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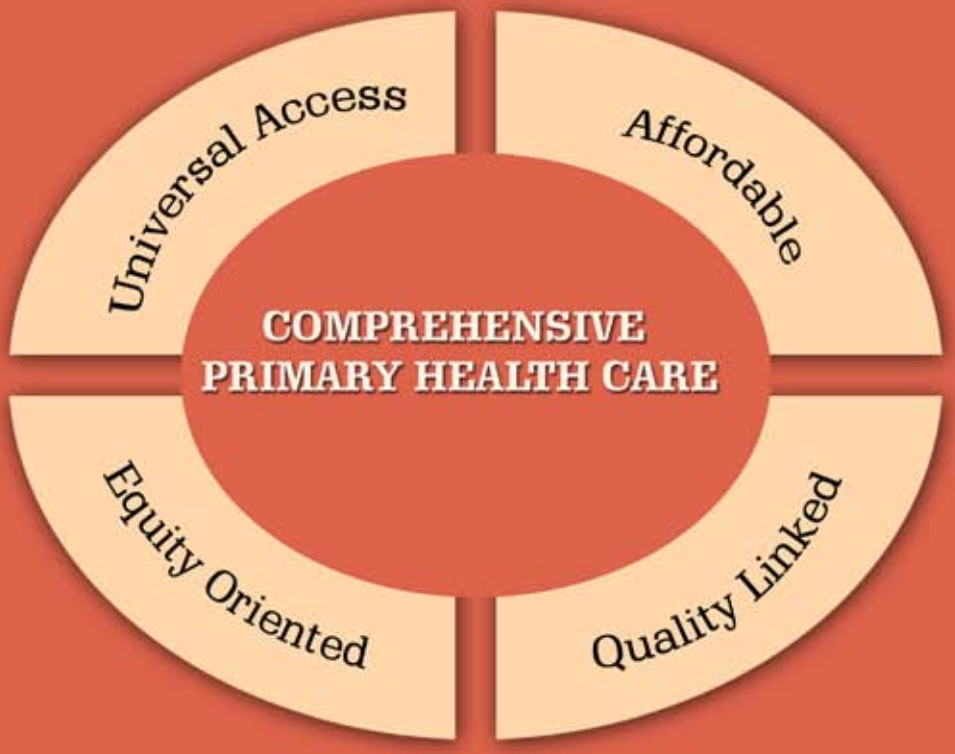
NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

AYUSHMAN BHARAT

Comprehensive Primary Health Care through Health and Wellness Centers

Operational Guidelines



NHSRC






AYUSHMAN BHARAT

Comprehensive Primary Health Care through Health and Wellness Centers

Operational Guidelines

जगत प्रकाश नड्डा
Jagat Prakash Nadda

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स्वास्थ्य एवं परिवार कल्याण मंत्री
भारत सरकार
Minister of Health & Family Welfare
Government of India

स्वच्छ भारत
एक कदम स्वच्छता की ओर

MESSAGE

Nearly 72% of Out of Pocket expenditure on health is on account of Primary Care. Comprehensive primary care reduces mortality and morbidity at much lower costs and significantly reduces the need for secondary and tertiary care.

The announcement of Ayushman Bharat with its twin pillars of Health and Wellness Centres for provision of comprehensive primary healthcare and the Pradhan Mantri Jan Arogya Yojana represents a paradigm shift in that it looks at health holistically and lays significant milestone towards India's path to Universal Health Coverage (UHC). The Health and Wellness Centres (HWCs) are envisaged to deliver an expanded range of primary healthcare services which address the basic primary healthcare needs of the entire population in their area thus expanding access, universality and equity in service delivery. An equally important mandate of the Health and Wellness Centre is to ensure an increased focus on health prevention and promotion, so that good health and wellness becomes a Jan Andolan and ushers in collective responsibility and care. These Centres should become facilitators and platform for all wellness activities including yoga in the community.

The Health and Wellness Centres are expected to harness the potential and benefits of technology for improved service delivery, capacity building and reporting in the healthcare sector. The effective delivery of universal Comprehensive Primary Health Care will directly and positively impact the other pillar of Ayushman Bharat through the decongestion of secondary care facilities and reduction of healthcare costs.

The journey to strengthen the Health and Wellness Centres is a learning process, building on a shared vision of universal coverage and access. I expect that these guidelines will evolve as we go forward, building on state and district experiences, so that the Health and Wellness Centres herald significant improvements in health outcomes.

(Jagat Prakash Nadda)

348, ए-स्कंध, निर्माण भवन, नई दिल्ली-110 011
348, A-Wing, Nirman Bhawan, New Delhi-110 011
Tele. : (O) : +91-11-23061661, 23063513, Telefax : 23062358, 23061648
E-mail : hfwminister@gov.in

अश्विनी कुमार चौबे
Ashwini Kumar Choubey

सत्यमेव जयते

सर्वेसन्तु निरामया

एक कदम स्वच्छता की ओर

स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री
भारत सरकार
MINISTER OF STATE FOR
HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

MESSAGE

The National Health Policy, 2017 set the vision and the tone for achieving universal Health coverage. One of the policy shifts is the strong advocacy for movement from selective primary care to assured comprehensive care with linkages to referral hospitals

As countries commemorate forty years of the Alma Ata declaration, 1978 that identified primary health care as the key to the attainment of the goal of Health for All, the announcement of Ayushman Bharat with Health and Wellness centres as its strategic component for provision of comprehensive primary health care represents our commitment towards Universal Health coverage.

The Health and Wellness Centres will be a game changer to increase health system responsiveness to people by bringing services closer to communities, and being able to address the needs of most marginalized, through the Primary Health Care team.

The Operational Guidelines are intended to facilitate states and districts to convert this policy announcement into implementation. Preventive and promotive care as a core component of Wellness and wellbeing are concepts we must imbibe in our quest for Universal Health Coverage.

I am happy to note that these guidelines set out, in simple terms, the contours for implementation. I urge the States to use these guidelines as a framework to move expeditiously towards transforming the existing sub health centres and primary health centres to Health and Wellness Centres.

(Ashwini Kumar Choubey)

New Delhi

Office : 250, 'A' Wing,
Nirman Bhavan, New Delhi-110 011
Tel. : 011-23061016, 011-23061551
Telefax : 011-23062828
E-mail : moshealth.akc@gov.in

Residence :
30, Dr. APJ Abdul Kalam Road,
New Delhi-110003
Tel. : 011-23794971, 23017049

I/3184775/2018

अनुप्रिया पटेल
Anupriya Patel

सत्यमेव जयते

स्वच्छ भारत
एक कदम स्वच्छता की ओर

स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री
भारत सरकार
Minister of State For
Health & Family Welfare
Government of India

MESSAGE

The announcement of Ayushman Bharat marks a translational shift in prioritising policies and programmes towards achieving Universal Health Coverage.

Health and Wellness Centres, which represents the base pillar of Ayushman Bharat, are envisaged to deliver an expanded range of services to address the basic primary health care needs of the entire population in their area, rather than focus selectively on population sub-groups, thus expanding access, universality and equity close to community. The emphasis on health prevention and promotion is designed to bring focus on keeping people healthy by engaging and empowering individuals and communities to choose healthy behaviours and make changes that reduce the risk of developing chronic diseases and other morbidities.

Many components of the Health and Wellness Centres are new and will involve a paradigm shift at several levels. I am sure that these operational Guidelines for Comprehensive primary Health Care through Health and Wellness Centres will provide guidance and smoothen the process of implementation challenges.

My sincere hope is that States take strong ownership of the programme and leverage the central support to scale up and expand the scope of Health and Wellness Centres.

(Anupriya Patel)

कार्यालय : 652, 'ए' खण्ड, निर्माण भवन, नई दिल्ली–110 011. दूरभाष : 23063230 फैक्स : 23061238
Office : 652, 'A' Wing, Nirman Bhavan, New Delhi-110 011. Telephone : 23063230, Fax : 23061238
कैम्प कार्यालय, मिर्जापुर : भरूहना चौराहा (पुरानी हीरो हौंडा एजेंसी के सामने) , मिर्जापुर–231001 (उ.प्र.) फोन : 05442 - 220133
आवासीय कार्यालय, दिल्ली : सी–1/16, पंडारा पार्क, नई दिल्ली–110 003 फोन : 011-23782610
E-mail: officeanupriyapatel@gmail.com

प्रीति सूदन
सचिव
PREETI SUDAN
Secretary

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare
Dated : 17th September, 2018

MESSAGE

The Operational Guidelines for the delivery of Comprehensive Primary Health Care through Health and Wellness Centres are intended as a framework document for states and districts as they build upon the platform created by the National Health Mission, to enable integrated delivery of vertical programmes and address all population sub groups.

The guidelines in their final form have benefited enormously from wide ranging consultations with state policy makers and implementers as well as other stakeholders, eminent public health experts and civil society organizations. The guidelines also integrate lessons and experiences from early pilots in some states.

The guidelines clearly express the key features of Comprehensive Primary Health Care, namely integrated and quality health care services maintaining the continuum of people centric service delivery.

I am happy to note that the Operational Guidelines are comprehensive and provide details on strategic approaches to implement the multiple work streams and at the same time ensure flexibility to be adapted in various contexts and scenarios, within and across states.

While there is no one size fits all approach, there must be a shared understanding of the basic principles and design features of the Health and Wellness Centres. I hope that these guidelines are discussed and disseminated at the level of the state and also in the districts. We also look forward to the feedback of the states based on their experiences so that the guidelines may be kept abreast.

Delivering comprehensive primary health care through Health and Wellness Centres is a key component of Ayushman Bharat and I urge all states to institutionalize the policy and the necessary institutional and governance reforms for building a robust health system to anchor the Health and Wellness Centres. Let the Centers become a hub of activities for a healthy India.

(Preeti Sudan)

Tele : (O) 011-23061863, Fax : 011-23061252, E-mail : secyhfw@nic.in
Room No. 156, A-Wing, Nirman Bhavan, New Delhi-110011

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare

MESSAGE

The launch of these Operational Guidelines for Comprehensive Primary Health Care through Health and Wellness Centres marks a major milestone in the history of public health in India. They are based on the premise of an effective health systems, acknowledging the changing disease burden and it also includes interventions that account for high proportions of morbidity and mortality leveraging a slew of programmes launched in the past few years to reduce out of pocket expenditures.

The operational guidelines are comprehensive and draw on the lessons of the National Health Mission in various contexts. They are ambitious in their scope and scale and include guidance on physical and financial requirements, service packages, IT requirements, monitorable targets and also suggest reforms in payment packages including team-based incentives.

The delivery of Comprehensive Primary Health Care is not without challenges, since it involves a paradigm shift at all levels of the health system. The NHM has paved the way for effective implementation of HWC, and states must leverage this learning for effective implementation of HWC.

The guidelines, albeit very comprehensive, are a road-map, and states will need to adapt these to their contexts. However, I do hope that states will use the guidelines to develop a state specific road map, and build shared accountability at district and sub district level, so that there is a clear goal and focus to help us reach the target of operationalizing 1.5 lakh Health and Wellness Centres.

The Operational Guidelines are based on inputs from states which have been valuable in strengthening these guidelines. I would also like to thank the team at the National Health Systems Resource Centre, experts and state government officials whose relentless efforts have made the launch of these guidelines possible.

MANOJ JHALANI
Additional Secretary & Mission Director

MANOHAR AGNANI
Joint Secretary (Policy)

RAJANI R. VED
Executive Director, NHSRC

LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
AWCs	Anganwadi Centres
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha And Homeopathy
BCC	Behaviour Change Communication
BCM	Block Community Manager
BMO	Block Medical Officer
BPM	Block Programme Manager
CHC	Community Health Centre
CHO	Community Health Officer
COPD	Chronic Obstructive Pulmonary Disease
COTPA	Cigarettes and Other Tobacco Products Act
CPHC	Comprehensive Primary Health Care
CSR	Corporate Social Responsibility
DCM	District Community Manager
DH	District Hospital
DPM	District Programme Manager
EML	Essential Medicines List
FRU	First Referral Unit
GNM	General Nursing And Midwifery
HRH	Human Resource for Health
SHC	Sub Health Centres
ICDS	Integrated Child Development Services
ICPS	Integrated Child Protection Scheme
IEC	Information Education Communication
IGNOU	Indira Gandhi National Open University
MAS	Mahila Arogya Samiti
MDM	Mid Day Meal
MLA	Member of Legislative Assembly

MLHP	Mid Level Health Provider
MMUs	Mobile Medical Units
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MO	Medical Officer
MOIC	Medical Officer In charge
MP	Member of Parliament
MPW	Multi Purpose Worker
NACO	National Aids Control Organisation
NGO	Non-Governmental Organisation
NPCDCS	National Programme For Prevention And Control Of Cancer, Diabetes, Cardiovascular Diseases And Stroke
OOPE	Out of Pocket Expenditure
OPD	Out Patient Department
PHC	Primary Health Centre
RCH	Reproductive and Child Health
SBA	Skilled Birth Attendant
SHGs	Self Help Groups
SHSRC	State Health Systems Resource Centre
STGs	Standard Treatment Guidelines
UHC	Universal Health Coverage
UHND	Urban Health and Nutrition Day
ULB	Urban Local Body
UPHC	Urban Primary Health Centre
VHSNC	Village Health Sanitation And Nutrition Committee
WCD	Women and Child Development

CONTENTS

SECTION 1

INTRODUCTION

The National Health Mission (NHM), the country's flagship health systems strengthening programme, particularly for primary and secondary health care envisages "attainment of universal access to equitable, affordable and quality health care which is accountable and responsive to the needs of people". Investments during the life of the NHM in its earlier phases were targeted to strengthen Reproductive and Child Health (RCH) services and contain the increasing burden of communicable diseases such as Tuberculosis, HIV/AIDS and vector borne diseases. While such a focus on selective primary health care interventions, enabled improvements in key indicators related to RCH and select communicable diseases, the range of services delivered at the primary care level did not consider increasing disease burden and rising costs of care on account of chronic diseases.

Studies show that 11.5% households in rural areas and about only 4% in urban areas, reported seeking any form of OPD care - at or below the CHC level (except for childbirth) primary care facilities, indicating low utilization of the public health systems for other common ailments[1]. National Sample Survey estimates for the period-2004 to 2014 show a 10% increase in households facing catastrophic healthcare expenditures. This could be attributed to the fact that private sector remains the major provider of health services in the country and caters to over 75% and 62% of outpatient and in-patient care respectively. India is also witnessing an epidemiological and demographic transition, where non-communicable diseases such as cardiovascular diseases, diabetes, cancer, respiratory, and other chronic diseases, account for over 60% of total mortality.[2]

There is global evidence that Primary Health Care is critical to improving health outcomes. It has an important role in the primary and secondary prevention of several disease conditions, including non-communicable diseases. The provision of Comprehensive Primary Health Care reduces morbidity and mortality at much lower costs and significantly reduces the need for secondary and tertiary care. For primary health care to be comprehensive, it needs to span preventive, promotive, curative, rehabilitative and palliative aspects of care. Primary Health Care goes beyond first contact care, and is expected to mediate a two-way referral support to higher-level facilities (from first level care provider through specialist care and back) and ensure follow up support for individual and population health interventions.

In India, the need for and emphasis on strengthening Primary Health Care was firstly articulated in the Bhore Committee Report 1946 and subsequently in the First and Second National Health Policy statements (1983

1 Key Indicators of Social Consumption in India on Health, National Sample Survey 71st Round, 2014, Ministry of Statistics and Programme Implementation, Government of India

2 WHO. Non Communicable Diseases; Country Profile for India; 2014

and 2002). India is also a signatory to the Alma Ata declaration for Health for All in 1978. The Twelfth Five Year Plan Identified Universal Health Coverage as a key goal and based on the recommendations of the High- Level Expert Group Report on UHC had called for 70% budgetary allocation to Primary Health Care in pursuit of UHC for India.

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 and called for a commitment of two thirds of the health budget to primary health care.

In February 2018, the Government of India announced that 1,50,000 Health & Wellness Centres (HWCs) would be created by transforming existing Sub Health Centres and Primary Health Centres to deliver Comprehensive Primary Health Care and declared this as one of the two components of Ayushman Bharat. This was the first step in the conversion of policy articulations to a budgetary commitment.

The Report of the Primary Health Care Task Force, Ministry of Health and Family Welfare, Government of India while reiterating that primary health care is the only affordable and effective path for India to Universal Health Coverage, also provided valuable insights into structure and processes that are required in health systems to enable Comprehensive Primary Health Care (CPHC).

The delivery of CPHC through HWCs rests substantially on the institutional mechanisms, governance structures, and systems created under the National Health Mission (NHM). NHM, as part of health system reform in the country, in its nearly 12 years of implementation, has supported states to create several platforms for delivery of community-based health systems, expanding Human Resources for Health and infrastructure towards strengthening primary and secondary care. Though largely limited to a few conditions, NHM created mechanisms for expanded coverage and reach, and developed systems for improved delivery of medicines, diagnostics and improved reporting. About five years ago, these components were also introduced in urban areas.

Thus, although the delivery of universal Comprehensive Primary Health Care, through HWCs builds on existing systems, it will need change management and systems design at various levels, to realise its full potential. The other component of Ayushman Bharat, namely the Pradhan Mantri Jan Arogya Yojana (PMJAY) aims to provide financial protection for secondary and tertiary care to about 40% of India's households. Its success and affordability rests substantially on the effectiveness of provision of Comprehensive Primary Health Care through HWCs. Together, the two components of Ayushman Bharat will enable the realization of the aspiration for Universal Health Coverage.

1.1. About the Guidelines

These guidelines were developed after consultation with policy makers and practitioners at national and state level and with technical experts. It also draws on implementation experiences of government, NGO and private sector in the delivery of Primary Health Care. These guidelines are intended to serve as a framework for operationalizing the multiple components required for the delivery of Comprehensive Primary Health Care services through the Health & Wellness Centres. These guidelines are expected to support programme managers at state and district levels in rolling out Comprehensive Primary Health Care. They provide an overview of the systems requirements and strategies for change management to deliver CPHC.

The use of these guidelines would enable the states to put in place the necessary design elements and sub-systems required for Health and Wellness Centres to be created and deliver the health services expected of them. However, states have the flexibility to make necessary modifications based on their specific needs and capacities. The implementation of Comprehensive Primary Health Care would require substantial change management in processes for planning, service delivery, monitoring and financing and will require the active participation of several stakeholders including civil society, NGOs, academic and research agencies,

development partners, the private sector and, most importantly, the community. Operationalizing HWCs will be incremental in nature with contextual variations in models and processes evolving in different states.

These guidelines do not cover grounds included in several other guidelines already issued but highlight areas in which transformation and change management is needed, besides clarifying key concepts related to Comprehensive Primary Health Care and Health and Wellness Centres.

These guidelines are envisaged to be reviewed periodically and revised based on implementation lessons from the field so that they continue to provide meaningful and updated guidance to programme implementers and inform policy adaptation and modification.

SECTION 2

DEFINING HEALTH AND WELLNESS CENTRES

In order to ensure delivery of Comprehensive Primary Health Care (CPHC) services, existing Sub Health Centres covering a population of 3000-5000 would be converted to Health and Wellness Centres (HWC), with the principle being "time to care" to be no more than 30 minutes. Primary Health Centres in rural and urban areas would also be converted to HWCs. Such care could also be provided/ complemented through

Box 2.1. Key Principles

1. Transform existing Sub Health Centres and Primary Health Centres to Health and Wellness Centers to ensure universal access to an expanded range of Comprehensive Primary Health Care services.
2. Ensure a people centered, holistic, equity sensitive response to people's health needs through a process of population empanelment, regular home and community interactions and people's participation.
3. Enable delivery of high quality care that spans health risks and disease conditions through a commensurate expansion in availability of medicines & diagnostics, use of standard treatment and referral protocols and advanced technologies including IT systems.
4. Instil the culture of a team-based approach to delivery of quality health care encompassing: preventive, promotive, curative, rehabilitative and palliative care.
5. Ensure continuity of care with a two way referral system and follow up support.
6. Emphasize health promotion (including through school education and individual centric awareness) and promote public health action through active engagement and capacity building of community platforms and individual volunteers.
7. Implement appropriate mechanisms for flexible financing, including performance-based incentives and responsive resource allocations.
8. Enable the integration of Yoga and AYUSH as appropriate to people's needs.
9. Facilitate the use of appropriate technology for improving access to health care advice and treatment initiation, enable reporting and recording, eventually progressing to electronic records for individuals and families.
10. Institutionalize participation of civil society for social accountability.
11. Partner with not for profit agencies and private sector for gap filling in a range of primary health care functions.
12. Facilitate systematic learning and sharing to enable feedback, and improvements and identify innovations for scale up.
13. Develop strong measurement systems to build accountability for improved performance on measures that matter to people.

outreach services, Mobile Medical Units, health camps, home visits and community-based interaction, but the principle should be a seamless continuum of care that ensures the principles of equity, quality, universality and no financial hardship.

