Bihar, District Health Societies, Patna City Health Society and JEEViKA structures. The engagement is deliberately activity-based: the human resources the agency deploys are the means of delivering defined activities, outputs and outcomes, and their costs are to be built into the respective activity costs rather than billed as separate staff salary lines.

3. Objectives

3.1 Overall objective

To deliver, by 31 March 2027, measurable improvements in the reach and equity of urban primary healthcare in Patna, in the coverage, quality and governance of e-Sanjeevani 2.0 across Bihar, and in the demonstrated feasibility of a women-collective-driven family health model — with the systems, tools and evidence generated transferred to government and community institutions for continuation and scale-up.

3.2 Component 1 — specific objectives

- Establish a validated digital picture of all 34 Patna Urban PHC catchments and use it to select five priority catchments on transparent vulnerability criteria.
- Map and line-list high-risk pockets, households and individuals within the five selected catchments.
- Ensure that at least 70% of line-listed high-risk individuals receive scheduled screening and follow-up through the UAAM.
- Establish functional referral pathways from UAAM/UPHC through polyclinic to district hospital and medical college.

- Increase planned and repeat utilization of UAAM services among vulnerable urban populations, including populations in unlisted settlements.
- Strengthen Mahila Arogya Samitis and Jan Arogya Samitis as durable demand-generation and oversight structures.
- Codify the approach in a costed scale-up playbook for the remaining Patna catchments and other Bihar cities.

3.3 Component 2 — specific objectives

- Institutionalize data-driven governance within the SHSB e-Sanjeevani Cell: monthly district performance review, reinstated call-loss reporting, and a standardized monthly data schema with mandatory cadre coding.
- Expand service availability by activating providers and facilities — CHO login coverage ≥70%, active spokes ≥8,500 per month, NIN-matched AAM onboarding coverage ≥65%.
- Optimize hub performance through duty rosters, protected teleconsultation slots and case-triaging protocols, achieving ≥90% call acceptance at supported hubs.
- Build provider capacity through virtual e-Sanjeevani 2.0 refresher training for all active CHOs, ANMs and hub Medical Officers, and improve consultation quality through SOPs, checklists and documentation registers.
- Provide intensive, root-cause-specific support to low-performing districts and document a replicable district support framework.

3.4 Component 3 — specific objectives

- Grade all AAMs in the selected block against national standards and demonstrably improve their readiness to deliver the priority service package.
- Enumerate and mobilize SHG women aged 30+ and their households, with active peer educators in every participating SHG.
- Establish predictable Pink Day fixed-day service delivery covering the four priority interventions, linked to e-Sanjeevani teleconsultation for specialist advice.
- Establish follow-up, referral and closed-loop tracking, supported by NCD diaries and CBAC assessments.
- Institutionalize community feedback and SHG representation in Data Validation Committees.
- Produce a documented, costed replication framework suitable for adoption across districts under NHM.

4. Component 1: Optimizing Urban AAMs in Five UPHC Catchments, Patna

4.1 Geography and how the five catchments are chosen

Component 1 delivers intensive work in five UPHC catchments of Patna. Because the city has no consolidated planning base, the first activity maps all 34 catchments; that map is both a standalone deliverable for Patna City Health Society and the evidence on which the five are chosen. Selection will be

made jointly with Jhpiego, Patna City Health Society and the District Health Society within the first six weeks, against criteria agreed at inception — density of vulnerable settlements, presence of unlisted slums or construction sites, absence or weakness of ASHA coverage, NCD and TB screening shortfall, and facility readiness.

Digha Mushari (Ward-1) is included among the five by default. A completed rapid assessment already documents it: an informal railway-land settlement of approximately 1,180 residents across 218 households, with no ASHA support, weak household-level tracking, limited NCD screening, open drainage and narrow lanes, and a predominantly daily-wage, high-mobility population. The four remaining catchments are to be selected as above.

