REQUEST FOR PROPOSALS

26th October 2023

German Financial Cooperation with Health Department
Government of Khyber Pakhtunkhwa

For
Procurement
of
INSURANCE SERVICES' PROVIDER FOR
OUTPATIENT DEPARTMENT HEALTH (OPD) SCHEME

Country	:	Pakistan
Project	:	Social Health Protection Initiative Phase II (SHP II)
Project ID	:	BMZ No. 2013 66 228
Services for	:	Pilot of the OPD Insurance Scheme in Khyber Pakhtunkhwa
Employer/Implementing Agency	:	Department of Health, Government of Khyber Pakhtunkhwa
KfW Procurement No	:	509041
RFP No.	:	SHPI/II/KfW/Pilot/ISP

Social Health Protection Initiative (Sehat Card Plus)
DEPARTMENT OF HEALTH,
GOVERNMENT OF KHYBER PAKHTUNKHWA

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LETTER OF INVITATION

Project ID: BMZ No. 2013 66 228 Peshawar, the 26th October 2023

Mr. Fayyaz Noor,
Zonal Head (H&AI),
Peshawar Zone,
State Life Insurance Corporation of Pakistan,
State Life Building,
34-The Mall,
Peshawar Cantt.

Dear Mr. Fayyaz.

1. The Islamic Republic of Pakistan (hereinafter called "Recipient") has received financing from KfW Development Bank ("KfW") in the form of a "financial contribution" (hereinafter called "grant"*)* toward the cost of "Social Health Protection Initiative Phase II (SHP II)". The Department of Health, Government of Khyber Pakhtunkhwa acting as the implementing agency of the Recipient and referred to as the "Employer", intends to apply a portion of the proceeds of this "grant" to eligible payments under the contract for which this Request for Proposals is issued.

   Payments by KfW will be made only at the request of the Employer and upon approval by KfW, and will be subject, in all respects, to the terms and conditions of the financing agreement. No party other than the Employer shall derive any rights from the financing agreement or have any claims to the proceeds of the grant.

2. The Employer now invites **Proposals** to provide the following services (hereinafter called "Services"): **"Pilot of the OPD Insurance Scheme"** in up to four districts in Khyber Pakhtunkhwa, starting with the service delivery in the district of Mardan and rolling it out, based on evidence and cost. The current procurement process and proposals are being invited for start-up at District Mardan. More details on the Services are provided in the Terms of Reference (Section VII).

3. This Request for Proposals (RFP) has been addressed to the following shortlisted Service Providers:

Sr. #	Service Provider
1.	State Life Insurance Corporation of Pakistan

   It is not permissible to transfer this invitation to any other Service Provider.

4. A Service Provider will be selected in accordance with the procedures described in the KfW Guidelines for the Procurement of Consulting Services, Works, Goods, Plant and Non-Consulting Services in Financial Cooperation with Partner Countries, which can be found on the website www.kfw-entwicklungsbank.de, and in the present document.

5. The RFP includes the following Sections:

   Section I : Instructions to Service Providers (ISP)
   Section II : Data Sheet
   Section III : Technical Proposal - Standard Forms
   Section IV : Financial Proposal - Standard Forms
   Section V : Eligibility Criteria

Section VI : KfW Policy – Sanctionable Practice – Social and Environmental Responsibility
Section VII : Terms of Reference
Section VIII : Conditions of Contract and Contract Form

6. Please inform us by ***3rd November 2023***, in writing at following address, by facsimile or by E-mail:

Dr. Muhammad Riaz Tanoli
CHIEF EXECUTIVE OFFICER
Social Health Protection Initiative (Sehat Card Plus),
Department of Health, Government of Khyber Pakhtunkhwa,
House No. 9-A, Rehman Baba Road, University Town,
Peshawar, Pakistan.
Postal Code: 25000
Phone: +92(91) 9216013
Fax: +92(91) 5841792
Email: projectdirector.shp.kp@gmail.com

(a) that you have received this Letter of Invitation; and

(b) whether you intend to submit a **Proposal** alone or intend to enhance your experience by requesting permission to associate with other Service Provider(s) (if permissible under **ISP 14.1.2)**.

7. Details on the **Proposal**'s submission date, time and address are provided in **ISP 17.4** and **ISP 17.9**.

Yours sincerely,

[DR. MUHAMMAD RIAZ TANOLI]
Chief Executive Officer

PART 1

TENDERING PROCEDURES

Section I.
Instructions to Service Providers (ISP)

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Section I.
Instructions to Service Providers (ISP)

A. General Provisions

1. Scope of Proposals and Definitions

1.1 The Employer named in the **Data Sheet** intends to select a Service Provider from those listed in the LOI, in accordance with the method of selection specified in the **Data Sheet**.

1.2 Throughout these Request for Proposal the following definitions apply:

(a) "Affiliate(s)" means an entity that directly or indirectly controls, is controlled by, or is under common control with the Service Provider.

(b) "Applicable Law" means the laws and any other instruments having the force of law in the Employer's country, or in such other country as may be specified in the **Data Sheet**, as they may be issued and in force from time to time.

(c) "Service Provider" means a legally-established professional firm or an entity that may provide or provides the Services to the Employer under a Contract. The terms "Service Provider" and "Bidder" are used in this document interchangeably.

(d) "Contract" means a legally binding written agreement signed between the Employer and the Service Provider, which includes all the attached documents listed in its Clause 1 (the General Conditions (GC), the Special Conditions (SC), and the Appendices).

(e) "**Data Sheet**" means an integral part of the Instructions to Service Providers (ISP) Section 2 that is used to reflect specific country and assignment conditions to supplement the provisions of the ISP. In case of conflict between the ISP and the **Data Sheet**, the **Data Sheet** shall prevail.

(f) "Day" means a calendar day.

(g) "Employer" means the contracting party that legally concludes the Contract for the Services with the selected Service Provider notwithstanding the representation by KfW in case of an agency contract.

(h) "Experts" means, collectively, Key Experts, other experts, or any other personnel of the Service Provider, Sub-Service Provider or Joint Venture member(s).

(i) "Government" means the government of the Employer's country.

(j) "Guidelines" means Guidelines for the Procurement of Consulting Services, Works, Plant, Goods and Non-Consulting Services in Financial Cooperation with Partner Countries available at www.kfw-entwicklungsbank.de.

(k) "ISP" (Section 2 of this RFP) means the Instructions to Service Providers that provides the shortlisted Service Providers with all information needed to prepare their Proposals.

(l) "Joint Venture (JV)" means an association with or without a legal personality distinct from that of its members, of more than one Service Provider where one member has the authority to conduct all business for and on behalf of any and all the members of the JV, and where the members of the JV are jointly and severally liable to the Employer for the

performance of the Contract. The terms Joint Venture and Consortium can be used interchangeably.

(m) “Key Expert(s)” means an individual professional whose skills, qualifications, knowledge and experience are critical to the performance of the Services under the Contract and whose CV is taken into account in the technical evaluation of the Service Provider’s **Proposal**.

(n) “LOI” (Section 1 of this RFP) means the Letter of Invitation being sent by the Employer to the shortlisted Service Providers.

(o) “Proposal” means the Technical Proposal and the Financial Proposal of the Service Provider.

(p) “RFP” means the Request for Proposals to be prepared by the Employer for the selection of Service Providers.

(q) “Services” means the work to be performed by the Service Provider pursuant to the Contract.

(r) “Sub-Service Provider” means an entity to which the Service Provider intends to subcontract any part of the Services while remaining responsible to the Employer during the performance of the Contract.

(s) “TOR” (Section VII of this RFP) means the Terms of Reference that explain the objectives, scope of work, activities, and tasks to be performed, respective responsibilities of the Employer and the Service Provider, and expected results and deliverables of the assignment.

1.3 The shortlisted Service Providers are invited to submit a Technical Proposal and a Financial Proposal for services required for the assignment named in the **Data Sheet**. The Proposal will be the basis for negotiating and ultimately signing the Contract with the selected Service Provider.

1.4 The Service Providers should familiarize themselves with the local conditions and take them into account in preparing their Proposals; including attending a pre-proposal conference if one is specified in the **Data Sheet**. Attending any such pre-proposal conference is at the Service Providers’ expense.

1.5 The Employer will timely provide, at no cost to the Service Providers, the inputs, relevant project data, and reports required for the preparation of the Service Provider’s Proposal as specified in the **Data Sheet**.

2. Source of Funds, Responsibilities

2.1 The Employer as indicated in the **Data Sheet** has applied or received financing (hereinafter called “funds”) from KfW Development Bank (hereinafter called “KfW”) towards the cost of the project named in the **Data Sheet**. The Employer intends to apply a portion of the funds to eligible payments under the contract(s) resulting from this procurement process.

2.2 The procurement process is the responsibility of the Employer. KfW shall verify that the procurement process is fair, transparent, economical, free of discrimination and according to the provisions in this document. KfW exercises its monitoring function on the basis of the contractual arrangements with the Employer and the Applicable Guidelines detailing the requirement for KfW’s approval and no objection. No contractual relationship between KfW and any third party shall be deemed to exist other than with the Employer.

3. Sanctionable Practice

3.1 KfW requires compliance with its policy in regard to Sanctionable Practice as defined and set forth in Section VI.

3.2 In further pursuance of this policy, Service Providers shall permit and shall cause its agents to provide information and permit KfW or an agent appointed by

KfW to inspect on site all accounts, records and other documents relating to bid submission and contract performance (in the case of award), and to have them audited by auditors or agents appointed by KfW.

4. Eligible Service Providers and Eligible Materials, Equipment, and Services

4.1 A Service Provider may be a firm that is a private entity, a government-owned entity — subject to ISP 4.3 — or a combination of such entities in the form of a joint venture ("JV") under an existing JV Agreement or with the intent to enter into such an agreement supported by a Letter of Intent to execute a JV Agreement, in accordance with ISP 11.2. In the case of a JV, all members shall be jointly and severally liable for the execution of the Contract in accordance with the Contract terms. The Service Provider shall nominate an authorized representative who shall have the authority to conduct all business for and on behalf of the Bidder and any and all its members, if the Service Provider is a JV, during tendering and contract execution (in the event the Service Provider is awarded the Contract). The authorization shall be in the form of a written power of attorney attached to the Technical Proposal. Unless specified in the **Data Sheet**, there is no limit on the number of members in a JV.

4.2 It is the Service Provider's responsibility to ensure that its Experts, joint venture members, Sub-Service Providers, agents (declared or not), sub-contractors, service providers, suppliers and/or their employees meet the requirements of eligibility and conflict of interest as established hereunder.

4.3 KfW's eligibility criteria to bid are described in Section V, Eligibility Criteria.

4.4 This tendering procedure is open only to prequalified Service Providers.

4.5 A Service Provider shall provide such evidence of eligibility satisfactory to the Employer, as specified in Clause 4.3 or as the Employer shall reasonably request.

4.6 The materials, equipment and services to be supplied under the Contract and financed by the KfW may have their origin in any country subject to the restrictions specified in Section V, Eligibility Criteria, and all expenditures under the Contract will not contravene such restrictions. At the Employer's request, Service Providers may be required to provide evidence of the origin of materials, equipment and services.

5. Conflict of Interest

5.1 The Service Provider is required to provide professional, objective, and impartial advice, at all times holding the Employer's interests paramount, strictly avoiding conflicts with other assignments or its own corporate interests, and acting without any consideration for future work.

5.2 Bidders shall be disqualified if they:

(a) are an affiliate controlled by the PEA or a shareholder controlling the PEA, unless the stemming conflict of interest has been brought to the attention of KfW and has been fully resolved to the satisfaction of KfW;

(b) have a business or a family relationship with a PEA's staff involved in the tender process or the supervision of the resulting Contract, unless the stemming conflict of interest has been brought to the attention of KfW and resolved to its satisfaction;

(c) are controlled by or do control another Bidder or are under common control with another Bidder, receive from or grant subsidies directly or indirectly to another Bidder, have the same legal representative as another Bidder, maintain direct or indirect contacts with another Bidder which allow them to have or give access to information

contained in the respective applications, to influence them or influence the decisions of the PEA;

(d) are engaged in a services activity which, by its nature, may be in conflict with the assignment that they would carry out for the PEA;

(e) were directly involved in drawing up the terms of reference or other relevant information for the tender process. This shall not apply to Service Providers who have produced preparatory studies for the project or who were involved in a preceding project phase, insofar as the information they prepared, especially feasibility studies, was made available to all Bidders and the preparation of the terms of reference was not part of the activity.

(f) were during the last 12 months prior to publication of the tender process indirectly or directly linked to the project in question through employment as a staff member or advisor to the PEA, and are or were able in this connection to influence the award of contract.

(g) are state-owned entities, which are not able to provide evidence that (a) they are legally and financially autonomous and (b) they do operate under commercial laws and regulations.

5.3 The Service Provider has an obligation to disclose to the Employer any situation of actual or potential conflict that impacts its capacity to serve the best interest of its Employer. Failure to disclose such situations may lead to the disqualification of the Service Provider or the termination of its Contract.

6. Unfair Competitive Advantage

6.1 Fairness and transparency in the selection process require that the Service Providers or their Affiliates competing for a specific assignment do not derive a competitive advantage from having provided services related to the assignment in question or have otherwise been involved in the preparation of this tender procedure. To that end the Employer shall indicate in the **Data Sheet** and make available to all shortlisted Service Providers together with this RFP all information that would in that respect give such Service Providers any unfair competitive advantage over competing Service Providers. Subject to aforementioned provision Service Providers who have produced preparatory studies for the assignment or who were involved in the preceding phase may participate, except when they have prepared the Terms of Reference.

B. Preparation of Proposals

7. General Considerations

7.1 In preparing the Proposal, the Service Provider is expected to examine the RFP in detail.

7.2 A substantially responsive Proposal is one that conforms to the terms, conditions, and specifications of the RFP without material deviation or reservation which are likely to jeopardize the achievement of the objective of this assignment and which by their nature are beyond the pure technical evaluation as per ISP 21.1. A material deviation or reservation is one that:

a) affects in any substantial way the scope, quality, or performance of the Services; or

b) limits in any substantial way, inconsistent with the RFP, the Employer’s rights or the Service Provider’s obligations under the Contract; or

c) if rectified would unfairly affect the competitive position of other Service Providers presenting substantially responsive Proposals.

Substantially non-responsive Proposals shall be rejected by the Employer.

8. Cost of Preparation of Proposal

8.1 The Service Provider shall bear all costs associated with the preparation and submission of its Proposal, and the Employer shall not be responsible or liable for those costs, regardless of the conduct or outcome of the selection process. The Employer is not bound to accept any **Proposal**, and reserves the right to annul the selection process at any time prior to Contract award, without thereby incurring any liability to the Service Provider.

9. Language

9.1 The Proposal, as well as all correspondence and documents relating to the Proposal exchanged between the Service Provider and the Employer shall be written in the language(s) specified in the **Data Sheet**.

10. Documents Comprising the Proposal

10.1 The Proposal shall comprise the documents and forms listed in the **Data Sheet**.

10.2 The Service Provider shall include a Declaration of Undertaking in the format provided in Form TECH-2 (Section III).

10.3 The Service Provider shall furnish information on commissions, gratuities, and fees, if any, paid or to be paid to agents or any other party relating to this Proposal and, if awarded, Contract execution, as requested in the Financial Proposal submission form (Section IV).

11. Only One Proposal, Sub-Service Providers, Key Experts

11.1 The Service Provider (including the individual members of any Joint Venture) shall submit only one Proposal, either in its own name or as part of a Joint Venture in another Proposal. If a Service Provider, including any Joint Venture member, submits or participates in more than one **Proposal**, all such **Proposal**s shall be rejected.Sub-Service Providers may participate in more than one Proposal unless ISP 11.2 applies and if not otherwise stipulated in the **Data Sheet**..

11.2 A Sub-Service Provider whose qualification was taken into account during the prequalification phase along with the one of a Service Provider shall only participate in the Proposal of this Service Provider. The ladder shall integrate services from the respective Sub-Service Provider into the Proposal as indicated in the prequalification.

11.3 Individuals[1] (regular staff or temporarily engaged freelance experts) shall not participate as Key Experts in more than one Proposal unless when circumstances justify and if stated in the **Data Sheet.**

12. Proposal Validity

12.1 The **Data Sheet** indicates the period during which the Service Provider's Proposal must remain valid after the Proposal submission deadline. During this period, the Service Provider shall maintain its original Proposal without any change, including the availability of the Key Experts, the proposed rates and the total price.

12.2 A replacement of Key Experts in the initial Proposal validity period is acceptable only for duly justified reasons beyond the control of the Service Provider (e.g. sickness or accident). The Service Provider shall propose an alternative expert with an equal or better qualification. If the replacement Key Expert's qualification is not equal or better than the qualification of the initial candidate or the justification for replacement is unsubstantiated the Proposal shall be rejected.

[1] An individual (natural person) which is not part of the regular staff ("freelancer") but engaged temporarily as Key Expert for the relevant Contract shall not be considered as Sub-Service Provider (subcontractor) in this context.

Extension of Validity Period

12.3 The Employer will make its best effort to complete the evaluation within the **Proposal**'s validity period. However, should the need arise, the Employer may request, in writing, all Service Providers who submitted Proposals prior to the submission deadline to extend the Proposals' validity period.

12.4 If the Service Provider agrees to extend the validity period of its Proposal, it shall be done without any change in the original Proposal and with the confirmation of the availability of the Key Experts.

12.5 The Service Provider has the right to refuse to extend the validity period of its Proposal in which case such Proposal will not be further evaluated.

Substitution of Key Experts at Validity Extension

12.6 If any of the Key Experts becomes unavailable during the extended validity period, the Service Provider shall provide a written substitution request to the Employer.

12.7 The replacement Key Expert shall have equal or better qualifications than the Key Expert being replaced. If the Service Provider fails to provide a replacement Key Expert with equal or better qualification, such a Proposal will be rejected.

12.8 Substitution requests shall not delay the evaluation process.

Sub-Contracting

12.9 The Service Provider shall not subcontract the whole of the Services to one or more Sub-Service Providers.

13. Clarification and Amendment of RFP

13.1 The Service Provider may request a clarification of any part of the RFP until the deadline indicated in the **Data Sheet**. Any request for clarification must be sent in writing, or by standard electronic means, to the Employer's address indicated in the **Data Sheet**. The Employer will respond in writing, or by standard electronic means, and will send written copies of the response (including an explanation of the query but without identifying its source) to all shortlisted Service Providers not later than ten (10) days prior to the deadline for the submission of Proposals. Should the Employer deem it necessary to amend the RFP as a result of a clarification, it shall do so following the procedure described below:

13.1.1 At any time before the **Proposal** submission deadline, the Employer may amend the RFP by issuing an amendment in writing or by standard electronic means. The amendment shall be sent to all shortlisted Service Providers and will be binding on them.

13.1.2 If the amendment is substantial, the Employer may extend the **Proposal** submission deadline to give the shortlisted Service Providers reasonable time to take an amendment into account in their Proposals.

13.2 The Service Provider may submit a modified Proposal or a modification to any part of it at any time prior to the Proposal submission deadline. No modifications to the Technical or Financial Proposal shall be accepted after the deadline.

14. Preparation of Proposals – Specific Considerations

14.1 While preparing the Proposal, the Service Provider must give particular attention to the following:

14.1.1 To establish that the Service Provider continues to meet the eligibility and qualification criteria used at the time of prequalification, the Service Provider shall submit the Form E/QUAL, as stipulated in the

Section 3 – Technical Proposal Forms, and updated information on any assessed aspect that changed from that time.

14.1.2 If a shortlisted Service Provider considers that associating with other Service Providers in the form of a Joint Venture or as Sub-Service Providers may enhance its expertise for the assignment, it may do so with either (a) non-shortlisted Service Provider(s), or (b) shortlisted Service Providers with prior approval of the Employer, and only if sufficient competition continues to be guaranteed. Association with a non-shortlisted Service Provider shall be subject to approval of the Employer. When associating with non-shortlisted firms in the form of a joint venture or a sub-consultancy, the shortlisted Service Provider shall be the Lead Service Provider. If shortlisted Service Providers associate with each other, any of them can be the Lead Service Provider.

14.1.3 The Employer may indicate in the **Data Sheet** the estimated Key Experts' time-input or the Employer's estimated total cost of the assignment, but not both. This estimate is indicative and the Proposal shall be based on the Service Provider's own estimates.

14.1.4 If so required in the **Data Sheet**, the Service Provider shall include in its Proposal at least the minimum time-input (in the same units) required from the Key Experts. If the Service Provider includes a lower time input, the Employer shall adjust the respective Financial Proposal to make it comparable with the other Proposals in accordance with the method in the **Data Sheet**.

14.1.5 If the evaluation method as stipulated in the **Data Sheet** is not standard quality – cost based evaluation but fixed budget selection, the estimated time-input of the Key Experts shall not be disclosed, but the **Data Sheet** shall provide the total available budget for the assignment with an indication of whether taxes are included or are not included in this amount.

15. Technical Proposal Format and Content

15.1 The Technical Proposal shall not include financial information. A Technical Proposal containing material financial information shall be declared non-responsive.

15.2 The Service Provider shall not propose Key Experts inconsistent with the Key Experts profiles described in the TOR (Section VII). Only one CV shall be submitted for each Key Expert position.

15.3 The Technical Proposal shall be prepared using the Standard Forms provided in Section III of this RFP.

16. Financial Proposal

16.1 The Service Provider shall submit a Financial Proposal based on the requirement as described in the TOR (Section VII) and taking into account the remuneration mode as specified in the **Data Sheet**. If a contract period is provided in the **Data Sheet** the Service Provider shall assume this contract period in the preparation of the Financial Proposal. The Financial Proposal shall contain the information and be structured as detailed in Section IV.

Price Adjustment

16.2 For assignments with a duration exceeding 24 months, a price adjustment provision for foreign and/or local inflation for remuneration rates shall apply in line with the provisions stated in the **Data Sheet**.

Taxes

16.3 The Service Provider, its Sub-Service Providers and Experts are responsible for meeting all tax liabilities and public duties in connection with the

Contract according to Applicable Law in the Employer's country, unless they are exempted from such payments. The details of the applicable regime are indicated in the **Data Sheet.** In any case taxes, duties, levies and fees payable by the Service Provider, its Sub-Service Providers and Experts outside the Employer's country shall be considered to be included in the overhead fees..

Currency of Proposal

16.4 The Service Provider may express the price for its Services in Euro unless otherwise stated in the **Data Sheet**. If indicated in the **Data Sheet**, the portion of the price representing local cost shall be stated in the national currency.

Currency of Payment and Payment Conditions

16.5 Payments under the Contract shall be made in the currency or currencies in which the payment is requested in the Proposal.

16.6 The Service Provider shall calculate the Financial Proposal on the basis of the general payment conditions as per model Contract for services attached under Section VIII if not otherwise stated in the **Data Sheet**.

Contributions by the Employer

16.7 The Service Provider shall assume in the financial Proposal that the Employer shall make the following contributions:

16.7.1 provide the Service Provider with all the information, documents, maps, aerial photographs, etc. in his possession and necessary for the completion of his services, free of charge, for the duration of the project;

16.7.2 ensure that the Service Provider has all the necessary permits to obtain further documents, maps and aerial photographs;

16.7.3 support the Service Provider in obtaining all the necessary working permits, residence permits and import licenses;

16.7.4 provide other contributions as stipulated in the **Data Sheet.**

C. Submission, Opening and Evaluation

17. Submission, Sealing, and Marking of Proposals

17.1 The Service Provider shall submit a signed and complete Proposal comprising the documents and forms in accordance with ISP 10 (Documents Comprising Proposal). The submission can be done by mail (postal or courier service) or by hand.

17.2 The authorized representative of the Service Provider according to ISP 4.1. shall sign the original submission letters in the required format for both the Technical Proposal and the Financial Proposal.

17.3 A Proposal submitted by a Joint Venture shall be signed by all members so as to be legally binding on all members, or shall be signed by the authorized representative according to ISP 4.1 who has a written power of attorney from each member signed by the member's authorized representative and attached to the Technical Proposal.

17.4 Any modifications, revisions, interlineations, erasures or overwriting shall be valid only if they are signed or initialized by the persons signing the Proposal.

17.5 The signed Proposal shall be marked "Original", and its copies marked "Copy" as appropriate. The number of copies and recipients are indicated in the **Data Sheet**. All copies shall be made from the signed original. If there are discrepancies between the original and the copies, the original shall prevail.

17.6 The original and all the copies of the Technical Proposal shall be placed inside of a sealed envelope clearly marked "Technical Proposal", "[Name of the Assignment]“, reference number, name and address of the Service Provider, and

with a warning "Do Not Open until [insert the date and the time of the Technical Proposal submission deadline]."

17.7 Similarly, the original and all copies of the Financial Proposal (if required for the applicable selection method) shall be placed inside of a sealed envelope clearly marked "Financial Proposal" followed by the name of the assignment, reference number, name and address of the Service Provider, and with a warning "Do Not Open With The Technical Proposal."

17.8 The sealed envelopes containing the Technical and Financial Proposals shall be placed into one outer envelope and sealed. This outer envelope shall bear the submission address, RFP reference number, the name of the assignment, Service Provider's name and the address, and shall be clearly marked "Do Not Open Before [insert the time and date of the submission deadline indicated in the **Data Sheet**]".

17.9 If the envelopes and packages with the Proposal are not sealed and marked as required, the Employer will assume no responsibility for the misplacement, loss, or premature opening of the Proposal.

17.10 The original of the Proposal or its modifications must be sent to the address indicated in the **Data Sheet** and received no later than the deadline indicated in the **Data Sheet**, or any extension to this deadline. Any Proposal or its modification received after the deadline shall be declared late and rejected, and promptly returned unopened. The timely receipt of the original of the Proposal at the address and date indicated in the **Data Sheet** is decisive for the timely submission of the Proposal.

17.11 The Service Provider may be requested to send additional copies of the Proposal to other recipients as indicated in the **Data Sheet**. In this case the same requirements for envelopes and packages apply as for the original of the Proposal. The receipt of such copies shall not be decisive for the timely submission.

18. Confidentiality

18.1 From the time the Proposals are opened to the time the Contract is awarded, the Service Provider shall not contact the Employer on any matter related to its Technical and/or Financial Proposal. Information relating to the evaluation of Proposals and award recommendations shall not be disclosed to the Service Providers who submitted the Proposals or to any other party not officially concerned with the process, until the Contract is awarded.

18.2 Any attempt by shortlisted Service Providers or anyone on behalf of the Service Provider to influence improperly the Employer in the evaluation of the Proposals or Contract award decisions may result in the rejection of its Proposal.

19. Opening of Technical Proposals

19.1 The Employer's evaluation committee shall proceed with the opening of the Proposals shortly after the submission deadline as indicated in the **Data Sheet** and establish and sign an opening protocol as per ISP 19.4.

19.2 The Employer's evaluation committee shall be composed of at least three members unless otherwise detailed in the **Data Sheet**. One member of the Evaluation committee shall not be staff from the Employer's administration or organisation. However, if a tender agent conducts the selection procedure on behalf of the Employer as indicated in the **Data Sheet** the opening of Proposals shall be done by the tender agent in presence of a witness and both shall sign the opening protocol as per ISP 19.4

19.3 The envelopes with the Financial Proposal shall remain sealed and shall be securely stored until they are opened in accordance with ISP 22.

19.4 At the opening of the Technical Proposals the following shall be recorded in the opening protocol: (i) the presence or absence of a signed Technical Proposal Submission Form (TECH-1) and the name and business address of the Service Provider or, in case of a Joint Venture, the name and business address of the Joint Venture, the name and business address of the lead member and the names and business addresses of all members as stated in TECH-1; (ii) the presence or absence of a duly sealed envelope with the Financial Proposal; (iii) the presence or absence of the Declaration of Undertaking (TECH-2), (iv) any modifications to the Proposal submitted prior to the Proposal submission deadline; and (v) any other information deemed appropriate or as indicated in the **Data Sheet**.

20. Proposals Evaluation

20.1 The evaluation of the Technical Proposals shall be conducted in conformity with the provisions below. The report shall include all clarifications with Service Providers during the technical evaluation and be signed by all members of the Evaluation committee, pursuant to ISP 19.2.

20.2 The Service Provider is not permitted to alter or modify its Proposal in any way after the Proposal submission deadline except as permitted in accordance with ISP 12.6. While evaluating the Proposals, the Employer will conduct the evaluation only on the basis of the submitted Technical and Financial Proposals.

20.3 Services or items that the Service Provider is required to offer as an option as per the TOR shall not be included in the technical and financial evaluation, unless otherwise explicitly stated in the **Data Sheet**.

20.4 Alternative offers will not be taken into consideration unless permitted in the **Data Sheet**.

21. Evaluation of Technical Proposals

21.1 The Employer shall evaluate the Technical Proposals on the basis of the criteria and point system set out in the **Data Sheet**. Each responsive Proposal will be given a technical score. A Proposal shall be rejected at this stage if it is determined to be non-responsive in accordance with ISP 7.2 or if it fails to achieve the minimum technical score of 75 % of the maximum score in accordance with ISP 22.1. If specified in the **Data Sheet** a minimum score may be applied not only to the overall technical score but also to the achievement of the ESHS minimum score.

21.2 For the purposes of scoring individual sub-criteria the following qualitative approach may be applied:,

a) 100% of the max. score: Excellent, no errors or omissions at all are noted. Exhaustive, conclusive, comprehensive, precise and further leading suggestion / idea / offering with respect to the sub-criterion.

b) 75% of the max. score: Good, minimal errors or omissions noted. Exhaustive, conclusive, comprehensive and precise with respect to the sub-criterion.

c) 50% of the max. score: Unsatisfactory, major errors or omissions noted not comprising the fulfilment of the sub-criterion, basically meets the requirement of the respective sub-criterion.

d) 25% of the max. score: Poor, major errors or omissions are noted comprising the fulfilment of the sub-criterion, substantially deviates from or indicates misunderstanding of the requirement of the respective sub-criterion.

e) 0 % of the max. score: Insufficient / Fail, does not meet the requirement of the respective sub-criterion at all or does not provide any information regarding the requirement of the sub-criterion.

22. Opening and Evaluation of Financial Proposals

22.1 The Financial Proposals of those Service Providers which have achieved the minimum score in accordance with ISP 21.1 shall be opened. The Financial Proposals of those Service Providers below the minimum score shall not be opened and returned unopened after completing the selection process and Contract signing.

22.2 The opening of the Financial Proposals shall be done in accordance with ISP 19.2 and ISP 19.4.

23. Evaluation of Financial Proposals

23.1 The Financial Proposals shall be assessed using the total price after correcting any arithmetical errors.

Time Based contracts

23.2 If a Time-Based contract form is included in the RFP, the Employer's evaluation committee will (a) correct any computational or arithmetical errors, (b) adjust the prices if they fail to reflect the duration of the contract in accordance with ISP 14.1.3, and (c) adjust the prices if they fail to reflect all inputs, which, in accordance with the RFP have to be indicated and priced separately, using the highest rates for the corresponding items indicated in the Financial Proposals of competing Bids, determined to be responsive in accordance with ISP 7.2. In case of discrepancy between (i) a partial amount (sub-total) and the total amount, or (ii) between the amount derived by multiplication of unit price with quantity and the total price, or (iii) between words and figures, the former will prevail. In case of discrepancy between the Technical and Financial Proposals in indicating quantities of input, the Technical Proposal prevails and the Employer's evaluation committee shall correct the quantification indicated in the Financial Proposal so as to make it consistent with that indicated in the Technical Proposal, apply the relevant unit price included in the Financial Proposal to the corrected quantity, and correct the total Proposal cost.

Lump Sum contracts

23.3 If a Lump-Sum contract form is included in the RFP, the Service Provider is deemed to have included all prices in the Financial Proposal, therefore no price adjustments shall be made. The total price, net of taxes understood as per Clause ISP 25 below, specified in the Financial Proposal (Form FIN-1) shall be considered as the offered price.

Other Cost

23.4 Notwithstanding the above, the offered price may be adjusted for reimbursable items to allow for comparison, but only for such items explicitly requested to be offered in the RFP. Reimbursable items will be either considered or not considered for all Bidders.

23.5 In case of a mixed contract containing parts with Lump Sum remuneration (i.e. for project design) and Time Based remuneration (i.e. project supervision) corrections to the respective parts of the Proposal shall be applied according to the applicable provisions in ISP 23.2 and ISP 23.3.

24. Taxes

24.1 The Employer's evaluation of the Service Provider's Financial Proposal shall exclude customs and excise duties, taxes and levies in the Employer's country, directly attributable to the Contract, if not otherwise specified in the **Data Sheet**.

25. Conversion to Single Currency

25.1 For the evaluation purposes, prices shall be converted to a single currency using the selling rates of exchange, source and date indicated in the **Data Sheet**.

26. Combined Evaluation of Technical and Financial Proposals

26.1 The Proposal Score shall be calculated by weighting the Technical Score with 80% and the Financial Score with 20% and adding them as per the formula and instructions in the **Data Sheet**.

26.2 A final evaluation report shall be established by the Evaluation committee with the result of the combined evaluation and including the verification of the qualification as per ISP 27. The Service Provider with the highest Proposal Score shall be declared the winner and invited for negotiations.

27. Qualification of the Service Provider

27.1 The Employer shall determine to its satisfaction whether the Service Provider, whose Proposal has achieved the highest Proposal score in accordance with ISP 26.1 continues to meet the eligibility and qualifying criteria specified at the prequalification stage. The determination shall be based upon an examination of Form E/QUAL as provided in Section 3, Technical Proposal Forms.

27.2 An affirmative determination shall be a prerequisite for award of the Contract to the Service Provider. A negative determination shall result in disqualification of the Proposal, in which event the Employer shall proceed to the Proposal, which has achieved the next-highest Proposal score to make a similar determination of that Service Provider’s eligibility and qualifications to perform satisfactorily.

28. Employer’s Right to Reject All Proposals

28.1 The Employer reserves the right to annul the bidding process and reject all Proposals at any time prior to contract award, without thereby incurring any liability to Service Providers.

D. Negotiations and Award

29. Negotiations

29.1 The Employer shall conduct contract negotiations with the Service Provider who has attained the highest Proposal Score in accordance with ISP 26.

29.2 The Employer shall prepare minutes of negotiations, which shall be signed by the Employer and the Service Provider’s authorized representative.

Availability of Key Experts

29.3 The invited Service Provider shall confirm the availability of all Key Experts included in the Proposal as a pre-requisite to the negotiations, or, if applicable, a replacement in accordance with Clause 12 of the ISP. Failure to confirm the Key Experts’ availability shall result in the rejection of the Service Provider’s Proposal, in which case the Employer shall proceed to negotiate the Contract with the next-ranked Service Provider.

29.4 Notwithstanding the above, the substitution of Key Experts at the negotiations may be considered if due solely to circumstances outside the reasonable control of and not foreseeable by the Service Provider, including but not limited to death or medical incapacity. In such case, the Service Provider shall offer a substitute Key Expert within the period of time specified in the letter of invitation to negotiate the Contract, who shall have equivalent or better qualifications and experience than the original candidate.

Technical Negotiations

29.5 The scope of the contract negotiations shall be limited to the following points:

a) clarifying the work and the methods to be used, where necessary adjusting the staffing schedule;

b) clarifying any counterpart services to be provided by the Employer

Such negotiations shall be limited to items identified in the evaluation report and shall not be subject to material changes.

Financial Negotiations

29.6 Fees and unit prices for incidental costs and for all services that were to be offered on a lump-sum basis pursuant to the invitation to tender are in principle not subject to negotiation, as they were already taken into account during the evaluation of the Financial Proposal.

29.7 All terms and conditions of the Contract, including the payment schedule, shall be strictly in accordance with the terms and conditions set out in the contract form provided in Section VIII. For the avoidance of doubt, the Contract terms and conditions shall not be subject to any material changes in the course of negotiations.

30. Conclusion of Negotiations

30.1 The negotiations are concluded with a review of the finalized draft Contract, which then shall be initialed by the Employer and the Service Provider's authorized representative.

30.2 If the negotiations fail, the Employer shall inform the Service Provider immediately in writing of all pending issues and disagreements and provide a final opportunity to the Service Provider to respond. If disagreement persists, the Employer shall terminate the negotiations informing the Service Provider of the reasons for doing so and invite the next-ranked Service Provider to negotiate the Contract. Once the Employer commences negotiations with the next-ranked Service Provider, the Employer shall not reopen the earlier negotiations.

31. Award of Contract, Information of Service Providers

31.1 After completing the negotiations with the Service Provider the Employer shall promptly inform all shortlisted Service Providers on the outcome of the selection procedure. The information sent to the Service Providers shall contain the name and the contract amount of the winning Service Provider, the combined Proposal Score of the winner and the respective Service Provider. Additional requirements for the publication of the results of the selection procedure are indicated in the **Data Sheet**, if any.

31.2 In case a Service Provider requests additional information on the result of the evaluation in writing to the Employer, the Employer shall promptly provide a debriefing to the Service Provider informing on the weaknesses of the Proposal in relation to the winning Service Provider. No additional information shall be disclosed.

31.3 Subject to KfW's no-objection to the draft Contract the Employer shall sign the Contract. The Service Provider is expected to commence the assignment on the date and at the location specified in the **Data Sheet**.

Section II. Data Sheet

A. General	
ISP Clause Reference	
1.1	The name of the Employer is: **Social Health Protection Initiative (Sehat Card Plus),** **Department of Health,** **Government of Khyber Pakhtunkhwa** The method of selection is: **Quality & Cost Based Selection** in conjunction with the procedures set out in the the KfW Guidelines for the Procurement of Consulting Services, Works, Plant, Goods and Non- Consulting Services in Financial Cooperation with Partner Countries, January 2021, https://www.kfw-entwicklungsbank.de/International-financing/KfW-Development-Bank/Publications-Videos/Publication-series/Guidelines-and-contracts/ as well as Khyber Pakhtunkhwa Public Procurement of Goods, Works and Services Rules, 2014. However, in case of any conflict between the provisions of KfW Guidelines and KP Public Procurement Rules, the earlier will take precedence. **management4health GmbH (m4h)** has been selected to support the Department of Health in the implementation of the pilot of the OPD scheme and shall be assisting the Evaluation Commission as Technical Agency.
1.2 (c)	Applicable Laws shall be the laws of the **"Islamic Republic of Pakistan".**
1.3	The name of the assignment is: **Pilot of the OPD Insurance Scheme in Khyber Pakhtunkhwa.**
1.4	A pre-proposal conference will be held on **13th November 2023, 1100 hours (PST)** at Conference Room of **Social Health Protection Initiative (Sehat Card Plus), Department of Health, Government of Khyber Pakhtunkhwa located at House No. 9-A, Rehman Baba Road, University Town, Peshawar.** Contact Person: **Dr. Muhammad Riaz Tanoli** **CHIEF EXECUTIVE OFFICER** Social Health Protection Initiative (Sehat Card Plus), Department of Health, Government of Khyber Pakhtunkhwa, House No. 9-A, Rehman Baba Road, University Town, **Peshawar, Pakistan.** Phone: +92(91) 9216013 Fax: +92(91) 5841792 Email: projectdirector.shp.kp@gmail.com **Please forward all your queries before coming to pre-proposal conference at above email address.** **Maximum two (02) representatives of a Service Provider, will be allowed and mobile phone/recording of the proceedings will not be allowed. A Protocol will**

	be prepared and signed by all participants and shared with all interested Bidders.
1.5	The Employer will assist the Service Provider and make available relevant data and reports and generally support the Service Provider in the implementation of the insurance scheme pilot.
6.	**Not Applicable**
B. Preparation of Proposals	
9.1	Proposals shall be accepted in the **English** Language, which shall be the governing language of the Contract. All correspondence exchange shall be in **English** Language.
10.1	The Proposal shall be submitted in two envelopes comprise the following documents: Technical Proposal Envelope: (1) Power of Attorney to sign the Proposal (2) TECH-1 Technical Proposal Submission Form (3) TECH-2 Declaration of Undertaking (4) TECH-3 Comments or Suggestions on the TOR and Counterpart Staff (5) TECH-4 Description of the Approach, Methodology, and Work Plan (6) TECH-5 Work Schedule (7) TECH-6 Personnel Schedule (8) E/QUAL [Continued Eligibility and Qualification] (9) If Services Providers are participating in a Joint Venture association, a legally registered JV Agreement for the intended services be provided, having therein addresses and the roles and responsibilities of all the partners (10) Copies of "Contract Agreements", along with "Completion Certificates" (for all completed projects) duly signed and stamped by the issuing authority/person, from the respective Clients in respect of specific experience of the Services Providers/JV Partners which the Services Provider/JV shall quote in their Technical Proposal, related to the assignment. Financial Proposal Envelope: (1) FIN-1 Financial Proposal Submission Form (2) FIN-2 Financial Proposal – Cost Breakdown

11.1	Sub-Contractors **are not permitted to** participate in more than one Proposal. Shortlisted Service Providers may associate with **(a) non-shortlisted Service Provider(s):** (i) Allowed, however, the shortlisted Service Provider shall be a **“Lead Firm”** and the non-shortlisted firm(s) shall be a specialized sub-contractor. (ii) **A newly formed Joint Venture post Prequalification stage is not allowed**. (iii) It is reiterated that prior permission from the Employer to this association, shall be mandatory. **(b)** other shortlisted Service Providers: **Not Allowed**
11.3	Individuals **are not permitted to** participate in more than one Proposal.
12.1	Proposals shall remain valid for **120** days after the Proposal submission deadline i.e., **11th April 2024.**
13.1	The deadline for clarifications by Service Providers is **seven (07)** days prior to the submission date as per Clause 17.9 Clarifications requests shall be addressed via email to: **Dr. Muhammad Riaz Tanoli** **CHIEF EXECUTIVE OFFICER** Social Health Protection Initiative (Sehat Card Plus), Department of Health, Government of Khyber Pakhtunkhwa, House No. 9-A, Rehman Baba Road, University Town, **Peshawar, Pakistan.** Postal Code: 25000 Email: projectdirector.shp.kp@gmail.com
14.1.3	The estimated total cost of the assignment is **EUR 7,500,000**.
14.1.4	**Not applicable**
14.1.5 and 26.1	**Not applicable**
16.1	The contract period shall be*:* **Two (02) Years**. However, it may be extended with mutual consent of the parties at the same conditions. The Financial Proposal shall be calculated under the assumption that services will be remunerated on a lump sum basis. The Service Provider shall include at least the following miscellaneous items *(Items 8 and 9 in the Detailed Cost Calculation in FIN-2)* in the Financial Proposal which shall only be based on the Admin. Cost of the Health Insurance Provider ***[Sr. # F of Summary Overview Table in FIN 2]***:

	(1) a per diem allowance in respect of Personnel of the Service Provider for every day in which the Personnel shall be absent from the home office and, as applicable, outside the Employer's country for purposes of the Services, (2) cost of necessary travel, including transportation of the Personnel by the most appropriate means of transport and the most direct practicable route, (3) cost of office accommodation, and related services, (4) cost of applicable international or local communications such as the use of telephone and facsimile required for the purpose of the Services, (5) cost, rental and freight of any instruments or equipment required to be provided by the Service Provider for the purposes of the Services, (6) cost of printing and dispatching of the reports to be produced for the Services, (7) other allowances where applicable and provisional or fixed sums (if any), and (8) cost of such further items required for purposes of the Services not covered in the foregoing. Before mentioned items shall deemed to be included in the overall lump sum price/cost of the financial proposal. The number of working days per week shall be **five (5)**.
16.2	Not Applicable.
16.3	Amounts payable by the Employer to the Service Provider under the agreement to be subject to local taxation: **Service portion of contract: Yes** **Per capita payments for insurance portion of contract: No** For the purpose of the evaluation, the Employer will exclude: (a) all local identifiable **indirect taxes** such as sales tax, excise tax, VAT etc. on the contract's invoices; and (b) all additional local indirect tax on the remuneration of services rendered by **non-resident experts** in the Employer's country. If a Contract is awarded, at Contract negotiations, all such taxes will be discussed, finalized (using the itemized list as a guidance but not limiting to it) and added to the Contract amount as a separate line, also indicating which taxes shall be paid by the Service Provider and which taxes are to be withheld and paid by the Employer on behalf of the Service Provider. **"Information on the Service Provider's tax obligations in the Employer's country can be found on FBR and others relevant websites.** http://www.fbr.gov.pk
16.4	All Service Providers shall have to express/state their Financial Proposal in Pakistani Rupees (**PKR)** The Financial Proposal **shall** state local costs in the Employer's country currency i.e. **PKR**

16.6	The data of beneficiaries shall be provided by the Employer.
	C. Submission, Opening and Evaluation
17.4	The Service Provider must submit the proposals as follows: (a) **Technical Proposal:** **One (1) original** and **five (5) copies.** Every page of the Original Proposal must be signed and stamped, and the additional copies must be made from the original proposal. **In addition, Technical Proposal should also be provided on one USB/DVD as a scan of the Original**. (b)**Financial Proposal:** **One (1) original,** every page must be signed and stamped. In addition, Financial Proposal should also be provided on a second USB as a scan of the Original. The file shall be password-protected, and Service Providers shall only share the password if requested by the Evaluation Committee/Employer in writing. **Financial & Technical Proposals must be in separate, sealed and clearly marked envelopes both of which should be in one outer, sealed envelope** duly mentioning the name of the firm and the tender number. It is reiterated that the Financial Proposal Envelope must be clearly marked and should contain the words "**DO NOT OPEN WITH THE TECHNICAL PROPOSAL**", clearly readable. Neither Financial Proposal nor a reference to financial cost be provided in USB/DVD containing Technical Proposal. Failure would lead to automatic rejection of the Proposal of the Service Provider in the selection process. **Any document/paper not in the respective sealed envelopes for technical and financial proposals shall not be considered for evaluation. If any financial information is on any such document, this will lead to automatic rejection of the whole Bid as well.**
17.9	**The Proposals must be submitted no later than:** **Date: 11th December 2023** **Time:** 1400 hours local time (PST). **The Proposal submission address is as follows:** **Dr. Muhammad Riaz Tanoli** **CHIEF EXECUTIVE OFFICER** Social Health Protection Initiative (Sehat Card Plus), Department of Health, Government of Khyber Pakhtunkhwa, House No. 9-A, Rehman Baba Road, University Town, **Peshawar, Pakistan** Postal Code: 25000 Phone: +92(91) 9216013 Fax: +92(91) 5841792 **For courier purposes only**, the telephone number is: 92(91)- 9216013 All other communication in this selection process MUST be in writing only.
19.1	The opening shall take place at following address on due date i.e., 11th **December 2023**, at **1430 hours** local time (PST) in presence of representatives of the Service Providers who shall choose to be present:

	Social Health Protection Initiative (Sehat Card Plus), Department of Health, Government of Khyber Pakhtunkhwa, House No. 9-A, Rehman Baba Road, University Town, **Peshawar, Pakistan** Postal Code: 25000
19.2	The Employer will form an Evaluation Committee/Commission. Whereas management4health GmbH (m4h) has been selected to support the Department of Health in the implementation of the pilot of the OPD scheme and shall be assisting the Procurement Committee as Technical Agency.
21.1	The technical evaluation shall be carried out based on the following criteria and point system. No additional criteria or sub-criterion than those indicated in the RFP shall be used for the evaluation of the Technical Proposal.