The HWC at the sub health centre level would be equipped and staffed by an appropriately trained Primary Health Care team, comprising of Multi-Purpose Workers (male and female) & ASHAs and led by a Mid-Level Health Provider (MLHP). Together they will deliver an expanded range of services. In some states, sub health centres have earlier been upgraded to Additional PHCs. Such Additional PHCs will also be transformed to HWCs.

A Primary Health Centre (PHC) that is linked to a cluster of HWCs would serve as the first point of referral for many disease conditions for the HWCs in its jurisdiction. In addition, it would also be strengthened as a HWC to deliver the expanded range of primary care services.

The Medical Officer at the PHC would be responsible for ensuring that CPHC services are delivered through all HWCs in her/his area and through the PHC itself. The number and qualifications of staff at the PHC would continue as defined in the Indian Public Health Standards (IPHS).

For PHCs to be strengthened to HWCs, support for training of PHC staff (Medical Officers, Staff Nurses, Pharmacist, and Lab Technicians), and provision of equipment for "Wellness Room", the necessary IT infrastructure and the resources required for upgrading laboratory and diagnostic support to complement the expanded ranges of services would be provided. States could choose to modify staffing at HWC and PHC, based on local needs.

The HWC would deliver an expanded range of services (Box 2.2). These services would be delivered at both SHCs and in the PHCs, which are transformed as HWCs. The level of complexity of care of services delivered at the PHC would be higher than at the sub health centre level and this would be indicated in the care pathways and standard treatment guidelines that will be issued periodically.

Box 2.2: Expanded Range of Services

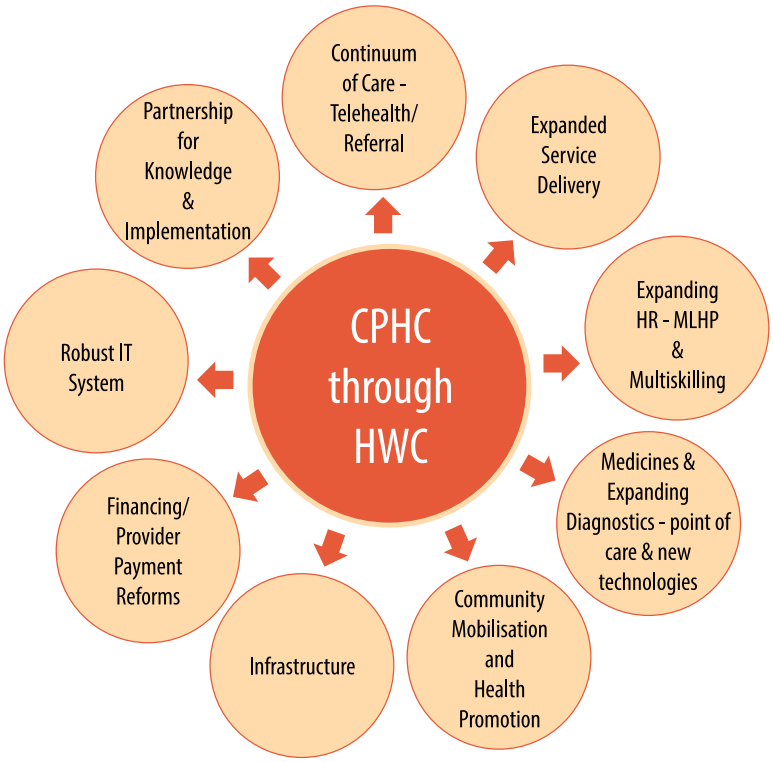
1. Care in pregnancy and child-birth.
2. Neonatal and infant health care services.
3. Childhood and adolescent health care services.
4. Family planning, Contraceptive services and other Reproductive Health Care services.
5. Management of Communicable diseases including National Health Programmes.
6. Management of Common Communicable Diseases and Outpatient 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.
12. Screening and Basic management of Mental health ailments.

In many states, the Primary Health Centre would serve as the first point of referral and administrative hub for sub health centres. However, in certain states, the sub health centre is linked directly to the Community Health Centre (CHC) at the block level (which in some blocks is a role performed by the Block PHC). Across all contexts however, it must be ensured that administrative, technical/mentoring and referral support be provided by a MBBS Medical Officer in a facility that is in geographic proximity to the cluster of HWCs and is equipped to manage referral support for HWC. This could therefore be either a PHC or a CHC.

Similarly, in the urban context, the Urban Primary Health Centres or Urban Health Posts, where they exist, would be strengthened as HWCs to deliver Comprehensive Primary Health Care. The norm of One MPW-(F) per 10,000 population supported by four to five ASHAs, will enable outreach services, preventive and promotive care and home and community-based services. Therefore, in the urban context, the team of MPWs (F) and ASHAs would be considered equivalent to a front-line provider team with the first point of referral being the UPHC catering to about at 50,000 population. All the key principles of HWCs indicated above will be applicable to PHCs in urban areas. Initial action for upgrading UPHCs to HWCs would require capacity building of staff and field functionaries in the expanded range of services. Population enumeration, empanelment, disease screening would also be required. In many cities, where specialists' consultation is currently being made available through evening OPDs on pre-fixed days, these could be leveraged as a strategy for ensuring continuity of care. However, states are free to undertake modifications that best fit their contexts.

In planning for HWCs, states need to pay close attention to improving geographic accessibility, ensure the full complement of staff at each level, enable regular capacity building and supportive supervision, ensure uninterrupted supply of medicines and diagnostics, and maintain a continuum of care seamlessly linking people to various levels of care so that the services offered at the primary health care level fully meet the promise of expanded range and commensurate outcomes.

Figure 2.1: Key Elements of HWC



As the principle of HWC is that they provide a continuum of care for all illnesses in the community, strategic modifications of components of health systems at secondary and tertiary levels and re-organization of workflow processes would be needed in parallel to effectively implement Comprehensive Primary Health Care through HWCs.

Clear demarcation of services that are provided in the Community, HWC and PHC/CHC levels is difficult. Services provided at the primary health care level, are in fact, a shifting goal post, affected by a range of factors. However, this initiative under Ayushman Bharat, proposes to use diagnostic and technological innovation to bring services as close to people and communities as possible. We need to recognize that poor service delivery at HWC will, adversely impact the gate-keeping role and push patients unnecessarily into costlier secondary and tertiary care facilities. It could also result in pushing patients to the private sector with adverse implications for out of pocket expenditure and impoverishment. Figure 2.1 illustrates the key elements of HWC.

2.2. Inputs for Health Wellness Centres

The ***key inputs*** to be provided at a HWC are listed below:

2.2.1 **Primary health care team** to deliver the expanded range of services.

- **a. At the upgraded SHC** – A team of at least three service providers (one Mid-level provider, at least two (preferably three) Multi-Purpose Workers – two female and one male, and team of ASHAs at the norm of one per 1000.
- **b. At the strengthened PHC –** PHC team as per IPHS standards. Although all the PHCs have been expected to provide 24*7 nursing care, this has not been possible in several states for variety of reasons. In 24*7 PHCs having inpatient care, an additional nurse should be posted where cervical cancer screening is being undertaken/ planned. In PHCs that are not envisaged to provide inpatient care, the existing nurses should receive modular training in certificate course for primary care. In urban areas, the team would consist of the MPW- F (for 10,000 population) and the ASHAs (one per 2500).

2.2.2 **Logistics** – Adequate availability of essential medicines and diagnostics to support the expanded range of services, to resolve more and refer less at the local levels, and to enable dispensation of medicines for chronic illnesses as close to communities as possible.

2.2.3 **Infrastructure –** Sufficient space for outpatient care, for dispensing medicines, diagnostic services, adequate spaces for display of communication material of health messages, including audio visual aids and appropriate community spaces for wellness activities, including the practice of Yoga and physical exercises.

2.2.4 **Digitization –** HWC team to be equipped with tablets/smart Phones to serve a range of functions such as: population enumeration and empanelment, record delivery of services, enable quality follow up, facilitate referral/continuity of care and create an updated individual, family and population health profile, and generate reports required for monitoring at higher levels.

2.2.5 **Use of Telemedicine/IT Platforms –** At all levels, teleconsultation would be used to improve referral advice, seek clarifications, and undertake virtual training including case management support by specialists.

2.2.6 **Capacity Building –** Mid Level Health Providers will be trained in a set of primary healthcare and public health competencies through an accredited training programme that combines theory and practicum with on the job training. Other service providers at HWC will also be trained appropriately to deliver the expanded range of services.

2.2.7 **Health Promotion –** Development of health promotion material and facilitation of health promotive behaviours through engagement of community level collectives such as – Village Health Sanitation and Nutrition Committee (VHSNCs), Mahila Arogya Samiti (MAS) and Self-Help Groups (SHGs), and creating health ambassadors in schools. Enabling behaviour change communication to address life style related risk factors and undertaking collective action for reducing risk exposure, improved care seeking and effective utilization of primary health care services.

2.2.8 **Community Mobilization –** for action on social and environmental determinants, would require intersectoral convergence and build on the accountability initiatives under NHM so that there is no denial of health care and universality and equity are respected.

2.2.9 **Linkages with Mobile Medical Units –** Linkages with Mobile Medical Units (MMU) could serve to improve access and coverage in remote and underserved areas where there is difficulty in establishing HWCs. In such cases, medicines and other support could be provided to frontline workers, with

periodic MMU visits. MMUs could also be linked to nearby HWCs, where medical consultation could be arranged on scheduled days, for those unable to travel to referral sites. MMUs could be used in conjunction with specific service delivery platforms, which otherwise are difficult to operationalize in that locality. MMUs can be designed to meet the specific needs in that locality, as a supplement to the HWC network. The visit calendar of the MMUs would need to be planned and displayed at HWC.

2.3. Financing

Suitable payment mechanism for primary health care will need to be explored. Once the systems for population empanelment and record of services are streamlined, the possibility of financing on a per capita basis can be explored. In addition, team based incentives would be initiated. This will be done to facilitate accountability to outputs/outcomes and provide individual centred care.

2.4. Essential Outputs of HWC

2.4.1 **The HWC Data Base:** Population enumeration and empanelment implies the creation and maintenance of database of all families and individuals in an area served by a HWC. This is planned such that every individual is empanelled to a HWC. This also involves active communication to make residents aware of this facility.

2.4.2 **Health Cards and Family Health Folders:** These are made for all service users to ensure access to all health care entitlements and enable continuum of care. The health cards are given to the families and individuals. The family health folders are kept at the HWC or nearby PHC in paper and/or digital format. This ensures that every family knows their entitlement to healthcare through both HWC and the Pradhan Mantri Jan Arogya Yojana or equivalent health schemes of state and central government.

2.4.3 **Increased Access to Services:** HWCs would provide access to an expanded range of services indicated in Box 2.2. The availability of services would evolve in different states gradually, depending on three factors- the availability of suitably skilled human resources at the HWC, the capacity at district/sub-district level to support the HWC in the delivery of that service, and the ability of the state to ensure uninterrupted supply of medicines and diagnostics at the level of HWC. States will also have the flexibility to expand the range of service to address local health problems as defined by disease prevalence.

2.5. Outcomes

2.5.1 **Improved population coverage:** Active empanelment and HWC database will improve the population coverage. The HWC database would enable HWC staff to monitor and identify the left out population and improve coverage of national health programmes.

2.5.2 **Reduced out of pocket expenditure and catastrophic health expenditure:** Improved access to expanded services closer to the community, assured availability of medicines and diagnostic services and linkages for care coordination with Medical Officers/specialists across levels of care will reduce financial hardships faced by community.

2.5.3 **Risk factor mitigation:** Health promotion efforts by primary health care team would support in addressing the risk factors for diseases.

2.5.4 **Decongestion of secondary and tertiary health facilities:** A strong network of HWCs at the sub district level would facilitate resolving more cases at primary level and reduce overcrowding at secondary and tertiary facilities for follow up cases as well as serve a gate keeping function to higher-level facilities.

2.6. Impact

2.6.1 **Improved population health outcomes:** Improved availability, access and utilization will in turn contribute to equitable health outcomes measured through periodic population based surveys for key indicators listed in Section 10.1- Monitoring.

2.6.2 **Increased responsiveness:** Provision of care by primary care team will be based on principles of family led care including dignity and respect for individuals and communities with particular focus on marginalized, information sharing, encouraging participation, including intersectoral collaboration that will lead to increased trust building, comfort in access to care and enable addressing social and environmental determinants.

While not all inputs can be provided immediately, the state needs to have a road map for HWC strengthening, in which some inputs can be added in an incremental manner. However, addition of the services for chronic conditions with requisite HR who is trained, and with the medicines and diagnostics would be a critical first step. The centres which do not fulfil all criteria but have only initiated expanded service delivery, would be referred to as "HWCs – progressive," and have a clear time line to become "fully functional HWC"- i.e., with the entire complement of the primary health care team, and delivery of the expanded range of services, identified for Comprehensive Primary Health Care.

SECTION 3

SERVICE DELIVERY AND CONTINUUM OF CARE

3.1. Expanded Service Delivery

3.1.1 Population Enumeration and Empanelment of Families at HWC

The Primary Health Care team at the HWC would serve as the fulcrum of Comprehensive Primary Health Care and support system, for planning, delivery and monitoring services for the defined catchment population. Once the HWCs have been decided, population enumeration to facilitate empanelment is a critical first step.

In order to ensure equitable population coverage and to address issues of marginalization, the frontline workers would create population-based household lists and undertake registration of all individuals and families residing within the catchment area of a Health and Wellness Centre. It is this registration that is referred to as empanelment. It is a right of anyone, resident in that area to be enrolled. Care should not be denied to those who are not enrolled but seek care at the HWC. An active process of enrolment is encouraged to ensure that there is an active contact between the HWC team and the entitled population.

Empanelment of all individuals to a particular HWC serves several roles. It lays the foundation for trust between the community and the primary health care team. It declares the HWC as the first port of call for health for the community that the government is providing. It makes the HWC responsible for the health of population, and it enables a facilitatory role for access to secondary and tertiary care through its referral mechanisms and linkages. Finally it also provides follow up support as per the treatment plan provided by the higher facility. Empanelment of individuals and families would also facilitate monitoring universal coverage for all programmes viz. Maternal and Child Health, Family Planning, Immunization and chronic disease screening, long term communicable diseases. It also enables a basis for payment by capitation at a later stage, which would be most useful for HWCs catering to larger than expected populations.

This is however likely to be a challenge in urban and other areas where population density is high. Population empanelment, updated at shorter periodic intervals would clarify the geographic and population coverage. The HWC is responsible for undertaking this, so as to make explicit the population under its care. This makes it possible for the team to understand the specific needs of population sub-groups, local specific needs, and enable monitoring and evaluation of the performance of the team including assessment of quality of care and coverage. Families can choose to be empanelled with one of the many HWCs in urban areas.

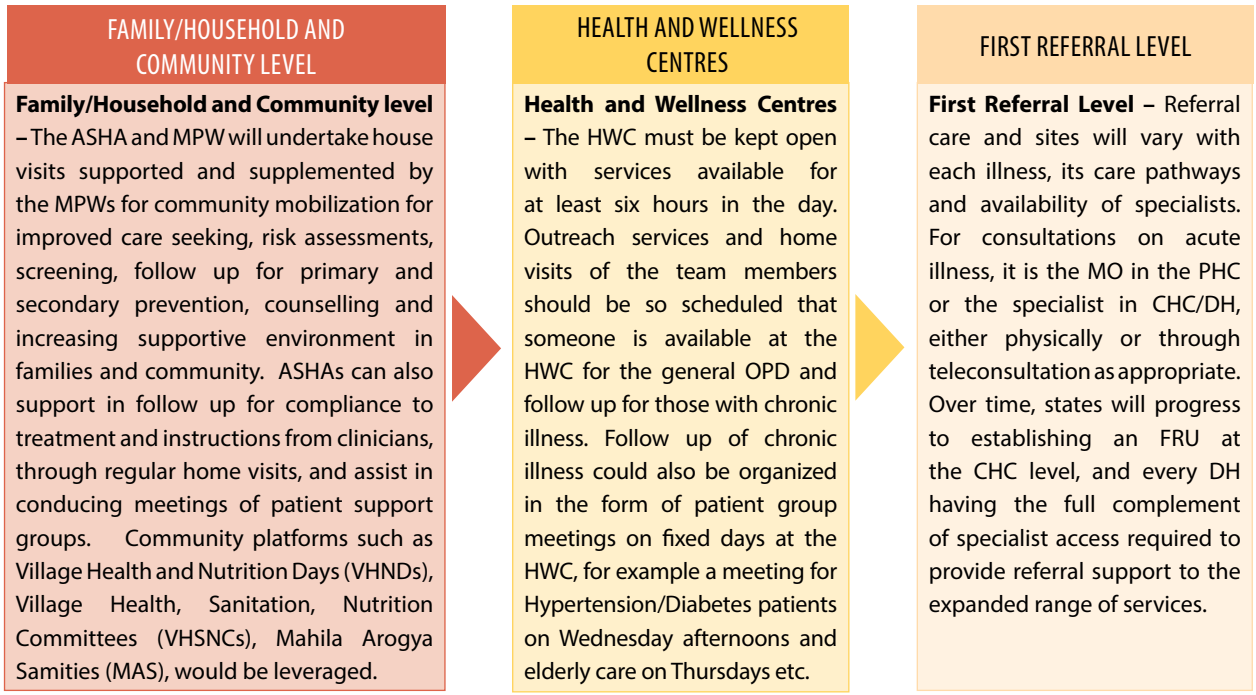
Family Health Folders and an individual health records will be created through the ASHAs and the MPWs and stored in the HWC. A digital format of the family health records will be implemented in a phased manner depending on the state of readiness for connectivity and resource availability. Population Based Records/

Data Base already available should be leveraged to initiate HWC based digital records of demographic information of individuals.

3. 1.2. Organization of Services

Delivery of an expanded range of services, closer to the community at HWCs would require re-organization of the existing workflow processes. The delivery of services would be at three levels i.e., i) Family/Household and community levels, ii) Health and Wellness Centres and iii) and Referral Facilities/Sites. Delivery of services closer to the community and close monitoring would enable increased coverage and help in addressing issues of marginalization and exclusion of specific population groups.

Figure 3.1: Organization of Service Delivery



3.1.3. Service Delivery Framework

The services envisaged at the HWC level will include early identification, basic management, counselling, ensuring treatment adherence, follow up care, ensuing continuity of care by appropriate referrals, optimal home and community follow up, and health promotion and prevention for the expanded range of services. The primary health care team led by the Mid-level health provider would be trained to provide first level of management and triage i.e. refer the patient to the appropriate health facility for treatment and follow up.

Care provision at every level would be provided as per clinical pathways and standard treatment guidelines. This would facilitate the decongestion of the secondary and tertiary care facilities as the primary care services would be made available at the HWC level closer to the community with adequate referral linkages and early identification and management will prevent disease progression that would require secondary/ tertiary care interventions. Thus, the HWC team would play the critical role of coordination by assisting people in navigation of the health system and mobilizing the support for timely access to specialist services when required.

The HWC would also play an important role in undertaking public health functions in the community leveraging the frontline workers and community platforms.

