Consolidated Responses to pre-bid Queries

RFA: SWASTHYA HARYANA-Transforming Active Case Finding (ACF) through AI-Powered Thoracic & Non-Communicable Disease (NCD) Screening in Haryana

S.No	Questions / Clarification sought	Response of TIFA
1.	Eligibility & Structure: Can the lead applicant engage specialised partners as vendors (not sub-awardees) under the project budget — for example, for programme management, app development, or community mobilisation?	Yes, the implementing partner can engage a vendor with a clearly defined scope of work with an estimated resource requirement. Sub-awards are not allowed under TIFA.
2.	Is a proprietorship company eligible to apply as the lead applicant under this RFA?	Yes, if it is registered in India.
3.	CTD App & Digital Platform: What is the expected readiness/handover date of the CTD self-registration app, given that the implementing partner must deploy within 15 days of award?	The CTD is in the process of finalising the requirements for the self-registration app/platform within Ni-kshay. The implementing partner will be provided user access for the field operation.

4.	Will the CTD app be handed over deployment-ready, or will the implementing partner be expected to customise, configure, or localise it?	The app/platform will be built by CTD. The implementing partner can propose additional customisation requirements for the field-level activity during the co-design phase, if required.
5.	Will API documentation and sandbox access for Ni-kshay integration be provided to the implementing partner — and if so, at what stage (pre-award or post-award)?	The app/platform is expected to be built within the Ni-kshay environment; user-access will be provided to the implementing partner post-award.
6.	If the CTD app is not ready at the time of award, is the implementing partner permitted to deploy an interim digital registration solution to avoid delay in screening camp operationalisation?	This would need to be determined during co-design.
7.	HHX Machines, DeepCXR & Sputum Testing Are the 90 HHX machines in scan-ready condition — calibrated, charged, and operationally configured — or will the implementing partner be responsible for any setup, testing, or commissioning before deployment?	The State NTEP is expected to ensure operational readiness of the 90 HHX machines. The implementing partner will not be responsible for the operationalization of the HHX machines. If any support is desired from the state, then it will be finalised during the co-design period.
8.	Is the DeepCXR AI interface pre-configured and active on the 90 HHX units, or will the implementing partner	No, the state NTEP team will be responsible for the integration of DeepCXR to all 90 HHX units.

	be responsible for software installation, configuration, and integration?	
9.	Is the implementing partner expected to conduct sputum collection at camp sites, or is the role limited to facilitating referral and linkage to the nearest government facility?	No, the state NTEP team will facilitate specimen collection and transportation.
10.	NCD Screening & Consumables: For CBNAAT/TrueNat testing — will tests be conducted at government/DTD facilities, and who will be responsible for sample collection, transportation, result reporting, and linkage to the Ni-kshay portal — the implementing partner or the DTD/government system?	All NAAT (CBNAAT/TruNAT) tests will be conducted at designated government centres. The implementing partner will not be responsible for sample collection or transportation unless discussed and agreed during the co-design period.
11.	For NCD screening at single-window camps — will consumables (glucometer strips, BP apparatus, Hb testing strips) be supplied by the state NHM, or is the implementing partner expected to procure these within the project budget?	The state NTEP team will supply the consumables. The implementing partner will not be responsible for procuring any consumables.

12.	Geographic Planning & Microplan: For nutrition and anaemia assessment — is the expectation limited to point-of-care Hb testing, or does it include full anthropometric assessment and dietary counselling at camp sites?	This will be decided during the co-design phase.
13.	Will the geographic microplan identifying vulnerable populations and priority areas across 22 districts be pre-prepared by the State TB Cell/NTEP and shared with the implementing partner, or is the applicant expected to develop this from scratch?	The list of vulnerable populations (population size and their locations) is already available with the State NTEP. The implementing partner is expected to develop a microplan for population screening across 22 districts.
14.	Is the 18.7 lakh screening target distributed proportionally across all 22 districts, or will priority districts and phased deployment areas be determined during the co-design workshop?	A district-wise list of the vulnerable populations across 22 districts will be shared with the implementing partner during the co-designing process.
15.	Training & Upskilling: Is there an existing state-level estimate of the total number of healthcare workers and frontline staff (ASHAs, CHOs, ANMs, AWWs, radiographers, and lab	The state-level estimated number of healthcare workers and frontline staff to be upskilled will be determined during the co-design.

	technicians) to be trained across 22 districts, or will this be determined during co-design?	
16.	Will the training curriculum, content, and job aids be provided by CTD/NTEP, or is the implementing partner expected to develop all training materials independently?	The implementing partner needs to prepare upskilling material as per the state requirements finalised during the co-design period, referring to the standard screening protocol used by NTEP.
17.	Is training expected to be residential/centralised (state or district level) or decentralised (block/facility level), and will the state provide venue and logistical support?	Applicants should not plan on costly, in person/residential training exercises. Virtual, hybrid on-the-job training and/or integrated training are strongly encouraged.
18.	KPIs & Accountability: Achieving 18.7 lakh screenings across 90 HHX units over 10 months mathematically requires approximately 69 screenings/day/HHX — leaving virtually no operational buffer. How will JSI/TIFA account for machine downtime, public holidays, weather disruptions, and low-turnout days in milestone verification — or will this be determined during co-design?	KPIs will be determined during the co-design phase.

19.	The 48-hour treatment initiation KPI (90%) depends significantly on government laboratory turnaround, PHC doctor availability, and patient factors outside the implementing partner's control. Will this indicator be jointly owned with State NTEP and NHM, and will the implementing partner's accountability be limited to notification, referral, and linkage rather than actual treatment initiation?	The implementing partner is expected to refer and link the diagnosed TB cases to the designated treatment centres within two working days (48 hrs) from the day of the TB diagnosis. Actual treatment initiation is the responsibility of the NTEP programme.
20.	The NCD linkage rate KPI has no specified percentage target in the RFA. Will the implementing partner be expected to propose a target during co-design, and is benchmark data from similar integrated TB-NCD programmes available to inform a realistic target?	Yes, the implementing partner is expected to propose a target. Additional information will be made available during the co-design phase.
21.	MEL Framework: Will JSI/TIFA provide a standard MEL framework or indicator matrix, or is the implementing partner expected to develop the full MEL plan independently?	The implementing partner is expected to develop a full MEL plan in coordination with the state NTEP for the operationalisation of 90 HHX units.