4.2 Activities, outputs and outcomes

Activity and key tasks	Outputs by Mar 2027	Outcomes / indicators
C1.1 Digital mapping of Patna's 34 UPHC catchments and selection of five. Prepare a digital, GIS-enabled map of all 34 Urban PHC catchments showing service-area boundaries, catchment population, listed and unlisted slum pockets, construction sites and homeless shelters, and the location of UAAMs, sub-centres, polyclinics, referral hospitals and medical colleges. Reconcile boundaries against Patna Municipal Corporation ward maps and NUHM records; validate populations against AWW/ASHA registers and census/HMIS sources. Apply the agreed criteria to rank catchments and facilitate joint selection of the five.	Digital catchment map of all 34 UPHCs with boundary, population and facility layers, handed over in an editable open format; vulnerability ranking note; minuted joint selection of five catchments.	Patna City Health Society holds, for the first time, a single validated planning base for urban primary healthcare; 100% of the 34 catchments mapped; selection of the five is evidence-based and documented.
C1.2 Vulnerability mapping and ward micro-planning in the five catchments. Conduct ward- and household-level vulnerability assessment using standard NHSRC tools; line-list high-risk pockets, households and individuals (TB, hypertension, diabetes, maternal anaemia, child undernutrition, geriatric care needs); facilitate preparation of Ward Health Action Plans with UPHC/UAAM teams and the City Health Society.	Vulnerability assessment report; household line-list covering 100% of households in the five catchments, including all ~218 households in Digha Mushari; five Ward Health Action Plans prepared and endorsed.	Risk-informed micro-plans govern UAAM outreach and service delivery in all five catchments.
C1.3 Strengthening UAAM service delivery. Support UAAMs to deliver the full CPHC package — NCD screening and management, TB screening and treatment follow-up, maternal and child health, geriatric care, essential diagnostics and medicines, teleconsultation and referral. Conduct facility readiness assessment and handhold gap closure; establish scheduled screening and follow-up rosters against the	Readiness assessment and gap-closure record for each of the five UAAMs; follow-up roster and tracking register operational; teleconsultation linkage functional; medicine-indenting calculator prototype piloted and documented with a user guide.	≥70% of line-listed high-risk individuals receive scheduled screening and follow-up through the UAAM; reduced stock-outs of tracer essential medicines in pilot facilities, baseline against endline.

Activity and key tasks	Outputs by Mar 2027	Outcomes / indicators
line-list. Develop and pilot a prototype medicine-indenting calculator that converts caseload and screening data into rational monthly drug and diagnostic indents.		
C1.4 Referral matrix. Develop and validate a referral matrix defining pathways and clinical criteria from UAAM/UPHC to polyclinic to district or referral hospital to medical college, by service and condition — NCDs, TB, maternal and child health, gynaecological and cancer screening, mental health, and emergency. Specify points of contact, transport arrangements and feedback protocols; obtain City Health Society endorsement; disseminate to all 34 UPHCs.	Referral matrix endorsed by Patna City Health Society; job aid displayed at all 34 UPHCs; referral registers and formats issued; UPHC teams oriented.	Documented referral pathways available city-wide; referral completion tracked and improving across the five catchments.
C1.5 Targeted outreach and linkage. Facilitate door-to-door mobilization and follow-up by ASHAs and outreach workers for line-listed households; organize outreach sessions and health camps in vulnerable pockets, explicitly including unlisted slums, construction sites and homeless shelters; track referrals to closure using the C1.4 matrix.	Monthly outreach calendar implemented; at least one outreach session or camp per month per catchment; referral and follow-up tracker maintained with completion status.	Increased planned and repeat utilization of UAAM services by vulnerable households, baseline against endline; measurable referral completion rate.
C1.6 Community engagement through MAS and JAS. Strengthen or reconstitute Mahila Arogya Samitis and build their capacity to raise awareness, mobilize households and support treatment adherence; deploy IEC/BCC materials and community events. In parallel, strengthen or reconstitute facility-level Jan Arogya Samitis and build JAS capacity to map and drive service demand in listed and unlisted slums, construction sites and homeless shelters, and to direct untied funds to identified local gaps.	MAS functional and meeting monthly across the five catchments; JAS constituted or reactivated and meeting quarterly with documented action points; MAS and JAS members oriented; IEC/BCC package deployed; hard-to-reach settlement register maintained by JAS.	Strengthened demand generation and adherence support, evidenced in MAS and JAS records and in utilization data; previously unreached settlements brought into routine service coverage.
C1.7 Review, documentation and the scale-up playbook. Institutionalize ward- and facility-level review using routine NUHM, HMIS and UAAM platforms; document processes, results and lessons; prepare an operational scale-up playbook containing step-by-step protocols, tools, formats, staffing norms, indicative costs and a phased roll-out plan for the remaining Patna catchments and other Bihar cities.	Monthly review notes; endline assessment; process documentation; costed scale-up playbook submitted and presented to the City and State Health Societies.	A government-endorsed model ready for scale-up; improved early identification and continuity of care across the five catchments.