No	Issue	Points	
1.	**Concept and methodology**		**70**
1.1	Completeness of the proposed methodology and strategies	9	
1.2	Quality of the description of the governance arrangements, management structure, and staffing	9	
1.3	Quality of the description of the HI providers in handling wide registration of the population, including formats and grievance redressal mechanism for beneficiaries	9	
1.4	Quality of the description of the HI-providers role in empanelment of Primary Health Care Providers, inspection of these and providing regular update of data about the performance of Primary Care Health Providers	9	
1.5	Quality of the payment system to be established by the HI-provider, for handling timely payments and related modalities, to the beneficiaries and HS-providers	9	
1.6	Comprehensive details along with flow diagrams describing the HI-provider's electronic MIS Networking relevant for the assignment	9	
1.7	Comprehensiveness of the description of the HI-provider's role in M&E including provision of data to the DoH	8	
1.8	Comprehensiveness of measures, the HI-provider will undertake to support the implementation of the Communication & Visibility-Strategy	8	
2	**Qualification and skills of key staff proposed as well as personnel in the home office who will monitor and control the team, and provide dedicated back-up services for OPD Scheme** ***[Details of qualification & experience requirements for each position, are given in Part 2: Section VII viz. Terms of Reference]***		**30**
2.1	Senior OPD Health Insurance Project Director	**6**	
2.2	Senior OPD Health Insurance Expert and Team Leader	**6**	

	(table continued below)

2.3	Senior OPD Health Insurance M&E, IT and Innovation Expert	**6**	
2.4	Senior OPD Health Insurance Financial Expert	**6**	
2.5	Senior OPD Health Status Improvement and Utilisation Expert	**6**	
Total (maximum)			**100**

The number of points to be assigned to each of the above positions or disciplines shall be determined considering the following sub criteria and relevant percentage weights:

1. General qualifications (general education, training, and experience): ***10 % weight***

2. Adequacy for the Assignment (relevant education, training, experience in the sector/similar assignments): ***80% weight***

3. Relevant experience in the region (working level fluency in local language(s)/knowledge of local culture or administrative system, government organization, etc.): ***10% weight***

Total ***100%***

The higher qualification shall be valued.

The minimum technical score (PT) required to qualify technically/pass is: 75 Points

Notes to Service Provider:

(i) The Service Provider is required to provide a Technical Approach & Methodology on **EACH** of the Components of the assignment responding to ToRs with due consideration to:

(ii) Adequacy and connections between the logical actions proposed to demonstrate anticipated outcomes against prescribed performance indicators,

(iii) Each position number of Key Staff corresponds to the same for the Key Experts in Form TECH-6 to be prepared by the Service Provider.

25.1	The single currency for the conversion of prices expressed in other currencies into a single one shall be **PKR** The source of exchange rate **(Selling rate – Closing rate)** shall be: **The State Bank of Pakistan.** The date for the exchange rate shall be two working days before **Technical Proposal's opening date.**
26.1	The weights given to the Technical (T) and Financial (F) Proposals are as follows: W_T = **80 %**, and W_F = **20 %**

	The weighted technical score is calculated as follows: PT = WT * T, with PT = weighted technical score (points) of a technical Proposal, T = technical score (points) as per technical evaluation, WT = weight of the technical Proposal (in percent). The weighted financial score is calculated as follows PF = WF * Co/C, with PF = financial score (points) of a financial Proposal, C = evaluated price of the financial Proposal for the Service Portion of the Contract only, Co = lowest evaluated price of all financial Proposals for the Service Portion of the Contract only. and the overall score is calculated as: **P = PF + PT.**
D. Negotiations and Award	
31.1.	The award recommendations shall be published on GTAI, as well as the websites of the Employer and Khyber Pakhtunkhwa Public Procurement Regulatory Authority with standstill period of fifteen (15) days.
31.2.	The expected commencement date of the assignment is: **February 2024**

Section III. Technical Proposal – Standard Forms

CHECKLIST OF REQUIRED FORMS

FORM	DESCRIPTION	CONFIRMATION Provided/ Not provided
Power of Attorney	No pre-set format/form. In the case of a Joint Venture, several are required: a power of attorney for the authorized representative of each JV member, and a power of attorney for the representative of the lead member to represent all JV members.	
	If Services Providers are participating in a Joint Venture association, a legally registered JV Agreement for the intended services be provided, having therein addresses and the roles and responsibilities of all the partners	
TECH-1	Technical Proposal Submission Form. If Service Providers/Services Providers are participating in a Joint Venture association, a legally registered JV Agreement for the intended services be provided, having therein addresses and the roles and responsibilities of all the partners.	
TECH-2	Declaration of Undertaking	
TECH-3	Comments or Suggestions on the Terms of Reference and on Counterpart Staff and Facilities to be provided by the Employer.	
TECH-3A	A. On the Terms of Reference	
TECH-3B	B. On the Counterpart Staff and Facilities	
TECH-4	Description of the Approach, Methodology, and Work Plan for Performing the Assignment	
TECH-5	Work Schedule (Tasks and Activities Bar Chart)	
TECH-6	Personnel Schedule (Bar Chart) and attached Curriculum Vitae (CV)	
E/QUAL	Continued Eligibility and Qualification	
	Copies of “Contract Agreements”, along with “Completion Certificates” (for all completed projects) duly signed and stamped by the issuing authority/person, from the respective Clients in respect of specific experience of the Services Providers/JV Partners which the Services Provider/JV shall quote in their Technical Proposal, related to the assignment.	

All pages of the original Technical and Financial Proposal shall be initialled by the same authorized representative of the Service Provider who signs the Proposal.

FORM TECH-1

TECHNICAL PROPOSAL SUBMISSION FORM

[Location, Date]

To: *[Name and address of Employer]*

Dear Sirs:

We, the undersigned, offer to provide the services for *[Insert title of assignment]* in accordance with your Request for Proposals dated *[Insert Date]* and our Proposal. We are hereby submitting our Proposal, which includes this Technical Proposal and a Financial Proposal sealed in a separate envelope.

*[If the Service Provider is a joint venture, insert the following: "*We are submitting our Proposal in a joint venture between: *[Insert a list with full name and the legal address of each member, and indicate the lead member].* We have attached a copy *[insert: "of our letter of intent to form a joint venture" or, if a JV is already formed, "*the relevant information of the existing JV agreement*"]* signed by every participating member, which details the likely legal structure of and the confirmation of joint and severable liability of the members of the said joint venture*."*

or

*If the Service Provider's Proposal includes Sub-Service Providers, insert the following: "*We are submitting our Proposal with the following firms as Sub-Service Providers: *[Insert a list with full name and address of each Sub-Service Provider."]*

We hereby declare that:

(a) All the information and statements made in this Proposal are true and we accept that any misinterpretation or misrepresentation contained in this Proposal may lead to our disqualification by the Employer.

(b) Our Proposal shall be valid and remain binding upon us for the period of time specified in ISP 12.1.

(c) We have no conflict of interest in accordance with ISP 3.

(d) Except as stated in ISP 12, we undertake to negotiate a Contract on the basis of the proposed Key Experts. We accept that the substitution of Key Experts for reasons other than those stated in ISP 27.4 may lead to the termination of Contract negotiations.

(e) Our Proposal is binding upon us and subject to any modifications resulting from the Contract negotiations.

We undertake, if our Proposal is accepted and the Contract is signed, to initiate the Services related to the assignment no later than the date indicated in ISP 29.

We understand that the Employer is not bound to accept any Proposal that the Employer receives.

We remain,

Yours sincerely,

Authorized Signature [In full and initials]: ____
Name and Title of Signatory: ____
Name of Service Provider (company's name or JV's name):
In the capacity of: ____

Address: ____
Contact information (phone and e-mail): ____

[For a joint venture, either all members shall sign or only the lead member, in which case the power of attorney to sign on behalf of all members shall be attached.]

FORM TECH-2

Declaration of Undertaking

Reference name of the Application/Offer/Contract: ("**Contract**")[2]

To: (**"Project Executing Agency"**)

1. We recognise and accept that KfW only finances projects of the Project Executing Agency ("PEA")[3] subject to its own conditions which are set out in the Funding Agreement it has entered into with the PEA. As a matter of consequence, no legal relationship exists between KfW and our company, our Joint Venture or our Subcontractors under the Contract. The PEA retains exclusive responsibility for the preparation and implementation of the Tender Process and the performance of the Contract.

2. We hereby certify that neither we nor any of our board members or legal representatives nor any other member of our Joint Venture including Subcontractors under the Contract are in any of the following situations:

   2.1) being bankrupt, wound up or ceasing our activities, having our activities administered by courts, having entered into receivership, reorganisation or being in any analogous situation;

   2.2) convicted by a final judgement or a final administrative decision or subject to financial sanctions by the United Nations, the European Union or Germany for involvement in a criminal organisation, money laundering, terrorist-related offences, child labour or trafficking in human beings; this criterion of exclusion is also applicable to legal Persons, whose majority of shares are held or factually controlled by natural or legal Persons which themselves are subject to such convictions or sanctions;

   2.3) having been convicted by a final court decision or a final administrative decision by a court, the European Union, national authorities in the Partner Country or in Germany for Sanctionable Practice in connection with a Tender Process or the performance of a Contract or for an irregularity affecting the EU's financial interests *(in the event of such a conviction, the Applicant or Bidder shall attach to this Declaration of Undertaking supporting information showing that this conviction is not relevant in the context of this Contract and that adequate compliance measures have been taken in reaction)*;

   2.4) having been subject, within the past five years to a contract termination fully settled against us for significant or persistent failure to comply with our contractual obligations during such Contract performance, unless this termination was challenged and dispute resolution is still pending or has not confirmed a full settlement against us;

   2.5) not having fulfilled applicable fiscal obligations regarding payments of taxes either in the country where we are constituted or the PEA's country;

   2.6) being subject to an exclusion decision of the World Bank or any other multilateral development bank and being listed on the website http://www.worldbank.org/debarr or respectively on the relevant list of any other multilateral development bank *(in the event of such exclusion, the Applicant or Bidder shall attach to this Declaration of Undertaking supporting information showing that this exclusion is not relevant in the context of this Contract and that adequate compliance measures have been taken in reaction)*; or

---

[2] Capitalised terms used, but not otherwise defined in this Declaration of Undertaking have the meaning given to such term in KfW's "*Guidelines for the Procurement of Consulting Services, Works, Goods, Plant and Non-Consulting Services in Financial Cooperation with Partner Countries*".

[3] The PEA means the purchaser, the employer, the client, as the case may be, for the procurement of Consulting Services, Works, Plant, Goods or Non-Consulting Services.

2.7) being guilty of misrepresentation in supplying the information required as condition to participation in this Tender Procedure.

3. We hereby certify that neither we, nor any of the members of our Joint Venture or any of our Subcontractors under the Contract are in any of the following situations of conflict of interest:

   3.1) being an affiliate controlled by the PEA or a shareholder controlling the PEA, unless the stemming conflict of interest has been brought to the attention of KfW and resolved to its satisfaction;

   3.2) having a business or family relationship with a PEA's staff involved in the Tender Process or the supervision of the resulting Contract, unless the stemming conflict of interest has been brought to the attention of KfW and resolved to its satisfaction;

   3.3) being controlled by or controlling another Applicant or Bidder, or being under common control with another Applicant or Bidder, or receiving from or granting subsidies directly or indirectly to another Applicant or Bidder, having the same legal representative as another Applicant or Bidder, maintaining direct or indirect contacts with another Applicant or Bidder which allows us to have or give access to information contained in the respective Applications or Offers, influencing them or influencing decisions of the PEA;

   3.4) being engaged in a Consulting Services activity, which, by its nature, may be in conflict with the assignments that we would carry out for the PEA;

   3.5) in the case of procurement of Works, Plant or Goods:

      i. having prepared or having been associated with a Person who prepared specifications, drawings, calculations and other documentation to be used in the Tender Process of this Contract;

      ii. having been recruited (or being proposed to be recruited) ourselves or any of our affiliates, to carry out works supervision or inspection for this Contract;

4. If we are a state-owned entity, and compete in a Tender Process, we certify that we have legal and financial autonomy and that we operate under commercial laws and regulations.

5. We undertake to bring to the attention of the PEA, which will inform KfW, any change in situation with regard to points 2 to 4 here above.

6. In the context of the Tender Process and performance of the corresponding Contract:

   6.1) neither we nor any of the members of our Joint Venture nor any of our Subcontractors under the Contract have engaged or will engage in any Sanctionable Practice during the Tender Process and in the case of being awarded a Contract will engage in any Sanctionable Practice during the performance of the Contract;

   6.2) neither we nor any of the members of our Joint Venture or any of our Subcontractors under the Contract shall acquire or supply any equipment nor operate in any sectors under an embargo of the United Nations, the European Union or Germany; and

   6.3) we commit ourselves to complying with and ensuring that our Subcontractors and major suppliers under the Contract comply with international environmental and labour standards, consistent with laws and regulations applicable in the country of implementation of the Contract and the fundamental conventions of the International

Labour Organisation[4] (ILO) and international environmental treaties. Moreover, we shall implement environmental and social risks mitigation measures when specified in the relevant environmental and social management plans or other similar documents provided by the PEA and, in any case, implement measures to prevent sexual exploitation and abuse and gender based violence.

7. In the case of being awarded a Contract, we, as well as all members of our Joint Venture partners and Subcontractors under the Contract will, (i) upon request, provide information relating to the Tender Process and the performance of the Contract and (ii) permit the PEA and KfW or an auditor appointed by either of them, and in the case of financing by the European Union also to European institutions having competence under European Union law, to inspect the respective accounts, records and documents, to permit on the spot checks and to ensure access to sites and the respective project.

8. In the case of being awarded a Contract, we, as well as all our Joint Venture partners and Subcontractors under the Contract undertake to preserve above mentioned records and documents in accordance with applicable law, but in any case for at least six years from the date of fulfillment or termination of the Contract. Our financial transactions and financial statements shall be subject to auditing procedures in accordance with applicable law. Furthermore, we accept that our data (including personal data) generated in connection with the preparation and implementation of the Tender Process and the performance of the Contract are stored and processed according to the applicable law by the PEA and KfW.

Name: ______________________________ In the capacity of: ______________________

Duly empowered to sign in the name and on behalf of[5]: ________________________________

Signature: Dated:

[4] In case ILO conventions have not been fully ratified or implemented in the Employer's country the Applicant/Bidder/Contractor shall, to the satisfaction of the Employer and KfW, propose and implement appropriate measures in the spirit of the said ILO conventions with respect to a) workers grievances on working conditions and terms of employment, b) child labour, c) forced labour, d) worker's organisations and e) non-discrimination.

[5] In the case of a JV, insert the name of the JV. The person who will sign the application, bid or proposal on behalf of the Applicant/Bidder shall attach a power of attorney from the Applicant/Bidder.

FORM TECH-3

COMMENTS AND SUGGESTIONS ON THE TERMS OF REFERENCE, COUNTERPART STAFF, AND FACILITIES TO BE PROVIDED BY THE EMPLOYER

[Form TECH-3: comments and suggestions on the Terms of Reference that could improve the quality/effectiveness of the assignment; and on requirements for counterpart staff and facilities, which are provided by the Employer, including: administrative support, office space, local transportation, equipment, data, etc.]

A - On the Terms of Reference

[The Consultant is explicitly encouraged to present a detailed critical analysis and the Consultant's interpretation of the project's objectives and the TOR. This might encompass critical comments and doubts about the suitability, consistency and feasibility of individual aspects and the concept as a whole, if any. The methodology suggested must take constructive account of these.]

B - On Counterpart Staff and Facilities

[Comments on counterpart staff and facilities to be provided by the Employer. For example, administrative support, office space, local transportation, equipment, data, background reports, etc., if any.]

Form TECH-4
Description of Approach, Methodology, and Work Plan in Responding to the Terms of Reference

[Form TECH-4: a description of the approach, methodology and work plan for performing the assignment, including a detailed description of the proposed methodology and staffing for training, if the Terms of Reference specify training as a specific component of the assignment. The texts and information should be compiled and presented in a way that is related to the project. Service Providers shall refrain from long explanations in the style of a textbook. The presentation of diagrams, tables and graphics is preferred. Suggested structure of the Technical Proposal:

a) Technical Approach and Methodology
b) Work Plan
c) Organization and Staffing
d) Back-up Services
e) Quality Control and Management
f) Logistics]

a) **Technical Approach and Methodology** *[Please explain your understanding of the objectives of the assignment as outlined in the Terms of Reference (TOR), the technical approach, and the methodology you would adopt for implementing the tasks to deliver the expected output(s), and the degree of detail of such output. The Service Provider is explicitly encouraged not to repeat the TOR in here but to show the suitability of his concept in regard to the TOR and his comments made on these.]*

b) **Work Plan** *[Please outline the plan for the implementation of the main activities/tasks of the assignment, their content and duration, phasing and interrelations, milestones (including interim approvals by the Employer), and tentative delivery dates of the reports. The proposed work plan should be consistent with the technical approach and methodology, showing your understanding of the TOR and ability to translate them into a feasible working plan. A list of the final documents (including reports) to be delivered as final output(s) should be included here. The work plan should be consistent with the Work Schedule Form.]*

c) **Organization and Staffing** *[Please describe the structure and composition of your team, including the list of the Key Experts, other experts and relevant technical and administrative support staff. Responsibilities within the project team have to be defined. Please include an organisation chart showing the Service Provider's internal organisation as well as the interactions with the Employer as well as with other stakeholders. The Service Provider is encouraged to include junior staff in his team subject to available guidance within a team headed by senior professional staff and application of adequate rates. If certain tasks are not exclusively performed at site, the Service Provider has to describe how the execution and co-operation between site and home office staff is assured.]*

d) **Back-up Services** *[Please describe the envisaged backstopping by the home office for the team working locally on technical and administrative questions that could arise during project implementation as well as for the controlling and monitoring of the work.]*

e) **Quality Control and Management** *[Please outline the procedures for quality control management of services (reports, documents, drawings), including those prepared by associates, sub-Service Providers and local partners, before submission to the Employer. Plain reference to ISO 9001 is not considered to be adequate.]*

f) **Logistics** *[Please describe the planned logistics and facilities for the execution of the services.]*

FORM TECH-5 (INDICATIVE FORMAT)

WORK SCHEDULE (TASKS AND ACTIVITIES BAR CHART)

N°	Tasks [1] (T-..)	Months [2 3]											
		1	2	3	4	5	6	7	8	9	.....	n	TOTAL
T-1	*[e.g., Task #1: Report A*												
	1) data collection												
	2) drafting												
	3) inception report												
	4) incorporating comments												
	5)												
	6) delivery of final report to Employer]												
T-2	*[e.g., Task #2:...............]*												
n													

1 List the tasks with the breakdown for activities, deliverables and other benchmarks such as the Employer's approvals. For phased assignments, indicate the activities, delivery of reports, and benchmarks separately for each phase.

2 Duration of activities shall be indicated in a form of a bar chart.

3 Include a legend, if necessary, to help read the chart.

FORM TECH-6 (INDICATIVE FORMAT)
PERSONNEL SCHEDULE (BAR CHART)

N°	Name	Position		Months [1] [2]											Total time-input [3] (in person-months)		
				1	2	3	4	5	6	7	8	9	.....	n	Internat'l	National	Total
KEY EXPERTS																	
K-1	*[e.g., Mr/Mrs. A]*	*[e.g., Team Leader]*	Home														
			Field														
K-2																	
K-3																	
n																	
														Subtotal:			
OTHER EXPERTS																	
E-1			[*Home*]														
			[*Field*]														
E-2																	
n																	
														Subtotal:			
														Total:			

1 Months are counted from the start of the assignment/mobilization.
2 "Home" means work in the office in the expert's country of residence. "Field" work means work carried out in the Employer's country or any other country outside the expert's country of residence.
3 The assignment of international and national staff shall be treated separately.

ll time input Part time input

FORM TECH-6
(CONTINUED)

CURRICULUM VITAE (CV)

Position Title and No.	*[e.g., K-1, TEAM LEADER]*
Name of Expert:	*[Insert full name]*
Date of Birth:	*[day/month/year]*
Country of Citizenship/Residence	

Education: *[List college/university or other specialized education, giving names of educational institutions, dates attended, degree(s)/diploma(s) obtained]*

____

____

Employment record relevant to the assignment: *[Starting with present position, list in reverse order. Please provide dates, name of employing organization, titles of positions held, types of activities performed and location of the assignment, and contact information of previous clients and employing organization(s) who can be contacted for references. Past employment that is not relevant to the assignment does not need to be included.]*

Period	Employing organization and your title/position. Contact info for references	Country	Summary of activities performed relevant to the Assignment
[e.g., May 2005-present]	*[e.g., Ministry of ……, advisor/consultant/Service Provider to…* *For references: Tel………../ e-mail……; Mr/Mrs B, deputy minister]*		

Membership in Professional Associations and Publications:

____

Language Skills (indicate only languages in which you can work):

____

____

Adequacy for the Assignment:

Detailed Tasks Assigned on Service Provider's Team of Experts:	Reference to Prior Work/Assignments that Best Illustrates Capability to Handle the Assigned Tasks
[List all deliverables/tasks as in TECH- 5 in which the Expert will be involved)	

FORM E/QUAL
CONTINUED ELIGIBILITY AND QUALIFICATION

Name of Service Provider
Name of the JV Member (if applicable)

[Insert one of the two options, as applicable:

"We hereby certify that none of the information provided in our Application, demonstrating our ability to meet the eligibility and qualification requirements, has changed since the time of prequalification."

or,

"We hereby certify that the information provided in our Application, demonstrating our ability to meet the eligibility and qualification requirements, has changed since the time of prequalification. The changes are provided in the attached form(s):"]

[Mark the form(s), containing changes in the eligibility and qualification information and attach the form(s) including the actual information and data to the Proposal.]

- ☐ Declaration on Conflict of Interest and of Submitting a Proposal
- ☐ Declaration of Association
- ☐ Financial Capacity Statement
- ☐ Project Experience
- ☐ List of Available Personnel and Human Resource Capacity

Section IV. Financial Proposal - Standard Forms

[Financial Proposal Standard Forms shall be used for the preparation of the Financial Proposal according to the instructions provided in Section II.]

FIN-1 Financial Proposal - Submission Form

FIN-2 Financial Proposal - Cost Breakdown

FORM FIN-1
FINANCIAL PROPOSAL - SUBMISSION FORM

[Location, Date]

To: *[Name and address of Employer]*

Dear Sirs:

We, the undersigned, offer to provide the services for *[Insert title of assignment]* in accordance with your Request for Proposal dated *[Insert Date]* and our Technical Proposal.

Our attached Financial Proposal is for the amount of *[Indicate the corresponding to the amount(s) currency(ies)] [Insert amount(s) in words and figures]*, *[Insert "excluding" as standard or "including"]* of all indirect local taxes in accordance with Clause 25.1 in the **Data Sheet**. The estimated amount of local indirect taxes is *[Insert currency] [Insert amount in words and figures]* which shall be confirmed or adjusted, if needed, during negotiations. *[Please note that all amounts shall be the same as in Form FIN-2]*.

Our Financial Proposal shall be binding upon us subject to the modifications resulting from Contract negotiations, up to expiration of the validity period of the Proposal, i.e. before the date indicated in Clause 12.1 of the **Data Sheet**.

Commissions and gratuities paid or to be paid by us to an agent or any third party relating to preparation or submission of this Proposal and Contract execution, paid if we are awarded the Contract, are listed below:

Name and Address of Agents	Amount and Currency	Purpose of Commission or Gratuity
________________	________________	___
________________	________________	___

*[If no payments are made or promised, add the following statement: "*No commissions or gratuities have been or are to be paid by us to agents or any third party relating to this Proposal and Contract execution.*"]*

We understand you are not bound to accept any Proposal you receive.

We remain,

Yours sincerely,

Authorized Signature *[In full and initials]*: ______________________________
Name and Title of Signatory: ______________________________
In the capacity of: ______________________________
Address: ______________________________
E-mail: ______________________________

[For a joint venture, either all members shall sign or only the lead member/Service Provider, in which case the power of attorney to sign on behalf of all members shall be attached]

FORM FIN-2 FINANCIAL PROPOSAL – COST BREAKDOWN

Model for Financial Proposal – Overall Cost Breakdown

Item	Costs
	PKR
Proposed Percentage of Admin. Cost	-- %
Total Cost of Financial Proposal [Admin. Fee only] for 2 years	PKR
Taxes Indirect Local Tax Estimates – to be discussed and finalized at the negotiations if the Contract is awarded	PKR
Total Cost (Incl. Taxes) of Financial Proposal [Admin. Fee only] for 2 years	PKR

NOTES:

(a) The total budget of the Contract is the equivalent of EUR 7,500,000.00/-

(b) Service Providers are requested to provide a detailed Financial Proposal for the Service Portion of the Contract in the template below, however the maximum available budget for the Service Portion of the Contract is EUR 600,000/- total for the two years of pilot implementation.

(c) Any balance will be added to the Per Capita Portion of the Contract.

(d) The tax related details, as defined/envisaged at Special Condition of Contract Clause Ad 2.4 viz. Taxes, Section VIII viz. Contract for Services, should be comprehended fully and financial proposal must be submitted ensuring complete understanding of referred Clause vis-à-vis Special Condition related to Payments is defined in the Contract. The Service Provider should safeguard its all risks taking cognizance of all factors/laws of Islamic Republic of Pakistan.

Lump Sum Services (as per **Data Sheet** clause 16.1.and TOR)

<table>
<tr><td>Group of Activities (Phase):</td><td colspan="4">Description:</td></tr>
<tr><td rowspan="2">Cost component</td><td colspan="4">Costs</td></tr>
<tr><td colspan="4">[Insert the currency]</td></tr>
<tr><td>(A) Estimated Number of population, to be covered in Mardan District</td><td colspan="4">422,640</td></tr>
<tr><td>(B) Estimated Health Service Providers in Mardan District</td><td colspan="4">95</td></tr>
<tr><td>(C) Total Pilot Project Cost for Two Years</td><td colspan="4">Euro 7,500,000</td></tr>
<tr><td>(D) Maximum Admin. Cost for Two Years</td><td colspan="4">Euro 600,000</td></tr>
<tr><td>(E) Proposed Admin. Cost of Health Insurance Provider for Two years</td><td>Pak. Rs.</td><td></td><td>Percentage</td><td>%</td></tr>
<tr><td>(F) Capitation Cost for Two Years [C-E]</td><td colspan="4"></td></tr>
</table>

Detailed Cost Calculation *

Table # 1

SUMMARY**	**Sum in** [PKR]
1. – Staff cost	
2. – Allowance and accommodation	
Sub-Total – Staff cost	
3. – International travel costs (if any)	
4. – Local travel & transport cost	
5. – Project office	
6. – Reports and documents	
Sub-Total Logistics and transport	
Sub-Total – Fees, transport and logistics	
7. – Equipment cost	
8. – Miscellaneous cost	
Sub-Total – Other cost	
Total Lump Sum Services	

Table # 2

1. Staff Cost	**Unit**	**No.**	**Unit Rate (PKR)**	**Amount [PKR]**
1.1 Senior OPD Health Insurance Project Director	month	...		
1.2 Senior OPD Health Insurance Expert and Team Leader	month	...		
1.3 Senior OPD Health Insurance M&E, IT and Innovation Expert	month	…		
1.4 Senior OPD Health Insurance Financial Expert	month			
1.5 Senior OPD Health Status Improvement and Utilisation Expert	month			
1.6 NN [Add any other relevant staff, quantities and cost]	month			
			Sub-total staff	
3. Allowance, Accommodation, Complementary Travel Costs for Foreign Staff (If any)				
3.1 Allowance, accommodation - Long-term staff	month	...		
3.2 Allowance, accommodation - Short-term staff	month	...		
			Sub-total Allowance and accommodation	
4. International Travel				
4.1 International return flights	flight	...		
4.2 Complementary travel costs	flight	…		
4.3 …. other international flights	flight	…		
			Sub-Total International flights	
5. Local Travel & Transport Cost				
5.1 Vehicle lease/rent or use of own vehicles	month	...		

5.2 Vehicle O&M incl. driver, assurance, repairs	month	...		
5.3 Other local transport (short-term, peak)	day	…		
5.4 Local flights	flight	...		
5.5 other local travel cost (please specify)				
Sub-total Local transport				
6. Project Office				
6.1 Office rent	month	...		
6.2 Office operation	month	...		
6.3 other project office cost (please specify)				
Sub-total Project office				
7. Reports and Documents				
7.1 ... (Type of reports/documents to be stated)	/doc	...		
7.2 ...other (please specify)	...	...		
Sub-total Reports and documents				
8. Equipment				
8.1.Office equipment	…	…		
8.2 Project vehicles				
8.2 Other. equip. to be handed over/consumed	...	...		
8.3 other equipment (please specify)				
Sub-Total Total Equipment				
9. Miscellaneous Items				
9.1 Other miscellaneous items/services	…			
9.2 Contingencies	…	…		
Sub-Total Total Miscellaneous items/services				

* The detailed cost calculations of Table 2 should be provided to indicate the total amount for the Service Portion of the Contract.

**The cost overview presented for lump sum services shall only be used to demonstrate the basis for calculation of services and, if needed, for payments of possible additional services requested later. All items are remunerated on a lump-sum basis.

.

Explanation regarding the information contained in the Financial Proposal Form FIN 2

Important note: Each sub-item contained in items 3 to 7 shall be offered as lump-sum item specified in the respective unit according to the Detailed Cost Calculation sheet. In case of lump sum packages the rates presented here shall only be used to demonstrate the basis for calculation of services and, if needed, for payments of possible additional services. In case of time based packages the relevant lump sum unit rates shall be used for payments according to the actual quantities.

The Financial Proposal shall be structured as detailed in Form FIN 2 above and be calculated inclusive of all ancillary cost as detailed below.

Item 1 & 2 - Staff Cost
These items shall include international and local/regional staff monthly home office rate, including salary, social charges and overhead cost, bonus, home office cost, all medical examinations, internal professional training, back-up services from home office (professional, personal and administrative), cost of IT equipment, company's professional insurance, risk and profit. In addition, staff rates for local staff shall include accommodation and allowance for occasional local travel within the Employer’s country unless the assignment foresees extensive travel in the Employer’s country. In such case the Service Provider shall offer it separately.

Absence for vacation of staff as applicable in the Service Provider’s home office for foreign staff and in the Employer’s country for local staff shall be deemed to be included in the unit staff rates, as well as sick leave up to the same amount. Unless otherwise specified in this RFP backstopping services from the home office are deemed to be included in the overhead cost.

Item 3 - Allowance and accommodation
This item shall include for all foreign long term and short term staff as the case may be hotel fee, rent, furniture and running cost for flats/houses and, if necessary, also for local staff.

Item 4 - International Travel Cost
This item shall include:

- international air fares, including complementary travel cost (e.g. transfer cost to and from airports, visa, airport tax, excess baggage and / or air freight, medical expenses, visa, etc.) per round trip.
- air fares for inspection flights (including cost elements as above), if any

Item 5 – Local Travel & Transport Cost
This item shall include:

- lease or rent of project vehicles or depreciation cost of vehicles owned by the Service Provider as lump sum item per month of operation (for acquisition of vehicles under the project budget and the related procedures refer to item g) hereunder);
- running cost of own or leased/rented vehicles as a monthly lump sum item per car including gasoline, oil, tires and other consumables, all risk insurance, maintenance and repair costs as well as costs for driver;
- cost for local air, road and rail travel, if any
- taxi costs for local transport demand peaks, if any.

Item 6 - Cost for the Local Project Office

This item shall include office rent, office staff cost and office operation cost (including cleaning, electricity, water, heating, air conditioning, insurance, telecommunication, international and local freight, etc. and all office consumables).

Item 7 - Production of Reports

This item shall include reports and, if applicable any other documents to be produced/purchased in the frequency, number of copies and the format as specified in the TOR and include transport cost and distribution to the addresses as specified in the TOR. The cost of photo and video documentation of the project progress, whether specifically taken and used for the reports or not, shall be deemed included in the relevant lump sum item.

Item 8 – Equipment Cost

Unless otherwise specified all equipment purchased under this item shall be handed over to the Employer upon completion of the services taking into account normal wear and tear under the operational conditions of the project.

In case Equipment Cost items are not specified explicitly in ISP 16.1 or the TOR the following applies:
The Financial Proposal shall include procurement of all office and work equipment like vehicles (other than leased/ rented or owned by the Service Provider), furniture, appliances, survey, measuring and test instruments etc., which the Service Provider deems necessary for the execution of the project. In this case the respective cost will be reimbursed upon presentation of documentary evidence in the currency as occurred or in the project currency at the exchange rate of the invoice date. No handling charges will be accepted.

Note: Procurement of goods and services for the project implementation through a disposition fund or otherwise has to be managed and controlled through inclusion of qualified and adequate staff in the team.

Item 9 - Miscellaneous Cost

This item shall include all expenses and cost items that might not be covered by the above categories but are considered required in this assignment. The following examples may fall under miscellaneous cost:

- acquisition of town maps, aerial photographs, satellite images
- rental of project equipment (e.g. for geophysical surveys)
- topographical and soil surveys for sites and pipeline alignments
- workshop / factory inspection cost
- study tours for counterpart personnel
- preparation and management of workshops and seminars
- training measures or any other special services executed by third parties
- contingency funds or other provisional sums for services or expenses deemed necessary.

In case Miscellaneous Cost items are not specified explicitly in ISP 16.1 or the TOR the following applies:

The Service Provider shall include in its Financial Proposal such items considered necessary for the fulfillment of the requirements of the TOR. In this case the respective cost will be reimbursed upon presentation of documentary evidence in the currency as occurred or in the project currency at the exchange rate of the invoice date. No handling charges will be accepted.

Section V. Eligibility Criteria

Eligibility in KfW-Financed Procurement

1. Consulting Services, Works, Goods, Plant and Non-Consulting Services are eligible for KfW financing regardless of the country of origin of the Contractors (including Subcontractors and suppliers for the execution of the Contract), except where an international embargo or sanction by the United Nations, the European Union or the German Government applies.

2. Applicants/Bidders (including all members of a Joint Venture and proposed or engaged Subcontractors) shall not be awarded a KfW-financed Contract if, on the date of submission of their Application/Offer or on the intended date of Award of a Contract, they:

   2.1 are bankrupt or being wound up or ceasing their activities, are having their activities administered by courts, have entered into receivership, or are in any analogous situation;

   2.2 have been

      (a) convicted by a final judgement or a final administrative decision or subject to financial sanctions by the United Nations, the European Union and/or the German Government for involvement in a criminal organisation, money laundering, terrorist-related offences, child labour or trafficking in human beings; this criterion of exclusion is also applicable to legal Persons, whose majority of shares are held or factually controlled by natural or legal Persons which themselves are subject to such convictions or sanctions;

      (b) convicted by a final court decision or a final administrative decision by a court, the European Union or national authorities in the Partner Country or in Germany for Sanctionable Practice during any Tender Process or the performance of a Contract or for an irregularity affecting the EU's financial interests, unless they provide supporting information together with their Declaration of Undertaking (Form available as Appendix to the Application/Offer which shows that this conviction is not relevant in the context of this Contract and that adequate compliance measures have been taken in reaction;

   2.3 have been subject within the past five years to a Contract termination fully settled against them for significant or persistent failure to comply with their contractual obligations during Contract performance, unless this termination was challenged and the dispute resolution is still pending or has not confirmed a full settlement against them;

   2.4 have not fulfilled applicable fiscal obligations regarding payments of taxes either in the country where they are constituted or the PEA's country;

   2.5 are subject to an exclusion decision of the World Bank or any other multilateral development bank and are listed in the respective table with debarred and cross-debarred firms and individual available on the World Bank's website or any other multilateral development bank unless they provide supporting information together with their Declaration of Undertaking which shows that this exclusion is not relevant in the context of this Contract or

2.6 have given misrepresentation in documentation requested by the PEA as part of the Tender Process of the relevant Contract.

3. State-owned entities may compete only if they can establish that they (i) are legally and financially autonomous, and (ii) operate under commercial law. To be eligible, a state-owned entity shall establish to KfW's satisfaction, through all relevant documents, including its charter and other information KfW may request, that it: (i) is a legal entity separate from their state (ii) does not currently receive substantial subsidies or budget support; (iii) operates like any commercial enterprise, and, inter alia, is not obliged to pass on its surplus to their state, can acquire rights and liabilities, borrow funds and be liable for repayment of its debts, and can be declared bankrupt.

Section VI. KfW Policy – Sanctionable Practice – Social and Environmental Responsibility

1. Sanctionable Practice

The PEA and the Contractors (including all members of a Joint Venture and proposed or engaged Subcontractors) must observe the highest standard of ethics during the Tender Process and performance of the Contract.

By signing the Declaration of Undertaking the Contractors declare that (i) they did not and will not engage in any Sanctionable Practice likely to influence the Tender Process and the corresponding Award of Contract to the PEA's detriment, and that (ii) in case of being awarded a Contract they will not engage in any Sanctionable Practice.

Moreover, KfW requires to include in the Contracts a provision pursuant to which Contractors must permit KfW and in case of financing by the European Union also to European institutions having competence under European law to inspect the respective accounts, records and documents relating to the Tender Process and the performance of the Contract , and to have them audited by auditors appointed by KfW.

KfW reserves the right to take any action it deems appropriate to check that these ethics rules are observed and reserves, in particular, the rights to:

(a) reject an Offer for Award of Contract if during the Tender Process the Bidder who is recommended for the Award of Contract has engaged in Sanctionable Practice, directly or by means of an agent in view of being awarded the Contract;

(b) declare misprocurement and exercise its rights on the ground of the Funding Agreement with the PEA relating to suspension of disbursements, early repayment and termination if, at any time, the PEA, Contractors or their legal representatives or Subcontractors have engaged in Sanctionable Practice during the Tender Process or performance of the Contract without the PEA having taken appropriate action in due time satisfactory to KfW to remedy the situation, including by failing to inform KfW at the time they knew of such practices.

KfW defines, for the purposes of this provision, the terms set forth below as follows:

Coercive Practice	The impairing or harming, or threatening to impair or harm, directly or indirectly, any person or the property of the person with a view to influencing improperly the actions of a person.
Collusive Practice	An arrangement between two or more persons designed to achieve an improper purpose, including influencing improperly the actions of another person.
Corrupt Practice	The promising, offering, giving, making, insisting on, receiving, accepting or soliciting, directly or indirectly, of any illegal payment or undue advantage of any nature, to or by any person, with the intention of influencing the actions of any person or causing any person to refrain from any action.

Fraudulent Practice	Any action or omission, including misrepresentation that knowingly or recklessly misleads, or attempts to mislead, a person to obtain a financial benefit or to avoid an obligation.
Obstructive Practice	Means (i) deliberately destroying, falsifying, altering or concealing evidence material to the investigation or the making of false statements to investigators, in order to materially impede an official investigation into allegations of a Corrupt Practice, Fraudulent Practice, Coercive Practice or Collusive Practice, or threatening, harassing or intimidating any Person to prevent them from disclosing their knowledge of matters relevant to the investigation or from pursuing the investigation, or (ii) any act intended to materially impede the exercise of KfW's access to contractually required information in connection with an official investigation into allegations of a Corrupt Practice, Fraudulent Practice, Coercive Practice or Collusive Practice.
Sanctionable Practice	Any Coercive Practice, Collusive Practice, Corrupt Practice, Fraudulent Practice or Obstructive Practice (as such terms are defined herein) which is unlawful under the Financing Agreement.

2. Social and Environmental Responsibility

Projects financed in whole or partly in the framework of Financial Cooperation have to ensure compliance with international Environmental, Social, Health and Safety (ESHS) standards (including issues of sexual exploitation and abuse and gender based violence) Contractors in KfW-financed projects shall consequently undertake in the respective Contracts to:

(a) comply with and ensure that all their Subcontractors and major suppliers, i.e. for major supply items comply with international environmental and labour standards, consistent with applicable law and regulations in the country of implementation of the respective Contract and the fundamental conventions of the International Labour Organisation[6] (ILO) and international environmental treaties and;

(b) implement any environmental and social risks mitigation measures, as identified in the environmental and social impact assessment (ESIA) and further detailed in the environmental and social management plan (ESMP) as far as these measures are relevant to the Contract and implement measures for the prevention of sexual exploitation and abuse and gender-based violence.

PART 2

TERMS OF REFERENCE

Section VII.
Terms of Reference

1 Background and introduction

The German Development Bank (KfW) has since 2016 supported the development of Social Health Protection in Khyber Pakhtunkhwa (KP) and Gilgit Baltistan (GB). The Social Health Protection Phase I (SHP I) piloted a health insurance scheme covering the 21% of the poorest part of the population with inpatient health services (IPD) in the districts of Malakand, Mardan, Chitral and Kohat in KP and the district of Gilgit in GB, with the aim of increasing access of the poor to quality inpatient health services and financial risk protection.

The Governments in Pakistan have increasingly been financing a bigger share of the population with health insurance by expanding the targeted population, the number of districts and the range of services so the benefits package now covers secondary and tertiary IPD services for the entire population in all provinces. To this end, SHP I in KP and GB has been an effective catalyst for implementing the health insurance concept all over Pakistan.

Experience from SHP I also showed a clear demand for covering outpatient health services (OPD). Therefore, the Social Health Protection Initiative Phase II (SHP II) is designed to complement the existing IPD scheme with OPD services for the same original target population as SHP I, i.e., up to 21% of the poorest population in four districts in KP, as well as, in GB district.

The overall objective of SHP II is to “improve access to quality outpatient services and financial risk protection for the population in the project regions that are living below a Proxy Means Test (PMT) score of 16.17 by enrolling these families into an insurance scheme that covers OPD services in the same districts as covered under SHP I.

management4health (m4h) have been selected to support the DoHs in KP in the implementation of the pilot of the OPD scheme. In addition, KfW is preparing for the implementation of SHPIII that will support establishing better IT infrastructure to support the implementation of the OPD and IPD scheme.

The public health sector in Pakistan consists of a network of facilities that includes district headquarter hospitals in each district, civil hospitals, Rural Health Centres (RHCs), Basic Health Units (BHUs), Mother and Child Health Centres (MNCH), civil dispensaries, and first aid posts. All these health facilities provide Primary Health Care (PHC). In addition, a number of private providers are providing PHC, including General Practitioners (GPs).

According to Census-2017, the population in KP is 30.5 million, increasing from 17.7 million reported in Census-1998, giving an average annual growth rate of 2.89%. 5.7 million, or 18.8%, are living in urban areas, against 24.8 million, or 81.2%, in the rural part. The average household size, according to Census-2017, is 7.8 persons indicating a slight decline from 8.0 persons in Census-1998.

GB is located in the northeast of Pakistan with a total population of 1.6 million. Data provided by the DoH in GB shows an almost constant population since the Census in 1998. The prevailing poverty, shortage of health facilities and weak social sector portfolios lead to poor indicators of health. During the last few years, the number of health facilities has increased.

The GB DoH and the Aga Khan Health Services Pakistan (AKHSP) remain the two primary providers of health care services in GB.

Based on the Special Agreement with KfW, the DoHs in KP and GB are in the process of procuring the Health Insurance Providers (HI-providers) for OPD care / phase II. In addition, the DoHs are in the process of acquiring a Capacity Strengthening Provider (Capacity-provider), a Monitoring and Evaluation Provider (M&E-provider) and a Communication and Visibility Provider (C&V-provider). This Terms of Reference (ToR) describes the OPD scheme and the role of the Health Insurance Provider (HI-provider) for piloting the OPD scheme in KP.

2 The concept of the OPD scheme

2.1 Overall description of the OPD pilot concept

The OPD pilot concept is described in the Concept and Feasibility Report (a link is included as annex A), the concept can be summarised as follows:

Four districts in KP are foreseen to be included in the pilot: Chitral, Kohat, Malakand, and Mardan. However, to ensure financial sustainability and due to lack of data, the pilot will follow an adoptive approach, starting in the district of Mardan, and successively include the other districts when data proffer this is finically possible.

In terms of budget, KfW and the Governments of KP have made available EUR 7.5 million in total over a 2 years' period for support to the OPD scheme pilot. This amount cannot be exceeded and will cover reimbursement to the health service providers (HS-provider) as well as the administrative fee to the HI-provider.

The beneficiaries of the scheme are the population in the covered districts with a PMT score of 16.17 and below equal to 817 801 people in 2023. KP is using the family as the overall population unit.

The DoH, supported by the C&V-provider, will continuously provide public information and awareness among the beneficiaries and the empanelled HS-providers about the scheme and especially about the requirement of the beneficiaries to register at a HS-provider. An annual major campaign is also foreseen. An insurefamily will only be allowed to register with one single provider and the registration is binding for one year, except in cases of serious (written) complaints or provider drop-out. For those who have not managed to register with a PHC provider, registration will take place the first time they visit an empaneled provider. The detailed procedures for registration of beneficiaries at the HS-providers will be described in a Standard Operating Procedures (SOPs).

All PHC-services provided today, and which are part of the Essential Package of Health Services (EPHS) (see annex B) will be covered under the OPD scheme. However, while under the existing public PHC system, patients have to pay out of pocket for consultations, images, lab services and medicines, these items are foreseen to be covered under the OPD scheme.

It is further suggested to empanel Tehsil Head Quarters (THQs), Rural Health Centres (RHC) and some Basic Health Units (BHUs) as public PHC providers both in KP and equivalent facilities in GB. In addition, private providers in KP will be empaneled based on the same

selection criteria[7] that apply for the public providers and as long as they can accept the same uniform reimbursement scheme.

