INDIAN PUBLIC HEALTH STANDARDS

HEALTH AND WELLNESS CENTRE – PRIMARY HEALTH CENTRE

2022

VOLUME-III

Ministry of Health & Family Welfare

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Ministry of Health & Family Welfare

डॉ. मनसुख मांडविया
DR. MANSUKH MANDAVIYA

सत्यमेव जयते

स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक मंत्री
भारत सरकार
Minister for Health & Family Welfare
and Chemicals & Fertilizers
Government of India

आज़ादी का अमृत महोत्सव

MESSAGE

The National Health Policy 2017 envisages the attainment of the highest possible level of health and well-being for all. It aspires to achieve increased and more equitable access to healthcare by improving quality and investments in public health. An important step towards improving quality of healthcare delivery is through the Indian Public Health Standards (IPHS); a set of uniform standards to provide norms and benchmarks for quality of infrastructure, human resources and services to be delivered from public health facilities at all levels.

Since the last revision of IPHS in 2012, a whole host of important programmes and initiatives, such as the National Urban Health Mission, National Health Policy, Ayushman Bharat, Health & Wellness Centres, free drugs, etc. have been introduced by the Government. An expert group was set up to deliberate and recommend the revised standards to factor-in the needs of the new programmes and interventions. In the recent years, there has been a paradigm shift from selective care to assured comprehensive care. Corona Virus Infectious Disease (COVID-19) which spread rampantly across the globe, widely affected the health systems of the country, and highlighted the need for a resilient health system with assured critical care and robust supply chain. The Revised IPHS provide guidance on the infra-structural, human resource, drugs, diagnostics, equipment, quality and governance requirements for delivering health services at health facilities.

The IPHS have been revised with this approach covering both urban and rural health facilities for ensuring care across the full continuum of care. The revised guidelines also move from a prescriptive approach to decentralized plan approach. The focus now is on reducing Out of Pocket Expenditure by introducing assured functionality of services areas critical for provision of care.

I believe that revised IPHS 2021 will serve as a benchmark for states/ UTs for an improved healthcare delivery system. Accordingly, service delivery defined for each level of health facilities will be the basis for developing other health system strengthening components such as infrastructure, human resource, medicines, equipment etc.

It is my sincere hope that all States and UTs shall utilize these guidelines for strengthening the public health facilities holistically and put in their best efforts to strive towards high quality of health care at all public health facilities and to achieve goals envisaged for better health outcomes for the country.

(Dr. Mansukh Mandaviya)

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एक कदम स्वच्छता की ओर

MESSAGE

Indian Public Health Standards (IPHS) is an important tool towards achieving the quality healthcare delivery and better health outcomes under the Public Health Care System. Government of India has been revising these standards from time to time taking into account the changes and updates in the existing national programme as per requirement of public health care services. It is essential for public health facilities to deliver quality health services and assured availability of drugs, diagnostic services and Human Resource so that the National and International commitments in health care at various forums can be addressed.

The revised IPHS 2021 is a comprehensive document which includes the minimum standards to be adhered by the public health facilities at rural and urban areas. The document ensures equitable access of essential public health services at primary care through Ayushman Bharat- Health and Wellness Centre; subsequent referrals to secondary care facility assuring emergency, specialist and critical care services.

I urge all States and UTs to adopt and put these Standards into practice for strengthening the public health facilities and put in their best efforts to strive for improved quality of health care services at all public health care system.

I would take this opportunity to congratulate the team at Ministry of Health and Family Welfare led by Secretary HFW, National Health Systems Resource Centre, all subject experts and state representatives for coming up with comprehensive standards. I am sure this will help the states and UTs in further improving the public health services with provision of assured critical care.

BPW

(Dr. Bharati Pravin Pawar)

"दो गज की दूरी, मास्क है जरूरी"

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स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Message

Indian Public Health Standards (IPHS), last revised in 2012, are the benchmarks for quality of service delivery expected from various public health care facilities at all levels. They can also form the basis for assessing performance of public health care delivery system.

With the launch of National Urban Health Mission in 2013, National Health Policy in 2017, and Ayushman Bharat in 2018, the focus has shifted from selective health services to comprehensive and quality Primary and Secondary health care services to all population irrespective of their geographical location or financial status from Health & Wellness Centre (HWC) level to District Hospital level.

HWCs have been designated to provide 12 packages of comprehensive Primary Health Care while Community Health Centres (CHCs) have been designated to provide basic secondary care services nearer to the community with special focus to the under-served and remote areas of the country. District Hospitals supported by Sub-District Hospitals are the epicentre in a district for providing assured secondary care referral services for those referred from HWCs and CHCs.

Revision of IPHS guidelines for DHs, SDHs, CHCs and PHCs was required to include the widened scope of Comprehensive Primary Health Care services and strengthen the secondary healthcare service delivery. Government of India therefore constituted an expert group for revision of IPHS norms for DH, SDH, CHC, PHC, Polyclinics and UPHC. While undertaking revision, the experts have given due attention and care in incorporating the needs for various programmes in terms of services, and commensurate infrastructure, human resource, equipment etc. Focused attention has also been given to include delivery of comprehensive surgical services, widening public health surveillance, delivery of emergency and critical services, improving the availability of beds per one thousand population and capacity building of HR etc. in the revised guidelines.

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I extend my compliments to NITI Aayog for providing valuable guidance in development of the IPHS 2021. I also convey my thanks to Director General Health Services, National Health Mission team led by AS&MD, NHSRC, State and institutional representatives and all other experts for their best inputs in framing IPHS 2021.

I sincerely believe that all the States and UTs will expeditiously implement these standards to develop public healthcare institutions at all levels, so as to provide comprehensive and quality healthcare services to our citizens.

Place : New Delhi
Date : 21-09-2021

(Rajesh Bhushan)

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MESSAGE

Since the launch of the National Rural Health Mission in 2005, the Ministry of Health & Family Welfare, Government of India has endeavoured to provide universal and quality healthcare services to the people of India. To facilitate progress in this regard and to ensure quality services through public health facilities across the country, the MoHFW developed the Indian Public Health Standards for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals in 2007 and their subsequent revision ensued in 2012.

Several new programmes and initiatives have since been introduced, including National Urban Health Mission, NQAS, LaQshya, Free drugs and diagnostics, Health & Wellness Centres, SUMAN for maternal and new born care, NCD screening and their assured management, etc. necessitating revision of the IPHS.

The revised IPHS 2021 place a greater emphasis on the services to be provided at each level of public health facilities. To preserve equity in healthcare distribution, these services need to be acceptable, accessible, inexpensive, and responsive to the needs of the people, particularly for those who are marginalized. The revised IPHS provides benchmarks for rural & urban PHCs, Polyclinics in urban areas, non-FRU & FRU CHCs as well as District & Sub-District Hospitals in accordance with the changing needs.

This document endeavours to help the states and UTs in achieving the prescribed minimum standards for essential services and also strive for providing the desirable healthcare services for even better quality, assured primary, secondary as well as critical care services in the districts, which can be easily accessed by the community.

The constant guidance of Secretary H&FW helped in revising IPHS after extensive consultations with experts. I would like to thank the NITI Aayog, Directorate General of Health Services, officials of the NHM Program Divisions, teams at the National Health Systems Resource Centre, State government officials & experts whose inputs and contributions helped in development of the revised IPHS 2021.

I am confident these guidelines will prove useful to all the key stakeholders at state and district levels in improving the standards and quality of services being rendered at public health facilities.

(Vikas Sheel)

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FOREWORD

India has commitment to achieve Universal Health Coverage (UHC) by 2030. UHC envisages that all the people have access to quality health care services which can be accessed without facing any financial hardships or Out-Of-Pocket Expenditure (OOPE).

Since the last revision of Indian Public Health Standards in 2012 various new initiatives have been launched like Urban Health, augmenting emergency and critical care due to pandemics like COVID-19, provision of comprehensive surgical services beyond C-section, ensuring continuum of care under Ayushman Bharat, District Early Intervention Center, Integrated Public Health Labs, etc. therefore, a need was felt for the revision of IPHS 2012 guidelines.

These revised IPHS guidelines for PHCs, CHCs and DH & SDH have focus on ensuring services and accordingly standards for commensurate infrastructure, equipment, HR etc. to be given to States and UTs. The revised version also incorporates the commitments under NHP, 2017 to fulfill the objectives of delivering high quality services that are accountable, responsive, and sensitive to the needs of the community.

The revision of these standards was possible because of the combined efforts of all the experts who actively contributed as a part of main committee and sub-committee constituted by GoI. I would like to place my sincere thanks to DGHS, NCDC, Program Divisions, experts from Medical Colleges (AIIMS, PGIMER, VMMC, LHMC,), HLL, CDB, DCGI, NIHFW, Regional Directors of Health and Family Welfare, representatives of WHO, World Bank, UNFPA, JSS and other development partners, State/Union Territory Government representatives for their valuable inputs.

The continuous guidance given by the Secretary and AS&MD(NHM) helped us in framing the guidelines. I must give special thanks to the NHM Team especially the Directors and NHSRC Team for their continuous and untiring efforts in giving inputs, compiling responses, and undertaking several revised versions before the guidelines were finalized.

I request all the Principal Secretaries and Mission Directors in the States/UTs to initiate actions for providing commensurate resources through State and other budgetary channels for implementing IPHS 2021 guidelines at public health facilities. I hope that states will adopt these standards and utilize them to develop a state specific comprehensive road map for IPHS certification of their public health facilities.

(Vishal Chauhan)

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FOREWORD

In India, out of the total population of 1210.2 million as on 1st March, 2011, about 377.1 million are in urban areas registering an increase of 32% in the decade from 2001 to 2011. The overall slum population is estimated to be 20% of the total urban population. The National Urban Health Mission aims to address the health concerns of the urban poor by facilitating equitable access to health facilities.

In urban areas, usually the population density is high and there are various types of health care facilities which provide *in*-patient care. However, primary healthcare is inadequate and needs improvement especially in slums/poor localities. So, there was a felt need to expand primary health services in urban areas. Accordingly, a new initiative has been proposed to expand its reach in the community by bringing UHWC for a population of 10,000-20,000. Further, a polyclinic or specialist clinic at UPHC have been introduced for the first time in the programme.

The health care needs of the people in the urban area are different from rural areas. Therefore, looking at the various diversified needs of urban poor, the health facilities need to be equipped to deliver services like critical care, emergency care, and commensurate support services to address the shifting disease burden. Therefore, pre-existing UPHCs and UCHCs providing health care services also needed standards and norms under IPHS.

This is the first time that IPHS for urban health facilities have been developed after wide consultations with the states and experts. It is hoped that this will help states and UTs to upgrade their urban health facilities as per the norms defined under this document. The States/UT officials are expected to undertake gap analysis of services and prepare time bound action plan for filling these gaps for delivery of assured quality services to the people living in urban areas, particularly, in slums and vulnerable pockets.

My sincere gratitude to Shri Rajesh Bhushan, Secretary Health & Family Welfare, Ms. Vandana Gurnani, the then AS&MD and Shri Vikas Sheel, the AS&MD for their support and guidance. I appreciate the efforts taken by Shri Vishal Chauhan, JS (Policy), Director NUHM & NUHM team, Program Divisions of NHM, MoHFW, and NHSRC Team for formulating such uniform standards for the States/UTs which were very much required for further improving the implementation and penetration of urban health programs. I extend my heartfelt thanks to all the experts, state officials and development partners who worked for it and contributed towards the betterment of people in the country.

I hope the guidelines for Community Health Centres for urban and rural will help the States/UTs in improving the standards of services being rendered at public health facilities.

23/09/2021
(Dr. Harmeet Singh)

Dr. Himanshu Bhushan
Member Secretary

New Delhi
11th April 2022

The journey and the vision of IPHS 2022

For public health systems to deliver effectively, standards are important. Standards once developed need to be periodically revisited, so that they continue to be relevant for meeting program requirements. Revision of IPHS followed a systematic process that synthesised the evidences, norms, observations and professional views of the experts.

The IPHS 2022 focusses on the services to be delivered at each level of health facility, which form the basis for developing norms for other health system strengthening components like infrastructure, human resources and capacity building, drugs, diagnostics and equipment, administrative and support services, quality assurance and improvement, monitoring and supervision and related governance issues.

The revision took considerable time since the document was to be representative of the requirements of all the programs of the Health Ministry. Taking inputs from Program Divisions of MoHFW, States, Urban Local Bodies, Experts, Development Partners and other stakeholders helped us relate it further. Various rounds of group meetings and one-to-one discussions took place with all the Program Divisions, and thereafter inputs of senior officials of the Ministry were also incorporated.

It is important to pen down the path traversed for sharing the vision of IPHS 2022, the contribution of experts, the method and learnings, that have implications on implementation and subsequent iterations, which otherwise would be missed out by the people who read it. The long deliberations with the hospital planners, program officers and administrators on the numbers of HR, types of services, diagnostics, drugs, etc. is a reminiscence which I believe is imperative to share.

When it came to norms for human resources, it was unanimously viewed that field realities should not be allowed to dilute the standards. The expectation of services with quality ingrained cannot be fulfilled without adequate human resources. COVID-19 crisis reiterated this fact that human resources are not available in the required ratio which is paramount for service delivery. On one hand was the market demand for health services, and on the other hand was the scarcity of human resources in health, with long working hours and stress for those who chose to stay with public health institutions. This also highlighted the need for comprehensive planning for adequate infrastructure, services, and human resources in the IPHS.

The commitment for IPHS was unequivocal, right from Hon'ble Union Minister of Health and Family Welfare and Union Minister of State - MoHFW, to all senior levels of health functionaries Secretary (H&FW), AS & MD (NHM) and JS (Policy). During the 13th CCHFW, the Health Ministers of States/UTs, under the chairpersonship of the Hon'ble Union Minister of Health and Family Welfare, resolved to

achieve IPHS in all public health facilities across the country in a timebound manner. The Hon'ble Union Health Minister was also taking updates on the progress and his suggestions have been incorporated. Representatives from the NITI Aayog also gave valuable inputs and guidance from time to time.

During the process of this revision, deliberations were led by JS (Policy) Dr. Manohar Agnani, Mr. Vikas Sheel and Mr. Vishal Chauhan at various stages. I would like to place on record the inputs and contributions given by the present Health Secretary Shri. Rajesh Bhushan, former Health Secretary, Ms. Preeti Sudan, former AS & MD, Mr. Manoj Jhalani, and Ms. Vandana Gurnani, all Joint Secretaries (Policy) and ED NHSRC Dr. Atul Kotwal, in guiding us towards framing of these standards. I would also like to thank the experts from Medical Colleges like AIIMS -New Delhi, Patna & Bhopal, Lady Hardinge Medical College-Delhi, PGIMER-Chandigarh, VMMC and Safdarjung Hospital-Delhi and MGIMS-Sewagram. The contribution and valuable inputs given during the expert group meetings by Development Partners like UNICEF, UNFPA, WHO, World Bank, Jan Swasthya Sahyog (JSS), Medical Service Corporations of Kerala, Madhya Pradesh, Odisha, Rajasthan, Tamil Nadu, and also state and district representatives from Madhya Pradesh, Maharashtra, Odisha, Tamil Nadu, Uttar Pradesh, West Bengal is acknowledged in developing these guidelines.

I also recognise the immense support given by the team from NHM and NHSRC for drafting these guidelines. The constant support by all the Advisors at NHSRC and their valuable inputs and suggestions helped in further improving the quality. I vividly recall the contributions of Ms. Mona Gupta in finalizing the HRH norms, Dr. J. N. Srivastava in drugs, Dr. Ranjan Kumar Choudhury, in equipment and oxygen and Dr. M. A. Balasubramanya on wellness components of health. The relentless efforts by the PHA team, particularly, Mr. Prasanth K.S., Mr. Ajit Kumar Singh, Dr. Smita Shrivastava, Dr. Kalpana Pawalia, Dr. Aashima Bhatnagar, Dr. Poonam, Ms. Diksha Rathee, Dr. Aditi Joshi, Dr. Ashutosh Kothari and Ms. Neelam Tirkey in updating IPHS after receiving inputs from the stakeholders cannot be forgotten.

I hope that States will adopt these standards and utilize them to develop a state specific comprehensive road map for IPHS certification of their public health facilities for meeting the commitments under NHM. It is important to know that the journey of the IPHS has been a dynamic one, and all the key stakeholders must be responsive enough to meet the ever-evolving requirements and challenges. The expected output is IPHS certification of public health facilities and provision of respectful, dignified, and quality services to the patients is the outcome envisioned.

The inspiration behind the IPHS 2022 is the conviction to build health facilities that give rich treatment to poor people. These standards play a critical role in minimising the out-of-pocket expenditure by the people who cannot afford healthcare in private sector. This document is dedicated to the citizens of the country so that they remain hopeful of our public health delivery system.

(Dr. Himanshu Bhushan)

TABLE OF CONTENTS

ANNEXURES

LIST OF ABBREVIATIONS

AB-HWC	Ayushman Bharat – Health and Wellness Centre
AERB	Atomic Energy Regulatory Board
AFHC	Adolescent Friendly Health Clinics
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy
BCC	Behaviour Change Communication
BMO	Block Medical Officer
BMMP	Biomedical Equipment Management and Maintenance Program
BMW	Bio-Medical Waste
BMWM	Bio Medical Waste Management
BPL	Below Poverty Line
CDR	Child Death Review
CHC	Community Health Centre
CMO	Chief Medical Officer
CPHC	Comprehensive Primary Health Care
CRP	C- Reactive Protein
CVD	Cardiovascular Disease
DEO	Data Entry Operator
DMO	Duty Medical Officer
DOTS	Directly Observed Treatment Short Course
DH	District Hospital
EDL	Essential Drug List
EML	Essential Medicines List
EQAS	External Quality Assurance System
FDI	Free Diagnostic Initiative
FEFO	First Expiry First Out
FRU	First Referral Unit
GoI	Government of India
GDM	Gestational Diabetes Mellitus
GDMO	General Duty Medical Officer
GR	Grievance Redressal
HBYC	Home Based Care for Young Child

HR-MIS	Human Resource Management Information System
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Programme
IEC	Information, Education and Communication
ICT	Information and Communications Technology
IFA	Iron and Folic Acid
ILR	Ice-lined Refrigerator
IPD	In-Patient Department
IPHS	Indian Public Health Standards
IQC	Internal Quality Control
ISQHC	International Society for Quality in Health Care
IUCD	Intra-Uterine Contraceptive Device
JAS	Jan Arogya Samiti
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana (JSY)
LBW	Low Birth Weight
LDC	Lower Division Clerk
LDR	Labour Delivery Recovery
LHV	Lady Health Visitor
MAS	Mahila Arogya Samiti
MCH	Maternal and Child Health
MDSR	Maternal Death Surveillance and Response
MO	Medical Officer
MRD	Medical Record Room
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NACP	National AIDS Control Programme
NBC	National Building Code
NCDs	Non-Communicable Diseases
NIDDCP	National Iodine Deficiency Disorders Control Programme
NPCB & VI	National Program for Control of Blindness and Visual Impairment
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular disease and Stroke
NPPCD	National Program for Prevention and Control of Deafness
NPPCF	National Program for Prevention and Control of Fluorosis
NQAS	National Quality Assurance Standards
NQAP	National Quality Assurance Program
NRHM	National Rural Health Mission
NSV	Non-Scalpel Vasectomy
NTEP	National TB Elimination Program
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme

OPD	Out Patient Department
OT	Operation Theatre
PHC	Primary Health Centre
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PNC	Post Natal Care
PPTCT	Prevention of Parents to Child Transmission
QoC	Quality of Care
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SAM	Severe Acute Malnutrition
SDGs	Sustainable Development Goals
SDH	Sub District Hospital
SHC-HWC	Health and Wellness Centre-Sub Health Centre
SRH	Sexual Reproductive Health
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TOR	Terms of Reference
TLD	Thermo Luminescent Dosimeter
UHC	Universal Health Coverage
ULB	Urban Local Bodies
UCHC	Urban Community Health Centre
UHND	Urban Health and Nutrition Day
UPHC	Urban Primary Health Centre
USG	Ultrasound Sonography Test
VIA	Visual Inspection using Acetic Acid
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
VHSNC	Village Health Sanitation and Nutrition Committee
WCD	Women and Child Development

READER'S GUIDE FOR HEALTH AND WELLNESS CENTRE - PRIMARY HEALTH CENTRE

There is no right or wrong way to use the Indian Public Health Standards (IPHS) 2022. You can straight away go to the section you are interested in and want information on. This could be related to infrastructure, human resources for health (HRH), drugs, diagnostics, or you can read through the entire book to understand what the expected standards are at a particular level of facility. We expect that the public health planners would use this book as a reference and return to it time and again.

Each book has sections dedicated to the objectives of IPHS, its guiding principles, population norms, the essential and desirable standards **(desirable services/HR/diagnostic tests and equipment are over and above indications mentioned as essential)** for service provision, as well as framework for implementation of IPHS.

- **Section 1:** The **Background** section briefs on the journey towards the Global Strategy for Health for All and Universal Health Coverage (UHC) and the reasons the IPHS are needed.
- **Section 2:** The section on **Introduction** includes the rationality behind revising the IPHS. It briefly describes how IPHS can accelerate India's progress towards achievement of UHC and Sustainable Development Goal - 3 (SDG 3) in alignment with the National Health Policy 2017.
- **Section 3:** This section includes the key **objectives of the IPHS** for Health and Wellness Centres-Primary Health Centre/Urban Primary Health Centre.
- **Section 4:** It includes the types or categories of HWCs-PHCs/UPHCs, the purpose of establishing them and the population norms at which the PHCs are to be established in the rural as well as the urban areas.
- **Section 5:** It includes the bed requirement for primary care facilities (HWCs - PHCs/Urban PHCs) based on **Population norms.**
- **Section 6:** It contains the **General Principles** that are to be adopted by the States and Union Territories (UT) to strengthen the service delivery and ensure better implementation of National Health Programmes.
- **Section 7:** Defines the minimum **Criteria** for the healthcare facility to be identified as '**IPHS Compliant**'.
- **Section 8:** The section on **Service Provision** includes the details of:

    a. Types of service provision through the facilities;

    b. Basis for establishing health facilities, infrastructure requirement and general appearance and upkeep of facilities;

    c. Prescribed norms to be followed for illumination, fire safety, disaster and emergency preparedness, water and sanitation and power backup;

    d. Standard protocol to be adopted for better service delivery;

e. HRH requirement for ensuring service availability, conduct and behaviour standards and safety measures to be adopted for the HRH;

f. Essential medicines to be available free of cost in the health facilities under 'Free Drug Services Initiative' of GoI;

g. Essential diagnostics to be provided in the health facilities;

h. Equipment required for providing services being offered through the facilities;

i. Quality assurance protocol to be adopted including roadmap for health care facilities to achieve National Quality Assurance Standards (NQAS) certification;

j. Ensuring accountability and governance in service delivery; and

k. Framework of implementation of IPHS.

BACKGROUND

1 SECTION

India has a rich past in the field of medical sciences. Both physical and mental health were considered important parameters of health. The *'Charaka Samhita"* was the mainstay for medicine for centuries and *"Sushruta Samhita"* was the ancient medical compendium of surgery compiled around 6th century B.C.

The Buddhist era in the 6th century B.C. saw the establishment of *"Viharas"* - monasteries for the care of the sick, impoverished, and disabled, as well as medical education. Several hospitals were operational throughout King Ashoka's reign in the 2nd century B.C. Modern hospitals and healthcare systems were constructed. From the late 19th century through the early 20th century, the first medical colleges were established for organized medical training. Further, dispensaries were established at sub-division and district level and hospitals at provincial level were attached to medical colleges.

The present focus of public health evolved slowly across the globe. The broad foundations of public health later evolved when Winslow defined public health as "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals." [1]

With the emerging recognition of public health, government initiated efforts towards formal training in public health. The public health workforce consisted of personnel from both medical and non-medical backgrounds that included ANMs, nurses, midwives, sanitary inspectors, sanitary assistants, health officers, and physicians. In 1946, the Health Survey and Development Committee *(Bhore Committee)* recommended the establishment of health centres for providing integrated curative and preventive services.

Primary health care gained prominence in 1978 following an international conference in Alma-Ata. The primary health care approach is based on principles of social equity, nation-wide coverage, self-reliance, intersectoral coordination, and people's involvement in the planning and implementation of health programmes in pursuit of common health goals. The Declaration of Alma-Ata stated that primary health care is an important parameter for achieving an acceptable level of Health for All by 2000. As a signatory to the Alma-Ata Declaration, the Government of India, has pledged itself to provide primary health care.

With Article 21, Constitution of India guarantees that no person shall be deprived of his/her life or personal liberty. "Life" here is neither the mere physical act of breathing nor connotation of continued drudgery through life. It has a much wider meaning which includes right to live with human dignity, right to livelihood, right to pollution free air and right to health. Article 47 enforces the government's commitment further by directing the State to raise the level of nutrition and the standard of living and to improve public health.

The 30th World Health Assembly resolved in May 1977, that the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. The Alma-Ata Declaration called on all governments to formulate national policies, strategies and plans of action to launch and sustain

[1] *Ahmed F U. Defining public health. Indian J Public Health [serial online] 2011 [cited 2021 Jul 18];55:241-5. Available from:* https://www.ijph.in/text.asp?2011/55/4/241/92397

primary health care as part of a national health system. It was left to each country to innovate, according to its own circumstances to provide primary health care.

This was followed by the formulation and adoption of the Global strategy for Health for All by the 34th World Health Assembly in 1981. Health for All means that health is to be brought within the reach of everyone in a given community. It implies the removal of obstacles to health - that is to say, the elimination of malnutrition, ignorance, disease, contaminated water supply, unhygienic housing, etc. It depends on continued progress in medicine and public health. The foundation for Universal Health Coverage is a universal entitlement to comprehensive health security and an all- encompassing obligation on the part of the State to provide adequate food and nutrition, appropriate medical care, access to safe drinking water, proper sanitation, education, health-related information, and other contributors to good health.

Primary Health Care spans across the lifespan of a person and is based on principles of social justice, equity and right to health and in recognition of the fundamental right to the highest attainable standard of health, echoing Article 25 of the Universal Declaration on Human Rights. It is an integral part of overall social and economic development in addition to catering to the healthcare needs of the country. Primary health care strives to provide affordable, accessible, practical, quality and socially acceptable healthcare to the community

To meet all these national and international commitments, it is essential for public health facilities to deliver quality services through defined standards known as the Indian Public Health Standards (IPHS).

In the year 2005, National Rural Health Mission (now National Health Mission) was launched for "attainment of universal access to equitable, affordable and quality health care services, accountable & responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health".

Also, recently the Astana Declaration in October 2018 endorsed emphasizing the critical role of primary health care around the world. The declaration aims to refocus efforts on primary health care to ensure that everyone everywhere is able to enjoy the highest possible attainable standard of health.

To meet all these national and international commitments, it is essential for public health facilities to deliver quality services. Thus, the Indian Public Health Standards (IPHS) for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDH) and District Hospitals (DH) were published in 2007 and revised in 2012, as the reference point for public health care facility planning and up-gradation. They are a set of uniform standards envisaged to deliver quality services to citizens with dignity and respect. They provide guidance on the health system components such as infrastructure, human resource, drugs, diagnostics, equipment, quality, and governance requirements for delivering health services at these facilities.