The chapter on service delivery outlines the range of services that would be made available at the community level, at the HWC and at the referral sites to ensure effective delivery of primary care services. Task Forces are concurrently working on finalizing detailed care pathways for some of the services. These will be circulated to states as and when they are finalized. For services related to RCH, Communicable Diseases and five common Non-Communicable Diseases such care, pathways and Standard Treatment Guidelines are already available. However, these may require to be updated from time to time.

3.1.4. Continuity of Care and Patient Centric Care

Continuity of care is one of the key tenets of Primary Health Care. Continuum of care spans for the individuals from the same facility to her/his home and community, and across levels of care- primary, secondary and tertiary. Care must be ensured from the level of the family through the facility level.

- **Community/Household:** The ASHA would undertake home visits to ensure that the patient is taking actions for risk factor modification, provides counselling and support, including reminders for follow up appointments at HWC and collection of medicines.
- **HWC:** Dispensation of medicines, repeat diagnostics as required, identification of complications and facilitating referrals at a higher-level facility/teleconsultation with a specialist as required are undertaken at the HWC, including maintenance of records. The last activity would enable HWC team to identify stable patients, and to organize community level supportive activities to improve adherence to care protocols and reduction of exposure to risk factors.

  The referring HWC uses a clear referral format to provide information on reason for referral and care already being provided and other details as necessary (especially on insurance coverage). The referring HWC also ensures that the appropriate specialists are available in that facility and to the extent possible, facilitate the referral appointment.
- **Higher-Level Facility:** The referred medical officer or specialists would examine the patient and develop/modify the treatment plan, including instructions for the patient as well as a note to the HWC provider, indicating the need for change. Systems need to be in place so that a medicine prescribed by a specialist is made available to the patient at the HWC where she/he is empanelled. Periodic meetings (whether in person or through virtual platforms) between HWC team and the specialists/ medical officers referred to, are also essential to ensure that they all function as one team and ensure care continuum.

Developing Referral Linkages: In effect, every existing HWC providing the expanded range of services, would manage the largest proportion of disease conditions and organize referral for consultation and follow up with an MBBS doctor at the linked Primary Health Centre- HWC, (one per 30,000 population/20000 in hilly areas) that would also provide a similar set of services as the sub centre HWC, but of a higher order of complexity. The Block PHCs and CHCs would now need to provide referral services beyond emergency obstetric care, to include general medical and specialist consultation. Strengthening of health facilities as FRUs and first level of hospitalization would need to be done in a phased manner based on the availability of infrastructure, equipment and Human Resources for Health at the identified health facilities. For example, cases of acute simple illness need not be referred to DH/FRU but can be handled at PHC itself. On the other hand, high-risk pregnancy, sick new born, care for serious mental health ailments may be referred directly to a District Hospital.

Empanelment of population in HWC will facilitate gate keeping, as it will help families in identifying their closest health facility. Patient centric care, trust building by primary care team, adopting standard treatment protocols, and assured supply of medicines would facilitate in resolving more cases at the HWC level and reduce direct seeking of care at secondary level facilities.

Ensuring two-way referrals between various facility levels: The delivery of Comprehensive Primary Health Care particularly for chronic conditions requires periodic specialist referral. Treatment for chronic

conditions can be preferably initiated by MO at PHC, in consultation with concerned specialist at secondary/ tertiary care facilities. An IT system/teleconsultation can considerably facilitate this process. The loop between the primary care medical provider and the specialist must be closed. This can be achieved when the specialists at district facility or higher are able to communicate to the medical officer of the adequacy of treatment, any change in treatment plans, and further referral action.

Using Mobile Medical Units to Increase Access: In order to expand access to services, and reach remote populations, MMUs would enable an expansion of service delivery and serve the role of enabling the provision of Comprehensive Primary Health Care and serving to establish continuum of care.

Table 3.1- Service Delivery Framework*

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
Care in pregnancy and child birth	• Early diagnosis of pregnancy • Ensuring four antenatal care checks • Counselling regarding care during pregnancy including information about nutritional requirements • Identifying high risk pregnancies and follow up • Enabling access to Take home ration from Anganwadi centre. • Follow up to ensure compliance with IFA in normal and anaemic cases • Facilitating institutional delivery and supporting birth planning • Post- partum care visits • Identifying complications related to child birth, post-partum complications and facilitating timely referrals	• Early registration of pregnancy and issuing of ID number and Mother and Child protection card • Antenatal check-up including screening of Hypertension, Diabetes, Anaemia, Immunization for pregnant woman-TT, IFA and Calcium supplementation • Screening, referral and follow up care in cases of Gestational Diabetes, and Syphilis during pregnancy • Normal vaginal delivery in specified delivery sites as per state context - where Mid-level provider or MPW (F) is trained as Skill Birth Attendant (Type B SHC) • Provide first aid treatment and referral for obstetric emergencies, e.g. eclampsia, PPH, Sepsis, and prompt referral (Type B SHC)	• Antenatal and postnatal care of high-risk cases • Blood grouping and Rh typing and blood cross matching • Linkage with nearest ICTC/ PPTCT centre for voluntary testing for HIV and PPTCT services • Normal vaginal delivery and Assisted vaginal delivery • Surgical interventions like Caesarean section • Management of all complications including ante-partum and post-partum haemorrhage, eclampsia, puerperal sepsis, obstructed labour, retained placenta, shock, severe anaemia, breast abscess. • Blood transfusion facilities
Neonatal and infant Health	• Home based new-born care through 7 visits in case of home delivery and 6 visits in case of institutional delivery • Identification and care of high risk newborn - low birth weight/preterm newborn and sick newborn (with referral as required) • Counselling and support for early breast feeding, complimentary feeding practices • Iron Supplementation • Adoption of Safe and hygiene WASH practices	• Identification and management of high risk newborn - low birth weight/ preterm/ sick newborn and sepsis (with referral as required) • Management of birth asphyxia (Type B SHC) • Identification, appropriate referral and follow up of congenital anomalies • Management of ARI/Diarrhoea and other common illness and referral of severe cases • Screening, referral and follow up for disabilities and developmental delays	• Care for low birth weight newborns (<1800gms) • Treatment of asphyxia and neonatal sepsis • Treatment of severe ARI and Diarrhoea / dehydration cases • Vitamin K for premature babies • Childhood and Adolescent health care services including immunization Management of all emergency and complication cases

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
	• Growth monitoring • Counselling for Early Childhood Growth and Development • Identification of birth asphyxia, sepsis and referral after initial management • Identification of congenital anomalies and appropriate referral • Family /community education for prevention of infections and keeping the baby warm • Identification of ARI/Diarrhoea- identification, initiation of treatment-ORS and timely referral as required • Mobilization and follow up for immunization services	• Complete immunization • Vitamin A supplementation • Identification and follow up, referral • Reporting of Adverse Events Following Immunization (AEFI)	
Childhood and Adolescent health care services including immunization	• Growth Monitoring, IYCF continued and enable access to food supplementation- all linked to ICDS • Detection of SAM, referral and follow up care for SAM • Prevention of Anaemia, iron supplementation and deworming • Prevention of diarrhoea/ ARI, prompt and appropriate treatment of diarrhoea/ ARI with referral where needed • Pre-school and School Child Health: Biannual Screening, School Health Records, Eye care, De-worming • Screening of children under national program to cover 4'D's Viz. Defect at birth, Deficiencies, Diseases, Development delay including disability ***Adolescent Health*** • Counselling on- ◆ Improving nutrition ◆ Sexual and reproductive health ◆ Enhancing mental health /Promoting favourable attitudes for preventing injuries and violence ◆ Prevent substance misuse ◆ Promote healthy lifestyle ◆ Personal hygiene- Oral Hygiene and Menstrual hygiene	• Complete immunization • Detection and treatment of Anaemia and other deficiencies in children and adolescents • Identification and management of vaccine preventable diseases in children such as Diphtheria, Pertussis and Measles • Early detection of growth abnormalities, delays in development and disability and referral • Prompt Management of ARI, acute diarrhoea and fever with referral as needed • Management (with timely referral as needed) of ear, eye and throat problems, skin infections, worm infestations, febrile seizure, poisoning, injuries/accidents, insect and animal bites • Detection of SAM, referral and follow up care for SAM. • Adolescent health- counselling • Detection for cases of substance abuse, referral and follow up • Detection and Treatment of Anaemia and other deficiencies in adolescents • Detection and referral for growth abnormality and disabilities, with referral as required	• NRC Services • Management of SAM children, severe anaemia or persistent malnutrition • Severe Diarrhoea and ARI management • Management of all ear, eye and throat problems, skin infections, worm infestations, febrile seizure, poisoning, injuries/accidents, insect and animal bites • Diagnosis and treatment for disability, deficiencies and development delays • Surgeries for any congenital anomalies like cleft lips and cleft palates, club foot etc. • Screening for hormonal imbalances and treatment with referral if required • Management of growth abnormality and disabilities, with referral as required • Management including rehabilitation and counselling services in cases of substance abuse. • Counselling at Adolescent Friendly Health Clinics (AFHC)

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
	• Peer counselling and Life skills education • Prevention of Anaemia, identification and management, with referral if needed • Provision of IFA under National Program for Iron Supplementation		
Family planning, contraceptive services and other reproductive care services	• Counselling for creating awareness against early marriage and delaying early pregnancy • Identification and registration of eligible couples • Motivating for family planning (Delaying first child and spacing between 2 children) • Provision of condom, oral contraceptive pills and emergency contraceptive pills • Follow up with contraceptive users • Other reproductive care services • Counselling and facilitation of safe abortion services • Post abortion contraceptive counselling • Follow up for any complication after abortion and appropriate referral if needed • Education and mobilizing of community for action on violence against women • Counselling on prevention of RTI/ STI • Identification and referral of RTI/STI cases • Follow up and support PLHA (People Living with HIV/AIDS) groups • Ensure regular treatment and follow of diagnosed cases	• Insertion of IUCD • Removal of IUCD • Provision of condoms, oral contraceptive pills and emergency contraceptive pills • Provision of Injectable Contraceptives in MPV districts • Counselling and facilitation for safe abortion services • Medical methods of abortion (up to 7 weeks of pregnancy) on fix days at the HWC by PHC MO • Post abortion contraceptive counselling • Follow up for any complication after abortion and appropriate referral if needed • First aid for GBV related injuries - link to referral centre and legal support centre • Identification and management of RTIs/STIs • Identification, management (with referral as needed) in cases of dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse	• Insertion of IUCD and Post-Partum IUCD • Removal of IUCD • Male sterilization including Non-scalpel Vasectomy • Female sterilization (Mini- Lap and Laparoscopic Tubectomy) • Management of all complications • Provision of Injectable Contraceptives • Medical methods of abortion (up to 7 weeks of pregnancy) with referral linkages MVA up to 8 weeks • Referral linkages with higher centre for cases beyond 8 weeks of pregnancy up to 20 weeks • Treatment of incomplete/ Inevitable/ Spontaneous Abortions • Second trimester MTP as per MTP Act and Guidelines • Management of all post abortion complications • Management of survivors of sexual violence as per medico legal protocols. • Management of GBV related injuries and facilitating linkage to legal support centre • Management of hormonal and menstrual disorders and cases of dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse • Provision of diagnostic tests services such as (VDRL, HIV) • Management of RTIs/STIs • PPTCT at district level

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
Management of Communicable diseases and General Outpatient care for acute simple illness and minor ailments	• Symptomatic care for fevers, URIs, LRIs, body aches and headaches, with referral as needed • Identify and refer in case of skin infections and abscesses • Preventive action and primary care for waterborne disease, like diarrhoea, (cholera, other enteritis) and dysentery, typhoid, hepatitis (A and E) • Creating awareness about prevention, early identification and referral in cases of helminthiasis and rabies • Preventive and promotive measures to address musculo-skeletal disorders- mainly osteoporosis, arthritis and referral or follow up as indicated • Providing symptomatic care for aches and pains – joint pain, back pain etc.	• Identification and management of common fevers, ARIs, diarrhoea, and skin infections. (scabies and abscess) • Identification and management (with referral as needed) in cases of cholera, dysentery, typhoid, hepatitis and helminthiasis • Management of common aches, joint pains, and common skin conditions, (rash/urticaria)	• Diagnosis and management of all complicated cases (requiring admission) of fevers, gastroenteritis, skin infections, typhoid, rabies, helminthiasis, patitis acute • Specialist consultation for diagnostics and management of musculo-skeletal disorders, e.g.- arthritis
Management of Communicable diseases: National Health Programmes (Tuberculosis, Leprosy, Hepatitis, HIV-AIDS, Malaria, Kala-azar, Filariasis and Other vector borne diseases)	• Community awareness for prevention and control measures • Screening, Identification, prompt presumptive treatment initiation and referral as appropriate and specified for that level of care • Ensure compliance with follow up medication compliance • Mass drug administration in case of filariasis and facilitate immunization for Japanese encephalitis • Collection of blood slides in case of fever outbreak in malaria prone areas • Provision of DOTS/ensuring treatment adherence as per protocols in cases of TB	• Diagnosis, (or sample collection) treatment (as appropriate for that level of care) and follow up care for vector borne diseases – Malaria, Dengue, Chikungunya, Filaria, Kalazar, Japanese Encephalitis, TB and Leprosy. • Provision of DOTS for TB and MDT for leprosy • HIV Screening (in Type B SHC), appropriate referral and support for HIV treatment. • Referral of complicated cases	• Confirmatory diagnosis and initiation of treatment • Management of Complications, • Rehabilitative surgery in case of leprosy
Prevention, Screening and Management of Non-Communicable diseases	• Population empanelment, support screening for universal screening for population – age 30 years and above for Hypertension, Diabetes, and three common cancers – Oral, Breast and Cervical Cancer • Health promotion activities – to promote healthy lifestyle and address risk factors	• Screening and treatment compliance for Hypertension and Diabetes, with referral if needed • Screening and follow up care for occupational diseases (Pneumoconiosis, dermatitis, lead poisoning); fluorosis; respiratory disorders (COPD and asthma) and epilepsy	• Diagnosis, treatment and management of complications of Hypertension and Diabetes • Diagnosis, treatment and follow up of cancers (esp. Cervical, Breast, Oral) • Diagnosis and management of occupational diseases such as Silicosis, Fluorosis and respiratory disorders (COPD and asthma) and epilepsy

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
	• Early detection and referral for - Respiratory disorders – COPD, Epilepsy, Cancer, Diabetes, Hypertension and occupational diseases (Pneumoconiosis, dermatitis, lead poisoning) and Fluorosis • Mobilization activities at village level and schools for primary and secondary prevention • Treatment compliance and follow up for positive cases	• Cancer – screening for oral, breast and cervical cancer and referral for suspected cases of other cancers • Confirmation and referral for deaddiction – tobacco/ alcohol/ substance abuse • Treatment compliance and follow up for all diagnosed cases • Linking with specialists and undertaking two-way referral for complication	
Screening and Basic management of Mental health ailments	• Screening for mental illness- using screening questionnaires/tools • Community awareness about mental disorders (Psychosis, Depression, Neurosis, Dementia, Mental Retardation, Autism, Epilepsy and Substance Abuse related disorders) • Identification and referral to the HWC/ PHC for diagnosis • Ensure treatment compliance and follow up of patients with Severe Mental Disorders • Support home based care by regular home visits to patients of Severe Mental Disorders • Facilitate access to support groups, day care centres and higher education/ vocational skills	• Detection and referral of patients with severe mental disorders • Confirmation and referral to deaddiction centres • Dispense follow up medication as prescribed by the Medical officer at PHC/ CHC or by the Psychiatrist at DH • Counselling and follow up of patients with Severe Mental Disorders • Management of Violence related concerns	• Diagnosis and Treatment of mental illness • Provision of out -patient and in-patient services • Counselling services to patients (and family if available)
Care for Common Ophthalmic and ENT problems	• Screening for blindness and refractive errors • Recognizing and treating acute suppurative otitis media and other common ENT problems • Counselling and support for care seeking for blindness, other eye disorders • Community screening for congenital disorders and referral • First aid for nosebleeds • Screening by the Mobile Health Team/RBSK for congenital deafness and other birth defects related to eye and ENT problems	• Diagnosis of Screening for blindness and refractive errors • Identification and treatment of common eye problems –conjunctivitis, acute red eye, trachoma; spring catarrh, xeropthalmia as per the STG • Screening for visual acuity, cataract and for refractive errors • Management of common colds, Acute Suppurative Otitis Media, injuries, pharyngitis, laryngitis, rhinitis, URI, sinusitis, epistaxis • Early detection of hearing impairment and deafness with referral. • Diagnosis and treatment services for common diseases like otomycosis, otitis externa, ear discharge etc.	• Management of all Acute and chronic eyes, ear, nose and throat problems • Surgical care for ear, nose, throat and eye • Management of Cataract, Glaucoma, Diabetic retinopathy and Corneal ulcers • Diagnosis and management of blindness, hearing and speech impairment • Management including nasal packing, tracheostomy, foreign body removal etc.

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
		• Manage common throat complaints (tonsillitis, pharyngitis, laryngitis, sinusitis) • First aid for injuries/ stabilization and then referral. • Removal of Foreign Body. (Eye, Ear, Nose and throat) • Identification and referral of thyroid swelling, discharging ear, blocked nose, hoarseness and dysphagia	
Basic oral health care	• Education about Oral Hygiene • Create awareness about fluorosis, early detection and referral • Recognition and referral for other common oral problems like caries, gingivitis and tooth loss etc. • Symptomatic care for tooth ache and first aid for tooth trauma, with referrals • Mobilization for screening of oral cancer on screening day • Creating awareness about ill effects of Substance Abuse like tobacco, beetle and areca nut, smoking, reverse smoking and alcohol	• Screening for gingivitis, periodontitis, malocclusion, dental caries, dental fluorosis and oral cancers, with referral • Oral health education about dental caries, periodontal diseases, malocclusion and oral cancers • Management of conditions like apthous ulcers, candidiasis and glossitis, with referral for underlying disease • Symptomatic care for tooth ache and first aid for tooth trauma, with referral • Counselling for tobacco cessation and referral to Tobacco Cessation Centres	• Diagnosis and management of oral cancer • Management of malocclusion, trauma cases, Tooth abscess, dental caries • Surgical and prosthetic care
Elderly and palliative health care services	• Identification of high risk groups • Support to family in palliative care • Home visits for care to home bound/ bedridden elderly, disabled elderly persons • Support family in identifying behavioural changes in elderly and providing care. • Linkage with other support groups and day care centres etc. operational in the area. • Community mobilization on promotional, preventive and rehabilitative aspects of elderly. • Community awareness on various social security schemes for elderly • Identify and report elderly abuse cases, and provide family counselling	• Arrange for suitable supportive devices from higher centres to the elderly /disabled persons to make them ambulatory • Referral for diseases needing further investigation and treatment, to PHC/CHC/DH • Management of common geriatric ailments; counselling, supportive treatment • Pain Management and provision of palliative care with support of ASHA	• Diagnosis, treatment and referral for complications • Surgical care • Rehabilitation through physiotherapy and counselling

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
Emergency Medical Services, including for Trauma and Burns	• First aid for trauma including management of minor injuries, fractures, animal bites and poisoning • Emergency care in case of disaster	• Stabilization care and first aid before referral in cases of - poisoning, trauma, minor injury, burns, respiratory arrest and cardiac arrest, fractures, shock, chocking, fits, drowning, animal bites and haemorrhage, infections (abscess and cellulitis), acute gastro intestinal conditions and acute genito urinary condition • Identify and refer cases for surgical correction - lumps and bumps (cysts/ lipoma/ haemangioma/ganglion); anorectal problems, haemorrhoids, rectal prolapse, hernia, hydrocele, varicoele, epidymo-orchitis, lymphedema, varicose veins, genital ulcers, bed ulcers, lower urinary tract symptoms (Phimosis, paraphimosis), and atrophic vaginitis.	• Triage and management of trauma cases • Management of poisoning, • Management of simple fractures and poly trauma • Basic surgery and surgical emergencies (Hernia, Hydrocele, Appendicitis, Haemorrhoids, Fistula, and stitching of injuries) etc. • Handling of all emergencies like animal bite, Congestive Heart Failure, Left Ventricular Failure, acute respiratory conditions, burns, shock, acute dehydration etc.