Reimbursement of the PHC providers is suggested to be made based on per capita payment for each beneficiary registered at an empaneledHS-provider, with a uniform rate for both public and private providers. The annual per capita payment is expected to be transferred to the HS-provider in quarterly instalments by the HI-provider. . Key performance indicators (KPIs) for the providers delivering the required OPD services have to be established to allow for effective M&E

Patients registered with HS-providers not able to provide the full scope of PHC diagnostic services will have the option to go on a “fee for service” basis to other empanelled PHC providers who are in a position to deliver the required services, based on a formal referral note. In this way the OPD scheme is also piloting gatekeeping and referral functions. This will require that each empaneled PHC provider is assessed in terms of which diagnostic services and medicines they can provide. Accordingly, the size of the annual per capita payment will be established as a maximum payment for those HS-providers providing full scale diagnostic services and medications, another for those providing medicines but without access to laboratory services and ultrasound and one for those not being able to provide medicine and do not have access to diagnostic equipment. . Referral system to Secondary and Tertiary facilities, empanelled under SHPI will be pilloted to complete the continuum of the care

The administrative fee to be paid to the HI-provider, and to be suggested in their offer not exceeding 8%, is calculated as a percentage of the sum of the reimbursement, at any time, to the HS-providers. It means that the maximum administrative fee to be paid to the HI-provider over the two years of the pilot will equal EUR 7,5 million * x%.

Based on the abovementioned the following core functions shall be performed as part of the OPD pilot:

No	Function	Performed by	Checked by
1	Empanelment of HS-providers and registration of their ability to provide consultations, diagnostic services including lab and ultrasound well as their ability to provide the prescribed medicines	DoH assisted by the HI-provider	DoH
2	Establish list of beneficiaries	DoH	HI-provider
3	Registration of the beneficiaries at only one HS-provider of their choice	Beneficiaries supported by the C&V-provider	HI-provider
4	Verification of eligibility of the beneficiaries	HS-provider	HI-provider
5	Provision of PHC services to the eligible registered beneficiaries by the empanelled HS-providers	HS-providers	HI-provider and DoH
6	Calculation of reimbursement of the HS-providers and issue of their invoices	HI-provider	DoH
7	Calculation of the administrative fee to the HI-provider	HI-provider	DoH

[7] To be detailed in a Standard Operating Procedure

8	Request transfer of financial resources	DoH supported by the HI-provider	DoH
9	Pooling of resources from KfW and DoH	HI-provider	DoH
10	Timely Payment of the HS-providers and the HI-provider	HI-provider	DoH
11	Digital collection of patient data and regular sharing with relevant stakeholders	HS-provider	HI-provider
12	Digital collection of financial data and regular sharing with the relevant stakeholders	HI-provider	DoH
13	Sharing digital data with DoH	HI-provider	DoH
14	Safe & secure storage, analysis and evidence-based decision-making as well as updating of the operational procedures when needed	DoH	

The OPD pilot scheme seeks to strike a balance between maximal access to health care, and operational and financial sustainability. The key features of the OPD scheme are as follows:

- It is a health insurance scheme aimed at covering the marginal costs[8] of PHC services and to improve quality of PHC services at the supply side in the long term;
- It is an additionality to the existing IPD health insurance schemes and should result in seamless patient journeys across the entire spectrum of services;
- All members of a family are covered (a family includes the head, spouse, children as well as dependent parents living in the same house);
- The head of the family, spouse and children as well as dependent parents living in the same house will be registered at only one PHC provider;
- Capitation per registered persons per annum (graduated based on which services a HS-provider can cover) covering up to 6 visits per person per year as well as fee-for-services for referred diagnostic services that are not provided by the HS-provider with whom the person is registered;
- All ages are covered starting at birth;
- The services covered in the scheme will be the PHC services normally provided and included in the Essential Packages of Health Services (see annex B) at the primary-level (BHU, RHC, THQ level) such as consultation, basic diagnostics and prescribed medicines;
- Also, private PHC providers should be empanelled where criteria are satisfied.
- Reimbursement is the same for public and private providers;
- The HI-provider will be paid for its services based on a flat rate calculation as a percentage of the total realised cost of the OPD scheme;
- The total budget for the OPD scheme in KP is EUR 7,500,000 for the current 2 years of piloting; an extension is possible;
- The pilot scheme is adaptive and coverage can change according to evidence proving financial sustainability (within the budget).
- Integrated research is supporting the provision of evidence required and is dependent on sharing of required data

The OPD pilot is being implemented by the DoH supported by m4h and assisted by the HI-provider, and the HS-providers. The functioning of the OPD scheme and the role of the

[8]

partners is described in these ToR which forms an integral part of the contract to be signed between the DoH and the HI-provider.

The HI-provider's proposals should include a justified proposal for the percentage of the total costs of the scheme which should be paid to the HI-provider for its services, equal to or below 8%. Negotiation of the administrative fee can take place after the first year of the pilot.

The HI-provider's proposals should also include a description of data to be collected by the HI-provider needed to monitor the implementation of the OPD pilot and to ensure control of costs, to be provided to the DoH. The HI-provider will also describe how it will provide data to the DoH about quality of services and adherence toScope of work as well as for monitoring patient satisfaction. Further, regarding data the HI-provider deems useful, will collect, make available to the DoH as well as how DoH can assess these data, should be described in the proposal.

2.2 The beneficiaries and their utilization

The beneficiaries will, in both provinces, be the population with a PMT under 16.17 who are already beneficiaries of the KfW-supported IPD scheme. Recent data provided by the health IPD insurance providers for KP and GB details the covered population in the relevant districts, as illustrated in Table 1.

Pakistan has one of the highest population growth rates in the world and for KP the annual growth rate is for the relevant years 2.4% although, the population in GB is constant.

Table 1: Population under PMT 16.17 in the target districts 2021

	2021	2023	2024	2025
Population OPD-pilot KP	Population PMT <16.17	Population PMT <16.17	Population PMT <16.17	Population PMT <16.17
Mardan	400,433	419,884	429,962	440,281
Malakand	145,726	152,805	156,472	160,227
Kohat	156,364	163,960	167,895	171,924
Chitral	77,393	81,152	83,100	85,095
KP total pilot	779,916	817,801	837,428	857,527

Studies made about utilisation of OPD schemes vary widely, depending on beneficiaries' access to HS-providers, the level of education of the beneficiaries, the socioeconomic status of the beneficiaries, and the knowledge by the beneficiaries about how to use the scheme.

Since data about utilisation by the target beneficiaries for OPD services are not available for the pilot districts, the actuarial calculation estimating the reimbursement prices is assuming a utilisation of 6 visits per person per year. With that high utilisation the actuarial calculation shows that it is not possible to cover all four districts in KP right from the start. Therefore, it is suggested to start with Mardan in 2023 and to add Kohat, Chitral, and Malakand once there is sufficient evidence about trends for the future utilisation of the scheme. This adaptive implementation approach is fully aligned with the findings of the sensitivity analysis conducted for the actuarial calculation that shows a dramatic increase in the total cost of the scheme, with only small changes in the utilisation rate.

The OPD concept also includes that the insured population will have to select and register with their PHC provider of choice for the duration of a year. This process will require time and thus it is anticipated that the beneficiaries gradually will sign up over the pilot implementation.

2.3 Services to be covered

All PHC-services described in the Essential Health Package (EHP) under the primary care level, see annex B, will be covered under the OPD pilot scheme. However, while under the existing public PHC system, some patients have to pay out of pocket for consultations, diagnostic tests (images, lab services, and other) and medicines, these items will be covered under the OPD scheme.

2.4 Empanelment of the health service providers

The lists of health facilities in the four districts of KP have been provided by the DoH, showing a total of 225 health facilities encompassing hospitals and a specialised facility for TB patients. The PHC providing facilities are Tehsil Head Quarters (THQ) hospitals, Rural Health Centres (RHC), Basic Health Units (BHU), Civil Dispensaries (CD) and District Head Quarters (DHQs). In addition, a number of private PHC providers operate in the 4 districts.

Table 2: Number of health facilities in KP

	Lower Chitral	Upper Chitral	Kohat	Mardan	Malakand	Total 4 districts
THQ	2	1	0	6	1	10
RHC	3	3	4	5	6	21
BHU	9	10	20	50	20	109
CD	17	15	9	19	11	71
DHQ	1	0	1	1	1	4
Category-D	0	0	2	0	3	5
Specialised(W&C)	0	0	1	0	0	1
Sub Health Center	0	0	3	0	0	3
Total	32	29	40	82	42	225
Of which PHC	29	28	33	74	37	201

While the Basic Health Units (BHU) and Civil Dispensaries (CD) most often are staffed with part-time nurses or midwives, and thus with limited capacity; Tehsil Head Quarters (THQ) and Rural Health Centres (RHC) are staffed also with medical doctors, have labs, and provide imaging services (including ultrasound). Most CDs would not have electricity, water, or internet. The THQs and RHCs also possess administrative capacity to participate in a health insurance scheme. In addition, the vision of the government in KP, in line with the human development objectives in the health sector, is to rehabilitate all the RHCs to progressively scale up their services. In addition, a number of private providers are operating in KP.. On this background it is suggested to empanel THQs, RHCs and a few BHUs as public PHC providers in the pilot OPD scheme for KP. In addition a limited number of private PHC providers will be empanelled as per the prescribed empanelment criteria.

The DoH is in the process of elaborating SOPs on empanelment of the PHC providers and it is expected that criteria as opening hours, the availability of health professional staff authorised

by the Pakistan Medical Council and the approval of the health facilities by the Health Commission will be among the selection criteria. However, accessibility will also be prioritised. The empanelment process is expected to be led by the DoH that also will establish a data base of the empanelled HS-providers with description of address, opening hours, phone number, the type of services provided (also important for which capitation rate it will receive per registered patient) to be made available also to the HI-provider who will assist the empanelment process. The empanelled HS-providers will sign a contract to be co-signed by DoH and the HI-provider. It is expected that the HI-provider will assist the DoH in the process of empanelment and contracting. The approach for support shall be explained and presented in detail in the Technical Offer.

As a starting point it is anticipated that 95 different health facilities will be empanelled in KP (Mardan).

Table 4: Anticipated number and type of empanelled of health facilities in Mardan in KP

Type of health facility	No of health facilities empanelled in KP
RHCs	5
THQ	1
BHUs	26
Private	63
Total	**95**

It is important to stress that the SOP for reimbursement of the HS-providers, under elaboration by the DoHs, is expected to include provisions by which the provider can utilise part of the revenue it receives to purchase simple laboratory equipment, test stripes and medicines and those step-by-step to increase their per capita payment. The HI-provider is expected to assist in the inspection of and verification of the HS-providers and to update the empanelment register accordingly, related to diagnostic services and medicine provided.

2.5 Registration of beneficiaries at the health service providers

On a continuously basis the DoH supported by the C&V-provider will inform about registration. In addition, a major public information campaign will be conducted once a year to encourage the target population to register at their preferred PHC provider. An insured person will only be allowed to register with one provider and the registration is binding for one year, except in cases of written and justified complaints, as assessed by DoH.

For those who have not managed to register with a PHC provider during the annual campaign, the registration will take place the first time a beneficiary is visiting an empanelled provider.
To assist improving the knowledge of all the main partners about the OPD pilot scheme and how to utilise it, the DoH are in the process of contracting a C&V-providers.

The DoHs are also in the process of contracting a Capacity Strengthening Provider (Capacity-provider) to support the DoHs in establishing a database with information about the beneficiaries (name, address, phone number, name of head of family/household). In addition, this database will include information about eligibility of a person and about which HS-provider the beneficiary is registered at. The HI-provider will support the Capacity-provider, the C&V-provider and the M&E-provider The ToRs are attached as annex C.

2.6 Reimbursement of the health service providers

The number of providers and the limited electronic data available will require a very simple reimbursement procedure for the PHC providers. Per capita payment for registered patients is a simple and convenient reimbursement mechanism, which will be applied for reimbursement of the PHC providers at which the beneficiary is registered.
For patients registered with a PHC provider not able to offer the full package of diagnostic services, these services will be paid for on a fee for service basis to other empanelled PHC providers able to deliver those services, based on a formal referral note. In this way the OPD scheme is also piloting gatekeeping and referral functions.

The suggested reimbursement mechanism will require that each empanelled PHC provider is assessed in terms of which services they are able to provide (consultations, diagnostic services and medicines) as their per capita payment will depend on this.

The annual per capita reimbursement rates and the fee-for-service rates will be used for reimbursement of both private and public PHC health service providers. Implicitly this means that only providers who can accept this payment will be empanelled.

For per capita payment (which is an annual rate), the HS-providers are paid quarterly based on the number of new registered patients (4 instalments per registered patient), as well as remaining instalments for patients registered earlier. The transfer will take place the first day of the second month following the end of the quarter. E.g., the quarterly payment for January, February and March 2023 will be paid by the HI-provider on 1 May 2023.

Payment for services is suggested to be done monthly so that claims received before the 10th day in the following months will be paid not later than the 10th day in the following month. E.g., claims received before 10th of February, for the months of January, will be paid by the HI-provider not later than 10th of March.

To this end, the HI-provider shall in their offer describe how they will establish a payment system for reimbursement of the HS-providers and how this system will be integrated also into the M&E system. The HI provider shall specifically name any type of IT tools it plans to establish and or utilize and spell out each and every requirement HS providers need to comply with for effective reimbursement. These requirements shall be realistic to achieve.

The number of visits of the beneficiaries will be monitored carefully and if the number is lower/higher than expected, per capita payment will be revised accordingly during the year and additional coverage will be considered. In this way the budget cannot be exceeded.

During the pilot implementation it is also suggested to seek possibilities to include additional performance payments e.g., related to treatment of specific age groups, and/or providers with special demographic characteristics (e.g., providers in rural settings and scarcely populated areas) as soon as data can provide evidence for the need and the financial possibility to do this.

2.7 Payment of the health insurance provider

Payment of the HI-provider will be made through a service fee calculated as a percentage of the total payment to the HS-providers. In providing their offer for the service fee, the HI-provider needs to consider that the total budget for the 2 years of pilot in KP is EUR 7,500,000. The sum of the total payment to the HS-providers plus the payment of the HI-provider cannot exceed the total budget for the OPD pilot. In addition, the HI-provider needs to consider that it

does not take any risks. It is important to note that all cost of the HI-provider is to be covered by the service fee whether it is staff cost, transportation, office, app and systems, meetings, overhead, etc. The HI-provider shall in their financial offer provide a breakdown of the total service fee they expect to receive.

2.8 Piloting referral and gatekeeping

A key role of PHC will be the professional gatekeeping to the other parts of the health system. Establishing an effective gatekeeping and referral function takes time and requires a high degree of professionalism of the PHC providers to be trusted by the population as well as the ability to diagnose and treat the majority of cases in the PHC-sector.

The HI-provider will make arrangements involving very close monitoring aimed at limiting the demand for unnecessary hospital services which can be provided at PHC level. The HI-provider will in their offer describe mechanisms to be applied related to referral by the OPD scheme and how this will impact the IPD scheme. The HI-provider will also describe arrangements required for very close monitoring and intense population education aimed at referral between OPD and IPD.

The empanelled PHC providers that do not provide lab-services, X-ray, ultrasound, or ECG the HS-provider can, if medically justified, refer a beneficiary for further diagnostic services to another empanelled PHC provider offering these services, for which they will be reimbursed on a fee-for-service basis according to a predetermined price list. E.g., BHU can refer beneficiaries to RHUs and to THQs.

The SHP III project foresees to support the establishing of an electronic referral system.

2.9 Monitoring and evaluation

Monitoring and Evaluation (M&E) will form an integral part of the results-based management concept of SHP II. The M&E will enable programme managers to base their decisions on evidence about performance and results and to adjust the pilot during the implementation based on evidence. Patient access, mix of services and quality indicators will be monitored.
The DoHs are in the process of identifying a company to support establishing the M&E system based on the M&E methodology that is under elaboration.

Although the DoHs will be the owner of the M&E data and although m4h and the KfW Research Team will be supporting the DoHs in analysing the M&E data and to prepare for evidence-based decision-making, the HI-provider will have to reflect in their offer how they will establish automatic transfer of data needed in the M&E system.

2.10 Communication and visibility

Experience from the IPD scheme show how important sufficient knowledge about the way the scheme is functioning is for the utilization of the scheme. To ensure that all parties will have knowledge about the functioning of the OPD scheme, the DoHs are in the process of elaborating the Communication & Visibility Strategies (C&V Strategies) and acquiring a C&V-provider that will support the implementation of the C&V Strategy.

Although, the direct responsibility for implementation of the C&V Strategy rests with the DoHs supported by the C&V-providers, the HI-provider shall in their offer reflect how they as being

in touch with the beneficiaries and the HS-providers, can support the successful implementation of the C&V Strategy.

2.11 Capacity strengthening

In recognition of the innovative nature of the OPD scheme, funds have been included in the separate agreement between KfW and the DoHs for the purpose of organisational development or strengthening of the capacity of the DoHs and the HS-providers.

The DoHs are in the process of identification of organisations/companies to support capacity strengthening, foreseen to include training of the HS-providers and establishing the most needed IT infrastructure e.g., the databases for beneficiaries, for empanelled HS-providers, and for registration of beneficiaries at HS-providers.

The HI-provider shall in their offer provide a concept on how they also would support strengthening the capacities of the HS-providers and DoH, to be covered within the service fee paid to the HI-provider.

3. Inception phase

The HI-provider will be expected to complete the process of preparation for the OPD pilot including establish the required IT infrastructure, to inform the beneficiaries and the empanelled HS-providers about the pilot scheme, to agree and conclude 3-party contracts with the DoHs and the empanelled HS-providers, as well as to establish offices and recruitment of staff. The inception phase has to be finalised as early as possible but not later than four (4) months after signing of the contract with the DoH.

More detailed, establishing of the IT infrastructure will include creating data exchange links from the DoHs' databases for beneficiaries, for the empanelled HS-providers, for the registered beneficiaries, for the M&E system and for the reimbursement system established by the HI-providers.

Although a C&V-provider will support the DoH in informing the beneficiaries and the empanelled HS-providers about the pilot scheme, the HI-provider is expected to provide information directly to the same partners and explain its role and the operational procedures to the different partners. Messages and communication techniques used by the HI-provider shall be pre-approved by the DoH to ensure harmonized messaging.

The DoH will draft a 3-party contract to be agreed with the HI-provider and to be signed also by the empanelled HS-providers. The HI-provider is expected to undertake the process of getting the HS-providers signature.

4. Service Delivery Period

The contract to be signed between the DoH and the HI-providers for provision of the services described in this ToR, shall be for two years from the effective date subject to annual performance evaluations to be carried out by the Government through the SHPI policy board to review the agreement and performance of the HI-provider.

5. Payments

Periodical payments to the HI-provider will be made via Direct Disbursement Procedure by KfW upon receipt of adequate invoices and support documentation from the HI providers endorsed by the DoHs related to:
(i) Per capita payment to the HS-providers for registered beneficiaries;
(ii) Fee-for-services payment to the HS-provider for referred beneficiaries for diagnostic services that cannot be offered by the HS-providers where the beneficiary is registered;
(iii) a percent rate of the total payment to the HS-providers to be paid to the HI-provider.

The HI-provider shall in their offer describe how they will establish a payment system that regularly can generate invoices from the HS-providers, draft invoices for DoH, facilitate approval by the DoH, support the DoH's issuing of payment claims to KfW, receiving payment, and transferring payment to the HS-providers. The description should also include details of how the payment system will be integrated with the M&E system.

6. Summary of main tasks of the HI-provider

The tasks of the HI-Provider are summarised in the table below. It is important to underline that the list only is guiding and cannot be considered exhaustive. The Bidders are requested to structure their Technical Offers in exactly the sequence of tasks and sub-activities as presented in Table 5.

Table 5: Guiding list of main tasks of the HI-Provider

No	Tasks
0	**Management, quality assurance and back-up**
0.1	Regular coordination-meetings with DoH and its partners including m4h
0.2	Management of staff
0.3	Quality assurance of their service provision
0.4	Back-up procedures to ensure continuing service provision
1	**Inception**
1.1	Kick-off meetings with DoH and its partners including m4h
1.2	Participate in finalising of SOPs for Empanelment of HS-providers, for Contracting of HS-providers, for Registration of Beneficiaries, for Complaints and for Payment
1.3	Organise and conduct information meetings (coordinated with the C&V-provider) with the beneficiaries and the HS-providers to inform about the functioning of the OPD pilot scheme
1.4	Participate in finalising and undertake the procedure for concluding the tri-party contract between DoH, HS-providers and the HI-provider
1.5	Ensure legal and technical interlinkage for data exchange related to beneficiaries, empanelled HS-providers, and the M&E system
1.6	Establish, test, document, train and place into operation the payment system (IT infrastructure for the HS-providers are provided by the Capacity Strengthening Provider and the M&E-provider)
1.7	Draft, present, update and supporting the approval of the Inception Report
1.8	Acquire data for interim payment, process invoices from HS-providers, generate overall invoice to DoH, support approval by DoH, facilitate DoH in issuing claim to KfW, receive payment, transfer payment to HS-providers, provide documentation to DoH and relevant for audit as well as control.

1.9	Set-up of a digital filing repository, to which DoH and its partners including m4h receive access, where all relevant contractual and financial documents are properly filed.
2	**OPD pilot**
2.1	Acquire updated data on eligible beneficiaries and make them electronically available for DoH and the HS-providers
2.2	Acquire updated data on registration of beneficiaries on a daily basis, and share these electronically with DoH, the Hs-providers and the beneficiaries
2.3	Acquire updated data on utilisation of OPD services by the beneficiaries on a daily basis and share these electronically with DoH
2.4	Acquire updated data on categorisation of HS-providers in terms of which services they can provide and share it electronically with DoH and the HS-providers
2.6	Process invoices from the HS-providers on a monthly basis, generate overall invoice to DoH, support approval by DoH, facilitate DoH in issuing claim to KfW, receive payment, transfer payment to HS-providers and share documentation with DoH
2.7	Maintain and update the payment system
2.8	Establish, test, operate and update a system for monitoring complaints, patient satisfaction according to international accepted indicators also measuring the trust in the system as well as monitoring of formal and informa payment, satisfaction of the HS-provider and report regularly to DoH, as well as undertake follow-up actions
2.9	Suggest KPIs for monitoring of performance of the HI-provider e.g., timely payment, M&E framework, regular analytics and suggestions for improvement provided, MIS data reports including links to the existing hospital based health insurance system, etc.
2.10	Elaborate and present monthly, quarterly and annual reports to DoH and its partners including m4h
2.11	Participate in regular campaigns encouraging the beneficiaries to register and to inform about the functioning of the OPD scheme
2.12	Ad hoc tasks as requested by the DoH
1.13	Prepare and support audits
3	**Hand-over**
3.1	Hand over all documents, data, IT infrastructure and source-code to DoH
3.2	Elaborate, present and support the approval of the Final Report

7. Requirements

7.1 Personnel

The project is pursuing an equal opportunities policy. Gender balance, diversity and inclusion of members with disabilities in the proposed teams, at both administrative/secretarial and decision-making levels, are recommended.

For all staff suggested in the proposal the amount of working days shall be stated as well as the geographic location of the staff (in KP or elsewhere). CVs will also indicate the start and end of the each of the assignments (MM/YYYY) as well as the actual fulltime working months. Please note that 220 working days constitute one year of professional experience (FTE). Part-time must be converted into FTE.

7.2 Key staff

Key staff have a crucial role in implementing the contract and the tenderer shall submit CVs and statements of exclusivity and availability for the following key staff:

Key staff 1: Senior OPD Health Insurance Expert and Team Leader

Qualifications and skills:
- Master's Degree (or equivalent) in a field related to managing a private insurance scheme and the seamless cooperation with public health authorities e.g., economies, law, medical science, etc.;
- Excellent team and leadership abilities;
- Excellent abilities to guide clients and to explain even complicated technical issues in and understandable way;
- Experience with M&E system related to health care;
- Experience with performance measuring and establishing of relevant KPI;
- Excellent presentation and communication skills both oral and written;
- Excellent command of English both written and spoken;
- Fluency in one of the common languages in Pakistan.

Professional experience:
- At least 10 years of professional experience from the insurance business;
- At least 5 years of professional experience from a public health authority;
- At least 4 years of professional experience with health policy issues;
- At least 4 years of professional experience with social health insurance;
- At least 4 years of professional experience in leading teams of experts;
- Experience with social health insurance and the health system in KP would be an advantage.

Key staff 2: Senior OPD Health Insurance Financial Expert

Qualifications and skills:
- Master's Degree (or equivalent diploma) in the field of financing, economics, administration or any other relevant fields or 5 years of professional experience in one or more of these fields, in addition to the minimum general professional experience;
- Excellent team and leadership abilities;
- Excellent abilities to guide clients and to explain even complicated technical issues in and understandable way;
- Excellent presentation and communication skills both oral and written;
- Excellent command of English both written and spoken;
- Fluency in one of the common languages in Pakistan.

Professional experience:
- At least 10 years of professional experience from the insurance business including actuarial experience, experience with different payment methods, purchasing strategies, and claim verification;
- At least 5 years of professional experience from a public health authority;
- At least 4 years of professional experience with financial issues;
- At least 4 years of professional experience with social health insurance;
- At least 4 years of professional experience in leading teams of experts;

- Experience with social health insurance and the health system in KP would be an advantage.

Key staff 3: Senior OPD Health Status Improvement and Utilisation Expert

Qualifications and skills:

- University degree in the field of medicine;
- Specialisation in primary health care would be an advantage;
- Excellent team and leadership abilities;
- Excellent abilities to guide clients and to explain even complicated technical issues in and understandable way;
- Excellent presentation and communication skills both oral and written;
- Excellent command of English both written and spoken;
- Fluency in one of the common languages in Pakistan.

Professional experience:

- At least 5 years of professional experience practicing as a medical doctor;
- At least 3 years of professional experience practicing as a medical doctor in the primary health sector;
- At least 3 years of professional experience with hands-on improving of health promotion and disease prevention among pro-poor;
- At least 3 years of professional experience with improving the quality of clinical practice in primary health care including teaching, instructing, guiding medical professionals in best clinical practice and design of service packages;
- At least 3 years of professional experience in improving patient satisfaction including design of complaint system, patient satisfaction survey and actions to improve patient satisfaction;
- At least 3 years of professional experience in leading teams of experts;
- Experience with social health insurance and the health system in KP would be an advantage.

Key staff 4: Senior OPD Health Insurance M&E, IT and Innovation Expert

Qualifications and skills:

- Master's Degree (or equivalent diploma) in the field of planning, economics, public health or any other relevant fields or 5 years of professional experience in one or more of these fields, in addition to the minimum general professional experience;
- Excellent team and leadership abilities;
- Excellent abilities to guide clients and to explain even complicated technical issues in and understandable way;
- Excellent presentation and communication skills both oral and written;
- Excellent command of English both written and spoken;
- Fluency in one of the common languages in Pakistan.

Professional experience:

- At least 5 years of professional experience from the health sector including HI-management information systems;
- At least 3 years of professional experience from a public health authority;

- At least 3 years of professional experience from the health sector with monitoring & evaluation, analyses, preparing and supporting evidence-based decision-making;
- At least 3 years of professional experience with planning, acquiring and supporting the operation of IT infrastructure, preferable from the health sector
- At least 3 years of professional experience in leading teams of experts;
- Experience with social health insurance and the health system in KP would be an advantage.

7.3 Non key staff

CVs for non-key staff should not be submitted in the tender, but the tenderer will have to demonstrate in their offer that they have access to staff/experts with the required profiles. The contractor must select and hire other staff as required according to the profiles identified in the organisation & methodology and this ToR. It must clearly indicate the staffs' profiles so that the applicable daily fee rate in the budget breakdown is clear. All staff must be free from conflicts of interest in the responsibilities they take on. The procedures used by the HI-provider to select its staff must be transparent, and must be based on pre-defined criteria, including professional qualifications, language skills and work experience. The findings of the selection panel must be recorded. The selected staff must be subject to approval by the DoH before they start their assignment.

7.4 Support staff & backstopping

The HI-provider will provide support facilities to its team (back-stopping) during the implementation of the contract, and shall identify, from his staff, a Project Director who will coordinate the organisation of all activities under this contract and act as a quality controller. The CV of the project director has to be proposed in the offers and will be assessed by the evaluation committee under the headline "Backstopping function" based on the following requirements:

Key staff 5: Senior OPD Health Insurance Project Director

Qualifications and skills:
- Master's Degree (or equivalent diploma) in the field of insurance, economics, law, public health or any other relevant fields or 5 years of professional experience in one or more of these fields, in addition to the minimum general professional experience;
- Excellent team and leadership abilities;
- Excellent abilities to guide clients and to explain even complicated technical issues in and understandable way;
- Excellent presentation and communication skills both oral and written;
- Excellent command of English both written and spoken;
- Fluency in one of the common languages in Pakistan.

Professional experience:
- At least 15 years of professional experience from the insurance business;
- At least 5 years of professional experience from a public health authority;
- At least 4 years of professional experience with health policy issues;
- At least 4 years of professional experience with social health insurance;
- At least 4 years of professional experience in leading teams of experts;

- Experience with social health insurance and the health system in KP would be an advantage.

The cost of backstopping and support staff must be included in the fee rates.

7.5 Office accommodation

Office accommodation of a reasonable standard and of approximately 10 square metres per person for key staff 1-4 and for around 50% of the non-key staff, is to be established in KP by the HI-provider. Office accommodation includes the room, furniture, IT, etc., and running cost. The costs of the office accommodation are to be covered by the fee rates.

The HI-provider must ensure that its staff/experts are adequately supported and equipped. It must also ensure that its employees are paid regularly and in a timely fashion. The costs of these support services are included in the fees. The fees will also include all necessary communication and web services, including an adequate and user-friendly platform for sharing files within the team, with the DoH, m4h and our partners in a secured way. All necessary IT support to the staff will be provided by the HI-provider. For all travels, the staff/experts should have all necessary support for the preparation of the travel and during the travel.

7.6 Technical requirements

The technical evaluation shall be carried based on the following criteria and point system. No additional criteria or sub-criterion than those indicated in the RFP shall be used for the evaluation of the Technical Proposal.

Table 6: Requirements

No	Issue	Points	
1.	Concept and methodology		70
1.1	Completeness of the proposed methodology and strategies	9	
1.2	Quality of the description of the governance arrangements, management & decision-making structure (close to client), and staffing	9	
1.3	Quality of the description of the HI provider in handling registration of the population, including formats and grievance redressal mechanism for beneficiaries	9	
1.4	Quality of the description of the HI-providers role in empanelment of HS-providers, inspection of these and providing regular update of data about the performance of HS-providers	9	
1.5	Quality of the payment system to be established by the HI-provider, for handling timely payments and related modalities, to the beneficiaries and HS-providers	9	
1.6	Comprehensive details along with flow diagrams describing the HI-provider’s electronic MIS Networking relevant for the assignment	9	
1.7	Comprehensiveness of the description of the HI-provider’s role in M&E including provision of data to the DoH as well as the concept for learning and further developing the beneficiary driven HI OPD approach	8	
1.8	Comprehensiveness of measures, the HI-provider will undertake to support the implementation of the Communication & Visibility-Strategy	8	

2	Qualification and skills of key staff proposed as well as personnel in the home office who will monitor and control the team, and provide back-up services		30
2.1	Senior OPD Health Insurance Project Director	6	
2.2	Senior OPD Health Insurance Expert and Team Leader	6	
2.3	Senior OPD Health Insurance M&E, IT and Innovation Expert	6	
2.4	Senior OPD Health Insurance Financial Expert	6	
2.5	Senior OPD Health Status Improvement and Utilisation Expert	6	
Total (maximum)			100

The minimum technical score "T" required to pass is: 75 Points

The weights given to the Technical (T) and Financial (F) Proposals are as follows:
W_T = [*Insert weight, usually 80 %*], and
W_F = [*Insert weight, usually 20 %*]
The weighted technical score is calculated as follows:
PT = WT * T, with
PT = weighted technical score (points) of a technical Proposal,
T = technical score (points) as per technical evaluation,
WT = weight of the technical Proposal (in percent)
The weighted financial score is calculated as follows
PF = WF * Co/C, with
PF = financial score (points) of a financial Proposal,
C = evaluated price of the financial Proposal,
Co = lowest evaluated price of all financial Proposals.
and the overall score is calculated as:
P = PF + PT.

PART 3

CONTRACT FORM

Section VIII.

CONTRACT
INSURANCE SERVICES' PROVIDER FOR
OUTPATIENT DEPARTMENT HEALTH (OPD) SCHEME

German Financial Cooperation with Health Department
Government of Khyber Pakhtunkhwa

Lump-Sum

between

DEPARTMENT OF HEALTH,
GOVERNMENT OF KHYBER PAKHTUNKHWA

and

(NAME OF THE SERVICE PROVIDER)

Dated: --- February 2024

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PREAMBLE .... ERROR! BOOKMARK NOT DEFINED.

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GENERAL CONDITIONS

1 General Provisions

1.1 DEFINITIONS

Words and expressions used in this Service Contract (as defined below) shall have the following meaning unless the context requires otherwise.

"**Agreed Remuneration**" means the remuneration agreed pursuant to Paragraph 5 [*Remuneration*].

"**Commencement Date**" has the meaning given to such term in the Special Conditions.

"**Completion Period**" means the period for the completion of the Services as set out in the Special Conditions.

"**Service Contract**" means this contract for services, including its Preamble and its Annexes[9].[10]

"**Contract Value**" has the meaning given to such term in the Special Conditions.

"**Country**" has the meaning given to such term in the Special Conditions.

"**Force Majeure**" means an event which is beyond the reasonable control of a Party, is not foreseeable, is unavoidable, and makes a Party's performance of its obligations hereunder impossible or so impractical as reasonably to be considered impossible under the circumstances. It includes, but is not limited to, war, invasion, rebellion, terrorism, riots, civil disorder, natural catastrophe (e.g. earthquake, fire, explosion, hurricane, typhoon, volcanic activity), strikes, lockouts or other industrial action confiscation or any other action by government agencies. It includes, but is not limited to, circumstances such as crises, war or terror that lead to the Foreign Office of the Federal Republic of Germany calling upon German citizens to leave the country or the Project region in response to which the Service Provider withdraws all its staff. Force Majeure shall not include (i) any event which is caused by the negligence or wilful action of a Party or such Party's experts, sub-contractors or their respective directors, agents or employees, nor (ii) any event which a diligent Party could reasonably have been expected to both take into account at the time of the conclusion of this Service Contract and avoid or overcome in the carrying out of its obligations hereunder. Furthermore, Force Majeure shall not include insufficiency of funds or failure to make any payment required hereunder.

"**Foreign Currency**" means any currency other than the Local Currency.

"**Foreign Staff**" means the staff who do not hold the citizenship of the Country.

[9] If one or several of the Annexes should not be necessary in the actual Contract, to preserve the integrity of the references please retain the numbering of the Annexes and insert the words "not applicable" in the relevant Annexes.

[10] In case there are Minutes of Negotiations pursuant to the Special Conditions between the Parties these Minutes of Negotiations could be attached as an Annex. But in the interests of clear contractual stipulations, instead of including copious minutes of negotiations it is preferable to incorporate the agreed changes directly into the Special Conditions.

“**Funding Agreement**” means the *financing agreement entered into between KfW and Islamic Republic of Pakistan to* wholly or partly finances the Services.

“**Joint Venture (JV)**” means an association with or without a legal personality distinct from that of its members, of more than one Service Provider where the members of the JV shall be jointly and severally liable to the Employer for the performance of the Contract and one member has the authority to conduct all business for and on behalf of any and all the members of the JV. The terms Joint Venture and Consortium can be used interchangeably.

“**Local Currency**” has the meaning given to such term in the Special Conditions.

“**Other Costs**” means the additional costs of the Service Provider to the extent agreed in the Special Conditions.

“**Parties**” means the Employer and the Service Provider.

“**Project**” means the project specified in the Special Conditions.

“**Services**” means the contractual services described in **Annex 3** [*Terms of Reference plus Tender Documents*], **Annex 9** [*The Service Provider’s Bid*] and Paragraph 3.1 [*Scope of Services*], including without limitation any optional services (if any) as well as the standard and special services defined in Paragraph 3.2 [*Standard and Special Services*].

“**Special Conditions**” means the terms and conditions set out under the header “Part II: Special Conditions” of this Service Contract.

“**Standards**” means the metric system and German DIN or European EN standards, or internationally recognised standards that are at least equivalent to those published by ISO or IEC.

“**Written**” or “**in writing**” means written by hand or typed by machine, and produced in a printed or electronic form, the result being a non-editable permanent record.

1.2 INTERPRETATION

Unless a contrary indication appears, in this Service Contract:

1.2.1 Section, clause, annex and schedule headings are for ease of reference only.

1.2.2 The singular includes the plural and vice versa.

1.2.3 References to a "**Party**" or any other person shall be construed so as to include its successors in title, permitted assigns and permitted transferees to, or of, its rights and/or obligations under this Service Contract.

1.2.4 References to a "**director**" include any statutory legal representative(s) of a person pursuant to the laws of its jurisdiction of incorporation.

1.2.5 References to this " **Service Contract**" or any other agreement or instrument are references to this Service Contract or other agreement or instrument as amended, novated, supplemented, extended or restated.

1.2.6 References to a "person" shall include any individual, firm, company, corporation, government, state or agency of a state or any association, trust, joint venture, consortium or partnership or other entity (whether or not having separate legal personality).

1.2.7 References to euro, EUR or € are references to the lawful currency of the participating states of the European Monetary Union. References to US dollars, USD or US$ are references to the legal currency of the United States of America.

1.3 RANKING AND ORDER

1.3.1 In the event of a conflict between the Special Conditions and the General Conditions or any annex or schedule thereto, the provisions of the Special Conditions shall prevail.

1.3.2 In the event of a conflict between General Conditions and any annex or schedule thereto, the provisions set out in the respective annex or schedule shall prevail.

1.3.3 In the event of a conflict between the annexes, the provisions set out in the respective preceding annexes shall prevail over the provisions set out in the respective subsequent annexes.

1.4 COMMUNICATION AND LANGUAGE

Any communication to be made under or in connection with this Service Contract shall (i) be made in writing and, unless otherwise stated, may be made by fax or letter, and in the language specified in the Special Conditions and (ii) to the extent not otherwise stipulated in the Special Conditions, take effect upon receipt at the addresses specified in the Special Conditions and if by way of fax, when received in legible form.

1.5 GOVERNING LAW

This Service Contract is governed by the laws specified in the Special Conditions.

1.6 ENTRY INTO FORCE AND EFFECT

This Service Contract enters into force and effect immediately upon (i) execution hereof by both Parties, and (ii) receipt by the Employer of KfW's written confirmation that all conditions precedent to the first disbursement under the Funding Agreement have been satisfied in form and substance satisfactory to KfW. The Employer has to inform the Service Provider about KfW`s written confirmation immediately.

1.7 MEASUREMENTS AND STANDARDS

Any drawings, plans and calculations shall be based on the Standards; moreover, the Standards shall be applied to all Services.

1.8 ASSIGNMENT AND SUB-CONTRACTING

1.8.1 The Service Provider may not assign or transfer any of its rights or obligations under this Service Contract without the prior written consent of the Employer, which, in turn, shall not be provided without the prior written consent of KfW.

1.8.2 The Service Provider may conclude or terminate sub-contracts for the performance of any part of the Services only upon prior written consent of the Employer, which, in turn, shall not be provided without the prior written consent of KfW. None of the Service Provider's obligations under this Service Contract shall be limited, cancelled or in any other way affected by any sub-contracting of Services.

1.8.3 The Service Provider shall, and shall contractually oblige each subcontractor (if any), develop and implement measures for the safety of the personnel deployed, adapted to the current security situation. The Service Provider undertakes to contractually oblige each subcontractor (if any) contractually to pass on a corresponding obligation to any other subcontractors (if any).

1.8.4 In case of a JV, the consortium manager shall be responsible towards the Employer for all aspects relating to this Service Contract. In particular payments under this Service Contract will be made exclusively to the consortium manager on behalf of the entire consortium. The consortium manager hereby represents and warrants that it is entitled to enter into this Service Contract on behalf of the JV and to create the joint and several liability of the members of the JV.

1.9 COPYRIGHT AND RIGHTS OF USE

To the extent not otherwise stated in the Special Conditions, the Service Provider shall transfer to the Employer all rights to the Services performed under this Service Contract on the date any such rights arise, and in any event at the latest on the date they are acquired by the Service Provider. Insofar as a transfer of such rights is not possible, the Service Provider shall irrevocably grant the Employer an unrestricted, transferrable, licensable and exclusive right of use and exploitation that is unlimited with respect to time and place of use. Such transfer shall include the right to adapt any transferred rights. The Service Provider shall ensure that no third party rights exist or will be exercised that would preclude the aforementioned transfer of rights or their exercise.

1.10 OWNERSHIP OF DOCUMENTS AND EQUIPMENT

1.10.1 All studies, reports, data and documents such as diagrams, plans, statistics and annexes that are made available to the Service Provider by the Employer in relation to the performance of the Services, as well as software (including the respective source codes) produced or adapted to facilitate the performance of the Services, shall remain the property of the Employer. The Service Provider shall not be entitled to exercise any right of retention or similar rights with respect to these materials.

1.10.2 The Service Provider shall return any equipment made available by the Employer to the Service Provider to facilitate the performance of the Services, including any vehicles purchased for the performance of the Services and paid for fully by the Employer, to the Employer promptly after completion of the Services. The Service Provider shall handle and maintain any such equipment with due care.

1.11 CONFIDENTIALITY AND PUBLICATION

1.11.1 The Service Provider shall, and shall ensure that its employees, agents and representatives will keep confidential all documents made available to the Service Provider by the Employer and/or KfW, as well as all information exchanged and knowledge acquired concerning this Service Contract and its implementation, even if such documents, information or knowledge have not been expressly designated as confidential. This obligation of confidentiality upon the Service Provider and its employees shall remain effective for a period of 24 months after completion or termination (whichever occurs earlier) of the Service Contract.

1.11.2 The obligation of confidentiality set out in this Clause 1.11 shall not apply to information:

(a) which is or becomes public information other than as a direct or indirect result of any breach of this Service Contract;

(b) which is known by the receiving Party before the date the information is disclosed to the receiving Party in accordance with paragraph (a) above or is lawfully obtained by the receiving Party after that date from a source which is unconnected with the Employer and KfW and which has not been obtained in breach of, and is not otherwise subject to, any obligation of confidentiality.

(c) the disclosure of which is:

i. requested or required by any court of competent jurisdiction or any competent judicial, governmental, banking, taxation, supervisory or other regulatory authority or similar body or necessary to assert or defend claims or other legal rights in court or administrative proceedings;

ii. required pursuant to any applicable law or regulation; or

iii. made with the prior written consent of the Party providing the information.

1.11.3 Notwithstanding the foregoing each Party is entitled to disclose any information in connection with this Service Contract to KfW.

1.12 CONDUCT

During the term of this Service Contract, the Service Provider shall not, and shall ensure that its Foreign Staff will not, interfere with the political or religious affairs of the Country.

1.13 SANCTIONABLE PRACTICE

1.13.1 The Service Provider shall, and shall ensure that its representatives, agents and employees will:

a) comply with all applicable laws, rules, regulations and provisions of the relevant legal systems relating to the performance of any obligations under this Service Contract or if failure to comply would impair the Service Provider's ability to perform its obligations hereunder,

b) not engage at any time in any Sanctionable Practice; and

c) not enter into or continue any business relationship with specially designated nationals, blocked persons or entities maintained on any Sanctions List and not engage in any other activity that would constitute a breach of Sanctions.

For the purposes of this provision, the following capitalized terms shall have meaning as defined below:

Coercive Practice	The impairing or harming, or threatening to impair or harm, directly or indirectly, any person or the property of the person with a view to influencing improperly the actions of a person.
Collusive Practice	An arrangement between two or more persons designed to achieve an improper purpose, including influencing improperly the actions of another person.
Corrupt Practice	The promising, offering, giving, making, insisting on, receiving, accepting or soliciting, directly or indirectly, of any illegal payment or undue advantage of any nature, to or by any person, with the intention of influencing the actions of any person or causing any person to refrain from any action.
Fraudulent Practice	Any action or omission, including misrepresentation that knowingly or recklessly misleads, or attempts to mislead, a person to obtain a financial benefit or to avoid an obligation.
Obstructive Practice	Means (i) deliberately destroying, falsifying, altering or concealing evidence material to the investigation or the making of false statements to investigators, in order to materially impede an official investigation into allegations of a Corrupt Practice, Fraudulent Practice, Coercive Practice or Collusive Practice, or threatening, harassing or intimidating any Person to prevent them from disclosing their knowledge of matters relevant to the investigation or from pursuing the investigation, or (ii) any act intended to

	materially impede the exercise of KfW's access to contractually required information in connection with an official investigation into allegations of a Corrupt Practice, Fraudulent Practice, Coercive Practice or Collusive Practice.
Sanctionable Practice	Any Coercive Practice, Collusive Practice, Corrupt Practice, Fraudulent Practice or Obstructive Practice (as such terms are defined herein) which is unlawful under the Funding Agreement.
Sanctions	The economic, financial or trade sanctions laws, regulations, embargoes or restrictive measures administered, enacted or enforced by any Sanctioning Body.
Sanctioning Body	Any of the United Nations Security Council, the European Union and the Federal Republic of Germany.
Sanctions List	Any list of specially designated persons, groups or entities which are subject to Sanctions, as issued by any Sanctioning Body.

1.13.2 The Service Provider will inform its employees, agents, representatives and subcontractors (if any) engaged under this Service Contract of their respective obligations.

1.13.3 The Service Provider shall itself and contractually oblige its employees, agents, representatives and subcontractors (if any) to comply in all respects with (i) the Declaration of Undertaking described in Annex 1 [Declaration of Undertaking] and (ii) the laws of the Country.

1.13.4 The Service Provider shall, in connection with his/her activities in respect of the Services and/or the Project, treat the persons involved in the Services and/or the Project and any other persons involved at any time respectfully and with high ethical standards (requirement of respectful treatment). The Service Provider shall not treat any persons involved in the Services and/or the Project or any other persons differently without a justified reasonable cause (prohibition of discrimination). The Service Provider shall not use his position in connection with the Services and/or the Project for abusing of his/her competences and powers (prohibition of abuse). This includes in particular, but is not limited to, the abuse of a position of power for demanding and receiving sexual acts or harassment. The provisions on Sanctionable Practices shall remain unaffected.