INTRODUCTION

2 SECTION

The delivery of services through the public health sector in India follows the three-tier structure of primary, secondary, and tertiary health care services. This covers both rural and urban areas. While the health services in rural areas have always been integral part of the public health sector, focus on urban health came during RCH–I and continued in RCH-II as part of NRHM.

However, in 2013, while reorganizing National Health Mission, the National Urban Health Mission (NUHM) was launched with the aim to provide affordable primary healthcare through UPHCs, UCHCs and outreach services to the urban population in India, with special focus on people living in listed, unlisted slums, homeless, rag-pickers, migrants, and other vulnerable population.

Since then, some key policy shifts have been proposed under the National Health Policy (2017) for public health care delivery system in the following areas:

- **Clinical care** – from stand–alone curative to a preventive, promotive and rehabilitative approach for achieving comprehensive wellness in health.
- **Primary care** – from selective care to assured comprehensive care with linkages to referral hospitals.
- **Drugs, diagnostics, and emergency services -** from user fees and cost recovery to assured free drugs, diagnostic and emergency services to all in public hospitals.
- **Infrastructure and human resource development**– from normative approach to targeted approach to reach under-served areas with "time to care approach".
- **Urban health**– from token interventions to on-scale assured interventions to organize Primary Health Care delivery and referral support for urban poor. Collaboration with other sectors to address wider determinants of urban health is advocated.
- **National health programmes**- integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for efficiency.

Primary Health Centres essentially deliver preventive, promotive, basic curative, palliative, and rehabilitative services encompassing community and programmatic requirements. Primary healthcare services in India have till now been delivered through Sub-centres and Primary Health Centres in rural areas and Urban Primary Health Centres in urban areas.

In February 2018, the Government of India announced 1,50,000 Ayushman Bharat- Health and Wellness Centres (AB-HWCs) to be established across the country by December 2022. The existing Sub- Health Centres (SHC), Primary Health Centres (PHC) and Urban Primary Health Centres (UPHC) are being transformed into AB-HWCs to deliver Comprehensive Primary Health Care (CPHC) that includes preventive, promotive, curative, palliative and rehabilitative services which are universal, free, and closer to the community.

Since the last revision of the IPHS in 2012, a number of new initiatives, interventions, programmes and projects have been introduced in the public health system. The National Health Policy, 2017 recommended strengthening the delivery of Primary Health Care, through establishment of "Health and Wellness Centres",

as the platform to deliver Comprehensive Primary Health Care with the principle of "time to care" to be no more than 30 minutes.

To accommodate these developments, it is essential to incorporate them in existing IPHS so that the revised IPHS 2022 are informed by stakeholder feedback about the relevance and usefulness of these standards and remain fit-for-purpose in light of emerging evidence and advancements in health, science, and technology.

Revised IPHS guidelines 2022 also define the components specific to urban health facilities to set benchmarks to achieve the goal of universal health coverage.

The 2022 IPHS guidelines have been framed for-

- Sub-District Hospitals (SDH) & District Hospitals (DH),
- Community Health Centres (CHC) – rural and urban,
- Health and Wellness Centre – Primary Health Centre (PHC) – rural and urban, including Multispecialty UPHC (Polyclinics) in urban areas,
- Health and Wellness Centre – Sub Health Centre (SHC) – rural and urban.

The 2022 revised guidelines emphasize on the services to be delivered at each level of facility. Service delivery defined for each level of health facilities will be the basis for developing other health system strengthening components viz. infrastructure, human resources, drugs, diagnostics/equipment, quality improvement, monitoring/supervision, governance, and leadership.

The 2022 IPHS norms support government health facilities to attain a minimum acceptable functional standard (indicated as 'essential') while striving and aspiring for improvement (indicated as 'desirable') so as to accelerate India's progress towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG-3) in alignment with the National Health Policy 2017.

This document lays down norms for Primary Health Centres (PHC), Urban Primary Health Centres (UPHCs) and UPHCs with specialist services (Polyclinics) for delivery of comprehensive primary health care. This would facilitate state/district/facility level planning teams to considers health service provision holistically for a district and implementation of norms which should be based on the local burden of disease.

OBJECTIVES OF IPHS FOR HWC-PHC

3 SECTION

The broad objectives of the Indian Public Health Standards (IPHS) for PHC in rural and urban areas include the following:

1. To define uniform benchmark to ensure high quality services that are accountable, responsive, and sensitive to the needs of the community.
2. To specify the minimum assured (essential) and achievable (desirable) services that are expected to be provided at different levels of public health facilities.
3. To provide guidance on health systems strengthening components which includes architectural design of facilities, human resources for health, drugs, diagnostics, equipment, administrative and logistical support services to improve the overall health related outcomes
4. To achieve and maintain an acceptable standard of the quality of care at public facilities
5. To facilitate monitoring and supervision of the facilities
6. To provide guidance and tools for governance, leadership and evaluation.

4
SECTION

TYPES/CATEGORIES OF PHC/UPHC

In comparison with the IPHS guidelines of 2012, the revised IPHS 2022 guidelines classify the rural and urban PHC as:

a) **HWC-PHCs**: Ideally, for rural areas, the states should aspire to make all PHCs functional as 24x7 facilities. However, there is a need to prioritize PHCs conducting deliveries to function as 24x7 HWC-PHCs. All other PHCs should continue to provide routine care along with preventive and promotive health interventions and function as PHCs-HWCs.

b) **Urban HWC-PHCs:** In urban areas, assured round-the-clock emergency and secondary care services are readily available, owing to the presence of higher level health care facilities. Thus primary health centres are expected to provide routine OPD care along with preventive and promotive health interventions and function as UPHCs-HWCs. However, the UPHCs with indoor beds already conducting deliveries can continue to function as 24x7 UPHCs-HWCs.

c) **Specialist UPHC/Polyclinic (Urban):** "Multispecialty UPHC/Polyclinics" in urban areas should be established with the aim to further reduce morbidity and mortality by providing specialist services on ambulatory/day care basis, closer to the urban community. Such poly clinic services would be limited to outpatient care.

POPULATION NORMS FOR HWC-PHC

5 SECTION

Normally, a PHC in rural areas is to be established for a population of 20,000 (in hilly and tribal areas) and 30,000 (in plains). It should be established co-terminus with Panchayats (depending upon the population) to establish effective convergence and linkages with citizen centric services. A Primary Health Centre (PHC) that is linked to a cluster of Sub Health Centre - HWCs would be strengthened as HWC to deliver the expanded range of primary care services with complete 12 package of services. In addition, it would also serve as the first point of referral for all the SHC-HWCs in its jurisdiction.

In urban areas, usually the population density is high and there are various types of health care facilities which provide inpatient care. So, the approach in urban areas for establishing PHCs shall be different from that in rural areas. UPHCs are established for every 50,000 population, and in close proximity to urban slums. Multispecialty Polyclinics provide specialist healthcare services to a population of 2.5 to 3 lakhs, encompassing the catchment population of 5-6 UPHCs, depending upon geographic location, population density, available infrastructure, etc.

Population norm for HWC-PHC			
S. No.	**Type of PHC facility**	**Plain (population)**	**Hilly and Tribal areas (population)**
1	**Rural PHC**	30,000	20,000
2	**Urban PHC**	50,000	–
3	**Polyclinic**	2.5 lakh - 3 lakh	–

6 SECTION

GENERAL PRINCIPLES OF IPHS

- IPHS defines the standards in the local context of the country and its implementation is the state's/UTs responsibility with technical support from MoHFW. IPHS does not define the implementation process. However in the interest of rendering quality patient services, it suggests that in-house hiring of clinical and critical staff should be prioritized rather than those services which can efficiently be run even through outsourcing model like security, cleaning, laundry, etc.
- While planning and designing services at public health facilities, health needs of the entire district should be considered as a whole rather than focusing on individual facilities within that district. This holistic assessment should include a systematic review of the burden of disease in that district, the local epidemiology and the specific needs and requirements of communities in different parts of the district. While placing services at various levels, "continuum of care" approach needs to be ensured for the population.
- For each district/city, the final number of health facilities will be influenced by its population, time to care, geographical need, local epidemiology and burden of disease, community requirements and the health seeking behaviour of the population. Every district should have a district health action plan, with all health facilities identified and mapped, and indicating the type and level of services they provide.
- Depending on the services provided at a particular facility, it may be deemed as a primary or secondary care service provider facility:
  - Health and Wellness Centres (Sub-Centres and PHCs), in both rural and urban areas will provide primary care services.
  - Multispecialty polyclinics, nearer to the community, will provide ambulatory specialist services in urban areas.
  - Community Health Centres, in rural areas can be either non-FRU or FRU depending on the range of services provided. In urban areas, CHCs will provide services at par with FRU.
  - District and Sub-District Hospitals will provide secondary care services.
- Implementation of all national programmes at individual facilities must be in line with the latest GoI/state guidelines developed for that programme.
- Requirements of individual national health programmes (in terms of service delivery, infrastructure, human resources, drugs, and diagnostics) have been reviewed and included in IPHS. Therefore, achieving IPHS compliance would go a long way in fulfilling the requirements of various health programmes.
- The specific set of services to be provided at a particular facility is clearly defined in the list of services. Requirements of individual national health programs have already been considered in this list. This will help to identify requirements for infrastructure, HRH, drugs, diagnostics, and equipment.
- IPHS prescribes norms for allopathic services. However, AYUSH services have been retained in IPHS 2022 as desirable. The HRH, medicines, and other inputs required for AYUSH services shall be given by Ministry of AYUSH.

- All statutory and regulatory standards relevant to a particular facility should be followed and adhered to in accordance with the latest national/state guidelines, rules, and regulations.
- A Citizens' Charter should be prominently displayed near the entrance of the facility. This should provide information about the various services being offered, timings, responsibilities of patients and providers, details of referral vehicles and facilities, the number of free drugs and diagnostics being provided and other citizen friendly information. Patients' rights should be ensured, and they should also be made aware of their responsibilities (e.g., to keep the facility clean and avoid spitting in corners, avoiding over-crowding by attendants, respecting visiting hours, not causing any harm to public property or indulging in violence against healthcare professionals etc.). A sample Citizens' Charter is placed at **Annexure *1*.**
- All HWC-PHCs, should have façade branding as per the GoI guidelines. IT infrastructure should be set up to enable teleconsultation services and reporting on the respective databases.

7
SECTION

CRITERIA FOR IPHS COMPLIANCE

For any public health facility to be considered as compliant with IPHS norms, a minimum standard for both the quantity and quality of services should be achieved. A facility will be deemed as IPHS compliant if it fulfills the criteria that it provides all the 'essential' services identified for that level of facility rendered through requisite Infrastructure, Human Resources for Health, Drugs, and Equipment.

The norms for service provision, infrastructural and human resource requirements, drugs, diagnostics and equipment, quality assurance, monitoring and governance are defined for all facilities in rural and urban areas. General guidance on these components is presented in the sections that follow.

The mechanism and criteria for IPHS certification can be accessed at the link given below:

https://nhsrcindia.org/IPHS2022

SERVICE PROVISION

8 SECTION

Presently even a well-functioning primary health centre provides services that are limited to reproductive, sexual and child health along with some of the National Disease Control Programmes. These conditions put together for which people seek health care, represent less than 15% of all services. For all the rest, people have no option but to resort to either the local private care provider or travel to the crowded District Hospital or Medical College hospital.

Ayushman Bharat with its two inter-related components of Health and Wellness Centres (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY) represents a paradigm shift towards India's path to Universal Health Coverage (UHC). While PM-JAY is the largest health assurance scheme in the world which caters to BPL and certain other categories of the Indian population for secondary and tertiary care hospitalization, the AB- HWCs are envisaged to deliver an expanded range of comprehensive primary healthcare services which address the basic primary healthcare needs of the entire population in their area. The two combined, expand access, universality, and equity in health care service delivery in the country.

Primary healthcare plays a major role in delivering comprehensive set of services. In addition to the basic curative services of primary care level, Health and Wellness Centres have an important role in the prevention of several disease conditions, including both communicable and non- communicable diseases. They are envisaged to deliver people centred, holistic, equity sensitive response to people's health needs through a process of population enumeration, facility based and outreach services, regular home-based and community interactions and improve people's participation. A community based participatory approach, which ensures preventive and promotive actions, considered as a priority for health, is the primary objective of these centres.

The twelve packages envisaged under Comprehensive Primary Healthcare services (CPHC) are:

1. Care in Pregnancy and Childbirth
2. Neonatal and Infant Health Care Services
3. Childhood and Adolescent Health Care Services
4. Family Planning, Contraceptive Services, and other Reproductive Health Care Services
5. Management of Communicable Diseases: National Health Programmes
6. General Out-patient Care for Acute Simple Illnesses and Minor Ailments
7. Screening, Prevention, Control and Management of Non-communicable Diseases
8. Care for Common Ophthalmic and ENT Problems
9. Basic Oral Health Care
10. Elderly and Palliative Health Care Services
11. Emergency Medical Services including Burns and Trauma
12. Screening and Basic Management of Mental Health Ailments

The provision of health services includes, early identification, basic management, counselling, ensuring treatment adherence, follow-up care, ensuring continuity of care by appropriate referrals, optimal home and community follow-up, and disease surveillance.

These PHCs also play an important role in undertaking public health functions in the community leveraging the frontline workers and community platforms.

They go beyond first contact care, and hence are expected to mediate a two-way referral support to primary and secondary level facilities as well as ensure follow up support for individual and population health interventions. PHCs/UPHCs have a critical role in referral and follow up and should establish strong upward (CHC/UCHC) and downward (community and outreach) linkages.

Outreach services to the community will also be a part of the service package at PHCs/UPHCs (e.g., VHNDs, UHNDs, special outreach). The details are placed at ***Annexure 2.***

The multispecialty UPHC (polyclinic), in addition to the services provided by UPHC, would provide day care/ ambulatory specialist care to the urban population. Fixed day rotational multispecialty OPD for a minimum of six specialties, viz. Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology and Psychiatry would be provided at the polyclinic. However, states would have the flexibility to begin with 2-3 specialty services and gradually expand the range to six specialties. Over and above these, states may add any other specialist as per the needs of the population and availability of specialist. Polyclinic should plan and provide oral, physiotherapy and/or optometrist services also, as per local requirement. Diagnostic services for all the specialties concerned along with point of care testing should be made available at polyclinic.

Some of the specialized services such as X-ray, USG, CT scan, etc. are not essentially needed to be there but if required can be linked with the facility available nearby like FRU CHC, SDH or DH.

HWC-PHC should also be utilized as a platform for teleconsultation and expanding the range of diagnostic services in hub and spoke model.

The services to be provided at these types of facilities are identified as 'essential' and 'desirable'. The former includes those 'minimum assured services' that every facility at that level must provide. Desirable services are those that a facility should aspire to ultimately achieve (if not already being provided) over a period of time depending on the needs of community. Thus, **desirable will be over and above essential services.**

To ensure continuum of care, assured referral with facility readiness to manage referred cases must be established at HWC-PHC, UHWC-PHC and Polyclinic. The referral transport network should have the requisite number of equipped ambulances (depending on population norms) and adequately trained human resources.

All infrastructure plans and human resource requirements should be based on the range of services to be provided at that facility.

Service flow at PHC/UHWC-PHCs:

The suggestive flow of services as underneath should be followed for IPHS recognition in any PHC/UPHC-

Enquiry → Registration → Waiting Area → Doctor's Consultation Room → Injection Room/Dressing Room → Laboratory → Doctor's Consultation Room → Pharmacy → Exit.

Collaboration with other sectors have also been identified and listed for certain services such as nutritional support with the Department of Women and Child Development, school health with the education department and vector control activities with the ULBs/PRIs.

8.1. INFRASTRUCTURE

The HWC-PHC should be located such that they are easily accessible by the rural community which they plan to serve.

The UHWC-PHC should also be located such that under-served population in urban slums in cities and peri-urban areas can access the services. Similar to rural areas, where sub-centres are functional under PHCs, Urban Health and Wellness Centres (UHWCs) are functional under UPHCs. These UHWCs should preferably be located within 1 k.m. radius from the periphery of underserved population of urban slum, vulnerable pockets, and temporary settlements, which the National Urban Health Mission intends to serve.

The multispecialty polyclinic should be centrally located for easy access from all UPHCs and UHWCs. The existing UPHC should be augmented with adequate space/rooms for specialist consultation and other services, for strengthening it as multispecialty UPHC or Polyclinic.

At times, the availability of land is a challenge, so the possibility of vertical expansion can be considered. However, for a facility (PHC/UPHC) to be IPHS compliant, sufficient space along with essential services as prescribed in these guidelines should be provisioned for.

The infrastructure for PHCs/UPHCs and multispecialty polyclinics should follow the rules and regulations as laid down in the state by-laws and the National Building Code.

Infrastructure planning of a PHC, 24x7 PHCs/24x7 UPHC and UPHC should ideally be as per the standard layout plan. ***(Annexure 3a, 3b and 3c)***

Layout for 24x7 UPHCs will be same as of the 24x7 PHC. ***(Annexure 3b)***

For already existing facilities, the flow of services needs to be ensured as per the standard plan and if required, additional infrastructure can be created, or existing structures modified to meet the deficiencies. Old and dilapidated facilities may need to be demolished to build new infrastructure. However, while demolishing any old building, it should be ensured that alternate arrangements are made for effective and continued provision of the existing services. Factors to be considered while building a new facility or selecting a new site for a facility include:

- Accessibility to the community (with good road connectivity).
- Ensuring the facility is not in a flood prone area.
- Ensuring it is adequately serviced by public utilities such as water, electricity and telephone connectivity, sewage, and storm-water disposal.
- Ensuring elderly and disabled friendly access including visual and physical disability.
- Minimizing exposure to air, noise, water and land pollution and vector-breeding and ingress proof buildings.
- Reviewing land utilization in adjoining areas, obtaining the necessary environmental (including seismic safety), fire safety and administrative clearance.
- The state and area specific by-laws and rules should be strictly adhered to.

The foundation of the health facility infrastructure should be strong enough to meet the requirement of the seismic zones of that area and also for any future expansion. It should strictly adhere to the statutory fire safety norms. An open area to facilitate the management of disasters and emergencies is also recommended.

Location of PHC to be constructed should be decided through a consultative process involving community, gram panchayat/ULB members, community forest rights committees, BMO/DMO and others. Construction of the new building in rural areas should preferably be undertaken in a central location with high population density and not in the peripheral areas of the villages.

Emphasis should be given to create a positive, client friendly ambience and environment around the facility with space/room for yoga and other wellness activities. This includes due consideration to the provision of facilities for uninterrupted electricity supply, patient registration, waiting areas, clear wayfinding and signposting, parking, gardens, washrooms, drinking water and disable-friendly facilities. Processes such as registration and drug dispensing should be computerized with electronically supported queue systems in all service areas. The facility should be environment friendly with scope for adequate natural light, water harvesting and solar energy, if appropriate along with adequate Biomedical waste management and drainage. There should be enough storage space for medicines, equipment, documents, health records and registers. All infrastructure should be climate, environmental change and disaster resilient.

Infrastructural requirements for certain support services are common for all facilities. General principles to bear in mind are presented here:

8.1.1. General Appearance and Upkeep

The facility should have a high boundary wall. Adequate lighting should be ensured so that the facility is clearly visible from the approach road. There should be no encroachment in and around the facility. It should be plastered and painted in a uniform colour scheme and free from seepage, cracks, and broken windowpanes. There should be no unwanted/outdated posters or hoardings on the walls of building and the boundary wall of the facility. The floors should be anti-skid and non-slippery. Branding as per GoI norms should be completed for HWC-PHCs.

8.1.1.1. Way-finding/Signage

Adequate and clear signage should be displayed on the main and connecting roads to the facility. They should be in a font which is easily visible from a distance. A board clearly indicating the name of the facility, should be placed at the front of the facility (including in English, Hindi and local language, if any).

The layout of the facility should be displayed near the entrance. Safety, hazard and caution signs should be prominently displayed at relevant places. A fire exit plan with fluorescent signage should be placed where appropriate. Tactile pathways should be placed for visually incapacitated visitors.

Important information such as contact numbers (e.g., fire, police, ambulance, blood banks and referral centres) must be clearly displayed.

8.1.1.2. Parking

Facilities for parking commensurate to the estimated vehicle load (patients, staff, fringe) should be part of the infrastructure plan with ample access for vehicles and ambulances.

8.1.1.3. Garden and green areas

Gardens, other green areas and open spaces give a positive, healing environment that reduces stress, anxiety and mental fatigue. Thus, wherever possible, identify and promote greenery and open spaces. Herbal gardens should be promoted in the campus of the health facility.

8.1.1.4. Environment friendly features

The facility should be environment friendly and energy efficient. Where possible, the use of rainwater harvesting, solar energy and energy-efficient bulbs/equipment should be encouraged.

While constructing the facility building, the effect of sun, rain, wind, soil, and other climatic factors which could have an adverse effect on the building needs to be considered, e.g., dampness and seepage can lead to spoilage of medicines in the drug store.

8.1.1.5. Disabled and elderly friendly access

For easy access of non-ambulant (wheelchair, stretcher), semi-ambulant, physically, and visually disabled and elderly people, infrastructure norms in line with the 'Guidelines and Space Standards for barrier-free built environment for Disabled and Elderly Persons' of the Government of India should be followed. Provisions of the 'Persons with Disability Act, 2016' should be implemented. Those facilities that lack such amenities must plan and retrofit them in the facilities.

In order to support the needs of visually disabled visitors, it is also advised that tactile signs should be installed with a good contrast between letters and background. It is recommended to install one/two rows of tactile guiding blocks along the entire length of the accessible route. Care should be taken to ensure that there are no obstacles, such as trees, poles, or uneven surfaces, along the route traversed by the guiding blocks.

8.1.1.6. Circulation areas, corridors, and ramps

The flooring of circulation areas such as corridors, ramps, staircases, and other common spaces should be anti-skid and non-slippery. Patient & service lifts are preferred over ramps for buildings with vertical expansion. Ramps for patient movements from one floor to other are space occupying and costly whereas lifts can operate efficiently with little space. However if lifts are installed, alternative source of power needs to be ensured with maintenance facility for the lifts. The size of corridors, ramps, and stairs should be conducive for maneuverability of wheeled equipment. Ramps shall have a slope of 1:15 to 1:18 and should be checked for maneuverability.

8.1.1.7. Disaster and emergency preparedness

All health care facilities should be resilient to climatic and environmental changes. They should also be able to handle sudden healthcare needs during disasters and unforeseen emergencies/epidemics/pandemics etc. While creating infrastructure seismicity of zones needs to be considered. Wherever the health facilities are already existing possible retrofitting should be planned.

Healthcare facilities shall be inspected by competent licensed engineers after every damaging earthquake to document damages (if any) to Structural Element (SEs) and Non-Structural Element (NSEs) of the buildings, along with recommendations for detailed study and suitable retrofitting as found necessary.

Detailed norms for disaster preparedness and safe electricity are placed at ***Annexure 4.***

All staff should be trained on relevant disaster prevention and management procedures along with climate and environment resilient features. Structural and non-structural earthquake proof measures (in line with the State Govt. guidelines) should be incorporated. These include simple non-structural measures like fastening of shelves, almirahs and movable equipment, etc., as appropriate. Similarly, in flood prone areas, structural provisions like raised floor, sloping RCC roof for quick rainwater drainage, etc. should be factored in.

8.1.1.8. Fire safety

Compliance as per state and central government guidelines for fire regulations should be ensured while planning for a PHC/UPHC. Availability of open spaces, clearly visible fire exits with proper illumination and lighting (even during interruption in electric supply) are some of the important considerations for creating fire safe infrastructure.

As a principle, none of the fire exit doors should be kept locked. These doors should be fire resistant and can be opened towards outside with a push bar system on the doors. Fire detectors, extinguishers, sprinklers, and water connections should be functional and easily accessible. Periodic monitoring and audit for fire safety and drills should be organized and conducted. All healthcare facilities should be so designed, constructed,

maintained, and operated as to minimize the possibility of a Fire emergency requiring the evacuation of occupants. Safety of hospital occupants cannot be assured adequately by depending on evacuation alone. Hence measures should be taken to limit the development and spread of a fire by providing appropriate arrangements within the hospital through adequate staffing & careful development of operative and maintenance procedures consisting of:

- Design and Construction.
- Provision of Detection, Alarm and Fire Extinguishment.
- Fire Prevention
- Planning and Training programs for Isolation of Fire; and,
- Transfer of occupants to a place of ***comparative safety*** or evacuation of the occupants to achieve ***ultimate safety***

8.1.1.9. Electric power supply

The public health facilities should have access to adequate, affordable, continuous and reliable electricity supply. Distribution of electric load along with load balancing to various equipment and installations in a facility is very important since overloading at any point can result in mishap like electric fire hazard or can damage the equipment. Similarly, fluctuation in voltage also adversely affects the equipment and hence automatic voltage regulators which regulate fluctuating input power voltage and maintain constant output voltage should be provided. Electrical installation is a specialized job and must be given due importance to ensure reduced risks to the patient. Adequate no. of electric points on various walls (at < 1.5 m height from the floor) needs to be ensured for easy connection. Use of explosion proof plugs, plug connector and socket is essential to ensure safety against explosion. There should be a constant digital display for neutral and earthing. The voltage between neutral and earthing should not be more than 5 volts otherwise it can harm the semiconductor devices. Hence, digital display should be installed to monitor the voltage between neutral and earthing.

New electrical appliances should ideally have a 5-star or minimum 3-star rating from Bureau of Energy Efficiency or equivalent recognized organization to minimize the energy input. Use of low-energy LED lighting or alternate low-energy option to save indoor lighting energy is recommended. While designing the infrastructure, placing of important equipment particularly those requiring power supply needs to be decided to avoid haphazard supply which may lead to malfunctioning of equipment. Appropriate power backup/inverter should be in place to ensure that there is no disruption of services and cold chain for vaccine and diagnostics is properly maintained. Appropriate power backup/inverter should be in place to ensure that there is no disruption of services, and cold chain for vaccine and diagnostics is properly maintained. Two nos. of earthing should be there at each electrical installation. Copper plate earthing should be preferred.

The size of cabling and wiring should be about 1.5 times or more to the actual electrical load calculated. Adequate power back up with other sources such as DG, Photovoltaic etc. should be there in synchronization with the first source. Phase sequence should be proper as for motorized load. Health facilities have a lot of motorized as well as semiconductor material devices, hence, provision of power factor improvement should be made available. All the connections and joints should be tight with proper size of thimbling. Suitable place should be selected for electrical installation. The Electrical Switch Room should be housed in a dedicated room/cupboard located on the ground floor and in association with an external wall. It should have internal access. The room should be located in a manner that it does not present difficulties for services distribution from adjoining spaces or rooms. It should be located to provide for economic distribution of services. The main switchboard should ideally be of metal clad cubicle design to approved standards and regulations. Each switchgear assembly should have sufficient spare capacity. Electronic surge protection should be provided on the incoming mains. Periodic electrical audits by engineers should take place.

8.1.1.10. Illumination

The illumination and lighting at the PHC/UPHC should be according to the prescribed standards. The minimum lux required in general OPD area is 150 lux. Wards, stairs, and corridors should have minimum 100 lux. Medicine store and Minor OT (if available) should have 300 lux. Emergency portable light units should be provided in the ward. These illumination requirements should be as prescribed by Bureau of Indian Standards (BIS).