** Service Delivery Framework will be updated as per recommendations of the Task Forces.*
*** Referral sites also include PHCs which would be strengthened as HWCs.*

SECTION 4

HUMAN RESOURCES

4.1. Mid Level Health Provider

A key addition to the primary health team at the SHC-HWC, would be the Mid-level Health Provider (MLHP) who would be a Community Health Officer (CHO) - a BSc. in Community Health or a Nurse (GNM or B.SC) or an Ayurveda practitioner, trained and certified through IGNOU/other State Public Health/Medical Universities for a set of competencies in delivering public health and primary health care services.

The rationale for introducing this new cadre of health provider is to:

- Augment the capacity of the Health and Wellness Centre to offer expanded range of services closer to community, thus improving access and coverage with a commensurate reduction in OOPE.
- Improve clinical management, care coordination and ensure continuity of care through regular follow up, dispensing of medicines, early identification of complications, and undertaking basic diagnostic tests.
- Improve public health activities related to preventive and promotive health and the measurement of health outcomes for the population served by the HWC.

This will improve utilization of health services at primary care level, reduce fragmentation of care, and work load at secondary and tertiary care facilities. Districts will be encouraged to find MLHPs from within their district. However, since not all districts may have adequate availability of eligible candidates, it may be appropriate to plan MLHPs as a State cadre that will adhere to state specific cadre management rules. The state should make cadre rules and communicate to districts. States could also explore the possibility of creating a district cadre.

4.1.1 Selection of Mid Level Health Providers for the Health and Wellness Centres

It is important to ensure the following processes for selection of the MLHPs are followed so that candidates with the right attitude, competencies and motivation to work in rural and remote settings are recruited. States should especially undertake local selection to maximize retention.

- Widely published notification that are clear on eligibility norms, job deliverables, selection criteria, remuneration pattern, date of written test and interview.

- Transparent short listing of applications.
- Conduct of written assessment and interviews of the shortlisted candidates to assess competency of the candidates and willingness to serve in rural remote areas respectively.
- Finalization of the score sheet and submission of the list of selected candidates to State Health Mission for ratification.
- Appointment to posts based on a system of "counselling" where those higher on the final merit list get to choose first from the posts that are vacant. The district will however retain the right to transfer them, usually within the district or state, if a need to do so arises.

Recruitment of Mid- Level Health Providers can be undertaken through a state level advertisement that clearly indicates district wise positions and preference for selection of local candidates. States are free to select in-service candidates or candidates from the open market. If desirable, states can reserve a proportion of seats for women candidates. The recruitment process of Mid-Level Health Providers will be state specific but for ensuring transparency and quality in selection, each state will need to supervise and assist every district for initial screening of applicants based on the qualifications, followed by a written examination that the state conducts; with support from any suitable government organization/institutions/public/health university with expertise in conducting such exams for large scale quality selection of candidates. This should be followed by interviews to select the most competent candidates.

4.1.2 Roles

The Mid- Level Health Provider would broadly be expected to carry out public health functions, ambulatory care, management and provide leadership at the HWCs. They would be responsible for the following:

1. Ensure that all households in the service areas are listed, empanelled and a database is maintained- in digital format/ paper format as required by the state.
2. Provide clinical care as specified in the care pathways and standard treatment guidelines for the range of services expected of the HWC.
3. Clinical care provision would include coordinating for care/ case management for chronic illnesses based on the diagnosis and treatment plan made by the Medical Officer/specialists who will initiate treatment for chronic diseases, dispense drugs as per standing orders by the medical officer.
4. Such coordination could be facilitated through processes such as telehealth. However, MLHPs can also provide medicines as per the provisions of Schedule K, Item 23.
5. Focus attention in screening for chronic conditions on screening, enabling suspected cases confirmed and initiating treatment based on appropriate STGs or on basis of plans made by medical officer/specialists. As a team, ensure adherence, along with counselling and support as needed for primary and secondary prevention efforts. Such chronic conditions would include both non-communicable diseases and the chronic communicable diseases of tuberculosis, leprosy and HIV.
6. Coordinate and lead local response to diseases outbreaks, emergencies and disaster situations and support the medical team or joint investigation teams for disease outbreaks.
7. Support the team of MPWs and ASHAs on their tasks, including on the job mentoring, support and supervision and undertaking the monitoring, management, reporting and administrative functions of the HWC such as inventory management, upkeep and maintenance, and management of untied funds.

8. Support and supervise the collection of population based data by frontline workers, collate and analyse data for planning and report the data to the next level in an accurate and timely fashion. Use HWC and population data to understand key causes of mortality, morbidity in the community and work with the team to develop a local action plan with measurable targets, including a particular focus on vulnerable communities.
9. Coordinate with community platforms such as the VHSNC/MAS/SHGs and work closely with PRI/ ULB, to address social determinants of health and promote behaviour change for improved health outcomes.
10. Address issues of social and environmental determinants of health with extension workers of other departments related to gender based violence, education, safe potable water, sanitation, safe collection of refuse, proper disposal of waste water, indoor air pollution, and on specific environmental hazards such as fluorosis, silicosis, arsenic contamination, etc.
11. Guide and be actively engaged in community health promotion including behaviour change communication.

4.1.3 Training and Mentorship

The Mid Level Health providers would be trained in either Certificate Programme in Community Health, managed and certified by IGNOU/ state universities or have a B.Sc. degree in Community Health. The curriculum will enable the MLHP to attain a set of competencies related to public health and primary health care. In order to accommodate the needs of rapid scale up, states would be encouraged to partner with public /medical universities to also deliver the Certificate Programme. In addition, a modular course, while retaining the core competences would also be explored, combining theoretical and experiential components, and to enable the candidates to use a learning by doing approach.

To improve training quality states shall also institutionalize District Level Committee of Observers to monitor the ongoing trainings. These committees can have representation from-Service providers of NGO run hospitals/Nurse Training Colleges/Faculty of MPW Training Centres/Medical Colleges and Counsellors from programme study centres and may submit feedback to State NHM/District Health Officers/CMHOs on improvement areas if any.

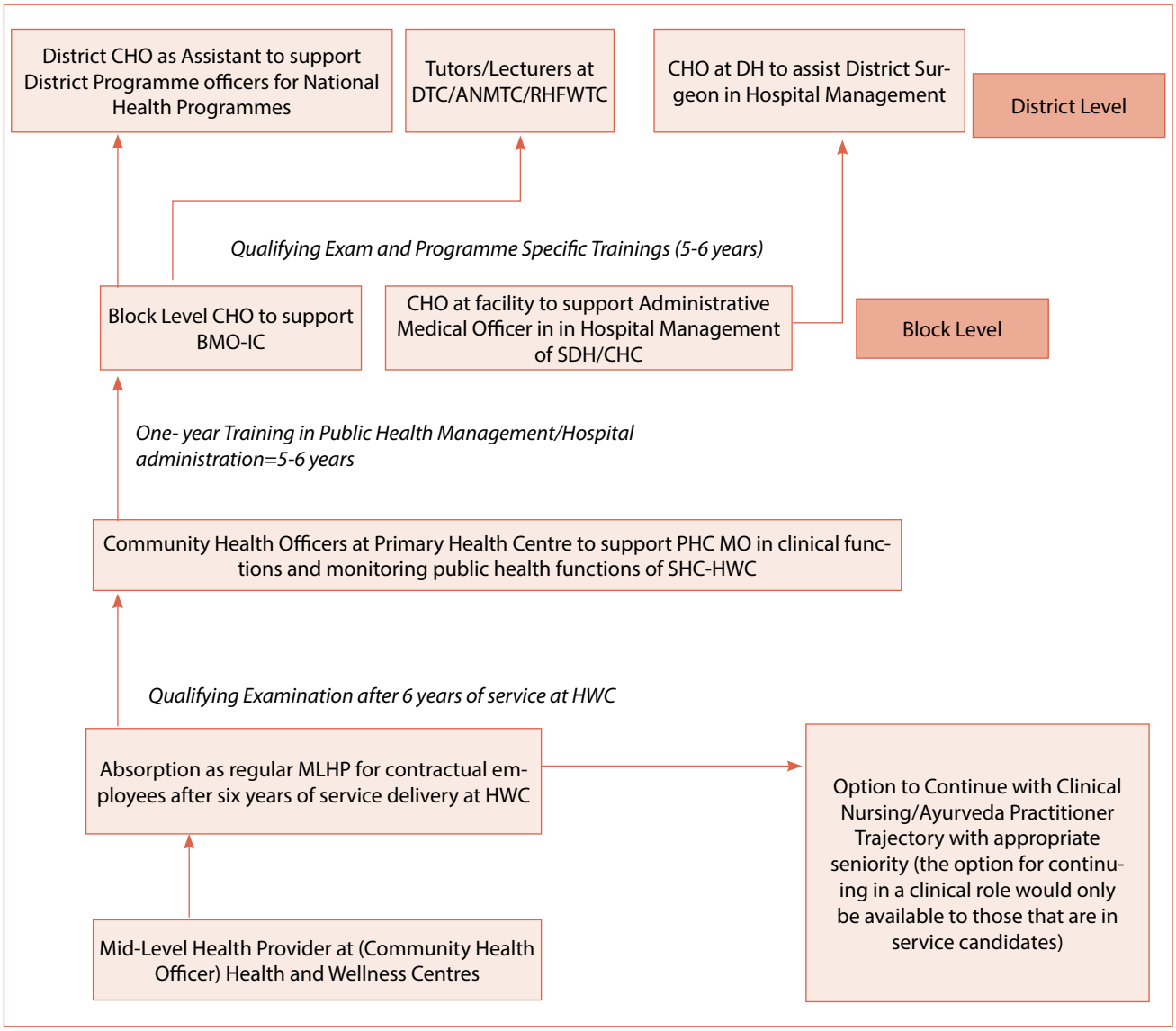
In addition, states will need to create a strong mentorship programme including through programmes like ECHO (Extension for Community Health Care Outcomes) for supporting the MLHPs through handholding, trouble shooting, problem solving, to enable building of technical competencies and sustaining motivation. The mentors could be drawn from schools of public health/medical colleges/district health teams/Technical support agencies and development partners.

4.1.4 Career Progression

As the programme matures, and for MLHP to see an aspirational future trajectory, avenues for career progression of Mid-Level Health Provider would be explored in public health functions up to block, and district level, in synergy with the public health cadre. The figure below shows a proposed career progression plan for the mid-level health providers.

While planning the career progression at block and district level, states have the flexibility to engage MLHPs in different areas as appropriate. Further, as means to ensure retention, preference or reservation of seats for MLHPs may be planned in other job opportunities at state/district level and in continuing Medical Education- MSc, PG-DPHM courses etc.

Figure 4.1: Suggestive Career Progression Plan for Mid- Level Health Providers



4.2 Multi-Skilling of other Frontline Health Workers

Frontline workers, and Service Providers posted at all levels would also be multi-skilled to address the mismatch in the services to be provided and present levels of training of primary care team members. The key principle is that as many skills as possible and appropriate at that level should be available within the team at the HWC, so that the services are assured to the population and the team is able to resolve more at their level including through telehealth with fewer referrals. MPW (M & F) would need skills to function as paramedics for undertaking laboratory, pharmacy and counselling functions. Similarly, at the HWC-PHC level, staff would be appropriately skilled to function as ophthalmic technicians, dental hygienists, physiotherapists, etc. Staff that opt to provide such services would be trained and equipped with specific skills, and be provided with additional compensation. The use of technology would be harnessed to undertake the training/multi-skilling given the sheer magnitude of the task. Platforms such as ECHO, Massive Open Online Courses, SatCom, etc. would be used. States will need to enter into partnerships with a range of academic and training organizations to help deliver such multi-skilling on an ongoing basis. See Table 4.1 on Human Resource Requirements, Skill Requirements and Training for details.

Table 4.1: Human Resource Requirements, Skill Requirements and Training

Facility	Human Resource Required	Skill Requirements	Training Requirements
Community Level	ASHA/1000 population or ASHA/500 population for tribal and hilly areas/ ASHA for 2500 population in urban areas	**Core skills:** • Community Mobilization, Communication, Negotiation, Leadership • Skills for community level management of Reproductive, Maternal, New Born and Adolescent Health care • Skills for identification, referral follow up care and ensuring treatment compliance related to communicable diseases-TB, Leprosy, Vector Borne Diseases etc. • Skills to address issues of marginalization and violence against women **Additional Skills:** • Population Enumeration and active facilitation for empanelment of families at HWCs • Community Based Health risk assessment for Chronic Illnesses • Health promotion, life style and health risk modification for management of common Non-Communicable Diseases • Skills for community level care provision for mental health, elderly care, ENT, ophthalmic care, palliative care etc.	• Eight Days of Induction Training • 20 Days of Skill based training in Modules 6 and 7 • Five Days of Training in Module for ASHAs on Non-Communicable Diseases • Supplementary trainings - refresher training and training on newer topics for about 15 days every year
Health and Wellness Centre	Multipurpose worker (F/M) SHC- 2 MPW (F) and 1 MPW (M), UPHC- one MPW (F) per 10000 population	**Core Skills** • Skilled Birth Attendant* • Essential New Born Care and stabilization of sick new born* • Assessment and Management of STIs and RTIs, Insertion and Removal of IUCDs; Management of Abortion and Adolescent Counselling* • Pregnancy Test, Haemoglobin, Urine Test and Blood Sugar* • Provision of immunization services and Management of Childhood Illnesses including timely referrals for malnutrition • Management of common ailments - fever, cough, diarrhoea, minor injuries and acute fever • Assessment, screening and management of communicable diseases-TB. Malaria, Leprosy, Kalazar and others • Organization of VHND and Special Day Health Clinics • Community based health education/counselling, life style management and health promotion for issues pertaining to RMNCH+A, Communicable and Non-Communicable Diseases etc. Reporting, inventory management, record maintenance and untied fund management • On the job mentoring support to ASHAs on a regular basis	• 21 days of SBA Training • 4-5 Days of Training for IUCD insertion, NSSK, HBNC Supervision, Management of Childhood Illnesses • Training on National Health Programmes as per programme guidelines • 3 days of Training on Universal screening, prevention and management of Non-Communicable Diseases • One-day joint training with ASHAs on universal screening of NCDs

Facility	Human Resource Required	Skill Requirements	Training Requirements
		Additional Skills • Screening for common NCDs-Hypertension, Diabetes, three common cancer-Cervix, Breast and Oral Cancer and timely referral and provision of follow up care, enabling periodic monitoring of BP, Blood sugar for patients on treatment • Support provision of first level of care for mental health, elderly care, palliative care, ENT, Ophthalmic care, etc. • Support to formation and handholding of Patient Support Groups • Skills to conduct some diagnostic test and dispensing of medicines as appropriate at the HWC level. • Skills to use digital applications wherever applicable for reporting, inventory management, record maintenance and use population based analytics • Maintaining Family Health Folders and Individual Health Records	• 3 days training on reporting and recording information using digital applications • 3-5 days training can be planned every year based on the expansion of range of services
	Mid Level Health Provider (MLHP)	• Public Health Skills • General Skills of Bio Medical Waste management, medicine dispensation, medicine refills and injections, suturing of superficial wounds • Laboratory Skills • Skills for Management of common conditions Fever, aches and pains • First aid Stabilization care for common emergencies • Maternal Health Skills • Reproductive and Adolescent Health Skills • Newborn and Child Health Skills • Skills to use digital applications wherever applicable for reporting, inventory management, record maintenance and use population based • Maintaining Family Health Folders and Individual Health Records • Supportive supervision of field level functionaries	• 6 months Certificate Programme in Community Health • 5-7 days Supplementary Training on new health programmes, new skills and refreshers every year. • 3 Days Training on use of IT application and telehealth • Regular monitoring/ training through ECHO platform
PHC	Two Medical Officer, Staff Nurses, Lab technician, Pharmacist, Lady Health Visitors	• Skills for provision of preventive, promotive, curative, rehabilitative and palliative care for expanded range of services • Skills for training and supportive and supervision of field functionaries of the concerned service area • Public health management involving: ◆ Implementation, monitoring and supervision of National Health Programmes ◆ Prevention and control of disease outbreaks/ epidemics, handling disaster situation ◆ Disease surveillance ◆ Administrative work, recording and reporting, conducting review meetings	• 10 days BEmONC training Basic Emergency Obstetric Care; 11+2 days F.IMNCI + NSSK; Safe abortion/MTP training, NSV skills, Conventional/ mini-lap training • Training on National Health Programmes as per programme guidelines for respective cadre

Facility	Human Resource Required	Skill Requirements	Training Requirements
		◆ Using population based analytics for capacity building and dialogues with primary care teams to improve health outcomes ◆ *Skills that can be planned phase wise in the long term* ◆ Skills in family medicine for Medical Officers to enable comprehensive and integrated care ◆ Multi-skilling of paramedic staff to function as an ophthalmic technician, physiotherapist, etc.	● 5 days training for PHC Staff to play a leadership role in the delivery of CPHC ● Online Certificate Course on Standard Treatment Guidelines/ Continuity of Care Protocols ● 5 days training in Population based screening, prevention and management of NCDs ● Other Distance mode certificate programmes in areas such as- Family Medicine/ NCD management/ MCH Care/Elderly Care/Mental Health etc. to be planned in long term ● Short term certificate courses for paramedic staff for multiskilling

** These functions will be undertaken by MPW (F).*

SECTION 5

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT)

The use of standardized digital health record and establishing a seamless flow of information across all levels of health care facilities is an aspirational goal. Such a system would take time to evolve. An IT system has been envisioned at the Health and Wellness Centres and will need to be inter-operable with the overall e- health architecture plans at the national and state level.

Use of Information Technology would be essential to enable efficient delivery of services at the HWCs. IT tool would support the HWC team in recording the services delivered, in enabling follow up of service users, in reporting to higher functionaries, and in population based analytics.

5.1. Key Functions of the IT system are as follows

5.1.1. Registration

- Empanel all individuals and families in the catchment area and update this database regularly when there is a new entrant into this area, or someone exits.
- Facilitate identification and registration of beneficiaries/ families for Pradhan Mantri Jan Arogya Yojana as per laid down criteria.
- Ensure that every family and individual have been allotted and are aware of their unique Health ID - which would also be used to seek services under various programmes such as RCH/ RNTCP/ NVBDCP etc and support beneficiaries to seek services under the PMJAY.
- Link the unique health ID with the AADHAAR ID at the back end in line with the current statute and Supreme Court directions.
- Identify and merge duplicates by verifying IDs.
- Create a longitudinal health record of each empanelled individual.

5.1.2. Service Delivery

- Record all services that are delivered at the HWC under different programmes.
- Enable follow up of services that individual patients are receiving by recording relevant parameters, diagnostic results, medication given etc.
- Send SMS/ reminders to individuals about the follow up visits.

- Facilitate clinical decision making for the service providers (based on standard treatment protocols).
- Track and support upward and downward referrals to support continuity of care.
- Ability to print key summary and prescription based on individual's requirement.
- Ability to provide standardized prescription, discharge summary and/or referral note which can be scanned/photographed or printed and uploaded as per requirement.
- Capture, store and transmit images to support teleconsultation, referral and follow up.

5.1.3. Management of Service Delivery

- Capture service delivery coverage and measure health outcomes using population-based analytics.
- Generate work plans for the teams with alert and reminder feature for services providers to support scheduling of appointments, follow up home visits and outreach activities.
- Use the service delivery data to validate use of services and enable Direct Bank Transfers to beneficiaries wherever required.
- Support Birth and death registrations and disease surveillance.
- Capture record of other preventive and promotive services delivered, like vector control etc.
- Send appropriate IEC/BCC messages.

5.1.4. Logistics

- Support Inventory management and regular supply of medicines, vaccines and consumables by linking with DVDMS – Drugs and Vaccines Delivery Management Systems.
- Support biomedical equipment maintenance of all equipment by maintaining database for equipment at HWC.