5. Component 2: A Coordinated and Sustainable e-Sanjeevani 2.0 System across Bihar

5.1 Geography and reach

Component 2 is state-wide. Governance, data and capacity-building activities cover all 38 districts and are anchored in the SHSB e-Sanjeevani / Telemedicine Cell. Within that state-wide frame, intensive district support is directed at the low-performing districts identified by the state assessment — the 14 districts in the Critical performance band — with the specific districts and sequence agreed with SHSB at inception. Training is delivered virtually so that state-wide coverage is achievable within the assignment period.

5.2 Activities, outputs and outcomes

Activity and key tasks	Outputs by Mar 2027	Outcomes / indicators
C2.1 Programme management and governance support to the SHSB e-Sanjeevani Cell. Provide dedicated programme management support to the Cell; institutionalize monthly district performance review against a balanced KPI framework covering volume, quality, equity, referral outcomes and patient experience; reinstate hub call-loss reporting for all districts and all months.	Monthly district performance review system operational and minuted; call-loss data reported for 100% of districts every month; KPI framework adopted by SHSB.	A functioning, data-driven governance and review mechanism institutionalized within SHSB, with review meetings chaired by government and supported — not run — by the agency.
C2.2 Data standardization and analytics. Standardize the monthly data schema and mandate cadre coding of all user accounts; support de-duplication of NIN registrations and validation of unmapped portal facilities; build and maintain district performance dashboards; transfer dashboard operation and data routines to SHSB staff.	Standardized monthly data format adopted; uncoded cadre reduced to <5%; duplicate and unmapped facility clean-up executed; district dashboards live and publicly viewable; data-routine handover note signed off.	Reliable, comparable monthly data available to SHSB and districts without external processing; target-setting rests on accurate denominators.
C2.3 Provider and facility activation. Support issuance of e-Sanjeevani logins to all posted CHOs, including those currently without active accounts; run a dormant-spoke activation sprint against defined active-spoke targets with weekly tracking; accelerate NIN-based onboarding of eligible AAM facilities through district drives prioritizing low-coverage districts; verify and eliminate login sharing under a one-provider-one-login rule.	CHO login coverage ≥70%; active spokes ≥8,500 per month; state NIN-matched AAM onboarding coverage ≥65%; login audit completed in the districts where sharing was identified.	Materially expanded teleconsultation availability at spoke level at minimal marginal cost.
C2.4 Hub optimization. Support establishment of hub Medical Officer duty rosters with protected teleconsultation time slots, including the use of Senior Residents and bond-period doctors at Medical College and district hubs; introduce case-triaging protocols; support call-acceptance targets published on district dashboards.	Duty rosters and protected slots operational at supported hubs; triage protocol issued and disseminated; call-acceptance targets published.	Call-acceptance rate ≥90% at supported hubs; reduced call loss against the 22–35% baseline.

Activity and key tasks	Outputs by Mar 2027	Outcomes / indicators
C2.5 Virtual capacity building and quality of care. Deliver e-Sanjeevani 2.0 refresher training virtually for CHOs, ANMs and hub Medical Officers using standardized self-paced and live modules with attendance and assessment tracking; develop and roll out a standardized teleconsultation SOP and training modules, a clinical checklist and a documentation register; support clinical mentoring, prescription-quality monitoring and closed-loop referral follow-up.	Virtual training modules and facilitator pack developed and handed over; 100% of active providers in supported geographies trained with assessment records; SOP, checklist and teleconsultation register rolled out; referral-tracking mechanism established.	Vitals recorded in ≥80% of observed calls; teleconsultation register operational at 100% of assessed facilities; improved consultation quality and continuity of care.
C2.6 Intensive support to low-performing districts. Diagnose root causes district by district rather than applying a uniform package; prepare and support district micro-plans; conduct supportive supervision visits; escalate equipment and connectivity gaps to the appropriate authority; facilitate peer learning and recognition of improving districts; document a replicable district support framework.	District micro-plans implemented in the agreed low-performing districts; monthly supportive supervision reports; district support framework documented and handed to SHSB.	Measurable improvement in the composite performance index of supported districts; replication roadmap accepted by SHSB.

