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Request for Proposals

Comparative Study of IPA-implementing vis-à-vis Non-implementing Facilities in Meghalaya

Terms of Reference

Issued by the Forum for Health Systems Design and Transformation
Health Systems Transformation Platform (HSTP)

Study focus: Assessment of current Outcome-Based Budgeting implementation, patient experience and community outreach in Meghalaya.

RFP schedule	Date and time
Issue date	10.11.2026
Deadline for queries	16.11.2026
Proposal submission deadline	20.11.2026

1 About HSTP

The Forum for Health Systems Design and Transformation, popularly known as the Health Systems Transformation Platform (HSTP), is a not-for-profit company registered under Section 8 of the Indian Companies Act, 2013, and established under the aegis of Tata Trusts. HSTP works with governments and other partners to generate and apply evidence for stronger, more equitable and responsive health systems through research, technical assistance and implementation support.

HSTP invites proposals from qualified research organisations, academic institutions and consulting agencies to assess the implementation of Internal Performance Agreement (IPA) now known as Outcome-Based Budgeting (OBB) in Meghalaya guided by the principle of results-based financing, with patient exit interviews and community outreach assessment as the principal components.

2 Background and rationale

Meghalaya's experience with Internal Performance Agreements (IPA) in selected health facilities informed the introduction of OBB in December 2025 and the subsequent transition of facilities across the state. OBB links financing with performance and seeks to strengthen local decision-making, accountability, service quality and responsiveness to community needs.

With facilities now operating under OBB, an IPA versus non-IPA comparison is no longer appropriate. Asking patients or community members to reconstruct their experiences from the earlier IPA period would also introduce substantial recall bias. The study will therefore assess current OBB implementation and service performance, without a historical comparison of a control group.

Patient exit interviews will capture the care received during the current visit. Community assessment will examine recent outreach, access barriers and unmet need, including the experiences of people who do not attend facilities. Facility and financial records will help explain how resources and implementation practices relate to these experiences and identify priorities for improvement.

3 Study objectives

3.1 Overall objective

To assess current OBB implementation in Meghalaya and how funded activities address patient and community needs, with particular emphasis on patient experience, affordability, effective outreach and equitable access to care.

3.2 Specific objectives

1. Assess patients' experiences of access, respectful care, communication, medicine and diagnostic availability, out-of-pocket expenditure, and advice on referral and follow-up during their current facility visit.
2. Assess the reach, regularity and responsiveness of community outreach, its links to service uptake and continuity of care, and barriers affecting underserved populations and non-users.
3. Examine current OBB fund flows, resource utilisation, facility autonomy, accountability and implementation constraints in relation to patient services and outreach.
4. Document community participation, provider and manager experiences, operational practices and service gaps that require attention.
5. Develop actionable recommendations to strengthen OBB implementation, monitoring and sustainable health financing in Meghalaya, with lessons relevant to other states.

4 Study approach and sampling

The study shall use a cross-sectional mixed-methods implementation assessment combining patient exit interviews, community surveys, facility and financial record review, and qualitative enquiry. IPA shall provide historical context only; prior IPA status shall not define study arms, sampling groups or analytical comparisons.

The sampling frame shall cover public health facilities and their linked communities across Khasi, Jaintia and Garo Hills. It shall consider Primary Health Centres, Community Health Centres, District Hospitals, Urban Primary Health Centres and State Dispensaries, with justified representation by facility type, geography, urban or rural setting and remoteness.

- Specify the numbers of facilities, exit interviews, community respondents, community clusters, key informant interviews, focus groups and case studies. Justify survey samples using precision targets, expected indicator levels, clustering and non-response; no intervention–control power calculation is required.
- Use systematic patient selection across different days, service periods and relevant service groups. Recruit community respondents through a defined catchment or population frame, including non-users, rather than beneficiary lists alone.

- Use purposive qualitative sampling to capture varied implementation conditions, including facilities and communities experiencing difficulties. Confirm the final sample, tools and analysis plan with HSTP during inception.

Exit questions shall relate to the current visit. Community questions shall generally use the preceding 30 days for recent care needs and up to three months for outreach, with clear dates and record checks where feasible. Any service-specific recall period must be justified. The study shall not ask respondents to compare present services with the period before December 2025.

5 Scope of work

5.1 Patient exit interviews

Conduct structured interviews after patients complete their visit, including pharmacy and diagnostic services where applicable. Interviewers shall be independent of providers and conduct interviews privately, outside staff hearing. Appropriate caregivers may respond for children or dependent patients, with proxy responses clearly identified.

- Assess the reason for attendance, travel and waiting time, service availability, services sought and received, and any service that could not be obtained.
- Assess respectful treatment, privacy, cleanliness, communication, understanding of treatment, and clarity of referral and follow-up advice. Measure overall satisfaction alongside these specific experiences.
- Record prescribed medicines and advised tests received, items unavailable, reasons for non-receipt and the need to seek services elsewhere. Verify prescriptions or visit records with permission where feasible.
- Record direct medical payments already incurred for the visit, including medicines, tests and fees. Report transport costs separately. Identify purchases still required after leaving, without recording anticipated costs as actual expenditure.
- Document suggestions for improving services, eligibility, refusals and incomplete interviews. Patients need not know the terms IPA or OBB to participate.