5.1.5. Capacity Building

- Provide Job aids (in the form of flow charts or audio/ video aids) for continuous learning and support of the primary health care team.
- Support access to Massive open online courses (MOOC) and use of platform such as ECHO for regular capacity building and problem solving for HWC teams both at SHC and PHC level.

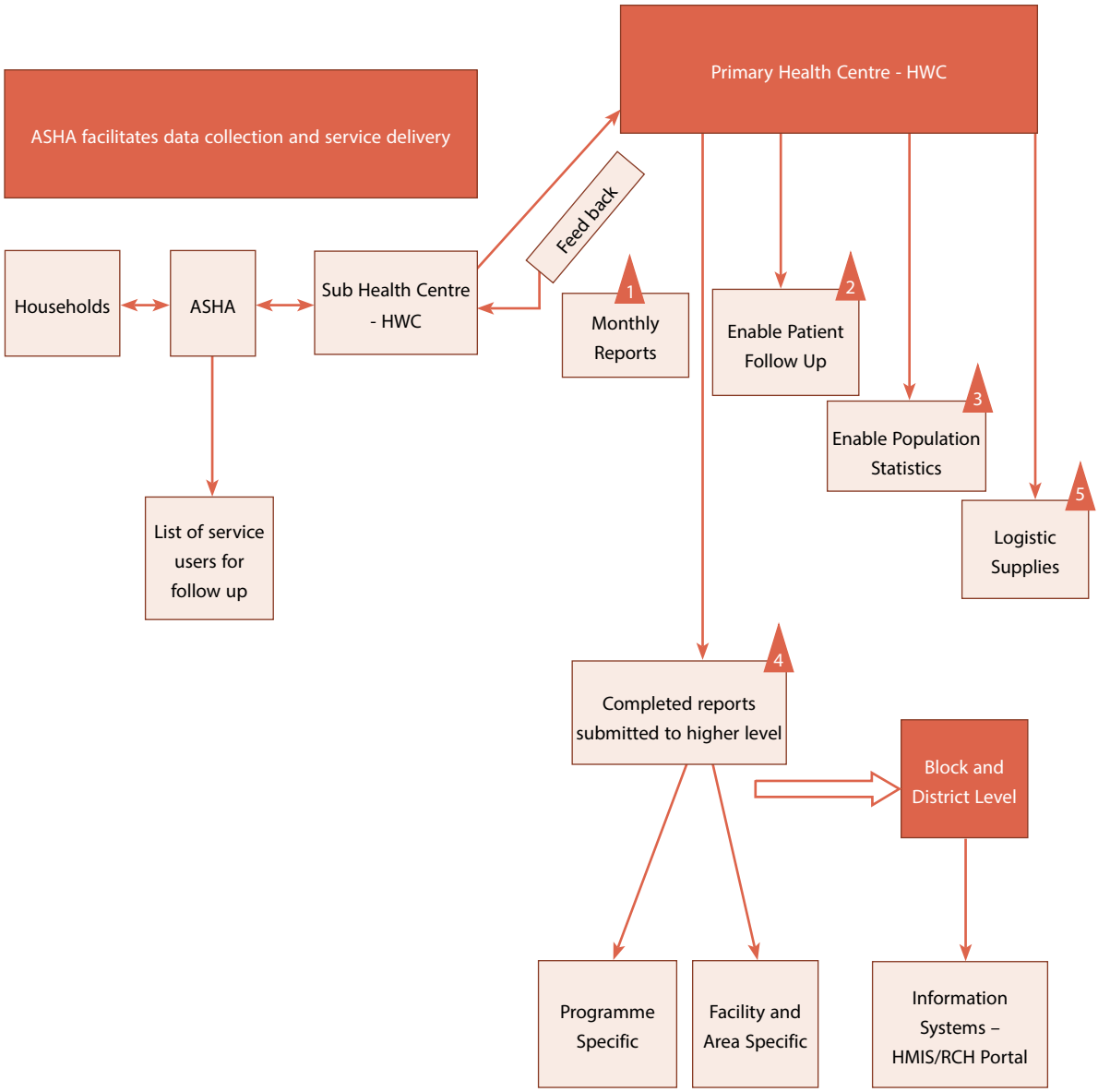
5.1.6. Reporting and Monitoring

- Generate population-based analytics reports for routine monitoring and to assess performance of health care providers.
- Support in generating performance matrix for all service providers, calculating incentives from the service transaction data in the system.

5.1.7. Teleconsultation

- Capture and transmit images, prescriptions and diagnostic reports for teleconsultation.
- Support video call using platforms like zoom and skype to connect with hubs identified for teleconsultation.

Figure 5.1: Flow of Information



A core design principle to be followed while building CPHC IT system should be to support needs of diverse stakeholders and strengthen service providers in undertaking their tasks with greater quality and efficiency, and that the data required for monitoring and reviews by programme managers at different levels becomes available.

The IT system would reduce the burden of data recording and reporting for front line workers and service providers to less than 10% of their total time. Once the digital system has been made operational, and all connectivity related challenges have been addressed, a gradual phase out of paper-based records and registers can be planned, if the system can make paper prints out available to meet the requirement of regular submission of Health Sub-Centre based reports for systems such as HMIS, IDSP, RCH portal and other national health programme specific reports.

Key Requirements

- Adherence to applicable standards laid down under Metadata and Data Standards for Health (MDDS) and EHR standard developed by MoHFW.
- Ensure security and data privacy by providing secured role-based access system coupled with end-to-end encryption. The system should adhere to the data privacy and security standards as per HER standards. In addition, a detailed logging system with essential audit trails (for critical read/write/modify/delete operations) and error reporting (android/mobile app notifications and emails) should be made operational.
- Configurability i.e., developed as a platform on which the various programs, state specific variations, family/ individual profile can be created - using metadata, configuration, pluggable user interface templates and rules. This would support- a) Addition of new programmes, b) Change in program definition over time and c) customization according to the local context and for various programs.
- High level of interoperability to integrate with state level MIS, RCH portal and other programme systems functional at national and state level. The integration architecture should be compatible with the recommended approaches in the MDDS for Health document and EHR standards.
- Ability to manage large data volumes i.e. approximately 6,000 active individual health service records as part of about 1000 active family health records at Health Sub Centre level. System would be horizontally scalable by addition of servers as to manage the high user load / data volume such that performance of the system is not compromised.
- Ability to function on offline mode – (even when Internet is unavailable for long period) and allow for auto or manual synchronization of data without any data loss when connection is available
- Application should be upgradeable via single click or auto-upgradeable by the end user without requirement of any additional technical support.

In order to ensure smooth introduction and functioning of the IT system, there will be need to deploy a support team that has the command over the functioning and technical details of the software system and will provide training to the end users, systems managers at the district, block, and HWC level. This team would also support in troubleshooting field level implementation issues from time to time.

Note – Population enumeration and database creation can start even without the software application base being in place. The data base of the population in catchment area and the registration of the population for chronic diseases should be started off in parallel with the upgrade of HWCs.

It is possible that data on basic demographic information may be available from existing population- based database such as- Socio economic Caste Census (SECC), Aadhaar, Public Distribution System, National Population Register etc and states can plan for obtaining such recently done survey data on migration if available. However, migration and import of this data in the software system should be followed with verification by house to house visits by the field level functionaries or verification at the time of empanelment in the Health and Wellness Centres. Authentication of service users is also possible at the time of service delivery – by using biometric, OTP, or backend analytics of photograph, if required.

SECTION 6

PLANNING, LOCATION AND INFRASTRUCTURE UPGRADE FOR HEALTH AND WELLNESS CENTRE

6.1. Road Map and Planning for HWCs

Several states are now moving forward with the implementation of Health and Wellness Centres. Overall, the designing, upgrading and establishment of HWCs should be such that states are able to achieve an equitable distribution of health care with an efficient utilization of resources. Steps for states to follow while planning HWCs are discussed below. The State, District and Sub district planning would vary based on local context and states should adopt the guidelines to suit their needs.

6.1.1 Developing a Road Map

- The first step for each state is to develop a short to medium term road map with number of Health and Wellness Centres that will be created over a five-year period and also develop robust and objective annual plans with specific targets for the state and district level to improve access to the CPHC facilities, keeping in mind local context and capacity.
- The plan should define target of the number of facilities (PHCs/Urban PHCs/ Sub Health Centres) that can be upgraded to effectively deliver expanded range of services on a year on year basis.

6.1.2 Phasing and Identification of Districts

- States should plan for a phase wise scale-up indicating districts that will be included in each phase.
- Conforming to the overall principles of equity, selection of those districts should be prioritized in the initial phase, which align with the 'Transformation of Aspirational Districts' Programme of Government of India. The programme for Universal Screening Prevention and Management of Common Non- Communicable Diseases has been rolled out in all the states and has been prioritized in districts where the National Programme for Control of Cancer, Diabetes and Cardiovascular Diseases has been well implemented. An overlap of Health and Wellness Centres with districts selected for Universal Screening of NCDs should be planned to leverage pre-existing investment in health systems to deliver care for NCDs.

6.1.3 Selection of Blocks

- Once the plan and phasing across the districts is clear, states should select the blocks, which would be taken up for creating HWCs. Within a district, the programme may be commenced in good performing blocks with human resources and better referral support. While doing so, simultaneous

attention will be required to identify and address HR/infrastructure gaps in other blocks to gradually include them in HWCs development plan for future phases.

- The plan should be to take up all SHCs and PHCs within any chosen block for upgradation into HWCs. In certain contexts, block saturation will be a challenge owing to constraints in availability of human resources, infrastructure, and geographic inaccessibility. In such cases, in the first year, state may plan to operationalize HWCs in 60-70% Sub Health Centres in the selected block and undertake necessary measures to strengthen HR and infrastructure in remaining Sub Health Centres so as to make them functional by next year. Within a block, such PHCs that are relatively well performing with MBBS MO should be prioritized for transforming as HWC. SHCs which are linked to these PHCs can be upgraded to HWCs to maintain continuum of care.
- The block level plan should identify facilities, which can serve as referral centre or for the cluster of HWCs. The referral center may vary for different services depending on the nearest site where the necessary skills are available. Thus, the MO in the PHC would be adequate for initiating treatment for chronic communicable diseases but for attending to a patient with a serious mental illness/NCD, consultation with concerned specialists at the nearest facility would be needed. However, the bulk of such referral needs are likely to be attended at the Sub-Divisional Hospital, a FRU- CHC or a Block PHC.
- Sub Health Centres for upgrading as Health and Wellness Centres should be prioritized:
    a. Where a community of about 3000- 5,000 populations is not within the reach of a PHC/ Block-PHC /CHC or a Sub-Divisional Hospital within 30 minutes.
    b. Where population coverage of Sub Health Centres could be lower but access available to serving population is constrained due to geographic access or otherwise and travel time to reach the Sub-Centre from the most remote place in the coverage area is more than half an hour.
    c. Where progress of health indicators is significantly lower than the block/district average due to social and cultural barriers of access such as the case of tribal hamlets, villages with high density of marginalized and vulnerable population groups etc.
- The Sub Health Centres situated within a distance of 1-2 km from the referral centres could be upgraded as Health and Wellness Centre at a late stage if required.
- However, population covered by these centres should be linked with the designated referral centre and population empanelment, health risk profiling and other outreach activities for CPHC services will continue to be provided by the team of Multi-Purpose Workers and ASHAs.

6.2 Infrastructure for Health and Wellness Centres

- Ensuring adequate infrastructure for the delivery of Comprehensive Primary Health Care and Health and Wellness Centres would need to cater to a population size as per IPHS norms for Sub Health Centers- one per 5000 population in all areas and one per 3000 in tribal, hilly and desert areas. Where currently sub-centers are catering to much larger population, their numbers need to be increased.
- Planning for infrastructure upgrade succeeds the finalization of number and type of facilities designated as Health and Wellness Centres. Most states have completed the development of infrastructure for PHCs/Additional PHCs, UPHC but there will be a need to undertake minor civil repair and infrastructure upgrade for existing buildings for meeting necessary gaps in enabling these centres to deliver patient friendly services.
- Patient reception and registration centers, citizen charters, electronic display boards for services, provision of sitting arrangement of patients, other amenities in the waiting area, TV screens for health communication, facilities for people with disabilities, provision of privacy for patient examination area/ examination table, good quality lab, pharmacy, a wellness room for conducting physiotherapy/

Yoga sessions, rehabilitative services, separate toilets for males and females etc. may be included in infrastructure upgrade.

- Major civil infrastructure upgrade would largely be required for developing the Sub Health Centres as Health and Wellness Centre. Essential requirements for strengthening a SHC to serve as a Health and Wellness Centres are:
  - A well-ventilated clinic room with examination space and office space for Mid-Level Health Provider/Community Health Officer.
  - Storage space for storing medicines, equipment, documents, health cards and registers.
  - Designated space for lab/diagnostic.
  - Separate male and female toilets.
  - Deep burial pit for Bio Medical Waste Management.
  - Proper system for drainage.
  - Assured water supply that can be drawn and stored locally.
  - Electricity supply linked to main lines or adequate solar source, inverter or back-up generator as appropriate.
  - Patient waiting area covered to accommodate at least 20-25 chairs.
  - Repairs of roofs and walls, plastering, painting and tiling of floors to be undertaken as per requirement.
  - Space/room for Yoga if adequate space for expansion is available.
  - Adequate residential facilities for the service providers.
  - Rain water harvesting facilities may be planned if required.
- Once the numbers of SHC to be upgraded as Health and Wellness Centres are final the identified blocks will need to systematically map Sub Health Centres: with and without buildings.
- For a PHC- HWC, infrastructure would be as per current Indian Public Health Standards.
- The concerned Block Medical Officer and a representative from the Engineering wing at the district level will do a joint site inspection and complete gap analysis for repair/renovation in existing buildings. The analysis should be based on the essential requirements stated above and will support in estimating necessary financial resources.
- A costed prototype for planning civil modification of existing Sub Health Centres buildings and new construction will be made available by Ministry of Health and Family Welfare, Government of India.
- States and district should consider the earmarked fund support of 7 lakh/SHC-HWC or 4 lakh PHC-HWC as a pooled grant rather than fixed grant per facility for infrastructure modification.
- When new construction is being planned, location of HWCs should be decided through a consultative process involving community, gram panchayat members, community forest rights committees, frontline health functionaries, Block Medical Officers and others. Construction of new building should be preferably undertaken in a central location with high population density and not in peripheral sites of the villages. Acquiring of land for this purpose would be a priority for the district.
- To save time and optimize resources, identification of government buildings available with other departments could be prioritized for operationalizing HWCs after necessary renovation.
- Old dilapidated buildings should be considered for renovation only after careful review of resources required. Wherever existing sub-centres are in dilapidated condition, it will be more cost effective to plan for a new HWC.

- Though financial provision for repair and new construction are made available under the National Health Mission, resource mobilization for new construction could also be explored from different government programmes such as- Members of Parliament/Members of Legislative Assembly Local Area Development Scheme, Labour component support available under Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA), District Mineral funds wherever applicable, Untied funds available with Local Self Governments in urban and rural areas, District Innovation Funds and other state government development programmes. Funding under NHM say, 50% support, should be provided to leverage support from above mentioned potential sources. Support from Corporate Social Responsibility and philanthropic organizations, NABARD, special funds like tribal affairs, minorities may also be explored.
- Convergent action will be needed at district level to identify land for new construction of HWCs. The MLHP/MPW (M/F) should be involved in site selection. This should be close to community and have access to essential amenities.
- Private buildings could be taken on rent, may be as an interim measure, however; the buildings identified should adhere to the specified infrastructure norms for strengthening a sub health centre to serve as a Health and Wellness Centres as much possible.

SECTION 7

MEDICINES, DIAGNOSTICS AND OTHER SUPPLIES

The credibility of a Health and Wellness Centre rests on the availability of essential medicines and diagnostics for a wide range of health care needs of the population served by the HWC. In line with the paradigm shift envisaged, the HWC will provide a broader range of services and this necessitates expanding the list of essential medicines and diagnostic services currently available.

7.1. Medicines at HWC

Medicines listed as per essential list of medicines for a PHC/Sub health Centre need to be ensured at respective HWCs. Additional medicines will be required at the HWC as the range of services expands. Suggestive essential medicine list for a SHC-HWC is at Annexure 1. The indicative list of medicines is as per National List of Essential Medicines 2015, this will be updated periodically based on new protocols and states will have the flexibility to adapt the list as appropriate.

Certain medicines for treatment of identified patients with chronic diseases (Hypertension, Diabetes Mellitus, Epilepsy, Chronic Obstructive Pulmonary Disease, Mental Disorders, and patients requiring palliative care) can be indented by the Mid-Level Health Provider, from the PHC/referral center essential medicine list. For a patient suspected of a chronic disease, confirmation and initiation of treatment will be by the Medical Officer at the PHC or a higher referral centre. However, for continuation of treatment, medicines will be dispensed at SHC-HWCs by MLHP to avoid patient hardship and ensure that the clinical condition is monitored regularly.

Based on the records in the health folder (electronic/manual), the MLHP will generate each month, a list of patients on treatment for chronic illnesses in the population served by HWC. The IT system envisaged at the HWC level would help the MLHP in stock management and estimating the requirement of medicines based on actual caseloads. According to the patient list, the MLHP can indent medicines from PHC- EML/ referral centre- EML for a three - month period per patient. The medicines are provided every month to the patient. Patients would be encouraged to come to the HWC so that their health status can be monitored. Home based distribution is recommended only for patients who are not able to travel. A list of these medicines is attached in Annexure 2.

7.2. Diagnostics to be available at HWC

The HWC should have the capacity to deliver a minimum range of basic diagnostics and screening capabilities for conditions that are mandated to be screened/treated at this level. Diagnostic services as per the Guidelines for National Free Diagnostic Initiative need to be available at HWC (SHC-7 and PHC-19 investigations). In addition, a Peak Flow Meter and Snellen's and Near Vision Chart are recommended for inclusion at SHC-HWCs.

7.2.1. Point of Care Diagnostics

There is a plethora of diagnostics, several of them are "point of care" that are currently available. However, the choice of those that need to be included should be taken after validation and Health Technology Assessment. On completion of HTA, states may consider use of the innovative diagnostics solutions from those empanelled through Government E-Market Place. Pilots on use of innovative diagnostics solutions may be planned and linked to innovation portal of NHM for further validation and Health Technology Assessment.

7.2.2. Hub and Spoke Model

With regards to the diagnostic services at the HWC, the primary objective is to minimize the movement of the patient and improve the timeliness of reporting. This can be achieved by following the hub and spoke model by creating the hub (Central Diagnostic Unit) at CHC or block level PHC for 20-30 HWCs, depending on the distance and population served. State will need to define context specific protocols for peripheral collection of samples from HWCs.

At the level of PHC- HWC, availability of diagnostics and medicine would be ensured as per the existing IPHS and Essential Medicine List PHC. A suggestive list of diagnostics to be available at HWC and CDU is attached in Annexure 3.

7.3. Rational Use of Diagnostics and Medicines

Medicines and diagnostics at the HWC should be made available as per the specified clinical pathways and standard treatment guidelines for all services. Clear treatment protocols ensure the correct and efficacious use of medicines and diagnostics. Monthly review meetings at sector PHC/ CHC will be a platform for dissemination of updated standard treatment protocols to the primary health care team. Service providers- MLHPs, MPWs and PHC staff will need to be trained to undertake counselling for rational use of medicines and appropriate consumptions based on treatment plan. States/Districts should plan for periodic prescription audits, robust quality checks on quality of medicines, use of IT system for ensuring rational use of medicines and diagnostics through periodic training of members from primary care team.

7.4. Equipment and Supplies at HWC

Equipment as well as consumables will be added at the HWC level in accordance with the expanded range of services. Similar to medicines, certain consumables will be indented by MLHP as per requirement from PHC/ referral centre. E.g. for home based palliative care of a patient in area catered by SHC-HWC, a kit will be maintained by MLHP at HWC and required consumables will be indented. Indicative list of items for Equipment and Supplies is attached in Annexure 4. The list of equipment is exhaustive and can be made available in incremental manner as range of services expand and budget provision increases.