8.1.1.11. Potable Water Supply

Arrangement should be made for round the clock piped water supply along with an overhead water storage tank with a provision to store at least 3 days water requirement. Adequate availability of potable water in various areas needs to be ensured. It should have pumping and boosting arrangements. Separate provision for firefighting should be made available.

8.1.1.12. Drainage and Sanitation

The construction and maintenance of drainage and sanitation system for wastewater, surface water, sub-soil water and sewerage should be in accordance with the prescribed standards. Reuse of wastewater in irrigation, cooking, cleaning and washing, etc. can be demonstrated in villages and urban slums for orientation of the community.

8.1.1.13. Waste Management

All such waste which can adversely harm the environment or health of a person is considered as infectious and termed as Bio-Medical Waste (BMW). Every health care facility should ensure appropriate collection, transportation, treatment, and disposal of bio-medical waste as per the latest Bio-Medical Waste Management Rules (BMWM). Each Healthcare facility should ensure that there is a designated central waste collection room situated within its premises for storage of bio-medical waste, till the waste is picked and transported for treatment and disposal at Common Bio-Medical Waste Treatment Facility. Such room should be under the responsibility of a designated person and should be under lock & key. It should also be ensured that disposal of human anatomical waste, soiled waste and biotechnology waste is done within 48 hours.

As per Biomedical waste management guidelines 2016, deep burial pits need to be constructed only at such PHCs where the common biomedical treatment plant is located at distance more than 75 kilometers. Before disposal of biomedical waste in the pits, the facility needs to ensure that biomedical waste is decontaminated and shredded. This will be carried out with prior approval from the prescribed authority and as per the Standards specified in Schedule-III.

General waste consists of all the waste other than bio-medical waste, which has not been in contact with any hazardous or infectious, chemical, or biological secretions and does not include any waste sharps. Such waste is required to be handled as per Solid Waste Management Rules and Construction & Demolition Waste Management Rules, as applicable.

Liquid waste management is another area which needs adequate attention for separate drainage system to ETP and for health care facilities the liquid waste and effluents can be treated in the area where it is generated, before disposal in drainage system.

Other waste consists of electronic equipment, used batteries, and radio-active wastes which is not covered under biomedical waste but have to be disposed as and when such waste is generated as per the provisions laid down under E-Waste (Management) Rules, Batteries (Management & Handling) Rules, and Rules/ Guidelines under the latest Atomic Energy Act, respectively.

8.1.1.14. Infrastructure for Clinical Services

Subsequent to general principles for infrastructure, following considerations should be kept in mind while planning for infrastructure of clinical services:

1. Out-Patient Services

The OPD area of PHC/UPHC should be planned keeping in mind the maximum peak hour patient load and should have scope for future expansion.

2. Screening & Holding Area

Before entering for registration, the HWC should have enough space (either open or closed) to hold and undertake preliminary screening for any symptom of infections which can quickly be transmitted specially during epidemics, pandemics or newer emerging diseases.

3. Registration

It should be well ventilated, well-lit, and spacious with each counter ensuring minimum space of 15 sq m. Two counters including at least one dedicated counter each for women, elderly and disabled should be provisioned for.

For registration, computers with attached printers should be available with facility for computerized registration. A patient calling system with electronic display should be installed for easy communication at the registration counter. There should either be no glass barrier between visitors and the registration clerk, or it should be at a height that allows audible communication between them.

Patients should be given a computer generated OPD registration slip mentioning the date, patient's particulars and OPD details. The facility should preferably have an electronically supported system or token system for queue management.

4. Waiting Area

Adequate seating arrangement preferably such, which is less space occupying and easy to maintain should be placed. Messages conveying people to provide seats to elderly, pregnant women, disabled persons, children, and patients should be properly displayed.

Adequate space should be allocated for persons using mobility devices, for example wheelchairs, crutches and walkers, cane, etc., as well as those walking with the assistance. The dimensions prescribed in NBC may be used for guidance while designing facilities and equipment to be used by persons with disabilities.

Waiting area for OPD should have a patient friendly ambience and can have colorful wall paintings. Play area can also be built for pediatric patients which can be equipped with toys, games, puzzles, etc., to create an environment where children enjoy themselves and learn while waiting to be treated.

Patient amenities in waiting areas should include:

- **Essential amenities**
  - Fans
  - Clean drinking water
  - Clean and gender sensitive toilets

- **Desirable amenities**
  - Air-conditioning
  - Television/LCD in waiting area displaying facility related information, health related IEC

5. Consultation Room

This should have enough space with minimum area of 12 sq. m. to accommodate the adequate furniture and examination equipment so that interaction with patients can be undertaken ensuring their privacy and dignity. It should be well lit and ventilated with just the required furniture in the room to ensure adequate space for the patient and/or attendants. An examination table, curtains (wheeled, wall mounted, single piece), X-ray view box and hand washing facilities should be provided, as per the need. Three colors should preferably not be used in clinical service areas of a health facility namely red/pink, blue and yellow to avoid interference with examining pallor, cyanosis, and icterus respectively. The services to be provided, cleaning schedule and monthly performance chart should be clearly displayed in the room.

The services to be provided and cleaning schedule should be clearly displayed outside the room. The monthly performance chart of the health facility should be prominently displayed inside the consultation room.

6. Immunization Room

Immunization room with waiting area having an area of 3 m × 4 m and cold chain facility should be provided in both rural and urban PHCs with adequate power backup.

7. Counselling Room

A dedicated room should be available for counselling services on diverse health issues at PHC/UPHC. The room should be designed in a way that it enables both interpersonal and group counselling as and when required. Integrated counselling should be done, and the design of the room should ensure privacy and confidentiality. It should have provision of space to keep necessary commodities and equipment.

8. Clinical/Central Laboratory

The laboratory should have adequate space from the point of view of workload as well as maintenance of cleanliness and hygiene to prevent cross-contamination and infections. The laboratory must provide space for patient reception, registration, waiting area and a nearby toilet facility. There should be adequate sample collection area for blood, urine, and faeces and a sample processing area. Storage space should be adequate to facilitate storage for refrigeration, reagents, supplies, patient records and separate storage space for inflammable items. Vented Storage for volatile solvents should be provided.

The laboratory area should not be a thoroughfare and various testing areas should be clearly marked. The layout should ensure logical flow of specimens from receipt to disposal. Zoning should clearly identify areas of restricted access within the laboratory, while ensuring efficient functionality of the lab. The various zones in the laboratory should include specific areas for sample collection, sample processing and testing, reporting and demarcated areas for collection/dispatch of reports.

The design should help in implementing "Single Prick Policy" i.e., irrespective of the number of tests for a single patient or location of the testing labs (in case of linkages for high end diagnostic tests), the blood sample of a patient would be taken only once, at the first point of contact.

The tabletop should be acid and alkali proof. There should be provision for safety, including eye flushing devices, and fire extinguishers. The drainage system of work areas where highly corrosive liquids are used

should consist of glass lined iron traps and pipes. Counter sinks for handwashing should be provided. Chemical and stain resistant materials should be used for laboratory work.

Laboratory should be cleaned regularly including at the beginning and end of the day and at times of spill. The use of personal protective equipment (full body suit, gum boots, apron, gloves, mask, face shield, etc.) and scrupulous attention to hand hygiene must be adhered to.

9. Medical Imaging

Optimal Utilization of any imaging services depends on availability of specialist for prescription, interpretation of test results and also competent human resource like technicians etc. for conducting the imaging tests.

PHCs/UPHCs are basically responsible to provide Comprehensive Primary Healthcare where the focus is more on preventive, promotive and treatment of common illnesses, so day to day need of any imaging services are very minimum. However, on the advice of the treating doctor if required such services can be linked with nearby higher facility or hub and spoke model.

10. Drug Dispensing Counter

The drug dispensing counter should be well ventilated, adequately lit, and spacious ensuring minimum space of 15 sq m. Storage space should be built for inventory for enough/sufficient consumption maximum for 5-7 days. Look-Alike Sound-Alike drugs (LASA drugs) should be identified and stored separately. Separate cool dark space for storage of temperature sensitive drugs should be ensured. There should be a computerized system for receiving, inspecting, storing, and dispensing of drugs. Principles for effective storage of drugs such as First In First Out (FIFO) and First Expiry First Out (FEFO), checking of pilferage, date of expiry, and pest and rodent control should be in place. Medicines should be dispensed based on the prescription of the consulting doctor. Proper record of medicine distribution and disposal should be maintained.

11. Dressing Room/Injection Room/Emergency

This should be located close to the OPD to cater to patients needing injections, dressings, and stabilization of emergencies after OPD hours. It should be well equipped with all the emergency drugs and instruments. Privacy of the patients should be ensured.

12. Minor OT

This caters to patients needing minor surgeries/procedures. It should be well equipped with all the emergency drugs and instruments. Privacy of the patients should be ensured. For ensuring good quality of services, any fixed day procedures should be limited to number of available beds.

13. In-Patient Ward/Day Care Room

There should be two essential and four desirable beds in a PHC while six essential and four desirable beds in a 24x7 PHC/UPHC. UPHC and multispecialty polyclinic will have two essential and four desirable day care beds to provide care to patients requiring stabilization, observation and/or monitoring. After stabilizing the patients, adequate referral to higher centres for further management, if required, should be done. Every bed should be provided with an IV stand, a bed side locker, and a stool for attendants. Oxygen cylinder and Ambu bags should be easily accessible and functional. Curtains should be available for privacy. There should be facilities for drinking water and separate clean toilets for all genders. Cleaning of the wards/day care room, etc. should be carried out at regular intervals.

UPHCs are not expected to provide in-patient care. However, such UPHCs that continue to provide delivery services, need to provide infrastructure as per 24x7 PHC.

Table: Bed Requirement at Primary Health Centres

Number of Beds	PHC		UPHC		24x7 PHC/UPHC	
	Essential	Desirable	Essential	Desirable	Essential	Desirable
	2 Beds	4 Beds	2 Day care Beds	4 Day care Beds	6 Beds	4 Beds

Note: The desirable will be over and above the essential beds.

14. Health and Wellness Room

The health and wellness room is a platform for the community interaction for all health education and promotional activities. The room should be provisioned with adequate space to accommodate 18-20 persons and facilities to conduct yoga, group counselling sessions on health, nutrition, adolescent, and other health promotional activities. The room should be equipped with training, audio-visual, and IEC material. The primary objective of this room is not to provide curative services but to provide preventive and promotive care.

15. Labour Room Complex (at 24x7 PHC/24x7 UPHC)

Labour room should be provisioned only in such PHCs/UPHCs which are existing delivery points. Wherever located, labour room complex should preferably be on the ground floor. At the entry, a waiting area and space for changing shoes before entering the labor room should be provided. After entry, facility for triage, change area for nurses and staff, clean store, nurses' station, Labor Delivery Recovery unit (LDR) unit with facility for autoclaving and dirty utility should be available.

Following principles should be kept in mind while planning for Labor Room Complex:

- It should have restricted entry with provision for change of footwear for entry.
- The unit should be well-lit and ventilated. It should be away from air draught with an attached toilet with each labor bed. Facilities for drinking water and hot water should be available.
- It should be fitted with a good source of light, preferably shadow-less.
- Separate areas for dirty linen and decontamination should be clearly demarcated.
- Standard Treatment Protocols for common problems during labor and for newborns to be provided in the unit.
- All the essential drugs and equipment (functional) should be available.
- Cleanliness should always be maintained by regular washing and mopping with disinfectants and should be done after every delivery.
- The labour room/LDR should have enough power points and electrical points to be used for radiant warmer and other essential equipment.
- Delivery kits and other instruments should be autoclaved.
- Facility for privacy of the women must be ensured by having curtains/walls/partitions between the labor beds. Each LDR unit should have enough space for one labor bed, space for alternate birthing positions and some area for the mother to move around. Ideally, it should be 350 sq. ft., however, in case of space constraints, minimum area of 15*15 (225) sq. ft. should be ensured for one LDR unit.
- Newborn care corner is a space within the labour room, (20-30 sq. ft in size), where a functional radiant warmer is present. It should be easily accessible from labour room and when a baby is placed, a trained nurse should be available for constant care.

- Resuscitation kit including Ambu Bag (pediatric size) should be placed with the radiant warmer.
- Oxygen cylinder and suction machine and accessible electrical outlets should be provided for the newborn in addition to the facilities required for the mother. Both the Oxygen Cylinder and Suction Machine should be functional, and their user ends cleaned and covered with sterile gauze in a ready to use condition. They must be cleaned after use and kept in the same way for future use.

16. ASHA Room

IPHS deals with core service areas and not for facilities such as room for ASHAs which may be required based on the availability of proactive ASHAs in the area. However, if there is no space crunch within the health care facility such welfare facilities can also be extended.

17. Communication Systems

A 24x7 working telephone line for both incoming and outgoing calls should be available at all PHCs/ UPHCs. Besides telephone and mobile network, web facilities can be used for both routine and emergency communication.

18. Storeroom

PHC/UPHC and Polyclinic should have adequate and spacious stores located away from patient traffic with facility for storing drugs, consumables, records, linen, furniture, equipment, and sundry articles. Service areas should only have a small space for keeping 5-7 days stock of drugs and linen whereas the main store should have enough area for storing adequate drugs and supplies of the facility.

Stores should be designed in such a way that spoilage, damage, pilferage, and other losses are minimized. Medicines should be stored in accordance with the storage recommendation of the manufacturers. Compactor system as compared to conventional racks may be used. The drugs are arranged on the racks in alphabetical/pharmacological order. Buffer stocks should be kept in separate spaces or cupboards in the drug store and basic principles like 'First-In First-Out (FIFO) and First-Expiry First-Out (FEFO)' for drugs and vaccines should be followed. Special provision of lock and key should be ensured for storage of Narcotic and Psychotropic medicines and record of their issuance and disposal should be maintained. Stored materials should be periodically inspected. It should be ensured that the heavier items are stored on the lower shelves of racks. Dunnage, to prevent moisture, termite and insects passing up the material, should be 45 cm high for outside stacks built on ground, and 30 cm high for stacks on floors. Depending on the volume of items requiring temperature control during storage, adequate number of refrigerators should be available.

The store should also have space clearly earmarked for keeping necessary records and registers, inventories, and records of financial accounts. A proper Bin Card system of collection, sorting, filing, indexing and storage of medicines, other items in stock and documents along with quick retrieval should be designed for effective and efficient inventory tracking and record management. It is also a mandatory requirement under the Right to Information Act, 2005. Digitalization of records wherever possible, should be done while adhering to the data security guidelines of GoI.

8.1.2. Other Support Services

8.1.2.1. Residential Quarters

All the essential medical staff and allied health professionals should be provided with residential accommodation to ensure their availability round the clock at 24 x 7 PHCs/UPHCs. Facility for parking, recreational activities, play areas should be made available. Well-equipped transit accommodation facilities

at larger facilities such as District Hospitals and geographically and strategically selected SDHs and CHCs can serve as a hub for health workers of all grades posted at nearby PHCs. Transport arrangements (such as employees led pooled shuttle service to and from the accommodation to the facility) will allow for staff to work at remote facilities while providing their families greater opportunities for quality education and employment.

8.1.2.2. Dietary Services

Provision of dietary services at 24x7 PHCs/24x7 UPHCs will depend on state specific directions and/or specific programme/scheme guidelines. However, if dietary services are being provided, care should be taken that respectful and quality food should be ensured.

8.1.2.3. Oxygen Support

The COVID 19 pandemic has affected not only secondary or tertiary level of care but also the primary level. Thus, oxygen support at PHC/UPHC and 24x7 PHCs/24x7 UPHCs through cylinder or concentrator is essential to manage COVID or other patients. Adequate care should be taken while storing the cylinder/concentrator as per GoI guidelines.

Table: Oxygen delivery systems in Primary Health Facility-HWC

S. No.	Facility Type	Bed Capacity	B Type (1500 L oxygen capacity) cylinder	Oxygen Concentrator (10 liters)
1.	**Primary Health Centre (Rural)**	6	4	1
2.	**Primary Health Centre (Urban)**	6 (Day Care)	4	1
3.	**Primary Health Centre/ UPHC (24 X7)**	10	5	1

Important Notes regarding Oxygen delivery systems

1. The requirement of oxygen indicated is as per the norms conveyed to the states/UTs (vide 2217044/2021/o/o JS (NV) file T-20017/03/2021-NCD). However, the actual requirement of the health care facility will vary depending upon bed occupancy, oxygen uses per bed and other local considerations including patient load.
2. While calculating the total requirements of the facility the above factors along with periodicity of refilling needs to be considered. Ideally every facility must ensure 48 hours in house storage of oxygen with assured refilling at regular defined periodicity.
3. For ambulances being served through National Ambulance Service network with toll free number have in built oxygen capacity, however all stand-alone ambulances/Patient Transport vehicle should have two Type B (capacity of 1500 liters of oxygen) oxygen cylinder per ambulance.
4. There is a requirement of one flowmeter with pressure regulator per bed for oxygen supported beds.
5. A separate dry, well ventilated well-lit room away from the main area should be available for storage of cylinders.
6. Oxygen cylinder refilling should be done with the nearest government facility (if available) or IOL supported facility under MOU/price agreement.

8.1.2.4. Toilets

Gender sensitive and disable friendly functional and clean toilets with facility for running water and flush should be provided. Cleanliness of toilets indicates the cleanliness of the hospital. It is important to adhere to infection control measures to keep the toilets dry, dampness and seepage free. Architectural design, location, plumbing, and drainage play a key role in defining the cleanliness of toilets. Being a high source of infection, it is critical that the toilets are well maintained and cleaned on a regular basis.

8.2. HUMAN RESOURCES FOR HEALTH

Apart from providing curative, preventive and promotive services, primary health centres are also the fulcrum for services related to national/state health programmes. The number and type of human resources for health (HRH) mentioned below have been specified taking into consideration all the services and programme requirements of PHCs, 24x7 PHC, UPHCs & 24x7 UPHC and multispecialty polyclinics. The Services defined above in the document have been categorized as essential and desirable and thus the HRH required for providing those services has also been categorized, in a similar manner, as essential and desirable.

While planning for human resource, it is important to prioritize in-house hiring of such staff which is required for rendering clinical services (Specialists, GDMOs, Nurses, Technicians, etc) rather than those whose services can be outsourced like Security guard, data entry operators and other group-IV employees.

A comprehensive Human Resource Policy at the State level, backed by an efficient Human Resource Management Information System (HR-MIS), should be adopted for better human resource planning and effective utilization of the existing HRH.

Usually, deprivation of services is proportional to the distance from cities and district headquarter towns, so, the provision of staff accommodation can substantially improve the recruitment and retention of health workers, especially at the health facilities in rural and remote areas. Wherever feasible, well equipped transit accommodation facilities at District Hospitals or geographically and strategically selected SDHs or CHCs or Block headquarters should be provided. Transport arrangements such as a shuttle service to and from the accommodation to the facility should be provided. Alternatively, house rent allowance can be provided.

The number of human resource and their roles & responsibilities at HWC-PHC/UPHC and 24x7 PHC/UPHC are given in detail at ***Annexure 5.***

The HR requirements for UPHCs and 24x7 PHCs/24x7 UPHCs are identified separately– and described as either 'essential' or 'desirable' - as shown below.

HR for Polyclinic will be same as UPHC. Additional Specialist for Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology or Psychiatry or any other specialty (based on local need and availability) can be provisioned on rotational basis by the states.

Suggestive numbers for Support Staff

Support Staff is crucial for smooth functioning of any health facility. A suggestive list of required numbers of support staff is provided in ***Annexure 5***. The exact number may vary based on area, infrastructure etc. The guards should be placed on the strategic gates only keeping the view of functionality of all gates.

- IPHS 2022 has not calculated leave reserves for any level of staff. However, states have the flexibility to determine their own level of 'leave reserve' to be sanctioned and this additional number of nurses and allied health professionals can be deployed to cover for leave and absences.
- Leave and Training Reserves of 15% or as per the state rule is recommended for all staff in IPHS.

Table: Minimum Performance Standards for human resource for health

S. No.	Staff	Break up of activities
1	**General Medicine**	• OPD = 60 pts/day • Invasive Procedures= 10 Procedures/week
2	**Obstetrics & Gynecologist**	• OPD= 60 pts/day
3	**Pediatrician**	• OPD= 60 pts/day • Invasive Procedures= 10 Procedures/week
4	**Ophthalmologist**	• OPD= 60 pts/day • OT= 7 major surgeries/week
5	**Dermatologist**	• OPD= 60 patient/day • Minor Procedures (Skin biopsies, cauterization etc.) 10 Procedures/week
6	**Psychiatrist**	• OPD= 20-30 pts/day • Consultation for referred patient
7	**Medical Officer**	• OPD = 75 patient/day • IPD 10 pts per/Day • OT assistance, emergency and other duties
8	**MO Dental**	• OPD = 20 pts/day • Dental Procedures= 8-10 (30 min./patient)
9	**Staff nurse**	As per INC norms (for OPD, IPD shifts and specialist services)
10	**Medical Laboratory Technologist/Lab Technician**	100 tests/day (semi-autoanalyzer), 200 tests/day (autoanalyzer)
11	**Physiotherapist**	15-20 physiotherapy intervention/day (15-20 minutes/service) Physiotherapy advice for IPD patient
12	**Counsellor**	20-25 counselling sessions (Group/Interpersonal)/day (10-15 min/patient for interpersonal counselling)
13	**Optometrist/Ophthalmic Assistant/Vision Technician**	• 30-40 cases per day. • 10-12 min/pts for refractive assessment • Detection of cataract and other basic EYE ailments • Appropriate referrals • Linkages with RBSK team for refraction and issue of spectacles.
14	**Dental Assistant**	• Assist the Dentist during dental procedures • Maintain dental laboratory records. • Ensuring adherence to infection prevention protocols including sterilization.
15	**Pharmacist**	120 dispensations of prescription/day, maintain stock registers, store, inventory management

8.2.1. Capacity Building

Along with placement of qualified HRH, the States should make all efforts to continuously build on their skills and competence as per their job requirement.

Special attention should be paid to training of MO at the PHC as he/she not only serves as the lead of the PHC and a clinician but must look after the overall health of the communities and ensure implementation of

the National Health Programs in their catchment area.

Different training programs for Induction, skill building and leadership, new programs and if required, refresher training should be planned systematically. Diligent records of all trainings attended by the HRH should be maintained by the facility in-charge. Cross-learning should be promoted where the HRH upon successful completion of the training program briefs the other staff about their key learnings.

8.2.2. Conduct and Behavioural Standards

The HRH placed in the public health facilities should adhere to the highest ethical and behavioural standards and provide patient care with utmost respect for the dignity of life. It is important that states orient health professionals to discharge their duties in a professional and courteous manner, facilitating greater acceptability of HRH in the community as well. They should also be oriented on gender sensitivity and efforts should be made to ensure that this concept is inculcated in their conduct and actions.

Soft skills including an empathetic attitude, manners and courteousness at bedside should be a core value, especially towards the marginalized and vulnerable. The privacy and dignity of patients should be maintained, and the principles of patient confidentiality strictly adhered to. Dress codes (with a name badge) and adherence to punctuality should be emphasized.

8.2.3. Safety Measures for HRH

It is crucial that the safety of the HRH providing services at all levels be ensured. For this purpose, the following must be adhered to:

- Sufficient provision of Protective gear like gloves, masks, gowns, caps, personal protective equipment, lead aprons, dosimeters etc. and their use by Health Care workers must be as per the standard protocols in place.
- Promotion of Hand Hygiene and practice of standard precautions by Health care workers should be standard practice.
- Display of standard operating procedures at strategic locations in the hospital.
- Regular training of Health care workers in standard precautions, Patient safety, infection control and Bio-medical waste management should be part of their training requirements.
- Immunization of Health care workers against Tetanus, Typhoid and Hepatitis B should be ensured.
- Provision of round the clock Post Exposure Prophylaxis (PEP) against HIV in case of needle stick injuries should be initiated in the emergency department.

8.3. MEDICINES

Access to essential medicines is a major determinant of health outcomes and an integral, and often crucial component of health care. An approach to ensuring access to medicines closer to community has been promoted through "Essential drug policy". It is necessary for the states to prioritize the medicines that should be made available based on the disease prevalence data and update the state EDL.

All essential medicines should be available free of cost in all PHCs/UPHCs under 'Free Drug Service Initiative' of GoI.

The list of medicines mentioned under IPHS is as per the List of Essential Medicines for HWC-PHC ***(Annexure 6)*** *(http://nhm.gov.in/New_Updates_2018/Om_and_orders/CPHC/Others/H_WC_SHC_and_PHC_updated_EML_as_on_March_2020_-.pdf)*. From the list**,** the state should identify types of medicines that are critical for

service delivery and ensure that these are always available in all health facilities. Additional medicines for the management of locally prevalent diseases should also be included. These norms do not preclude the inclusion of other medicines which are on the state list of essential medicines but not mentioned in the IPHS guidelines. With the launch of universal NCD screening and comprehensive primary care, long term dispensing (one to three months) of drugs for the management of chronic illnesses such as diabetes and hypertension has been initiated. Systematic inventory management for smooth procurement, adequate storage space and systematic NCD registers, and records will need to be maintained for these. Temperature sensitive medicines should be stored in proper cold chain/refrigerator as deemed by the manufacturer's instructions. Relevant AYUSH drugs and a pharmacist to dispense should be available at facilities where AYUSH services are being provided.

The PHC/UPHC should have Standard Operating Procedures (SOPs) for indenting, stocking of medicines, logistics for their stocking up and transportation. Indenting based on consumption, stock rotation and the distribution network should be robust and ideally through a centralized drug purchasing and distribution system to ensure that there is no stock-out of essential medicines at public facilities. This will ensure quality check and provision for recall, if required. Additionally, monitoring the rational use of higher generation antibiotics, slow- and fast-moving drugs, timely replacement of rapidly prescribed drugs, maintaining a buffer stock of critical drugs and quality control are other essential parameters.

Provisions for the local purchase of drugs during emergency situations and stock-outs of critical medicines, including during outbreaks, epidemics and pandemics, should be in place. Every effort should be made to procure generic medicines that include a mechanism for robust quality control. There should be a computerized system for receiving, inspecting, handing over, and retrieval of drugs.

All prescriptions should be clear, legible, in capital letters and contain the generic/non-proprietary name. Ideally, all electric physician order entries should be ensured. Standard treatment guidelines should be followed for drug prescriptions and patient management. Prescription audits should include a review of drugs being prescribed from outside (indicative of the not availability at the facility) and those that are not being prescribed under their generic names. Internal audit of stores should also be done on a regular basis to assess procurement of items as per laid down procedure by respective state governments.

Storage of medicines should be such that spoilage is minimized. Drug stores should avoid dampness (for example, no leaking roofs) and basic principles like 'first expiry, first out' for drugs and vaccines should be followed. Buffer stocks should be kept in separate spaces or cupboards for different programmes in the drug store; storage of drugs in clinical areas should be avoided beyond 5-7 days. The store should have refrigerators/ice- lined refrigerator (ILR) for drugs and vaccines that require maintenance of the cold chain.

8.4. DIAGNOSTICS

Diagnostics are an integral part of the health care system and provide information needed by service providers to make informed decisions about care provision related to prevention, screening, detection, treatment, and management of illness. Limited availability and access to quality laboratory and radiology services are among the major challenges contributing to delayed or inappropriate responses to disease control and patient management. The availability of necessary reagents and equipment, laboratory personnel and their capacity building, mechanisms for internal and external quality assurance and follow-up with clinicians should be strengthened.