6. Component 3: Women-Collective-Driven Family Health Care Model in One Block of Patna District

6.1 Geography and sequencing

Component 3 is a block-level demonstration. One block of Patna district will be selected jointly with Jhpiego, the District Health Society and JEEViKA within the first six weeks, on the basis of JEEViKA SHG density and maturity, the number and functionality of AAMs, and the willingness of block health and JEEViKA leadership to co-own the model. All AAMs in the selected block fall within scope.

Sequencing within the component is deliberate and must be respected: facilities are graded and strengthened first, mobilization follows, and fixed-day services begin only where the receiving AAM can credibly deliver. Generating demand ahead of capacity would damage both the model and community trust in it. Target beneficiaries are SHG women aged 30 and above and their households.

6.2 Activities, outputs and outcomes

Activity and key tasks	Outputs by Mar 2027	Outcomes / indicators
C3.1 Block selection, AAM facility grading and quality strengthening. Facilitate joint selection of the block against agreed criteria. Assess and grade every AAM in the block against national AAM and NQAS standards — infrastructure, human resources, essential drugs and diagnostics, service package availability,	Minuted block selection; grading tool applied and baseline grades assigned for all AAMs in the block; facility-wise quality improvement plans; gap-closure tracker; endline re-grading report.	Measurable improvement in grade or score for ≥80% of AAMs between baseline and endline; facilities demonstrably ready to absorb increased demand.

Activity and key tasks	Outputs by Mar 2027	Outcomes / indicators
teleconsultation readiness, records, and infection prevention. Assign grades, prepare facility-wise quality improvement plans, handhold gap closure, and re-grade at endline.		
C3.2 SHG mobilization and health literacy. Enumerate SHG women aged 30+ and their households across the block; conduct awareness and peer-education sessions within weekly SHG meetings covering NCDs, anaemia, RTI and gynaecological health, menopausal and mental health, and cervical and breast cancer; orient and support SHG peer educators; coordinate throughout with JEEViKA Community Mobilizers and Community Nutrition Resource Persons.	Enumeration list of SHG women in the block; session calendar delivered; peer educators oriented and active in participating SHGs.	An informed, mobilized SHG membership with predictable participation in fixed-day services.
C3.3 Pink Day: fixed-day screening and service delivery at AAMs. Establish a fixed-day ("Pink Day") schedule at each participating AAM covering the four priority interventions — screening and treatment of RTI and gynaecological conditions; anaemia awareness and supplementation; referral and care for menopausal problems and mental health; and cervical and breast cancer screening — integrated with NCD screening, antenatal care and immunization, and with e-Sanjeevani teleconsultation for specialist advice. Communicate the calendar in advance through SHG and ASHA channels.	Pink Day calendar published and operating at all participating AAMs; screening coverage reports disaggregated by intervention; documented use of teleconsultation for specialist referral.	Rising share of enumerated SHG women screened under each of the four interventions; early detection and treatment initiation documented.
C3.4 Follow-up, referral and continuity of care. Distribute NCD diaries to SHG members and households; support CBAC assessments; establish referral facilitation and closed-loop tracking to higher facilities for advanced diagnostics and specialist care.	NCD diaries distributed and in active use; referral tracker with completion status; follow-up protocols operational at all participating AAMs.	Improved treatment adherence and referral completion among screened women.
C3.5 Community feedback mechanism. Establish a structured system at participating AAMs to collect, analyze and act on patient and public feedback — exit interviews, feedback registers, SHG-facilitated community scorecards, and periodic community dialogue with the facility team. Feed findings into the quality improvement plans under C3.1 and into monthly review.	Feedback mechanism operational at all participating AAMs; quarterly feedback analysis reports naming actions taken and closed.	Demonstrated facility responsiveness to community feedback, reflected in endline re-grading.