7.5. Streamlining Supply Chain Logistics

In order to provide the assured set of services detailed in the previous section, availability of essential medicines and developing basic diagnostic facilities at the HWC is a priority. Issue of poor outcomes related to supply side deficiencies need to be addressed for this. Assured medicine availability closer to the homes of patients would support in treatment compliance for long term illnesses where patients generally discontinue the treatment due to the challenges of medicine refills. It would also have an impact on the levels of out of pocket expenditures and establish the credibility of public health care delivery system.

The first step would be to make all medicines as per the SHC- EML and consumables, equipment for diagnostics listed as per the SHC- Indian Public Health Standards available at the HWC. Subsequently,

additional medicines and equipment as well as consumables for diagnostics will be added at the HWC level in accordance with the expanded range of services.

The Essential Medicine List will guide the procurement and supply of medicines. The DVDMS system needs to be extended to the PHC level in those states where it is operational and be enabled on a priority basis where it is yet to be implemented. In future, efforts will be made to incorporate demographics of patients in e-Aushadhi software- and enable linkage with patient wise consumption data to estimate real time need.

In order to ensure free medicines and diagnostics, the state will have to ensure a state level robust system for procurement, involving real time utilization based indenting, well timed tendering, finalization of technical and financial bids, measures of rate contracting etc. A streamlined distribution, logistics and quality assurance is required that allows supply chain management to be responsive to changing and diverse patterns of consumption of consumables across facilities.

7.6. Planning Equipment and Supplies

SPMU/DPMUs could plan to provide equipment and supplies under the following categories to enable delivery of quality Comprehensive Primary Health Care services:

- Medicines and Vaccines
- Clinical Tools, material and equipment
- Linens and Consumables
- Furniture and Fixtures
- Laboratory and Diagnostic Materials

Most of these equipment and materials indicated in annexure would be available in the existing Health Sub health Centres. An efficient utilization of resources would demand a sub-centre wise gap analysis of available materials to avoid duplication and plan procurement only for those items, which are either not available, not functional or required in additional quantity.

** In case of creating HWCs at the PHCs, additional provision can be made for equipment at Wellness Room, which would involve-basic physiotherapy equipment, tools for exercise, mats etc. for arranging yoga sessions. In addition, a spirometer needs to be available at PHCs linked to HWCs, for confirmation of COPD.*

SECTION 8

QUALITY OF CARE

To ensure effective delivery of primary health care services, it is essential that protocols for quality assurance are institutionalized at HWC. Mere availability of services is not enough and the services need to be accessible, safe, patient-centred, acceptable, equitable and provided with dignity and confidentiality. In order to assure that quality standards are followed. the following critical measures should be taken:

a. Provision of Patient Centred and respectful care.
b. Enable Patient Amenities at HWC.
c. Adhere to standard treatment guidelines and clinical protocols for care provision.
d. Achieve Indian Public Health Standards with regards to HR, infrastructure, equipment, service delivery and supplies.
e. Implement the National Quality Assurance Standards for public health facilities, by focusing on eight critical areas - a) Service provision, b) Patient rights, c) Inputs d) Support services, e) Clinical services, f) Infection control, g) Quality management and h) Health outcomes.

8.1. Patient Centred Care

The care in the community, at outreach and at the HWC should be responsive to needs, respectful and meet the aspirations of individual service users. It should be delivered in ways that take into cognizance the dignity of the individual, the needs and circumstances of the family, and the culture of the community. The HWC has been conceived so that the smaller populations, the team based approach and the availability of a large number of services enable a more improved patient provider relationship, and the establishment of trust in the public health system.

8.2. Standard Treatment Guidelines

Compliance to Standard Treatment Guidelines would enhance safety and improve patient outcomes. It would also enable parameters of uniform standards of care delivery among service providers across different levels of care and would facilitate continuity of care for patients. The STGs would enable identification of medicines that can be dispensed and administered at the primary care / HWC level. In addition, STGs would define for each level of care, the management of the specified condition with referral linkages, requirement of medicines, diagnostics, consumables and skill sets required. As an immediate step, states should ensure that all existing Standard Treatment Guidelines under various national health programmes are available at HWC level and are adhered to through close supervision and monitoring.

8.3. National Quality Assurance Standards (NQAS)

National Quality Assurance Standards (NQAS) will be developed for HWC. The primary health care team would be trained to assess and improve key processes to deliver safe, timely, and accessible care. Similar to the process of accreditation followed in case of other facilities, the achievement of accreditation in HWC would also enable recognition and awards.

Other quality measures include implementation of Infection Control Measures, Biomedical Waste Management, and patient satisfaction and survey measures.

Key points to consider while ensuring quality:

- Experience from implementing NQAS in preparation for certification indicates that while availability of standards is crucial, it does not actually translate in to outcomes.
- Provider competency, behaviour, attitude and efforts are critical for delivering quality services, particularly at the HWC level, since this will serve as the first point of entry in to the system. Provider performance will in turn depend upon training, availability of STGs, protocols, supervision, and feedback.
- The MoHFW is in the process of developing standards for process and outcomes for ambulatory care, particularly focussed on effectiveness and patient safety.

SECTION 9

HEALTH PROMOTION, COMMUNITY MOBILIZATION AND ENSURING WELLNESS

9.1. Health Promotion and Social Behavioural Change Communication

Health promotion and information provision at the community level is an integral part of the expanded range of services under Comprehensive Primary Health Care. Health is affected by various social and environmental determinants and actions to address these issues often do not fall in the purview of health systems alone and therefore requires intersectoral convergence and people's participation.

The Health Promotion strategy recommended by the National Health Policy 2017 emphasizes institutionalizing intersectoral coordination at national and sub-national levels to optimize health outcomes, through constitution of bodies that have representation from relevant non-health ministries. This should be in line with the emergent international "Health in All" approach as complement to Health for All.

As envisioned in the policy, States should plan for a coordinated action on seven priority areas for improving the environment for health as part of CPHC:

- The Swachh Bharat Abhiyan.
- Balanced, healthy diets and regular exercises.
- Addressing tobacco, alcohol and substance abuse.
- Yatri Suraksha – preventing deaths due to rail and road traffic accidents.
- Nirbhaya Nari –action against gender violence.
- Reduced stress and improved safety in the work place.
- Reducing indoor and outdoor air pollution.

States will need to develop strategies and institutional mechanisms in each of the seven areas, to create "Swasth Nagrik Abhiyan" –a social movement for health in the form of Jan Andolan. Indicators and targets could also be defined to track progress for achievement in each of these areas.

9.2. Target Groups for Health Promotion

Given below are few examples of health promotion strategies that can be planned for different target groups. These are only illustrative and need to be expanded to develop a context specific health promotion strategy based on local needs.

9.2.1. General Population

This group is targeted for primary prevention.

Example:

- Population education on life style modifications such as healthy diet, regular exercise to prevent cardiovascular diseases and diabetes.
- Organizing sanitation drives for clean surroundings to prevent the spread of communicable diseases- malaria, gastroenteritis etc.
- Nutrition counselling in adolescents and women in reproductive age group to address issues of low birth weight in new-borns, promotion of early initiation of breastfeeding to prevent childhood illnesses.
- Displaying information by shopkeepers and retailers on High Fat Salt and Sugar (HFSS) Display Board with information on the daily FSS requirement that is not to be exceeded etc.
- Including section on healthy diets and arranging special session to promote health nutrition habits in school going children etc.

9.2.2. Population at Risk

This is for population groups, which have high risk of developing a disease/disorder and has higher exposure to risk factors**.**

Example:

- Targeted Behavioural Change strategies for population at risk of HIV/AIDS such as- female sex workers, MSM, truck drivers, migrant labours etc. and planning interventions to promote healthy behaviours that include messages to- decrease the number of sexual partners, safe sexual intercourse, counselling and testing for HIV, adherence to biomedical strategies -decrease sharing of needles and syringes, and decrease substance use etc.
- Ensure regular screening of adults for NCDs.

9.2.3. Individuals with Symptoms

This is for individuals and population groups who show obvious signs of a disease condition.

Example:

- Home visits by frontline functionaries for early identification of symptoms, prompt referral and follow up of cases like high-risk pregnancies, high-risk new born, malnourished children, and passive surveillance for malaria etc.

9.2.4. Population with Known Disorders

Example:

- Individual and family counselling- for treatment compliance and lifestyle modifications through home visits by ASHAs as part of interventions for NCDs, disease- based patient support groups –for improved compliance, IEC activities using patient education leaflets, banners, posters, etc. for NCDs and other morbidities.

Note: *Health promotion is not restricted to health education and behaviour change communication; but it has a broader perspective and includes all responsive measures discussed above; which have a direct or indirect bearing on health such as inequities, changes in the patterns of consumption, environment, cultural beliefs etc.*

9.3. Ensuring Wellness and Health Promotion through YOGA and Mainstreaming of AYUSH

Under Ayushman Bharat India's rich tradition of indigenous health, system and Yoga will be mainstreamed into the health care delivery system, by actively engaging practitioners of these systems. Health and Wellness Centres provide a sound platform for enabling this integration. This will require close coordination with Ministry of AYUSH/Department of AYUSH at the state and district level. To operationalize integration with Yoga and AYUSH, states and districts will need to:

- Identify a pool of Local Yoga Instructors at the HWC level. These could be an ASHA, ASHA Facilitator, Physical Instructor from village school, representatives from VHSNC, or other NGO groups active in community.
- Plan for systematic graded training and certification of these local Yoga Teachers. Department of AYUSH will lead this activity by identifying a pool of YOGA experts/YOGA schools who can undertake this training at the state/district/Sub-district level.
- Fix and widely disseminate weekly/monthly schedule of classes for Community Yoga Training at the HWCs. If space permits these classes could ideally be held in premises of HWC or in the nearby school, Panchayat Bhawan or even AWC.
- Earmark and disburse incentive/honorarium for these YOGA teachers that could be provided on a per session basis.
- Fix one day a week for conducting Ayurveda Clinics. These will particularly aim for useful diet counselling, management of chronic aches and pains, elderly care etc.

9.4. Agents and Platforms for Health Promotion

9.4.1 Mid-Level Health Provider

MLHP will provide individual and family based health promotion in HWCs and community. The MLHP will coordinate the health promotion activities via frontline workers, VHSNCs/MAS/SHGs/NGOs and patient support groups. The MLHP will ensure that it reaches all segments of population.

9.4.2 ASHA

- ASHAs have been an important community level resource to improve access to health care services in the areas of RCH and communicable diseases. The shift from 'selective primary healthcare' to 'Comprehensive Primary Health Care' would require ASHAs to play a key role as member of primary health care team at HWC. Continuing to perform their three roles– that of a facilitator, health activist and service provider at the community level she will be vital in improving access to care and undertake health promotion activities. However, focus of her work will now encompass wider range of services of RCH and communicable diseases to new services such as management of common NCDs, ophthalmology, oral health, elderly and palliative care. ASHAs would be able to provide the new services being rolled out under CPHC.
- As some of these conditions are chronic involving long-term treatment and life style modifications for management, ASHAs would need additional capacity building to undertake the tasks of health promotion, timely referral and active follow up for compliance.
- Health Promotion by ASHAs would use the same principles of listing the target population, community mobilization, supporting the HWC team in organizing camps (like VHNDs/ UHNDs) on a periodic basis, reaching the marginalized, support treatment compliance and follow up similar to follow up of her existing beneficiaries (pregnant women, new born and TB/ Leprosy patients etc).

- The long-term management of chronic illnesses requires active engagement of community members also. ASHAs would need to play the lead role in formation and functioning of disease specific patient support groups. They would also support the Village Health Sanitation and Nutrition Committees/ Mahila Arogya Samitis in community level planning and action and building accountability measures at the community level.

9.4.3. Village Health Sanitation and Nutrition Committees, Mahila Arogya Samitis, Self-Help Groups, Women Collectives

- VHSNC/ MAS are key community level forums to facilitate intersectoral convergence, local planning and action to address issues related to access and quality of care. They should lead the community action plan for surveillance and action on vector- borne disease control programmes, addressing risk modification for common NCDs, and undertaking social health campaigns for health promotion.
- VHSNC/ MAS should also engage with existing women groups and ensure greater participation of women to enable gender equity and promoting women's health issues. VHNSC should actively involve with Panchayat Raj Institutions representatives to build capacities for community level planning, action and monitoring to address social determinants of health. In urban areas, MAS would need to work closely with the representatives of Urban Local Bodies and existing community-based groups. Such joint efforts would be useful to undertake activities such as addressing sources reduction for vector borne diseases, promoting regular exercise and sports to promote healthy life styles, supporting the primary care team in outreach activities, reaching remote hamlets, and acting against alcohol, tobacco and other forms of substance abuse.
- The VHSNC/MAS, ASHA and her support mechanisms will play a critical role in delivery of Comprehensive Primary Health Care by demand generation for Health and Wellness Centres. They will need to undertake large-scale community level IEC activities planned in the form of campaigns, distribution of print materials and through folk programmes. These campaigns would inform the community about services offered at HWCs.
    - Details of the service providers-Multi-purpose workers, ASHA, Mid-Level Health Providers and PHC Medical Officers.
    - Benefits of HWC (closely accessible, Medicines available for all common ailments, collection of medicine refills, reduction in the chances of incurring out of pocket expenditure by families etc.)
    - Opening hours and location, importance of enrolment in HWC and availing the first screening services.
- These agents of Health Promotion will also play a critical role in building awareness for the other pillar of Ayushman Bharat-The PMJAY and inform the community about the various government schemes for financial risk protection and in helping the people understand where to avail, how to avail these schemes, who are the providers, what are specific entitlements under these schemes and what are the mechanisms of linkages for availing these health insurance benefits.

States will need to develop a monthly calendar of activities/campaigns/meetings for engagement of VHSNCs/ MAS. This will support in organizing systematic action on health promotion activities to be undertaken by these groups.

9.4.4. Patient Support Groups

- Formation of Patient support groups is facilitated by the MPWs/ASHA or other frontline workers around particular disease conditions to improve treatment compliance and engaging not only those with the disease condition but also family member.

- They are a useful mechanism to improve treatment compliance and engaging not only those with the disease condition but also family members. PSGs provide a platform wherein patients with similar illness and their family members or caregivers can have an open discussion about the disease, challenges associated with the illness and its treatment.
- Such groups would help patients and their family members by providing mutual support, providing information about diseases, raising awareness about complications, countering discrimination and stigma attached to a particular disease and enabling support for treatment continuation and changes in lifestyle behaviour.
- The ASHA should be actively engaged in facilitating these group discussions and must ensure that individuals from marginalised groups with the same disease condition are supported to become part of these groups.

9.4.5. AYUSHMAN Ambassadors

- In addition to Health and Wellness Centres and Pradhan Mantri Jan Arogya Yojana, the Ayushman Bharat aims to create about 2.2 million Health and Wellness Ambassadors in 1.1 million public schools for prevention and promotion of diseases among school children.
- The Ayushman Ambassadors or the Health and Wellness Ambassadors will be schoolteachers (one male and one female) who will be responsible for age appropriate learning for promotion of healthy behaviour and prevention of various diseases at the school level. This programme will ensure age appropriate skill-oriented, theme-based sessions for schoolchildren for which "Health and Wellness Ambassadors" will be trained in graded curriculum to implement the activities at primary, middle and high school level.
- The training will help to transact health promotion and disease prevention information in the form of interesting activities for one hour every week. 20-hour sessions will be delivered through weekly structured interactive classroom-based activities.
- Every Tuesday will be dedicated as Health and Wellness Day in the schools.
- These health promotion messages will also have bearing on improving health practices in the country and students will act as Health and Wellness Messengers in the society. This will help them, their parents and the families these students raise in future. Regular reinforcement of messages/ themes through IEC/BCC activities such as interactive activities/posters/class room/Assembly discussion and field level will need to be undertaken. Existing teacher capacity building mechanism and infrastructure of District Institute of Education and Training (DIET) will be appropriately utilized for capacity building of Health and Wellness Ambassadors.

9.5. Inter-Sectoral Convergence for Health Promotion

- Convergence is central for the success of health promotion strategies and require close coordination of health with other allied departments. Convergence has so far been undertaken with- education department for school- based health promotion camps, with ICDS for organizing camps and community level educational meetings on healthy diet, immunization, addressing malnutrition in children at AWCs during Village Health and Nutrition Days, with WCD for implementing Weekly Iron and Folic Implementation programme/Rashtriya Bal Swasthya Karyakram in AWCs for children in 2-6 years age group. Convergence initiatives to address spread of outbreaks of communicable diseases such as dengue, chikungunya, malaria for sanitation drives, vector control, controlling water coagulation, through cleaning of drains etc. are observed with rural development or municipal bodies in rural and urban areas respectively.

- Intersectoral convergence would now be required for promoting healthy behaviours related to NCDs. For example-different departments will need to come together to address the rising burden of dietary risk factors that are among the leading causes of health risk in Indian population and lead to increasing burden of death and disability from cardiovascular disease, diabetes, and also from cancer. Eat Right Toolkit developed by FSSAI should also be used to promote healthy diets.
- Health department will need to ensure that programmes such as - Rashtriya Bal Swasthya Karyakram, Rashtriya Kishore Swasthaya Karyakram, NPCDCS and Shaala Siddhi etc. to be focused now on both under and over nutrition.
- Other than Ayushman Ambassadors convergence from education may help in promoting better cooking practices for Mid- Day Meal programmes, training of MDM cooks, for enabling mandatory School Nutrition Clubs and competitions around health awareness for High fat, sugar and salty foods.
- Similarly, coordination from Women and Child Development will help in building awareness on ill effects of overweight-obesity through its flagship programmes like Integrated Child Development Services (ICDS), Integrated Child Protection Scheme (ICPS), Indira Gandhi Matritva Sahyog Yojana (IGMSY) and through SABLA, which mainly focuses on adolescent girls.
- Environmental Protection activities including provision of safe water, vector control, improvement of housing, control measures to check poor air quality etc. will also require intersectoral convergence.
- The states should plan health education and communication strategy in close coordination with Ministry of Rural development. Meetings with Zilla Panchayat, Block Panchayat and and Gram Panchayat need to be planned, at the commencement of HWCs. Later phased meetings at each of these levels would support in planning avenues and strategies for health promotion related to various dimensions of primary care.
- Existing guidelines under all programmes of MOHFW need to be suitably amended in light of the enhanced capacities and services being rendered by the HWCs.

SECTION 10

PROGRAMME MANAGEMENT

The goal of delivering Comprehensive Primary Health Care effectively in an equitable manner requires substantial change management. Robust and effective management strategies would need to be adopted to facilitate among other things, re-organization of health care services, intersectoral convergence and institutionalize mechanism for performance-linked payment for service providers.

Since the Comprehensive Primary Health Care approach relies primarily on integration of existing service delivery structures of various programme components under the NHM and intersectoral convergence, it is important that the nodal officers of different programmes such as RCH, NPCDCS, NVBDCP, Community Processes and Quality Assurance work in a coordinated manner, led by Assistant Mission Director or Joint / Deputy Director at the state level. Additional consultants (two for small states and three for big states) can be hired to support the process of planning, implementation and monitoring.

Nodal officers for this initiative at district level would need to be carefully selected from the rank of Deputy CMHO or DPM or DCM, based on their past performance and commitment demonstrated to improve the public health systems. It is desirable that an additional post is created at the district level programme management unit to manage the CPHC roll out. Similarly, the nodal officer should be selected at the block level from BMO or BPM or BCM based on performance and commitment. Roles for CPHC Management staff are listed in Annexure 5.

In order to improve the management mechanisms, following processes would be institutionalized:

a. **Performance based payments**: Mechanisms of performance linked payments and team-based incentives would be introduced to improve the performance of the service providers at HWCs and the overall performance of health systems.

b. **Use of IT tool for periodic review, supervision and monitoring**: Reports generated and data captured by the IT system should be used during district and block level monthly meetings to encourage "conversations on data". This would facilitate improving quality of care, improving coverage of population and tracking health outcomes using the information available from the data so generated.