The essential tests being offered at different levels of facilities as per free diagnostics list are placed at ***Annexure 7***. Additional diagnostic tests for the management of locally prevalent diseases should also be

included (e.g., screening tests for Kala Azar in locally endemic areas). These norms do not preclude the inclusion of other diagnostic tests that the state decides to provide at public health facilities.

The complete list of all tests being provided should be clearly displayed. For specialized, advanced, and specific diagnostic tests, linkages with multispecialty polyclinics, CHC/UCHC, SDH, District Hospitals, Medical Colleges and National Reference Laboratories should be established. In all cases, transport must be managed carefully in order to maintain integrity of the sample, giving attention to temperature, preservation needs, special transport containers and time limitations. It is also important to ensure the safety of those handling the material before, during and after transport.

The important and essential lab imaging and other diagnostic and support services have clearly been defined either as essential or desirable. Wherever applicable such services need to be established and delivered as per the centre, state and local applicable guidelines.

The sample collection and test results should be provided to patients during OPD hours when doctors are available, so that repeat visits by the patient, or their family members is avoided. The turnaround time for test results should also be standardized, adhered to, and monitored.

The availability of necessary reagents and equipment, laboratory personnel and their capacity building, mechanisms for internal and external quality assurance and follow-up with clinicians should be strengthened. Internal Quality Control (IQC) to detect, evaluate and correct errors due to test system failure, environmental conditions, or operator performance, before patient results are reported is also an essential measure.

Validation of procedures and equipment should be carried out by running samples in parallel using both old and new equipment and methods for a period of time to determine that the expected results can be obtained. These validation procedures should be completely recorded. The staff posted in diagnostic services can be trained under EQAS programme run by government institutes.

8.5. EQUIPMENT

Medical equipment plays a significant role in patient care. It is a crucial component of health systems, as it enables the service providers to diagnose, monitor and treat various kinds of diseases. Having appropriate quality of medical equipment, helps to prevent patients from being denied any health services. All the necessary equipment to provide clinical, support and other services should be meeting essential quality parameters through the state procurement policies and procedures. The equipment mentioned under IPHS should be included in the list of essential equipment at different levels of facilities. However, the list is not exhaustive and additional equipment, if required, can be procured to provide the full range of services being offered at the facility.

A systematic and robust programme for bio-medical equipment maintenance and monitoring should be in place at all public health facilities. To improve the functionality and life of equipment, simultaneously improving healthcare services in PHCs/UPHCs along with reducing cost of care and improving the quality of care, provisions have been made in the IPHS for bio-medical engineers and technicians to oversee equipment maintenance at public health facilities. The maintenance of medical equipment requires a wide range of technical abilities, and the costs and time required to train a technician increases with the level of skill that has to be attained. Training of technicians to do front-line maintenance for medical equipment in public health facilities is essential.

An effective equipment audit assesses the present equipment status and ensures better equipment procurement in the future. The audit should be done on a periodic basis and contain details like name, cost

of equipment, date of purchase, manufacture and installation, name and address of supplier, department where installed, environmental control, spare parts inventory, technical manual, after sales service agreement, guarantee, warranty period, life of equipment, depreciation per year, up/down time, date of condemnation and replacement. Number of services delivered by each major equipment needs to be noted down, to analyze the value for the money invested in purchasing high-cost equipment.

Along with maintenance and monitoring programme, it is also essential that a condemnation policy is in place at all facilities so that the practice of out-of-use equipment and furniture being scattered around the facility is mitigated. Condemnation should be done periodically by condemnation committee after careful examination of items. The list of items with code number, the date of purchase, repair, correct value and other relevant details should be thoroughly prepared by the committee.

Biomedical Equipment Management & Maintenance Program (BMMP) is an initiative by Ministry of Health and Family Welfare to provide support to state governments to outsource medical equipment maintenance comprehensively for all facilities so as to improve the functionality and life of equipment, simultaneously improving healthcare services in public health facilities- reducing cost of care and improving the quality of care. Detailed list of equipment is placed **at *Annexure 8.***

8.6. QUALITY ASSURANCE

Well maintained Infrastructure, adequate & skilled human resource, functional equipment & instruments, and sufficient drugs & consumables ensure the fulfilment of the 'Structural' requirements for establishing a well-functional health facility. However, for attaining enhanced satisfaction with improved clinical outcomes, it becomes equally pertinent to ensure 'Quality' in the 'Processes' of the care within a health facility.

As a healthcare provider, while it is important to ensure provision of safe and evidence based clinical care, it is equally fundamental to provide the care that makes patients' and visitors' experiences rewarding. Ensuring 'Quality of Care' as a key component would require undertaking conscious and concerted efforts to identify the 'Gaps' by measuring the Quality of Care (QoC) in all its three dimensions, namely structure, process and outcome (Donabedian Model of QoC).

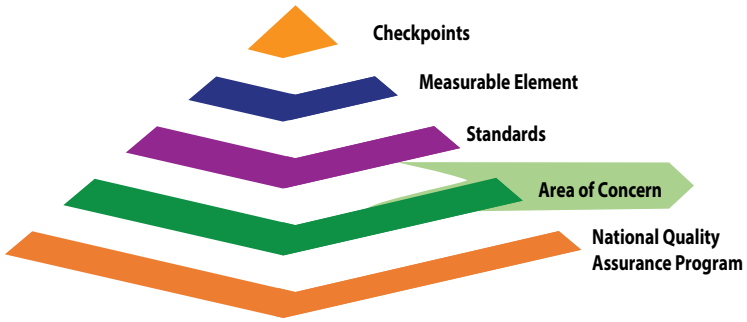
Subsequently, available resources are channelized, and focussed efforts undertaken for closing the gaps and bringing about the 'Improvement' in the services.

For ensuring provision of 'Quality of Care', IsQua (International Society for Quality in Healthcare) accredited *National Quality Assurance Standards (NQAS)* for District Hospitals, CHCs, PHCs, UPHCs and Health and Wellness Centre- Sub centres have been formulated by the Ministry of Health & Family Welfare, GOI. Setting standards is a dynamic process, and the standards provide roadmap for the health facilities to improve the care.

The main pillars of Quality Measurement Systems are Quality Standards. These standards have been defined for various level of facilities under NQAS. The standards have been grouped within the eight Areas of Concern. Each standard further has specific Measurable Elements. These standards and Measurable elements are checked in each department of a health facility through department specific checkpoints. These defined standards are available in following link:

http://qi.nhsrcindia.org/cms-detail/revised-national-quality-assurance-standards/MjM3

Figure: Measurement system under NQAS



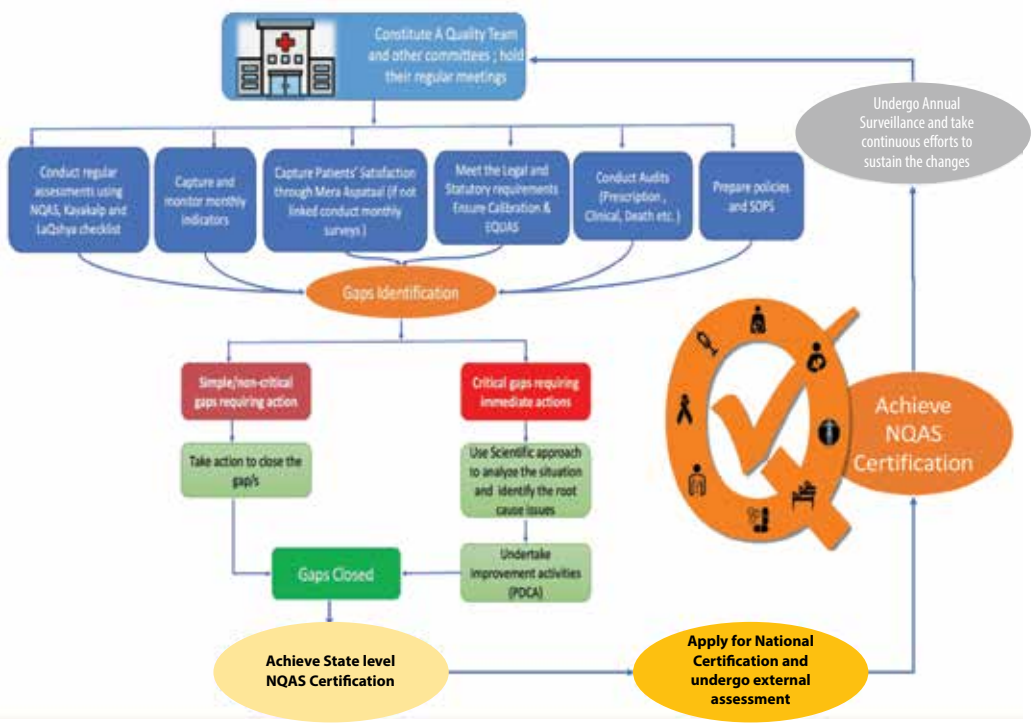
A well-built institutional framework from facility (Quality team) to the National level (Central Quality Supervisory Committee) supports the seamless implementation of the standards (Figure - Institutional Framework under NQAS). Facilities which are able to meet the defined standards and criteria are certified and incentivized (subject to annual surveillance and ensure sustaining the changes). With this, National Quality Assurance Program (NQAP) envisages to instil the culture of Quality and Safety in our health systems.

Figure: Institutional Framework under NQAS

It is expected that all public health facilities would implement these standards by undertaking following steps:

1. Formation of Quality team
2. Plan for quarterly Internal Assessment
3. Monthly Patient Satisfaction Survey
4. Collation and Analysis of Key Performance Indicators
5. Define Quality Policy and Objectives
6. Plan for Medical and Death Audits
7. Preparation of SOPs and Work instructions
8. External Quality Assurance of Lab-EQAS and Calibration of measuring Equipment
9. Traversing the Assessed Gaps
10. Quality Certification- State and National
11. Sustenance and incentives

Figure: Road map for healthcare facilities to achieve NQAS certification



Summary of the activities is given below:

Under the ambit of National Quality Assurance Programme various other initiatives like *Kayakalp, LaQshya and Mera Aspataal* (My Hospital) have also been initiated to work on specific domains of quality improvement. These domains together support the implementation of National Quality Assurance Programme.

- *Kayakalp* aims to promote Cleanliness, Hygiene, and Infection Prevention. It is an award scheme in which facilities are assessed at three-level (Internal, Peer, External) using objective checklist covering eight thematic areas (a) Hospital Upkeep, (b) Sanitation & Hygiene, (c) Waste Management, (d) Infection control, (e) Support Services (f) Hygiene Promotion, and (g) Beyond the hospital boundary. Facilities scoring 70% and above after external assessment are recognized and incentivized.
- *LaQshya* is quality improvement initiative, which aims to improve facility-based quality of care around birth, which normally takes place in the Labour Room and Maternity OT of a high case-load facility.
- *Mera Aspataal* (My Hospital) an ICT based platform which captures 'Voice of Patients' visiting and receiving care from the healthcare facilities. Inputs received on *Mera Aspataal* support facilities to identify the "Dissatisfiers" and to take up further actions to mitigate them.

Patient Safety and Infection Control

Some of the patient safety and infection control measures are given below:

- Hand washing facilities in all areas should be installed. Compliance with the correct method of hand hygiene by health care workers should be ensured.
- Safe clinical practices as per standard protocols to prevent health care associated infections should be instituted. ***(Annexure 9).***
- There should be proper written hand over system between health care staff.
- Safe Injection practices as per the prescribed protocol should be followed.
- Ensuring Safe disposal of Bio-Medical Waste as per rules should be adhered to.

- For reducing environmental pollution including those relating to Mercury, GoI Guidelines should be adhered to.
- Guidelines for Airborne Infection Control should be followed.
- Regular Training of Health care workers in patient safety, infection control and Bio-medical waste management should be scheduled and held.

8.7. IMPLEMENTATION OF IPHS

8.7.1. Governance

Effective governance of the public health system includes the establishment of institutional arrangements and policies along with their continuous monitoring to ensure proper implementation. Apart from promoting good leadership, it also includes specific interventions such as the establishment of facility based Jan Arogya Samiti (JAS); building accountability in to the system (e.g. performance appraisal, target setting and monitoring, social audit, citizens' charter); patient centric services (patient feedback, reducing out-of-pocket expenditure, improving the patient experience, grievance redressal); compliance with statutory norms (Acts and regulations) and ensuring robust clinical governance (adherence with SOPs and standard treatment guidelines, and MDSR/CDR).

Some aspects of governance relevant to public health facilities are described below:

8.7.2. Monitoring

Continuous monitoring, mentoring, ownership by the staff along with continuous support and encouragement by supervisors and higher levels of management as part of quality improvement initiatives will help achieving IPHS.

Internal mechanisms like systematic and proper record keeping and ensuring timely reporting mechanism for Robust internal and external monitoring is vital to maintain standards, identify gaps and address deficiencies in service delivery at public health facilities.

Internal monitoring mechanisms will include proper record keeping and maintenance, supportive supervision, and a regular system of audits (clinical audit, prescription audit, death audit, disaster preparedness audit) as part of clinical governance.

Health intelligence in terms of standard formats to capture data on key performance indicators will facilitate a system for robust internal monitoring. This should be regularly reviewed by senior administrative and clinical personnel to enable gap analysis. An action plan with corrective measures, the person/department responsible and timelines should be prepared and reviewed regularly.

A variety of measures should be used for external monitoring; these include patient satisfaction surveys, social accountability through Jan Aarogya Samitis/Rogi Kalyan Samitis and/or Panchayati Raj Institutions, community surveys and *Jan Sunawais* and *Jan Samvads*.

Institutional structures operational for community-based monitoring such as Village Health Sanitation and Nutrition Committees (VHSNC) and Community Action for Health - monitor delivery of preventive, promotive and curative services as part of CPHC. They are important to provide relevant inputs for decentralized health planning.

Along with monitoring of services at the facility level, a primary health centre is also responsible for monitoring and supervision of activities of:

- HWC-SC/UHWC,
- VHNDs/UHNDs, special outreach,

- ASHA, IEC/BCC,
- Implementation of National Health Programs,
- Timely payment of various entitlements

This can be done through regular meetings, periodic visits by Medical Officer, LHV, etc.

Checking and tracking of missed out and left out ANC/PNC, high risk pregnancies, vaccinations, cold chain etc. is also an essential activity of any PHC or UPHC.

A monthly review meeting chaired by facility in charge and attended by all the health workers (male/female), and health assistants (male/female) is to be organized at all PHCs and UPHCs.

8.7.3. JAS

The Jan Arogya Samiti serve as institutional platform of SHC/UHWC and PHC/UPHC level AB-HWCs in both rural and urban areas, for community participation in its management, governance and ensuring accountability, with respect to provision of healthcare services and amenities. They support AB-HWC team in working with VHSNCs/MAS, and serve as an umbrella, providing mentorship for Health Promotion and Action on Social and Environmental Determinants of Health, in community level activities of National Health Programmes and other community interventions. JAS also support and facilitate the conduct of activities pertaining to social accountability at AB-HWC in coordination with VHSNCs/MAS and act as Grievance Redressal Platform for families who access healthcare services at AB- HWCs, ensuring availability and accountability for quality services. JAS facilitate and support Gram Panchayats/Urban Local Bodies (ULBs) of the area in undertaking health planning.

At the facility level, the JAS members will identify gaps related to physical infrastructure, services (essential and desirable), human resources (HR), equipment, drugs, and diagnostics at PHC level based on the standards prescribed here.

8.7.4. Accountability

The MO at the PHC/UPHC must improve effectiveness and efficiency in the system by building mechanisms to strengthen answerability and accountability of service providers.

A system of annual performance appraisals that is objective, built upon key performance indicators from job descriptions and is linked to promotions, incentives and contract renewal should be introduced (or strengthened) by the state and implemented through the medical officer at the PHC/UPHC (and the HWCs in its jurisdiction).

Feedback from the community using different methods such as patient feedback, community/social accountability, *Jan Sunwai* and *Jan Samwad* must be encouraged, and timely and appropriate action taken on the feedback received.

Every facility must have a Citizens' charter displayed in a prominent place in a legible and locally appropriate format. This should include information on the range of services offered, timings, entitlements, user charges, rights and responsibilities of users and grievance redressal procedures. A list of the free drugs and diagnostics provided at the facility should be readily available with facility incharge and Pharmacist for perusal of any citizen. Ideally, the list of essential medicines and diagnostics should also be made available with the Panchayat. The total number of essential medicines and tests should be displayed in Citizens' Charter as well.

8.7.5. Patient Centric Services

All necessary efforts to ensure that patients and their attendants have a comfortable, respectful, and hassle-free experience at the facility. This includes an empathetic and compassionate attitude towards patients and relatives and a professional bedside manner. There should be no user fees at the facility.

8.7.6. Grievance Redressal

Every facility should have a robust grievance redressal mechanism. Apart from any centralized system introduced by the state (e.g., call centre) there should also be a method to lodge local complaints (e.g., complaints box, receipt provided for a complaint letter or an opportunity to meet with the facility In-charge). These should be acted up on in a timely manner and feedback provided to the complainant, wherever possible. In addition, there should be a time limit to resolve registered grievances; if this is not complied with it should automatically be escalated to the next higher level. This will strengthen efficiency and accountability.

8.7.7 Information and Communication Technology

Information and communication technology is essential to enable efficient service delivery at PHCs and teleconsultation is one of the essential components of Comprehensive primary health care structure. IT requirements should be set up to meet the needs of capturing, transmitting images, prescriptions and diagnostic reports for teleconsultations. Video calling feature should be enabled in the existing IT system to connect with hubs identified for teleconsultation services. Minimum requirement for HWC infrastructure for teleconsultation includes Telemedicine diagnostic kit, Desktop with headphone, microphone and HD web camera, Printer, and last mile connectivity (min 2 MBPS), IT applications and H-MIS.

IT system has following functions in PHCs;

- Registration/screening of the household/Individual in the catchment area of a particular PHC.
- Records of service delivery given to the patients under different health programmes
- Management of service delivery by registering births, deaths, disease prevalence, etc.
- Support inventory management and supply of medicines, vaccines and consumables linked with PHCs
- Support biomedical equipment maintenance of all the equipment by maintaining database of all the equipment used in PHCs.
- Provide aids for recruitment as PHC Primary health team staff
- Generate population -based analytical reports for routine monitoring and to assess performance of health care providers

8.7.8. Intersectoral Convergence

Convergence is central for the success of health promotion strategies and requires close coordination of health with other allied departments. Currently, convergence has been undertaken with:

- Education department for school-based health promotion camps.
- ICDS for delivery of six services, viz. supplementary nutrition, pre-school non-formal education, nutrition and health education, immunization, health check-up and referral services at Anganwadi Centres. Village Health and Nutrition Days/Urban Health and Nutrition Days act as a platform for interfacing between community and the health system.
- Panchayati Raj/ULBs to address spread of outbreaks of communicable diseases such as dengue, chikungunya, malaria for sanitation drives, vector control, controlling water accumulation, water

testing, chlorination in tanks/wells, cleaning of drains etc. and ensure participation of community during the times of disaster.

- Removal of garbage and general waste is also the responsibility of Panchayat/ULB/Municipality.

Both rural and urban Primary Health Centres will provide a platform for co-ordination and holding meetings with Zila/Block/Gram Panchayat and Urban Local Bodies for planning avenues and strategies for health promotion related to various dimensions of primary care. Such phase wise meetings will also support in planning health education and communication strategies.

8.7.9. Compliance with Statutory Norms

All the statutory Acts, rules and regulations must be strictly adhered to. It will be the duty of senior officials to comply with these and they can delegate roles and responsibilities to relevant officials along with a regular monitoring and feedback mechanism. The following needs to be adhered to:

- No objection certificate from the Fire Authority
- Compliance with state by-laws and the National Building Code (NBC) for all infrastructure
- Authorization under the revised Bio-medical Waste (Management and Handling Rules), 2016 (amended in 2018).
- Seismic safety guidelines
- Registration of Births and Deaths Act
- Consumer Protection Act
- Drugs and Cosmetics Act
- Indian Medical Council Act and the Code of Medical Ethics
- Indian Nursing Council Act
- Pharmacy Act
- Medical Termination of Pregnancy Act
- Persons with Disability Act
- PC & PNDT Act
- Mental Health Act
- Narcotics and Psychotropic substances Act
- Excise permit to store spirits
- Right to Information Act

***Note**: This is not an exhaustive list*

ANNEXURES

Logo Of State Government

CITIZENS' CHARTER

Name Of the State *Name & Type of The Facility (HWC-PHC/HWC-UPHC/24*7-PHC/24*7-UPHC) * Contact No: (Facility Incharge): _____

(This Facility is IPHS & KAYAKALP/NQAS/LaQshya* Certified)

Mission Statement & Objective:

The NHM envisages achievement of universal access to equitable, affordable & quality healthcare services as per IPHS for all with respect, dignity & without any discrimination.

General Information:

No. of General beds

Staff
No. of GDMO……
No. of Nursing staff……
No. of Paramedical staff……
Any other*……

Services Available:

Services (as per Type of PHC)		Days	Timings
OPD services including special services		Mon-Sat (except on public holidays)	8.00am- 2.00pm
Key services available during OPD			
General OPD			
Antenatal Care (ANC)			
Immunization			
Emergency Services		24 x 7	
Minor O.T./ Dressing		24 x 7	
Dental Clinic*			
AYUSH* OPD			
Yoga Day/ Wellness activities			
Fixed Day services			
NCD Clinic			
Geriatric Clinic*			
Disability & Palliative Clinic* (Support)			
Family Planning services			
Mental Health Clinic (Screening)*			
Eye/ Optometry (Screening)*			
ENT Clinic (Screening)*			
DOTS Centre			
Adolescent clinics			
Laboratory	Routine Lab	Mon-Sat	00.00-00.00
	Referral Lab	24 x 7 *(Hub & Spoke, if any)*	
Pharmacy		Mon-Sat	00.00-00.00
Ambulance Services		24 x 7	
Administrative Office Services		Mon-Sat	00.00-00.00
Medico-Legal Services*			

Outreach Services:

Services	Venue	Day/date	Time
Village Health & Nutrition Days (VHNDs)/UHNDs			
Mobile Medical Units (MMU) visits			
RBSK Team visit			
Population based screening			
Any Other*			

Support Services: (In House / Linked)

- Equipment sterilization services
- Laundry services
- Dietary services
- Security services

Other Basic Amenities:

- Stretcher and wheelchair
- Separate queue for senior citizens*
- Disabled & elderly-friendly facilities
- Potable water
- Washroom facility
- Waiting areas
- Generic Drug store*

Free Entitlements:

- Free drugs as per the Essential Drug List (EDL)
- Free diagnostics as per Free Diagnostic Initiative (FDI) guidelines
- 24x7 Ambulance services (including drop back services)
- Dietary services*
- Services under various schemes like
  - Pradhan Mantri Jan Aarogya Yojana (PM-JAY),
  - Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA),
  - Janani Suraksha Yojana (JSY),
  - Janani Shishu Suraksha Karyakaram (JSSK)
  - Mission Indradhanush
- Direct Observed Treatment Short course (DOTS)

#Paid Services: (*If applicable*)

*The user fee for the payable services is displayed in respective service areas. Do not pay any extra money to anybody.

Financial Benefits:

Schemes	Benefits	
Janani Suraksha Yojana (JSY)		
Compensation for Family Planning procedures ○ Tubectomy ○ NSV ○ IUCD ○ Indemnity Scheme		
National TB Elimination Program (NTEP)		

*Expanded range of comprehensive service packages being implemented:

- Care in pregnancy and childbirth.
- Neonatal and infant health care services
- Childhood and adolescent health care services.
- Family planning, Contraceptive services and other Reproductive Health Care services
- Management of Communicable diseases including National Health Programmes
- Management of Common Communicable Diseases and Outpatient care for acute simple illnesses and minor ailments.
- Screening, Prevention, Control and Management of Non-Communicable diseases
- Care for Common Opthalmic and ENT problems
- Basic Oral health care
- Elderly and Palliative health care services
- Emergency Medical Services
- Screening and Basic management of Mental health ailments

(State specific Programs to be entered)

Referral Services:

Toll free number:

Details of nearest CHC: ……
Details of nearest FRU: ……
Details of nearest District Hospital: ……
Details of nearest Tertiary care hospital……

Tele-Consultation Services:

Tele-medicine, Tele-radiology
Tele-conferencing – ECHO, ZOOM

Patient Rights:

- Right to informed consent prior to specific treatment/tests and digitalization of medical records
- Right to confidentiality and privacy during treatment
- Right to be treated with respect and dignity without any discrimination
- Timely release of dead body commensurate to legal protocols
- Right to emergency care and grievance redressal

Patient Responsibilities:

- Respect dignity of doctors and other hospital staff
- Never resort to violence
- Please refrain from causing any damage to public property
- Please do not cause inconvenience to other patients and staff
- Maintain queues and respect others, particularly the elderly, disabled, women & children
- Please do not spit on the floor/walls/ inside the campus
- Please cooperate to keep the facility clean and tidy. Use the dustbin
- Hospital is a no smoking zone and smoking is a punishable offence
- Please register your experience through Mera Aspataal

Visitor's Policy:

Visiting time: Morning: Evening:
Only one person allowed to visit at a time *(Mention about pass system)
Respect visiting hours.

Complaints And Grievances:

- Any Patient/ Attendant can register their grievance through Grievance Redressal (GR) Helpdesk/ calling toll free number (….)/ online GR web portal (www….)
- Every grievance will be duly acknowledged with an SMS and registration number for status tracking.
- We aim to settle your genuine complaints within (7) days of its receipt.
- Suggestions/Complaints may also put in the complaint boxes provided at every department.
- Contact details of the RTI officer are displayed below:

Grievance Redressal:

Toll free number:
Designated officer: (with Mobile & Email)
Compliant Box

Funds:

*RKS detail
*Untied fund detail – Rs……/-

Note: The details of the nodal person can be displayed based on the program requirements
''marked points can be edited according to the conditions/services provided in the respective facility.*
'#' Indicate amount, as applicable

Note - This is a suggestive draft for HWC PHC/UPHC. The states can add or delete as per the services available at the facility.