Activity and key tasks	Outputs by Mar 2027	Outcomes / indicators
C3.6 Data Validation Committees with SHG representation. Support constitution or revival of facility- and block-level Data Validation Committees; facilitate inclusion of SHG and Village Organization representatives as members; orient members on reading service and screening data; establish a monthly validation routine covering screening, follow-up and teleconsultation data.	Committees constituted or revived with documented SHG representation; monthly validation meetings held and minuted; discrepancy log maintained and resolved.	Improved accuracy and community ownership of AAM service data, with discrepancies corrected within the reporting cycle.
C3.7 Documentation and the replication framework. Maintain coordination among CHOs, ASHAs, Community Mobilizers, CNRPs, Jan Arogya Samitis and SHG leadership; track service coverage, adherence and outcomes; document the model — costs, processes, results, what worked and what did not — as a replication framework for adoption across districts under NHM.	Monthly coverage and outcome reports; learning brief; costed replication framework submitted and presented to the District Health Society and JEEViKA.	A demonstrated, scalable women-led family health model endorsed for replication.

7. Deliberate Linkages between Components

The three components are independent in geography and management but are expected to reinforce one another at four specific points. The agency must plan for these explicitly; they are not incidental.

- **Teleconsultation as a shared service.** The UAAMs strengthened under C1.3 and the AAMs strengthened under C3.1 are both e-Sanjeevani spoke facilities. Activation and training under C2.3 and C2.5 must cover them, and specialist advice sought under C1.3 and C3.3 must run through the e-Sanjeevani platform rather than around it.
- **Referral pathways.** The city referral matrix developed under C1.4 covers Patna. Where the Component 3 block falls within its reach, the same matrix and the same referral formats are to be used, not a parallel set.
- **Data discipline.** The standardized reporting and validation habits built under C2.2 should inform the Data Validation Committees under C3.6, so that facility data is validated the same way irrespective of component.
- **Shared learning products.** The C1.7 scale-up playbook and the C3.7 replication framework are separate documents for separate audiences, but must use consistent costing assumptions and a common results vocabulary so that Jhpiego and the Government can read them together.

8. Timeline and Phasing

The assignment runs from contract signing, targeted for end-August/September 2026, to 31 March 2027. All three components mobilize simultaneously.

Phase	Component 1 — Patna UPHC	Component 2 — e-Sanjeevani	Component 3 — Women-Collective
Inception & selection (Sep – Oct 2026)	Digital mapping of all 34 catchments completed; five catchments selected and endorsed; household line-listing begun; referral matrix drafted.	Login and onboarding drives launched; call-loss reporting reinstated; data schema standardized; low-performing districts agreed.	Block selected and endorsed; AAM grading baseline completed; SHG enumeration begun; quality improvement plans drafted.
Systems in place (Nov – Dec 2026)	Ward Health Action Plans endorsed; UAAM readiness gaps closed; indenting calculator piloted; outreach calendar running; MAS and JAS activated; referral matrix endorsed and disseminated.	Dormant-spoke activation sprint; hub rosters and triage protocols; virtual 2.0 training rollout; district dashboards live.	Quality improvement plans under implementation; peer educators active; Pink Day services launched at graded AAMs; Data Validation Committees reconstituted.
Full implementation (Jan – Feb 2027)	≥70% follow-up coverage trajectory on track; monthly ward and facility reviews; JAS-led coverage of unlisted settlements.	Monthly district performance reviews routinized; SOP and register in use; closed-loop referral tracking; district micro-plans in execution.	Pink Day screening coverage scaling; NCD diaries and CBAC in use; first community feedback cycles completed and acted on.
Consolidation & handover (Mar 2027)	Endline assessment; costed scale-up playbook; handover of digital map, datasets and tools to Patna City Health Society.	Handover of dashboards, data routines, training modules and district support framework to SHSB; capacity-transfer sign-off.	Endline AAM re-grading; costed replication framework; handover to District Health Society and JEEViKA.

9. Deliverables and Reporting Schedule

Deliverables are grouped by component. Those marked 'All' (1, 2, 11, 12 and 15) cover the whole assignment.

#	Comp.	Deliverable	Due
1	All	Inception report: detailed workplan, results framework with baselines and targets, selection criteria for the five catchments and the block, team deployment plan, activity-based budget	Within 3 weeks of signing
2	All	Monthly progress reports by component (activities, output indicators, issues, next month's plan) with monthly datasets	5th of each following month
3	C1	Digital catchment map and dataset for all 34 Patna UPHCs, with vulnerability ranking and minuted selection of the five catchments	31 October 2026
4	C1	Household vulnerability line-list and five Ward Health Action Plans; endorsed city referral matrix	30 November 2026