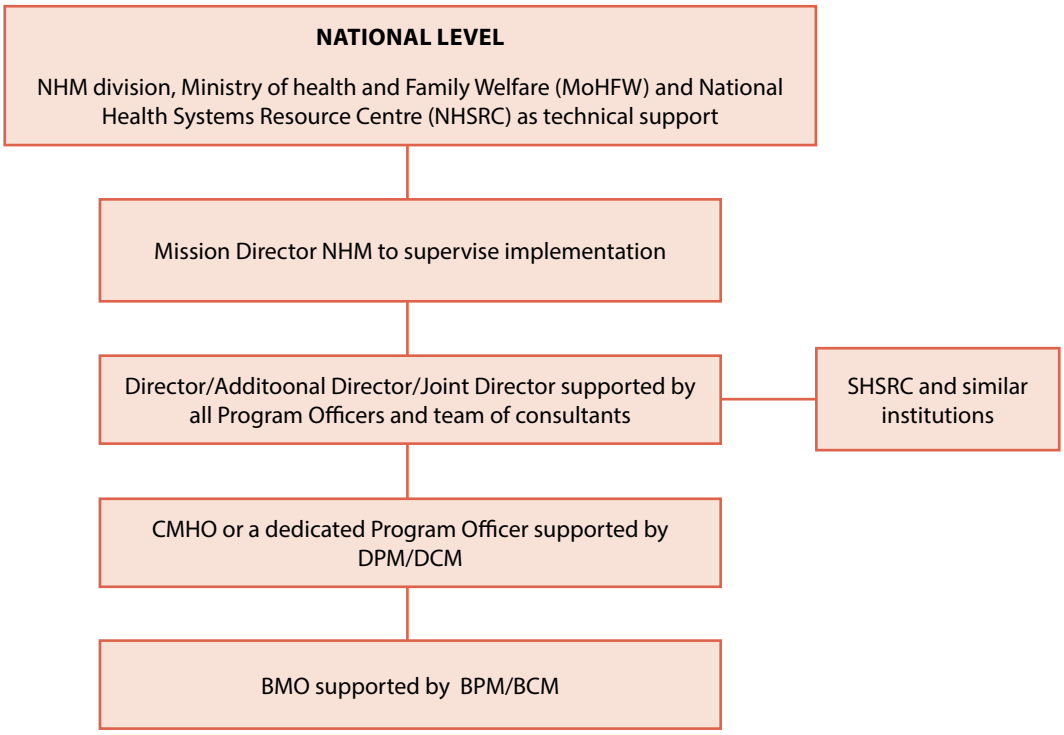
c. **Capacity Building**: Regular capacity building of programme managers at all levels and service providers through periodic workshops at state and district level should be conducted for refreshing skills and dissemination of new guidelines and protocols.

d. **Supportive Supervision**: Monthly visits would be undertaken by the PHC MOIC to the SHC to provide on the job mentoring and hand holding support. In addition, quarterly review meetings of block nodal officers at district level and biannual meetings of district nodal officers at the state level should be planned to act as a forum for performance review and problem solving.

e. **Social Recognition:** In addition to team-based incentives, annual awards based on pre-defined criteria can be introduced for Primary Health Care teams as well as individual performers at state and district level. This would create a sense of social recognition and may enhance the motivation levels of the Primary Health Care team to improve the performance.

The change management for this strategy would also require extensive public health and technical expertise. The National Health Systems Resource Centre would provide technical support to all States/UTs for strengthening primary health care and operationalizing HWCs. It is recommended that states should identify reputed Public Health Organizations/Academic/Research Organizations available within the government or Non-Government Organization to serve as the State Level Technical Partners in rolling out the Comprehensive Primary Health Care services through Health and Wellness Centres. The process of selection of Technical Partners would be state specific and could involve a process of composite bidding with higher weightage for technical competence than cost-based parameters alone. States could also use an already existing Technical Agency such as the State Health Resource Centers, working under a formal agreement with the State NHM/Departments of Health, which has demonstrated expertise and competence in supporting other government initiatives.

Figure 10.1 Program Management Structure



10.1. Monitoring

The designated programme management team at state and district level would be responsible for overall monitoring and supervision of the HWCs. At field level, the block nodal officer oversees the HWC roll out and monitors the progress made on a monthly basis. The IT platform would support generation of reports for population-based indicators and disease surveillance for effective programme monitoring at block, district and state level. States should use the existing indicators and data sources for monitoring till the IT system is able to provide programme specific reports.

In addition to the regular supervision and monitoring by the programme managers, states can also make the provision for Independent Monitoring to assess the effectiveness of the programme, evaluate the service delivery outputs, track improvements in health outcomes or for assessing the performance of HWCs team for the disbursal of team-based incentives.

States can identify technical agencies, public health organizations, academic institutions and research organizations to serve as Independent Monitors. Support of national and state level technical partners can be taken for the selection of such agencies for Independent Monitoring.

The following indicators may be used for monitoring the HWC services during the first phase. Based on the programme roll out, additional indicators may be added for the remaining services like – ophthalmology, ENT, mental health, elderly care, oral health, etc.

Table 10.1 Program Monitoring Indicators

Indicator A- sent by District to State and National Level	Indicator B- available at District	Source
Out-patient (OP) visits per capita population in each district/state	OP visits per capita for each facility	HMIS
Hospitalization Rate (per 100,000 population) in each district/state	i) Beds per lakh population ii) Bed Occupancy Ratio	HMIS
Annual Primary Care Empanelment Rate- proportion of families in district who are registered with a health and wellness centres	Same indicator by each HWC facility	MIS/CPHC IT System
Four ANC rate: Proportion of pregnant women receiving four ANCs	i) Anaemia in pregnancy rate ii) Hypertension in pregnancy rate iii) Full ANC rate	HMIS
SBA assisted delivery rate/ Institutional Delivery Rate:	i) C-Section Rate ii) Complicated Pregnancy rate iii) Medical Termination of Pregnancy rate iv) Stillbirth rate v) Low Birth Weight rate	HMIS
Maternal deaths – absolute numbers per district	Maternal deaths by cause of death. Death of women in 15 to 45 year age group due to unknown causes	HMIS & RGI
Perinatal Mortality Rate by district	Late still births Early neonatal deaths	HMIS & RGI
Under 5 mortality Rate by district	Neonatal deaths 0- 1 Infant deaths 1 to 4 deaths	HMIS & RGI
Full Immunization Rate by district	Rates by each vaccine	HMIS
Child Malnutrition Rate by district	Severe Acute Malnutrition (SAM), Moderately Acute Malnutrition (MAM) rates Mild, moderate and severe malnutrition rates	ICDS-MIS
Exclusive breast-feeding for six months after birth	Breastfeeding within first hour.	HMIS
Paediatric Hospitalization rate	Hospitalization specifically for: Sick newborn, pneumonia, diarrhoea and dehydration.	HMIS
Proportion of Diarrhoea/Acute Respiratory Infection (ARI) in children under 5 who got appropriate treatment	Oral Rehydration Therapy (ORT) for diarrhoea rate Appropriate treatment for ARI rate. Any notified vaccine preventable disease	Community survey done annually on fixed protocol

Indicator A- sent by District to State and National Level	Indicator B- available at District	Source
Patients with Hypertension under primary care	% of population of 30 years and above screened for HT % of those screened positive for HT who were examined at PHC/ CHC % of those who were initiated on treatment at PHC or above who are still under treatment, uninterrupted for last 3 months % of those currently on treatment who have achieved blood pressure control	HMIS
Patients with Diabetes Mellitus under primary care	% of population of 30 years and above screened for DM % of those screened positive for DM who were examined at PHC/ CHC % of those who were initiated on treatment at PHC or above who are still under treatment, uninterrupted for last 3 months % of those currently on treatment who have achieved blood sugar control	HMIS
Individuals screened for common cancers	% of population of 30 years and above screened for Oral Cancer % of women of 30 years and above screened for Breast Cancer % of women of 30 years and above screened for Cervical Cancer % of those who were screened positive for each of the cancers that underwent biopsy at CHC/ DH % of those who underwent treatment for each of the cancers who are screened periodically	HMIS
Cardiovascular mortality in the 15 to 60 year age group.	Mortality disaggregated by gender	RGI
Accidental death rates	Mortality disaggregated by type of accident.	RGI & Police
Major surgeries per 1 lakh population.		HMIS
Leprosy: Annual New Case Detection Rate/100,000 population Prevalence rate/100,000 New cases with Grade II Disability Treatment Completion Rate	Proportion of new cases detected: MB case incidence Child Cases. Grade II Disability Child Case with disability	HMIS/NLEP
Case detection rate for tuberculosis	Treatment completion rate MDR rate	TB-MIS
Annual parasite index for malaria	Also % PF, SPR	Malaria-MIS
HIV in ANC clinics rate/STD clinics		NACO_MIS
Rate of patients with chronic NCDs on regular medication or other follow up at the HWC	Rates for specific diseases- HT, diabetes, COPD/ asthma, epilepsy, mental illness, etc- where specialist initiates but regular follow up and medication locally	HMIS
Average Medical Out of Pocket (OOP) Cost of Care per hospitalization episode	Also break up of cost of care in medicines, diagnostics etc- in public and private facility	Based on exit interviews on fixed protocol

Indicator A- sent by District to State and National Level	Indicator B- available at District	Source
Average OOP cost of care on ARI or diarrhoea for children under five		Based on annual community survey on fixed protocol

Related program specific indicators are part of the respective program guidelines.

10.2. Grievance Redressal Mechanism

The existing mechanisms for grievance Redressal should be also extended to cover all services at Health and Wellness Centre. Dial 104 Helpline should be universalised and capture grievances or gaps relating to HWCs.

10.3. Community Based Monitoring and Social Accountability

The institutional frameworks set up for Community Based Monitoring and ensuring social accountability under the National Health Mission would continue to be strengthened to support the process of CPHC implementation. The facility surveys, preparation of score sheets and wide dissemination of the results through public hearings and dialogues will also be applicable for Health and Wellness Centres. Institutional structures operational for community-based monitoring such as Village Health Sanitation and Nutrition Committees and Community Action for Health will monitor delivery of preventive, promotive and curative service as part of CPHC and will continue to provide relevant inputs for decentralized health planning. This will support in increasing the accountability of the primary healthcare system to the Community and service users.

As has been made mandatory for other public health facilities under NHM, it would be compulsory for all the Health and Wellness Centres to prominently display information regarding financial support received, medicines and vaccines in stock, services provided to the patients as citizen's charter etc.

The VHSNCs/MAS facilitated by ASHAs/MPWs-F at the community level, the Rogi Kalyan Samitis at the facility level and structures for Community Action for Health would monitor the performance of the Health and Wellness Centres and other facilities in terms of- delivering the extended ranges of services, minimizing out of pocket expenditures by service users, free provision of essential medicines and diagnostics, patient centric care provision etc and suggest corrective measures for improving the performance.

All Public Reports on Health at the National, State and the district levels would report progress made on implementation of Comprehensive Primary Health Care. States should nominate and involve Civil Society Organizations, NGOs and other resource institutions and create a monitoring arrangement to track the progress, effectiveness and quality of health services.

SECTION 11

FINANCING

The Health and Wellness Centres along with the Pradhan Mantri Jan Arogya Yojana under the Ayushman Bharat are flagship initiatives of the Government of India. The budgetary allocation for the Health and Wellness Centres would be made under the National Health Mission as part of the State PIP fund allocations based on the principles followed for other programmes under the Mission.

11.1. Financial Provisions

Fund requirement for upgrading and operationalizing Health and Wellness Centres would vary depending on the type of facility i.e. SHCs, PHCs and Urban PHCs. In addition to the existing funds available under NHM and state budget for these facilities, additional funds would be required for the following additional components of HWCs:

a. Human Resource
b. IEC
c. IT support
d. Diagnostics
e. Infrastructure Strengthening
f. Independent Monitoring

Indicative costing of these additional components based on type of health facility is illustrated in Tables 1-3.

Table 11.1– SHC-HWC

	Non-Recurring	Recurring	Remarks
One Mid- level Service provider		4,80,000	For contractual MLHP: Rs.25000/- PM and Rs.15000/-PM (37.5% of total) as performance incentive. For regular candidates selected as MLHP, the incentive amount will be the difference between existing salary and Rs. 40,000
Team based incentives		1,00,000	Rs. 75,000 as per team-based guidelines and Rs. 25,000 for additional services.
ASHA incentives		60,000	Rs. 1000 pm (ceiling amount) ASHA for delivery of new range of services to be paid as per guidelines

	Non-Recurring	Recurring	Remarks
Training			
Certificate Course/Training on the Standard Treatment Protocol	1,03,400		IGNOU – Additional budget for infrastructure / faculty strengthening @ 2.5 L
Refresher training of MLHP		10,000	
Multi-skilling of MPWs (F & M) and ASHAs		20,000	
IEC		25,000	Rs.5 per capita
Cost of tablet; software for centre and MPWs (F & M)	70,000	5,000	Two tablets and one laptop for teleconsultation
Lab	1,00,000	30,000	
Infrastructure Strengthening	7,00,000		
Sub-Total	9,73,400	7,30,000	
Total	17,03,400		
Independent monitoring costs for performance assessment at 3%	51,102		
Total	**17,54,502**		

Table -11.2 - Rural PHC-HWC

Rural PHC-HWC	Non-Recurring	Recurring	Remarks
Training			
Medical officers (two)		20,000	10,000 per MO
Staff nurses (two)		15,000	7500 per SN
Multi-skilling of MPWs (F & M) and ASHAs		20,000	ASHAs and MPWs at collocated SHC
ASHA incentives		60,000	1000 pm per ASHA for additional range of services (linked with activities) at collocated SHC
Team based incentive		2,00,000	1 Lakh for PHC team and 1 Lakh for collocated SHC team
IEC		50,000	
IT support	60,000	5,000	One laptop for PHC MO and one tablet for collocated SHC
Lab	1,00,000	30,000	
Infrastructure Strengthening of PHC to HWC	4,00,000		
Sub-Total	5,60,000	4,00,000	
Independent Monitoring Cost		28,800	
Total	**9,88,000**		

Table 11.3- Urban PHC-HWC

Urban PHC	Non-Recurring	Recurring	Remarks
Training			
Medical officers (two)		20,000	10,000 per MO
Staff nurses (two)		15,000	7500 per SN
Multi-skilling of MPWs (F) – 5		25,000	5000 per MPW (F)
Multiskilling of ASHAs – 25		75,000	3000 per ASHA
Team Based Incentives		6,00,000	Assuming 50% population would need services of UPHC. @ Rs. 1 L per 5000 population for Frontline worker team and Rs. 1 Lakh for UPHC team
ASHA incentives		3,00,000	1000 pm per ASHA for additional range of services (linked with activities)
IEC		1,00,000	
IT support	1,00,000	10,000	One laptop for UPHC MO and five tablets for MPW (F)
Lab	1,00,000	50,000	
Infrastructure Strengthening of PHC to HWC	1,00,000		For wellness room
Sub-Total	3,00,000	11,95,000	
Independent monitoring costs for performance assessment at 3%		44850	
Total	**15,39,850**		

The budget has been estimated assuming the normative population coverage of 5000 per SHC, 30,000 per PHC and 50,000 per UPHC. These cost requirements may vary depending on the actual population coverage and the available HR at the selected health facility. States should take these variations in to considerations while estimating the actual budgetary requirement. E.g., Infrastructure strengthening may vary from Nil to Rs. 15 Lakh per SHC as per the condition of the building in different contexts.

In addition to these budgetary allocations, the untied funds for SHCs would be Rs. 50,000 per HWC to meet additional and non- anticipated requirements for delivery of CPHC services.

11.2 Performance Linked Payments

One of the key features of the HWCs is the introduction of performance-linked payments for service providers following the capitation-based payment models. This has been envisaged to improve the quality of services delivery by incentivizing providers to ensure better health outcomes for the population in the catchment area. This shift in payment mechanism, in our context, would also address perceived challenge of poor performance of the providers in public health facilities.

This would be achieved by linking one proportion of the salary with the performance/service delivery and providing team based incentives based on improvement in health outcomes.

a. **Performance Based Payments:** All service providers at HWCs i.e.; Mid- level Health Providers (at SHC-HWC), Medical Officers and Staff Nurses at PHCs/ UPHCs HWCs can receive 60% of their salary as a fixed remuneration while remaining 40% the salary may be linked with the performance based on measurable performance indicators. Suggestive indicators for performance measurement of MLHP will be shared with the States. Pre- requisite of implementing performance-based payments

is a robust IT system that is able to track the number of individuals (service users) empanelled with the HWCs, range of services delivered at HWCs and coverage of HWCs and the outputs/ outcomes achieved.

b. **Team Based Performance Incentives:** HWC teams will be provided annual/periodic monetary incentives based on the collective performance of the primary health teams in improving health outcomes of the population covered. This would instil team spirit and provide mechanisms to influence collective motivation among the team. It would also enable identification of areas of performance improvement and the need for skill up gradation. Suggestive indicators for team-based incentives will be shared with the States. In addition to the utilization of the IT system, assessment of HWC team's performance would require institutionalizing mechanisms for independent monitoring, either through partnerships through research organizations, NGOs, SHSRCs and medical colleges or through training the existing staff at district and block level to undertake these assessments on a biannual basis.

c. **Utilization of Other Resources:** Funds for supporting HWCs could also be leveraged from other sources such as MP/ MLALAD and Panchayat/ ULB funds. Funds available under Corporate Social Responsibility (CSR) may also be tapped to support infrastructure strengthening and service delivery at HWCs. As part of the convergence, funds available under various programmes like ICDS etc can also be utilized to support coordinated efforts for improving health outcomes.