ANNEXURE 2

List of Services

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
General Services										
6 hours of OPD services	E	-	E	-	E	-	E	-	E	-
Tele-consultation services	-	D	-	D	E	-	E	-	E	-
Facility for admitting patients	2-beds	4 beds	2-day care bed	4-day care beds	6 beds	4 beds	6 beds	4 beds	2-day care beds	4-day care beds
Clinical services										
Emergency Services										
24/7 Emergency Services	During OPD hours	-	During OPD hours	-	E	-	E	-	During OPD hours	-
Triage	During OPD hours	-	During OPD hours	-	E	-	E	-	During OPD hours	-
Resuscitation	During OPD hours	-	During OPD hours	-	E	-	E	-	During OPD hours	-
Stabilization	During OPD hours	-	During OPD hours	-	E	-	E	-	During OPD hours	-
Management and referral as appropriate	During OPD hours	-	During OPD hours	-	E	-	E	-	During OPD hours	-
24/7 Labour Room/LDR	-	-	-	-	E	-	E	-	-	-
General OPD	E	-	E	-	E	-	E	-	E	-
Antenatal clinic	E	-	E	-	E	-	E	-	E	-
NCD Clinic (screening, diagnosis, management, follow-up, and referral)	E	-	E	-	E	-	E	-	E	-
Fixed day special clinics	-	-	-	-	E	-	E	-	E	-
Dental Clinic	-	D	-	D	-	D	-	D	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Rotational Specialist clinic (6 core specialties at Polyclinics- Medicine, obstetrics & gynaecology, Paediatrics, Ophthalmology, Dermatology, Psychiatry/Psychosocial care)	-	-	-	-	-	D	-	D	E	-
Physiotherapy services	-	D	-	D	-	D	-	D	E	-
Indoor Patient Department										
Facility for admitting patients	During OPD Hours	-	During OPD Hours	-	E	-	E	-	During OPD hours	-
Surgical Procedures										
Minor procedures (Minor OT)										
Suturing of wounds	During OPD hours	-	During OPD hours	-	E	-	E	-	During OPD hours	-
Incision and drainage of abscesses	During OPD hours	-	During OPD hours	-	E	-	E	-	During OPD hours	-
Vasectomy, Tubectomies, Hydrocelectomy in PHCs with a functional minor OT and standard infection prevention protocols	-	-	-	-	E	-	E	-	-	-
Antenatal										
Antenatal care with associated services:										
Detecting pregnancy	E	-	E	-	E	-	E	-	E	-
Provision of ANC	E	-	E	-	E	-	E	-	E	-
Counseling services	E	-	E	-	E	-	E	-	E	-
Identification, management, and referral of High-Risk pregnancies;	E	-	E	-	E	-	E	-	E	-
Detection of alarming signs during pregnancy and labor with timely and appropriate referral	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Monitoring high risk pregnancies	E	-	E	-	E	-	E	-	E	-
Management of Malaria for pregnant women as per NCVBDC guidelines	E	-	E	-	E	-	E	-	E	-
Management of TB during pregnancy	E	-	E	-	E	-	E	-	E	-
Management of mild/moderate Anemia	E	-	E	-	E	-	E	-	E	-
Management of GDM as per GoI guidelines	E	-	E	-	E	-	E	-	E	-
Intra Natal Care										
24 hours delivery services (both normal and assisted) (wherever existing)										
Promotion of institutional deliveries ensuring skilled birth attendance	-	-	-	-	E	-	E	-	-	D
Timely identification, initial management, and assured referral of obstetric complications	-	-	-	-	E		E	-	-	-
Identification of post-natal complications	-	-	-	-	E	-	E	-	-	-
Management of normal deliveries and provision of basic obstetric emergency care	-	-	-	-	E	-	E	-	-	-
Assisted vaginal deliveries including forceps/vacuum delivery	-	-	-	-	E	-	E	-	-	-
Maternal and Child Health Care Including Family Planning										
Manual Removal of placenta	-	-	-	-	-	D	-	D	-	D

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Appropriate, prompt, and informed referral of cases needing specialist care	E	-	E	-	E	-	E	-	E	-
Management of pregnancy induced hypertension including referral	E	-	E	-	E	-	E	-	E	-
Pre-referral management (Obstetrics First Aid in emergencies that need expert assistance)	-	-	-	-	E	-	E	-	E	-
Minimum 48 hours stay after delivery	-	-	-	-	E	-	E	-	-	-
Early initiation of breast feeding	E	-	E	-	E	-	E	-	E	
Inj. Vit K prophylaxis for newborn	-	-	-	-	E	-	E	-	-	
Identification and initial management and stabilization for PPH, eclampsia, sepsis - and prompt referral	E	-	E	-	E	-	E	-	E	
Post Natal Care (mother and newborn)										
Ensure daily monitoring of newborn and mother with post discharge counseling for all births	E	-	E	-	E	-	E	-	E	-
Ensure six post-natal home visits by ASHA up to 42 days and at least one supervised visit by ANM	E	-	E	-	E	-	E	-	E	-
Additional visits for a low-birth-weight baby (less than 2500 gms) by ASHA as per GoI guidelines	E	-	E	-	E	-	E	-	E	-
Support for breast feeding and KMC for LBW babies	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Counseling on nutrition, hygiene, contraception, and immunization	E	-	E	-	E	-	E	-	E	-
Provision of facilities under Janani Suraksha Yojana (JSY)		-		-	E	-	E	-	-	-
Tracking of left and missed out PNC	E	-	E	-	E	-	E	-	E	-
Newborn Care										
Facilities for essential newborn care and resuscitation	-	-	-	-	E	-	E	-	-	-
Management of neonatal hypothermia (provision of warmth/kangaroo mother care)										
Infection prevention	-	-	-	-	E	-	E	-	-	-
Cord care	-	-	-	-	E	-	E	-	-	-
Identification & treatment of sick newborn	E	-	E	-	E	-	E	-	E	-
Prompt referral	E	-	E	-	E	-	E	-	E	-
Care of Child (In Emergency, IPD and OPD)										
Management of common illnesses and prevention in OPD as per HBYC guidelines	E	-	E	-	E	-	E	-	E	-
Management of sick child and recognition of danger signs as in HBYC	E	-	E	-	E	-	E	-	E	-
Counseling for exclusive breast feeding for 6 months and appropriate and complimentary feeding from 6 months of age while continuing breast feeding	E	-	E	-	E	-	E	-	E	-
Assess the growth of the infant and under 5 children and take necessary action	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Management of severe acute malnutrition cases after initiation of the treatment as per MoHFW facility-based SAM guidelines	-	-	-	-	E	-	E	-	E	-
Immunization of all infants and children against vaccine preventable diseases	E	-	E	-	E	-	E	-	E	-
Tracking of vaccination drop-outs	E	-	E	-	E	-	E	-	E	-
Vitamin A prophylaxis to the children as per national guidelines	E	-	E	-	E	-	E	-	E	-
Family Welfare										
Education, motivation, and counseling to adopt appropriate family planning methods	E	-	E	-	E	-	E	-	E	-
Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUCD insertions including post- partum contraceptive services and injectable contraceptives	E	-	E	-	E	-	E	-	E	-
Referral and follow up services for eligible couples adopting permanent methods (Tubectomy/Vasectomy) and LARC (IUCD, Injectable contraceptive MPA)	E	-	E	-	E	-	E	-	E	-
Counseling for couples with infertility	E	-	E	-	E	-	E	-	E	-
Permanent methods like tubal ligation and vasectomy/NSV where trained personnel and facilities exist	-	-	-	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Medical Termination of Pregnancy										
Safe abortion services	-	-	-	-	E	-	E	-	E	-
Counseling and appropriate referral for safe abortion services (MTP)	E	-	E	-	E	-	E	-	E	-
Medical Method of Abortion (MMA)	E	-	E	-	E	-	E	-	E	-
MTP using manual vacuum aspiration (MVA) technique where trained personnel and facilities exist	-		-	-	E	-	-	-	-	-
Management of Reproductive Tract Infection Sexually Transmitted Infections										
Health Education for Prevention of RTI's and STI's	E	-	E	-	E	-	E	-	E	-
Treatment of RTI's and STI's	E	-	E	-	E	-	E	-	E	-
Adolescent Health Care										
Package of services to be provided through AFHCs										
Information, education, and counseling on issues related to nutrition, SRH, Behavioural, Mental Health, Gender Based Violence, Non-Communicable diseases and Substance abuse and referral to appropriate higher facilities for management	E	-	E	-	E	-	E	-	E	-
Management of common adolescent health problems, RTI/STI, Anemia, menstrual problems, ANC for pregnant adolescents**.** Referral Services for ICTC, De-addiction centre, non-Communicable diseases clinics	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Nutritional Services										
Diagnosis, support and advice for malnourished children, pregnant women, and others	E	-	E	-	E	-	E	-	E	-
Other National Health Programmes										
National Tuberculosis Elimination Programme										
PHC as DOTS Centre	-	-	-	D	E	-	E	-	E	-
Deliver treatment as per NTEP guidelines through DOTS providers (including pregnant women)	-	-	-	D	E	-	E	-	E	-
Management of common complications of TB (including side effects of drugs)	-	-	-	D	E	-	E	-	E	-
Recording and reporting of NTEP activities	E	-	E	-	E	-	E	-	E	-
Facility for collection and transport of sputum samples as per NTEP guidelines	-	-	-	D	E	-	E	-	E	-
Monitoring & supervision of DOTS providers as per NTEP guidelines	-	-	-	D	E	-	E	-	E	-
National Leprosy Eradication Programme										
Health education/awareness raising	E	-	E	-	E	-	E	-	E	-
Diagnosis and management of Leprosy and its complications including reactions	E	-	E	-	E	-	E	-	E	-
Counseling of leprosy patients for treatment compliance, self-care, and prevention of disability	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Referral for reconstructive surgeries	E	-	E	-	E	-	E	-	E	-
Integrated Disease Surveillance Project										
Weekly reporting of epidemic prone diseases in S, P & L forms, and SOS reporting for any cluster of cases	E	-	E	-	E	-	E	-	E	-
PHC will collect and analyze data from Sub-Centre/UHWC for early intervention and forwarding to district surveillance unit	E	-	E	-	E	-	E	-	E	-
Appropriate preparedness and first level action in out-break situations	E	-	E	-	E	-	E	-	E	-
National Programme for Control of Blindness & Visual Impairment										
Early detection of visual impairment and their referral	E	-	E	-	E	-	E	-	E	-
Detection of cataract cases and referral	E	-	E	-	E	-	E	-	E	-
Follow up of post-operative cataract patients and distribution of spectacles to them	E	-	E	-	E	-	E	-	E	-
Screening of children and distribution of spectacles as per NPCBVI	E	-	E	-	E	-	E	-	E	-
Identification of Vitamin A deficiency and Bitot's spot	E	-	E	-	E	-	E	-	E	-
Provision of basic treatment of common eye diseases	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Awareness generation through appropriate IEC strategies for prevention and early detection of impaired vision and other eye conditions	E	-	E	-	E	-	E	-	E	-
Greater participation/role of community in primary prevention of eye problem	E	-	E	-	E	-	E	-	E	-
National Vector Borne Disease Control Programme										
Prevention, Diagnosis and Management of Vector borne Diseases as per NCVBDC guidelines for PHC										
Diagnosis of Malaria cases, microscopic confirmation, and treatment	E	-	E	-	E	-	E	-	E	-
Cases of suspected JE and Dengue to be provided symptomatic treatment, as per protocols	E	-	E	-	E	-	E	-	E	-
Cases of suspected JE and Dengue requiring hospitalization, case management and referral as per protocols	-	-	-	-	E	-	E	-	E	-
Treatment of Kala-azar cases in endemic areas as per national Policy	E	-	E	-	E	-	E	-	E	-
Complete treatment of microfilaria positive cases along with management of side reactions, if any. Morbidity management of Lymphoedema cases	E	-	E	-	E	-	E	-	E	-
Study of habits of vector (feeding habits, time of biting, resting habits, breeding habits, hibernation, dispersal, life span)	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
National AIDS Control Programme										
IEC activities to enhance awareness and preventive measures about STIs and HIV/ AIDS, Prevention of Parents to Child Transmission (PPTCT) services	E	-	E	-	E	-	E	-	E	-
Organizing School Health Education Programme	E	-	E	-	E	-	E	-	E	-
Condom Promotion & distribution of condoms for high-risk groups	E	-	E	-	E	-	E	-	E	-
Help and guide patients with HIV/AIDS receiving ART with focus on adherence	E	-	E	-	E	-	E	-	E	-
Integrated Counseling including nutritional counselling and Testing Centre, STI services	E	-	E	-	E	-	E	-	E	-
Screening for high-risk behaviour with rapid test and development of referral linkages with the nearest ICTC/DH for confirmation of HIV status	E	-	E	-	E	-	E	-	E	-
Risk screening of antenatal mothers with one rapid test for HIV and establish referral linkages with CHC or District Hospital for PPTCT services	E	-	E	-	E	-	E	-	E	-
Linkage with Microscopy Centre for HIV-TB coordination	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
National Programme for Prevention and Control of Deafness (NPPCD)										
Early detection and referral of hearing impairment and deafness	E	-	E	-	E	-	E	-	E	-
Diagnosis and management of common ear diseases (e.g., wax, discharge, otitis externa)	E	-	E	-	E	-	E	-	E	-
IEC and community awareness for prevention and early detection of hearing impairment/ deafness	E	-	E	-	E	-	E	-	E	-
National Mental Health Programme										
Early identification, counselling and referral of mental illness in the community	E	-	E	-	E	-	E	-	E	-
Basic Services: Diagnosis and management of common mental disorders such as psychosis, depression, anxiety disorders, Stress management during pregnancy and epilepsy with appropriate referral	E	-	E	-	E	-	E	-	E	-
IEC activities for prevention, stigma removal, early detection of mental disorders and greater participation/role of the community for primary prevention of mental disorders	E	-	E	-	E	-	E	-	E	-
National Programme for Prevention and Control of Cancer, Diabetes, CVD and Stroke (NPCDCS)										
IEC services for prevention of cancer	E	-	E	-	E	-	E	-	E	-
Population based Screening of Oral, Breast, Cervix cancer	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Early detection of cancer with warning signals like change in Bladder/Bowel habits, bleeding per rectum, blood in urine, lymph node enlargement, Lump or thickening in Breast, itching and/ or redness or soreness of the nipples of Breast, non-healing chronic sore or ulcer in oral cavity, difficulty in swallowing, obvious change in wart/mole, nagging cough or hoarseness of voice etc	E	-	E	-	E	-	E	-	E	-
Referral of suspected cancer cases with early warning signs	E	-	E	-	E	-	E	-	E	-
Health Promotion Services to modify individual, group and community behaviour especially through;	E	-	E	-	E	-	E	-	E	-
Promotion of health dietary habits	E	-	E	-	E	-	E	-	E	-
Increase physical activity	E	-	E	-	E	-	E	-	E	-
Avoidance of tobacco and alcohol	E	-	E	-	E	-	E	-	E	-
Stress Management	E	-	E	-	E	-	E	-	E	-
Early detection, management and referral of Diabetes Mellitus, Hypertension and other cardiovascular diseases and Stroke through simple measures like history, measuring blood pressure, checking for blood, urine sugar and ECG	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
National Iodine Deficiency Disorders Control Programme (NIDDCP)										
IEC activities to promote the consumption of iodized salt	E	-	E	-	E	-	E	-	E	-
Monitoring of Iodized salt through salt testing kits	E	-	E	-	E	-	E	-	E	-
National Programme For Prevention and Control of Fluorosis (NPPCF) (In affected endemic districts)										
IEC activities to prevent Fluorosis	E	-	E	-	E	-	E	-	E	-
Clinical examination and preliminary diagnostic parameters assessment for cases of Fluorosis	E	-	E	-	E	-	E	-	E	-
National Tobacco Control Programme										
Health education and IEC activities regarding harmful effects of tobacco use and passive smoke	E	-	E	-	E	-	E	-	E	-
Promoting quitting of tobacco in the community	E	-	E	-	E	-	E	-	E	-
Making PHC tobacco free	E	-	E	-	E	-	E	-	E	-
Screening, identification, and referral of potentially malignant lesions	E	-	E	-	E	-	E	-	E	-
Capacity Building										
Orientation of frontline workers in various National Health Programmes including 12 packages of CPHC	E	-	E	-	E	-	E	-	E	-
Orientation on various Program activities, public health surveillance	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Orientation & training needs assessment for various portals & applications	E	-	E	-	E	-	E	-	E	-
National Programme for Health Care of Elderly (NPHCE)										
Health education/awareness generation	E	-	E	-	E	-	E	-	E	-
Geriatric OPD through trained MO (Weekly/Bi-weekly as per case load)	E	-	E	-	E	-	E	-	E	-
Geriatric Physiotherapy/ Rehabilitation Services	-	D	-	D	-	D	-	D	-	D
Referral for Higher centre	E	-	E	-	E	-	E	-	E	-
Comprehensive Geriatric Assessment- Annual	-	-	E	-	E	-	E	-	E	-
Home based care to bedridden elderly	E	-	E	-	E	-	E	-	E	-
Capacity building of family members & Caregivers of elderly	E	-	E	-	E	-	E	-	E	-
National Programme for Palliative Care (NPPC)										
Health education/awareness raising	E	-	E	-	E	-	E	-	E	-
OPD services through trained manpower/Consultation for all patients requiring pain management due to any cause	-	D	-	D	E	-	E	-	E	-
Rehabilitation Services	-	D	-	D	E	-	E	-	E	-
Referral for higher centre	E	-	E	-	E	-	E	-	E	-
Home based care	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Capacity building	E	-	E	-	E	-	E	-	E	-
Community Health Services and Outreach Programme										
Linkages with outreach services										
Community Based Planning and monitoring										
Facilitating preparation of village/ Panchayat/city/ULB Health Action plan as per the GOI guideline	E	-	E	-	E	-	E	-	E	-
Facilitate approval of annual health action plan in Panchayat/ city/ULB	E	-	E	-	E	-	E	-	E	-
Facilitate Panchayati Raj institution/ULBs in preparation of monitoring plan of all programme activities	E	-	E	-	E	-	E	-	E	-
Community participation in implementation of health programme										
Meeting with community-based organizations, RWA, SSS, ward and gully committee	E	-	E	-	E	-	E	-	E	-
Organize campaign on issues such as cleanliness, reduction of vector breeding sites, gender-based violence and atrocity against vulnerable population & other Health Issues	E	-	E	-	E	-	E	-	E	-
Outreach services at community										
Village/Urban Health and Nutrition Day	E	-	E	-	E	-	E	-	E	-
Population based screening for Leprosy, TB, NCD, filaria etc.	-	D	-	D	-	D	-	D	-	D

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Deworming	E	-	E	-	E	-	E	-	E	-
Screening activities on fixed days										
Breast cancer	E	-	E	-	E	-	E	-	E	-
Oral cancer	E	-	E	-	E	-	E	-	E	-
Cervical cancer	E	-	E	-	E	-	E	-	E	-
Hypertension and diabetes	E	-	E	-	E	-	E	-	E	-
Community Health Services and Outreach Programme										
School health Linkage with RBSK										
Screening of general health, assessment of Anemia/ Nutritional status, visual acuity, hearing problems, dental check-up, common skin conditions, Heart defects, physical disabilities, learning disorders, behaviour problems, etc.	E	-	E	-	E	-	E	-	E	-
Referral Cards for priority services at District/Sub-District hospitals	E	-	E	-	E	-	E	-	E	-
Biannually supervised rounds in school and community	E	-	E	-	E	-	E	-	E	-
Immunization services	E	-	E	-	E	-	E	-	E	-
Micronutrient management (Vitamin A and IFA)	E	-	E	-	E	-	E	-	E	-
Administration of Vitamin-A	E	-	E	-	E	-	E	-	E	-
Counselling	E	-	E	-	E	-	E	-	E	-
Regular eye check-up for refractive errors	E	-	E	-	E	-	E	-	E	-
Early detection of impaired hearing	E	-	E	-	E	-	E	-	E	-
Mental health and addictions	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Nutritional Services (Coordinated with ICDS)										
Diagnosis of and nutrition advice to malnourished children, pregnant women, and others	E	-	E	-	E	-	E	-	E	-
Tracking of SAM	E	-	E	-	E	-	E	-	E	-
Monitoring and Evaluation										
Intersectoral convergence of various national level schemes	E	-	E	-	E	-	E	-	E	-
Promotion of safe drinking water and basic sanitation under WASH										
Disinfection of water sources and Coordination with Public Health Engineering department for safe water supply	E	-	E	-	E	-	E	-	E	-
Promotion of sanitation including use of toilets and appropriate garbage disposal	E	-	E	-	E	-	E	-	E	-
Testing of water quality using H_2S - Strip Test	E	-	E	-	E	-	E	-	E	-
Administrative and Maintainance Services (At the facility level)										
System for assured grievance redressal	E	-	E	-	E	-	E	-	E	-
Medical Records	E	-	E	-	E	-	E	-	E	-
Registration Counter	E	-	E	-	E	-	E	-	E	-
Pharmacy	E	-	E	-	E	-	E	-	E	-
Store	E	-	E	-	E	-	E	-	E	-
Pantry	E	-	E	-	E	-	E	-	E	-
Effluent Treatment Plant	E	-	E	-	E	-	E	-	E	-
Water tank	E	-	E	-	E	-	E	-	E	-

List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Availability of water @ 450 L per bed per day	E	-	E	-	E	-	E	-	E	-
IT platforms and services	E	-	E	-	E	-	E	-	E	-
Administrative offices/areas	E	-	E	-	E	-	E	-	E	-
Birth and Death Registrations	-	D	-	D	-	D	-	D	-	D
Server Room	-	D	-	D	-	D	-	D	-	D
Housekeeping Room	-	D	-	D	E		E		-	D
Digital Token System and Computerized Registration	-	D	-	D	-	D	-	D	-	D
Water ATM	-	-	-	-	-	-	-	D	-	D
Parking	-	D	-	D	E	-	E	-	E	-
Garden	-	D	-	D	E	-	E	-	E	-
Water harvesting	-	D	-	D	E	-	E	-	E	-
Staff Residences	-	D	-	D	-	D	-	D	-	D
Records of Vital events and Reporting										
Recording and reporting of Vital statistics including births and deaths	E	-	E	-	E	-	E	-	E	-
Maternal Death Surveillance and Response (MDSR)	-	D	-	D	E	-	E	-	-	D
Community Based MDSR shall be conducted from the PHC	-	D	-	D	E	-	E	-	-	D
RCH portal, HMIS, NISCHAY, NIKUSHTH, IDSP, NVBDCP, NCD, web portal, others	E	-	E	-	E	-	E	-	E	-

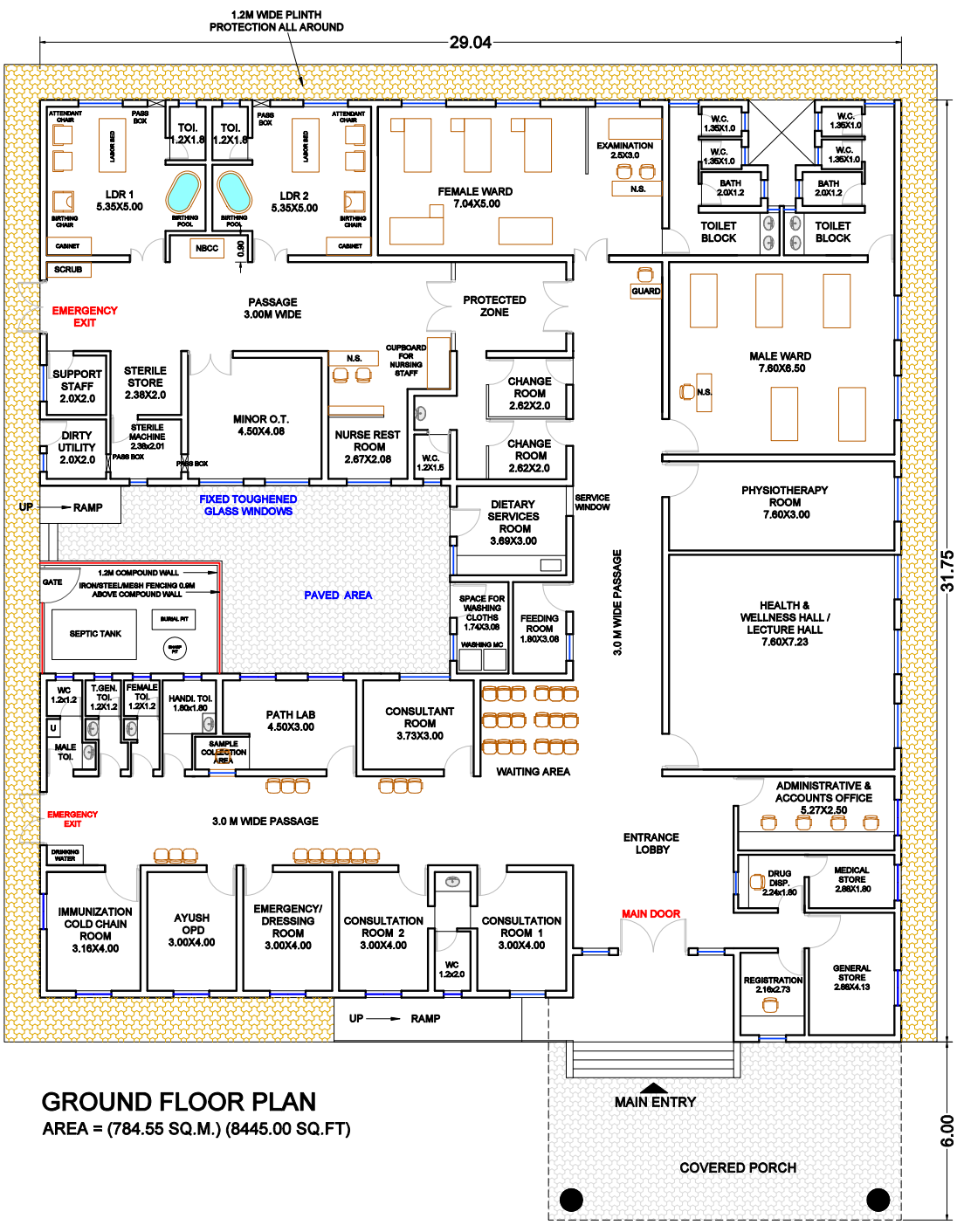
List of services available at Primary Health Care Facility										
Services	**PHC**		**UPHC**		**24x7 PHC**		**24x7 UPHC**		**Polyclinic**	
	E	**D**	**E**	**D**	**E**	**D**	**E**	**D**	**E**	**D**
Monitoring										
Monitoring and supervision of activities of HWC- Sub Centre through regular meetings/ periodic visits, by LHV, Health Assistant Male and Medical Officer etc.	E	-	E	-	E	-	E	-	E	-
Monitoring under HBYC, ANC visits, blindness, NCDs above 30, leprosy, oral health screening, DMF score	E	-	E	-	E	-	E	-	E	-
Tracking of missed out and left out ANC/PNC, Vaccinations etc. during monitoring visits and quality parameters (including using Partograph, AMTSL, ENBC etc.) during delivery and post-delivery	E	-	E	-	E	-	E	-	E	-
Timely payment of honorarium to ASHAs	E	-	E	-	E	-	E	-	E	-

Note: The services mentioned under desirable are over and above the services mentioned as essential.