5.2 Community outreach and access assessment

Undertake a structured household or individual survey in sampled catchments, supported by outreach record review, observation where feasible, and community discussions. Include outreach participants and non-participants, recent users of public and other providers, and people reporting a need for care who did not obtain it.

- Assess recent awareness, frequency and reach of home visits, outreach sessions, health education, maternal and child health services, immunisation, and non-communicable disease screening and follow-up, according to the facility's service mandate.
- Examine whether outreach reaches remote settlements and underserved populations. Record unique people reached where possible, distinguishing repeat contacts from coverage of the eligible population.
- Assess the pathway from outreach contact to identification of need, referral, receipt of care and follow-up. Record reasons for missed services or discontinuation, including distance, cost, timing, unavailable services and poor experience.

- Verify delivery against planned outreach activities, settlements covered and services provided, using recent registers and community accounts. Identify OBB's operational or financial contribution without attributing all outreach to OBB.
- Assess community participation in identifying needs, facility planning, feedback and grievance handling. Include Accredited Social Health Activists (ASHAs), community groups and relevant facility or village committees.

Facility users and outreach attendees alone cannot represent the population's access needs. The community component shall therefore explicitly include non-users and people who delay or forgo care. Recent recall shall be supported by clear event dates and available records, with residual recall limitations reported.

5.3 Facility and financial assessment

Review current service readiness and recent service, outreach and financial records for a consistent OBB-period window agreed at inception, normally the preceding three to six complete months. Assess record completeness and distinguish resources received through OBB from other funding sources.

- Review availability of staff, medicines, diagnostics and referral arrangements, together with recent service utilisation, follow-up and service interruptions relevant to patient and community findings.
- Assess allocations, funds received, receipt dates, expenditure, available balances, approval processes and completion of funded activities. Examine spending on patient services and outreach and identify release, procurement or operational delays.

5.4 Qualitative enquiry and case studies

Conduct key informant interviews with state and district officials, programme managers, facility heads, finance and data staff, and relevant partners. Hold separate discussions with frontline workers and communities on current autonomy, accountability, workload, outreach barriers, trust and responsiveness. Develop a small set of facility or outreach case studies covering practical achievements and implementation difficulties.

6 Analysis and reporting expectations

Use descriptive analysis with appropriate survey weights, cluster-adjusted uncertainty and clearly defined denominators. Summarise current findings by facility type, geography and relevant population characteristics where sample sizes permit. Analyse qualitative data thematically and triangulate patient and community accounts with records and observations.

Assessment domain	Core measures
Patient experience	Waiting time; services received; respectful care, privacy and communication; understanding of treatment and follow-up.
Medicines and diagnostics	Receipt of prescribed medicines and advised tests among eligible patients; unavailability and external purchase requirements.
Affordability and access	Medical payments for the current visit; travel costs separately; recent unmet need and reasons for delayed or forgone care.

Assessment domain	Core measures
Outreach and continuity	Activities delivered; eligible people and settlements reached; uptake after contact; referral completion within the defined follow-up period.
Community voice and equity	Participation in planning, feedback and grievance response; barriers affecting remote and underserved groups.
Implementation and finance	Timeliness and use of funds; completion of funded activities; service readiness, managerial constraints and accountability.

The findings shall describe current performance and implementation pathways. They shall not be presented as a causal estimate of OBB impact or as evidence of change from the earlier IPA period. Recommendations shall identify priority actions, responsible institutions, resource implications and practical timelines.

7 Roles and responsibilities

7.1 HSTP

- Provide technical leadership and approve the protocol, sample, tools, analysis plan and deliverables; facilitate government coordination and access to study sites and data.
- Monitor progress and data quality, provide consolidated feedback, and guide interpretation, knowledge products and agreed dissemination activities.

7.2 Research partner

- Refine the methodology; translate and pilot tools; recruit, train and supervise field teams; and implement all survey, record-review and qualitative components.
- Manage and analyse data securely, provide weekly progress updates, prepare the required products, address review comments and hand over approved de-identified data and analysis files.

7.3 Government and programme institutions

The Government of Meghalaya and relevant state, district and facility authorities shall be requested to facilitate administrative permissions, access to records and field coordination, nominate focal points and participate in factual validation. Facility staff shall not select respondents or be present during confidential patient or community interviews.

8 Quality assurance and data management

- Translate and back-check tools in Khasi, Garo and other required local languages; pilot them outside the final sample and document interviewer training and tool revisions.
- Use digital checks, daily data review, field supervision and independent back-checks. Track sample achievement, refusals, missing information and corrective action by study component.
- Verify selected administrative and financial entries against source records. Use clear indicator definitions and recent, consistent reference periods; record limitations in recall and record completeness.