1.14 SOCIAL AND ENVIRONMENTAL RESPONSIBILITY

(a) The Service Provider shall, and shall ensure that its representatives, agents and employees will, ensure compliance with international Environmental, Social, Health and Safety (ESHS) standards (including issues of sexual exploitation and abuse and gender based violence) and, consequently:

(b) comply with and ensure that all their subcontractors and major suppliers, i.e. for major supply items, comply with international environmental and labour standards, consistent with applicable law

and regulations in the country of implementation of the Contract and the fundamental conventions of the International Labour Organisation (ILO) and international environmental treaties; and

(c) implement any environmental and social risks mitigation measures, as identified in the environmental and social impact assessment (ESIA) and further detailed in the environmental and social management plan (ESMP) as far as these measures are relevant to the Contract and implement measures for the prevention of sexual exploitation and abuse and gender-based violence.

1.15 REIMBURSEMENTS

Unless otherwise set out in the Special Conditions, the Service Provider shall make all reimbursements, insurance payments, guarantee payments or similar payments:

(a) if in Foreign Currency, for the account of the Employer to KfW, Frankfurt am Main, BIC: KFWIDEFF, account IBAN: DE53 5002 0400 3800 0000 00; and

(b) if in Local Currency, to the special account of the Employer specified in the Special Conditions.

1.16 SEVERABILITY AND WRITTEN FORM

1.16.1 If any provision of this Service Contract is or becomes invalid, void or ineffective or if this Service Contract contains unintentional gaps, this will not affect the validity or effectiveness of the remaining provisions of this Service Contract and this Service Contract will remain valid and effective, save for the void, invalid or ineffective provisions, without any Party having to argue and prove the Parties' intent to uphold this Service Contract even without the void, invalid or ineffective provisions.

1.16.2 The void, invalid or ineffective provision shall be deemed replaced by such valid and effective provision which comes as close as possible to the purpose and intent of the invalid provision in legal or economic terms and any unintentional gap shall be deemed to be filled with a provision which best suits the purpose and intent of this Service Contract.

1.16.3 Any supplements and amendments to this Service Contract – including to this Article 1.15.3 – must be made in writing. Any waiver by the Parties of this writing requirement must also be in writing.

1.17 ROLE OF KFW

For the avoidance of doubt, notwithstanding any consent, no-objection and/or other rights which may be conferred to KfW pursuant to this Service Contract, KfW shall not and shall not be deemed to be a Party to this Service Contract and shall have no obligations hereunder.

2 The Employer

2.1 INFORMATION

During the term of this Service Contract, the Employer, shall, within a reasonable period of time and at its own cost and expense, provide the Service Provider with all data, documentation and information required or expedient for the performance of the Services that are available to it. This shall also include all Services- and Project-related provisions of any separate agreements relating to the Funding Agreement or to any other loan or grant made in respect of the Project, and, to the extent that KfW`s consent is required by this Service Contract and has been granted by KfW, the documents evidencing such consent.

2.2 DECISIONS AND COOPERATION

Where the Employer is vested with any discretion or decision right under this Service Contract, it shall, provided that the Service Provider has supplied the Employer with all the information reasonably required by the Employer including, but not limited to, drawings, studies and details of any replacement staff, exercise such discretion or (as applicable) take its decision pursuant to this Service Contract as soon as possible following the Service Provider's written request and, in any event, no later than the end of the expiry period specified in the Special Conditions.

2.3 SUPPORT

2.3.1 The Employer will support, to the extent reasonably possible, the Service Provider in discharging its obligations pursuant to this Service Contract. The Employer shall make available to the Service Provider as soon as reasonably practicable and in full all the services necessary for the performance of its tasks as detailed in Annex 3 [*Terms of Reference plus Tender Documents*].

2.3.2 In addition, the Employer shall support the Service Provider, the Service Provider's employees and directors and, where applicable, their [immediate] relatives in:

(a) obtaining as soon as reasonably practicable any documents necessary for entering, residing in, working in and leaving the Country (visa, work permit etc.);

(b) granting and/or obtaining unrestricted access to the Project where necessary for the performance of the Services;

(c) the import, export and customs clearance of personal items and of goods and commodities required for the performance of the Services;

(d) securing return transport in cases of emergency;

(e) obtaining permission to import Foreign Currency that is required by the Service Provider for the performance of the Services and for personal use by its Foreign Staff;

(f) obtaining permission to export the money paid by the Employer to the Service Provider under this Service Contract; and

(g) providing access to other organisations for the purpose of obtaining information to be procured by the Service Provider in relation to the performance of its obligations hereunder or any of the matters set out under any of the foregoing sub-paragraphs (a) through (f) above.

2.4 TAXES

2.4.1 The Service Provider is responsible for meeting any and all tax liabilities in the Employer`s country arising out of the Service Contract, unless it is stated otherwise in the Special Conditions. Tax liabilities of the Service Provider outside the Employer`s country are considered to be included in the Remuneration and may not be charged separately.

2.4.2 If, after the date of signing of this Service Contract by the Parties, there is any change in the applicable law in the Employer's country with respect to taxes and/or duties which increases or (as the case may be) decreases the cost incurred by the Service Provider in performing the Services, then the

Remuneration and other expenses otherwise payable to the Service Provider under this Service Contract shall be increased or (as the case may be) decreased accordingly by agreement to be concluded between the Parties hereto.

2.5 SERVICES AND FURNISHINGS

The Employer shall make available to the Service Provider, at the Employer's cost and expense, such technical and other equipment and offices as described in Annex 6 [*Equipment and Furnishings to be provided by the Employer and Third-party Services Commissioned by the Employer*] for the purpose of performing the Services.

2.6 CONTACT PERSONS OF THE EMPLOYER

The Employer shall appoint two natural persons to act as the Employer's contact person and deputy to the Service Provider in relation to this Service Contract, and the Employer further undertakes to appoint a substitute contact person without undue delay should either of the two individuals appointed (or the respective subsitutes) no longer be available. The contact persons shall be set out in the Special Conditions.

3 The Service Provider

3.1 SCOPE OF SERVICES

3.1.1 The Service Provider shall deliver the Services in full and on time.

3.1.2 The Service Provider shall cooperate in good faith with any third parties commissioned by the Employer pursuant to Paragraph 2.5 [*Services and Furnishings*]. The Employer shall not be liable for any costs, losses or liabilities caused by any of these third parties or their performance, except in the case of willful misconduct, gross neglicence, death or bodily injury. In addition, the Service Provider must, to the extent possible, comprehensively coordinate the services rendered by such third parties with the Services.

3.2 STANDARD AND SPECIAL SERVICES

3.2.1 In addition to the Services specified explicitly in the Contract, the Service Provider shall also perform all other services, if necessary, that are not listed under the contractual services, but are customarily required in order to properly discharge the contractual obligations ("**Standard Services**"). The Standard Services shall be fully compensated through the Agreed Remuneration.

3.2.2 "**Special Services**" are services that are not explicitly specified in this Service Contract and are not Standard Services, but must necessarily be delivered by the Service Provider in order to properly perform its duties under this Service Contract, because the external circumstances of service performance have changed unexpectedly, or because the Service Provider has suspended the Services pursuant to Paragraph 4.5 [*Force majeure*], or because the Employer, with the prior written consent of KfW, requires services that were not included in the invitation to tender but are necessary.

3.3
DUE DILIGENCE

Except to the extent otherwise stipulated in this Service Contract, or otherwise legally stipulated within the Country or within another legal system (including, without limitation, the legal system applicable in the Service Provider's jurisdiction) by provisions that impose higher diligence standards than this Service Contract, in which case and to which extent such other diligence requirements shall apply, the Service Provider shall perform its obligations under this Service Contract with due diligence and provide the Services in compliance with professional practice and the recognised quality standards, and in accordance with current scientific and generally accepted engineering standards. The Service Provider must document its work, the progress of the Project and the decisions it takes in an appropriate form that is acceptable to the Employer and, in the case of any Services which are not remunerated on a lump-sum basis, compliant with the requirements arising from Paragraph 5.8 [*Auditing*].

3.4
REPORTING AND INFORMATION

3.4.1 The Service Provider shall report to the Employer and KfW on the progress of the Services in accordance with the Special Conditions and/or the Terms of Reference as applicable. Unless otherwise agreed in the Special Conditions and/or the Terms of Reference and, in case of long-term assignments such as construction management, training or operational support, the Service Provider shall prepare and deliver to the Employer and KfW quarterly reports, and following the conclusion of the Services a final report covering the entire Completion Period. The reports shall include a comparison of targeted and actual costs of the planned activities; the progress of construction; developments in the time frame; financial develop-ments; and information on any events or circumstances which may jeopardise the fulfilment of any of the Service Provider's obligations or the implementation of the Project, and identification of possible solutions.

3.4.2 The Service Provider shall inform the Employer and KfW promptly of all extraordinary circumstances (including, without limitation, any compliance-relevant circumstances or substantial suspicions) that arise during the performance of the Services and of all matters requiring KfW's approval.

3.4.3 The Service Provider shall, at its own cost and expense, promptly deliver all records, documents and information requested by the Employer and/or KfW in connection with this Service Contract. This obligation shall survive the termination of the Service Contract for a period of 24 months.

3.5 STAFFING

3.5.1 The Service Provider shall employ the staff specified in Annex 5 [*Staffing Schedule*] to implement performance of the Services. The list of designated key staff and any changes to it shall require the prior written approval of the Employer and KfW.

3.5.2 Upon the Employer's request, the Service Provider shall terminate the contract of, or release or replace, any staff member who fails to meet the requirements set out in this Service Contract or violates Paragraph 1.12 [*Conduct*]. Any such request of the Employer must be submitted in writing to the Service Provider and must state the reasons for the requested termination, release or replacement.

3.5.3 If anyone of the Service Provider's staff becomes unavailable or otherwise inhibited in the performance of its work (including, without limitation, due to sickness), for more than one month, the Service Provider shall upon request of the Employer replace this staff member with another staff member. The foregoing shall be without prejudice to any other rights of the Employer under this Service Contract, including, without limitation, under Paragraph 4.6 [*Suspension or Termination*].

3.5.4 If any staff employed by the Service Provider need to be replaced, the Service Provider shall ensure that the staff member in question is replaced promptly by an individual with at least equivalent qualifications and experience.

3.5.5 Staff shall only be replaced after prior written approval by the Employer, such approval not to be unreasonably withheld. The exchange or replacement of key staff according to the Staffing Schedule (Annex 5) specified by name shall require the prior written approval of KfW.

3.5.6 If the Service Provider terminates the contract of, or releases or replaces, any staff during the term of this Service Contract, any costs thus accrued shall be borne by the Service Provider.

3.6 CONTACT PERSON OF THE SERVICE PROVIDER

3.6.1 The Service Provider shall appoint a natural person as its contact person for the Employer in relation to this Service Contract, and the Service Provider further undertakes to appoint a substitute contact person without undue delay should the individual appointed (or its substitute) no longer be available.

3.6.2 Moreover, the Service Provider shall specify and provide contact details to the Employer and KfW for an individual, as well as a deputy, at the Service Provider's place of business who can be reached at any time in cases of emergency or crisis. The Service Provider shall notify the Employer and KfW without delay of any change of any such elected person or its contact details.

3.7
INDEPENDENCE OF THE SERVICE PROVIDER

The Service Provider undertakes that neither the Service Provider nor any person or enterprise associated with the Service Provider as set out in the Declaration of Undertaking shall bid for the Project as manufacturer, supplier, or building contractor. This prohibition also applies to any bidding for any further services, insofar as such services might lead to a restriction of competition or a conflict of interests. Any violation of this stipulation entitles the Employer to the immediately terminate this Service Contract and require the reimbursement of any and all costs incurred by the Employer up to the time of such violation as well as compensation for any and all losses and damages incurred by the Employer as a result of such termination.

4 Commencement, Completion, Amendment and Termination of the Services

4.1
COMMENCEMENT AND COMPLETION

4.1.1 The Service Provider shall begin performing the Services on the Commencement Date. The Service Provider shall deliver the Services in accordance with the time schedule set out in Annex 7 [*Time Schedule for the Performance of the Services*], and shall complete the Services within the Completion Period (for the avoidance of doubt, subject to any adaptations (if any) in accordance with paragraph 4.1.3 below).

4.1.2 In the case of optional services (if any), the Service Provider shall commence delivery of such optional services not earlier than upon receipt of notification from the Employer, subject to the Employer having received KfW's prior written consent.

4.1.3 Any change to the time schedule in Annex 7 [*Time Schedule for the Performance of the Services*] due to a reasonable request by either party shall be mutually agreed upon in writing.

4.2
PENALITIES FOR DELAY AND DISSATISFACTORY SERVICES

4.2.1 If the Service Provider culpably fails to perform any of the Services within the respective time agreed for such Services, the Service Provider shall, except to the extent that the Special Conditions include a stipulation to the contrary, be obliged to pay to the Employer a penalty in an amount of 0.5% of the contract value for every week of delay, subject to an overall cap of 8% of the contract value. Any claims which the Employer may have as a consequence of such delay (if any) shall be deemed to be settled by such payment. The foregoing shall be without prejudice to the Employer's right of termination pursuant to Paragraph 4.6.2 [*Suspension and Termination*].

4.2.2 In the case the Service Provider has not provided the Services in accordance with the provisions set out in this Service Contract to the satisfaction of the Employer and if this has (i) been notified by the Employer to the Service Provider and (ii) not been remedied by the Service Provider within 21 days upon receipt of such notification, and provided that the Employer has requested payment of a penalty in accordance with Paragraph 4.2.1 [*Penalties for Delay and Dissatisfactory Services*] above, the Employer and KfW shall be entitled to prohibit the Service Provider from mentioning this Project as a reference for future project tenders.

4.3
AMENDED SERVICES

4.3.1 Subject to the prior written consent of KfW, the Employer shall be entitled to require at any time an amendment of the Service Contract (any amended or additional services or amended deadlines/periods for execution – "Amended Services").

4.3.2 In this case, the Agreed Remuneration and the Completion Period shall be adjusted accordingly by mutual agreement of the Parties. The Service Provider shall submit proposals for performance of and remuneration for the Amended Services.

4.3.3 The Service Provider shall execute the Amended Services if the Employer agrees, in writing, to the remuneration proposal.

4.4
IMPEDIMENT

4.4.1 If the performance of the Services is impeded or delayed by the Employer or the Employer's contractual partners ("impediment") and such impediment leads to an increase in the costs, the scope or the duration of the Services, the Service Provider shall immediately notify the Employer of the circumstances and the possible consequences.

4.4.2 If an impediment is caused by the Employer's wilful misconduct, intent or negligence, the Service Provider shall be entitled to reimbursement of the costs incurred by it as a result of such impediment, provided that the Service Provider proves the incurrence of these costs to the Employer.

4.5
FORCE MAJEURE

4.5.1 In the event of a Force Majeure, the contractual obligations, to the extent affected by such event, shall be suspended for as long as performance remains impossible due to the Force Majeure, provided that one Party receives notification of the Force Majeure event from the other Party within two weeks after its occurrence. Any and all liability of the Service Provider for damages arising due to its absence caused by the Force Majeure is excluded, provided that this shall not apply to any damages which the Service Provider could have, but has wilfully or negligently not, mitigated in light of the circumstances at that time.

4.5.2 In the event of a Force Majeure, the Service Provider shall be entitled to an extension of the Completion Period equal to the delay caused by such Force Majeure. If the performance of the Services is rendered permanently impossible by the Force Majeure, or if the Force Majeure event continues for more than 180 days, either Party to this Service Contract shall be entitled to terminate the Service Contract.

4.5.3 In the case of a suspension or termination of the Service Contract due to Force Majeure, the Service Provider shall be entitled to claim from the Employer payment of:

(a) a proportionate amount of the Agreed Remuneration for the Services performed up to the occurrence of the Force Majeure; and

(b) all necessary and evidenced expenditures of the Service Provider arising from the discontinuing of the Services,

in each case in accordance with the principles agreed in Paragraph 5 [*Remuneration*] and the Special Conditions as

well as the principles set out in Paragraph 4.6.4 [*Suspension or Termination*].

4.5.4 The Service Provider must, however, mitigate its loss and deduct any proceeds of such mitigation, which shall include:

(a) any remuneration paid to the Service Provider in consideration for working on other projects during the time the Service Provider was (but for the discontinuation) scheduled to work on the Project; and

(b) any remuneration that the Service Provider could reasonably have earned in consideration for working on other projects during the time the Service Provider was (but for the discontinuation) scheduled to work on the Project, but which the Service Provider has not received as a result of the Service Provider's wilful misconduct or negligence.

4.5.5 The Service Provider shall not have any further payment claims as a consequence of the Force Majeure Event.

4.6 SUSPENSION OR TERMINATION

4.6.1 The Employer may, with the prior written consent of KfW, fully or partially request suspension of the Services or terminate this Service Contract, in each case by serving written notice of at least 30 days. In this event, the Service Provider must immediately take all measures necessary to ensure that the Services are discontinued, and any expenditures minimized. The Service Provider shall hand over all reports, drafts and documents to be prepared by the date in question to the Employer. If the suspension continues for more than 180 days, the Service Provider may terminate the Service Contract. In the case of such termination Paragraph 4.5 [*Force majeure*] shall apply mutatis mutandis.

4.6.2 If the Service Provider fails to meet any of its contractual obligations within the agreed time for such obligations, the Employer may serve a notice upon the Service Provider and request it to duly perform its Services. If the Service Provider fails to remedy the performance deficit within a reasonable time frame as determined by the Employer which shall be, however, not less than 21 days of having been called upon to do so by the Employer, the Employer shall be entitled, after this period has elapsed, to terminate the Service Contract by written notice.

4.6.3 The Service Provider may terminate this Service Contract if any amounts due and payable to it under this Service Contract have not been reasonably disputed or paid within 60 days after the receipt by the Employer of the corresponding invoice, provided that (i) the Service Provider has delivered to the Employer a written reminder within 30 days after the initial 60 days deadline has passed and (ii) the Employer has not paid the due amounts within a further grace period of 30 days upon receipt by it of such reminder. Without prejudice to the right to terminate due to Employer`s nonpayment the Service Provider may suspend the performance of this Contract if and for so long as any amounts due and payable under this Service Contract have not been reasonably disputed or paid

within 60 days after the receipt of the Service Provider`s corresponding invoice by the Employer, provided that the Service Provider has submitted a written reminder notice to the Employer after the initial 60 days deadline has passed and the Employer does not pay the due amounts within a further period of 21 days after the reminder notice.

4.6.4 In the case of a termination or suspension of the Service Contract, the Service Provider shall be entitled to demand payment of:

(a) the due but unpaid proportion of the Agreed Remuneration for the Services performed until the date of termination or suspension; and

(b) if the termination or suspension of the Service Contract is not caused by a default by the Service Provider, all necessary and evidenced expenditures of the Service Provider arising from the discontinuing of the Services, provided, however, that the Service Provider must mitigate its loss and deduct any proceeds of such mitigation, which shall include:

(i) any remuneration paid to the Service Provider in consideration for working on other projects during the time the Service Provider was (but for the termination or suspension) scheduled to work on the Project; and

(ii) any remuneration that the Service Provider could reasonably have earned in consideration for working on other projects during the time the Service Provider was (but for the termination or suspension) scheduled to work on the Project, but which the Service Provider has not received as a result of the Service Provider`s wilful misconduct or negligence.

4.6.5 If the termination or suspension of the Contract has been caused due to a default of the Service Provider, the Employer shall be entitled to demand compensation for any direct damages caused by the default.

4.7
BREACH OF PARAGRAPH 1.13

4.7.1 If the Service Provider has breached Paragraph 1.13 [*Sanctionable Practice*], the Employer may, notwithstanding any sanctions which may be applicable according to the law of the Country or any other legal system, terminate this Service Contract in writing with immediate effect.

4.7.2 The Employer may also terminate this Service Contract in writing with immediate effect if the Declaration of Undertaking submitted by the Service Provider [in accordance with Paragraph 1.13.3] is untrue or inaccurate in any respect or if the any obligations thereunder have been breached.

4.8
RIGHTS AND OBLIGATIONS OF THE PARTIES IN CASE OF TERMINATION

For the avoidance of doubt, a termination of this Service Contract shall not prejudice or affect any rights, claims or obligations of any Party which have arisen before the termination takes effect. Notwithstanding the foregoing, in the case of a termination pursuant to Paragraph 4.7 [*Breach of Paragraph 1.13*] the Employer shall be entitled, in cooperation with KfW, to request the repayment of any remuneration (in total or in part considering the circumstances of the violations) which

has been paid to the Service Provider pursuant to this Contract. The burden of proof that a case of termination is given lies with the Employer.

5 Remuneration

5.1
FORMS OF REMUNERATION

In consideration for the performance of the Services, the Employer shall pay to the Service Provider the remuneration as agreed in the Special Conditions subject to the conditions listed therein and the conditions set out below, and subject further to Annex 8 [*Cost Calculation and Invoicing Table*], depending on the type of Services agreed which may be either

(a) lump sum services;

(b) time-based services; or

(c) a combination of lump sum services and time based services.

5.2
GENERAL PAYMENT TERMS

To the extent not otherwise agreed in the Special Conditions, the Employer shall pay the Service Provider's remuneration as follows:

(a) An advance payment as set forth in the Special Conditions, but not exceeding 20% of the Contract Value shall be due within 30 days following the date of this Service Contract upon presentation of an invoice and against presentation of an advance payment guarantee if required in accordance with the Special Conditions.

(b) Instalments shall be paid upon presentation of corresponding invoices with a maximum of one payment per quarter. The first invoice following the advance payment shall not be issued before the expiry of three months following the Commencement Date.

(c) The final payment shall be made after the Services have been performed in full and written confirmation has been provided by the Employer to the Service Provider and prior written non-objection has been obtained from KfW.

(d) The remuneration for Special Services are included in the Contract Value. Notwithstanding, the Service Provider shall only be entitled to a separate remuneration for Special Services if the Services are amended, the Special Services therefore constitute Amended Services and a separate remuneration for the Special Services has been agreed pursuant to paragraph 4.3. [*Amended Services*].

5.3
PAYMENT CONDITIONS

(a) In case of a lump sum remuneration, payments to the Service Provider shall be made in a pre-determined number of instalments as further specified in the Special Conditions. In case the instalments are to be made dependent on milestones, these will be clearly stipulated in the Special Conditions.

(b) In case of a time-based remuneration, payments to the Service Provider shall be made based on the unit prices set forth in Annex 8 [*Cost Calculation and Invoicing Table*) as further specified in the Special Conditions. Each invoice shall

be accompanied by a list of expenditures based on Annex 8 [*Cost Calculation and Invoicing Table*] stating Contract Value, previous cumulative expenses, current expenses, cumulative expenses and remaining budget. The instalments shall be reduced on a pro-rata basis by (i) the advance payment and (ii) the retention amount as agreed in the Special Conditions.

(c) The minimum amount for an invoice is EUR 20,000, except for the final payment.

(d) Other Costs, if any, shall be invoiced together with the agreed instalments. Unless the remuneration for Other Costs is included in the lump sum instalments, the invoices must be accompanied by a list of expenditures based on Annex 8 [*Other Cost Calculation and Invoicing Table*] stating previous cumulative expenses, current expenses and remaining budget as well as the date, price and exchange rate and the Euro equivalent amount, if applicable.

The original documentation evidencing the Other Costs shall be sent to the Employer, unless this Service Contract has been entered into pursuant to an agency contract in which case the original documentation shall remain with the Service Provider and be delivered to the Employer or (as the case may be) KfW promptly upon request of the Employer.

5.4 LIMITATIONS

(a) The remuneration of the Service Provider (including, for the avoidance of doubt, Other Costs, if any) shall not exceed the Contract Value set forth in the Special Conditions.

(b) If, in case of a time-based remuneration, (a) the remuneration which is payable to the Service Provider under this Service Contract has accumulated to an amount equivalent to 70% of the Contract Value and (b) in the reasonable opinion of the Service Provider, the final date of the Completion Period as set out in the Special Conditions will be postponed and therefore, the Contract Value will be exceeded, then the Service Provider shall immediately inform the Employer thereof in writing together with (i) an updated timeline, (ii) the forecast for additional costs, based on the terms as agreed in the Special Conditions and (iii) justification that the delay has not been caused by the Service Provider. The Employer may, in its full discretion upon KfW's prior written non-objection, then agree in writing upon an increase of the Contract Value.

(c) As soon as the overall payments to the Service Provider under this Service Contract have reached an amount equivalent to 70% of the Contract Value, payments will only be made subject to the conditions that (i) the Service Provider has provided evidence of the Services rendered forthwith in accordance with Paragraph 3.4 [*Reporting and Information*] satisfactory to the Employer together with the invoice and (ii) written non-objection of KfW has been obtained. For the avoidance of doubt, the Employer has the right to (i) suspend payments or reject any invoice at any time if the Service Provider fails to perform its obligations under this Service Contract and (ii) to request evidence of Services at any time. The Employer shall also have the right to suspend payment of any lump sum instalment at any stage in the event of substantial deviations from the time

schedule. If the payment of instalments is suspended, the Employer must proceed in accordance with Paragraph 5.7 [*Objections to Invoices*].

5.5 INVOICING

(a) Payments are made against invoices. The original invoices shall specify (i) the period for which the underlying Services have been performed and (ii) correct banking details and shall be addressed to the Employer.

In the case of conclusion of this Service Contract pursuant to an agency contract: the Service Provider's invoices (other than the final invoice) shall be addressed to the Employer "c/o KfW". Except for the final invoice, the Service Provider shall send each original invoice to KfW and a copy of each invoice to the Employer directly. The original final invoice is to be addressed to the Employer and KfW will receive a copy.

(b) With each invoice the Service Provider implicitly declares that the performance and/or costs invoiced have actually incurred and that the lists accompanying the respective invoices are true and complete.

5.6 PAYMENT DEADLINE

(a) Other than in the case of an advance payment or unless otherwise stated in the Special Conditions, payment shall be made within 60 days of presentation of a verifiable invoice by the Service Provider to the Employer.

(b) If the Employer does not make the payment within the period set out in Paragraph 5.6(a) [*Payment Deadline*] and the Employer has not raised an objection pursuant to Paragraph 5.7 [*Objection to Invoices*] within that date, the Employer shall pay to the Service Provider a compensation at the rate agreed in the Special Conditions. This shall be calculated on a daily basis from the date on which the relevant amount became due and payable in the currency set out in the Special Conditions. The Service Provider shall have no further rights or claims arising from any delay of the Employer.

5.7 OBJECTION TO INVOICES

Should the Employer object to any invoice of the Service Provider (or any aspect or part thereof), the Employer shall notify the Service Provider of its intention to withhold payment and shall state the reasons why. If the Employer objects only to a part of an invoice, it shall pay that part of the invoiced amount to which it has not objected within the period specified in Paragraph 5.6 [*Payment Deadline*].

5.8 AUDITING

For any Services (or parts thereof) that are not remunerated on a lump-sum basis, the Service Provider shall maintain up-to-date records that meet professional standards and that clearly and systematically indicate the Services provided and the time and expense involved. The Service Provider shall permit the Employer and KfW (as well as their respective advisors and auditors) to audit these records at any time and make copies of them.

5.9 PRICE ADJUSTMENTS

(a) Price adjustments, if any, will be agreed upon in the Special Conditions.

(b) In case of an increase of the Contract Value, price adjustments of the amount by which the Contract Value has been increased shall be calculated on the basis of the original unit price.

6 Liability

6.1
GENERAL LIABILITY OF THE SERVICE PROVIDER

The Service Provider shall be liable to the Employer for culpable breaches of its contractual obligations, including, without limitation, of its obligations under Article 3 [*The Service Provider*]. The liability of the Service Provider shall be limited to the Contract Value. The foregoing limitation shall not apply in the case of wilful misconduct or gross negligence.

6.2
LIABILITY FOR SUB-CONTRACTORS

For the avoidance of doubt, the Service Provider shall also be liable for the Services provided by a sub-contractor pursuant to Paragraph 1.8 [Assignment and Sub-contracting].

6.3
PERIOD OF LIABILITY

The Service Provider's liability shall terminate according to the law governing the Service Contract as set out in the Special Conditions, unless a different point of time has been agreed in the Special Conditions.

6.4
LIABILITY FOR CONSEQUENTIAL DAMAGE

Liability for consequential damages is excluded.

6.5
LIABILITY OF THE EMPLOYER

The Employer shall be liable for culpable breaches of its contractual obligations, including, without limitation, of its obligations under Paragraph 2 [*The Employer*].

7 Insurance against Liability and Damages / Guarantees

7.1
INSURANCE AGAINST LIABILITY AND DAMAGES

7.1.1 The Service Provider shall take out and maintain adequate insurance for the entire duration of the Service Contract and on the terms specified in the Special Conditions, including, but not limited to, the following:

(a) professional liability insurance;

(b) personal liability insurance;

(c) equipment insurance covering loss of or physical damage to all equipment acquired, used, provided or paid for by the Employer within the context of this Service Contract; and

(d) motor vehicle third party liability insurance and motor vehicle comprehensive hull insurance for the vehicles acquired in connection with this Service Contract.

7.1.2 The costs incurred in connection with the insurance specified in Paragraph 7.1.1 [*Insurance Against Liability and Damages*] shall be fully compensated by the Agreed Remuneration and may not be charged separately.

7.1.3 The Employer shall take out the insurances to the extent agreed in the Special Conditions.

7.2 GUARANTESS

Any guarantees shall be in the form set out in Annex 10 [*Form of Advance Payment Guarantee*] and shall always be provided as bank guarantees issued in favour of the Employer as beneficiary. They must be acceptable to the Employer and KfW. The original of the guarantee shall be sent to the Employer, with a copy, together with a confirmation of delivery of the original, to be sent to KfW.

8 Disputes and Arbitration Procedure

8.1 AMICABLE SETTLEMENT

Should a dispute arise from or in connection with this Service Contract, Parties shall, within 21 days of one party submitting a written request to the other party, endeavour in good faith to settle the dispute amicably.

8.2 MEDIATION

8.2.1 If an amicable settlement cannot be reached within a period of 3 months after the written request pursuant to Paragraph 8.1 [*Amicable Settlement*], the Parties shall, insofar as both sides agree, attempt to settle the dispute in accordance with the Special Conditions by way of mediation prior to initiating arbitral proceedings. Notwithstanding, the Parties may agree to begin mediation immediately. Unless the Parties agree otherwise within a period of 14 days, either party may require that the mediator is appointed by the institution named in the Special Conditions.

8.2.2 Mediation shall begin no later than 21 days after the mediator has been appointed. The mediation process shall be implemented in accordance with the procedure selected by the appointed mediator.

8.2.3 All negotiations and talks held in the course of mediation shall be treated confidentially.

8.2.4 If the Parties accept the recommendations of the mediator or agree to settle the dispute another way, the agreement reached shall be recorded in writing and signed by the representatives of the Parties.

8.2.5 If the dispute is not settled within 3 months after the mediator has been appointed, the dispute shall be settled by way of the arbitration procedure pursuant to Paragraph 8.3 [*Arbitration Procedure*].

8.3 ARBITRATION PROCEDURE

If the Parties do not reach an amicable agreement pursuant to Paragraph 8.1 [Amicable settlement] or by way of mediation pursuant to Paragraph 8.2 [Mediation], the dispute shall finally and exclusively be settled – except where otherwise stipulated in the Special Conditions – in accordance with the Rules of Conciliation and Arbitration of the International Chamber of Commerce in Paris by one or several arbitrators appointed in accordance with the Rules. The place of arbitration and the language of the arbitration procedure shall be stipulated in the Special Conditions.

Part II: Special Conditions

Ad Article 1: General Provisions

Ad 1.1: Definitions

“Beneficiary (ies)”: shall mean beneficiaries in the nominated districts, enrolled under “OPD Insurance Scheme” and whose OPD insurance premium shall be paid by the Government of Khyber Pakhtunkhwa.

“Claim Payment”: shall mean the Payment of claim to the health providers under the scheme based on agreed procedure for payment between the organization and the health providers and duly approved by the Employer.

“Completion Period”: The completion period shall be the period starting on the Commencement Date and ending on **[●].**

“Country”: Islamic Republic of Pakistan

“Commencement Date”: Fifteen (15) Days after the entry into force of this Service Contract.

“Government”: shall mean the Department of Health, Government of Khyber Pakhtunkhwa.

“Health Provider”: shall mean the Hospital, Nursing Home, Day Care Center or such other medical aid provider, as has been contracted by the Organization to provide health care services under “OPD Insurance Scheme’.

“Law”: includes all Statutes, Enactments, Acts of Legislature, Laws, Ordinances, Rules, Bye Laws, Clauses, Regulations, Notifications, Guidelines, Policies, and orders of any Statutory Authority or Court of Islamic Republic of Pakistan.

“Licensed Health Providers”: shall mean hospitals, clinics, nursing/maternity home etc duly licensed by the Health Regulatory Authority

“Other Provider”: shall mean health provider not owned/ managed by the government of Khyber Pakhtunkhwa.

“Project”: BMZ No. 2013 66 228, as further specified in Annex 3.
Social Health Protection Initiative Phase II (SHP II)

“Project Office”: shall mean the office of the Organization located at capital head quarters of the Province which shall coordinate the provision of health Insurance Services under this Agreement.

“Policy”: shall mean the health insurance policy of the Service Provider provided to the policy holders covered through the “OPD Insurance Scheme”.

“Policy Holder”: shall mean the eligible members of the family/household for which the premium has paid for availing the OPD insurance.

“Premium”: shall mean an amount agreed by both Parties charged per capita on an annual

basis as consideration for providing OPD insurance under this Agreement.

"Scheme": shall mean the " OPD Insurance Scheme" as operational in the aforementioned districts and as otherwise outlined in this Agreement.

"Service Area": shall mean the district(s) or parts of district(s) within which the Government has authorized the Organization, to provide health insurance service under " OPD Insurance Scheme".

Ad 1.4: Communication and Language

The language for notices, instructions, reports and other communication shall be **English**.

Notices
Address of the Employer
Postal address

CHIEF EXECUTIVE OFFICER
Social Health Protection Initiative (Sehat Card Plus),
Department of Health, Government of Khyber Pakhtunkhwa,
House No. 9-A, Rehman Baba Road, University Town,
Peshawar, Pakistan.
Postal Code: 25000
Phone: +92(91) 9216013
Fax: +92(91) 5841792
Email: projectdirector.shp.kp@gmail.com

Address of the Service Provider
Postal address
Email: **[•]**
Phone: **[•]**
Fax:

Address of KfW
Postal address
Palmengartenstrasse 5 – 9
60325 Frankfurt
Germany
Email: [•]@kfw.de
Phone: +49 (69) 7431-[•]
Fax: **+49 (69) 7431-**[•]

Ad 1.5: Governing law

The law governing this Service Contract shall be: **Laws of the Islamic Republic of Pakistan.**

The language of the Contract shall be: **English**

d 1.9: Copyright and rights of use

All plans, marketing campaigns, advertising material, photographs, reports, database, softwares, protocols, strategies and other documents prepared by the Service Provider as part of the OPD Insurance Scheme shall become and remain the exclusive property of the Employer, and the Service Provider shall, not later than upon termination or expiration of

this Contract, deliver/share (if not already delivered/shared) all such plans, marketing campaigns, advertising material, photographs, reports, database, software, protocols, strategies and other documents to the Employer, together with a detailed inventory thereof.

The Service Provider shall not use any of plans, marketing campaigns, advertising material, photographs, reports, database, software, protocols, strategies and other documents for purposes unrelated to this Contract during its currency without the prior written approval of the Employer. A certificate to this effect shall be provided by the Service Provider whenever the Employer shall require.

The Service Provider shall obtain the Employer’s prior approval in writing before making any proceedings of the assignment public / sharing with media. Employer shall have the ownership of the plans, marketing campaigns, advertising material, photographs, reports, database, software, protocols, strategies and other documents, gathered/ maintained for the assignment. The Service Provider shall neither be allowed to retain copies of the data in any digital or other form.

Ad 1.14: Reimbursements

Account details of the Employer’s special account for reimbursements in Local Currency: **Not Applicable**

Ad Article 2: The Employer

Ad 2.2: Decisions and cooperation

Decisions/discretions/cooperative actions of the Employer pursuant to Paragraph 2.2 [Decisions/cooperation] must be taken/exercised/performed at the latest within **four (04)** weeks from receipt by the Employer of the respective written request of the Service Provider.

Ad 2.4: Taxes

The contractual parties agree on the following provisions regarding taxes and public duties in the country of the Employer:

(i) Withholding Tax, on each invoice related to the **Administrative Fee** of the Service Provider, shall be deducted at source by the Employer while making payments, as per the taxation laws of the Islamic Republic of Pakistan.

(ii) All the withdrawals against “Per capita payment” for registered patients with the Primary Health Care (PHC) providers with whom the beneficiary is registered, which shall be claimed on reimbursement mode of payment, by the Service Provider from the Employer, shall also be subject to Withholding Tax deduction as per the applicable laws of the Islamic Republic of Pakistan. If withholding is mandatory, necessary deductions shall be made as per laws.

Whereas, in case, a Service provider claims an exemption, documentary evidence explicitly confirming the exemption of deduction of Withholding Tax, related to this contract, by the relevant Tax Authorities, shall be a MUST which shall be provided/obtained by the Service Provider.

The Service Provider shall ensure invariably that a double taxation on this account would occur (i.e., when withholding tax is deducted by the Employer, further deduction of withholding tax from the per capita payment to Primary Health Care (PHC) providers should not happen). The Employer shall provide a Tax Deduction Certificate against every related payment and the Service Provider shall ensure the adjustment of

Withholding Tax amount, against further payments to Primary Health Care (PHC) providers with relevant tax authorities".

(iii) It will be an exclusive and conclusive responsibility of the Service Provider to ensure that full amount of earmarked Per Capita OPD Insurance shall be provided by the Primary Health Care (PHC) providers. Any deviation in this context, shall construe a breach of contract.

(iv) The Services provided by the Service Provider are currently under exemption by the Khyber Pakhtunkhwa Revenue Authority in respect of General Sales (indirect) Tax. If at any point in time, the exemption is revoked, the amount on account of chargeable GST in respect of this Contract, shall discussed and agreed upon mutually through a contract amendment. Any additional modality, if applicable, shall also be adhered to.

(v) The Service Provider and its foreign staff are subject to local taxes and public duties directly attributable to the Contract which will be borne by the Service Provider and its staff. In such cases offered prices are considered inclusive of local taxes and public duties, i.e. local taxes and public duties shall be considered to be included in the overhead cost calculation and will not be subject to any separate payment.

Ad 2.6: Contact person of the Employer

The Employer's contact person shall be:

CHIEF EXECUTIVE OFFICER
Social Health Protection Initiative (Sehat Card Plus),
Department of Health, Government of Khyber Pakhtunkhwa,
House No. 9-A, Rehman Baba Road, University Town,
Peshawar, Pakistan.
Postal Code: 25000
Phone: +92(91) 9216013
Fax: +92(91) 5841792
Email: projectdirector.shp.kp@gmail.com

Ad Article 3: The Service Provider

Ad 3.3: Due diligence

The Service Provider shall perform the Services and carry out the Services with all due diligence, efficiency and economy, in accordance with generally accepted professional standards and practices, and shall observe sound management practices, and employ appropriate technology and safe and effective equipment, machinery, materials and methods. The Service Provider/Service Provider shall always act, in respect of any matter relating to this Contract or to the Services, as a faithful adviser to the Employer, and shall at all times support and safeguard the Employer's legitimate interests in any dealings with the third parties.

The Service Provider shall perform the Services, meeting the compulsory requisites, as specified in the Terms of Reference.

Ad 3.4: Reporting and information

The Service Provider shall submit the following reports, on quarterly basis, during the currency of the contract and in support of its payment claims:

(i) An Inception Report, within forty-five (45) days from the date of signing of contract, acceptable to the Employer, explaining therein the processes and protocols to be employed for execution of intended services, including registration of beneficiaries, empanelment of Health Services Providers, effective payment mechanism, quality control, Data Management etc., pursuant to the final scope of service, including detailed implementation and staff plans indicating clearly any deviations from the methods as per submitted technical proposal as well.

(ii) Quarterly Progress Report with all the data of beneficiaries who got registered and/or availed the OPD Services during the reporting period, with all the necessary verifiable documents, payments made to Health Service Providers, diagnosis, treatment, complaints, grievance redressal, turnaround time, etc.

Ad 3.6.1: The Service Provider's contact person

The Service Provider's contact person shall be **[●]**.
Contact details **[●]**.
The deputy shall be **[●]**.
Contact details **[●]**.

Ad 3.6.2: The Service Provider's contact person for cases of emergency or crisis

The Service Provider's contact person for cases of emergency or crisis shall be **[●].**
Contact details **[●]**.
The deputy shall be **[●]**.
Contact details **[●]**.

Ad Article 5: Remuneration

Ad 5.1: Forms of Remuneration

In consideration of the Services, the Employer shall pay to the Service Provider an amount of

up to **[●]** in [● currency]
(the "**Contract Value**") inclusive of local indirect taxes.

In accordance with the Terms of Reference, the Services will be rendered as Lump sum services

This Contract Value is composed of

up to **[●]** in [● currency]
(the "**Contract Value for Services**" exclusive of indirect taxes).
and

up to **[●]** in [● currency]
(the "**Cost of Indirect (GST) Taxes**").

It is agreed that the Employer may make payments in Euro even if the invoice is issued in a currency other than Euro. In such cases, the payments in Euro will be based on the exchange rate (reasonably to be determined by KfW) applicable on the day on which the payment is made. For these purposes, the Employer or (in case of an Agency Contract,

KfW on its behalf) is entitled to request the Service Provider to provide a bank account which is able to receive Euro.

Ad 5.2 (a): General Payment Terms

Following shall be the general terms & conditions for payments:

(i) Per capita payment for registered patients is a simple and convenient reimbursement mechanism, which shall be applied for reimbursement of the Primary Health Care (PHC) providers at which the beneficiary is registered. The Service Provider shall invariably provide the necessary verifiable documents with regards to the registration of the beneficiary and the OPD Services obtained. The Service Provider shall also be liable to reconcile the documentary record with the Employer.

(ii) For patients registered with a PHC provider not able to offer the full package of diagnostic services, these services shall be paid for on a fee for service basis to other empanelled PHC providers able to deliver those services, based on a formal referral note. In this way the OPD scheme is also piloting gatekeeping and referral functions.

(iii) The annual per capita reimbursement rates and the fee-for-service rates shall be used for reimbursement of both private and public PHC health service providers. Implicitly this means that only providers who can accept this payment shall be empanelled.

(iv) For claiming quarterly payments, under reimbursement mode, the number of registered patients shall be calculated at the first day of the second month following the end of the quarter. e.g., the payment for patients registered during January, February and March 2023 shall be paid by the Service Provider/Service Provider on 1st May.

(v) Payment for services is also suggested to be made quarterly based on the number of registered patients who received the services. The transfer will take place on the first day of the second month following the end of the quarter. e.g., the quarterly payment for January, February and March 2023 will be paid by the HI-provider on 1st May.

(vi) The number of and reasons for visits of the beneficiaries shall be monitored carefully and if the number is lower/higher than expected, per capita payment shall be revised accordingly during the year and additional coverage will be considered. In this way the budget should not be exceeded.

(vii) The payments shall be made within forty-five (45) days upon acceptance of an invoice along with respective report, by the Employer.

(viii) The Service Provider shall submit separate invoices along with respective quarterly report and the Employer shall make payment against respective invoices, within the period ascribed above subject to the acceptance of the respective report.

(ix) The Service Provider shall comply with the implementation requisites, which have been prescribed at Article 3.3, hereinabove.

5.3: Payment Conditions

(i) **Ten (10%) percent** of the total contract cost shall be paid on receipt of an Inception Report, within forty-five (45) days from the date of signing of contract, acceptable to the Employer, explaining therein the processes and protocols to be employed for execution of intended services, including registration of beneficiaries, empanelment of Health Services Providers, effective payment mechanism, quality control, Data Management etc., pursuant to the final scope of service, including detailed implementation and staff plans.

(ii) **Ninety (90%) percent** of the total contract cost, shall be paid to the Service Provider, on reimbursement mode, against actual number of registered beneficiaries/ patients, at time intervals of each quarter, subject to the conditions prescribed in Clause 5.2 (a).

Ad 5.5: Invoicing

The Service Provider's invoice against Per Capita Payments' reimbursements, shall indicate the BMZ-No. (see Definition of "Project" pursuant to Article 1.1).

Payments against Per Capita Payments' reimbursements may be made to the Service Provider directly by KfW according to the direct disbursement procedure if agreed between KfW and the Employer. Whereas, in case of payment on account of Indirect (GST) Tax, if becomes applicable on Administration Fee, shall be reimbursed by the Employer.

Payments shall be made to the following account:

Account holder: **[●]**
Bank: **[●]**
Account number: **[●]**
[where applicable:
IBAN: **[●]**
BIC: **[●]**

If the Service Provider's account-holding bank is not located in the currency area of the currency of payment:

BIC of correspondent bank: **[●]**

Ad 5.9: Price adjustment

Not Applicable.

Ad 5.6: Payment deadline

Not Applicable.

Ad Article 6: Liability

Ad 6.3: Period of liability

Not Applicable.

Ad Article 7: Insurance

The Service Provider (i) shall take out and maintain, and shall cause any Sub-contractor to take out and maintain, at its (or the Sub-contractors', as the case may be) own cost, insurance coverage from companies enlisted with Pakistan Credit rating Agency Limited,

with A+ rating or above, against the risks, and for the coverage specified hereunder**,** and (ii) at the Employer's request, shall provide evidence to the Employer showing that such insurance has been taken out and maintained and that the current premiums therefore have been paid

(a) Professional liability insurance, **DoH, Go/KP being the beneficiary,** with a minimum coverage of PKR Million = 110% of the Contract Amount

(b) Third Party motor vehicle liability insurance in respect of motor vehicles operated in the Employer's country by the Service Provider or its Experts or Sub-contractors, with a minimum coverage in accordance with the applicable law in Pakistan;

(c) Third Party liability insurance, with a minimum coverage of **PKR 1,000,000**;

(d) employer's liability and workers' compensation insurance in respect of the experts and Sub-contracotss in accordance with the relevant provisions of the applicable law of the Islamic Republic of Pakistan, as well as, with respect to such Experts, any such life, health, accident, travel or other insurance as may be appropriate: **PKR 400,000 per occurrence** in case of death **and PKR 100,000 per occurrence** in case of injury; and

(e) insurance against loss of or damage to (i) equipment purchased in whole or in part with funds provided under this Contract, (ii) the Service Provider's property used in the performance of the Services, and (iii) any documents prepared by the Service Provider in the performance of the Services – Full Coverage.