ANNEXURE 3

Layout for PHC

Layout for 24x7 PHC



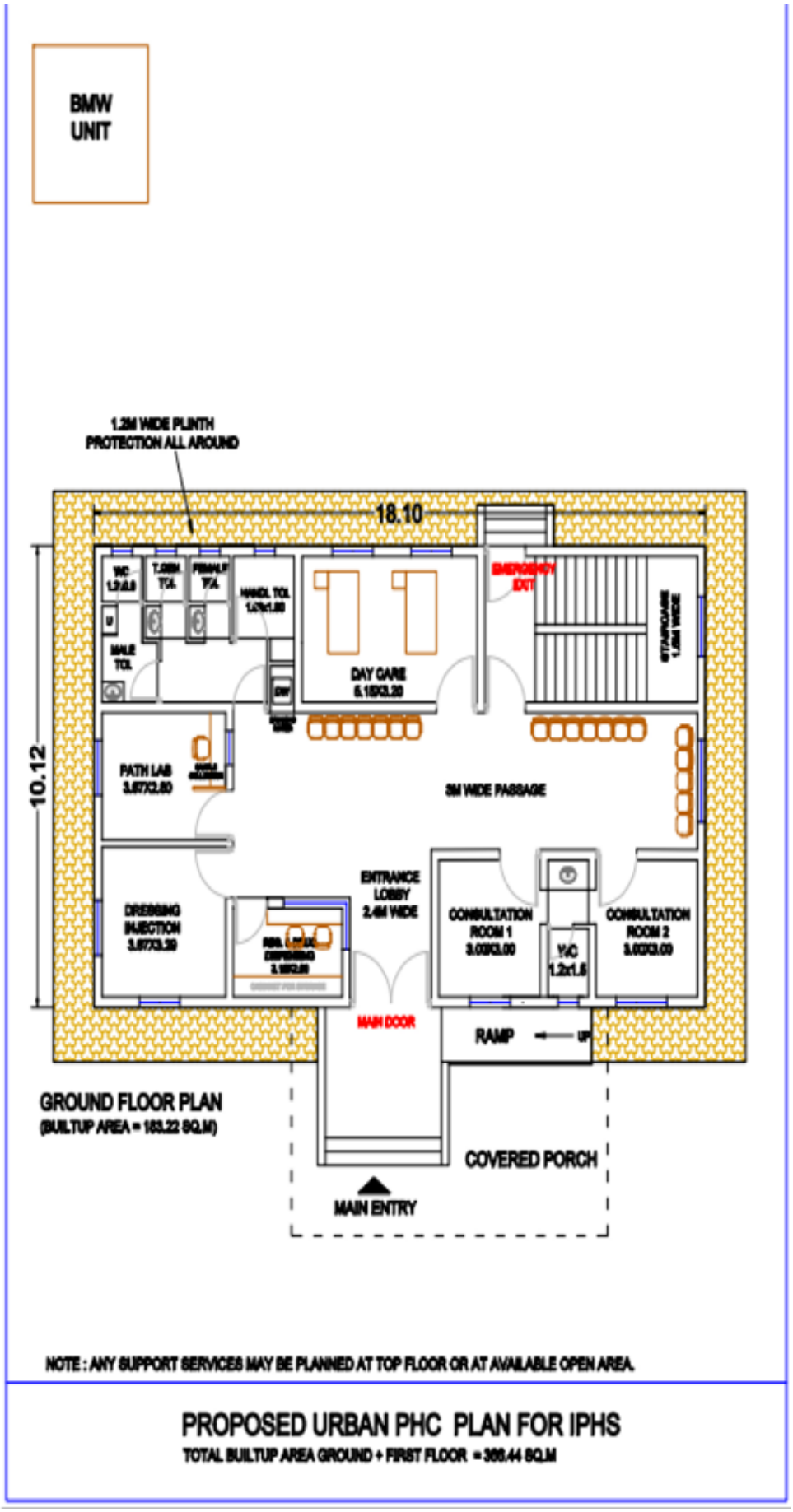
GROUND FLOOR PLAN

AREA = (784.55 SQ.M.) (8445.00 SQ.FT)

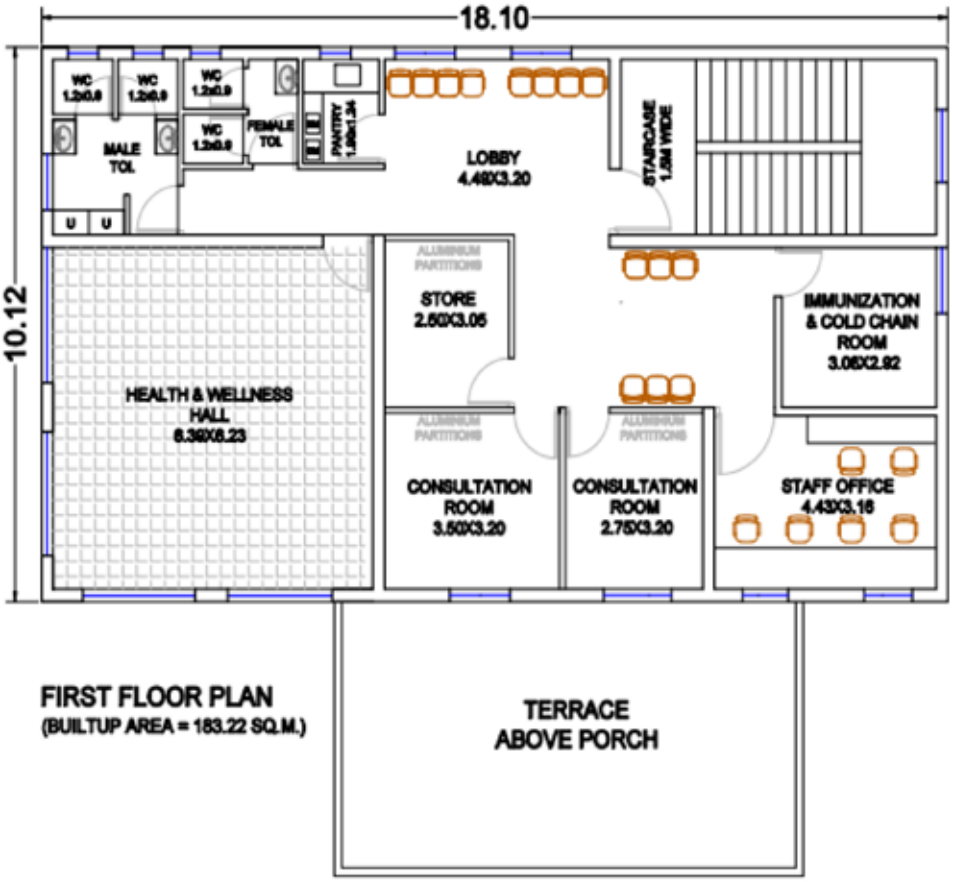
NOTE : ANY SUPPORT SERVICES MAY BE PLANNED AT TOP FLOOR OR AT AVAILABLE OPEN AREA.

PROPOSED 24X7 PHC PLAN FOR IPHS.

Layout for UPHC (Ground Floor)



Layout for UPHC (First Floor)



NOTE : ANY SUPPORT SERVICES MAY BE PLANNED AT TOP FLOOR OR AT AVAILABLE OPEN AREA.

PROPOSED URBAN PHC PLAN FOR IPHS

TOTAL BUILTUP AREA GROUND + FIRST FLOOR = 366.44 SQ.M


PRIMARY HEALTH CENTER (PHC)

The detailed layout plan for PHCs with varying bed strength can be accessed through the link provided:
https://nhsrcindia.org/IPHS2022

ANNEXURE 4

Disaster Management & Preparedness

Fire safety Norms

Provisions laid down in National building code 2016 (4.5.2 - sub division C-1) are the minimum requirements for a reasonable degree of safety from fire emergencies in hospitals, such that the probability of injury and loss of life from the effects of fire are reduced. All healthcare facilities should be so designed, constructed, maintained, and operated as to minimize the possibility of a fire emergency requiring the evacuation of occupants, as safety of hospital occupants cannot be assured adequately by depending on evacuation alone. Hence measures shall be taken to limit the development and spread of a fire by providing appropriate arrangements within the hospital through adequate staffing & careful development of operative and maintenance procedures consisting of:

- Design and Construction.
- Provision of Detection, Alarm and Fire Extinguishment.
- Fire Prevention
- Planning and Training programs for Isolation of Fire; and,
- Transfer of occupants to a place of ***comparative safety*** or evacuation of the occupants to achieve ***ultimate safety***.

Expected Levels of Fire Safety in Hospitals

Hospitals shall provision for two levels of safety within their premises:

(1) ***Comparative Safety:*** which is protection against heat and smoke within the hospital premises, where removal of the occupants outside the premises is not feasible and/or possible. Comparative Safety may be achieved through:

(a) Compartmentation (b) Fire Resistant wall integrated in the Flooring (c) Fire Resistant Door of approved rating (d) Corridor, Staircase (e) Pressurized Shaft or naturally ventilated stair balconies (f) Refuge Area (g) Independent Ventilation system (h) Fire Dampers (i) Automatic Sprinkler System (j) Automatic Detection System(k) Manual Call Point(l) First Aid (m) Fire Fighting Appliances (n) Fire Alarm System (o) Alternate Power Supply (p) Public Address System (q) Signage (r) Fire Exit Drills and orders.

(2) ***Ultimate Safety:*** which is the complete removal of the occupants from the affected area to an assembly point outside the hospital building. Ultimate Safety may be achieved through:

(a) Compartmentation (b) Fire Resistant Door of approved rating (c) Protected Lobby, Corridor, Staircase and Shaft (d) Public Address System (e) Signage (f) Fire Drills and orders

Open space

- Hospitals shall make provisions for sufficient open space in and around the hospital building to facilitate the free movement of patients and emergency/fire vehicles.
- These open spaces shall be kept free of obstructions and shall be motorable.
- Adequate passageway & clearance for fire fighting vehicles to enter the hospital premises shall be provided.
- The width of such entrances shall not be less than 4.5 meters with clear head room not less than 5 meters.

- The width of the access road shall be a minimum of 6 meters.
- A turning radius of 9 meters shall be provided for fire tender movement.
- The covering slab of storage/static water tank shall be able to withstand the total vehicular load of 45 tone equally divided as a four-point load (if the slab forms a part of path/driveway).
- The open space around the building shall not be used for parking and/or any other purpose.
- The setback area shall be a minimum 4.5 meters.
- The width of the main street on which the hospital building abuts shall not be less than 12 mtrs & when one end of that street shall join another street, the street shall not be less than 12 meter wide.
- The roads shall not be terminated in dead ends.

Instructions for Fire Safety for Hospital Staff Instructions for Personal Safety

All Hospital Staff should know:

- The location of MOEFA push button fire alarm boxes. They should read the operating instructions.
- Location of the fire extinguishers, hose reel, etc. provided on their respective floors.
- The nearest exit from their work areas.
- The assembly point in emergencies.

Matters to be reported to the Fire officer

- If any exit door/route is obstructed by loose materials, goods, boxes, etc.
- If any staircase door, lift lobby door does not close automatically, or does not close completely.
- If any push button fire alarm point or fire extinguisher is obstructed, damaged or apparently out of order.

Instructions for Fire Incidents

During any fire incident in the hospital premises, staff should:

- Break the glass of the nearest fire alarm (if they are the first ones to discover the fire)
- Attack the fire with fire extinguishers/hose reel provided on the floor

Safe electricity

- Two numbers of earthing should be there at each electrical installation. Copper plate earthing should be preferred.
- Provision of surge protection/suppressor should be there. Surge suppressors are rated according to size of voltage spike they can handle, so only units of high enough joules rating to protect the equipment should be used.
- Load calculation should be proper, accordingly the distribution, electrical switchgear rating, circuitry, cabling, and electrical installation should be there.
- The size of cabling and wiring should be about 1.5 times or more to the actual electrical load calculated.
- Adequate power back up with another source such as DG, Photovoltaic etc. should be there in synchronization with the first source.
- Some places which are very important, provision of uninterrupted power supply should be there.
- Phase sequence should be proper as for motorized load.

- Load monitoring should be there to avoid any overloading
- A lot of motorized as well as semiconductor material devices are there hence provision of power factor improvement should be there.
- All the connection and joint should be tight with proper size of thimbling.
- Balancing of electrical load should be proper and monitored via measuring devices.
- Suitable place should be selected for electrical installation.
- Sensitive equipment should be provided with proper rating UPS for extra safety against disturbances as voltage spike and noise.
- The Electrical Switch Room shall be housed in a dedicated room/cupboard located on the ground floor and in association with an external wall and shall have internal access. The room shall be located so that it does not present difficulties for services distribution from adjoining spaces or rooms, and it shall be located to provide for economic distribution of services. The main switchboard shall be of metal clad cubicle design to approved standards and regulations. Each switchgear assembly shall have sufficient spare capacity. Electronic surge protection shall be provided on the incoming mains.

Earthquake Safety Provisions

All new hospital buildings or hospital buildings being retrofitted in seismic zone IV and V, and hospital buildings in wind zones with basic wind speed 42 m/s or more, shall be instrumented with proper mechanism prescribed in NBC.

Safer and functional Hospital: One of the main concerns regarding the safety of hospitals is that hospital structures (i.e., the buildings) are themselves vulnerable to collapse in the face of extreme forces (such as those experienced during earthquakes). Therefore, to ensure the safety of hospitals and achieve the goal of 'safer and functional hospitals', mitigation measures (as presented in NBC) need to be undertaken in a programmatic manner by the Ministry of Health on an urgent basis.

Post-Earthquake Assessment of Hospital Structures

Hospital buildings shall be inspected by competent licensed engineers after every damaging earthquake to document damages (if any) to Structural element (SEs) and Non-Structural Element (NSEs) of the buildings, along with recommendations for detailed study and suitable retrofitting as found necessary

ANNEXURE 5

Roles & Responsibilities of staff at PHC/UPHC

Human Resource for Health	PHC		UPHC		Polyclinic		24x7 PHC*		24x7 UPHC*		Remarks
	E	D	E	D	E	D	E	D	E	D	
MO MBBS	1	1	2	-	2	-	2	1	2	1	**One doctor round the clock*
MO AYUSH	-	1	-	-	-	-	-	1	-	-	
MO Dental	-	1	-	1	1	-	-	1	-	1	
***Specialist for Medicine, Obstetrics & Gynecology, Pediatrics, Ophthalmology, Dermatology and Psychiatry**	-	-	-	-	1*	#	-	-	-	-	** These specialists are on rotational basis* *# Option to add more specialties besides the 6 core specialties as per need and availability.* *Services for specialist consultation (Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology, Psychiatry/Psycho-social care), would be provided on a rotational basis at UHWC-PHCs or at Urban CHCs. Such poly clinic services would be limited to outpatient care to minimize the need for specialized equipment at every UPHC level AB-HWCs. Access to specialist services/ Polyclinics is envisaged for every 2.5-3 lakh population depending on the local context*
Staff Nurses	2	1	1	1	2	-	7*	-	7*	-	**1 in IPD in each shift including FP services* *+1 for Labour Deliver Recovery in each shift* *+1 for OPD including NCD screening*
Pharmacist	1	-	1	-	1	1*	1	1*	1	1*	*1 Allopathy (Pharmacist) +1* Storekeeper*

Human Resource for Health	PHC		UPHC		Polyclinic		24x7 PHC*		24x7 UPHC*		Remarks
	E	D	E	D	E	D	E	D	E	D	
Medical Laboratory Technologist/Lab Technician	1	-	1	-	1	-	2	1	2	1	
Optometrist/Ophthalmic Assistant/Vision Technician	-	1	-	-	1	-	-	1	-	1	
Health Worker (Female)/ ANM	1*	-	5**	-	5**	-	1*	-	5 **	-	**For Sub-centre of PHC* *** A normative coverage of a population of 10,000 served by 1 ANM (1 for every 10,000 population)*
Health Worker/Health Assistant (Male)	1	-	-	-	-	-	1	-	-	-	*No male Health Assistant in urban areas*
Health Assistant (Female)/ Lady Health Visitor	1	-	1	-	1	-	1	-	1	-	
Health Educator/ Counsellor	-	1	-	1	1	-	-	1	-	1	
Dental Assistant*	-	1	-	1	-	1	-	1	-	1	**Health assistant Male or any other staff can be trained to support dentists for the logistics required during the treatment/dental procedure.*
Cold chain/Vaccine logistic Assistant	-	1	-	1	-	1	1	-	1	-	*If the PHC/UPHC is a cold chain point, there should be a cold chain/vaccine logistic assistant, or such work can also be handled by Health worker or any other staff.*
Physiotherapist	-	-	-	-	1	-	-	1	-	1	
Public Health Manager	-	-	1	-	1	-	-	-	1	-	
Dresser	1	-	1	-	-	-	1	-	1	-	
LDC-1/Accountant	1	-	1	-	1	-	1	-	1	-	
Data Entry Operator	1	-	1	-	1	-	1	-	1	-	*DEO (Responsible for Data Entry+ Registration+ other IT related activities at Health care facility).*

Suggestive numbers for Support Staff

Human Resource of Health	PHC		UPHC		Polyclinic		24x7 PHC		24x7 UPHC		Remarks
	E	D	E	D	E	D	E	D	E	D	
Sanitation staff	1	-	1	-	2	-	4*	-	4*	-	**2 Morning+ 1 Evening + 1 Night- At least one female*

Note:

1. The number of HR indicated as desirable is over and above the HR indicated as essential.

2. All the HR indicated under the support staff is to be only hired in-house, if the related services are not outsourced.

3. Meaning thereby, for outsourced services, the HR is to be provided by the outsourcing agency

Job Responsibilities of Medical Officer - PHC

1. Clinical Work

- The Medical Officer will be organizing and performing duties necessary for the routine Outpatient services and also ensure emergency cases are attended and taken care of.
- He/she will screen cases needing specialized medical attention, refer them to referral institutions and will cooperate and coordinate with other institutions providing medical care services in his/her area.
- He/she will attend all calls from the in-patients, while He/she is 'on-call duty'.
- As a member of the health care team, he/she will exemplify an example in attitude toward patients and staff, thereby, performing duties with respect, dignity, privacy, and modesty to the patients.
- He/she will be friendly, courteous and sympathetic while working with patients and ensure privacy and confidentiality of the patients.
- He/she will perform any other duties which a Medical Officer is expected to perform in view of his position and any other duties which will be assigned as and when required.

2. Public Health Work

- He/she will make arrangements and provide guidance for rendering health care services at the community level and at the PHC through the Health Assistants, Health Workers and others.
- The Medical Officer will ensure that all the members of his/her Health Team are fully conversant with the various National Health & Family Welfare Programs including NHM to be implemented in the area allotted to each health functionary.
- He/she will prepare operational plans and ensure effective implementation of the same to achieve the laid down targets under different National Health and Family Welfare Programmes.
- Any services, speciality or otherwise, being rendered in the hospital, its quality delivery and other necessary coordination will be ensured by the MO.
- The MO will ensure the effective implementation of all National Health Programmes – Reproductive and Child Health Programme, Universal Immunization Programme, National Vector Borne Disease Control Programme, National Programme for control of Blindness, Non-Communicable Diseases Programmes, National Mental Health Programme, Control of Communicable Diseases, Leprosy, Tuberculosis, Sexually Transmitted Diseases and Ayushman Bharat.
- He/she will be responsible for proper and successful implementation of the Programmes in PHC area, including education, motivation, delivery of services and aftercare.
- He/she will be responsible for all administrative and technical matters regarding the operations of National Health Programmes in his/her PHC area.
- He/she will be responsible for all Health Education activities in his/her area.
- He/she will take the necessary steps for institutionalizing public health surveillance and undertake timely actions in case of any outbreak of epidemic in his/her area.

3. Administrative Work

- He/she will supervise the work, scrutinize the programmes of his/her staff and suggest changes if necessary to suit the priority of work of staff working under him/her.
- He/she will hold monthly staff meetings to evaluate the progress of work and suggest steps to be taken for further improvements.
- He/she will ensure the maintenance of the prescribed records and registers at PHC level and will issue various kinds of certificates in the capacity of a medical officer.

- He/she will ensure that the problems and grievances of the staff are solved promptly.
- He/she will ensure the confidentiality of the patients.
- He/she will take actions timely for legal matters, medico-legal cases, RTIs, court cases and expeditions implementation of orders of the courts.
- He/she will organize training programmes including continuing education for the staff of PHC and ASHA under the guidance of the district health authorities and Health & Family Welfare Training Centres and will ensure that the staff working under his office regularly gets appropriate training.
- He/she will assess the performance of the staff and arrange for retraining if required.
- He/she will ensure appropriate utilization of funds as per the guidelines and GFR (General Financial Rules) provisions.
- He/she will ensure auditing procedures are completed well in advance, and audit reports are furnished to all the concerned authorities.
- He/she will dispose of all of the obsolete/condemned items and vehicles as per the Government orders in force.
- He/she will monitor and guide the activities of Hospitals/PHC/CHC committees, patient welfare societies of hospitals, village health & sanitation committees.
- He/she will ensure inter-sectoral/inter-departmental coordination; involvement of community leaders, various social welfare agencies and people for effective provision of patient centric healthcare.
- He/she will be involved in 'performance audit' of staff as per the guidelines of 'Performance Audit'.
- He/she will facilitate, coordinate, supervise, monitor and implement the provisions of all the health sector Acts and the Rules.

Job Responsibilities of Staff Nurse

1. Clinical Work

- S/he will assess the needs of the patients in the ward, explain the medicines to be taken, make a nursing care plan for all patients consulting with ward sister.
- S/he will give direct patient care and allotted responsibility to her/him by the ward sister.
- S/he will provide comfort to the patient and maintain the safety of the patient (universal safety precaution).
- S/he will be friendly, courteous, and sympathetic while working with patients and ensure privacy and confidentiality of the patients.
- S/he will carry out procedures of admission, discharge and transfer of patient of the ward.
- S/he will take care that discharged patients have a proper understanding of the follow-up procedures and details of the diet, medication, exercise, etc.
- S/he will be responsible for taking a history of the patient.
- S/he will prepare and assist in the diagnostic procedure in the ward.
- S/he will provide minor dressing in an emergency.
- S/he will administer drugs by injection upon written order of the Doctor.
- S/he will learn the handling of special gadgets & equipment.
- S/he will distribute diet, milk, etc.
- S/he will maintain a duty room in readiness for all time.

- S/he will be responsible for observation of the patient's condition, take prompt action and report to the concerned medical officer.
- S/he will give health education to the patients and their family members under care.
- S/he will make records of all procedures of her/his patients and keep them up to date.
- S/he will take care that case papers are not allowed to be handled by anyone except the doctor-in-charge of the patient. This is specifically for medico-legal cases.
- S/he will provide assistance and instructions to the patients and their relatives.
- S/he will be responsible for providing antenatal, intra-natal, postnatal care as taught in the nursing curriculum.
- S/he will assess the progress of labour by using partograph in the labour room.
- S/he will assist the doctors in any procedure the labour room.
- S/he will conduct normal delivery, provide care to the new born and to resuscitate newborn if needed in the labour room.
- S/he will repair episiotomy wounds accordance to the laid down policy of the hospital in the labour room.
- S/he will perform any other duties which a Staff Nurse is expected to perform in view of his position and any other duties which will be assigned as and when required.

Administrative work

- S/he will ensure that all articles are sterilized, all equipment, gadgets, electrical connections, light, fan etc. are maintained.
- S/he will ensure that the specimens are collected, labelled and dispatched.
- S/he will ensure to escort the patient to and from the department.
- S/he will ensure that the reports are received and given to the patients as well as the doctor is informed.
- S/he will ensure that the patient's problems are listened to and help them to solve them through various means.
- S/he will ensure the confidentiality of the patients.
- S/he will ensure that the cultural and religious differences of the patients are respected.
- S/he will ensure to carbolize the Labour room daily.
- S/he will supervise the students and ancillary staffs.
- S/he will ensure that all records, outcome indicators as per LaQshya guidelines are maintained.
- S/he will ensure to make the ward clean and tidy, including the bed.
- S/he will keep all articles well-arranged and maintain the inventory.
- S/he will maintain all records and mandates.
- S/he will assist the ward sister in orientation programme of new staff and students and in the supervision of work of Group D allotted in the ward for maintenance of cleanliness and sanitation.
- S/he will accompany doctors and senior nursing officers during 'ward round'.
- S/he will help ward sister in indenting and checking of drugs, supplies and maintaining inventories.
- S/he will perform the functions of the ward sister during her/his absence.
- S/he will assist in orientation of new staff nurses.
- S/he will support and guide the ASHAs working in the PHC area.

- S/he will participate in staff education and staff meeting.
- S/he will maintain good interpersonal relations with all other staff.
- S/he will give information about MLC cases to Head/Officer in charge.
- S/he will co-operate in activities related to the National Health Programmes.
- S/he will ensure safe disposal of biomedical waste.
- S/he will keep herself/himself up to date with nursing knowledge by taking part in in-service education programmes.
- S/he will perform any other duty that may be assigned to her/him from time to time including field work

Job Responsibilities of Medical Lab Technologist/Lab Technician

Sampling and Testing

- He/she will receive and process samples.
- He/she will draw blood samples for testing (by finger prick/venous punctures).
- He/she will label specimens/vials accurately and distribute them to the appropriate departments/ processing centres at the recommended transportation condition.
- He/she will prepare samples/slides for testing using various types of laboratory equipment.
- He/she will conduct all the necessary laboratory investigations including routine microscopy.

Patient-Centric Care

- He/she will give instructions to the patient regarding sample collection as applicable.
- He/she will be friendly, courteous and sympathetic while working with patients.
- He/she will write/print and issue the laboratory reports to the patients.
- He/she will ensure that patient confidentiality is maintained at all times.

Laboratory Stock Maintenance

- He/she will be responsible for the upkeep and routine maintenance of the instruments in the laboratory and update of instrument maintenance records.
- He/she will clean/sterilize and maintain work area and all lab equipment, accessories and supplies.
- He/she will make timely indents for chemical, reagents & equipment repairs.
- He/she will prepare chemical reagents, stains, solutions and biological media according to formulae, accurately label all reagents and other stock in the laboratory.

Quality of Services

- He/she will take care of all quality assurance and quality control norms in the laboratory, including EQAS, IQAS.
- He/she will follow all safety protocols and standard operating procedures to maintain hygiene and for prevention of the infection.

Data/Record Keeping

- He/she will maintain the data about all lab procedures and will maintain records of supplies, stock and investigations that are done.
- He/she will submit weekly/monthly reports of the laboratory work.

Knowledge/Skill Updation

- He/she will keep himself/herself updated about new laboratory techniques.
- He/she will participate in the development of new medical laboratory procedures and techniques.
- He/she will participate in training, workshops and continuing education programmes.
- He/she will keep himself/herself updated regarding various guidelines on hospital infection control and management of spills (e.g., Mercury, Chemicals, Body fluids).

Others

- He/she will be responsible for the implementation of biomedical waste management as per guidelines.
- He/she shall maintain the containers and specimens that are involved in court cases.
- He/she will act as auditee during an internal audit of the lab.
- He/she will inform important information/observations (found during his/her work) to senior officials.
- He/she should provide any valuable inputs for better and quality service by the health care institution.
- He/she will assist other staff members/senior officials whenever needed.
- He/she will take up other responsibilities as assigned by the competent authority.