#	Comp.	Deliverable	Due
5	C1	Medicine-indenting calculator prototype with user guide and pilot results	31 January 2027
6	C2	Provider and facility activation status report (logins, spokes, onboarding) and standardized data schema adoption note	31 December 2026
7	C2	Virtual training package (modules and facilitator pack) and training completion report with assessment records	31 December 2026
8	C2	District support framework, with micro-plans and supervision reports for supported low-performing districts	28 February 2027
9	C3	Block selection note and AAM facility grading baseline report with quality improvement plans	31 December 2026
10	C3	Pink Day service operations and screening coverage report; first community feedback analysis	31 January 2027
11	All	Mid-term review presentation to Jhpiego, SHSB, Patna City Health Society and District Health Society	December 2026
12	All	Endline assessment against the results framework, including AAM re-grading	15 March 2027
13	C1	Costed scale-up playbook, presented to the City and State Health Societies	31 March 2027
14	C3	Costed replication framework and learning brief, presented to the District Health Society and JEEViKA	31 March 2027
15	All	Final report with process and results documentation, handover and capacity-transfer plan, and handover of all datasets, dashboards and tools in open editable formats	31 March 2027

10. Team Composition and Qualifications

The agency shall deploy a dedicated team sufficient to deliver all three components within the period. Jhpiego does not prescribe headcount; it specifies the levels at which capacity must exist and the competencies required. Bidders shall propose their own team size and structure and justify it against the activity clusters in Sections 4, 5 and 6, showing clearly which personnel serve which component. All CVs are subject to Jhpiego's approval before deployment, and replacements require prior written approval with an equivalent or better profile.

Level	Function	Indicative competencies
State level	Overall assignment leadership and Jhpiego interface; embedded programme management support to the SHSB e-Sanjeevani Cell for Component 2; government liaison; quality assurance of all deliverables.	Postgraduate in public health, health management or health informatics; 7+ years in health systems strengthening, including urban health/NUHM and/or digital health and telemedicine; demonstrated experience working inside State Health Society structures; strong analytical and representation skills.

Level	Function	Indicative competencies
District / city level	Coordination with Patna City Health Society, District Health Society and block structures; facility readiness and grading; training rollout; supportive supervision; data quality and review facilitation. Separate capacity is expected for Patna urban work and for the Component 3 block.	Postgraduate; 5+ years in primary healthcare or digital health implementation; experience in facility strengthening, provider training, monitoring and supportive supervision; familiarity with HMIS and NUHM reporting.
Block / field level	Household line-listing, outreach facilitation, MAS and JAS engagement in Component 1; SHG mobilization, Pink Day organization, referral follow-up and community feedback collection in Component 3.	Graduate; 3+ years of grassroots community health experience; familiarity with ASHA, MAS/JAS and SHG/JEEViKA platforms; local language fluency; comfortable with mobile-based data capture.
Technical and specialist inputs (may be part-time or pooled)	GIS and digital mapping; data analytics and dashboard development; clinical quality and training content design; documentation and knowledge products.	Demonstrable prior work in GIS mapping of health catchments, health data analytics, clinical training design and technical writing; may be supplied from the agency's central pool rather than full-time field deployment.

At minimum, the team must maintain continuous presence at state level, at city/district level for Patna, and at field level in both the five catchments and the Component 3 block, for the full duration. All personnel costs are embedded in activity costs under Section 11.

11. Budget Structure and Costing Principles

The agency shall submit an activity-based budget in the prescribed format, with unit costs, quantities and totals shown separately for each of the three components and for each quarter. Human resource costs shall not appear as separate staff salary lines: the remuneration, travel, communication and field support of the personnel described in Section 10 shall be apportioned across the activity lines they deliver and reflected in those activities' unit costs. GST shall be shown separately, if applicable.