Ad Article 8: Disputes and Arbitration Procedure

Ad 8.2: Mediation

Disputes shall be settled by arbitration in accordance with the Pakistan Arbitration Act 1940.

The mediator shall be nominated by **the Secretary, Department of Health, Government of Khyber Pakhtunkhwa but mutually agreed** and the appointment shall be binding for the Parties[11].

The costs of the mediation and of the mediator's services shall be shared equally between the Parties.

The decision of the sole arbitrator or of a majority of the arbitrators (or of the third arbitrator if there is no such majority) shall be final and binding and shall be enforceable in any court of competent jurisdiction, and the Parties hereby waive any objections to or claims of immunity in respect of such enforcement.

Ad 8.3: Arbitration Procedure

Proceedings shall, unless otherwise agreed by the Parties, be held in ***Islamic Republic of Pakistan.***

The place of arbitration shall be **Peshawar.**

The language of the arbitration procedure shall be **English.**

The courts of Peshawar shall have the exclusive jurisdiction.

(Place, date)

_______________________________ _______________________________

(for the Employer) (for the Service Provider)

List of Annexes

Annex #	Title
1	Declaration of Undertaking
2	Minutes of Negotiation (if relevant)
3	Terms of Reference
4	Implementation Schedule
5	Provision of Services by Health Service Providers
6	Empanelment of Health Service Providers Guidelines
7	Monitoring & Evaluation Guidelines
8	Performance Evaluation of OPD Insurance Service Providers & Health Service Providers
9	Grievance Redressal Mechanism
10	The Service Provider/Service Provider's Technical & Financial Proposal

Declaration of Undertaking

Reference name of the Application/Offer/Contract: ("**Contract**")[12]

To: ("**Project Executing Agency**")

1. We recognise and accept that KfW only finances projects of the Project Executing Agency ("PEA")[13] subject to its own conditions which are set out in the Funding Agreement it has entered into with the PEA. As a matter of consequence, no legal relationship exists between KfW and our company, our Joint Venture or our Subcontractors under the Contract. The PEA retains exclusive responsibility for the preparation and implementation of the Tender Process and the performance of the Contract.

2. We hereby certify that neither we nor any of our board members or legal representatives nor any other member of our Joint Venture including Subcontractors under the Contract are in any of the following situations:

   2.1) being bankrupt, wound up or ceasing our activities, having our activities administered by courts, having entered into receivership, reorganisation or being in any analogous situation;

   2.2) convicted by a final judgement or a final administrative decision or subject to financial sanctions by the United Nations, the European Union or Germany for involvement in a criminal organisation, money laundering, terrorist-related offences, child labour or trafficking in human beings; this criterion of exclusion is also applicable to legal Persons, whose majority of shares are held or factually controlled by natural or legal Persons which themselves are subject to such convictions or sanctions;

   2.3) having been convicted by a final court decision or a final administrative decision by a court, the European Union, national authorities in the Partner Country or in Germany for Sanctionable Practice in connection with a Tender Process or the performance of a Contract or for an irregularity affecting the EU's financial interests *(in the event of such a conviction, the Applicant or Bidder shall attach to this Declaration of Undertaking supporting information showing that this conviction is not relevant in the context of this Contract and that adequate compliance measures have been taken in reaction)*;

   2.4) having been subject, within the past five years to a contract termination fully settled against us for significant or persistent failure to comply with our contractual obligations during such Contract performance, unless this termination was challenged and dispute resolution is still pending or has not confirmed a full settlement against us;

   2.5) not having fulfilled applicable fiscal obligations regarding payments of taxes either in the country where we are constituted or the PEA's country;

   2.6) being subject to an exclusion decision of the World Bank or any other multilateral development bank and being listed on the website http://www.worldbank.org/debarr or respectively on the relevant list of any other multilateral development bank *(in the event of such exclusion, the Applicant or Bidder shall attach to this Declaration of Undertaking supporting information showing that this exclusion is not relevant in the context of this Contract and that adequate compliance measures have been taken in reaction)*; or

---

[12] Capitalised terms used, but not otherwise defined in this Declaration of Undertaking have the meaning given to such term in KfW's "*Guidelines for the Procurement of Consulting Services, Works, Goods, Plant and Non-Consulting Services in Financial Cooperation with Partner Countries*".

[13] The PEA means the purchaser, the employer, the client, as the case may be, for the procurement of Consulting Services, Works, Plant, Goods or Non-Consulting Services.

2.7) being guilty of misrepresentation in supplying the information required as condition to participation in this Tender Procedure.

3. We hereby certify that neither we, nor any of the members of our Joint Venture or any of our Subcontractors under the Contract are in any of the following situations of conflict of interest:

   3.1) being an affiliate controlled by the PEA or a shareholder controlling the PEA, unless the stemming conflict of interest has been brought to the attention of KfW and resolved to its satisfaction;

   3.2) having a business or family relationship with a PEA's staff involved in the Tender Process or the supervision of the resulting Contract, unless the stemming conflict of interest has been brought to the attention of KfW and resolved to its satisfaction;

   3.3) being controlled by or controlling another Applicant or Bidder, or being under common control with another Applicant or Bidder, or receiving from or granting subsidies directly or indirectly to another Applicant or Bidder, having the same legal representative as another Applicant or Bidder, maintaining direct or indirect contacts with another Applicant or Bidder which allows us to have or give access to information contained in the respective Applications or Offers, influencing them or influencing decisions of the PEA;

   3.4) being engaged in a Consulting Services activity, which, by its nature, may be in conflict with the assignments that we would carry out for the PEA;

   3.5) in the case of procurement of Works, Plant or Goods:

   i. having prepared or having been associated with a Person who prepared specifications, drawings, calculations and other documentation to be used in the Tender Process of this Contract;

   ii. having been recruited (or being proposed to be recruited) ourselves or any of our affiliates, to carry out works supervision or inspection for this Contract;

4. If we are a state-owned entity, and compete in a Tender Process, we certify that we have legal and financial autonomy and that we operate under commercial laws and regulations.

5. We undertake to bring to the attention of the PEA, which will inform KfW, any change in situation with regard to points 2 to 4 here above.

6. In the context of the Tender Process and performance of the corresponding Contract:

   6.1) neither we nor any of the members of our Joint Venture nor any of our Subcontractors under the Contract have engaged or will engage in any Sanctionable Practice during the Tender Process and in the case of being awarded a Contract will engage in any Sanctionable Practice during the performance of the Contract;

   6.2) neither we nor any of the members of our Joint Venture or any of our Subcontractors under the Contract shall acquire or supply any equipment nor operate in any sectors under an embargo of the United Nations, the European Union or Germany; and

   6.3) we commit ourselves to complying with and ensuring that our Subcontractors and major suppliers under the Contract comply with international environmental and labour standards, consistent with laws and regulations applicable in the country of implementation of the Contract and the fundamental conventions of the International Labour Organisation[14] (ILO) and international environmental treaties. Moreover, we shall

[14] In case ILO conventions have not been fully ratified or implemented in the Employer's country the Applicant/Bidder/Contractor shall, to the satisfaction of the Employer and KfW, propose and implement appropriate measures in the spirit of the said ILO conventions with respect to a) workers grievances on working conditions and terms of employment, b) child labour, c) forced labour, d) worker's organisations and e) non-discrimination.

implement environmental and social risks mitigation measures when specified in the relevant environmental and social management plans or other similar documents provided by the PEA and, in any case, implement measures to prevent sexual exploitation and abuse and gender based violence.

7. In the case of being awarded a Contract, we, as well as all members of our Joint Venture partners and Subcontractors under the Contract will, (i) upon request, provide information relating to the Tender Process and the performance of the Contract and (ii) permit the PEA and KfW or an auditor appointed by either of them, and in the case of financing by the European Union also to European institutions having competence under European Union law, to inspect the respective accounts, records and documents, to permit on the spot checks and to ensure access to sites and the respective project.
8. In the case of being awarded a Contract, we, as well as all our Joint Venture partners and Subcontractors under the Contract undertake to preserve above mentioned records and documents in accordance with applicable law, but in any case for at least six years from the date of fulfillment or termination of the Contract. Our financial transactions and financial statements shall be subject to auditing procedures in accordance with applicable law. Furthermore, we accept that our data (including personal data) generated in connection with the preparation and implementation of the Tender Process and the performance of the Contract are stored and processed according to the applicable law by the PEA and KfW.

Name: _______________________________ In the capacity of: ________________________

Duly empowered to sign in the name and on behalf of[15]: ________________________________

Signature: Dated:

[15] In the case of a JV, insert the name of the JV. The person who will sign the application, bid or proposal on behalf of the Applicant/Bidder shall attach a power of attorney from the Applicant/Bidder.

Annexures

Social Health Protection Initiative Phase II

Islamic Republic of Pakistan

Client

KfW and Department

of Health of Khyber Pakhtunkhwa and Gilgit Baltistan

Concept and Feasibility Report

Reference Number
BMZ Nr. 2013 66 228

Date
21 May 2022

management4health GmbH

Hebelstr.11,

60318 Frankfurt
am Main
Germany

Social Health Protection Initiative - Phase II

Concept and Feasibility Report

management4health
Hebelstr.11 60318, Frankfurt, Germany

Sub Consultant

Milliman LLP

11 Old Jewry
London. EC2R 8DU
United-Kingdom

PROJECT SUMMARY

Project Title	Social Health Protection Initiative Phase II
Project Number	KfW - Pakistan: BMZ Nr. 2013 66 228
Development Cooperation Programme	KfW
Consulting Services for SRH	management4health GmbH (m4h) and Milliman Ltd
Team Leader	Poul Thim
Phase	Conceptualisation
Report submitted on	6 May 2022
Report Prepared by	Elaborated by: Dr Irum Shaikh, Dr Sohail Amjad, Dr Habib Ur Rehman, and Mr Poul Thim Reviewed by: Mr Edward Tourtellotte, Dr Michael Niechzial

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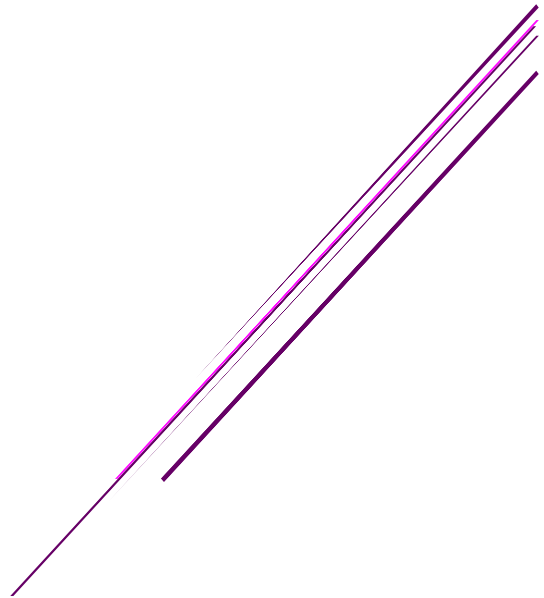
ABBREVIATIONS

AKHSP	Aga Khan Health Services Pakistan
BHU	Basic Health Unit
BISP	Benazir Income Support Scheme
DHQ	District Head Quarters
DoH	Department of Health
EPHS	Essential Package of Health Services
GB	Gilgit Baltistan
IPD	Inpatient Department
KfW	German Development Bank (Financial Cooperation)
KP	Khyber Pakhtunkhwa
LHW	Lady Health Workers
M&E	Monitoring and Evaluation
m4h	management4health GmbH
MO	Medical Officer
NCD	Non-Communicable Disease
OOP	Out-of-Pocket (Payment)
OPD	Outpatient Department
PHC	Primary Health Care
PMT	Proxy Means Test
RHC	Rural Health Centre
SDG	Sustainable Development Goals
SHP I	Social Health Protection Initiative, Phase I
SHP II	Social Health Protection Initiative Phase II
SLIC	State Life Insurance Company
THQ	Tehsil Head Quarters
ToR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization
WMO	Woman Medical Officer

EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

The ToR for the KfW funded Social Health Protection II (SHP phase 2) describes the services to be provided by the Consultant (management4health GmbH – m4h) with respect to conceptualisation of the Out-Patient Department (OPD) scheme as "*provision of technical advice and support to the Departments ofHealth in Khyber Pakhtunkhwa (KP) and Gilgit-Baltistan GB*". The programme aims to support the development of a "*feasible concept for the OPD health insurance scheme in selected districts, including a costed benefit package, entitlements, coverage, reimbursement mechanisms, enrolment criteria, referral mechanisms, reporting mechanisms, etc. to be piloted*". The purpose of this Report is to present the concept and the actuarial feasibility calculation of the concept.

The Inception Report included a detailed analysis of the health sector in Pakistan (with a focus on KP and GB provinces) as well as lessons learned from other OPD schemes implemented in Pakistan and the wider region, and from the KfW funded In-Patient scheme, that will not be repeated in this Report.

The purpose of the OPD pilot scheme is defined in the ToR as to improve access to quality outpatient services and financial risk protection for the population living below a Proxy Means Test (PMT) score of 16.17, by enrolling these families/households into an insurance scheme in selected districts of KP and in GB. In addition, the purpose of the project is to contribute to improved Universal Health Coverage (UHC) and learn how to strengthen UHC by reinforcing outpatient-based care.

Four districts in KP are foreseen to be included in the pilot: Chitral, Kohat, Malakand, and Mardan, as well as the Gilgit district in GB. The OPD scheme is considered as enlargement of the already ongoing IPD scheme and the pilot is foreseen to start on 1 January 2023 and run for two consecutive years.

In terms of budget, KfW and both Governments of KP and GB have made available EUR 7.9 million over a 2 years period for support to the OPD scheme pilot.

A Technical Working Group (TWG), was established in August 2021 by the DoHs to provide a platform for the conceptualisation and ensuring uptake of experiences from Phase I. A first concept for a "full OPD package" was presented in September 2021 but had to be amended as it was approximately 6 times more expensive than the available budget. A "hospital-based OPD Scheme" was presented on 27 January 2022 and while the concept was found to be financially feasible, it did not include PHC services to a sufficient extent. Consequently, a "balanced PHC/OPD concept" was presented to the stakeholders on 9 March 2022. Besides of being financially feasible, the participants agreed with the overall concept and provided suggestions for technical improvements.

The amended "balanced PHC/OPD concept" was discussed with the PMUs and the Finance and Health Minister of KP on 25th March 2022 and with the Health Steering Committee in GB on 29th March 2022. During these meetings the high-level decision-makers agreed with the concept and suggested technical adjustments (see annex 4.4). This adjusted balanced PHC/OPD concept and its actuarial feasibility calculations that is presented in this Report.

From the start of the conceptualisation, data about current utilisation of PHC services in KP and GB were not readily available. Data collected from a few health facilities in KP and GB suggested a utilisation rate of 0.64 visits per person per year for KP and 0.2 for GB. However, in the Evidence Note No 1 from April 2022, the KfW funded Research Project responded to a call from the m4h Team for more evidence-based data on utilisation of OPD services. In this Note the Research Project summarises the result of the household surveys conducted in 2022 in the 4 districts included in the OPD pilot. The Note concludes, that for the providers empanelled in the OPD pilot scheme, the average number of OPD visits per person for consultations and diagnoses is 4.8 per year and 2,64 for provision of medicines.

Knowing that utilisation rates depend on the socio-economic status of the population, that household surveys tend to overestimate utilisation, and considering actuarial experiences, the annual utilisation rate used in this calculation is 1,351 for diagnoses, 2,622 for consultations and 2,097 for provision of medicines. This is significantly higher than what was foreseen in the previous calculations.

Based on the assumption that the annual growth rate of the population in the four districts in KP is 2.4% the actuarial calculation shows that it is not feasible to cover all four districts in KP right from the start of the pilot. With this background it is suggested to start with Mardan in 2023 and to add Kohat, Chitral and Malakand when sufficient evidence has been collected on the expected utilisation rate and the appropriateness of the capitation fees. This adoptive implementation approach is also fully aligned with the findings of the sensitivity analysis that shows a dramatic increase in the total cost of the scheme along with small changes in utilisation.

All PHC-services provided today and described in the Essential Package of Health Services (EPHS) will be covered under the OPD scheme. However, while under the existing public PHC system, patients have to pay out of pocket for consultations, images, lab services and medicines, these items will be paid for under the OPD scheme. It is further suggested to empanel THQs, RHCcertainly not in a non-Mandator ystystem) s and a few BHUs as public PHC providers both in KP and GB. In addition, private providers in KP and the Aga Khan Network in GB will be empanelled based on the same selection criteria that applies for the public providers and as long as they can accept the same uniform reimbursement scheme.

Once a year (first time in October 2022) both DoHs will conduct a public information campaign to encourage potential beneficiaries to register with their preferred PHC provider. An insured person will only be allowed to register with one single provider and the registration is binding for one year, except in cases of serious (written) complaints. For those who have not managed to register with a PHC provider, registration will take place the first time they visit an empanelled provider. The actuarial calculation assumes that the registration rate for GB will be 50% of the target population in 2023, increasing to 65% in 2024 and while it would be around 70% in 2023 and 80% in 2024 for KP we assume 100% of the target to be registered in both provinces by 2025.

Reimbursement of the PHC providers is suggested to be made based on per capita payment for each beneficiary registered, with a uniform rate for both public and private providers. To this end it should be noted that simplicity has been preferred compared with more complex systems such as risk adjusted per capita payment. The proposed reimbursement mechanism will require that each empanelled PHC provider is assessed in terms of scope and quality of services they provide. Accordingly, their annual per capita payment will vary between a maximum and a minimum, as detailed in this report.

Patients registered with providers not capable of providing the full scope of PHC services will have the option to go on a "fee for service" basis by Insurance partner, to other PHC providers who are in a position to deliver the required services, based on a formal referral note. In this way the OPD scheme is also piloting gatekeeping and referral functions. Administrative costs to be paid to the health insurance (HI) provider is set at 8% of the total expenditure under the scheme (12% under the IPD scheme). The final percentage will be known after negotiation and signing of the contract with the HI-provider.

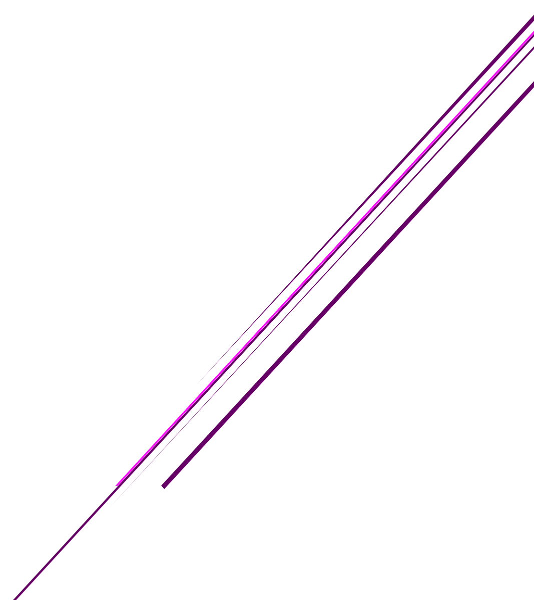
To promote registration of members at the PHC provider, 30% of the amount to be paid to the health insurance provider shall be paid through a uniform performance rate for each insured patient registered at an empanelled PHC health care provider.

A robust M&E system will enable programme managers to base their decisions on evidence and to adjust the pilot during implementation.

Sustainability is important and the Report presents a cost calculation for the continuation of the OPD scheme beyond the pilot phase.

Seven years ago, KfW started the support of the conceptualisation of the IPD health insurance scheme in KP and GB. At that time the scheme was new and unknown in Pakistan but was quickly scaled-up by the provincial government and by the Prime Minister’s Health Initiative. In 2022, the entire population of Pakistan is covered by the IPD insurance scheme. To this end, the Report presents cost calculation for including additional four districts in KP (Peshawar, Swat, Abbottabad, and Dera Ismail Khan) to offer some prospects for the scaling-up of outpatient services in Pakistan.

1 Requirements and the Process for Developing the Concept



1 Concept Development

1.1 Requirements for the Piloting of the OPD Scheme

The purpose of the OPD pilot scheme is defined in the ToR for the project as follows

- To improve access to quality outpatient services and financial risk protection for the population living below a PMT score of 16.17 by enrolling these families into an insurance scheme
- To contribute to improving Universal Health Coverage (UHC)
- To learn how best to provide UHC for OPD services

Further, the ToR mention that the provision of OPD services has pilot character and should include:

- Outreach to rural areas and improving supply side of PHC providers
- Empanelment of primary health care facilities
- Definition of benefits package for OPD services, along the needs of the target group and the availability and quality of OPD services
- Piloting referral and gate-keeping systems
- Development of provider payment schemes.

Four districts in Khyber Pakhtunkhwa (KP) were foreseen to participate as follows: Chitral, Kohat, Malakand and Mardan and Gilgit district in Gilgit-Baltistan (GB). The OPD scheme is considered as an enlargement of the coverage of the already ongoing IPD scheme covering the same segment of the population.

The start of the OPD pilot scheme is foreseen to take place on 1 January 2023 and run for two consecutive years.

In terms of budget, KfW and the Governments of KP and GB have made available altogether EUR 7.9 million over a 2 years period to support the piloting of the OPD scheme, as detailed Table 1.

Table 1: Budget for the OPD pilot in KP and GB

KP-OPD			
In mill. EUR	**Year 1**	**Year 2**	**Year 3**
Premium financed by KfW	0	3,56	3,375
Premium financed by KP	0	0,19	0,375
Total premium	0	3,75	3,75
GB - OPD			
In mill. EUR	**Year 1**	**Year 2**	**Year 3**
Premium financed by KfW	0	0,19	0,18
Premium financed by GB	0	0,01	0,02
Total premium	0	0,2	0,2

1.2 The Process of Developing the OPD Concept

A Technical Working Group (TWG), was appointed by the DoHs in August 2021. The TWG provides a platform for conceptualisation of the OPD pilot scheme and ensures uptake of experiences from Phase I. The m4h Team is providing guidance and support to the DoHs and is acting as secretariat for the TWG.

The ToR for the TWG and the list of participants are included in annex 4.2 and 4.3.

Figure 1: The 1st & 2nd TWG meeting in August 2021 and Jan 2022

Following the first TWG meeting in August 2021, a Concept Note for the Piloting of the OPD scheme was drafted, also specifying the data required to conduct the first actuarial feasibility calculations. The actuarial calculation No°1 was based on a full package of OPD services including both Hospital outpatient and PHC services. The result of the calculation, that was presented at a TWG meeting on 14 September 2021, showed that the cost of the "full OPD package" was approximately 6 times above the available budget.

Considering the above, consultative meetings were conducted with the DoHs to identify priority services for the OPD scheme. This resulted in a benefit package focusing on the treatment of selected non-communicable diseases (NCDs) to be provided as hospital based OPD services. The actuarial calculation of this "hospital-based OPD scheme" was presented at a TWG meeting on 27 January 2022. While the concept was found to be financially feasible, it did not sufficiently include PHC services.

Following additional TWG meetings, meetings with the DoHs and a mission to KP, a "balanced PHC / OPD concept" was developed. The actuarial calculation was presented to all stakeholders on 9 March 2022. The cost calculation confirmed the financial feasibility of the concept. Participants agreed with the proposed concept and provided suggestions for technical improvements (see annex 4.3).

Continued connection with the SHP I consultants were maintained to get feedback for the conceptualisation of the outpatient benefit package and scheme.

Getting access to relevant data for the design / development of the scheme remained an issue for all SHP II technical partners and it is therefore suggested to hold a dedicated workshop including SHP-2 consultants, DoHs KP &GB, NARDA, SLIC, IMU, BISP and access to all data repositories will be needed to finalise cost calculations required to support the next phases of procurement and implementation.

The "balanced PHC OPD concept" and the actuarial calculations was then distributed to the DoHs and discussed with the PMUs and the Minister of Finance and Health in KP in a meeting on 25 March and with the Health Steering Committee in GB on 29 March 2022. During these meetings the high-level decision-makers agreed with the concept and suggested technical adjustments (see annex 4.4).

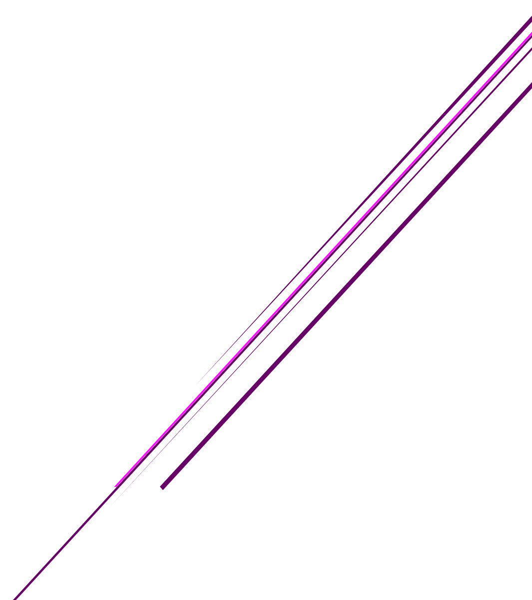
It is this adjusted concept and its actuarial feasibility calculations that is presented in this report.

Figure 2: Team on field visits in RHC Mangah in the district Mardan in KP in Feb 2022

**Laboratory and manual maternal data registry maintained by Lady Health Workers in RHC Mangah*

Figure 3: Meeting with Health Minister - KP and Steering committee GB, April 2022

2 Concept and Feasibility for Piloting the OPD Scheme



2 Concept and Feasibility for Piloting the OPD scheme

2.1 Definition of OPD

OPD services consist of outpatient-based hospital services and PHC services including public health outpatient services.

Outpatient hospital services[1] cover many diagnostic and treatment procedures that can be provided on an outpatient basis by a hospital, e.g.,

- Emergency services and (same) day surgery
- Laboratory tests performed in hospitals
- X-ray and other imaging and radiology services performed in hospitals
- Medical supplies, including splints and casts provided in hospitals
- Preventive and screening services provided in hospitals
- Certain drugs and biologicals including injectable drugs provided in hospitals.

WHO defines PHC[2] as: “a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment."

PHC includes three inter-related components: 1) comprehensive integrated PHC health services; 2) multi-sectoral policies and actions to address the upstream and wider determinants of health; and 3) engaging and empowering individuals, families, and communities for increased social participation and enhanced self-care and self-reliance in health.

WHO is also pointing out that for Universal Health Coverage (UHC) to be truly universal, a shift is needed from health systems designed around diseases and medical disciplines towards health systems designed for the people, together with the people. PHC requires governments at all levels to underscore the importance of action beyond the health sector, including health-in-all-policies, a strong focus on equity and interventions that encompass the entire life-course.

For more information about PHC see also The Lancet Global Health Commission on Financing PHC.

The suggested concept for piloting the OPD scheme is primarily focused on PHC.

2.2 Methodology

This section should be read in conjunction with the actuarial report ‘Social Health Protection (SHP) Phase II OP pricing – 06052022.pdf’, which contains important information on key assumptions, the sensitivity of the estimated cost to those assumptions and caveats and limitations of the analysis.

The main steps included:

Develop a final actuarial cost model (net of administration payment to health insurers), detailing the utilisation and average cost by the different benefits/services covered by the product, split by types of providers. This was done for KP and GB regions separately.

[1] Outpatient Services in Hospitals Coverage (medicare.gov)

[2] Primary health care (who.int)

A different actuarial cost model was built for each provider category based on different reimbursement structures, including the benefits provided under each. The actuarial cost model includes the following:

Annual Utilisation per 1,000 members - Derived using the assumed utilisation, based on a mix of actuarial judgement, experience elsewhere with similar schemes, and the evidence note supplied with a survey of recent OPD use in KP.

Average Cost per Service (ACPS) – As per the fee schedule, already loaded for a 5% administration cost for providers.

Final Cost Per Member Per Year (PMPY) – Derived from the above two as –

$$\frac{\text{Annual Utilisation per 1,000} * \text{Average Cost per Service}}{1{,}000}$$

The final Cost PMPY was then loaded for the 8% assumed administration fee payment to insurers.

Key assumptions in developing the cost model include:

- 80% of the OPD consults (covering OPD consultations and emergency visits) utilisation require medicines to be dispensed (Pharmacy).
- The utilisation rate for providers remains the same, regardless of whether the provider is paid Fee for Services (FFS) or capitated, or partially capitated.
- ACPS includes a 5% administration cost for providers
- There is an 8% load for the administration cost to be paid to the health insurance provider.

Sign-up (enrolment) rate assumed by the target population in the year 2023-2025 for GB and KP regions separately

On the assumption that the OPD scheme will be established gradually and enrolment will increase over time, the following sign-up rates are assumed for the target population:

Table 2: Percent of insured under the OPD scheme registered with PHC providers

Target Population with PMT<16.17	Scheme sign-up by the target population Year 2023	Scheme sign-up by the target population Year 2024	Scheme sign-up by the target population Year 2025
GB - Entire Population	50%	65%	100%
KP – Starting with Mardan District only	70%	80%	100%

Sensitivity tests to assess impact of changing key assumptions on the final cost PMPY

Due to the uncertainty around the key assumptions made in step 1 and 2, we performed sensitivity tests of key assumptions by creating different scenarios by varying the following assumptions:

Cost Model

Aggregate utilisation factor – Relative change in the assumed utilisation at an overall level.

Utilisation factor for Fee-For-Service (FFS) – Increase in the utilisation for providers reimbursed on an FFS basis. All the benefits except for OPD visits will be referred from providers with no labs to providers based on FFS reimbursement. For the base scenario, the utilisation for FFS is set equal to utilisation under the capitated providers.

Scheme sign-up rate by the target population

- Sign-up rate for the year 2023-2025 for GB and KP separately
- Target population for the KP region by inclusion of combination of different districts
- Comparison of estimated cost of the scheme with the available budget.

The estimated cost of the scheme was calculated as a product of:

- Final cost PMPY, including administration loadings
- Target population
- Scheme sign-up rate

The calculated estimated cost of the scheme was compared with the budget available for each region under each scenario. The sensitivity analysis provides some comparison points; however, it is not an exhaustive list of possible scenarios or outcomes.

2.3 The Beneficiaries and their Utilisation

The insured population will, in both provinces, be the population with a PMT under 16.17 who are already beneficiaries of the KfW-supported IPD I scheme.

Recent data provided by the health insurance providers for KP and GB details the covered population in the relevant districts, as illustrated in Table 3.

Pakistan has one of the highest population growth rates in the world and for KP the annual growth rate is 2.4%[3] although, the population in GB is constant.

Table 3: Population under PMT 16.17 in the target districts 2021

	2021	2023	2024	2025
Population	**Population**	**Population**	**Population**	**Population**
OPD-pilot KP	**PMT <16.17**	**PMT <16.17**	**PMT <16.17**	**PMT <16.17**
Mardan	400.433	419.884	429.962	440.281
Malakand	145.726	152.805	156.472	160.227
Kohat	156.364	163.960	167.895	171.924
Chitral	77.393	81.152	83.100	85.095
KP total pilot	**779.916**	**817.801**	**837.428**	**857.527**
OPD pilot GB				
Gilgit	38.639	38.639	38.639	38.639
GB total pilot	**38.639**	**38.639**	**38.639**	**38.639**

Data about utilisation of PHC services in KP and GB were not readily available, and data collected from the THQ Dargai in KP and PH Gilgitin GB for 2021 indicates a utilisation rate of 0.64 services per person and 0.2 respectively.

However, in Evidence Note No 1 from April 2022, the KfW Research Project respond to a call from the m4h Team for more evidence-based data on utilisation of OPD services, see annex 4.8. In this Note the Research Project summarises the result of the household surveys conducted between 29 January to 15 March 2022 in the districts of Chitral, Kohat, Malakand and Mardan, where one adult family member was asked to report about OPD service use by the adults and adolescents >14 years in the family.

[3] Annual Report 2020 UNICEF

The Note concludes that for the providers empanelled in the OPD pilot scheme the average monthly OPD visits per person is 0.11 for public PHC facilities and 0.29 for public secondary facilities which equals 1.32 and 3.48 visits per person per year or 4.8 in total. In addition, the utilisation rate for pharmacies (visits to pharmacies or scripts dispensed) is estimated to 0.22 per months or 2.64 per year.

The household survey covers the entire population and knowing that the utilisation rate is high for the well-educated, rich, and longer-living part of the population, and knowing that this type of household surveys tends to overestimate utilisation as many people do not exactly remember their use of OPD services and wether is was during this month or the previous one. In addition, the level of studies made about utilisation rates in similar settings varies widely, depending on access to facilities, education about the scheme, the level of utilisation prior to the introduction of the scheme, as well as the demographics and health status of the covered population. Considering the above, the annual utilisation rate used in the actuarial calculations has been estimated as shown in Table 3.

Table 4: Annual utilisation rates used in calculation of the OPD scheme

Benefits Covered	Annual Utilisation per person
Diagnostic Tests	1.351
OPD Consults	2.622
Pharmacy	2.097
Total	6.070

The OPD concept assumes that the insured population will have to select and register with their PHC provider. This process will require time and thus it is anticipated that for KP 70% of the population will sign up the during the first year of the pilot (2023), 80% during 2024 and for GB it will be 50% in 2023 and 65% in 2024. Full sign-up is expected to be reached for both provinces in 2025.

The actuarial calculation made under these assumption (see annex 4.5) shows that it is not possible to cover all four districts in KP right from the start. Therefore, it is suggested to start with Mardan in 2023 and to add Kohat, Chitral, and Malakand once there is sufficient evidence for trends in the future utilisation of the scheme. This adoptive implementation approach is fully aligned with the findings of the sensitive analysis conducted for the actuarial calculation that shows a dramatic increase in the total cost of the scheme, with only small changes in the utilisation rate (see annex 4.5).

2.4 Services to be Covered

All PHC-services provided today and described in the Essential Health Package (EHP) will be covered under the OPD health insurance scheme. However, while under the existing public PHC system, patients have to pay out of pocket for consultations, diagnostic tests (images, lab services, and other) and medicines, these items will be covered under the OPD insurance scheme. A link to the detailed list of OPD services is provided in annex 4.6 and 4.7.

Data about PHC services provided today are not available. The number of services to be used in the actuarial feasibility calculation is estimated based on data obtained by m4h team from THQ Dragai in KP for 2021. These data have been adjusted for the anticipated utilisation rate as described in the previous sub chapter. The same data was also used to do the calculation for GB.

2.5 Empanelment of the health service providers

The lists of health facilities in the four districts of KP have been provided by the DoH, showing a total of 225 health facilities encompassing hospitals (5) and a specialised facility for TB patients. The other PHC providing facilities are Tehsil Head Quarters (THQ) hospitals (10), Rural Health Centres (RHC -

21), Basic Health Units (BHU 109), Civil Dispensaries (CD 71) and 4 Department of Health Head Quarters (DHQs). In addition, a number of private PHC providers operates in the 4 districts.

For all these PHC providers, health professional staff are authorised by the Pakistan Medical Council and the health facilities are approved by the Health Commission.

Table 5: Number of health facilities in KP

	Lower Chitral	Upper Chitral	Kohat	Mardan	Malakand	Total 4 districts	Total 3 districts
THQ	2	1	0	6	1	10	10
RHC	3	3	4	5	6	21	17
BHU	9	10	20	50	20	109	89
CD	17	15	9	19	11	71	62
DHQ	1	0	1	1	1	4	3
Category-D	0	0	2	0	3	5	3
Specialised(W&C)	0	0	1	0	0	1	0
Sub Health Center	0	0	3	0	0	3	0
Total	**32**	**29**	**40**	**82**	**42**	**225**	**185**
Of which PHC	**29**	**28**	**33**	**74**	**37**	**201**	**168**

For the district of Gilgit in GB data are provided in Table 6. In the Gilgit district there is mix of Primary Health Care (PHC) Providers which are: I. PHC facilities under the management control of District Health Officer (DHO) owned by the Department of Health GB. II. PHC facilities under the management control of the People's Primary Healthcare Initiative (PPHI) under the administrative control of the Department of Health GB. III. PHCs under the management and administrative control of the Aga Khan Health Services (AKHSP).

Table 6: Number of health facilities in Gilgit-Baltistan

Description	District: Gilgit
Class A Dispensaries	10
BHU	2
CD	29
TB Leprosy Centre	1
DHQ	1
FAP	17
MCH	14
Civil Hospitals	2
Psychiatry Hospital	1
City Hospital	2
Total	79
Of which PHC	72

While the Basic Health Units (BHU) and Civil Dispensaries (CD) most often are staffed with parttime nurses or midwives, and thus with limited capacity; Tehsil Head Quarters (THQ) and Rural Health Centres (RHC) are staffed also with medical doctors, have labs, and provide imaging services (including ultrasound). Most CDs would not have electricity, water, or internet.

The THQs and RHCs also possess administrative capacity to participate in a health insurance scheme. In addition, the vision of the government in KP, in line with the human development objectives in the

health sector, is to rehabilitate all the RHCs to progressively scale up their services including full availability round the clock, every day of the year. Under this PC-1 scheme, 50 RHCs will be converted into being open 24/7; while 60 RHCs would be upgraded to provide comprehensive essential PHC services.

The basic input package proposed under this PC-1 includes:

- Provision of outpatient curative services by the family physicians
- Screening of Hepatitis, AIDS, TB, Anaemia, Hypertension, and Diabetes
- Early detection of communicable and non-communicable diseases and referral to secondary and tertiary levels, if needed
- Provision of around the clock obstetrical services
- Regular antenatal and postnatal check-ups
- Care of the new-born, infant, and child and their growth monitoring
- Nutritional services to malnourished children and adolescent girls and their referral if needed
- Public awareness about diseases and incorporation of health seeking behaviour
- Behaviour change communication (hygiene, sanitation, smoking, obesity, and eating habits)
- Facility-based immunization against various communicable diseases
- Early warning about (endemic) communicable diseases
- Overall achievement of important health indicators especially the Sustainable Development Goals (SDG) 2 (zero hunger) and 3 (good health and well-being);
- Introduction of E monitoring and reporting systems for collection of real-time good quality data.

In addition, a number of private providers are operating in KP and in GB the Aga Khan Network is providing PHC services. On this background it is suggested to empanel THQs, RHCs and a few BHUs as public PHC providers in the pilot OPD scheme for KP in GB. In addition to the 31 public PHC providers (27 in 3 districts of KP and the 4 in GB) a limited number of private PHC providers will be empanelled in KP and the Aga Khan Network in GB.

The private PHC providers will be selected based on a survey conducted among the insured population mapping their preferences for the public and private providers located near the beneficiaries. To this end, KfW’s Research Project has already planned to conduct a household survey. SOPs defining the criteria for empanelment and for standard requirements for the health care providers will be elaborated before the start of the pilot.

It is important that the RHCs and GPs are establishing strong linkages with community-based health care workers, and all the health facilities in their catchment area as following:

- Nearby Health facilities like BHU and CDs
- Outreach teams especially Lady Health Workers (LHWs)
- Local Family Physicians
- Community influential
- Non-governmental organisations
- Community based organisations;
- Other departments e.g., population welfare department, education department etc.

These facilities will also establish linkages with secondary level hospitals under the supervision of district health offices for the purpose of training and referral of patients.

2.6 Registration of Beneficiaries at the Health Service Providers

Once a year in October (first time October 2022) the DoHs will conduct a public information campaign to encourage the target population to register at their preferred PHC provider (also the task

of the Visibility Providers to be contracted by the DoHs). An insured person will only be allowed to register with one provider and the registration is binding for one year, except in cases of written complaints.

For those who have not managed to register with a PHC provider during the October campaign, the registration will take place the first time they visit an empanelled provider.

The KfW SHP III Project will support the development of an IT application (app) in which the information about the family/household is available. The app will also inform the insured persons about the list of PHC providers operating under the OPD scheme. The PHC facilities will be able to use the app to register the insured persons. In addition, the PHC facility will, as part of the registration, inform about their contact details, name of the responsible person, bank account, opening hours, etc.

The app is also foreseen to include the personal health record for each of the eligible beneficiaries, a first step toward a full scale Electronic Medical Record (EMR). In this way the existing paper-based reporting system can gradually be replaced by digital reporting which will provide data on real time basis and will facilitate monitoring and evaluation (M&E), real time reporting, referral and verification. This application should be available in a net-based version that can be accessed from different devices.

Although the providers will support the annual campaign for registration of patients with their PHC provider, it is anticipated that the population only gradually will obtain 100% registration as illustrated in Error: Reference source not found.

Leaving the choice for the health care provider to the beneficiaries, will require upfront information to all health care providers so they know what to do and how to do it. It will also require an ex-post handling of those providers for which very few people are signing up. It will also require information to the beneficiaries concerning what they need to do to register and change their health care provider.

Training will be provided to Woman Medical Officers (WMOs) Medical Officers (MOs), General Practitioners (GPs) on the latest developed treatment/diagnosis SOPs, referral protocols and data entry. They will get hands on training at DHQ hospitals.

Availability of essential medicines and health commodities are key for good performance of any health system. Although, improvement of the supply chain system is a priority for the governments of KP and GB, certain challenges with timely availability of quality health commodities at the PHC level remain.

With additional funds retained from the OPD scheme it is an opportune time to device and introduce a more cost effective and efficient model to address the time lag for the availability of essential medicines at the provincial warehouse, the district, and the health facilities; especially when the Public Insurance Fund comes into operation. Additional funds retained at PHC from the insurance scheme could be used for procurement of generic essential medicines, rapid assessment test kits etc.

2.7 Reimbursement of the Health Service Providers

The number of providers and the limited electronic data available will require a very simple reimbursement procedure for the PHC providers. Per capita payment for registered patients is a simple and convenient reimbursement mechanism. The flipside of per capita payment is that it tends to favour registration of the youngest and most healthy part of the population (cream skimming) and to treat them as little as possible (under supply).

Considering advantages and disadvantages, however, it is suggested to apply per capita payment for reimbursement of the PHC providers at which the beneficiary is registered. It is suggested to apply a uniform rate for both public and private providers.

The actuarial calculation has been conducted based on the data and the assumptions mentioned earlier in this chapter as well as based on the cost that today is paid OOP by the patients, plus 5% as administrative cost for the PHC providers to report, issue claims and administer the scheme, as detailed in Table 7.

Table 7: OOP payments for services offered by PHC providers in KP and GB

Exchange rate		**176,150**	**198,186**
	Unit cost	**Unit cost**	**Unit cost**
Services used for both KP and GB	Rupee	USD	EURO
OPD consultation	52.50	0,30	0,26
Emergency visit	105.00	0,60	0,53
Digital X-Ray	157,50	0,89	0,79
X-RAY-PI	42,00	0,24	0,21
LAB	105,00	0,60	0,53
U/ Sound	189,00	1,07	0,95
ECG	63,00	0,36	0,32
Medicine	840,00	4,77	4,24

Source: OPD prise list for the Tehsil Head Quarter in Dargai in Mardan with +5% for administrative overhead.

It is assumed that 80% of all OPD consultations will require medicines. For KP it is assumed that 80% of the demand for OPD services will be provided by public providers and 20% by private providers. For GB it is assumed that 80% is provided by public providers and 20% by private providers.

For patients registered with a PHC provider not able to offer the full package of diagnostic services, these services will be paid on a fee for service basis to other empanelled PHC providers, able to deliver those, based on a formal referral note. In this way the OPD scheme is also piloting gatekeeping, and referral functions. To this end it is assumed that for both KP and GB, 50% of the insured will use providers able to provide all services.

The annual per capita payment for each registered patient for the PHC facilities is calculated using the actuarial feasibility model as detailed in Table 8. It shows that if the provider is able to offer the full scale PHC-packaged the annual per capita payment will be around EUR 10.51 and if only OPD consultations can be provided the payment is EUR 1.01.

Table 8: Annual per capita payments per registered patient

Services	**Cost per person per year (EUR)**
OPD Consultation	1,01
Diagnostic Tests	0,67
Drugs	8,89
Total	**10,57**

The suggested reimbursement mechanism will require that each empanelled PHC provider is assessed in terms of which services they are able to provide. Provision of these services for patients referred from a provider that is not able to provide them will be paid based on a fee-for-services pricelist as detailed in Table 9. A SOP will be developed to guide the process.

Table 9: Annual per capita payment per registered patient according to diagnostic services

Services	Cost per service (EUR)
OPD Consultations	0,39
Diagnostic Tests	0,50
Drugs	4,24

The annual per capital reimbursement rate detailed in Table 8 and the fee-for-service rates shown in Table 9, will be used for both private and public PHC health service providers. Implicitly this means that only providers who can accept this payment will be empanelled.

For per capita payment, it is suggested that the PHC health service providers are paid quarterly based on the number of registered patients, the first day of the second month following the end of the quarter. E.g., the payment for patient registered during January, February and March 2023 will be paid by the health insurance provider on 1 May 2023.

Payment for services is suggested to be done monthly so that claims received before the 10th day in the following months will be paid not later than the 10th day in the following month. E.g., claims received before 10th of February for the months of January will be paid by the health insurance not later than 10th of March.

The number of visits of the beneficiaries will be monitored carefully and if the number is lower/higher than expected, per capita payment will be revised accordingly during the year.

During the pilot implementation it is also suggested to seek possibilities to include additional performance payments e.g., related to treatment of specific age groups, and/or providers with special demographic characteristics (e.g., providers in rural settings and scarcely populated areas) as soon as data can provide evidence for the need and the financial possibility to do this. To that end, it is important that the app, to be developed with support from SHP III Project, would allow to track the person's primary PHC provider, age, gender, and which diagnostic services are provided by other PHC health service providers.

Currently, only secondary and tertiary level public health facilities have the provision to retain health insurance revenue under the IPD scheme thus, both DOHs need to take into consideration the importance of public sector primary health facilities having the right to retain earnings from the OPD scheme. It is also important that these health facilities are being given the freedom to use these funds to provide staff incentives and to improve the scope and quality of their services.

2.8 Payment of the Health Insurance Provider

Payment of the health insurance (HI) provider is set at 8% of the total cost of the scheme. This can be considered low compared to the 12% paid under the IPD scheme. However, while the IPD scheme was a pilot establishing all the operational procedures for the health insurance system, the OPD scheme just adds to the existing one. Further, while the IPD scheme mostly pays according to fee for services and thus must keep track of each single service provided, the HI-providers under the OPD scheme mostly are paying through quarterly per capita payments.