ANNEXURES

Annexure 1
Essential Medicine List for SHC- Health and Wellness Centres

Sr. No.	Name of Medicine	Dosage Type
General anaesthetic and oxygen		
1	Oxygen	Inhalation (Medicinal gas)
Local anaesthetics		
2	Lignocaine	Topical forms 2-5%
Analgesics, antipyretics, non steroidal anti inflammatory medicines, medicines used to treat gout and disease modifying agents used in rheumatoid disorders		
3	Diclofenac	Tablet 50 mg
4		Injection 25 mg/ml
5	Paracetamol	Tablet 500 mg
6		Tablet 650 mg
7		All licensed oral liquid dosage forms and strengths
Anti allergic and medicines used in anaphylaxis		
8	Cetrizine	Tablet 10 mg
9	Chlorpheniramine	Tablet 4 mg
10		Oral liquid 2 mg/5 ml
Intestinal Anti helminthes		
11	Albendazole	Tablet 400 mg
12	Diethylcarbamazin (Antifilarial)	Tablet 50 mg
13		Tablet 100 mg
Anti bacterial		
14	Ciprofloxacin	Tablet 250 mg
15		Tablet 500 mg
16	Gentamicin	Injection 10 mg/ml
17		Injection 40 mg/ml

Sr. No.	Name of Medicine	Dosage Type
18	Metronidazole	Tablet 200 mg
19		Tablet 400 mg
20	Amoxicillin	Capsule 250 mg
21		Capsule 500 mg
22		Oral liquid 250 mg/5 ml
Anti-fungal medicines		
23	Fluconazole	Tablet 100 mg
Anti Malarial		
24	Chloroquine	Tab 150 mg
25	Primaquine	Tablet 2.5 mg
26		Tablet 7.5 mg
27		Tablet 15 mg
28	Artesunate (A) + Sulphadoxine – Pyrimethamine (B). Combi pack (A+B)	1 Tablet 25 mg (A) + 1 Tablet (250 mg + 12.5 mg) (B)
		1 Tablet 50 mg (A) + 1 Tablet(500 mg + 25 mg) (B)
		1 Tablet 100 mg (A) + 1 Tablet(750 mg + 37.5 mg) (B)
		1 Tablet 150 mg (A) + 2 Tablet(500 mg + 25 mg) (B)
		1 Tablet 200 mg (A) + 2 Tablet(750 mg + 37.5 mg) (B)
Anemia		
29	Ferrous salts	Tablet equivalent to 60 mg of elemental iron
30		Oral liquid equivalent to 25 mg of elemental iron/ml
31	Ferrous salt (A) + Folic acid (B)	Tablet 45mg elemental iron (A) +400 mcg (B)
32		Tablet 100 mg elemental iron (A) + 500 mcg (B)
33		Oral liquid 20 mg elemental iron (A) + 100 mcg (B)/ml
34	Folic acid	Tablet 5 mg
Dermatological medicines (Topical)		
35	Clotrimazole	Cream 1%
36	Methylrosanilinium chloride (Gentian Violet)	Topical preparation 0.25% to 2%
37	Povidone iodine	Solution 4% to 10%
38	Silver sulphadiazine	Cream 1%
39	Framycetin	Cream 0.5%
Disinfectants and antiseptics		
40	Ethyl alcohol (Denatured)	Solution 70%
41	Hydrogen peroxide	Solution 6%
42	Methylrosanilinium chloride (Gentian Violet)	Topical preparation 0.25% to 2%
43	Povidone iodine	Solution 4% to 10%
44	Bleaching powder	Containing not less than 30% w/w of available chlorine (as per I.P)
45	Potassium permanganate	Crystals for topical solution

Sr. No.	Name of Medicine	Dosage Type
Gastrointestinal medicines		
46	Ranitidine	Tablet 150 mg
47	Domperidone	Tablet 10 mg
48	Dicyclomine	Tablet 10 mg
49	Oral rehydration salts	As licensed
50	Zinc sulphate	Dispersible Tablet 20 mg
Contraceptives		
51	Ethinylestradiol (A) + Norethisterone	Tablet 0.035 mg (A) + 1 mg (B)
52	Hormone releasing IUD	Contains 52 mg of Levonorgestrel
53	IUD containing Copper	As licensed
54	Condom	As per the standards prescribed in Schedule R of Drugs and Cosmetics rules, 1945
55	Ethinylestradiol	Tablet 0.01 mg
56		Tablet 0.05 mg
57	Levonorgestrel	Tablet 0.75 mg
Anti-infective medicine		
58	Ciprofloxacin	Drops 0.3 %
59		Ointment 0.3%
Oxytocics and Antioxytocics		
60	Methylergometrine	Tablet 0.125 mg
61	Misoprostol	Tablet 100 mcg
Solutions correcting water, electrolyte disturbances		
62	Water for Injection	Injection
Vitamins and minerals		
63	Ascorbic acid (Vitamin C)	Tablet 100 mg
64	Cholecalciferol	Tablet 1000 IU
65		Tablet 60000 IU
66		Oral liquid 400 IU/ml
67	Vitamin A	Capsule 5000 IU
68		Capsule 50000 IU
69		Capsule 100000 IU
70		Oral liquid 100000 IU/ml
71	Phytomenadione (Vitamin K1)	Injection 10 mg/ml
Additional medicines*		
Antidotes and other substances used in poisoning		
72	Activated charcoal	Powder (as licensed)
73	Atropine	Injection 1 mg/ml
74	Snake venom antiserum	a) Injection
75	Lyophilized polyvalent	b) Powder for Injection
76	Pralidoxime chloride (2-PAM)	Injection 25 mg/ml

Sr. No.	Name of Medicine	Dosage Type
	Analgesics	
77	Acetylsalicylic Acid	Tablet 300 mg to 500 mg
78		Effervescent/ Dispersible/ Enteric coated Tablet 300 mg to 500 mg
79	Ibuprofen	Tablet 200 mg
80		Tablet 400 mg
81		Oral liquid 100 mg/5 ml
82	Mefenamic acid	Capsule 250 mg
83		Capsule 500 mg
	Ear, nose and throat medicines	
84	Ciprofloxacin	Drops 0.3 %
85	Clotrimazole	Drops 1%
86	Normal Saline nasal drops : sodium chloride	Drops 05%w/v
87	Xylometazoline nasal drops	pediatric (0.05%), adult (.1%)
88	Wax-solvent ear drops : benzocaine, chlorbutol, paradichlorobenzene, turpentine oil	
89	Boro-spirit ear drops	0.183gm boric acid in 2.08 ml of alcohol
90	Combo ear drops	(Chloramphenicol (5%w/v) + Clotrimazole (1%)+ Lignocaine hydrochloride (2%)
91	Liquid paraffin – menthol drops	(Menthol 10gm+Eucalyptus 2ml+Camphor 10gm+Liquid paraffin to 100ml)

Emergency Medicine Kit

1. Inj. Adrenaline
2. Inj. Hydrocortisone
3. Inj. Dexamethasone
4. Glyceryl trinitrate- Sublingual tablet 0.5 mg

** Additional medicines are included as suggested by the task forces and will be updated after approval.*

Annexure 2

Medicines which can be indented by MLHP at SHC- HWC from referral centre as per requirement*

Antihypertensive medicines		
1	Amlodipine	Tablet 2.5 mg
2		Tablet 5 mg
3		Tablet 10 mg
4	Atenolol	Tablet 50 mg
5		Tablet 100 mg
6	Enalapril	Tablet 2.5 mg
7		Tablet 5 mg
8	Propanalol	Tablet 40 mg
9		Tablet 80 mg
10		Tablet 10 mg
Cardiovascular medicines (Medicines used in angina)		
11	Isosorbide dinitrate	Tablet 5 mg
12		Tablet 10 mg
13	Clopidogrel	Tablet 75 mg
Diuretics		
14	Furosemide	Tablet 40 mg
15		Oral liquid 10 mg/ml
16	Hydrochlorothiazide	Tablet 25 mg
17	Spironolactone	Tablet 25 mg
18		Tablet 50 mg
Antidiabetic		
19	Glimepiride	Tablet 1 mg
20		Tablet 2 mg
21	Insulin (Soluble)	Injection 40 IU/ml
22	Intermediate Acting (NPH) Insulin	Injection 40 IU/ml
23	Premix Insulin30:70 Injection (Regular:NPH)	Injection 40 IU/ml
24	Metformin	Tablet 500 mg
25		Tablet 750 mg
26		Tablet 1000 mg
Anticonvulsants/ Antiepileptic		
27	Carbamazepine	Tablet 100 mg
28	Diazepam	Oral liquid 2 mg/5 ml
29	Phenobarbitone	Tablet 30 mg Tablet 60 mg
30		Oral liquid 20 mg/5 ml

31	Phenytoin	Tablet 50 mg
32		Tablet 100 mg
33		Tablet 300 mg
34		ER Tablet 300 mg
35		Injection 25 mg/ml
36		Injection 50 mg/ml
37	Sodium valproate	Tablet 200 mg
38		Tablet 500 mg
COPD		
39	Salbutamol	Tablet 2 mg
40		Tablet 4 mg
41		Oral liquid 2 mg/5 ml
42		Respirator solution for use in nebulizer 5mg/ml
43		Inhalation (MDI/DPI) 100 mcg/dose

**Medicines included in PHC- EML are included in the above mentioned list. This is a suggestive list and is not exhaustive. Medicines as prescribed by doctor/ specialist at referral center for expanded range of services will be included in this list and can be indented by MLHP.*

Annexure 3

A. Indicative List of Diagnostic Services for CPHC

At the Central Diagnostic Unit-Hub (can be block PHC/CHC/SDH/DH)	PHC	SHC- HWC
Haemoglobin	Haemoglobin*	Haemoglobin*
Complete Blood Count	Total Leucocyte Count*	
	Differential Leucocyte Count*	
	Platelet count*	
Peripheral smear	Peripheral smear	
ESR	ESR*	
Bleeding and Clotting time	Bleeding and Clotting time* (CT where snake bites are common)	
Blood grouping and typing	Blood grouping and typing*	
Urine Pregnancy Rapid Test	Urine Pregnancy Rapid Test*	Urine Pregnancy Rapid Test*
Urine Dipstick	Urine Dipstick*- urine albumin and sugar	Urine Dipstick*- urine albumin and sugar
Blood Glucose & HBA1C	Blood glucose* (biochemistry)	Blood Glucose* (glucometer)
Malaria Smear Rapid Diagnostic Kit (RDK)	Malaria smear* RDK*	Malaria smear, RDK*
Serology for vector borne disease- Dengue, Chikungunya, Filariasis, Malaria, Kala-Azar (some of this at higher hub)	RDK for Dengue*	RDK for Dengue*
Rapid Syphilis Test	Rapid Syphilis Test (Rapid Plasma Reagin- RPR Kit Test)*	
HIV Serology: Rapid Test	HIV Serology: Rapid Test*	
Typhoid serology	Typhoid serology	
Hepatitis testing- basic HBs Ag- (more advanced at a higher hub)		
Sickle Cell testing- (other blood tests at higher hub)	Sickle Cell rapid test	Sickle Cell rapid test
TB Microscopy- AFB Smear	Collection of sputum samples* and AFB smear where PHC serves as designated microscopy centre	Collection of sputum samples
Wet Mounts – Direct Microscopy (RTI/ STD)	Wet Mounts – Direct Microscopy (RTI/STD)	
Liver Function Tests (enzymes)	Serum bilirubin*	
Blood urea, creatinine		
Lipid profile		
Stool for OVA and cyst	Stool for OVA and cyst*	
	Water Quality Testing-H2S Strip test for Faecal Contamination*	
X ray		
Ultrasound		
ECG		

*Diagnostics marked with * are to be available at the specified level of facility as per 'Free Diagnostics Service Initiative'.*

B. Indicative List of Screening Methods for CPHC

	At Hub	At HWCs
Non communicable diseases-general		• Weighing Machines- for different age groups and Stadiometers for Body Mass Index • Blood Pressure • Peak flow meter • Questionnaire- for detection of risk factors- e.g. smoking, substance abuse, and for chronic respiratory disease (CBAC)
Cervical cancer	Colposcope/Cryotherapy Equipment	Visual Inspection through Acetic Acid
Mental disorders		Questionnaire algorithm for mental disorder detection and epilepsy
Eye care	Ophthalmoscope	Snellen's and Near vision Chart
Malnutrition		Weight Charts and weighing machine
New born and Child Screening for development delays and disabilities		RBSK Screening Tools
Disability and Palliative care		Questionnaire to assess requirement

Annexure 4
Equipment, consumables and miscellaneous supplies at SHC-HWC

I. Clinical Material, Tools and Equipment

1	Basin 825 ml. Ss (Stainless Steel) Ref. IS 3992
2	Basin deep (capacity 6 litre) ss Ref: IS: 5764 with Stand
3	Tray instrument/Dressing with cover 310 x 195x63mm SS, Ref IS: 3993
4	Flashlight/Torch Box-type pre-focused (4 cell)
5	Torch (ordinary)
6	Dressing Drum with cover 0.945 litres stainless steel
7	Hemoglobinometer – set Sahli type complete
8	Weighing Scale, Adult 125 kg/280 lb
9	Weighing Scale, Infant (10 Kg)
10	Weighing Scale, (baby) hanging type, 5 kg
11	Sterilizer
12	Surgical Scissors straight 140 mm, ss
13	Sphygmomanometer Aneroid 300 mm with cuff IS: 7652
14	Kelly's haemostat Forceps straight 140 mm ss
15	Vulsellum Uterine Forceps curved 25.5 cm
16	Cusco's/Graves Speculum vaginal bi-valve small,
17	Cusco's/Graves Speculum vaginal bi-valve medium
18	Cusco's/Graves Speculum vaginal bi-valve large
19	Sims retractor/depressor
20	Sims Speculum vaginal double ended ISS Medium
21	Uterine Sound Graduated
22	Cheatle's Forceps
23	Vaccine Carrier
24	Ice pack box
25	Sponge holder
26	Plain Forceps
27	Tooth Forceps
28	Needle Holder
29	Suture needle straight -10
30	Suture needle curved
31	Kidney tray
32	Artery Forceps, straight, 160mm Stainless steel
33	Dressing Forceps (spring type), 160 mm, stainless steel
34	Cord cutting Scissors, Blunt, curved on flat, 160 mm ss
35	Clinical Thermometer oral & rectal

36	Talquist Hb scale
37	Stethoscope
38	Foetoscope
39	Hub Cutter and Needle Destroyer
40	Ambu Bag (Paediatric size) with Baby mask
41	Suction Machine
42	Oxygen Administration Equipment
43	Tracking Bag and Tickler Box (Immunization)
44	Measuring Tape
45	I/V Stand
46	Artery Forceps-Curved
47	BP Apparatus (Digital)
48	Dental Probe
49	Digital Thermometer
50	Examination Lamp
51	Tongue Depressor
52	Weighing Scale Adult (Digital)
53	Oxygen Cylinder with trolley
54	Mouth Gag
56	Mouth Mirror
57	Snellen vision chart
58	Near vision chart
59	Stadiometer
60	Nebulizer
61	Gauze Cutting Scissors Straight
62	Episiotomy Scissors
63	Kits for testing residual chlorine in drinking water
64	Tuning fork
65	Labour Table
66	Form Matteress

II. Linens, Consumables and miscellaneous items

1	Syringe (10 cc, 5 cc, 2 cc) and AD Syringes (0.5 ml and 0.1 ml) for immunization
2	Disposable gloves
3	Mucus extractor
4	Disposable Cord clamp
5	Disposable Sterile Urethral Catheter (rubber plain 12 fr)
6	Foley's catheter (Adult)
7	Dry cell/Battery

8	Disposable lancet (Pricking needles)
9	Disposable Sterile Swabs
10	Routine Immunization Monitoring Chart
11	Blank Immunization Cards/Joint MCH Card (one per pregnant mother) and Tally Sheets (one per immunization session)
12	Partograph charts
13	IV canula and Intravenous set
14	Interdental cleaning aids
15	Chlorine tablets
16	Sanitary napkins
17	200-watt Bulb (2)
18	Salt – Iodine test kit
19	Mackintosh Sheets – 5 metres
20	Wooden spatula
21	Suture Material
22	Online UPS 1 KVA with 60 minute backup
23	Fire Extinguisher
24	Buckets Big (Plastic)
25	Buckets Small (Plastic)
26	Dust bins- Blue
27	Dust Bins – Red
28	Dust Bins – Yellow
29	Dust Bins- Black
30	Black Disposal bags
31	Red Disposal Bags
32	Yellow Disposal Bags
33	Blue Disposal Bags
34	Hand Towels
35	Bed Sheet for Examination Tables
36	Cleaning material, detergent
37	Insecticide treated nets

III. Furniture and Fixtures

1	Chairs for patient waiting area
2	Foot Step
3	Office Chair
4	Office Table
5	Screen Separators with stand
6	Steel Almirah / Cupboard/storage chests
7	Stool for attendants

IV. Lab -Diagnostic Materials and Reagents for Screening

1	Glucometer
2	Glucometer Testing Strips
3	Slide drying rack
4	Specimen collection bottle
5	Spirit lamp
6	Test tube holding clamp
7	Test tube rack
8	Test tubes
9	Glass rods
10	Glass Slide box of 25 slides
11	Rapid Pregnancy Testing Kit
12	Rapid Test Kit for Dengue and Malaria
13	N/10 Hydrochloric Acid
14	Reagents such as Hydrochloric acid, acetic acid, Benedict's solution, Bleaching powder, Hypochlorite solution, Methylated spirit etc.
15	Acetic Acid Solution
16	Micropipette
17	Yellow Tips for Micropipette
18	Dipsticks for urine test for protein and sugar (1 container of 25 strips)
19	Whole Blood Finger Prick HIV Rapid Test and STI Screening Test each

Annexure 5
Specific Roles for CPHC Management

State Nodal Officer

- Team building and human resource development.
- Plan, manage and supervise implementation of CPHC at state level.
- Issue orders, guidelines and ensure streamlined supply chain logistics.
- Build capacity of district and block level teams.
- Monthly Programme review.
- Oversee fund releases and collection of utilization certificates.
- Coordinate with Technical Support Agency at state and national level for smooth implementation of activities.
- Coordinate with IGNOU/Public Health Universities for roll out of Certificate Program in Community Health.

State Level Technical Support Unit

- Planning and monitoring trainings under Certificate Program in Community Health for MLHPs and support other trainings such as NCDs and multi-skilling of personnel for CPHC.
- Support in selection of MLHPs through developing state specific guidelines, drafting assessment tools in coordination with NHSRC, District Teams and state NHM.
- Plan and prepare formats for gap analysis for infrastructure strengthening for HWCs.
- Undertake relevant operational research, for assessment of CPHC interventions in coordination with NHSRC.
- Support effective information system for monitoring progress (on three fronts: service use, health outcomes, and out of pocket expenses on healthcare), performance measurement and to ensure use of standard treatment guidelines and a reliable referral mechanism for maintaining continuum of care.
- Document and assess the efficacy of work processes, challenges, best practices, and other associated requirements of implementing the CPHC through HWC.
- Undertake periodic field based reviews in pilot districts to document the progress of implementation, identification of gaps and suggest corrective measures to State Nodal Officer/District Nodal Officer.
- Build coordination partnerships for consultative action on technical support.

District Nodal Officer

- Roll out of activities at district and blocks; manage, monitor and support the work on CPHC through HWCs in consultation with state team.
- Support the state team in selection, training and posting of MLHPs; and ensure timely release of salaries of MLHPs and other staff engaged in delivery of CPHC services.

- Track mechanisms of enabling performance-based incentives to MLHPs and team-based incentives to Primary Health Care Team.
- Coordinate for collection of utilization certificates and furnish reports on release of funds to the district to support preparation of PIP.
- Regular monitoring of service delivery, strengths, gaps and fund utilization; Identify evolving best practices under CPHC.
- Coordinate with PHC MOs, BPMs and MLHPs to gather service delivery data and generate district, block and facility wise analytical reports.
- Systematic documentation, analysis and submission of reports in supervision of Technical Agency to State level.
- Disseminate and facilitate implementation of guidelines and ensure streamlined supply chain logistics.

Block Nodal Officer

- Roll out of activities at block level; manage, monitor and support the work on CPHC through HWCs.
- Undertake gap analysis for infrastructure strengthening and ensure supplies and adequate stocks of requisite medicines, clinical and laboratory equipment, reagents and other consumables at the SHC-HWCs and the referral PHCs.
- Undertake field visits to address challenges in project implementation and appraise District/State Nodal Officer on progress.
- Coordinate and prepare an action plan for annual PIP and ensure timely submission of utilization certificates.
- Coordinate with PHC MOs, BPMs and MLHPs to gather service delivery data and generate block and facility wise analytical reports.
- Submit monthly and quarterly reports in prescribed format to State Nodal Officer.
- Implement mechanisms of assess performance-based incentives to MLHPs and team based incentives to other Primary Health Care Team.
- Coordinate with Zilla Panchayat and Gram Panchayats / Urban Local Bodies in ensuring IEC for awareness about HWCs, CPHC.
- Ensure periodic review meeting with the Primary Health Care Teams at the PHCs or SHCs.

PHC Medical Officer

- Provide support and supervision to the Primary Health Care team; review service delivery and performance at HWCs through monthly visits.
- Review and manage all cases referred by MLHP/MPWs as per Standard Treatment Guidelines. Support the primary health care team at HWC- SHCs through telehealth and undertake teleconsultation with specialists at higher-level facilities wherever required.
- Systematically document health conditions, treatment plan, disease progression and detailed instructions for further management by primary healthcare team or referral to higher facilities.
- Ensure continuum of care for patients as per care pathways that provide detailed guidelines for diagnoses, treatment, management and referral to higher levels for specific disease conditions.

- Ensure timely submission of updated monthly reports and records for programme monitoring and strategic planning; Utilize records to undertake population-based analytics, and planning of activities for the Primary Health Care team.
- Assess the performance of Primary Health Care Team at SHC-HWCs on a monthly basis based on the performance monitoring criteria shared by state NHM. Ensure timely submission of performance report to Block and District level Officer for CPHC, District Health Officer for the release of monthly performance based incentives to the members of HWC team.
- Ensure regular supply and sufficient stocks of medicines, equipment and reagents at the PHC and at all the SHC-HWCs as per IPHS and NLEM.
- Apart from the Medicines listed in the Essential List of SHCs, a PHC Medical Officer should ensure availability of adequate stocks of the medicines that can be dispensed by MLHPs.

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NIHFW Campus, Baba Gangnath Marg
Munirka, New Delhi – 110067
E-mail: nhsrc.india@gmail.com
Website: www.nhsrcindia.org