Budget head (activity-based)	Illustrative unit basis	Cost inclusions (HR embedded)
1. Digital mapping, assessments, vulnerability line-listing and micro-planning	Per catchment mapped / per household surveyed / per ward	Survey teams, GIS and mapping inputs, tools and devices, data collection and analysis, facilitation time, Ward Health Action Plan workshops
2. Facility grading, readiness assessment and quality improvement support	Per facility assessed / per improvement cycle	Assessment teams, grading tools, handholding visits, technical time
3. Workshops, review meetings and governance support	Per workshop / per review cycle	Venue, participants, materials, facilitation and programme-management time
4. Training and capacity building (virtual e-Sanjeevani 2.0 modules,	Per module developed / per batch / per participant	Trainers, content and module development, virtual platform costs, materials, logistics,

Budget head (activity-based)	Illustrative unit basis	Cost inclusions (HR embedded)
SOPs, MAS/JAS, SHG peer educators)		coordination time
5. Outreach sessions, camps and Pink Day service facilitation	Per session / per fixed-day event	Mobilization, logistics, screening support, field facilitation time
6. IEC/BCC and community engagement materials	Per package / lumpsum	Design, printing, community events, NCD diaries, feedback tools
7. Digital tools, dashboards, referral matrix and data support	Per tool or dashboard / per month of data support	Dashboard and prototype development including the medicine-indenting calculator, data cleaning and analytics, analyst time
8. Monitoring, supportive supervision, documentation and knowledge products	Per visit / per product	Supervision visits, endline assessment and re-grading, documentation, playbook and replication framework production
9. Travel and field logistics	Actuals, capped as a percentage of activity cost	Project-related travel not costed within other heads
10. Agency management fee and overheads	Percentage of activity cost, to be quoted	Institutional overheads, statutory compliance
11. GST, if applicable	As per prevailing rates	To be shown separately against each head and in the total

Payments are milestone-based and linked to Jhpiego's acceptance of deliverables under Section 9, on an indicative schedule of: 20% on approval of the inception report; 25% on acceptance of Deliverables 3, 6 and 9; 25% on acceptance of Deliverables 4, 5, 7, 10 and 11; and 30% on acceptance of Deliverables 8, 12, 13, 14 and 15 and financial closure. All payments are subject to satisfactory performance and statutory deductions.

12. Institutional and Coordination Arrangements

- The agency reports to Jhpiego, which provides overall technical guidance, quality assurance and approval of all deliverables.
- Component 1 is executed through existing NUHM and Patna City Health Society structures, with UAAM teams, ASHAs, outreach workers, MAS and JAS delivering services and engaging communities, and oversight from the City and State Health Societies. Boundary and population data are reconciled with Patna Municipal Corporation records.
- Component 2 is anchored in the SHSB e-Sanjeevani / Telemedicine Cell, working with District Health Societies, hub institutions (Medical Colleges and District, Sub-divisional and Referral Hospitals) and spoke facilities.
- Component 3 is implemented in convergence with the District Health Society Patna, the block health administration, and JEEViKA at block level (Community Mobilizers, CNRPs, Village Organizations and SHGs), together with CHOs, ASHAs and Jan Arogya Samitis.

- The agency shall follow an explicit capacity-transfer approach. By March 2027, the digital map and datasets, referral matrix, dashboards, data routines, training modules, SOPs, grading tools, rosters and trackers introduced under this assignment must be operable by government and JEEViKA counterparts, and handed over in open, editable formats.
- All data collected belong to Jhpiego and the Government of Bihar. The agency shall comply with data-protection, safeguarding and ethical requirements, and obtain Jhpiego's written approval before any external communication or publication.

13. General Conditions

- Contract type: deliverable-linked, activity-based service contract. No separate reimbursement of agency staff salaries.
- Duration: from contract signing, targeted end-August/September 2026, to 31 March 2027. No-cost extensions only by prior written agreement.
- The agency shall maintain auditable records of all activities and expenditures, and permit Jhpiego or its designees to verify activities in the field.
- Non-performance against agreed milestones may lead to withholding of milestone payments or to termination in accordance with the contract.
- The agency shall adhere to Jhpiego's policies on safeguarding, prevention of sexual exploitation and abuse, anti-fraud and conflict of interest, and to Government of Bihar protocols when working in health facilities and communities.

Section 4

Financial Proposal

Financial Proposal should be made as per the details given under **point No 11. Budget Structure and Costing Principles**

Note: The Financial Proposal should be in PDF format with password protected.

Section 5

Payment Schedule

Payments are milestone-based and linked to Jhpiego's acceptance of deliverables under Section 9, on an indicative schedule of:

20% on approval of the inception report;

25% on acceptance of Deliverables 3, 6 and 9;

25% on acceptance of Deliverables 4, 5, 7, 10 and 11; and

30% on acceptance of Deliverables 8, 12, 13, 14 and 15 and financial closure.

All payments are subject to satisfactory performance and statutory deductions.