The actuarial feasibility calculation shows that the total annual payment of the HI-provider if utilisation rate and registration rate are as foreseen for KP is EUR 248,643 in 2023, 290,984 for 2024 and 372,460

per years for 2025 and forward. For GB the same figures are respectively EUR 16,344, 21,246 and 32,687.

Table 10: Total payment to the Health Insurance providers

EUR	2023	2024	Total Pilot	2025 onward
Total payment HI Provider KP	248,643	290,984	539,627	372,460
Total payment HI Provider GB	16,344	21,246	37,590	32,687
Total	264,987	312,230	577,217	405,147

Table 11: Payment of the health insurance provider in KP and GB

Payment of HI Provider KP (Euro in Millions)	**2023**	**2024**	**2025 onward**
Payment of HI-provider fixed monthly payment (70%)	14,504	16,974	21,727
Payment HI-provider per registered person (30%) per year	0.25	0.25	0.25

Payment of HI Provider GB (Euro in Millions)	**2023**	**2024**	**2025 onward**
Payment of HI-provider fixed monthly payment (70%)	953	1,239	1,907
Payment HI-provider per registered person (30%) per year	0.25	0.25	0.25

2.9 Piloting Referral and Gatekeeping

A key role of PHC is to be the professional gate to the other parts of the health system. Establishing of an effective gatekeeping and referral function takes time and requires a high degree of professionalism of the PHC providers to be trusted by the population as well as the ability to diagnose and treat the majority of cases in the PHC-sector.

The OPD pilot provides a unique opportunity to engage health service providers in awareness raising and to test different elements of gate keeping and rational referral practise. To this end it is suggested to pilot gate keeping and referrals in the following ways:

For the empanelled PHC providers that do not provide lab-services, X-ray, ultrasound, or ECG the provider can, if medically justified, refer a beneficiary for further diagnostic services to another empanelled PHC provider offering these services, for which they will be reimbursed on a fee for service basis according to the price list detailed in section 2.7. E.g., BHU can refer beneficiaries to RHUs and to THQs.

Detailed SOPs will be elaborated and the health care seeking behaviour of the population and providers will be continuously monitored. However, change of behaviour takes time and needs to be backed by information campaigns. It should be noted that the agreement between KfW and the DoHs in KP and GB includes financial resources to support the information campaigns and other visibility activities.

2.10 Quality Assurance

The OPD scheme envisages capacity strengthening support to DoHs, the health service providers and the HI-providers. For the DoHs and the health providers, support is foreseen to establish PHC treatment protocols and guidelines as well as monitoring of the use of these.

2.11 Monitoring and Evaluation

Monitoring and Evaluation (M&E) will form an integral part of the results-based management concept of SHP II. The M&E will enable programme managers to base their decisions on evidence about performance and results and to adjust the pilot during implementation. Patient access and mix of services and quality indicators will be monitored. The clear focus of the pilot will be how helpful these measures and modalities are to move towards the systemic goals of reaching out to the most vulnerable, increase efficiency in service delivery, etc., and how well the OPD scheme is complementing the IPD scheme.

2.12 Presentation of the Actuarial Feasibility Calculation

The actuarial calculation of the pilot concept demonstrates its feasibility: it is possible to implement the pilot phase within the budget available as illustrated in Table 12 for KP and in Table 13 for GB. The calculation has been made for each of the two pilot years 2023 and 2024 as well as for 2025, representing the cost of continued operation of the OPD scheme beyond the pilot period. The difference in costs between the years is due to population growth (mainly in in KP) and a 100% sign-up rate in 2025. For KP the actuarial calculation shows that the total cost of the pilot, covering the district of Mardan in the beginning, is EUR 7.3 million (available budget: EUR 7.5 million).

Table 12: Actuarial calculation of the OPD pilot scheme in KP

KP	2023	2024	Total Pilot	2025 onward
Total payment of health service providers	3.108.044	3.637.297		4.655.748
Total payment of health insurance provider	248.643	290.984		372.460
Total cost of OPD in KP	**3.356.687**	**3.928.281**	**7.284.968**	**5.028.208**
Budget for piloting the OPD scheme in KP				
In mill. EUR	**Year 1**	**Year 2**	**Year 3**	**Total**
Premium financed by KfW	0	3,56	3,375	
Premium financed by KP	0	0,19	0,375	
Total premium	0	3,75	3,75	7,5

The actuarial calculation for GB shows that the total cost of the pilot covering the Gilgit district, is EUR 0.5 million (EUR 0.1 M above the budget of 0.4 M). However, the special agreement between KfW and DoH in GB includes contingences amounting to EUR 0.4 M, and it is recommended to reallocate EUR 0.1 M of the contingency line to pilot implementation to secure its financial feasibility.

Table 13: Actuarial calculation of the OPD pilot scheme in GB

GB	2023	2024	Total Pilot	2025 onward
Total payment of health service providers	204.299	265.578		408.588

Total payment of health insurance provider	16.344	21.246		32.687
Total cost of OPD in KP	220.643	286.825	507.468	441.275

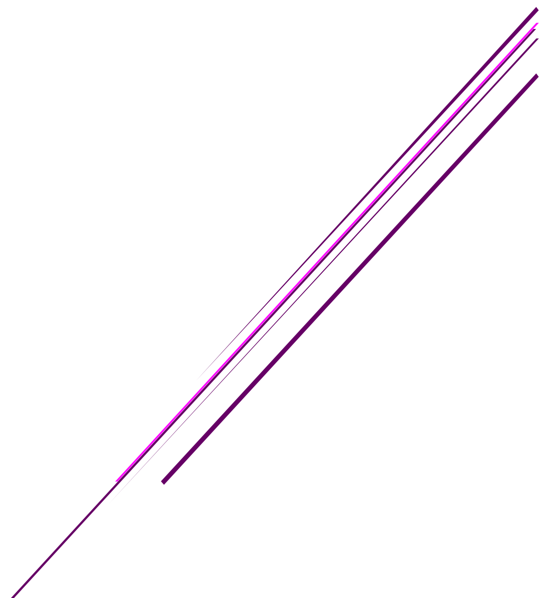
Budget for piloting the OPD scheme in GB

In mill. EUR	**Year 1**	**Year 2**	**Year 3**	**Total**
Premium financed by KfW	0	0,19	0,18	0,37
Premium financed by GB	0	0,01	0,02	0,03
Total premium	0	0,2	0,2	0,4

The sensitive analysis is included in annex 4.5 and shows that even small changes in the utilisation rates has a huge impact on the total cost of the pilot. E.g., if the sign-up rate in GB increases from 50% in 2023 to 70% and from 65% to 80% in 2024, the total cost of the pilot will increase by 65%.

Based on the above and the fact that the quality of the data used for the actuarial calculation cannot be fully verified, it is recommended to follow an adoptive implementation approach for the pilot scheme. This together with a strong M&E system is expected to provide the financial space required for the scaling-up of the pilot by including the Malakand district in KP, and by adding more providers, etc.

3 Sustainability and Scale-up



3 SUSTAINABILITY AND SCALE-UP

3.1 Scope and Perspectives

Sustainability is important for any project. However, to providing OPD service insurance for the poorest part of the population for a period of two years without knowing what it will cost to continue the scheme beyond the pilot, would be a catastrophe for the beneficiaries, for the respective Departments of Health of the two provinces, and for the KfW Development Bank. Thus, this chapter presents the cost calculation for the continuation of the scheme beyond the end of the pilot phase (2025 and onwards).

Seven years ago, KfW started the support of the conceptualisation of the IPD health insurance scheme in KP and GB. At that time the scheme was new and unknown in Pakistan, but the scheme was scaled-up by the provincial governments and by the Prime Ministers Health Initiative to an extent where today the entire population in Pakistan, in all provinces, are covered by the IPD services insurance scheme. To this end it is important for the DoHs in KP and GB to know what the cost would be of scaling up the OPD scheme. For this purpose, this chapter presents the cost calculation for including additional four districts (as proposed by the KP DOH): Peshawar, Swat, Abbottabad, and Dera Ismail Khan.

3.2 Cost Calculation for Sustainability and Scale-up

Sustainability means that the DoHs are able to plan the financial resources needed to rollout the scheme by adding districts and by increasing the share of the population benefitting from the scheme. The calculation of long-term costs (from 2025 onwards) is shown in annex 4.5. It is based on the assumption, that both provinces will reach a sign-up rate of 100% and that a sufficient number of providers will participate. For the population below PMT 16.17 the same utilisation rate as presented above is used but the utilisation rate for the part of the population with a PMT above 16.17 is assumed to be 75% higher.

For KP it is assumed that the population in the 4 pilot districts will increase by 2.4% per year and the resulting actuarial calculation for KP is shown in Table 14. Annual costs of including all four districts covering the population of PMT <16.17 is EUR 9.8 M. To cover the part of the population >PMT 16.17, additional EUR 52.9 M will be needed. The same calculation for GB shown in Table 15 results in EUR 0.4 M and EUR 4.1 M p.a., respectively.

Table 14: Annual costs for continued operation and scale up - four pilot districts in KP

Estimated cost for population with a PMT < 16.17		
Districts in the KP region	Target population-2025 (000’s)	Estimated cost of the scheme-2025 (€ 000’s)
Mardan	440	5.028
Malakand	160	1.830
Kohat	172	1.963
Chitral	85	972
Total	858	9.793

Estimated cost for population with a PMT>16.17		
Districts in the KP region	Target population-2025 (000’s)	Estimated cost of the scheme-2025* (€ 000’s)

Mardan	1.165	23.286
Malakand	632	12.626
Kohat	447	8.928
Chitral	407	813
Total	2.650	52.970

Total cost for the entire population		
Districts in the KP region	Target population-2025 (000's)	Estimated cost of the scheme-2025* (€ 000's)
Mardan	1.605	28.314
Malakand	792	14.456
Kohat	619	10.891
Chitral	492	9.102
Total	3.508	62.763

Table 15: Annual costs for continued operation and scale up - one pilot district in GB

Estimated cost for population with a PMT < 16.17		
Districts in the GB region	Target population-2025 (000's)	Estimated cost of the scheme-2025* (€ 000's)
Gilgit	39	441
Total	39	441
Estimated cost for population with a PMT>16.17		
Districts in the GB region	Target population-2025 (000's)	Estimated cost of the scheme-2025* (€ 000's)
Gilgit	205	4.091
Total	205	4.091
Total cost for the entire population		
Districts in the GB region	Target population-2025 (000's)	Estimated cost of the scheme-2025* (€ 000's)
Gilgit	243	4.532
Total	243	4.532

The DoH in KP has asked for a cost estimate for the scaling up of the OPD scheme to four additional districts (Peshawar, Swat, Abbottabad, and Dera Ismail Khan). An estimation of the population in these districts is provided in Table 16, which has been made under the assumption that the share of the population with a PMT<16.17 is the same as the average for the 4 pilot districts (25%). Altogether the population in the 4 additional districts is expected to reach 11.8 million by 2025.

Table 16: Population in four additional districts in KP (estimate)

Districts	**Population in 1998**	**Growth rate**	**Population expected in 2025**	**Of which PMT<16.18**	**Of which PMT>16.18**
Peshawar	2.026.851	3,58%	5.239.276	1.309.819	3.929.457
Swat	1.257.602	3,37%	3.077.479	769.370	2.308.110

Abbottabad	880.666	1,82%	1.433.193	358.298	1.074.895
Dera Ismail Khan	852.995	3,26%	2.028.214	507.053	1.521.160
KP total additional districts	**5.018.114**		**11.778.163**	**2.944.541**	**8.833.622**

Based on the estimate of the population in the 4 additional districts the actuarial calculation is presented in Table 17.

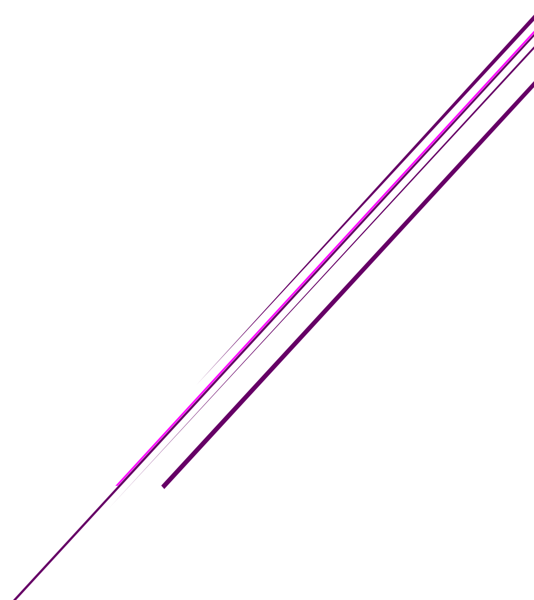
Table 17: Annual cost of additional four districts in KP

Estimated cost for population with a PMT < 16.17		
Additional districts in KP	Target population-2025 (000’s)	Estimated cost of the scheme-2025 (€ 000’s)
Peshawar	1.310	14.958
Swat	769	8.786
Abbottabad	358	4.092
Dera Ismail Khan	507	5.791
Total	2.945	33.627

Estimated cost for population with a PMT>16.17		
Additional districts in KP	Target population-2025 (000’s)	Estimated cost of the scheme-2025 (€ 000’s)
Peshawar	3.929	78.550
Swat	2.308	46.139
Abbottabad	1.075	21.487
Dera Ismail Khan	1.521	30.408
Total	8.834	176.584

Total cost for the entire population		
Additional districts in KP	Target population-2025 (000’s)	Estimated cost of the scheme-2025 (€ 000’s)
Peshawar	5.239	93.508
Swat	3.077	54.925
Abbottabad	1.433	25.579
Dera Ismail Khan	2.028	36.199
Total	11.778	210.211

4 LIST OF ANNEXES



4 List of Annexes

To avoid unnecessary printing and that the report would be too large, the annexes have been made available through URL links.

4.1 ToR for SHP II

https://m4healthmy.sharepoint.com/:b:/g/personal/edward_tourtellotte_m4health_pro/EZN5TecG1INLt_zJhSlqUYEBPt55PoZrg3bAql9mVBTWfg?e=zk5SxN

4.2 ToR for the TWG for Conceptualising the Outpatient Scheme

https://m4health-my.sharepoint.com/:b:/g/personal/edward_tourtellotte_m4health_pro/EU4qfh2XqfhKiZTnzf-j3lUBqxGNny9pPTvMwx1R3rSVGg?e=p22SoB

4.3 Members of the TWG

For KP:

https://m4health-my.sharepoint.com/:i:/g/personal/edward_tourtellotte_m4health_pro/EbwSFW_HBDNHj5W__h5n6QIB-UqLq-IsbAIQ2MTYYtycjQ?e=Q4cu93

For GB:

https://m4health-my.sharepoint.com/:i:/g/personal/edward_tourtellotte_m4health_pro/EWEZigGmvqxlizpjLo7FXu8BmAUhQ_62sHN5XgaHfIQiUg?e=6rYkMb

4.4 Summary of Technical Adjustments from KP and GB

https://m4health-my.sharepoint.com/:f:/g/personal/edward_tourtelotte_m4health_pro/EqxhGCu4GIZBjX5B5nolldUBANYyTrIxh6lcYbBvTTqrTQ?e=2UF207

4.5 Actuarial Calculation and Sensitivity Analysis

https://m4health-my.sharepoint.com/:b:/g/personal/edward_tourtellotte_m4health_pro/EbgJOMGfvu9Eiv1P-W9OI6EBZYh_rPIPUZVSft5J18NfrA?e=owyocO

4.6 Long-list of Diagnostic OPD services

The list is available at the following link:

Word Format:

https://m4health-my.sharepoint.com/:w:/g/personal/edward_tourtellotte_m4health_pro/EXpd87Bic7JHrQF-E-znPfoB26IKYVYp1a5UD9DcuQ-Tsw?e=Rr7gFf

PDF Format:
https://m4health-my.sharepoint.com/:b:/g/personal/edward_tourtellotte_m4health_pro/EW8ZNAnKWyIBgm02aSqs9KMBNptQUSh7XcthojRKkkcLxw?e=HUgZL3

4.7 Long-list of OPD Treatment services

The list is available at the following link:

Word Format:
https://m4health-my.sharepoint.com/:w:/g/personal/edward_tourtellotte_m4health_pro/EZ0AvIGUM1RDiTfd4-C1RqYB8BCgqKWigexw2Qe-DCPOsw?e=tYpK22

PDF Format:
https://m4health-my.sharepoint.com/:b:/g/personal/edward_tourtellotte_m4health_pro/EfZxP_xha69ErBchr2B1qlwB97KaVm4rZK0bLJ3y-oCrNw?e=IjL3uS

4.8 Evidence Note No 1

The list is available at the following link:

https://m4health-my.sharepoint.com/:b:/g/personal/edward_tourtellotte_m4health_pro/EU7dd2GgcOJKpVRIabvJLNUBdu-FNx9RcNxv0CoiR_ruSw?e=42lnIR

LIST OF ESSENTIAL HEALTH PACKAGE

Annex A: List of diagnostic OPD services

Amount = estimated price per service

X-RAYS		
Sr. No	**Description of Services**	**Amount**
1	PERCUTANEOUS TRANSHEPATIC CHOLANG	5.000
2	T-TUBE CHOLANGIOGRAPHY	3.000
3	MCUG	7.000
4	HSG	4.000
5	MYELOGRAPHY	5.000
6	SIALOGRAPHY	5.000
7	LOOPOGRAM	4.000
8	SINOGRAPHY / FISTULOGRAPHY	4.000
9	DUCTOGRAPHY BREAST (SINGLE)	4.000
10	ENEMA REDUCTION OF INTUSSUSCEPTION	7.000
11	X-RAY CHEST PA	800
12	C/SPINE AP.LAT	1.000
13	L.P SPINE AP.LAT	1.000
14	T/SPINE AP.LAT	1.000
15	HAND AP.LAT	1.000
16	SKULL AP.LAT	1.000
17	CHEST LAT	800
18	CHEST AP.LAT	1.000
19	WRIST JOINT	1.000
20	SHOULDER JOINT AP.LAT	1.000
21	KNEE JOINT AP.LAT	1.000

22	PELVIS	800
23	LEG AP.LAT	1.000
24	FOOT AP.LAT	1.000
25	ANKLE JOINT AP	1.000
26	N/BONE B/L	1.000
27	FEMUR AP.LAT	1.000
28	FOREARM AP.LAT	1.000
29	PNS PA	1.000
30	MANDIBLE AP.LAT	800
31	MAMMOGRAPHY	1.200
32	XR FACIAL BONES SINGLE	800
33	XR FACIAL BONES	1.000
34	XR ORBITS AP VIEW	800
35	XR ORBITS AP,LAT VIEW	1.000
36	XR NECK AP VIEW	800
37	XR NECK AP, LAT VIEW	1.000
38	XR CERVICAL SPINE AP, LAT VIEW	1.000
39	XR CERVICAL SPINE AP,LAT,OBLIQUE VIEW	1.450
40	XR SHOULDER JOINT ONE AP,LAT VIEWS	1.000
41	XR SHOULDER JOINT BOTH AP,LAT VIEWS	2.000
42	XR CHEST LORDOTIC VIEW	800
43	XR THORACIC SPINE AP,LAT VIEW	1.000
44	XR LS SPINE AP,LAT VIEWS	1.000
45	XR PELVIS	800
46	XR BOTH HIPS AP,LAT VIEWS	2.000
47	XR FEMUR AP,LAT VIEWS	1.000

48	XR KNEE JOINT AP VIEW	1.000
49	XR BOTH KNEE JOINT AP,LAT AND SKYLINE	2.500
50	XR KNEE SL VIEW (SINGLE SIDE)	800
51	XR BOTH KNEES AP SINGLE VIEW	1.000
52	XR BOTH KNEES AP,LAT VIEWS SL WEIGHT BEARING	2.500
53	XR TIBIA/FIBULA AP,LAT VIEWS	1.000
54	XR ANKLE AP,LAT VIEWS	1.000
55	XR FOOT AP,LAT VIEWS	1.000
56	XR HAND AP VIEW (SINGLE VIEW)	800
57	XR HAND AP,LAT VIEWS	1.000
58	XR WRIST JOINT AP VIEW (SINGLE VIEW)	800
59	XR WRIST JOINT AP,LAT VIEWS	1.000
60	XR RADIUS/ULNA AP,LAT VIEWS	1.000
61	XR ADENOIDS (SINGLE VIEW)	800
62	XR HEAL AP,LAT VIEWS (TWO VIEWS)	1.000
63	XR HEAL AP VIEW	800
64	XR ELBOW AP,LAT VIEWS	1.000
65	XR HUMERUS AP,LAT VIEWS	1.000
66	XR SHOULDER AP VIEW	800
67	XR SHOULDER AP,LAT VIEWS	1.000
68	XR KUB	800
69	XR ABDOMEN (ERECT)	800
70	XR ABDOMEN (SUPINE)	800
71	XR SKULL AP,LAT VIEWS	1.000
72	XR BOTH HANDS AP (TWO VIEWS)	1.000
73	XR BOTH HANDS AP,LAT VIEWS (FOUR VIEWS)	2.000

74	XR BOTH WRISTS AP	1.000
75	XR BOTH WRISTS AP,LAT (FOUR VIEWS)	1.800
76	XR OPG	1.200
77	XR HAND INDEX FINGER AP,LAT	1.000
78	XR T1 V1 JOINTS(OPEN,CLOSED AND CLENCHED)	2.500
79	XR CHEST PA (FOR MEDICAL EXAMINATION)	800
80	XR LEG OR T/F AP LATERAL-ANY SIZE	1.000
81	XR NASAL BONE BOTH SIDES AP,LAT	2.000
82	XR FOOT AP, LAT ,OBLIQUE	1.450
83	X-RAY IMAGE (CD)	200
84	XR CLAVICAL	12.000
85	XR CHEST APICAL VIEW	700
86	XR CHEST BOTH LAT VIEWS	600
87	XR PNS SINGLE PA VIEW	800
88	XR KNEE JOINT AP,LAT VIEWS	1.000
89	XR PNS LAT VIEW	800
90	XR PNS OM VIEW	800
91	XR MASTOID BOTH (TWO VIEW)	1.000
92	XR CHEST PA VIEW	800
93	XR TM JIONTS OPEN & CLOSED	1.700
94	XR MANDIBLE PA,OBLIQUE VIEW (SINGLE SIDE)	1.000
95	XR MANDIBLE PA,OBLIQUE VIEW (BOTH SIDE)	2.000
96	XR NASAL BONES BOTH SIDES	1.000
97	XR SHOULDER JOINT	800
98	XR LUMBER SPINE AP/LAT & CONDOWN VIEW	1.500
99	XR EXTRA FILM CHARGES	350

100	XR CEPH	1.000
101	XR CHEST PA/LAT	1.000
102	XR WHOLE SPINE (PEADS)	1.200

ULTRASOUND		
Sr. No	**Description of Services**	**Amount**
1	US BIOPHYSICAL PROFILE	4.000
2	US FWB TWINS	3.500
3	US ANOMALY SCAN TWINS	5.000
4	US KUB	1.200
5	US KUB AND PELVIS	2.000
6	US GENITAL/TESTICULAR	2.500
7	US HEPATIC DOPPLER	4.000
8	US VARICOSE VEINS SINGLE	4.000
9	US VARICOSE VEINS DOUBLE	7.000
10	US DIALYSIS FISTULA DOPPLER	2.500
11	US ILIAC DOPPLER FOR TRANSPLANT KIDNEY	3.500
12	PERCUTANEOUS NEPHROSTOMY	10.000
13	PERCUTANEOUS LUNG BIOPSY	5.000
14	ARTHROGRAPHY INJECTION	3.000
15	USG GUIDED FNAC / BIOPSY	8.000
16	PERCUTANEOUS THERAPEUTIC RENAL CYST	5.000
17	PERICARDIAL EFFUSION CATHETER DRAINAGE	5.000
18	ASCITIC / PLEURAL FLUID ASPIRATION DIAG	5.000
19	ASCITIC / PLEURAL FLUID ASPIRATION THE	6.000

20	USG GUIDED PERCUTANEOUS DRAINAGE	5.000
21	AMNIOCENTESIS / CHORONIC VILLOUS SA	5.000
22	ULTRASOUND (BREAST)	2.500
23	ASITIC FUID ASPIRATION	5.000
24	DOPPLER (CAROTID)	5.000
25	DOPPLER (PERIPHERAL-ARTERIAL)	4.000
26	DOPPLER (PERIPHERAL-VENOUS)	4.000
27	DOPPLER RENAL ARTERY DOPPLER	4.000
28	DOPPLER VEINOUS STUDY FOR DVT (BOTH)	7.000
29	DOPPLER VEINOUS STUDY FOR VARICOSE VEINS	7.500
30	FETAL DOPPLER	3.600
31	KIDNEYS ONLY	4.000
32	PANCREAS ONLY	2.000
33	ULTRASOUND (ABDOMEN AND PELVIS)	2.000
34	US ASITIC FLUID ASPIRATION (USG GUIDANCE FOR ASPIRATION)	3.000
35	DOPPLER CAROTID	3.500
36	DOPPLER (PERIPHERAL-ARTERIAL) PER LEG	3.000
37	DOPPLER (PERIPHERAL-VENOUS) PER LEG	2.000
38	DOPPLER RENAL ARTERY	3.600
39	DOPPLER VENOUS STUDY FOR DVT BOTH	3.600
40	DOPPLER VENOUS STUDY FOR VARICOS VIENS	3.600
41	DOPPLER FETAL	3.600
42	US KIDNEYS ONLY	1.500
43	US PANCREAS ONLY	1.500
44	US ABDOMEN & PELVIS	3.000
45	US BREAST	1.800

46	US CRANIAL	2.000
47	US PORTABLE	1.800
48	US THYROID	2.500
49	US TRANS-VEGINAL	4.500
50	US ABDOMEN	2.000
51	US BOTH ORBITS	2.000
52	US CHEST	2.000
53	US GUIDED FNA+TRUCUT-SUPERFECIAL LESION	10.000
54	US GUIDED BREAST CYST ASPIRATION	5.000
55	US HIPS BILATERAL	4.000
56	US I.V.F FOLLICULAR MONITERING (THREE USG)	3.600
57	US MARKING FOR NEEDLE BIOPSY	3.000
58	US PELVIS	2.000
59	US PELVIS OBSTETRIC	2.500
60	US PROSTATE	2.000
61	US GYNAE ABDOMEN	850
62	US KIDNEY,URETER,BLADDER	2.000
63	DOPPLER UPPER LIMB VENOUS BOTH	4.000
64	US UPPER LIMB VENOUS ARTERIAL SINGLE	3.000
65	US UPPER LIMB VENOUS ARTERIAL BOTH	6.000
66	US ANOMALY SCAN	4.000
67	US FETAL WELL-BEING	2.000
68	US SOFT TISSUES (SINGLE)	2.000
69	US SOFT TISSUES (DOUBLE)	3.000
70	US BREAST (DOUBLE)	4.000
71	US KUB PELVIS FEMALE	2.000

PORTABLE X-RAYS		
Sr. No	**Description of Services**	**Amount**
1	PXR CHEST PA	1.300
2	PXR C/SPINE AP.LAT	1.500
3	PXR L.P SPINE AP.LAT	1.500
4	PXR T/SPINE AP.LAT	1.500
5	PXR HAND AP.LAT	1.500
6	PXR SKULL AP.LAT	1.500
7	PXR SHOULDER JOINT ONE AP,LAT VIEWS	1.500
8	PXR SHOULDER JOINT BOTH AP,LAT VIEWS	1.500
9	PXR CHEST LAT	1.300
10	PXR CHEST AP.LAT	1.500
11	PXR WRIST JOINT	1.500
12	PXR SHOULDER JOINT AP.LAT	1.500
13	PXR KNEE JOINT AP.LAT	1.500
14	PXR LEG AP.LAT	1.500
15	PXR FOOT AP.LAT	1.500
16	PXR ANKLE JOINT AP	1.500
17	PXR N/BONE B/L	1.500
18	PXR FEMUR AP.LAT	1.500
19	PXR FOREARM AP.LAT	1.500
20	PXR PNS PA	1.500
21	PXR MANDIBLE AP.LAT	1.300
22	PXR FACIAL BONES SINGLE	1.300
23	PXR FACIAL BONES DOUBLE	1.500

24	PXR ORBIT AP VIEW	1.300
25	PXR ORBIT AP,LAT VIEW	1.500
26	PXR NECK AP VIEW	1.500
27	PXR CERVICAL SPINE AP,LAT VIEW	1.500
28	PXR CERVICAL SPINE AP,LAT,OBLIQUE VIEW	1.500
29	PXR CHEST LORDOTIC VIEW	1.300
30	PXR THORACIC SPINE AP,LAT VIEW	1.500
31	PXR LS SPINE AP,LAT VIEW	1.500
32	PXR PELVIS	1.300
33	PXR BOTH HIPS AP, LAT VIEWS	2.500
34	PXR FEMUR AP,LAT VIEWS	1.500
35	PXR BOTH KNEE JOINT AP,LAT AND SKYLINE	3.000
36	PXR KNEE SL VIEW (SINGLE SIDE)	1.300
37	PXR BOTH KNEES AP SINGLE VIEW	1.500
38	PXR BOTH KNEES AP,LAT VIEWS SL WEIGHT BEARING	3.000
39	PXR TIBIA/FIBULA AP,LAT VIEWS	1.500
40	PXR ANKLE AP,LAT VIEWS	1.500
41	PXR FOOT AP ,LAT VIEWS	1.500
42	PXR HAND AP VIEW (SINGLE VIEW)	1.300
43	PXR HAND AP,LAT VIEWS	1.500
44	PXR WRIST JOINT AP VIEW (SINGLE VIEW)	1.300
45	PXR WRIST JOINT AP, LAT VIEWS	1.500
46	PXR RADIUS/ULNA AP,LAT VIEWS	1.500
47	PXR ADENOIDS (SINGLE VIEW)	1.300
48	PXR HEAL AP,LAT VIEWS (TWO VIEWS)	1.500
49	PXR HEAL AP VIEW	1.300

50	PXR ELBOW AP,LAT VIEWS	1.500
51	PXR HUMERUS AP,LAT VIEW	1.500
52	PXR SHOULDER AP VIEW	1.300
53	PXR SHOULDER AP, LAT VIEWS	1.500
54	PXR KUB	1.300
55	PXR ABDOMIN (ERECT)	1.300
56	PXR ABDOMEN (SUPINE)	1.300
57	PXR SKULL AP,LAT VIEWS	1.500
58	PXR BOTH HANDS AP(TWO VIEWS)	1.500
59	PXR BOTH HANDS AP,LAT VIEWS (FOUR VIEWS)	2.500
60	PXR BOTH WRIST AP	1.500
61	PXR BOTH WRIST AP,LAT (FOUR VIEWS)	2.500
62	PXR OPG	1.700
63	PXR HAND INDEX FINGER AP,LAT	1.500
64	PXR CHEST PA (FOR MEDICAL EXAMINATION)	1.300
65	PXR LEG OR T/F AP LATERAL	1.500
66	PXR NASAL BONE BOTH SIDES AP,LAT	2.500
67	PXR FOOT AP,LAT, OBLIQUE	1.950
68	PXR CLAVICAL	1.300
69	PXR CHEST APICAL VIEW	1.300
70	PXR CHEST BOTH LAT VIEW	1.500
71	PXR KNEE JOINT AP, LAT VIEW	1.500
72	PXR CHEST PA VIEW	1.300
73	PXR MANDIBLE PA,OBLIQUE VIEW (SINGLE SIDE)	1.500
74	PXR MANDIBLE PA,OBLIQUE VIEW (BOTH SIDES)	2.500
75	PXR NASAL BONES BOTH SIDES	1.500

76	PXR SHOULDER JOINT	1.300
77	PXR LUMBER SPINE AP/LAT & CONDOWN VIEW	2.000
78	PXR CHEST PA/LAT	1.500
79	PXR WHOLE SPINE (PEADS)	1.700
80	PXR KNEE JOINT AP VIEW	1.500
81	PXR SHOULDER JOINT BOTH AP,LAT VIEWS	2.500

PORTABLE ULTRASOUND		
Sr. No	**Description of Services**	**Amount**
1	PUS BIOPHYSICAL PROFILE	5.000
2	PUS FWB TWINS	4.500
3	PUS ANOMALY SCAN TWINS	6.000
4	PUS KUB AND PELVIS	2.800
5	PUS GENITAL/TESTICULAR	2.800
6	PUS HEPATIC DOPPLER	4.500
7	PUS VARICOSE VEINS SINGLE	4.000
8	PUS VARICOSE VEINS DOUBLE	6.000
9	PUS DIALYSIS FISTULA DOPPLER	3.500
10	PUS ILIAC DOPPLER FOR TRANSPLANT KIDNEY	4.500
11	P PERCUTANEOUS NEPHROSTOMY	11.000
12	P PERCUTANEOUS LUNG BIOPSY	6.000
13	P USG GUIDED FNAC/ BIOPSY	7.000
14	P PERCUTANEOUS THERAPEUTIC RENAL CYST	6.000
15	P PERICARDIAL EFFUSION CATHETER DRAINAGE	6.000
16	P ASCITTIC/ PLEURAL FLUID ASPIRATION DIAG	4.000

17	P ASCITIC / PLEURAL FLIUD ASPIRATION THE	6.000
18	P USG GUIDED PERCUTANEOUS DRAINAGE	6.000
19	P ULTRASOUND (BREAST)	2.800
20	P ASITIC FUID ASPIRATION	4.000
21	P DOPPLER (PERIPHERAL-ARTERIAL)	4.000
22	P DOPPLER (PERIPHERAL-VENOUS)	3.000
23	P DOPPLER RENAL ARTERY DOPPLER	4.500
24	P DOPPLER VEINOUS STUDY FOR DVT (BOTH)	5.000
25	P DOPPLER VEINOUS STUDY FOR VARICOSE VEINS	4.000
26	P FETAL DOPPLER	4.600
27	P KIDNEYS ONLY	2.500
28	P ULTRASOUND (ABDOMEN AND PELVIS)	3.000
29	P PANCREAS ONLY	2.500
30	P DOPPLER CAROTID	4.500
31	P DOPPLER UPPER LIMB VENOUSBOTH	5.000
32	PUS UPPER LIMB VENOUS ARTERIAL SINGLE	4.000
33	PUS ANOMALY SCAN	3.500
34	PUS FETAL WELL-BEING	3.000
35	PUS SOFT TISSUE (SINGLE)	2.500
36	PUS SOFT TISSUES (DOUBLE)	4.000
37	PUS BREAST (DOUBLE)	4.600
38	PUS KUB PELVIS FEMALE	3.000
39	PUS ASITIC FLUID ASPIRATION (USG GUIDANCE FOR ASPIRATION)	3.000
40	PD DOPPLER CAROTID	3.250
41	PD DOPPLER (PERIPHERAL-ARTERIAL) PER LEG	4.000
42	PD DOPPLER (PERIPHERAL-VENOUS) PER LEG	3.000

43	PD DOPPLER RENAL ARTERY	4.600
44	PD DOPPLER VENOUS STUDY FOR DVT BOTH	5.000
45	PD DOPPLER VENOUS STUDY FOR VARICOS VIENS	4.000
46	PD FETAL DOPPLER	4.000
47	PUS KIDNEYS ONLY	2.500
48	PUS PANCREAS ONLY	2.500
49	PUS ABDOMEN & PELVIS	3.000
50	PUS BREAST	2.500
51	PUS CRANIAL	2.500
52	PUS PORTABLE	2.000
53	PUS THYROID	3.000
54	PUS TRANS-VEGINAL	4.000
55	PUS ABDOMEN	2.500
56	PUS BOTH ORBITS	3.000
57	PUS CHEST	2.000
58	PUS GUIDED FNA+TRUCUT-SUPERFECIAL LESION	6.000
59	PUS GUIDED BREAST CYST ASPIRATION	6.000
60	PUS HIPS BILATERAL	3.000
61	PUS I.V.F FOLLICULAR MONITERING (THREE USG)	5.000
62	PUS MARKING FOR NEEDLE BIOPSY	2.500
63	PUS PELVIS	2.500
64	PUS PELVIS OBSTETRIC	3.000
65	PUS PROSTATE	2.500
66	PUS GYNAE ABDOMEN USG	1.100
67	PUS KIDNEY,URETER,BLADDER	2.500

Special Chemistry		
Sr. No	Description of Services	Amount
1	Erythropoietin levels	8.000
2	Anti Intrinsic factor Ab	3.850
3	Anti Parietal cell Ab	7.000
4	HbA1c (Glycated Hemoglobin)	1.200
5	Thyroid Function Tests (TFTs)	3.200
6	Free T3	1.100
7	Free T4	1.100
8	TSH	1.200
9	B-HCG	1.500
10	FSH	1.500
11	LH	1.500
12	Prolactin	1.500
13	Total PSA	2.000
14	Serum Ferritin	1.400
15	Vancomycin Trough Levels	1.730
16	HIV (ELIZA/ELFA)	1.800
17	Vitamin D Total	3.000
18	Bone Profile	5.150
19	Free Testosterone	3.200
20	HOMA-IR (Homeostatic Model of Insulin Resistance)	2.850
21	HbsAg (Hepatitis B surface antigen) Architect	1.800
22	Anti-HCV Antibodies (Architect)	1.800
23	hsTnI (High Sensitivity Trop I) /Cardiac Enzyme	1.600

24	C-Reactive Protein (Quantitative)	850
25	Interleukin 6 (IL-6)	1.770
26	Progesterone	1.900
27	C3	1.450
28	C4	1.300
29	Cyclosporine	6.000
30	ENA Profile	6.300
31	Gamma GT	550
32	HEV IgM	2.500
33	IgE	1.200
34	Iron	700
35	Lipase	1.150
36	Magnesium	800
37	Parietal Cell Ab	2.750
38	B12	1.600
39	BNP/NT-pro BNP	4.000
40	Hep A IgG	2.250
41	Hep A IgM	2.250
42	Anti TG (Thyroglobulin Ab)	1.400
43	Anti TPO	1.400
44	Carbamazepine	1.550
45	CEA	2.300
46	Anti CCP	2.650
47	ANA Screen	2.500
48	CVM IgG	1.450
49	CVM IgM	1.750

50	Alpha Fetoprotien (AFP)	2.150
51	Anti Cardiolipin IgG	3.700
52	Anti Cardiolipin IgM	3.700
53	CA 125	3.000
54	CA-19-9	3.500
55	CMV IgG	1.550
56	CMV IgM	1.900
57	Cortisol	1.650
58	C-Peptide	3.500
59	D-Dimer	2.000
60	DHEA-SO4	2.300
61	Digoxin	1.700
62	Estradiol (Oestradiol) (E2)	1.800
63	Folate (Folic Acid)	1.500
64	Free Androgen Index	2.750
65	Hep B Core IgM	2.250
66	Hep B Core Total	2.250
67	Hep Be Ag	2.250
68	Hep Be Antibody	2.000
69	Hep Bs Ag (E) (Qualitative)	1.400
70	Hep Bs Antibody	1.500
71	Hep C Ab	2.350
72	Hep B Profile (CoreM, CoreT, HBE Ag, AntiBE, AntiBs)	10.000
73	HIV I/II Antibody	1.950
74	Homocystine	2.000
75	HSV I & II IgM	1.800

76	Insulin (Fasting)	2.500
77	PTH (PARATHYROID Hormone)	2.250
78	Rubella IgG	1.500
79	Rubella IgM	1.700
80	Sex Hormone Binding Globulin (SHBG)	2.250
81	Tacrolimus (FK506)	6.700
82	Testosterone	1.750
83	Thyroid Antibodies (Anti-Tg, Anti-TPO)	2.750
84	Torch Profile (ToxoM, RubelaM, CMVM, HSV)	7.500
85	Torch Screening (Toxo G & M, Rubela G & M,CMV G&M, HSV)	7.500
86	Toxoplasma IgG	1.300
87	Toxoplasma IgM	1.500
88	Urine Cannabinoides	2.300
89	Urine Opiates	1.850
90	Valproic Acid (Epilim)	1.600
91	Vitamin D Total 25-OH	2.800
92	24 hr Urinary VMA	2.450
93	Adrenocorticotropic Hormone (ACTH)	3.800
94	HYDROXY PROGESTERONE	3.950
95	KARYOTYPING	7.500
96	Syphilis (Anti TP)	1.200
97	Procalcitonin (PCT)	6.000
98	ACE Levels	3.800
99	Ammonia	1.200
100	Lactate	1.250
101	24 Hrs Urinary Copper	2.100

102	Serum Ceruloplasmin	2.000

Serology		
Code	**Description of Services**	**Amount**
1	Syphilis ICT	450
2	Mycodot	550
3	Dengue Serology	2.150
4	ASOT	900
5	Serum H. Pylori IgM	1.800
6	Viral Serology (Screening)	1.000
7	MP ICT	500
8	Anti-ds DNA	1.900
9	Brucella	1.000
10	FDP	1.800
11	H. Pylori Antibody Quantitative (Elisa)	1.800
12	Stool For H. Pylori Antigen	4.800
13	Monospot	1.100
14	TB IgG & IgM (ELISA)	1.500
15	Widal	900
16	Gene Xpert MTB PCR	4.000
17	HIV ICT	550
18	VDRL / RPR / Syphilis	550
19	Mantoux Test (5 TU, 10 TU)	400
20	Urthral Smear Gram Stain (GC,PC)	300

Microbiology		
Sr. No	**Description of Services**	**Amount**
1	Gram Stain	500
2	Leishman Stain	350
3	COVID-19 IgG	1.500
4	COVID-19 IgM	1.500
5	COVID-19 IgG & IgM	2.500
6	Culture for Any Site (EXCEL-LAB)	1.900
7	Culture for HVS	1.600
8	Culture for Urine	1.600
9	Culture for Any Site	1.500
10	Culture for Blood	1.700
11	Culture for Bone Marrow	1.650
12	Culture for CSF	1.600
13	Culture for Ear Swab	1.600
14	Culture for Nasal Swab	1.600
15	Culture for PUS	1.600
16	Culture for Semen	1.600
17	Culture for Sputum	1.600
18	Culture for Stool	1.600
19	Culture for Throat Swab	1.600
20	Culture for Uretheral Swab	1.500
21	Culture for Water	1.600
22	Air Sampling for Bacterial Culture	1.550
23	Surface Sampling for Bacterial Culture	1.550
24	Equipment Sampling for Bacterial Culture	1.550
25	Z. N. Stain	350

Profiles		
Code	**Description of Services**	**Amount**
1	RBC Morphology (Profile)	1.100
2	Medical Examination Profile 1	250
3	Viral Hepatitis Profile	2.400
4	Medical Examination Profile	1.250
5	Nephro Followup (I) for negative patients	5.000
6	Nephro Followup (II) for HCV positive patients	4.400
7	Bone Profile Without PTH	4.430
8	Cardiac-1	5.500
9	Cardiac-2	3.900
10	Cardiac-3	8.050
11	Cardiac-4	2.750
12	Peripheral Film with CBC	1.000
13	Bone Profile With PTH	6.320
14	Nephro Followup (III) for HBV positive patients	3.800

Immunology		
Sr. No	**Description of Services**	**Amount**
1	Tissue Typing HLA A-B DR	24.300
2	Tissue Typing Total HLA	30.350
3	HLA-B27 Typing (BS-22)	10.800
4	Chronic Lymphoid Leukemia (CLL) IFT Panel	18.360
5	Immunization Challenge Test	4.860
6	IgA, IgG, IgM, IgE Assay	5.640
7	17 Hydroxy Progesterone (17OHP)	5.970
8	Acetyl Cho lene Receptor Antibody	4.650

9	Ab to Heparin & Platelet Factor 4 IgG	9.290
10	AFB C/S	4.050
11	Aldosterone	4.050
12	Aldosterone Renin Ratio	6.380
13	Alpha 1 Antitrypsin	2.160
14	AMA	1.620
15	ANA Anti nuclear Antibody	2.160
16	ANA Group/ Autoimmune Liver Profile	2.450
17	ANCA-Anti GBM Profile	4.860
18	ANCA-Antineutrophil Cytoplasmic Ab (CE45)	4.200
19	Androstenedione	6.480
20	Angiotensin Convert. Enzym (ACE)	5.620
21	Anti Mullerian Hormone	5.780
22	Anti Adrenal Ab IgG	2.700
23	Anti Aquaporin 4 Ab	7.000
24	Anti Centromere Antibodies	2.160
25	Anti dsDNA + Anti Histone + Anti Nucleosome	3.350
26	Anti GAD Antibodies	1.620
27	IGG ANTI GANGLIOSIDES ANTIBODIES	3.250
28	Anti Gastric Parietal Cell AB	2.160
29	Anti GBM	3.860
30	Anti Gliadin IgA (CE48)	2.700
31	Anti Gladin IgG (CE49)	3.350
32	Anti Insulin AB	2.200
33	Anti Islet CellAntibodies/GAD Antibodies	2.160
34	Anti LKM	2.330
35	ANTI MOG Antibody (Anti Myelin Olgodentroyte Glycoprotein)	5.780
36	Anti Neuronal Profile	5.510
37	Anti Thrombin III	5.940
38	Anti TSH Receptor Ab	2.850
39	Anti VGKC Associated Protein	7.550
40	Antibody Identification	4.110

41	Antibody Screening	1.140
42	Anticardiolipin IgG (CE22)	3.240
43	Antibody Titration	1.620
44	Anticardiolipin IgM (CE23)	3.240
45	ANTI-Phospho Lipase A2 Receptor	4.220
46	Antitransglutaminase IgA	2.490
47	Antitransglutaminase IgG	2.490
48	Any other non-cancer hereditary panel	155.000
49	ASMA	1.620
50	B/M For Karyotyping of Sex Mismatched B/M transplantation	7.560
51	BCR - ABL BY FISH	14.420
52	BCR - ABL Quantification	23.600
53	Beta 2 Glycoprotein IgG	1.620
54	Beta 2 Glycoprotein IgM	1.620
55	Beta 2 Micro Globulin	4.220
56	Blood For PNH Disease (CD55+CD59)	17.280
57	Blood Ketone	540
58	Blood Led Level	6.480
59	Body Fluid CA 19-9	4.050
60	Body Fluid CEA	3.140
61	Brca 1,2	60.000
62	CD4 Counts(Lymphocyte Subsets)	21.600
63	CDC Cytoxicity Crossmatch-Quantitative	16.200
64	Celiac DQA1/DQB1	20.850
65	Cento Cancer	145.000
66	CentoDx	145.000
67	CentoNIPT	60.000
68	Centoscreen	185.000
69	Centoxome	155.000
70	Ceruloplasmin	2.000
71	Clostrdium Diffcile (PCR For Toxin & Antigen) (Genexpert)	3.250
72	CMV IgG	2.160