ANNEXURE 6

List of Essential Medicines Required at Primary Health Centre

S. No.	Medicine
Anesthetics Agent	
1	Oxygen gas for inhalation
2	Lignocaine Injection 2% Lignocaine Topical form 2%
3	Lignocaine Injection 2% + Adrenaline Injection 1:200000 (5 mcg/ml)
4	Atropine Injection 0.6 mg/ml Atropine Injection 1 mg/ml
5	Midazolam Injection 1 mg/ml
6	Ketamine Injection10 mg/ml (Should be stored in lock and key) (Schedule X -prescription shall be in duplicate and one copy of which shall be retained by the licensee for a period of 2 Years)
7	Injection Thiopentone 500 mg
8	Bupivacaine Injection (Sensorcain) 0.5 mg
9	Neostigmine Injection 0.5 mg/ml
10	Vecuronium Powder for Injection 4 mg
11	Pentazocine Injection 30 mg/ml*
Analgesics, antipyretics, non-steroidal anti-inflammatory medicines, medicines used to treat gout and disease modifying agents used in rheumatoid disorders	
12	Asprin (Acetylsalicylic acid) Tablet 150 mg Asprin (Acetylsalicylic acid) Tablet 75 mg (Not to be used in suspected dengue patients and other clinical conditions without prescription)
13	Diclofenac Tablet 50 mg Diclofenac Injection 25 mg/ml
14	Ibuprofen Tablet 200 mg (Not to be used in suspected dengue patients and other clinical conditions without prescription)
15	Ibuprofen Oral Liquid 100 mg/5 ml, 50 ml bottle (Not to be used in suspected dengue patients and other clinical conditions without prescription) (Recommended by RBSK Program Division)
16	Paracetamol Tablet 500 mg, Paracetamol Tablet 100 mg Paracetamol Syrup 125 mg/5 ml Paracetamol Suppository 100 mg
Anti-allergics and medicines used in anaphylaxis	
17	Levocetirizine Tablet 5mg Levocetrizine Oral liquid 2.5 mg/5 ml (Paediatric Use)
18	Chlorpheniramine Tablet 4 mg
19	Dexamethasone Tablet 0.5 mg Dexamethasone Injection 4 mg/ml
20	Hydrocortisone Succinate Injection 100 mg
21	Pheniramine Injection 22.75 mg/ml
22	Prednisolone Tablet 5 mg Prednisolone Oral liquid 5 mg/5 ml
23	Hydroxyzine oral syrup
24	Betamethasone Injection 4 mg per 1 ml in 1 ml ampule
Anti-dotes and other substances used in poisoning	
25	Activated charcoal
26	Calcium gluconate Injection 100 mg/ml
27	Snake venom antiserum Injection

S. No.	Medicine
Anti-convulsants/Anti-epileptics	
28	Magnesium Sulfate Injection (50% solution), 2 ml ampoule
29	Diazepam Oral liquid 2 mg/5 ml Diazepam Injection 5 mg/ml Diazepam Tablet 5 mg*
30	Phenobarbitone Tablet 30 mg Phenobarbitone Oral liquid 20 mg/5 ml
31	Phenytoin Tablet 50 mg Phenytoin Tablet 300 mg Phenytoin ER Tablet 300 mg Phenytoin Injection 25 mg/ml
32	Sodium valproate Tablet 250 mg Sodium valproate Tablet 500 mg Sodium valproate Syrup each 5 ml contains 200 mg
33	Midazolam Nasal Spray* (For emergency purpose)
34	Carbamazepine Tablet 100 mg Carbamazepine Tablet 200 mg
35	Diphenylhydantoin Tablet 100 mg
Intestinal Anthelmintics	
36	Albendazole Tablet 400 mg Albendazole Oral liquid 200 mg/5 m
Anti-filarial	
37	Diethylcarbamazine Tablet 100 mg Diethylcarbama
Anti-bacterial	
38	Amoxicillin Capsule 250 mg Amoxicillin Capsule 500 mg Amoxicillin Oral liquid 250 mg/5 ml
39	Amoxicillin 500 mg + Clavulanic acid 125 mg Tablet
40	Azithromycin Tablet 250 mg Azithromycin Tablet 500 mg Azithromycin Oral liquid 200 mg/5 ml
41	Ciprofloxacin Tablet 250 mg Ciprofloxacin Tablet 500 mg Ciprofloxacin Oral liquid 250 mg/5ml
42	Cefixime Tablet 200 mg Cefixime Oral liquid 50 mg/5 ml Cefixime Oral liquid 100 mg/5 ml*
43	Tab Co-trimoxazole [Sulphamethoxazol 80 mg +Trimethoprim 400 mg] Tab. 20 mg trimethoprim + 100 mg sulphamethoxazole Co-trimoxazole Oral Liquid [Sulphamethoxazol e 200 mg + Trimethoprim 40 mg/5 ml]
44	Gentamicin Injection 10 mg/ml Gentamicin Injection 80 mg/ml
45	Doxycycline Capsule 100 mg Doxycycline Dry Syrup 50 mg/5 ml
46	Norfloxacin tab/oral liquid
47	Penicillin V Tablet 250 mg
48	Benzyl penicillin Powder for Injection 10 lac units
49	Cefazolin Injection 500 mg Cefazolin Injection 1 gm
50	Cefotaxime Injection 250 Cefotaxime Injection 500 mg Cefotaxime Injection 1 g*
51	Ceftriaxone Injection 250 Ceftriaxone Injection 500 mg Ceftriaxone Injection 1 g*
Anti-leprosy medicines	
52	As per current program guidelines (Adults and Pediatrics)
Anti-tuberculosis medicines	
53	As per current program guidelines (Adults and Pediatrics)
Anti-fungal medicines	
54	Clotrimazole Pessary 100 mg Clotrimazole Vaginal Tablet Clotrimazole Drops 1% Clotrimazole Cream 1%
55	Fluconazole Tablet 150 mg
56	Miconazole ointment Miconazole Tablet
Anti-protozoal medicines	
57	Metronidazole Tablet 200 mg Metronidazole Tablet 400 mg Metronidazole Oral liquid 200 mg/5 ml
Anti-malarial medicines	
58	As per program guidelines (Adults and Pediatrics)

S. No.	Medicine
Medicines used in Palliative care	
59	Amitriptyline Tablet 10 mg Amitriptyline Tablet 25 mg
60	Lactulose Oral liquid 10 g/15 ml
61	Tramadol capsule 50 mg* (Should be stored in double lock and key)
62	Povidone Iodine Lotion and Ointment
63	Ethamsylate Tablet
64	Deriphylline Tablet sustained release
Anti-parkinsonism medicines	
65	Levodopa (A) + Carbidopa (B) 100 mg (A) + 10 mg (B)
Anti-anemia medicines	
66	Ferrous salt 100 mg + Folic acid 500 mcg Tablet Ferrous salt 60mg + Folic acid 500mcg Tablet Ferrous salt 45 mg + Folic acid 100 mcg Tablet Ferrous salt 20 mg + Folic acid 100 mcg Tablet
67	Folic acid Tablet 5 mg Folic acid Tablet 400 mcg
68	IFA Syrup
69	Phytomenadione Injection 10 mg/ml
70	Clopidogrel Tablet 75 mg
71	Diltiazem Tablet 60 mg Diltiazem Tablet 90 mg SR
72	Isosorbide-5- mononitrate Tablet 5 mg
73	Metoprolol Tablet 25 mg Metoprolol SR Tablet 25 mg Metoprolol SR Tablet 50 mg
74	Isosorbide dinitrate Tablet 5 mg (sublingual)
75	Dopamine Injection 40 mg/ml
Anti-hypertensive medicine	
76	Amlodipine Tablet 2.5 mg Amlodipine Tablet 5 mg
77	Enalapril Tablet 5 mg
78	Hydrochlorothiazide Tablet 12.5 mg Hydrochlorothiazide Tablet 25 mg
79	Labetalol Tablet 100 mg Labetalol Injection 5 mg/ml
80	Methyldopa Tablet 250 mg
81	Telmisartan Tablet 40 mg
Medicines used in shock and heart failure	
82	Adrenaline Injection 1 mg/ml
Hypolipidemic medicines	
83	Atorvastatin Tablet 10 mg
Dermatological medicines (Topical)	
84	Framycetin Cream 0.5%
85	Silver sulphadiazine Cream 1%
86	Calamine Lotion
87	Betamethasone Cream 0.1%
88	Benzoyl peroxide Gel 2.5%
89	Benzyl Benzoate ointment/lotion
90	Mupirocin Ointment
91	Potassium Permanganate 0.1%
92	Zinc Oxide cream 10%

S. No.	Medicine
93	Fusidic Acid Cream 5mg/10gm preparation 2% or 20mg per gram Fusidic Acid Cream 2%: 5 mg/10 mg Preparation
94	Pemethrin Cream 5%
Disinfectants and antiseptics	
95	Cetrimide Solution 20% (concentrate for dilution)
96	Chlorhexidine Solution 5 (Concentrate for dilution)
97	Ethyl alcohol (Denatured) Solution 70%
98	Hydrogen peroxide Solution 6%
99	Methylrosanilinium chloride (Gentian Violet)
100	Bleaching powder Containing not less than 30% w/w of available chlorine (as per I.P)
101	Gama Benzene Hexachloride
Diuretics	
102	Furosemide Tablet 40 mg Furosemide Injection 10 mg/ml
103	Mannitol Injection 10% Mannitol Injection 20%
Ear, nose and throat medicines	
104	Xylometazoline Nasal drops 0.05 % Xylometazoline Nasal drops 0.1 %
105	Wax solvant ear drops: benzocaine, chlorbutol, paradicholorobenzene, turpentaine oil
106	Combo ear drop-Chloramphenicol 5% w/v +clotrimazole 1% +Lignocaine hydrochloride 2%
107	Normal saline nasal drops (.05%w/v)
108	Boro-Spirit ear drop
109	Ofloxacin Tablet 200 mg Ofloxacin Tablet 400 mg
Gastrointestinal medicines	
110	Omeprazole Capsule 20 mg
111	Ranitidine Injection
112	Metoclopramide Tablet 10 mg Metoclopramide Oral liquid 5 mg/5 ml Metoclopramide Injection 5 mg/ml
113	Ondansetron Tablet 4 mg Ondansetron Oral liquid 2 mg/5 ml Ondansetron Injection 2 mg/ml
114	Domperidone Tablet 10 mg Domperidone Syrup
115	Hyoscinebutylbromide Tablet 10 mg Hyoscinebutylbromide Injection 20 mg/ml
116	Ispaghula Granules/Husk/Powder (Herbal medicine)
117	Drotavarin Tablet 500 mg
118	Bisacodyl Tablet 5 mg Bisacodyl Suppository 5 mg
119	Oral rehydration salts (ORS)
120	Zinc sulphate Dispersible Tablet 20 mg Zinc sulphate syrup
121	Dicyclomine Tablet 10 mg
122	Senna Powder (Herbal medicine)
123	Dioctyl sulfosuccinate sodium
124	Magnesium Hydroxide liquid
125	Sucralfate Tablet 10 mg, Sucralfate Oral Liquid 1 mg/ml
126	Hyoscine butylbromide Tablet 500 mg
Medicines used in diabetes mellitus	
127	Glimepiride Tablet 2 mg
128	Metformin Tablet 500 mg Metformin SR Tablet 500 mg

S. No.	Medicine
129	Insulin (Soluble) Injection 40 IU/ml
130	Premix Insulin 30:70 Injection (Regular:NPH) Injection 40 IU/ml
131	Glibenclamide Tablet 2.5 mg Glibenclamide Tablet 5 mg
132	Glucose Packet 75 mg for OGTT Test
Thyroid and Anti-thyroid medicines	
133	Levothyroxine Tablet 25 mcg Levothyroxine Tablet 50 mcg Levothyroxine Tablet 100 mcg
Vaccines	
134	As per current National programme guidelines
135	Rabies vaccine
Oxytocic & Abortificents Medicines	
136	Misoprostol Tablet 200 mcg
137	Oxytocin Injection 5 IU/ml (Only where deliveries are conducted)
138	Nifedipine Tablet 10 mg
139	Methylergometrine Injection 0.2 mg/ml
Psychotherapeutic Drugs	
140	Alprazolam Tablet 0.25 mg*
141	Clonazepam Tablet 0.5 mg
142	Olanzapine Tablet 5 mg
Medicines acting on the Respiratory tract	
143	Budesonide Inhalation (MDI/DPI) 100 mcg/dose Budesonide Respirator solution for use in nebulizer 0.5 mg/ml
144	Salbutamol Tablet 2 mg Salbutamol Oral liquid 2 mg/5 ml Salbutamol Respirator solution for use in nebulizer 5 mg/ml
145	Montelukast Syrup Montelukast Tablet
146	Syrup Dextromethorphan
147	Syrup Bromhexine Hydrochloride
148	Syrup Pheniramine Maleate
149	Ipratropium Inhalation (MDI/DPI) 20 mcg/dose Ipratropium Respirator solution for use in nebulizer 250 mcg/ml.
Solutions correcting water, electrolyte disturbances and acid-base disturbances	
150	Ringer lactate Injection
151	Sodium chloride injection 0.9%
152	Pediatric solution like Isolyte P, N/2 & N/5
153	Potassium chloride Oral liquid 500 mg/5 ml
154	Dextrose 5% Dextrose 25%
Vitamins and minerals	
155	Ascorbic acid (Vitamin C) Tablet 100 mg
156	Calcium carbonate Tablet 500 mg
157	Cholecalciferol Tablet 60000 IU
158	Pyridoxine Tablet 25 mg Pyridoxine Tablet 50 mg Pyridoxine tablet 100 mg
159	Vitamin A Oral liquid 100000 IU/ml
160	B Complex Tablet B Complex Injection

S. No.	Medicine
Ophthalmological Medicines	
161	Lignocaine Eye drop 4%
162	Tropicamide Drops 1%
163	Ciprofloxacin Drops 0.3 %
164	Sodium cromoglycate 2% eye drop
165	Methylcellulose Eye drops
Contraceptives	
166	Ethinylestradiol (A) + Levonorgestrel Tablet 0.03 mg (A) + 0.15 mg (B)
167	Copper bearing intra-uterine device IUCD 380A & 375
168	Male Condom
169	Non- hormonal Ormeloxifene (30 mg Tablet)
170	Emergency Contraceptive Pill Levonorgestrel 1.5 mg
171	Medroxprogesterone Acetate Injection 150 mg

**Schedule H1 (Separate H1 Register shall be maintained- Name of drug, patient, prescriber and dispensed quantity shall be recorded).*

ANNEXURE 7

List of Diagnostic tests & Equipment at Primary Health Centre

S. No.	List of diagnostics for PHC/UPHC	List of equipment for PHC/UPHC
1.	**Essential** Haemoglobin, Total Leucocyte Count, Differential Leucocyte Count, Platelet count, Complete Blood Count, Erythrocyte Sedimentation Rate, Blood Group And Rh Typing, Blood Cross Matching, Peripheral Blood Film, Reticulocyte Count, Absolute Eosinophil Count, Bleeding Time And Clotting Time, Sickling Test For Screening Of Sickle Cell Anemia*, Sickle Cell Test Rapid For Screening Of Sickle Cell Anemia (Strip Test) *, NESTROFT Test for screening of Thalassemia*, DCIP test for screening HbE hemoglobinopathy*, Screening test for G6PD enzyme deficiency, MP slide method, Malaria rapid test, Human chorionic gonadotropin (HCG) (Urine test for pregnancy), Urine test for ph, specific gravity, leucocyte esterase, glucose, bilirubin, urobilinogen, ketone, protein, nitrite, Urine Microscopy, Urine for microalbumin, Stool for ova and cyst, Stool for Occult Blood, RPR/VDRL test for syphilis, HIV test (Antibodies 1/2 and HIV 1/2), Hepatitis B surface antigen test, HCV Antibody Test (Anti HCV), Sputum, pus etc. for AFB, Typhoid test (IgM), Blood sugar, Glucose Tolerance test (GTT), S. Bilirubin (T), S. Bilirubin direct and indirect, Serum creatinine, Blood Urea, SGPT, SGOT, S. Alkaline Phosphatase, S. Total Protein, S. Albumin & AG ratio, S. Globulin, S. Total Cholesterol, S. Triglycerides, S.VLDL, S.HDL, S. LDL, S. Uric acid, Glycosylated haemoglobin (HbA1C), Serum Calcium, Wet mount and Gram stain for RTI/STD, Gram staining for clinical specimen, Throat swab (Albert stain) for Diphtheria, Stool for hanging drop for Vibrio Cholera, Visual Inspection Acetic Acid (VIA), rK39 for Kala Azar, TB – Mantoux, Troponin – I, Pap smear	**Essential** Hemoglobinometer, 3 Part Hematology analyzer*, Manual with reading using, Blood group kit (manual), Microscopy, Manual, Rapid Card test, Manual with microscopy/Solubility test/Cover slip test, Rapid card tests for combined P. Falciparum and P. vivax, Multiparameter urine strip (dipstick), Turbidometer/Nephelometer, Manual Kit, Glucometer, Semi Automated Biochemistry analyzer*, Wet mounting, gram staining, Microscopy/Filaria Strip test, HemeChip Point of Care device (D)
2.	**Desirable** D- Dimer, S. Sodium, S. Potassium, Magnesium, Test for Filariasis, S.TSH (including for new-born screening), CRP (including newborn) (Quantitative)	**Desirable** ESR Analyzer, Turbidometer, Indirect ion selective electrode Electrolyte Analyzer*,

** For Hub Lab*

Note: The Diagnostic tests and equipment mentioned under desirable are over and above the services mentioned as essential.

S. No.	List of diagnostics for 24x7 PHC/24x7 UPHC/Polyclinic	List of equipment for 24x7 PHC/24x7 UPHC/Polyclinic
1.	**Essential** Haemoglobin, Total Leucocyte Count, Differential Leucocyte Count, Platelet Count, Complete Blood Count, Erythrocyte Sedimentation Rate, Blood Group And Rh Typing, Blood Cross Matching, Peripheral Blood Film, Reticulocyte Count, Absolute Eosinophil Count, Bleeding Time and clotting time, Sickling Test for Screening Of Sickle Cell Anemia*, Sickle Cell Test Rapid For Screening Of Sickle Cell Anemia (Strip Test) *, NESTROFT Test for screening of Thalassemia*, DCIP test for screening HbE hemoglobinopathy*, Screening test for G6PD enzyme deficiency, MP slide method, Malaria rapid test, Human chorionic gonadotropin (HCG) (Urine test for pregnancy), Urine test for ph, Specific Gravity, Leucocyte Esterase, Glucose, Bilirubin, Urobilinogen, Ketone, Protein, Nitrite, Urine Microscopy, Urine for microalbumin, Stool for ova and cyst, Stool for Occult Blood, RPR/VDRL test for syphilis, HIV test (Antibodies 1/2 and HIV 1/2), Hepatitis B surface antigen test, HCV Antibody Test (Anti HCV), Sputum, pus etc. for AFB, Typhoid test (IgM), Blood sugar, Glucose Tolerance test (GTT), S. Bilirubin (T), S. Bilirubin direct and indirect, Serum creatinine, Blood Urea, SGPT, SGOT, S. Alkaline Phosphatase, S.Total Protein, S. Albumin & AG ratio, S. Globulin, S. Total Cholesterol, S. Triglycerides, S.VLDL, S.HDL, S. LDL, S. Uric acid, Glycosylated hemoglobin (HbA1C), Serum Calcium, Wet mount and Gram stain for RTI/STD, Gram staining for clinical specimen, Throat swab (Albert stain) for Diphtheria, Stool for hanging drop for Vibrio Cholera, Visual Inspection Acetic Acid (VIA), rK39 for Kala Azar, TB – Mantoux, Troponin – I, Pap smear, S. Sodium, S. Potassium, S. Magnesium	**Essential** Hemoglobinometer, 3 Part Hematology analyzer, Manual with reading using ESR analyzer, Blood group kit (manual), Microscopy, Manual, Rapid Card test, Manual with microscopy/Solubility test/Cover slip test, Rapid card tests for combined P. Falciparum and P. Vivax, Multiparameter urine strip (dipstick), Turbidometer/Nephelometer, Manual Kit, Glucometer, Semi Automated Biochemistry analyzer, HbA1C, Analyzer, Wet mounting, gram staining, Microscopy/Filaria Strip test
2.	**Desirable** D- Dimer, Test for Filariasis, S.TSH (including for new-born screening), CRP (including newborn) (Quantitative)	**Desirable** Filaria Strip test, Turbidometer, Indirect ion selective electrode Electrolyte Analyzer#

** For Hub Lab*

Note: - The Diagnostic tests and equipment mentioned under desirable are over and above the services mentioned as essential.

ANNEXURE 8

List of Equipment & Consumables for Primary Health Centres

Essential list of equipment for PHC/UPHC/24x7 PHC/24x7 UPHC/Polyclinic

S. No.	Equipment	PHC		UPHC		24x7 PHC		24x7 UPHC		Polyclinic	
		E	D	E	D	E	D	E	D	E	D
24x7 Emergency Services with Triage, Resuscitation & Stabilization											
1	Emergency Drug Tray, Oxygen Cylinder, Suction Machine, Ambu Bags (for adult & neonatal), Laryngoscope curved & straight (one set)	E	-	E	-	E	-	E	-	E	-
2	Surgical Blade, Radiant Warmer, Pulse oximeter	-	D	-	D	E	-	E	-	E	-
LDR											
3	Labour Bed, Fetal Dopler, Kelly pads & Blankets, Phototherapy Unit, Pulse Oximeter, Delivery Trolley, Lights for conducting deliveries, 7 Trays (Delivery tray, Episiotomy tray, Medicine tray, Emergency drug tray, Baby tray, MVA tray, PPIUCD tray), Sponge holding forceps, Vulsellum uterine forceps, Normal Delivery Kit, Equipment for assisted forceps delivery, Standard Surgical Set (for minor procedures like episiotomies stitching), Equipment for Manual Vacuum Aspiration, IUCD insertion kit,	-	-	-	-	E	-	E	-	-	-
OPD Services (ANC, NCD screening, Diagnosis, follow-up & referral)											
4	Examination Table with footstep, BP apparatus, Weighing Scale – Adult, Infantometer, Baby Weighing Scale, Stethoscope, Thermometer, Examination lamp with white light, Cusco's speculum, Dental Mouth Mirrors.	E	-	E	-	E	-	E	-	E	-
5	Dental Chair, Ophthalmoscope and other accessories* (only at Polyclinic),	-	D	-	D	-	D	-	D	E	-
Indoor Patient Services											
6	Beds, Thermometer, Weighing Scale, Puncture proof box, Pulse oximeter	E	-	E	-	E	-	E	-	E	-

S. No.	Equipment	PHC		UPHC		24x7 PHC		24x7 UPHC		Polyclinic	
		E	D	E	D	E	D	E	D	E	D
Minor Surgical Procedures											
7	Self-inflating bag and Mask Neonatal Size (0 & 1), Oxygen Hood Neonatal, Laryngoscope and ET Intubation Tubes, Mucus Extractor with Suction Tube, Foot Operated Suction Machine,	-	-	-	-	E	-	E	-	E	-
Immunization Services											
8	ILR with Voltage Stabilizer, DF Small with Voltage Stabilizer, Freeze Tag - 2 no per ILR bimonthly, Thermometer.	-	D	-	D	E	-	E	-	E	-
9	Vaccine Carries with Ice packs, Cold box, Waste Disposable twin buckets	E	-	E	-	E	-	E	-	E	-
Note- If the PHC/UPHC is a cold chain point, the Equipment ticked under desirable should also be available.											
Rehabilitation Services											
10	Shoulder Wheel, Wall ladder finger Exerciser, Finger Exerciser web, Shoulder Pulley, Walking aid for training – Adjustable Walker, Reciprocal walker, Exercise Couch, One wheelchair, Spiro meter, Lower & upper extremity cycle/basic ergo meter.	-	-	-	-	-	D	-	D	-	D
Furniture/Non-Consumables											
12	Chairs for patient waiting area, Footstep, Office Chair, Office Table, Screen Separators with stand, Steel Almirah/Cupboard/storage chests, Stool for attendants.	E	-	E	-	E	-	E	-	E	-

Note: The above is the essential & basic list of equipment, instruments and accessories etc. depending upon the type and case load the state can add on. The equipment, consumables and furniture mentioned under desirable are over and above the services mentioned as essential.

ANNEXURE 9

Cleaning Protocols at HWC-PHC/UPHC/24x7 UPHC/24x7 UPHC

Routine cleaning is of utmost importance in every area of a health care facility. Certain chemicals are recommended for cleaning, particularly in moderate and high-risk areas, but such chemicals keep on changing based on scientific updates. It needs to be understood that since none of the chemicals used on walls and floors provide 100% safety from various microorganisms and spores. So, behaviour of staff towards routine cleaning and adherence to infection prevention protocols is the most important action which needs to be followed by health care staff and workforce.

Cleaning frequency, level of cleaning/disinfection and evaluation/auditing frequency according to the type of functional area risk category Functional Area Risk Category	Frequency of cleaning	Level of cleaning/ disinfection (As per Spaulding's Classification)	Method of cleaning/ Disinfection	Evaluation/ auditing frequency
High risk areas • Labour Room Complex (24*7 PHC) • Dressing room/Injection Room/Emergency • Minor OT • Laboratory	Floors, walls and Surfaces: Routine cleaning once in two hours with aldehyde free high-level disinfectant (HLD) like 70% isopropyl alcohol Spot Cleaning: As required OT table, Labour beds and other such surfaces to be cleaned and disinfected after every use. Intensive deep cleaning: Weekly/ Holidays	Cleaning and Intermediate level disinfection	Routine Cleaning with soap detergent plus disinfection with aldehyde free high-level disinfectant (HLD) like 70% isopropyl alcohol Spot Cleaning: As required after disinfection with 0.5% chlorine solution. All equipment and instruments to be disinfected and cleaned with aldehyde free high-level disinfectant like peracetic acid and autoclaving accept heat sensitive equipment & instruments.	Weekly or monthly if cleanliness of high standards is maintained as certified by Officer I/C Sanitation and Infection Control Team
Moderate risk areas • Consultation Room • Health & Wellness Room • Counselling Room • Inpatient ward/Day-Care room • Toilets	Floors, walls and Surfaces: Routine cleaning once in four hours with aldehyde free high-level disinfectant (HLD) like 70% isopropyl alcohol Spot Cleaning: As required	Cleaning and low-level disinfection	Routine Cleaning with soap detergent plus disinfection with aldehyde free high-level disinfectant (HLD) like 70% isopropyl alcohol	Once in a month or once in two months if cleanliness of high standards is maintained as certified by Officer I/C Sanitation and Infection Control Team

Cleaning frequency, level of cleaning/disinfection and evaluation/auditing frequency according to the type of functional area risk category Functional Area Risk Category	Frequency of cleaning	Level of cleaning/ disinfection (As per Spaulding's Classification)	Method of cleaning/ Disinfection	Evaluation/ auditing frequency
	Intensive deep cleaning: Weekly/ Holidays		Spot Cleaning: As required after disinfection with 0.5% chlorine solution. All equipment and instruments to be disinfected and cleaned with aldehyde free high-level disinfectant like peracetic acid and autoclaving accept heat sensitive equipment & instruments.	
Low risk areas • Corridors • Waiting halls/Waiting Rooms/ Registration Area • Stores (Medicine Store, Linen Store) • Pharmacy • Cafeteria	Floors, walls and Surfaces: Routine cleaning for areas working round the clock at least once in a shift or in areas having general shift at least twice in the shift with water and Soap/Quaternary Ammonium Compound Spot Cleaning: As required Intensive deep cleaning: Weekly/ Holidays	Cleaning with water and detergent	Routine physical removal of soil, dust or foreign material followed by cleaning with water and Soap/ Quaternary Ammonium Compound. Spot Cleaning: As required after disinfection with 0.5% chlorine solution	Once in three months

Note: For infective spills like blood, it should be first treated with 0.5% hypochlorite solution.

General Cleaning Practices for All Healthcare Settings

Before Cleaning

- Check for additional (isolation) precautions signs
- Follow precautions as indicated
- Remove clutter before cleaning
- Follow the manufacturer's instructions for proper dilution and contact time for cleaning and disinfecting solutions

- Gather materials required for cleaning before entering the room
- Visibly check and ensure all cleaning equipment itself is clean
- Clean hands before entering the room
- Prepare chemical dilutions and put on gloves before beginning cleaning.