- Use coded identifiers, restricted access, secure storage and encrypted transfer. Separate any contact details from survey data and maintain an audit trail of corrections and analysis.

9 Ethical considerations

The research partner shall secure all required administrative permissions before recruitment or access to identifiable research data. Obtain informed consent in an appropriate language, ensure voluntary participation and protect privacy. Refusal or withdrawal shall not affect care or benefits. The protocol shall specify safeguards for minors and people unable to consent independently.

Obtain separate consent for recording, recontact or record linkage, where proposed. Avoid disruption of treatment and establish a procedure for urgent care concerns identified during fieldwork. Report findings in aggregate and protect against identification of individuals or small communities. Data stewardship, retention, publication and authorship arrangements shall be agreed with HSTP and relevant authorities, consistent with ethics approval.

10 Timeline and deliverables

The assignment shall be completed within two months of the agreed date. The proposal shall identify approval and data-access dependencies. No participant recruitment shall begin before the required approvals; any necessary schedule adjustment shall be agreed in writing with HSTP.

Stage	Timing	Required output
Inception	Week 1	Protocol, justified sample, outcome definitions, tools, analysis plan and work plan for HSTP approval.
Field readiness	Week 2	Required approvals, translated and piloted tools, training and field supervision arrangements.
Data collection	Weeks 2–5	Exit and community surveys, record review, qualitative enquiry and case studies; weekly progress and quality updates.
Analysis	Weeks 5–7	Cleaned datasets, codebook, quality report, preliminary findings and review presentation.
Draft products	Week 7	Draft report and knowledge products; stakeholder validation and responses to consolidated feedback.
Final submission	Week 8	Final products accepted by HSTP and complete data and analysis handover.

The final deliverables shall include:

- **Study report:** Executive summary, methods, patient and community findings, facility and financial assessment, integrated interpretation, limitations and prioritised recommendations, with tools and relevant technical annexes.

- **Policy brief and guidance document:** Actionable recommendations for Meghalaya and practical lessons on implementing performance-based health financing, with attention to patient experience and community outreach.
- **Manuscript and presentation:** A manuscript suitable for peer-reviewed journal submission and an editable presentation for the agreed dissemination meeting. Publication is outside the assignment timeline.
- **Data package:** De-identified quantitative data, codebook, sampling and weighting information, permitted anonymised qualitative materials, analysis code and output tables.

Submit reports in editable Word and PDF, presentations in PowerPoint, and data and code in agreed formats. Deliverable acceptance shall depend on completeness, methodological consistency, data quality and resolution of HSTP's review comments.

11 Financial proposal

Provide an itemised budget in Indian rupees, with unit costs, quantities, person-days, taxes, overheads and assumptions. Separately identify patient exit interviews and community outreach assessment costs. Include personnel, translation, piloting, training, fieldwork, travel, supervision, data management, analysis, reporting and agreed dissemination. Specify any costs expected to be borne by HSTP or other partners.

The budget shall support the proposed sample and full scope. Payment milestones, deliverable acceptance and other financial terms shall be finalised in the contract.

12 Eligibility and team requirements

Applicants shall demonstrate experience in health systems research, health financing, mixed-methods evaluation and independent field surveys, with field capacity in Meghalaya or a credible local partnership. The team shall cover quantitative and qualitative research, community engagement, financial review, data management and field supervision, with appropriate local language skills. Submit relevant CVs, roles and time commitments, and disclose any involvement in programme implementation or other conflicts of interest.

13 Proposal evaluation criteria

Criterion	Weight	Assessment focus
Understanding and relevance	20%	Understanding of current OBB implementation, patient needs and community outreach in Meghalaya.
Methodological rigour and feasibility	25%	Appropriate cross-sectional design, sampling precision, recall safeguards, independent surveys and quality assurance.
Technical expertise and team	15%	Relevant experience, multidisciplinary skills, local field capacity and availability.
Work plan and timeline	15%	Feasible sequencing, permissions, staffing, supervision and milestones.

Criterion	Weight	Assessment focus
Budget and value for money	10%	Transparent costs consistent with the sample, scope and deliverables.
Innovation and added value	10%	Practical approaches to verifying outreach and understanding patient and community experience.
Dissemination and policy translation	5%	Usable recommendations, knowledge products and stakeholder engagement.
Total	100%	

14 Proposal submission

Submit separate technical and financial proposals electronically in Word format by the deadline notified by HSTP. The technical proposal shall include:

- Organisation and investigator details; executive summary; understanding of the assignment; design, sampling justification, tools and analysis plan.
- Quality assurance, ethics and data-management arrangements; work plan; deliverables; team CVs and responsibilities; relevant assignments and conflict-of-interest declaration.

The financial proposal shall follow Section 11. HSTP may seek clarifications, discuss the proposed approach and verify relevant experience before selection. Late or incomplete proposals may not be considered.

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All proposals must be submitted @ hstp@hstp.org.in by 20th November 2026. Late submissions will not be considered.