73	CMV IgM	2.160
74	Cold Agglutinin (HS08)	650
75	Complement Dependent Cellular Cytotoxity Xmat	7.290
76	Copper	1.840
77	C-Peptide	5.350
78	Cryptococcus Neoformans Antigen	2.270
79	Crystal Examination	1.300
80	CT/NG DETECTION & DIFFERENTIATION (GENEXPERT)	12.750
81	Cyclosporine	5.940
82	DHEA-SO4	2.970
83	Digoxin Level (Lenoxin)	1.840
84	Dihydrorhodamine (DHR)	5.510
85	Discharge - Cytology	1.620
86	Drugs of Abuse Screening Profile	13.400
87	Echinococcus IHA	2.500
88	Effusion - Cytology	2.970
89	ENA Profile (CE24)	6.750
90	Endomysium IgA	2.700
91	Erythropoietin	10.800
92	Estradiol	1.800
93	Extended Auto immune Liver Profile	4.430
94	Factor - VIII	2.650
95	Factor II & V Mutation	16.900
96	FILM ARRAY GASTROINTESTINAL (GI) PANEL	40.900
97	FILM ARRAY MENINGITIS/ENCEPHALISTIS (ME) PANEL	47.200
98	FILM ARRAY RESPIRATORY PANEL	41.580
99	FISH ANALYSIS OF XX/XY	19.660
100	Flow Cross Match	19.440
101	Flu A, Flu B & 2009 H1N1 By PCR (GeneXpert)	9.510
102	Gastrin	5.190
103	Gentamicin (Gentacin)	2.430
104	Growth Hormone	2.220

105	Helicobacter	2.970
106	Hepatitis A Virus Ab IgM	2.380
107	Hepatitis A Profile	4.490
108	Hepatitis A Virus AB IgG	2.270
109	Hepatitis B Core IgM	2.380
110	Hepatitis Be Antibody	2.380
111	Hepatitis Be Antigen	2.380
112	Hepatitis C Virus Genotyping	18.700
113	Hepatitis Delta Antibody	4.110
114	Hepatitis E Virus Ab (HEV)	3.000
115	Hepatitis E Virus IgG (HEV IgG)	3.410
116	HepatitisB Core Ab (HBc Ab) (total)	2.060
117	HepatitisB Profile(HBsAg, HBCAb, HBSb)	4.860
118	Her2Neu By Fish	34.670
119	Herpes Simplex Virus BY PCR	6.550
120	HERPES-1/2 IgG	2.220
121	HERPES- 1/2 IgM	2.380
122	HLA Typing (Class I)	19.440
123	HLA Typing (Class II)	10.970
124	HLA-B27 Typing (BS-22)	10.800
125	Homocysteine	2.540
126	Human C1 Inactivator NL RID	3.840
127	IgG	1.140
128	IGG INDEX	7.290
129	IgM	1.140
130	Immunoflourescence 2 Ab	5.510
131	Immunoflourescence	8.210
132	Immunofluorescence Skin	7.620
133	Immunoglobulins	2.920
134	Immunogloublin IGG Sub class	10.320
135	Immuno histochemistry (02 Antibodies)	5.240
136	Immunohistochemistry (Lymphoma Panel)	9.180

137	India Ink Preparation	540
138	Infectious Mononucleosis (monospot)	1.250
139	Influenza A & Influenza B viruses	2.160
140	Inhalation Specific Allergen IgE	9.510
141	Insect Venom IgE	3.950
142	Insulin	4.160
143	Insulin-like growth Factor-1 (IGF-1)	8.210
144	Insulinoma-associated Antigen 2 (IA2)	1.620
145	Intrinsic Factor Ab IgG	1.620
146	Leukemia Basic Panel	20.520
147	Leukemia Coprehensive Panel	21.600
148	Leukemia Screening Panal	14.580
149	Lithium	1.520
150	Luminex Class I AB Detection	30.350
151	Luminex Class II AB Detection	32.780
152	Luminex SAB Class 1 (Single AG BEADS)	53.410
153	Luminex Screen For Anti HLA AB	21.600
154	Lumnex SAB Class II (Single AG Beads)	43.200
155	Lupus Anticogulant	5.300
156	Meningitis Serology Test (LPA)	4.590
157	MIC-Amphotericin B	1.550
158	Methotrexate	3.140
159	MIC- Ceftriaxone	1.550
160	MIC-Colistin	4.050
161	MIC-Fluconazole	1.680
162	Microflaria	650
163	Microscopic Examination	390
164	MIC-Tigecycline	1.680
165	MIC-Voriconazole	1.550
166	Milk Microbal Analysis	2.000
167	MTB DNA by PCR (GenXpert)(MS44)	7.510
168	Mucopolysacchrides	710

169	Myeloma /Plasma Cells	17.660
170	Nitro Blue Tetrazolium (NTB) reduction test	1.300
171	NMDA Receptor Ab IgG By Serum	9.500
172	NMDA Receptor Ab IgG CSF	9.500
173	Oligoclonal Bands	6.590
174	Other Hereditary cancer Panel	145.000
175	Pancreatic Cyst Profile with CA 19-9 (PCP)	4.920
176	Pap Smear - Cytology	2.000
177	PCP Silver Stain	540
178	PCR for Donor Chimerism	19.340
179	Peripheral Blood for fanconi Anemia	9.720
180	Peripheral Blood For Karyotyping	11.880
181	Phenobarbitol	2.000
182	Phenytoin (Dilantin)	1.680
183	PIVKA II	2.600
184	PML/RARA By Fish	14.880
185	Progesterone	1.900
186	Protein S (CE31)	5.300
187	Protein C	5.300
188	RBC Folate	3.240
189	Renal Stone Analysis	2.700
190	Renal Transplant Biopsy Profile	10.970
191	Renin	4.160
192	Respiratory Syncytial Virus (RSV)	1.620
193	Reticulocyte Count	960
194	Rotavirus & Adenovirus in feces	2.000
195	Rubella IgG	1.840
196	Rubella IgM	2.270
197	S.Tricyclic Antidepressants (TCD)	1.680
198	Screening Test for LAD	10.800
199	Serum Cryoglobulin	650
200	Serum Free Light Chain (Kappa + Lambda)	7.560

201	Serum Immunofixation	9.720
202	Spot Urine Porphobilinogen	980
203	Stool Cryptosporidium	6.320
204	Streptococcus Group A Antigen	1.550
205	Sugar Chromatography	2.600
206	Tetanus Toxoid IgG	1.620
207	Theophylline (Aminophylline)	2.270
208	Thyroglobulin	2.600
209	Thyroid Antibodies	2.380
210	Torch Profile	7.400
211	Toxo IgM	1.840
212	Toxo-G	1.730
213	Toxoplasma Antibody	1.250
214	TPHA	2.330
215	U.ALA	4.700
216	U.Amphetamine	1.890
217	U.Barbiturates	1.680
218	U.Benzodiazepine	1.730
219	U.Cannabinoid	2.160
220	U.Citric Acid	2.270
221	U.Cocaine	1.890
222	U.Meth .Dioxy Methamphetamine (MDMA)	2.000
223	U.Methadone (MTD)	2.000
224	U.Methamphetamine (MET)	1.730
225	U. Morphine(MOP)	1.980
226	U.Opiates	1.840
227	U.Phencyclidine (PCP)	1.680
228	Urea/UNN Urine	720
229	Urine Copper	2.760
230	Vancommycin	1.730
231	Vanillyl Mandelic Acid (VMA)	2.870
232	Varicella Zoster Antibody IgG	2.490

233	Water Microbial Analysis	2.110
234	Galactomannan By Elisa	3.000
235	HEP DELTA VIRUS (QL/QT) & HEP B PCR (QL)	12.000
236	HEP DELTA VIRUS (QL/QT) & HEP B PCR(QT)	18.000
237	ANCA IgG	4.430
238	FISH ANALYSIS OF LSI 1p36/1q25 & LSI 19q13/19p 13	25.440
239	FISH ANALYSIS OF MILL GENE REARRANGEMENT	17.930
240	GBS (GROUP B STREPTOCOCCUS) PCR (GENEXPERT)	13.670
241	HEPATITIS DELTA VIRUS (HDV) BY PCR (QUAL/QUANT)	7.500
242	IgM Anti Ganglioside Antibodies	3.780
243	IHC (BRAF V600-1 AB)	8.540
244	IHC (PDL-1 AB)	7.350
245	Microsatellite Instability Profile- MSI	12.150
246	PANCREATIC CYST PROFILE W/O CA 19-9	3.410
247	QuantiFERON-TB	7.560
248	Beta-D-Glucan	7.000

Histopathology		
Sr. No	**Description of Services**	**Amount**
1	Cytology (any site)	2.000
2	IHC (Vimentin)	2.000
3	Cytology (for 2nd opinion)	900
4	Cytology (PAP Smear)	1.100
5	Histo/Biopsy (Large)	6.150
6	Histo/Biopsy (Small)	3.600
7	Histo/Biopsy Needle	3.800
8	IHC (any 4 stains)	5.700
9	IHC (AE-1/AE-3)	1.500
10	IHC (AFP)	1.500
11	IHC (ASMA)	2.000

12	IHC (Calritinin)	2.000
13	IHC (CD-10)	2.000
14	IHC (CD-117)	2.000
15	IHC (CD-3)	2.000
16	IHC (CD-34)	2.000
17	IHC (CD-45)	2.000
18	IHC (CD-5)	2.000
19	IHC (CD-66e)	2.000
20	IHC (Chromogranine)	2.000
21	IHC (CK-20)	2.000
22	IHC (CK-7)	2.000
23	IHC (Desmin)	2.000
24	IHC (ER/PR/Her2N)	12.500
25	IHC (Estrogen Receptor)	6.500
26	IHC (Her 2 New)	5.550
27	IHC (PreogesteroneReceptor)	5.500
28	IHC (RCC)	1.500
29	IHC (S-100 Protein)	2.000
30	IHC (TTF-1)	1.500
31	Cytology (FNA)	3.000

MRI		
Sr. No	**Description of Services**	**Amount**
1	MRI TEMPORAL BONE WITHOUT CONTRAST	12.000
2	MRI CERVICAL SPINE WITHOUT CONTRAST	9.600
3	MRI MRCP	12.000
4	MRI SHOULDER	10.000
5	MRI SI JOINTS	9.600
6	MRI WRIST JOINT WITHOUT CONTRAST	9.600
7	MRI ELBOW WITHOUT CONTRAST	9.600

8	MRI HIP JOINT WITHOUT CONTRAST	9.600
9	MRI FOOT WITHOUT CONTRAST	9.600
10	MRI ANKLE WITHOUT CONTRAST	9.600
11	MRI CERVICAL SPINE WITH CONTRAST	11.000
12	MRI DORSAL SPINE WITH CONTRAST	11.000
13	MRI DORSAL SPINE WITH CONTRAST	11.000
14	MRI DORSAL SPINE WITH CONTRAST	11.000
15	MRI DORSAL SPINE WITH CONTRAST	11.000
16	MRI DORSAL SPINE WITH CONTRAST	11.000
17	MRI DORSAL SPINE WITH CONTRAST	11.000
18	MRI LUMBER SPINE WITH CONTRAST	11.000
19	MRI PELVIS WITH CONTRAST	11.000
20	MRI BRAIN WITH CONTRAST	11.000
21	MRI BRAIN + MRA WITH CONTRAST	17.000
22	MRI BRAIN + MRV + MRA WITH CONTRAST	18.000
23	MRI ORBIT WITH CONTRAST	11.000
24	MRI KNEE JOINT SINGLE WITH CONTRAST	11.000
25	MRI WRIST WITH CONTRAST SINGLE	11.000
26	MRI FOOT WITH CONTRAST SINGLE	11.000
27	MRI ANKLE WITH CONTRAST SINGLE	11.000
28	MRI HIP WITH CONTRAST SINGLE	11.000
29	MRI SI JOINT WITH CONTRAST	11.000
30	MRI SHOULDER WITH CONTRAST	11.000
31	MRI NECK SOFT TISSUE WITH CONTRAST	11.000
32	MRI ABDOMEN PELVIS WITH CONTRAST	17.000
33	MRI ABDOMEN & PELVIS WITHOUT CONTRAST	15.000
34	MRI BRAIN WITHOUT CONTRAST	9.600
35	MRI BRAIN WITH MRA	14.400
36	MRI CERVICAL SPINE WITHOUT CONTRAST	9.600
37	MRI LUMBAR SPINE WITHOUT CONTRAST	9.600
38	MRI DORSAL SPINE WITHOUT CONTRAST (THORACIC SPINE)	9.600
39	MRI EAR/LAMS WITHOUT CONTRAST	12.000

40	MRI FEMUR/THIGH WITHOUT CONTRAST	9.600
41	MRI HUMERUS WITHOUT CONTRAST	9.600
42	MRI FOOT WITHOUT CONTRAST	9.600
43	MRI HAND WITHOUT CONTRAST	9.600
44	MRI ANKLE JOINT WITHOUT CONTRAST	12.000
45	MRI HIP JOINT WITH OUT CONTRAST	9.600
46	MRI KNEE JOINT WITH OUT CONTRAST	9.600
47	MRI WRIST JOINT WITHOUT CONTRAST	9.600
48	MRI LIMITED STUDY WITHOUT CONTRAST	6.600
49	MRI LUMBAR SPINE WITHOUT CONTRAST	9.600
50	MRI PELVIS WITHOUT CONTRAST	9.600
51	MRI PETURITY FOSSA WITHOUT CONTRAST	12.000
52	MRI SHOULDER WITHOUT CONTRAST	9.600
53	MRI SHOULDER BOTH WITHOUT CONTRAST	19.200
54	MRI TM JOINT WITHOUT CONTRAST	9.600
55	MRI SINUSES WITHOUT CONTRAST	9.600
56	MR ELBOW WITHOUT CONTRAST	8.000
57	MRI NECK SOFT TISSUE WITHOUT CONTRAST	9.600
58	MR INTERPRETATION CHARGES FOR MRI	2.400
59	MR BRAIN MRA ONLY	9.600
60	MR BRAIN MRV ONLY	9.600
61	MR BRAIN MRA+MRV WITH CONTRAST	18.000
62	MR FISTULA PERI ANNAL	9.600
63	MR MRA NECK ONLY WITHOUT CONTRAST	9.600
64	MR ORBIT WITHOUT CONTRAST	9.600
65	MR FOREARM WITHOUT CONTRAST	9.600
66	MR TIBIA/LEG WITHOUT CONTRAST	9.600
67	MR KNEE BOTH WITHOUT CONTRAST	18.000
68	MR BRACHIAL PLEXUS WITHOUT CONTRAST	12.000
69	MR BRAIN WITH STROKE PROTOCOL	12.000
70	MR MRA SPECIFIC AREA	7.800
71	MR MRCP	12.000

72	MR EXTRA FILM CHARGES (PER FILM)	600
73	MRI CONTRAST ONLY	3.000
74	MRI LIMITED - I	5.000
75	MRI LIMITED - II	6.000
76	MRI LIMITED - III	10.000

Haematology		
Code	**Description of Services**	**Amount**
1	PT, INR	300
2	CSF RE	950
3	Fluid RE	500
4	Anti Beta-2 Glycoprotein-1 IgG	1.790
5	Anti Beta-2 Glycoprotein-1 IgM	1.790
6	Reticulocytes Count	350
7	Serum Ascitic Fluid Albumin Gradient (SAAG)	1.000
8	Anti Thrombin	5.200
9	Fibrinogen	1.700
10	Fungus (KOH) Smear	550
11	Factor V Leiden	5.000
12	Lupus Anticoagulant	5.400
13	AFB Stain	400
14	Fluid Fungal Hypae	1.000
15	India Ink for CSF	550
16	LE Cells	700
17	Leishmania Tropica	1.500
18	Leishmania Donovani	1.500
19	Microfilariae	450
20	Pro C Global	4.200
21	Thrombophilia Profile	25.000
22	Wet Smear	350

23	Wright Stain	500
24	Peripheral Film	800
25	Platelet Concentrate	1.500
26	Complete Blood Picture (42 P)	700
27	ESR	300
28	MP (P-film)	350
29	Eosinophil Count	350
30	RBCs Morphology	950
31	Bleeding Time	350
32	Clotting Time	350
33	Coagulation Profile	1.100
34	Sickle Cells	250
35	Bone Marrow Aspiration	4.000
36	Bone Marrow Terphine	5.000
37	L.D. Bodies	350
38	APTT	700

Chemical Pathology/Chemistry		
Sr. No	**Description of Services**	**Amount**
1	Venous Blood Gases	880
2	Blood Glucose (Fasting)	350
3	Anti GBM	4.000
4	Blood Glucose (Random)	350
5	Bilirubin Direct	500
6	Bilirubin Indirect	400
7	Renal Function Tests (RFTs)	1.100
8	Bilirubin Total	350
9	Arterial Blood Gases (ABGs)	1.100
10	JAK-2 MUTATION	8.000
11	Serum Sodium	500

12	Serum Chloride	500
13	Serum Potassium	500
14	CK/ CPK	400
15	Creatine Kinase MB (CK-MB)	1.200
16	Glucose Tolerance Test (OGTT with 75g glucose)	1.550
17	Glucose Challenge Test (GCT with 50g glucose)	700
18	Phosphorous	550
19	ABG PLUS	2.000
20	HbA1C	1.400
21	Glucose Tolerance Test (OGTT with 100g glucose)	1.350
22	Fluid for LDH	500
23	Fluid for Total Proteins	500
24	Fluid for Albumin	200
25	Bone Profile	5.150
26	Urine Toxicology	5.000
27	Albumin	400
28	Anti Mitochondrial Ab	4.200
29	Anti Transglutaminase IgA	2.000
30	Anti Transglutaminase IgG	2.000
31	Anti Mullerian Hormone	4.000
32	ASMA (Anti Smooth Muscle Antibody)	4.000
33	ANCA (Anti Neutrophil Cytoplasmic Antibodies)	6.800
34	Auto Immune Liver Disease Profile (07 Autoantibodies)	5.000
35	Bicarbonate	500
36	Blood Alcohol	2.500
37	Candida Albicans IgG	4.400
38	Calprotectin	3.000
39	Chlamydia Tracomatis Ag	2.500
40	Chylomicrons	400
41	Coeliac Profile (05 Autoantibodies)	9.550
42	Fluid ADA (Adenosine Deaminase)	3.600
43	Free PSA	2.600

44	Globulin	650
45	Gliadin IgA	3.000
46	Gliadin IgG	3.000
47	Insulin Like Growth Factor 1	6.500
48	Intrinsic Factor Ab	2.700
49	IgA	950
50	IgG	950
51	IgM	950
52	Immunoglobulins (IgA, IgE, IgG, IgM)	3.900
53	Liver Kidney Microsomal Ab	3.400
54	Lipoprotien A (Lpa)	1.200
55	Mumps IgG	2.500
56	Mumps IgM	2.500
57	Osmotic Fragility	1.550
58	Platelet Aggregation Studies for Therapeutic Monitoring (Aspirin & Clopidogeral)	2.500
59	QuantiFERON (R) TB Gold	9.000
60	Rheumatoid Factor	950
61	RBC Folate	2.300
62	Serum Osmolality	1.700
63	Serum Lithium	1.500
64	TIBC	1.400
65	Total Lipids	800
66	Transferrin Saturation	1.500
67	Urine Amphetamine	1.800
68	Urine Cocaine	2.150
69	Urine for Amylase	900
70	Urine for Calcium 24 Hrs	750
71	Urine for Calcium Spot	1.000
72	Urine for Cortisol 24 Hrs	1.750
73	Urine for Cortisol Spot	1.850
74	Urine for Creatinine 24 Hrs	750
75	Urine for Creatinine Spot	550

76	Urine for Electrolytes 24 Hrs	1.050
77	Urine for Electrolytes Spot	900
78	Urine for Magnesium 24 Hrs	900
79	Urine for Magnesium Spot	800
80	Urine Albumin 24 Hrs	900
81	Urine for Microalbumin Spot	900
82	Urine for Osmolality	1.500
83	Urine for Phosphorous 24 Hrs	700
84	Urine for Phosphorous Spot	550
85	Urine for Protein Spot (Quantitative)	500
86	Urine for Urea/Bun 24 Hrs	750
87	Urine for Urea/Bun Spot	450
88	Urine for Uric Acid 24 Hrs	750
89	Urine for Uric Acid Spot	550
90	Urine Prot/Creatinine Ratio Spot	1.000
91	Urine/Sr. Crea Clearance 24 Hrs	900
92	Stool Cryptosporidium	700
93	Urine Bence Jones Protein	600
94	Ionized Calcium	1.200
95	Serum Copper	1.750
96	Aldolase	1.400
97	Serum Urea	450
98	Serum Creatinine	450
99	Serum Uric Acid	550
100	Total Protein	500
101	Serum Albumin	350
102	Serum Electrolytes	950
103	Serum Calcium	500
104	Serum Phosphates	500
105	Serum Cholestrol	500
106	Serum Triglycerides	500
107	Lipid Profile	1.800

108	Bilirubin Profile	950
109	Serum Alanine Transaminase (ALT)	500
110	Serum Alkaline Phosphatase (ALP)	500
111	Liver Function Tests (LFTs)	2.000
112	Serum Aspartate Transaminase(AST)	500
113	Lactate Dehydrogenase (LDH)	400
114	Serum Amylase	850
115	24 hrs Urine Proteins	500
116	24 hrs Creatinine Clearance	1.000

Blood Bank		
Sr. No	**Description of Services**	**Amount**
1	Coomb's Profile (Direct, Indirect)	1.500
2	Blood Donation -01 Pint (Blood Grouping, Crossmatch and Screening)	5.000
3	Fresh Frozen Plasma (FFP)	1.500
4	RCC from outside source (1 Unit)	2.500
5	Rh Antibodies Titer	1.000
6	Cryoprecipitate	1.500
7	Blood Grouping and Rh Typing (with Du Testing)	500
8	Coomb's Test Direct	750
9	Coomb's Test Indirect	750
10	Venesection Therapentic	1.500

CT		
Sr. No	**Description of Services**	**Amount**
1	CT TRAUMA SERIES	15.000
2	CT KUB	8.000
3	CT TEMPORAL BONES	8.000
4	CT HEAD/FACE WITH 3D RECONSTRUCTION	9.000
5	CT SHOULDER JOINT	8.000
6	CT ELBOW JOINT	8.000
7	CT WRIST JOINT	8.000
8	CT HIP JOINTS	8.000
9	CT FEMUR	8.000
10	CT KNEE JOINT SINGLE	8.000
11	CT ANKLE JOINT	8.000
12	CT GUIDED PERCUTANEOUS DRAINAGE	10.000
13	CT ORBIT AND BRAIN WITH CONTRAST	10.000
14	CT NECK AND CHEST WITH & WITHOUT CONTRAST	10.800
15	CT NECK WITH AND WITHOUT CONTRAST	8.000
16	CT EXTRA FILM CHARGES (PER FILM)	600
17	CT FISTULOGRAM	10.000
18	CT UPPER LIMB WITH & WITHOUT CONTARST	12.000
19	CT TRIPHASIC LIVER (SPECIALLY FOR LIVER)	18.000
20	CT SPINE WITHOUT CONTRAST	10.000
21	CT NECK, CHEST, ABDOMEN AND PELVIS WITH & WITHOUT CONTRAST	18.000
22	CT CONTRAST ONLY	3.000
23	CT DENTAL 3D	10.000
24	CT UROGRAPHY WITH & WITHOUT CONTRAST	12.000

25	CT SINOGRAM	10.000
26	CT SCANIGRAM	4.500
27	CT SCAN REPORTING ONLY	1.200
28	CT RENAL PROTOCOL	18.000
29	CT PULMONARY ANGIOGRAM WITH CONTRAST	15.000
30	CT PULMONARY ANGIOGRAM AND CHEST WITH CONTRAST	13.800
31	CT PITUITARY FOSSA WITHOUT CONTRAST	8.000
32	CT PERFUSION HEAD	15.000
33	CT PELVIS WITH AND WITHOUT CONTRAST	10.000
34	CT PELVIMETERY PLANNING	6.000
35	CTABDOMEN WITH & WITHOUT CONTRAST	12.000
36	CT ANGIO LOWER EXTREMETY	20.000
37	CT ABDOMEN , PELVIS WITH & WITHOUT CONTRAST	14.000
38	CT ANGIO UPPER EXTREMETY	15.000
39	CT ANGIOGRAM (ABDOMINAL AORTA AND PELVIS)	18.000
40	CT ORBIT AND BRAIN WITH AND WITHOUT CONTRAST	8.000
41	CT PARANASAL SINUSES WITH AND WITHOUT CONTRAST	9.000
42	CT LOWER LIMB WTH AND WITHOUT CONTRAST	9.600
43	CT INTRANCRANIAL ANGIOGRAM	12.000
44	CT INNER EAR WITHOUT CONTRAST	8.000
45	CT INNER EAR ,ICA/TEMPORAL BONES WITH AND WITHOUT CONTRAST	10.000
46	CT HEAD AND NECK WITH AND WITHOUT CONTRAST	12.000
47	CT FACE WITH AND WITHOUT CONTRAST	10.000
48	CT CHEST,ABDOMEN AND PELVIS WITH AND WITHOUT CONTRAST	18.000
49	CT CHEST,THORAX WITH AND WITHOUT CONTRAST	10.000
50	CT BRAIN WITH AND WITHOUT CONTRAST	6.000

51	CT BMD (BONE MINERAL DENSITY)	3.000
52	CT ABDOMEN WITHOUT CONTRAST	10.000
53	CT ABDOMEN, PELVIS WITHOUT CONTRAST	12.000
54	CT ANGIOGRAM (EXTRACRANIAL/NECK/CAROTID)	15.000
55	CT ANGIOGRAM (RENAL/MESNETERIC/HEPATIC)	15.000
56	CT ANGIOGRAM (THORACIC AORTA AND CHEST)	15.000
57	CT AORTOGRAM RUNOFF (ABDOMEN,PELVIS AND BILATERAL EXTREMITY)	15.000
58	CT BIPHASIC, CCT LIVER (SPECIALLY FOR HCC)	12.000
59	CT BRAIN WITHOUT CONTRAST	5.000
60	CT CHEST HIGH RESOLUTION (HRCT CHEST)	7.800
61	CT CHEST THORAX WITHOUT CONTRAST	8.000
62	CT CHEST, ABDOMEN, PELVIS WITH CONTRAST	12.000
63	CT FACE WITHOUT CONTRAST	8.000
64	CT HEAD+NECK WITHOUT CONTRAST	10.000
65	CT NECK AND CHEST WITHOUT CONTRAST	10.000
66	CT NECK WITHOUT CONTRAST	8.000
67	CT NECK, CHEST, ABDOMEN AND PELVIS WITHOUT CONTRAST	18.000
68	CT PARANASAL SINUSES WITHOUT CONTRAST ONLY	7.000
69	CT PELVIS WITHOUT CONTRAST	9.000
70	CT UROGRAPHY WITH CONTRAST	8.000
71	CT HRCT	7.800
72	CT DEXA SCAN	3.000
73	CT LIMITED -I	4.000
74	CT LIMITED -II	5.000

Annex B: list of services to be included in the OPD pilots

Table 1

PHC and secondary Hospitals

OPD Diagnostic Services Related to IPD treatment

Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
C45	Identify and refer patients with high risk including pregnant women, young children, and those with underlying medical conditions	Infectious Disease Cluster	68		Hospitals	8.39	0.90	CBC,Haematology,chem	
C8-com	Detection and management of acute severe malnutrition and referral in the presence of complications	Health Services	89		PHC & SHC (Hospitals)	15.56	20.05	CPC,Blood chem, haematology	CXR
HC3	Provision of condoms and hormonal contraceptives, including emergency contraceptives	RMNCH	90		PHC & SHC (Hospitals)	18.46	176.75	Strip/urine pregnancy test	

Table 1

PHC and secondary Hospitals

OPD Diagnostic Services Related to IPD treatment

Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals /SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
C14-com	Provision of vitamin A and zinc supplementation to children according to WHO guidelines, and provision of food supplementation to women and children in food insecure households	Health Services	98		PHC & SHC (Hospitals)	44.13	20.8	CPC,Blood chem	
C43-com	Early detection and treatment of leishmaniasis, dengue, chikungunya, rabies, trachoma, and helminthiasis	Infectious Disease Cluster	101		PHC & SHC (Hospitals)	51.94	12.71	CBC,Haematology,chem	
C28-com	Community-based HIV testing and counselling (for example, mobile units and venue-based testing), with appropriate referral or linkage to care and immediate initiation of lifelong ART	Infectious Disease Cluster	113		PHC & SHC (Hospitals)	00	2.24	HIV screening/ Virology, CPC, haematology	

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
C3B-com	Basic neonatal resuscitation following delivery	NCD & IPC	2	Y	PHC & SHC (Hospitals)	0.11	1.62	Basic serology	
C3a-com	Management of labour and delivery in low-risk women by skilled attendant	NCD & IPC	3	Y	BS/PHC & SHC (Hospitals)	1.51	23.14		
HC28-com	Screening for HIV in all individuals with a diagnosis of active T B; if HIV infection is present, start (or refer for) ARV treatment and HIV care	Infectious Disease Cluster	4	Y	Hospitals	00	2.46	CBC,Haematology,chem	CXR, HRCT
C3c-com	Management of labour and delivery in low-risk women by skilled attendant	NCD & IPC	5	Y		33.97	23.90		
C10-com	Education on handwashing and safe disposal of children's stools	Health Services	9	Y	PHC & SHC (Hospitals)	2.32	1.19		
HC1-phc	Management of miscarriage or incomplete abortion and post abortion care	RMNCH	10	Y	Hospitals	3.24	5.46	CBC,Haematology,chem	
HC12-phc	Psychological treatment for mood, anxiety, ADHD, and disruptive behaviour disorders	RMNCH	10	Y	PHC & SHC (Hospitals)	1.00			

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
C2-Com	Counselling of mothers on providing thermal care for preterm new-borns (delayed bath and skin-to-skin contact)	NCD & IPC	11	Y	PHC & SHC (Hospitals)	0.17	0.75		
C4-com	Promotion of breastfeeding or complementary feeding by lay health workers	Health Services	12	Y	PHC & SHC (Hospitals)	2.22	1.14		
HC27-phc	Diagnosis of TB, including assessment of rifampicin resistance using rapid molecular diagnostics (Ultra expert), and initiation of first-line treatment per current WHO guidelines for drug-susceptible T B; referral for confirmation, further assessment of drug resistance, and treatment of drug-resistant TB	Infectious Disease Cluster	13	Y	PHC & SHC (Hospitals)	19.14	92.76	CBC,Haematology,chem	CXR, HRCT
C1-Com	Antenatal and postpartum education on family planning	NCD & IPC	14	Y	PHC & SHC (Hospitals)	1.07	0.55		
C16-com	Childhood vaccination series (diphtheria, pertussis, tetanus, polio, BCG, measles, hepatitis B, Hib, rubella)	RMNCH	20	Y	PHC & SHC (Hospitals)	40.63	18.67		

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals /SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
HC42-PHC	Treatment of acute pharyngitis in children to prevent rheumatic fever	NCD & IPC	24	Y	PHC & SHC (Hospitals)	37.27	4.87	CBC,Haematology,chem	
C19-com	Vision pre-screening by teachers; vision tests and provision of ready-made glasses on-site by eye specialists	RMNCH	26	Y	PHC & SHC (Hospitals)	31.95	2.95		
C27a-com	Provision of iron and folic acid supplementation to pregnant women, and provision of food or caloric supplementation to pregnant women in food insecure households (CL)	RMNCH	27	Y	PHC & SHC (Hospitals)	55.24	56.63		
HC32-phc	Provision of insecticide-treated nets to children and pregnant women attending Health Centre	Infectious Disease Cluster	29	Y	PHC & SHC (Hospitals)	13.05	8.58		
C30b-com	Provision of disposable syringes to people who inject drugs (IDU)	Infectious Disease Cluster	30	Y	PHC & SHC (Hospitals)	0.26	8.05	Basic serology, Morphology,haematology	
C27b-com	Provision of iron and folic acid supplementation to pregnant women,	RMNCH	31	Y	PHC & SHC	53.10	57.09		

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
	and provision of food or caloric supplementation to pregnant women in food insecure households (PHC)				(Hospitals)				
HC4a-com	Provision of condoms and hormonal contraceptives, including emergency contraceptives and IUDs	RMNCH	32	Y	RHC Upwards	1.17	15.2		
FLH16-FLH	Vasectomy	RMNCH	33	Y	Hospitals	0.46	184.96	CBC,Haematology,chem	
HC23-phc	Provider-initiated testing and counselling for HIV, STIs, and hepatitis, for all in contact with health system in high-prevalence settings, including prenatal care with appropriate referral or linkage to care including immediate ART initiation for those testing positives for HIV	Infectious Disease Cluster	38	Y	THQ 7 above	0.34	4.37	CBC,Haematology,chem	
HC5a	Counselling of mothers on providing kangaroo care for new-borns (PHC)	RMNCH	39	Y	PHC & SHC (Hospitals)	0.14	0.67		
HC5B-phc	Management of neonatal sepsis, pneumonia, and meningitis using injectable and oral antibiotics	RMNCH	40	Y	PHC & SHC	0.31	0.67		CXR, HRCT

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
					(Hospitals)				
HC38-phc	Provision of aspirin for all cases of suspected acute myocardial infarction	NCD & IPC	41	Y	PHC & SHC (Hospitals)	0.66	0.89	CBC,Haematology,chem	
HC17-phc	For individuals testing positive for hepatitis B and C, assessment of treatment eligibility by trained providers followed by initiation and monitoring of antiviral treatment when indicated	Infectious Disease Cluster	43	Y	Hospitals	24.79	5.10	CBC,Haematology,chem	CXR
HC45-phc	Opportunistic screening for hypertension for all adults and initiation of treatment among individuals with severe hypertension and/or multiple risk factors	NCD & IPC	49	Y	Hospitals	35.58	21.85	CBC,Haematology,chem	
C46	In the context of an emerging infectious outbreak, provide advice and guidance on how to recognize early symptoms and signs and when to seek medical attention	Infectious Disease Cluster	50	Y	PHC & SHC (Hospitals)	16.78	0.45	CBC,Haematology,chem,micro bio	CXR
C11-com	Pneumococcus vaccination	Health Services	52	y	PHC & SHC (Hospitals)	46.82	18.34		

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
HC57a-phc	Dental extraction (PHC)	Health Services	54	Y	RHC &above	1.89	19.37	CBC,Haematology,chem	Dental Xray
C18-com	Education of schoolchildren on oral health	RMNCH	56	Y	PHC & SHC (Hospitals)	14.53	1.34		
C51	WASH behaviour change interventions, such as community-led total sanitation	NCD & IPC	58	Y	Hospitals	70.41	1.08		
FLH14-FLH	Insertion and removal of long-lasting contraceptives (IUCDs and Implants)	RMNCH	59	Y	PHC & SHC (Hospitals)	0.18	1.86		
HC41-phc	Secondary prophylaxis with penicillin for rheumatic fever or established rheumatic heart disease	NCD & IPC	60	Y	PHC & SHC (Hospitals)	0.63	2.98	CBC,Haematology,chem	CXR,USG
HC36-phc	Long-term combination therapy for persons with multiple CVD risk factors, including screening for CVD in community settings using non-lab-based tools to assess overall CVD risk	NCD & IPC	61	Y	Hospitals	2.61	9.93	CBC,Haematology,chem	ECG, ECHO,XRAY,CT/MRI
HC64-PHC	Basic management of musculoskeletal and neurological injuries and disorders,	Health Services	62	Y	Hospitals	6.23	8.43	CBC,Haematology,chem	MRI Brain

PHC and secondary Hospitals OPD Services									
Code	**Nomenclature**	**Cluster**	**Cost Effectiveness & Ranking Priority Intervention**	**OPD**	**HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)**	**Cost/ capita PKR**	**Unit cost/ intervention ($)**	**Labs**	**Radiology**
	such as prescription of simple exercises and sling or cast provision								
HC33-phc	Identify and refer to higher levels of health care patients with signs of progressive illness	Infectious Disease Cluster	63	Y	PHC & SHC (Hospitals)	34.16	4.90	CBC,Haematology,chem	XRAY,MRI
HC62-PHC	Suturing laceration	Health Services	65	Y	PHC & SHC (Hospitals)	2.61	2.83	CBC,Haematology,chem	
HC68-PHC	Health centre pathology services - Cost included in relevant interventions	Health Services	70	Y	PHC & SHC (Hospitals)	5.15	22.14	CBC,Haematology,chem	
HC60-phc	Management of non-displaced fractures	Health Services	71	Y	Hospitals	2.07	13.47	CBC,Haematology,chem	XRays/MRI
HC57b-phc	Dental extraction (FLH)	Health Services	72	Y	PHC & SHC (Hospitals)	2.53	22.29	CBC,Haematology,chem	Dental Xray
C32	Routine contact tracing to identify individuals exposed to TB and link them to care	Infectious Disease Cluster	73	Y	2,3	304.03	13.86	CBC,Haemaology,chem	CXR, HRCT

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
HC19-FLH	Hepatitis B and C testing of individuals identified in the national testing policy (based on endemicity and risk level), with appropriate referral of positive individuals to trained providers	Infectious Disease Cluster	75	Y	Hospitals	374.37	301.91	CBC,Haematology,chem	CXR
FLH1-FLH	Detection and management of foetal growth restriction	RMNCH	77	Y	Hospitals	830.38	514.33	CBC,Haematology,chem	USG
HC7-phc	Screening of hypertensive disorders in pregnancy	RMNCH	79	Y	PHC & SHC (Hospitals)	2.27	17.18		CXR, USG,ECHO
HC56-phc	Targeted screening for congenital hearing loss in highrisk children using otoacoustic emissions testing	NCD & IPC	80	Y	Hospitals	0.63	14.01	CBC,Haematology,chem	
HC4b-com	Counselling of mothers on providing kangaroo care for new-borns (CL)	RMNCH	81	Y	PHC & SHC (Hospitals)	9.87	15.2		
FLH15-FLH	Tubal ligation	RMNCH	82	Y	Hospitals	52.24	189.17	CBC,Haematology,chem	

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
HC50-phc	Management of depression and anxiety disorders with psychological and generic antidepressant therapy	NCD & IPC	83	Y	Hospitals	11.89	32.58	CBC,Haematology,chem	
HC59-PHC	Drainage of superficial abscess	Health Services	84	Y	PHC & SHC (Hospitals)	13.13	16.03	CBC,Haematology,chem	Dental Xray
HC58a-phc	Drainage of dental abscess (PHC)	Health Services	86	Y	PHC & SHC (Hospitals)	0.96	14.56	CBC,Haematology,chem	Dental Xray
HC10-flh	Management of labour and delivery in low risk women (BEmNOC), including initial treatment of obstetric or delivery complications prior to transfer	RMNCH	87	Y	PHC & SHC (Hospitals)	2.96	25.54	CBC,Haematology,chem	
C5-phc	Tetanus toxoid immunization among schoolchildren and among women attending antenatal care	Health Services	88	Y		3.18	1.07		
RH14	Cataract extraction and insertion of intraocular lens	Health Services	91	Y	Hospitals	179.64	242.94	CBC, Haematology, chem	
HC14-phc	Post gender-based violence care, including counselling, provision of emergency contraception, and rape-response referral (medical and judicial)	RMNCH	97	Y	PHC & SHC (Hospitals)	3.34	2.05		XRAY

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
	- to be executed as inter-sectoral intervention								
HC63a-phc	Treatment of caries	Health Services	99	Y	PHC & SHC (Hospitals)	20.89	28.38	CBC,Haematology,chem	XRAY,MRI
HC39a	Screening of albuminuria kidney disease including targeted screening among people with diabetes	NCD & IPC	100	Y	PHC & SHC (Hospitals)	9.69	10.06	CBC,Haematology,chem	USG
HC37-phc	Low-dose inhaled corticosteroids and bronchodilators for asthma and for selected patients with COPD	NCD & IPC	104	Y	PHC & SHC (Hospitals)	3.76	2.54		
FLH7-FLH	Management of preterm labour with corticosteroids, including early detection	RMNCH	105	Y	PHC & SHC (Hospitals)	96.55	252.26	CBC,Haematology,chem	
C12-com	Rotavirus vaccination	Health Services	106	Y`	PHC & SHC (Hospitals)	23.12	9.06		
HC9b-phc	Screening and management of diabetes in pregnancy	RMNCH	107	Y	PHC & SHC	23.79	7.11		

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals/SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
	(gestational diabetes or pre-existing type II diabetes)				(Hospitals)				
HC9a-com	Screening and management of hypertensive disorders in pregnancy	RMNCH	108	Y	PHC & SHC (Hospitals)	1.00	0.43		CXR,USG,ECHO
HC26-phc	For PLHIV and children under five who are close contacts or household members of individuals with active T B, perform symptom screening and chest radiograph; if there is no active T B, provide isoniazid preventive therapy according to current WHO guidelines	Infectious Disease Cluster	110	Y	PHC & SHC (Hospitals)	0.59	20.19	CBC,Haematology,chem	CXR, HRCT
HC25-phc	Provision of male circumcision service	Infectious Disease Cluster	114	Y	PHC & SHC (Hospitals)	85.82	40.05	BTCT,PT,PTTK	
HC30-phc	Evaluation and management of fever in clinically stable individuals using WHO IMAI guidelines, with referral of unstable individuals to first-level hospital care	Infectious Disease Cluster	116	Y	Hospitals	1.33	4.20	CBC,Haematology,chem	CXR,USG
P5-COM	Systematic identification of individuals with TB symptoms among high-risk groups and linkage to care ("active case finding")	Infectious Disease Cluster	118	Y	PHC & SHC (Hospitals)	30.40	0.78	CBC,Haematology,chem	CXR,HRCT,USG

PHC and secondary Hospitals OPD Services									
Code	Nomenclature	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	HC Provision LEVELS OR/BHU/RHC (PHC) THQH/DHQ/MTI (Hospitals /SHC)	Cost/ capita PKR	Unit cost/ intervention ($)	Labs	Radiology
HC24-flh	As resources permit, hepatitis B vaccination of high-risk populations, including healthcare workers, PWID, MSM, household contacts, and persons with multiple sex partners	Infectious Disease Cluster	119	Y	PHC & SHC (Hospitals)		2.67		
HC16-phc	Syndromic management of common sexual and reproductive tract infections (for example urethral discharge, genital ulcer, and others) according to WHO guidelines	RMNCH	120	Y	PHC & SHC (Hospitals)	2.33	15.04	CBC,Haematology,chem	XRAY,USG

Note: The cases requiring indoor management, which have been removed from this original list of interventions have been selected and deleted as per the following assumptions.

1. Cases requiring short/ full admission (bed head ticket generated) after any initial management in OPD or emergency department.
2. The cases requiring any sort of medical/ surgical interventions.
3. The cases requiring observations from 24-72 hours.
4. Cases requiring full supportive treatment during hospital stay.
5. Cases requiring repeated labs and diagnostics.

6. Cases requiring continuous nursing care and medical supervision.

Interventions in Tertiary Hospital EPHS OPD Diagnostic Services Related to IPD treatment						
Code	**Intervention**	**Cluster**	**OPD**	**IPD**	**Lab + Radio**	**Remarks**
FLH33	Craniotomy for Trauma	Health Services		Y	Y	
FLH37B	Hernia Repair including Emergency Surgery for neonates and infants	Health Services		Y	Y	
FLH40	Management of osteomyelitis, including surgical debridement for refractory cases	Health Services		Y	Y	Maybe OPD
FLH41C	Management of septic arthritis	Health Services		Y	Y	
FLH48B	Trauma laparotomy in children	Health Services		Y	Y	
RH3	Management of refractory febrile illness including etiologic diagnosis at reference microbiological laboratory	Infectious Disease Cluster		Y	Y	
RH4	Management of acute ventilatory failure due to acute exacerbations of asthma and COPD; in COPD use of bilevel positive airway pressure preferred	NCD & IPC		Y	Y	HRCT
RH6	Use of percutaneous coronary intervention for acute myocardinal infraction where resources permit	NCD & IPC		Y	Y	ECG
RH7	Treatment of early stage breast cancer with appropriate multimodal approaches (including generic chemotherapy), with curative intent, for cases that are detected by clinical examination at Health Centre	NCD & IPC		Y	Y	OPD follow up
RH8	Treatment of early stage colorectal cancer with appropriate multimodal approaches (including generic chemotherapy), with curative intent, for cases that are detected by clinical examination at Health Centre	NCD & IPC		Y	Y	
RH9	Treatment of early-stage childhood cancers (such as Burkitt and Hodgkin lymphoma, acute	NCD & IPC		Y	Y	

Interventions in Tertiary Hospital EPHS OPD Diagnostic Services Related to IPD treatment						
Code	**Intervention**	**Cluster**	**OPD**	**IPD**	**Lab + Radio**	**Remarks**
	lymphoblastic leukaemia, retinoblastoma, and Wilms tumour) with curative intent in paediatric cancer units or hospitals					
RH11	Urgent, definitive surgical management of orthopaedic injuries (for example, by open reduction and internal fixation)	NCD & IPC		Y	Y	
RH12	Repair of cleft lip and cleft palate	NCD & IPC		Y	Y	
RH13	Repair of club foot	NCD & IPC		Y	Y	
RH15	Repair of anorectal malformations and Hirschsprung's Disease	Health Services		Y	Y	
RH16	Repair of obstetric fistula	Health Services		Y	Y	
RH17	Insertion of shunt for hydrocephalus	Health Services		Y	Y	Maybe OPD
RH18	Surgery for trachomatous trichiasis	Health Services		Y	Y	

Interventions in Tertiary Hospital EPHS OPD Services									
Code	Intervention	Cluster	Cost Effectiveness & Ranking Priority Intervention	OPD	IPD	Cost/ capita PKR	Unit cost/ intervention ($)	Lab + Radio	Remarks
RH10	Elective surgical repair of common orthopaedic injuries (for example, meniscal and ligamentous tears) in individuals with severe functional limitation	NCD & IPC	3	Y	Y	18.88	383.83	Y	MRI
RH5	Retinopathy screening via telemedicine, followed by treatment using laser photocoagulation	NCD & IPC	5	Y		0.00	2.75		
FLH25	Calcium and vitamin D supplementation for secondary prevention of osteoporosis	NCD & IPC	16	Y		732.47	236.76	Y	
RH2	Specialized TB services, including management of MDR- and XDR-TB treatment failure and surgery for TB	Infectious Disease Cluster	21	Y	Y	8.19	789.13	Y	

Key :

Green : Cases normally accepted as OPD at different levels of Health Care

Blue : Cases normally accepted as Indoor cases at different levels of Health Care

Maroon : Cases requiring lab and radiology investigations

Golden : Cases which may be transferred to OPD at some stage

TERMS OF REFERENCE (TOR)

For Capacity Building Provider for the Social Health Protection Initiative Phase II – Pakistan

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1. Background & Introduction

KfW-funded Social Health Protection Program II (SHP II) is an Outpatient Department (OPD) pilot scheme, which aims to improve access to quality OPD services and financial risk protection for the population living below a Poverty Score of 16.17 determined through Proxy Means Test (PMT) by enrolling these families/households into an insurance scheme in selected districts of Khyber Pakhtunkhwa (KP) and Gilgit Baltistan (GB). In addition, the purpose of the project is to contribute to improved Universal Health Coverage (UHC) and learn how to strengthen it by reinforcing Primary Health Care (PHC). It is aimed to implement the pilot in selected four districts in KP namely Chitral, Kohat, Malakand, Mardan, and Gilgit District in GB. The OPD scheme is considered as enlargement of the already ongoing In-Patient Department (IPD) scheme. The implementation of the pilot project is expected to commence in March 2024 and will be executed continuously for two consecutive years, at least. In KP, it will start with Mardan and proceed with the other districts when evidence has been obtained to ensure financial sustainability.