During Cleaning

- Progress from the least soiled areas to the most soiled areas and from high surfaces to low surfaces
- Remove gross soil (visible to naked eye) prior to cleaning and disinfection
- Minimise turbulence to prevent the dispersion of dust that may contain micro-organisms
- Never shake mops
- Use dust control mop prior to wet/damp mop. Do not use brooms
- Wash the mop under running water before doing wet mopping
- Do not 'double-dip' mops (dip the mop only once in the cleaning solution, as dipping it multiple times may re contaminate it)
- An area of 120 square feet to be mopped before re-dipping the mop in the solution
- Cleaning solution to be changed after cleaning an area of 240 square feet (This does not apply to critical areas like OT and ICU)
- Change more frequently in heavily contaminated areas, when visibly soiled and immediately after cleaning blood and body fluid spills
- Be alert for needles and other sharp objects. Safely handle and dispose sharps into puncture proof container. Report incident to supervisor
- Collect waste, handle plastic bags from the top (do not compress bags with hands)
- Clean hands on leaving the room.

After Cleaning

- Do not overstock rooms
- Tools used for cleaning and disinfecting should be cleaned and dried between uses
- Launder mop heads daily
- All washed mop heads should be dried thoroughly before re-use
- Clean sanitation cart and carts used to transport biomedical waste daily.

ANNEXURE 10

Service Area Wise Protocol

Service Area (Please Mark): (OPD/Clinical/Central Lab/LDR Complex/Minor OT/IPD Area/Dietary Service Area/TSSU/any other etc.)

Room No:

Timings:

Staff in the room:

Designation	Name
Specialists	
MO	
CHO	
Nurses	
Other Health Care Staff	
Sanitation staff	

Activities (Key services provided):

1.

2.

3.

List of equipment and its maintenance:

S. No.	Equipment/ material	Quantity	Frequency of utilization	Cleaning material & frequency	Responsible person

Toll Free number of BMMP:

Nodal person at the facility with contact details:

Records and Registers:

S. No.	Name of the register	Key information recorded in the register	Frequency of updating	Person responsible	Designation of authority responsible for verification of register

Performance Indicators (Number/type of services/number of patients served/numbers of procedures undertaken/number of data recorded/medicines dispensed/diagnostics conducted etc or any key services being provided in the service area to be indicated below and their performance chart comparing current and previous month/year may also be displayed):

1.

2.

Performance

Periodicity: → / Indicators ↓	Cumulative from April to March		1st quarter (April to June)		2nd quarter (July to September)		3rd quarter (October to December		4th quarter (January to March)	
	Previous Year	Current Year	Previous Year	Current Year	Previous Year	Current Year	Previous Year	Current Year	Previous Year	Current Year

Performance Bar Graph:

Cleaning Protocols:

Category of Service Area (Please tick)	High Risk	Moderate Risk	Low Risk	Remarks
Availability of colour coded Bins	Not Available	Partially Available	Available	
Adherence to IPC protocols	Poor	Needs Improvement	Good/Satisfactory	
Segregation of BMW	Not Practiced	Partially Practiced	Fully adhered	
Frequency of BMW disposal (please indicate in hours)				
Frequency of cleaning (please indicate in hours)				
Date and time of last cleaning				
Date & time of supervision				
Name & Signature of Supervisor				

ANNEXURE 11

Checklist for Daily Rounds

S. No.	Observe/Monitor and guide Date:	1	2	3	4	5	6	7	8	9	10
1.	Display of duty roster and presence of staff accordingly in their respective duty station										
2.	Staff is in proper uniform & maintains decorum										
3.	Department/Service Area wise protocols and performance displayed in respective service areas.										
4.	Clinical practices as per the SoPs in each service area										
5.	Privacy during patients' examination is maintained in all service areas										
6.	Quality of services maintained by nursing and other junior staff										
7.	Wards' readiness for doctors' round										
8.	Infection control protocols are adhered										
9.	BMW is segregated properly										
10.	Adherence to handing over-taking over protocols in all critical areas										
11.	Records of IPD are maintained and complete in each service area										
12.	Availability of stock required in every service area (drugs, gloves, mask, inj. etc.)										
13.	Necessary equipment are available and functional in every service area										
14.	Sterilization of the instruments is as per protocols in										
	14.1 Operation theatre										
	14.2 Labour Room										
	14.3 Casualty										
	14.4 Any other department										
15.	Only sterilized/autoclaved instruments are used in service areas										
16.	Records of sterilization are maintained										
17.	Cleanliness and check the cleaning checklist for completion in the below mentioned areas (OPD, Wards, Labor room, OT, Lab. & diagnostic rooms, Injection & dressing room, Toilets etc.) as per cleaning protocols										
18.	Presence of junk or unnecessary item in service areas										

S. No.	Observe/Monitor and guide Date:	1	2	3	4	5	6	7	8	9	10
19.	Availability of linens and quality of laundry services										
20.	Availability of food to patients is on time, hot and fresh and quality of food is good										
21.	Requisitions for special diet are sent to dietician/kitchen and is served accordingly										
22.	Visiting times are maintained										

Round taken by (Please tick and sign):

1. MO/Health Facility In charge:

2. Staff Nurse:

3. Any Other:

ANNEXURE 12: LIST OF CONTRIBUTORS
(Indian Public Health Standards)

A. COMMITTEE MEMBERS

1. Main Committee (As per order No. F.NO. P/17029/02/2-17-NHM-IV, Dated 21st May 2018)

1. Dr. Manohar Agnani, Joint Secretary- Policy- Chairman
2. Dr. Anil Kumar, Addl. DDG, DGHS-Co- Co-chair
3. Prof. Jayanta K. Das, Director, NIHFW
4. Dr. Rajani Ved, ED, NHSRC
5. Dr. Rajesh Kumar, Prof & Head of Public Health, PGIMER, Chandigarh
6. Dr. Pankaj Arora, Asst. Prof Dept. of Hospital Administration, PGIMER, Chandigarh
7. Dr. Yogesh Jain, JSS
8. Dr. Suresh Mohammad, World Bank
9. Dr. B. S Arora, Ex DGFW, Advisor NHM, UP
10. Special Secretary, DHS, Orissa
11. Director Public Health- Tamil Nadu
12. Dr. Satish Pawar (Additional Mission Director)- Maharashtra
13. CMO- Rajasthan (State to nominate)
14. CMO- Uttar Pradesh (State to nominate)
15. Dr. J. N. Srivastava, Advisor, Quality Division NHSRC
16. Dr. S. B Sinha Advisor NHSRC
17. Ms. Mona Gupta- Advisor NHSRC
18. Dr. Mayank Sharma, Consultant NHM
19. Dr. Himanshu Bhushan, Advisor, PHA division, NHSRC- Member Secretary

2. Sub-Committee - Physical Infrastructure (As per order No. F.NO. P/17029/02/2-17-NHM-IV, Dated 21st May 2018)

1. Dr. Anil Kumar, Addl. DDG, DGHS, MoHFW
2. Dr. Rajesh Kumar, Prof & Head of Public Health PGIMER, Chandigarh
3. Dr. Srikumar Venkataraman- Assistant Professor of Physical Medicine & Rehabilitation, AIIMS Delhi
4. Dr. J. N. Srivastava, Advisor, Quality Division NHSRC
5. Mr. Anurag Salwan, Head (ID) & VP (O), HITES
6. Mr. Rajiv Kanaujia, Sr. Architect Head of CDN, MoHFW
7. Mr. Mukesh Bajpai, Sr. Architect, CDB, MoHFW
8. Dr. Himanshu Bhushan, Advisor, PHA division, NHSRC- Member Secretary
9. Mr. Rajneesh Upmanyu Sr. Consultant Infrastructure MoHFW
10. Dr. Krushna Sirmanwar, Consultant NHM, MoHFW

3. Sub- Committee – Human Resource for Health (As per order No. F.NO. P/17029/02/2-17-NHM-IV, Dated 21st May 2018)

1. Dr. Mohd. Shaukat, Advisor NCD

2. Dr. Nobhojit Roy, Advisor PHP, NHSRC
3. WHO representative
4. Nodal person HRM- MP
5. Ms. Sumitha Chalil, Sr. Consultant NHM
6. Dr. Rakshita Khanijou, Consultant NHM
7. Ms. Mona Gupta, Advisor policy and planning- NHSRC-Member Secretary

4. Sub Committee - Urban Health facilities (As per order No. F.NO. P/17029/02/2-17-NHM-IV, Dated 21st May 2018)

1. Dr. Basab Gupta, DC NUHM- Chair
2. Dr. Ranjana Garg, AC NUHM
3. Dr. Chandrakant Lahariya, WHO representative
4. MD-NHM West Bengal or representative
5. Municipal Corporations Mumbai- representative
6. Municipal Corporations Chennai- representative
7. Dr. Adil Shafie, Sr. Consultant NUHM
8. Dr. Himanshu Bhushan, Advisor PHA- Member Secretary.

5. Sub Committee - Equipment list (As per order No. F.NO. P/17029/02/2-17-NHM-IV, Dated 21st May 2018)

1. Dr. Sandhya Kabra- Additional Director NCDC- Chair
2. HLL- representative
3. Kerala Medical Service Corporation-rep
4. Odisha Medical Service Corporation-rep
5. Mr. Mandar Randive, Consultant, NHM
6. Dr. S.B. Sinha, Advisor NHSRC-Member Secretary

6. Sub Committee - Essential drug List (As per order No. F.NO. P/17029/02/2-17-NHM-IV, Dated 21st May 2018)

1. Dr. V.S. Salhotra, Add. DDG (RNTCP)- Chair
2. DCGI- Representative
3. Dr. C. D Tripathi, Director Professor, Department of Pharmacology, Vardhman Mahavir Medical College, New Delhi
4. Dr. Anil Gurtoo, Director Professor, Department of Medicine, Lady Hardinge Medical College, New Delhi
5. Nodal Person- Rajasthan Medical service Corporation
6. Nodal Person- Madhya Pradesh Medical service Corporation
7. Nodal Person- Tamil Nadu Medical Service Corporation
8. Nominee Kerala Medical Service Corporation
9. Dr. Rakshita Khanijou, NHM Consultant
10. Dr. J.N Srivastava- Advisor NHSRC- Member Secretary

B. MINISTRY OF HEALTH AND FAMILY WELFARE

S No	Name	Designation
1.	Mr. Rajesh Bhushan	Secretary
2.	Prof. (Dr.) Sunil Kumar	Director General of Health Services
3.	Ms. Preeti Sudan	Former Secretary
4.	Mr. Vikas Sheel	Additional Secretary & Mission Director, NHM
5.	Mr. Manoj Jhalani	Former Additional Secretary & Mission Director, NHM
6.	Ms. Vandana Gurnani	Former Additional Secretary & Mission Director, NHM
7.	Mr. Vishal Chauhan	Joint Secretary, Policy
8.	Dr. Harmeet Singh	Joint Secretary, Urban Health
9.	Ms. Preeti Pant	Former Joint Secretary, Urban Health
10.	Dr. Sachin Mittal	Director – NHM
11.	Dr. Neha Garg	Director – NHM
12.	Dr. Harsh Mangla	Director – NHM
13.	Dr. N. Yuvaraj	Former Director – NHM

C. NITI Ayog

S No	Name	Designation
1.	Dr. K Madan Gopal	Senior Consultant (Health)

D. OTHER INVITED MEMBERS

1. MOHFW Representatives

S No	Name	Designation
1.	Dr. C. Das	DADG (NCD), DGHS
2.	Dr. Manas P. Roy	DADG, DGHS
3.	Dr. Rathi Balachandran	ADG
4.	Dr. Gowri N Sengupta	ADG, DGHS
5.	Dr. L. Swasticharan	Addl. DDG
6.	Dr. Raghuram Rao	DD (TB)
7.	Dr. Neeraj Dhingra	Add. Dir, NVBDCP
8.	Dr. Arun K Bansal	Add. Dir, NVBDCP
9.	Dr. Sandhya Kabra	Add. Dir, NVHCP, NCDC
10.	Dr. Indu Grewal	CMO (NFSG), DGHS
11.	Dr. Sushil Vimal	DC (NUHM)
12.	Dr. Sumita Ghosh	AC In Charge(Child Health, RBSK, AH,CAC & AD)
13.	Dr. Sila Deb	AC (CH & I/C - Nutrition)
14.	Dr. Jyoti Rawat	AC (NUHM)
15.	Dr. Dinesh Baswal	Former DC (MH) IC
16.	Dr. Sandhya Bhullar	Former Dir, NHM-2
17.	Mr. S. Nayak	Dy. Secretary
18.	Mr. VK Bhalla	US (NHM)
19.	Ms. Chandni Chandran	Asstt Sec
20.	Mr. Sanjeev Gupta	FC, NHM

S No	Name	Designation
21.	Dr. Renu Srivastava	Advisor, MNCH
22.	Dr. Bhumika Talwar	Lead Consultant
23.	Dr. Vinita Srivastava	National senior consultant, Blood cell, NHM
24.	Dr. Kumkum Marwah	Sr. Consultant (Nutrition), DGHS
25.	Dr Pranav Bhushan	Senior Technical Officer, ADU
26.	Mr. Vikas Sheemar	Sr. Consultant
27.	Mr. Mohd. Kamil	Sr. Consultant
28.	Dr. Shikha Bansal	Sr. Consultant
29.	Dr. Nisha Kadyan	Sr. Consultant, NUHM
30.	Er. Dinesh Kumar	Sr. Consultant
31.	Dr. Richa Saxena	Sr. Consultant
32.	Dr. Narendra Goswami	Sr. Consultant
33.	Dr. Sarita Sinha	Sr. Consultant, HMIS
34.	Dr. Shraddha Masih	Sr. Consultant, NHM
35.	Dr. Abhiskek Gupta	Sr. Consultant, NUHM
36.	Dr. Vishal Kataria	National Technical Consultant, CH
37.	Dr. Kapil Joshi	Sr Consultant CH
38.	Dr. Disha Agarwal	Senior Consultant, Immunization
39.	Dr. Sudipta Basa	Sr. Consultant
40.	Dr. Pankaj Agarwal	Consultant, Immunization
41.	Dr. Akriti Mehta	Consultant NOHP
42.	Dr. Gaurav Chauhan	Consultant, PHPP
43.	Dr. Ashish Bhat	Consultant, NHM
44.	Dr. Sneha Mutreja	Consultant, NHM
45.	Dr. Deepak Kumar	Consultant Adolescent Health
46.	Dr. Pooja Gupta	Consultant
47.	Dr. Prayas Joshi	Consultant, NUHM
48.	Ms. Seema Pati	Consultant, NUHM
49.	Dr. Apurva Kohli	Jr. Consultant
50.	Mr. Maisnam Niresh	Tech- Consultant
51.	Dr. Asif Shafie	Tech- Consultant
52.	Dr. Nadeem Shaikh	Intern
53.	Dr. Prashant	Intern
54.	Mr. Shahid Ali Warsi	Intern, NHM
55.	Mr. Suresh Kumar Singh	SSO

2. State Representatives

S No	Name	Designation	State
1.	Dr. Bishnu Prasad Mahapatra	Add. Dir (HRH)	Odisha
2.	Dr. PK Srinivas	Advisor, NUHM, NHM	Karnataka
3.	Dr. Archana Mishra	DD, MH, NHM	Madhya Pradesh
4.	Dr. Mangala Gomare	Dy EHO-FWMCH/ NUHM	Mumbai, Maharashtra
5.	Dr. Sanjeev Tak	CMHO, Medical & Health Dept	Udaipur, Rajasthan
6.	Dr. V.B. Singh	CMO, Medical & Health Dept	Varanasi, UP

S No	Name	Designation	State
7.	Mr. Mrunal Das	HMD, NHM	Odisha
8.	Dr. KL Sahu	Retd. DHS	Bhopal, MP
9.	Dr. Bhavana Sharma	Prof, Head, Ophthalmology, AIIMS	Bhopal
10.	Dr. RK Singh	Specialist, Cardiologist	Bhopal
11.	Dr. Kamlesh Deopujari	Specialist MS (Ortho)	Bhopal
12.	Dr. Mrs. Priti Chaturvedi	Anaesthetist	Bhopal
13.	Dr. Mrs. Nirmala Dubey	Sr. dental Surgeon	Bhopal
14.	Dr. B.D Pawar	Sr. IPHS Consultant, NHM	PHD, Maharashtra
15.	Dr. K. Kolanda Swamy	DPH & PM	Chennai
16.	Dr. V. Prakash	Health Officer, Dir of PH	Chennai
17.	Dr. B. Viduthalai Virumbi	Medical Officer, DPH&PM,	SPMU Chennai
18.	Dr. Rakesh Shrivastava	Medical Specialist	Bhopal
19.	Mr. Sanjay Nema	Consultant civil, NHM	MP
20.	Dr. John	Add. Prof Surgery	Bhopal
21.	Dr. Sharma	Asso. prof.	Bhopal
22.	Dr. Mahesh Maheshwaran	Asso. Prof. Paediatrics	Bhopal
23.	Dr. Surendra K. Shrivastava	Associate Prof. Surgery	GMC, Bhopal
24.	Dr. Kamlesh Jain	Associate Professor cum SNO, DHS	Chhattisgarh
25.	Dr. Gauvav Khandelwal	Asst. Prof. Cardiology	Bhopal
26.	Dr. Nitin Pandya	Asst. prof. Derma	Bhopal
27.	Dr. Rajesh	Asst. Prof. Medicine	Bhopal
28.	Dr. Mahendra Attani	Asst. Prof. Nephrology	Bhopal
29.	Dr. Saurabh Jain	Asst. Prof. Urology	Bhopal
30.	Mr. Urya Nag	SPM	Chhattisgarh
31.	Dr. Sonia	SPM, NHM	Punjab
32.	Mr. Adait kumar Pradhan	SPM, NHM	Odisha
33.	Dr. Sudha Gupta	SPM, NHM	UP
34.	Mr. Sukanta Kumar Mishra	Program Manager, NHM	Odisha
35.	Ms. K. Priya	SUHM, NHM	Tamilnadu
36.	Mr. Navdeep Gautam	SNO- NUHM, NHM	Punjab
37.	Mr. V Ramaswamy	Executive engineer	Tamil Nadu service corporation
38.	Mr. K Anandan	Senior manager	Tamil Nadu service corporation
39.	Dr. M Sharmila	General manager	Tamil Nadu service corporation
40.	Dr. D S Nagesh	Scientist G	SCTIMST Trivandrum
41.	Mr. A L Biran Chandra	SM HITES	HITES, Noida
42.	Dr. Dileep Kumar	General Manager	Kerela Medical Service Corporation
43.	Mr. Prakash Mallick	Biomedical Enginner	NHM Odisha
44.	Dr. Ritesh Tanwar	DD, Ayushman Bharat	DGHS, MP
45.	Dr. Himani Yadav	DD, Child health, RBSK, Nutrition	DGHS, MP

3. Institutional Experts

S No	Name	Designation	Organisation
1.	Mr. Bijender Singh	EA	Health
2.	Dr. Jyoti	DD	IDSP, NCDC
3.	Dr. B.S. Garg	Director & Prof. of Community Medicine	MGIMS, Sewagram
4.	Dr Aakash Srivastava	Addl. Director &HOD, NPCCHH	NCDC
5.	Dr Rameshwar Sorokhaibam	Deputy Director, NPCCHH	NCDC
6.	Dr. Anu George	APD	SHARE India
7.	Dr. Vinay Garg	DD	NCDC
8.	Mr. J Chaudhary	AMD, WB	H&FW, Govt Of WB
9.	Mr. Prem Prakash	DGM	HITES, Noida
10.	Dr. Anubhav Srivastav	Asstt. Director	NCDC
11.	Dr. Manish Chaturvedi	Professor	NIHFW
12.	Dr. Rajesh Kumar	Prof. & HOD, SPH	PGIMER, Chandigarh
13.	Dr. C M Singh	Professor	AIIMS Patna
14.	Dr. Rajesh Khadgawat	Professor, Department of Endocrinology & Metabolism	AIIMS, Delhi
15.	Dr. Ashish Pathas	Prof. Paediatric	RD Gardi Med. College, Ujjain
16.	Dr. Deepika Garg	Professor, ENT & HNS	MGIMS Sewagram, Maharashtra
17.	Dr. Rajib Das Gupta	Professor	JNU, New delhi
18.	Dr. Mayank Dwivedi	Public Health Specialist & Lab advisor	CDC
19.	Dr. Suraj Singh	Associate Prof.	AIIMS, New Delhi
20.	Dr. Bhawna Gulati	Associate Professor	ASCI, HYD
21.	Dr. Tej Prakash Singh	Associate Professor, Dept of Emergency Medicine JPNATC	AIIMS, Delhi
22.	Dr. Ravikirti	Associate Prof.	AIIMS, Patna
23.	Dr. Rekha Singh	Associate Prof	AIIMS, Bhopal
24.	Dr. Vikas Gupta	Associate Prof.	AIIMS, Bhopal
25.	Dr. Abhir singh	Associate Prof.	AIIMS, Bhopal
26.	Dr. NP Singh	Asst. Prof. Surgery	AIIMS, Bhopal
27.	Dr. R R Bonde	Associate Prof.	EpMC
28.	Dr. Dhiraj Bhandari	Associate Prof & Intensivist	MGIMS, Maharashtra
29.	Dr. Arun Singh	HOD, Dept. of Neonatology	AIIMS, Jodhpur
30.	Dr. Priyanka Bhushan	Prof & Head, Public health Dentistry	ITS Dental College
31.	Lt Col (Dr.) Kundan Kumar	Dental officer	Base Hospital, Army Dental Corps
32.	Dr. R K Singh	HOD, Emergency Medicine Department	SGPGI, Lucknow
33.	Dr. Kirti Iyengar	NPO (RH)	UNFPA
34.	Dr. Dilip Singh Mairembam	NPO	WHO India
35.	Dr. Madhur Gupta	Technical officer, Pharmaceutical	WHO , New Delhi
36.	Er. Dhirendra Chaudhary	Superintendent Engineer	CPWD, GOI
37.	Mr. Rohit	FC	NHM-Finance
38.	Dr. Vandana Kumar	Consultant	WHO India
39.	Dr. Sushant Agarwal	Consultant QI	ADB, NHSRC

4. NHSRC

S. No.	Name	Designation
1.	Maj Gen (Prof) Atul Kotwal	Executive Director
2.	Dr. M. A Balasubramanya	Advisor, CP-CPHC
3.	Dr. Ranjan K Choudhury	Advisor, HCT
4.	Ms. Sweta Roy	Lead Consultant, HRH & HPIP
5.	Dr. Neha Dumka	Lead Consultant, KMD
6.	Dr. Deepika Sharma	Lead Consultant, QPS
7.	Mr. Sandeep Sharma	Lead Consultant, HCF
8.	Mr. Prasanth KS	Senior Consultant, PHA
9.	Dr. Smita Shrivastava	Senior Consultant, PHA
10.	Dr. Aashima Bhatnagar	Senior Consultant, PHA
11.	Mr Divya Prakash	Senior Consultant, HRH
12.	Ms. Vertika Agarwal	Senior Consultant, HCT
13.	Mr. Anjaney Shahi	Senior Consultant, HCT
14.	Mr. Padam Khanna	Senior Consultant, KMD
15.	Dr. Suman	Senior Consultant, CP-CPHC
16.	Dr. Vinay Bothra	Former Sr. Consultant, PHA
17.	Mr. Ajit Kumar Singh	Former Sr. Consultant, PHA
18.	Mr. Mohd. Ameel	Former Sr. Consultant, HCT
19.	Dr. Parminder Gautam	Former Sr. Consultant, QPS
20.	Dr. Neha Jain	Former Sr. Consultant, PHA
21.	Dr. Rupendra Sahota	Former Sr. Consultant, CP-CPHC
22.	Dr. Kalpana Pawalia	Consultant, PHA
23.	Dr. Poonam	Consultant, PHA
24.	Dr. Ashutosh Kothari	Consultant, PHA
25.	Ms. Neelam Tirkey	Consultant, PHA
26.	Dr. Aditi Joshi	Consultant, PHA
27.	Dr. Nidhi Awasthi	Consultant, PHA
28.	Ms. Diksha	Consultant, PHA
29.	Ms. Isha Sharma	Consultant, HRH
30.	Ms. Charu	Consultant, HCT
31.	Ms. Manisha Sharma	Consultant, HCT
32.	Dr. Arpita Agrawal	Consultant, QPS
33.	Mr. Gulam Rafey	Consultant, QPS
34.	Dr. Anwar Mirza	Consultant, CP-CPHC
35.	Ms. Vasudha Khanna	Legal Consultant, PHA
36.	Mr. Mohd. Shoeb Alam	Architect, New Delhi
37.	Mr. Sangramsinh Gaikwad	Architect, Maharashtra
38.	Dr. Shuchi Soni	Former Consultant, PHA
39.	Ms. Shivangi Rai	Former Legal Consultant, PHA
40.	Dr. Gurinder Randhawa	Former Consultant, QPS
41.	Dr. Shifa Arora	Former Consultant, PHA
42.	Mr. PS Vigneshwaran	Former Consultant, HCT

S. No.	Name	Designation
43.	Dr. Yogita Kumar	Former Consultant, HCT
44.	Mr. Ajai Basil	Former Consultant, HCT
45.	Dr. Archana Pandey	Former Consultant, PHA
46.	Dr. Rashmi Wadhwa	Former Consultant, QPS
47.	Ms. Ritu	Junior Consultant, HCT
48.	Mr. Hariom Tiwari	Short term Consultant, QPS
49.	Ms. Vasundhra Bharti	Former External Consultant, PHA
50.	Ms. Nasrain Nikhat Khan	Former External Consultant, QPS
51.	Dr. Bhupinder Singh	Former External Consultant, PHA
52.	Ms. Akshita Singh	Former External Consultant, PHA
53.	Dr. Sujeet Sinha	Former Short-term Consultant, QPS
54.	Ms. Shilpa Pawar	Former Short-term Consultant, QPS
55.	Ms. Ashu Ranga	Fellow, PHA
56.	Dr. Musarrat Siddiqui	Fellow, PHA
57.	Dr. Syeda Tahseen Kulsum	Fellow, PHA
58.	Dr. Isha Chalotra	Former Fellow PHA
59.	Dr. Ishita	Former Fellow PHA
60.	Mr. Pawan	Former Fellow HCT
61.	Ms. Purnima	Former Fellow HCT
62.	Dr. Kushagr Duggal	Former Fellow, PHA
63.	Dr. Diksha Dhupar	Former Fellow, PHA
64.	Dr. Deepak Bhagat	Former Fellow, PHA
65.	Dr. Charu Chandrika	Fellow, PHA
66.	Dr. Priya Goel	Fellow, PHA
67.	Dr. Zeba Bano	Fellow, PHA

5. RRCNE

S. No.	Name	Designation
1.	Dr. Ashok Roy	Director, RRCNE
2.	Dr. Joydeep Das	Lead Consultant, RRCNE
3.	Dr. Pankaj Thomas	Sr. Consultant, RRCNE
4.	Dr. Surajit Choud'hury	Consultant, RRCNE
5.	Dr. Sidharth Maurya	Consultant, RRCNE
6.	Ms. Sagarika Kalita	Consultant, RRCNE

6. Administrative and Secretarial Support

S. No.	Name	Designation
1.	Brig. Sanjay Baweja	Principal Administrative Officer
2.	Ms. Garima Verma	Consultant, Publications
3.	Ms. Megha Mathur	Consultant, Publications
4.	Ms. Manju Bisht	Secretarial Assistant
5.	Mr. Ravi Kumar	Office Assistant
6.	Mr. Prakash Chemjung	Office Assistant

Ministry of Health and Family Welfare
Government of India