Based on the lessons learned from the IPD scheme, building the capacity of selected health facilities is essential to implement a successful pilot OPD scheme. The Departments of Health (DoHs) in KP and GB possess the financial resources within the separate agreement with KfW for engaging a Capacity Strengthening Provider to implement this scope of services as required hereunder. The ToRs explain the objectives, scope of work, key deliverables, contract duration, approximate budget limit, key services and staff to be provided by the capacity building Provider, and the technical and financial evaluation criteria for selection.

2. Objective

The primary objective of the capacity strengthening service provider is:

“The DoHs/DHOs, the Health Facilities and the Health Insurance provider have the essential capacity to participate in the OPD pilot scheme including the capacity to manage and lead the pilot as well as to deliver essential primary health care services according to the minimum health delivery package (MHSDP)[1]”.

The Capacity Strengthening Service Provider, under the supervision of the DoHs of KP and GB, will work closely with the District Health Office and Health Services Providers (HS-providers), m4h - the Technical Assistance Firm hired by the Departments to support the implementation of the OPD pilot, and the Health Insurance Provider (HI-provider) to achieve this primary objective.

3. Scope of Work

The Capacity Strengthening Service Provider will support the DoHs, health service providers and the HI-provider in strengthening their skills and knowledge competencies through learning interventions and procurement of required equipment/IT, instruments, and supplies to enable the DoHs and the health services providers better to implement the OPD pilot scheme.

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[1] http://healthkp.gov.pk/public/uploads/downloads-197.pdf

The capacity strengthening provider will be responsible to ensure transparency, adherence to government policies and high quality and standards in delivery of services (including purchase of equipment, goods and material).

4. Deliverables

Table 1 provides details of the deliverables of the Capacity Strengthening Service Provider. For each activity, the table provides the description, timeframe expected of the Capacity Strengthening Service Provider to deliver the activity, and indicator(s) of achievement. The deliverables/outputs given in the "Indicator of Achievement" shall be subject to approval.

Table 1: Deliverables of the Capacity Strengthening Service Provider

Domain & Activities	Description	Indicator of achievement
A. Strengthen the capacity of the DoHs - PMUs		
International study tour of Provincial Health Managers (for KP and GB)	Arrange an international exposure/study visit for Provincial Health Managers (5 from KP and 5 from GB) to a country with similar OPD schemes for better understanding and implementation of the OPD scheme.	-Enlist the approved provincial managers -Approvals and coordination from the visiting country's administration -Arrange for visa and travel documentation -Develop travel and visits plan/schedules -Arrange travel, lodging and related arrangements -Provide travel records, receipts, invoices in accordance with the Government policies & procedures -Report of the activity
Orientation of Provincial, District and facility level health managers as well as staff of the HI-provider on SHP II (KP and GB)	Through a 1-2 days Orientation Workshop at the Provincial Level, orient the 45 policy makers and health mangers on the OPD pilot scheme	-Contents of the workshop approved -Approved list of participants -Report of the workshop
International training in health insurance schemes,	International training of 2 staff from the DoH in KP and 2 from GB in 2 weeks on health insurance	Successful training completion reports

Domain & Activities	Description	Indicator of achievement
reimbursement schemes, contribution collection and pooling as well as risk mitigation (KP and GB)	schemes, reimbursement schemes, contribution collection and pooling as well as risk mitigation	
Annual international health insurance conference (KP)	100 participants of which 80 from Pakistan (half of which from Islamabad) and 20 are international guests, at the 2 days event, organised at one of the international hotels in Pakistan- First year organised by KP	-Contents of the conference approved -Approved list of participants -Report of the conference
Additional meetings, training and workshops (KP)	400 meeting days half with boarding	-Report of the conference
IT equipment and office furniture for PMU (KP)	5 complete IT workplaces, 5 office furniture, highspeed internet WiFi, server and minor office devices	Delivery, installation and positive assessment
Strengthening of human resources capacity in PMU (KP)	Pool of national experts e.g., office coordination, health insurance, IT EUR 125 per day in 250 days	Successful implementation
Support of transportation for supervision of the OPD pilot (KP)	Purchase of two office vehicles: -1 car 4x4 for remote area visits -1 car normal for asphalt roads	Shopping report & Registration of vehicles in the names of the DoH KP
		Financial and audit reports
B. Material and supplies for the PHC Facilities		
IT equipment	Procure and deliver computers with approved specs to the health care facilities and training	-Specifications of computer systems approved -Approval of procured computers -Installation, integration & configuration of procured computers -Computers delivered and received by the facilities in functional form

Domain & Activities	Description	Indicator of achievement
Development of applications and training	To develop, test, document and provide training in applications for: empanelment, eligibility of beneficiaries, registration of beneficiaries at the HSs, and basic health record of the patient	-Training plan developed & approved -Training contents developed and approved -Pre & post training tests implemented & available -Training completed -Monitoring report of training through quality checklist -Training report developed and submitted
Ultrasound machines	Procure and deliver Ultrasound machines with approved specs to the health care facilities	-Specifications of Ultrasound machines approved -Approval of procured ultrasound machines delivered and received by the facilities in functional form -Installation, integration & configuration of machines
ECG apparatus	Procure and deliver ECG Apparatus with approved specs to the health care facilities	-Specifications of ECG Apparatus approved -Approval of procured ECG apparatus delivered and received by the facilities in functional form -Installation, integration & configuration of procured apparatus
Lab kits	Procure, and deliver the required PHC lab kits/equipment with approved specs to the health care facilities	-Type & Specifications of Lab kits/equipment approved -Approval of procured lab kits/equipment delivered and received by the

Domain & Activities	Description	Indicator of achievement
		facilities in functional form
Equipment/ instruments for BHUs	Small Lab equipment and sticks for routine Lab diagnostic tests procured and supplied to the BHUs	Type & Specifications of equipment/ instruments approved -Approval of procured material - Material/equipment delivered and received by the BHUs in functional form -Installation, integration & configuration of procured equipment/instruments
C. Training of Service Providers		
Training of 70-100 Service Providers through 5-day class room training on the identified areas	Each batch will comprise of 20-25 participants [Total 4-5 batches] Identified areas/contents of the training are: **1. Program (1 day):** • PHC & Essential Health Package • OPD pilot scheme: empanelment of HS-providers and registration of services, check of eligibility of patient, registration of beneficiaries, referral for services not provided, payment of HS-providers, reporting and data management (M&E are provided separately) **2. Technical (1/2 day):** • ECG- Recording, interpretation • Ultrasound- Male • Referral for services	-Training plan developed & approved -Training contents developed and approved -Pre & post training tests implemented -Training programs completed -Monitoring report of trainings through quality checklist -Training report developed

Domain & Activities	Description	Indicator of achievement
	• Basic obstetrics & incomplete expulsion foetus **3. Communication & Behaviour (IPC & BCC) (1/2 day)** • Interpersonal Communication Skills • Behaviour Change Communication • Counselling Sills	
Class room & hand-on training of 15 IT/Data Persons of facilities	• OPD pilot scheme on data entry, responsibility and reporting	-Training plan developed & approved -Training contents developed and approved -Pre & post training tests implemented & available -Training completed -Monitoring report of training through quality checklist -Training report developed
International study tour for District Health Managers	Arrange an international exposure/study visit for 5 District Health Managers to a country with similar OPD schemes for better understanding and implementation of OPD scheme.	-Enlist the approved provincial managers -Approvals and coordination from the visiting country's administration -Arrange for visa and travel documentation -Develop travel and visits plan/schedules -Arrange travel, lodging and related arrangements -Provide travel records, receipts, invoices in accordance with the Government policies &

Domain & Activities	Description	Indicator of achievement
		procedures
D. Strengthening capacity of HI-providers		
Review of SOPs for the OPD pilot together with HI-provider and the DoHs	1 week workshop with 3 DoH staff, 5 HI staff as well as 5 others - one for each pilot	Final version of SOPs agreed
Agree plan for starting the OPD pilots	1 day workshop with 3 DoH staff, 5 HI staff as well as 5 others - one for each pilot	Plan for starting the OPD pilots agreed
Pool of health insurance experts	10 workdays of expert-support in issues related to health insurance and PHC, to be identified based on need together with the HI-provider, for each DoH	Reports confirming well implemented assignments

5. Contract Duration

The total estimated duration of the contract shall be 12 months.

6. Approximate Budget Limit

The approximate budget limits for the Capacity Building Provider activities are EUR 115,000 for GB and EUR 454,000 for KP. In their proposals, the potential service providers should make sure that all tasks are completed under these budget limits. They should also explain how they will provide the best value for money i.e., the greatest impact for every Euro spent.

7. Key Staff:

The quality of staff, expertise, and their numbers, shall be the key factors in evaluation of the consultant's proposal. The firm may propose inputs required to complete the assignment within the contractual time. The firm must be experienced in respective fields and have capacity to carry out the required services of the proposed works. However, an indicative staff requirement with level of expertise, is given here:

S. No.	Personnel	Responsibilities/ qualification
1	Team Lead	• Lead overall planning and operations of the capacity Building assignments and activities • Maintain updated plans/timelines • Coordinate with DoH & stakeholders to obtain their support for smooth implementation of activities • Review progress and performance of team members

		• Ensure deliverables and timelines are met as per plan • Ensure compliance to TOR as per the agreement
2	Project Manager/Coordinator	• Support Team Leader in the planning and operations of all capacity building activities, and in performing all his/her responsibilities. He will keep coordination with provincial, district health authorities and health facilities
3	IT Specialist	• The Specialist should have expertise & experience in the procurement and supply of medical equipment/instruments and computer/electronic material • Follow the rules and procedure of government for procurement and supplies • Provide all records for audit purposes • Responsible for the provision of material/supplies, as specified, at the health facilities
	App specialist	• The App Specialist should have expertise & experience in the development, testing, documenting and providing training in software applications. • Develop and pre-test the applications for: empanelment, eligibility of beneficiaries, registration of beneficiaries at the HSs, and basic health record of the patient • Document the process of developing the applications • Impart training on the developed applications • Follow the rules and procedures of government for developing the software application
4	Training Specialist	• Manage the overall planning and operations of the training activities • Maintain updated training plans/timelines • Develop training schedule, contents and reports • Coordinate with stakeholders to obtain their support for smooth implementation of training activities • Review progress and performance of training specialists/ staff • Ensure training deliverables and timelines are met as per plan
7	Medical Specialist/ Technical Trainer/ Facilitators (2 to 3)	• MBBS and Post graduate qualification • Experience in imparting Technical Trainings to doctors and paramedics • Provide training on ECG- Recording, interpretation, Ultrasound- Male, Basic Obstetrics Services, Referral for services and Emergency Obstetric Care
8	IPC & BCC Expert	• Masters • BCC Expert • Experience in imparting trainings on interpersonal communication (IPC) and Behaviour Change Communication (BCC), Counselling Skills; especially in the context of health services

8. Requirements

The Capacity Strengthening Service Provider will be selected following Fixed Budget Method, making selection based on the least cost budget within the given budget threshold of a service provider whose technical proposal shall achieve minimum 80 marks out of 100 base marks, applying the following sub- criteria:

Sr. #	Criteria	Score
1	Specific experience in the relevant field i.e., carrying out health-related Capacity Building/Strengthening projects with Health Managers, Service Providers and Health Facilities	10
2	Adequacy and quality of the proposed methodology in responding to the Terms of Reference (ToRs)	40
3	Work and Staff Plans	10
4	Appropriateness of Key Experts' qualifications and competence for the Assignment, as per the requirements given in Section G, shall be determined considering the following sub-criteria:	40
4.1	General qualifications (general education, training, and experience)	20%
4.2	Adequacy for the Assignment (relevant education, training, experience in the sector/similar assignments)	60%
4.3	Relevant experience in the region (working level fluency in local language(s)/knowledge of local culture or administrative system, government organization, etc.	20%
Total =		**100**

TERMS OF REFERENCE (TOR)

For the Communication and Visibility (C&V) Provider for the Social Health Protection Initiative Phase II – Pakistan

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1. Background & Introduction

The KfW-funded SHP II is an Outpatient Department (OPD) pilot scheme, which aims to improve access to quality OPD services and financial risk protection for the population living below a Proxy Means Test (PMT) score of 16.17 by enrolling these families/households into an insurance scheme in selected districts of Khyber Pakhtunkhwa (KP) and Gilgit Baltistan (GB). In addition, the purpose of the project is to contribute to improved Universal Health Coverage (UHC) and learn how to strengthen it by reinforcing Primary Health Care (PHC). Four districts in KP are foreseen to be included in the pilot: Chitral, Kohat, Malakand, and Mardan as well as the Gilgit District in GB. The OPD scheme is considered as enlargement of the already ongoing In-Patient Department (IPD) scheme. The pilot is foreseen to start on 1 January 2023 and run for two consecutive years. In KP, it will start with Mardan in 2023 and proceed with the other districts when evidence has been obtained to ensure financial sustainability.

An important lesson learned from the IPD scheme is that the success of the pilot is very tightly related to the knowledge of the beneficiaries, the Health Services Providers (HS-providers) and the Health Insurance Provider (HI-provider) about how to utilise the scheme. The Departments of Health (DoHs) in KP and GB possess the financial resources within the special agreement with KfW for engaging a C&V Provider to support the TOR. The TOR explains the primary objective, scope of work, key deliverables, contract duration, approximate budget limit, key staff, and facilities to be provided by the C&V Provider, and the technical and financial criteria for firm selection.

2. Primary Objective

The primary objective of the C&V provider is:

- Eligible families have the knowledge, attitudes, and practices required to actively participate in SHP II.

The C&V Provider will work under the supervision of the DoHs of KP and GB. It will collaborate closely with the Health Services Providers (HS-providers) and the Health Insurance Provider (HI-provider) to achieve this primary objective.

3. Scope of Work

The C&V Provider will support the respective DoHs by building capacity, creating content, effectively implementing selected C&V activities, and providing technical support for monitoring and evaluation (M&E) during the pre-testing phase. (See Section D on key deliverables for a detailed account of the support the C&V provider shall supply.) It is important to note that the activities the C&V Provider will support are designed to avoid the use of media that is not appropriate for the target communities and may create perceptions of unfairness outside these communities. The activities the C&V provider will support shall make use of the following channels to reach the target communities: Face-to-face, community media, digital media, publication, dumb and smart phones, and local radio. Face-to-face communication will focus on Interpersonal

Communication (IPC). It will utilise Lady Health Workers (LHWs), community leaders, schoolteachers, Health Facilitation Officers (HFOs), administration staff of HS-Providers, and Social Mobilisers (SM) for face-to-face engagement. LHWs will undertake an initial door-to-door campaign in the targeted communities, after which they will engage with the communities regarding SHP II as part of their ongoing work. Community leaders will reach communities through public announcements and community meetings at regular intervals and during information campaigns. School teachers will engage school children and their parents on how to effectively participate in SHP II. Health facilitation officers and administration staff shall engage with eligible persons and families within the facilities of the empanelled HI-providers.

Social mobilisers will be attached to digital caravans, and they shall engage community members through meetings in all the pilot districts. Community media will include call centre/helpline support through toll-free numbers and digital caravans. Digital caravans will disseminate audio-visual content in all the pilot districts. Digital media will include social media and website content dissemination during information campaigns and on an on-going basis. Publications will be distributed during face-to-face engagement activities and through the placement of selected content to optimise outreach to selected audiences. All publication content will be designed for low-literacy populations, with an emphasis on pictorial representation. Key messages will be disseminated through SMS and Robocalls, which will make them accessible to those with dumb and smart phones. Local radio will deliver key messages and talk shows to provide target communities with detailed information about SHP II.

4. Deliverables

Table 1 provides details of the deliverables of the C&V Provider. This includes the output and related activities. For each activity, the table provides the description, timeframe expected of the C&V Provider to deliver the activity, and indicator(s).

Table 1: Deliverables of the C&V Provider

OUTPUTS & ACTIVITIES	DESCRIPTION	INDICATOR
Output 1: Capacity to implement the communication and visibility strategy developed.		
1.1. Develop two communication and visibility manuals, one each for Khyber Pakhtunkhwa and Gilgit Baltistan	The C&V Provider will produce two visibility manuals, one each for Khyber Pakhtunkhwa and Gilgit Baltistan. Each manual will be customised to meet the need of pilot projects. Each manual will include (a) a toolkit that provides a step-by-step guidance on how to effectively apply the visibility strategy (including branding guidelines and	Visibility manuals approved by competent authorities.

OUTPUTS & ACTIVITIES	DESCRIPTION	INDICATOR
	messages) and make optimal use of the visibility content and (b) training content based on the toolkit.	
1.2. Training of 25 trainers	The C&V Provider will train 25 trainers (20 for Khyber Pakhtunkhwa and 5 for Gilgit Baltistan) to implement training for Lady Health Supervisors (LHS), Lady Health Workers (LHWs)/Community Health Workers, staff of HI-Provider, staff of empanelled healthcare providers, and call centre staff in line with the visibility manuals. There will be three two-day training workshops – two training workshops in Khyber Pakhtunkhwa and one for Gilgit Baltistan. The training workshops shall take place in private facilities and C&V Provider will cover all costs of training.	Training workshops completed in line with the standards specified in the visibility manuals as per the assessment of the monitors.
1.3. Train 10 LHS	LHS oversee the work of 20-25 LHWs, and they will be provided five one-day training workshops, one for each pilot project district. The training will focus on IPC, the pilot programme, and management of LHWs. The training workshops shall take place in government facilities and C&V Provider will cover all costs of training, except venue costs.	All Lady Health Supervisors agree that the training met their learning needs.
1.4. Training for 250 LHWs	LHWs will be trained in door-to-door engagement in relation to the visibility of pilot project. 50 LHWs will be trained for each pilot project district, and there will be two one-day training of 25 LHWs each in every pilot project district. The training will focus on IPC, key messages related to the pilot programme, and effective use of communication material The training workshops shall take place in private	80% of LHWs agree that the training met their learning needs

OUTPUTS & ACTIVITIES	DESCRIPTION	INDICATOR
	facilities and C&V Provider will cover all costs of training.	
1.5. Train 40 HFOs appointed by the HI-Provider	HFOs will be provided a one-day training in each pilot project district. The C&V Provider will cover all costs of training. The training will focus on IPC, key messages related to the pilot programme, and effective use of communication material	80% of HFOs agree that the training met their learning needs
1.6. Train 40 administration staff from empanelled HS-Providers.	Administration staff of HS-Providers will be provided a one-day training in each pilot project district. The training will focus on IPC, key messages related to the pilot programme, and effective use of communication material. The C&V Provider will cover all costs of training.	80% of administration staff agree that the training met their learning needs
1.7. Train 30 call centre staff	Call centre staff of HS-Providers (20 from KP and 10 from GB) will be provided two one-day training workshops, one each for Khyber Pakhtunkhwa and Gilgit Baltistan, with emphasis on two-way communication and responding to Frequently Asked Questions. The C&V Provider will cover all costs of training.	80% of call centre staff agree that the training met their learning needs
1.8. Train 20 SMs	SMs, who will accompany district caravans (two caravans for each pilot project) shall be provided two one-day training workshops, one each for Khyber Pakhtunkhwa and Gilgit Baltistan. The C&V Provider will cover all costs of training.	80% of SMs agree that the training met their learning needs
1.9. Orient and engage 100 community leaders and 50 schoolteachers	20 community leaders per district and teachers of 40 schools in KP and 10 in GB will be oriented and engaged to communicate the messages for OPD services to their respective communities. Teachers will engage their students and their parents/guardians. Two one one-day	80% of community leaders agree that the training met their learning needs

OUTPUTS & ACTIVITIES	DESCRIPTION	INDICATOR
	orientation will be conducted in each district, one each for community leaders and teachers. The C&V Provider will cover all costs of training. Content will also be shared with them (leaflets, colouring books etc.) for further distribution.	
1.10. Training of 15 managers from DoHs and HI-Provider on visibility and communication for SHP-II	Two-day training will be conducted for 15 managers from DoHs and HI-Provider on SHP-II's visibility and communication. The training will focus on the communication visibility strategy and its implementation.	All participants agree that the training met their learning needs
Output 2: Content developed for the implementation of the visibility strategy		
2.1. Design and print out-door visibility material	The C&V Provider will design and print public space visibility material i.e., 10 billboards to be placed for a period of three months (2 per district), 250 banners (50 per district), 50 standees (10 per district), 600 streamers/pole signs (125 per district), and 10,0000 posters (2,000 per district) for low literacy audiences in all pilot project districts. It will also deliver the physical copies of the material to relevant DoH premises for further dissemination.	Design of content approved by competent authority. Printed content approved by competent authority. Stipulated number of physical copies received at relevant premises by competent authorities.
2.2. Design and print visibility material for field and call centre staff	The C&V Provider will design and print visibility material for LHWs, SMs, community leaders, and relevant staff stationed at HS-Providers. This will include 10,000 A4 one-pagers (including speech materials, FAQs, and announcement materials) and 540 USBs including all print and audio-visual visibility material. The content for call centre staff will include FAQs and guidance on two-way communication. The provider will also deliver the physical copies of the material to	

OUTPUTS & ACTIVITIES	DESCRIPTION	INDICATOR
	relevant DoH premises for further dissemination.	
2.3. Design and print visibility material for call centre staff	The C&V Provider will design and print visibility material for call centre staff. The content for call centre staff will include FAQs and guidance on two-way communication. It will also deliver the physical copies of the material to relevant DoH premises for further dissemination.	
2.4. Develop multipurpose audio-visual content	The C&V Provider will develop four two-minute animations dubbed in two regional languages. This will cover basic information on the pilot project, registration, and utilisation. All content will be delivered online and through a hard drive/USB key.	Audio-visual content approved by competent authority.
2.5. Develop campaign and regular digital content	The C&V Provider will develop the content of and design social media posts and develop website content on the pilot project for two campaigns (one one-month campaign each year). These campaigns will require the development of 200 posts (100 for KP and 100 for GB). The Provider will also address on-going information needs of the target population. All content will be delivered online and through a hard drive/USB key. The provider will also deliver the kiosks to relevant DoH premises for further dissemination.	Digital content approved for dissemination by competent authority.

OUTPUTS & ACTIVITIES	DESCRIPTION	INDICATOR
2.6. Develop 125 kiosks for empanelled HS-Providers	The C&V Provider will design, produce, and deliver 125 kiosks for use at empanelled HS-Providers. Each kiosk will be placed near the main entrance of a public hospital to inform the patients about the OPD scheme, check their eligibility status, and guide them on the registration process.	Design of kiosks approved by competent authority. Physical copies of kiosks approved by competent authority. Stipulated number of physical copies received at relevant premises by competent authorities.
2.7. Develop 10 audio messages for local radio dissemination	10 audio messages in local language that provide key messages on the pilot project. Non-celebrity voices will be used for this purpose.	Audio messages approved by competent authority.
Output 3: Effective implementation of selected visibility activities.		
3.1. Deliver digital campaigns	The C&V Provider will deliver two targeted digital campaigns. There will be one one-month campaign each year, and it will include dissemination through the official website and social media, including the boosting of social media content to targeted communities.	Targeted populations reached, disaggregated by medium.
3.2. Deliver digital caravans.	The C&V Provider will deliver one digital caravan for 50 days each for each province. One caravan will stop in two locations each day and it will include (a) two SMs to undertake two-way communication and (b) a mid-sized vehicle with a television screen that will display audio-visual content. In 50 days, one digital caravan will cover an entire province/region, and the caravans spend	

OUTPUTS & ACTIVITIES	DESCRIPTION	INDICATOR
	majority of their time in parts of the districts that are uncovered by LHWs.	
3.3. Place billboards and pole signs.	The C&V Provider will place all billboards and pole signs to maximise outreach to target populations.	
3.4. Deliver local radio campaigns.	Key messages and detailed discussion in the local language will be channelled through audio messages and talk shows as part of radio campaigns, which will take place thrice a year for two years.	
3.5. Disseminate key messages through SMS and Robocalls	250,000 SMS and 100,000 Robocalls will be sent to as many numbers in each district over ten phases, preferably including any numbers that the government might already have of the eligible users. Both robocalls and SMS can be delivered on both Smart and Dumb phones.	Official certified letter by Mobile Service Providers of sending SMS to the target districts issued.
Output 4: Technical assistance for pre-testing visibility activities.		
4.1. Develop monitoring and evaluation (M&E) framework for pre-testing C&V activities.	The C&V Provider will support the pre-test of the C&V activities by developing a M&E framework and undertaking all activities leading up to the development of the pre-test report, which will provide recommendations on how to improve the C&V activities.	M&E framework for pre-testing C&V activities approved by competent authority.
4.2. Undertake data collection, entry cleaning, and analysis.		Pre-test report approved by competent authority. Recommendations of pre-test report incorporated.
4.3. Develop a report on pre-test.		

5. Contract Duration

The total estimated duration of the contract shall be twenty-four (24) months.

6. Approximate Budget Limit

The approximate budget limits for the C&V activities by the Provider are 115,000 Euro for GB and 340,000 Euro for KP. In their proposals, potential suppliers should make sure that all tasks are completed under these budget limits. They should also explain how they will provide the best value for money i.e., the greatest impact for every Euro spent.

7. Key Staff:

The quality of staff, expertise, and their numbers, shall be the key factors in evaluation of the consultant's proposal. The firm may propose inputs required to complete the assignment within the contractual time. The firm must be specialised and have capacity to carry out the required services of the proposed works. However, an indicative staff requirement with level of expertise, is given hereunder:

Sr. #	Description of Personnel	Job Descriptions
1	Team Leader	• Lead overall planning and operations of the V&C activities • Maintain updated plans/timelines • Coordinate with stakeholders to obtain their support for smooth implementation of activities • Review progress and performance of staff • Ensure deliverables and timelines are met as per plan • Ensure compliance to TOR as per the agreement
2	Project Manager	• Support Team Leader in the planning and operations of all V&C activities, and in performing all his/her responsibilities.
3	Capacity Building Specialist	• Develop two V&C manuals, one for KP and one for GB. • Train trainers • Train key personnel from respective DoHs and HI-Provider on SHP II's V&C

Sr. #	Description of Personnel	Job Descriptions
4	Trainer	• Train LHS, LHWs, HFOs, SMs, administration staff of HS-Providers, community leaders, and teachers in line with V&C manuals.
5	Social Mobiliser (SM)	• Undertake IPC on SHP II with eligible communities.
6	Content Specialist	• Undertake desk research for content creation • Write messages for billboards, banners, standees, pole signs, posters, leaflets, infographics, audio messages, SMS, and Robocalls. • Write scripts for animation videos • Write questions and answers to guide talk shows • Write website and social media content for campaigns and regular updating of content • Work with translators to ensure good quality translation of all content from English and Urdu into local languages. • Design kiosks, billboards, banners, standees, pole signs, posters, A4 leaflets, and infographics, and undertake any graphic designing required for social media and website content
7	Audio-Visual Director	• Review and revise audio and video scripts developed by content specialists. • Supervise the development of audio-visual content, including animation, non-celebrity voiceovers, subtitling in English, Urdu, and local languages, and background music.
8	Monitoring and Evaluation Specialist	• Develop an M&E framework for the pre-testing of C&V activities • Supervise data collection, cleaning, entry, and analysis • Develop a pre-test report

Sr. #	Description of Personnel	Qualification	Quantity	Person-months
1	Team Leader	Master's Degree or above in a social science. Minimum (15) fifteen years relevant work experience in leading C&V projects	1	06
2	Project Manager	Master's Degree or above in a social science. Minimum (10) ten years relevant work experience in C&V and project management.	1	12
3	Capacity Building Specialist	Master's Degree or above in a social science. Minimum (10) ten years relevant work experience in C&V and capacity building	1	02
4	Trainer	Master's Degree or above in a social science. Minimum (5) five years relevant work experience in training on community engagement. Knowledge of English, Urdu, and a widely spoken local language is desirable.	25	0.5
5	Social Mobiliser	Bachelor's Degree or above in a social science and a minimum of (3) years of experience in community engagement. Knowledge of Urdu and a widely spoken local language is mandatory.	4	2.5
6	Content Specialist	Master's Degree or above in a social science. Minimum (10) ten years relevant work experience in desk research,	2	12

Sr. #	Description of Personnel	Qualification	Quantity	Person-months
		content writing, and graphic design.		
7	Audio-visual Director	Bachelor's degree or above in a social science. Minimum of (05) five years of experience in creating and supervising the creation of audio-visual content, including animation videos.	1	4
8	Monitoring and Evaluation Specialist	Master's Degree or above in a social science. Minimum (10) ten years relevant work experience in developing M&E systems, supervising quantitative, qualitative, and mixed methods evaluations, and authoring evaluation reports.	1	2

8. Facilities to be arranged by the C&V Provider

The C&V Provider has a mandatory obligation to have dedicated self-office space in Islamabad or Peshawar. Office equipment/vehicles, such as vehicles, office furniture, communications equipment, photocopying equipment, fax machines, and computers and printers, including relevant software, shall also be the responsibility of the consultant. All documents, equipment, software purchased for project, facilities related to the works are, and shall remain the property of the Client after completion of assignment for which registration and licensing should be named to the client.

9. Requirements

The C&V Provider will be selected based on the following selection criteria:

Criteria	Score
Technical evaluation	**80%**
Service provider provides copies of company registration certificates, including proof of valid government registration income tax and sales tax registration.	10%
Service provider demonstrates sufficient financial capacity- Financial Statement of last 3 years	10%
The experience of the service providers in carrying out health-related C&V projects with poor communities.	20%
The extent to which technical requirements stated in the TOR have been satisfactorily addressed.	40%
Financial evaluation	**20%**
Total cost is below the approximate budget limit	20%

TERMS OF REFERENCE (TOR)

For the Monitoring and Evaluation (M&E) Provider to support the DoH in implementing the pilot for the Out Patient Benefit of Social Health Protection Initiative Phase II - Pakistan

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1 Introduction

Since 2016, KfW supported the Social Health Protection Initiatives Phase I (SHP I) in Khyber Pakhtunkhwa (KP) and Gilgit Baltistan (GB). The SHP I piloted a health insurance scheme covering 21% of the poorest part of the population[1] with Inpatient Health Department (IPD) services in the districts of Malakand, Mardan, Chitral and Kohat in KP and the district of Gilgit in GB. Health insurance services are provided by State Life Insurance Company (SLIC) in KP and by Jubilee Life Insurance (JLI) in GB.

The Governments of KP, GB as well as the Federal Government are increasingly financing a bigger and bigger share of the population with health insurance by expanding the targeted population, the districts and the range of services, so the benefit package now covers secondary and tertiary IPD services for the entire population. SHP I has been an effective catalyst for implementing the health insurance concept all over Pakistan.

Experiences from SHP I also show a clear demand for covering Outpatient Department (OPD) services. Therefore, the Social Health Protection Initiative Phase II (SHP II) is designed to complement the existing IPD scheme with OPD Primary Health Care (PHC) services, covering the same population and the same districts as SHP I. The KfW funded OPD scheme is being implemented by the Department of Health (DoH) in in KP and GB with support from management4health (m4h) – which is an international development assistance firm based in Frankfurt, Germany.

The overall objective of the OPD scheme is to “improve access to quality outpatient services and financial risk protection for the population in the project regions that are living below a Proxy Means Test (PMT) score of 16.17[2] by enrolling these families / households into an insurance scheme that covers OPD services.

The OPD pilot scheme also aims to:

- Improve access to quality outpatient services and financial risk protection for the population living below a PMT score of 16.17 by enrolling these families into an insurance scheme;
- Contribute to improving UHC;
- Learn how best to provide UHC for OPD.

SHP II will finance the following in the two provinces:

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[1] Identified by a nationwide proxy means test (PMT) by the Benazir Income Support Scheme (BISP) with a PMT of 16.17 corresponds or below corresponding to approximately the poorest 21% with an approximate income of USD 1 / day

[2] BISP is in the process of updating the socioeconomic registry and we are checking from time to time when the update is ready.

For KP: Pilot of provision of insurance premium or equivalent for the provision of OPD services to the population, which is already covered under the KfW supported under SHP I. This concerns households/individuals living below a PMT of 16.17 in the districts of Malakand, Mardan, Chitral and Kohat, but starting with Mardan.

For GB: Pilot of provision of insurance premium or equivalent for the provision of OPD services to the population in Gilgit district, which is already covered under phase I. This includes the households/individuals with a PMT score below 16.17, in the district of Gilgit.

The funds for the project are provided through a Special Agreements concluded between the DoHs (in KP and GB) and KfW. Besides financial resources for engaging the health insurance provider the Special Agreements included resources for other deliverables e.g., for Monitoring and Evaluation (M&E) of the OPD pilot scheme which under the expected approval of the reallocation request amounts to EUR 190 000 for GB and EUR 220 000 for KP.

In addition, KfW is preparing for the implementation of SHPIII that will support establishing better IT infrastructure for the OPD and IPD scheme. SHP III is, among other issues, foreseen to support the establishment of an electronic patient record and a referral system.

Very little data are upfront available about OPD/PHC. A Conceptualisation and Feasibility Report commissioned for this purpose, concluded that the cost of the OPD scheme is highly related to the utilisation of the scheme. Thus, to ensure financial sustainability an adoptive approach will be followed starting with a simple scheme in only one district in KP (Mardan) but scaling up when evidences have been provided to support such a decision. To this end good M&E system is key to ensure the trade-off between sustainability and coverage.

This ToR describes the task of the M&E Provider in supporting the DoHs establishing the required M&E system.

1.1 Project Goal

The goal of the project is for the social health protection OPD scheme to be established with enhanced coverage of and utilisation by the poor and disadvantaged in selected districts of KP and GB.

1.2 Project Purpose

The specific purpose is improved access to quality services (aligned with the EHS package) and financial risk protection within the OPD Pilot scheme for the eligible population in the project regions through health insurance.

The provision of OPD services has a pilot character and includes:

- OPD services aligned with the Essential Health Services package as approved by the Departments of Health of KP and GB, provided to the registered individuals under a health insurance scheme that pays the health insurance provider on capitation basis for the eligible registered individuals;

- The said service shall be made available through empaneled health service providers (HSPs);
- The OPD health services will be health promotion-oriented and will maintain a client-centric focus;
- The pilot scheme intends to enhance access especially in rural areas and for population that are below the PMT score of 16.17 making it pro-poor and equity driven;
- Both public and private health service providers will be empaneled and will be included in the purview of M&E;
- Piloting referral and gate-keeping systems; and,
- Learning lessons and generating evidence for scale-up of OPD scheme.

The current project aims to pilot the OPD scheme in one district in GB and four districts in KP.

However, at the moment only one the scheme will be implemented in only one district in KP also and for the purposes of this TOR the districts will be as follows:

Province	Districts
KP	Mardan
GB	Gilgit

Also to note:

- The OPD scheme is considered as an enlargement of the coverage of the ongoing IPD scheme covering the same segment of the population and will need integration for a seamless service provision and utilisation experience;
- The OPD pilot scheme is scheduled to start from 01 January 2023 and run for two consecutive years.

2 Purpose and scope of work

The basic purpose of contracting a firm to provide services as M&E provider is to establish an initial M&E System for the OPD pilot scheme in the selected districts as per the M&E system package. It is important to note that the SHP III is expected to start during 2023 and provide additional support for making the M&E system more comprehensive. However, until this an initial monitoring system for the OPD pilot scheme needs to be installed, tested and demonstrated to be functioning effectively so that it can:

1) Enable initial monitoring of progress and generating data to allow effective decision-making, support project management and assessment of implementation successes, guide decisions about issues and challenges and to test what works and what does not;

2) Build capacity of relevant section/personnel at the DoHs;

3) Be taken to scale within the DoH in KP and GB also as part of the SHP III and as the OPD scheme is expanded and mainstreamed.

The DoH of KP and GB therefore intend to contract the services of a competent firm /organization for the above purposes.

The Project has developed a comprehensive M&E system package approved by the DoH of KP and GB, that the contracted firm will implement the initial part of. The contracted firm – referred to as M&E Provider - will be responsible to organise a team of dedicated professionals, and all logistics, to collect requisite data related to registered individuals, clients, health service providers and health insurance provider(s), to establish relevant dash-boards for regular monitoring, to test and finalise the process for generation of evidence and reports (on the entire range of indicators as per Results Framework), and provide documentation of the system as well as training for relevant staff of the DoHs, the m4h Team the HI-provider. The contracted M&E Provider shall work in close collaboration with both DoHs as well as with the public and private health service providers (HSP) and health insurance provider.

More specifically the M&E Provider shall be responsible for the following deliverables:

1) Implementation of the initial monitoring system for the OPD Pilot scheme as per the M&E Framework (Annex 2);

2) Develop and provide the M&E software to DoH (owner) and train the users (both in DoHs, HSPs and health insurance providers) for effective utilisation of digital M&E system;

3) Update/finalize data collection tools based on the project M&E Framework (Annex 2) and strategic approach for the targeted areas;

4) To the largest extent possible, the framework should leverage on existing tools and systems under the respective intervention areas and update/ modify accordingly;

5) Based on implementation experience give recommendations to DoH of KP and GB to amend, include or exclude indicators to make the Results Framework more aligned with project goal and purpose:

    a. In case of any approval of modification in indicators, make changes to the Results Framework, Monitoring Framework and the entire cascade of data to align with the changes; no change may be made without approval of the relevant authority.

6) Develop Phone App and Website for real time/online data collection, reporting and electronic medical record of clients, keeping in view the indicators, tools and sources as explained in the M&E Framework (Annex 2);

7) Establish Client Feedback and Complaint System at health facilities (each empaneled Health Service Provider), as explained in the M&E Framework (Annex 2);

8) Develop relevant dash-boards for routine monitoring;

9) Test and finalise process, content requirements and standards for programme Monitoring and Evaluation reports as per the Monitoring Framework;

10) Document the M&E system;

11) Provide Training of to the DoH, m4h, the HI-provider, and other relevant stakeholders in the use of the M&E system, e.g. on reporting activities using the tools (qualitative and quantitative) along the cascade of data flow from point of service delivery through the HSP, District and Province level.

12) Conduct Quality Reviews of HSPs as explained in the M&E Framework (Annex 2)

13) The M&E Provider will be required to establish and maintain strong working collaboration and relationship with the DoH of KP and GB, District Health Departments, the empanelled HSPs and health insurance provider.

14) The M&E Provider shall report to the focal persons designated by DoH in KP and GB which shall facilitate communication between the M&E Provider and relevant staff in the DoHs and external actors. The M&E Provider will work closely together with the m4h team.

15) The DoHs shall manage the contract and the M&E Provider shall be auditable by them for both performance and finances.

While maintaining independence in conducting the exercise, the institution will work with DoH in KP and GB, hold consultations with key teams supporting implementation of the work and understand existing data sources for reference.

3 Duration of contract.

The contract shall be awarded for a period of one year.

4 Work Assignments, Deliverables & Payment Schedule

Deliverables	Timeline
1. **Inception phase report** detailing approach, methodology and timelines on the assignment (based on the required activities as explained in the M&E Framework Annex 2)	One month after signing the contract
2. Well defined/specified **monitoring tools** (quantitative and qualitative) including gender and social inclusion sensitive indicators	Before the end of 2nd month of the contract award
3. The workplan should show time **schedules of implementation and reporting** of the Monitoring activities,	– same as above –

(when activity will be implemented, at what level and by whom), data sources and methodologies/ tools for primary data collection (according to the M&E Framework- Annex 2)	
4. **Client Feedback and Complaint System** and its establishment at each empanelled HSPs along with linkages with billing and quality assessments of HSPs	– same as above –
5. Proposal on use of innovative technologies with clear descriptions and definitions, Standard Operating Procedures and requirements for implementing the new technologies for M&E system a. Demonstration on proposed mechanisms (how does it work?) b. Finalize the interface and Technology (Establishment of phone App/ website)	Before the end of 3rd month of the contract award
6. Functioning Client Feedback and Complaint System at each empaneled HSPs 7. Monitor and Track Implementation status of the program as per M&E Framework (Annex 2) (Coverage: Output and outcome level) and report, also compile and report issues and challenges in implementation 8. Conduct Quarterly HSPs Quality Review as explained in M&E Framework (Annex 2) and Generate Quarterly Quality Review Reports 9. Monitor and Compile Data and Reports from Client Feedback and Complaint System at each empanelled HSPs 10. Standard package DOH M&E section/personnel capacity building for implementing M&E activities at HSP level using both qualitative and quantitative methods; data compilation/analysis and reporting. 11. Report on DOH M&E section/personnel capacity – capacity building of staff 12. Quarterly M&E Provider report including progress and finances 13. Final Report	All remaining deliverables: From 6th month of the contract award till contract end

5 Selection Criteria

The following selection criteria shall be applied for applicant firms:

Skills and Experience

- Experience of relevant, effective, and efficient monitoring and/or evaluation of large-scale health service delivery programs in complex and challenging environments. Experience with social protection initiatives in particular is highly desirable – Annex on Sample to demonstrate experience in this criterion in which at least one of the proposed core team members have been engaged.
- Experience with impact evaluation strategies and methodologies to include the entire monitoring cycle which is guided by a theory of change (i.e. framing the boundaries of the evaluation, defining questions asked and at what intervals and to what populations, designing/deciding what mixed methods to use to determine causal attributions including possible unforeseen/unintended consequences, applying an analysis framework, and plan for regularly reporting/disseminating findings for evidence-based decision-making) – Annex on Sample to demonstrate experience in this criterion in which at least one of the proposed core team members have been engaged.
- Ability to deliver appropriate training and supportive supervision to relevant partner as to the rationale behind M&E procedures, need for conducting regularly evaluation exercises, use of developed data collection tools and data management processes (in alignment with the M&E Framework) – provide experience in design and delivery of such training by proposed core team members.
- Demonstrated ability to work with high levels of government both nationally and internationally – provide list of assignments in which at least one of the proposed core team members have been spearheaded such activity.
- Demonstrated commitment to applied learning and drive for data-driven programming/interventions.
- The team leader should have at least 15 years of progressively responsible experience in designing, managing, and implementing results-based M&E activities, programme design and delivery in health sector, including capacity-building of partners.
- Demonstrated relevant technical skills in using existing data, creating primary data collection tools, and analyzing and interpreting quantitative and qualitative data and disseminating to diverse audiences – the M&E specialist as part of the core team should have demonstrated experience of at least 5 years in this area.
- Progressively responsible experience in monitoring and evaluation of key populations, program beneficiaries, and staff in health programme contexts – at least one of the members of the proposed core team should have this experience

- Proficiency in Microsoft Office programs, i.e., Excel, Word, PowerPoint, etc., and the ability to use various commercially available statistical software programs audiences – the M&E specialist as part of the core team should have demonstrated experience of at least 5 years in this area.
- Extensive experience working in challenging environments, preferably in KP and/or Gilgit.
- Key and respective staff of the consultancy firm/institution should be available to participate in meetings and consultations in Islamabad, and also travel to the KP and GB Provinces as per the work requirements.
- Must have experience working in a multi-sectorial humanitarian programming context with international NGOs and institutions and Government of Pakistan (Federal level and Provincial level) - audiences – both the Team Leader and M&E Specialist as part of the proposed core team should have demonstrated experience of at least 5 years in this area.

6 Evaluation Criteria and Weightage

The evaluation procedure will focus on both technical and financial suitability. The weights of 70% and 30% shall be applied for technical and financial compliance respectively. Only firms scoring at least 70% of the maximum score during technical evaluation will be considered for financial evaluation.

Category	Maximum points
Technical Evaluation	
Organizational and Technical Strength of the applicant firm (based on the selection criteria described above)	15
Prosed Methodology - Understanding of the Terms of Reference - Responsiveness and comprehensiveness of proposed methodology - Fit-for-purpose proposed team - Identification of risks and mitigation strategies	30

Category	Maximum points
Personnel Strength Proposed team has the following qualification and experience: - The team leader should have at least 10-15 years of progressively responsible experience in designing, managing, and implementing results-based M&E activities, including capacity-building with local/international teams for effective implementation. - Within the team there should be demonstrated capacity and experience in conducting qualitative and quantitative monitoring and evaluation activities; capacity building for Provincial, District and health facility level teams and experience in utilizing gender and social inclusion sensitive indicators and measures.	25
Financial Evaluation	
PRICE (Use the attached template. All cost should be accompanied with brief narrative indicating the costing modality, risks and mitigation measures. The quote should be without GST. GST should be indicated as separate budget line.	30
TOTAL MARKS	**100**

7 Annexes

Annex A.1: M&E_Results Framework 29Jun22 ZERO DRAFT – attached as separate file

Annex A.2: M&E_Reporting Template_SHP II OPD HI Scheme_DoH and M4H_D#6_V3– attached as separate file

Annex A.3: Standard Financial Response Template

Personnel Cost					
Name	Position	Rate/Unit	Qty	Total in (Euro/PKR)	Remarks
Travel and Meeting Cost					
Item	Description	Rate/Unit	Qty	Total in (Euro /PKR)	Remarks
Operation Cost					
Item	Description	Rate/Unit	Qty	Total in (Euro /PKR)	Remarks
Direct					
Indirect/Management Fee					
Equip					
Total					