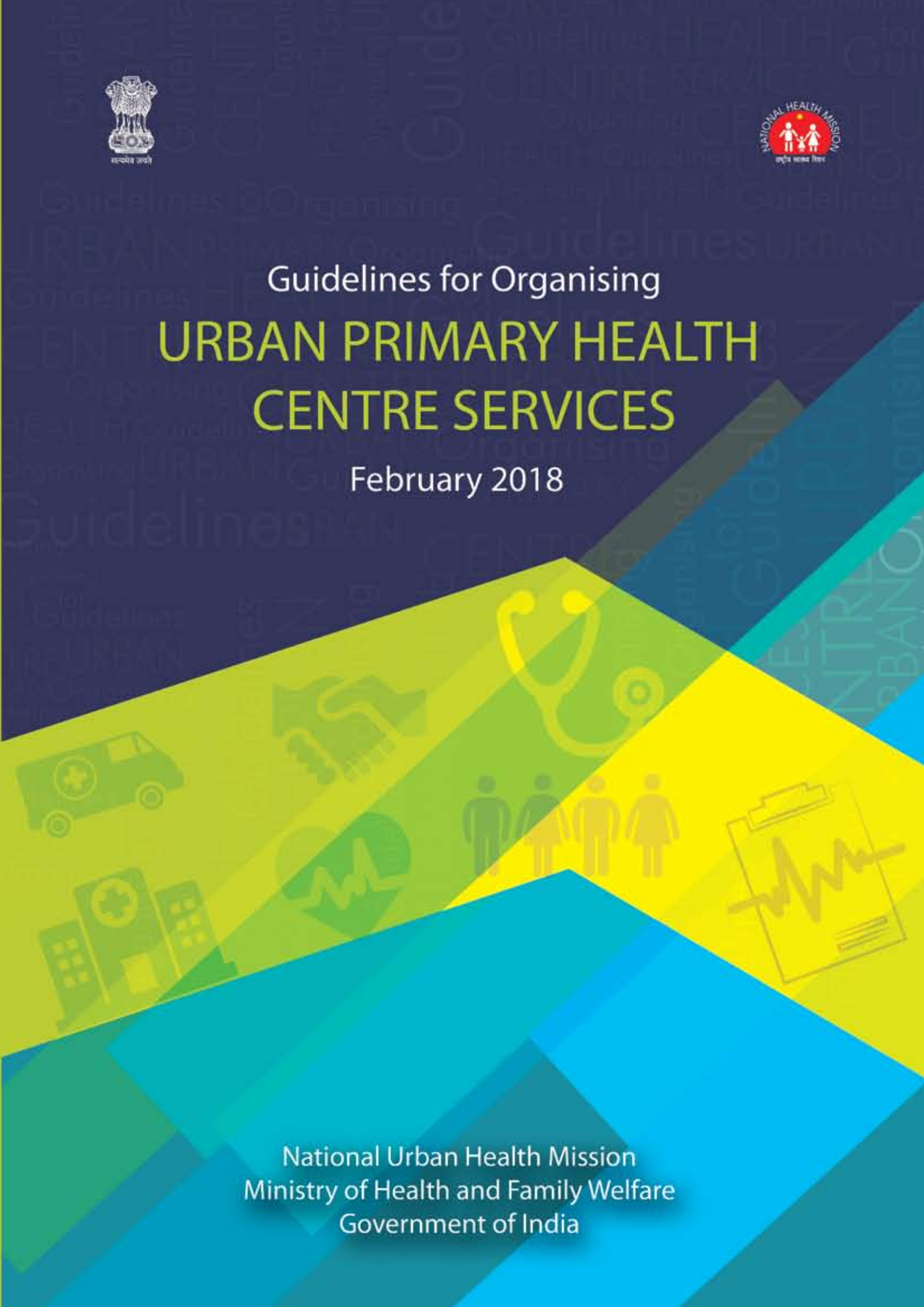
Guidelines for Organising

URBAN PRIMARY HEALTH CENTRE SERVICES

February 2018



National Urban Health Mission
Ministry of Health and Family Welfare
Government of India

सत्यमेव जयते

राष्ट्रीय स्वास्थ्य मिशन

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प्रीति सूदन
सचिव
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Secretary

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

Dated : 8th December, 2017

PREFACE

Over the last two decades, India's urban population has increased from 217 million to 377 million and is expected to cross 600 million by 2031. As per 71st round of National Sample Survey (NSSO), there are an estimated 52 million poor people living in the cities and towns of India. The challenge is not just the sizeable numbers but also the unplanned manner the population is growing thereby increasing the burden on the health system and related health and social indicators. The health indicators of the urban poor are comparable to, and in many cases, worse off than, the poor living in rural areas of the country.

In order to effectively address the health concerns of the urban population, Government of India launched the National Urban Health Mission (NUHM) in May 2013. The initiatives under the NUHM aims to provide the comprehensive primary healthcare services in urban areas, through Urban Primary Health Centres (U-PHCs), Urban Community Health Centres (U-CHCs; which act as First Referral Units/FRUs), strong outreach services and accessible frontline health workers. This is also in accordance to the strategic direction provided under the National Health Policy-2017.

NUHM has identified some key activities to accelerate the pace of work such as: vulnerability mapping of urban poor; service delivery and assured referral to urban poor through U-PHCs and U-CHCs; outreach services through Urban Health and Nutrition Days (UHND). Furthermore, the mission also focuses on specific urban health needs, in addition to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) services like Non-Communicable diseases (NCDs), urban centric vector borne diseases, Tuberculosis etc. U-PHCs are required to roll out the community based screening for five common NCDs like Hypertension, Diabetes Mellitus, Cancer of Breast, Cervix and the Oral Cavity.

I appreciate the efforts undertaken by the Urban Health Division of the Ministry, National Health Systems Resource Centre (NHSRC) and other experts/partners in bringing out this document, which will be an informative and useful resource not only for the staff of the UPHCs but also for all the concerned stakeholders associated with NUHM.

(Preeti Sudan) 8/12/17

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FOREWORD

Urban population, unlike the rural population, is highly heterogeneous. Most of the published data do not capture the heterogeneity, as the Standard of Living Index often does not disaggregate it, income-wise. Urban average figures thereof mask the health conditions of the urban poor. NUHM aims to address the health concerns of the urban poor by facilitating equitable access to available health facilities by rationalizing and strengthening the existing capacity of health delivery system.

U-PHC is the interface between health system and the urban poor. It is the epi-centre for the preventive, promotive and curative healthcare, which operates and manages outreach sessions, special camps, home visits by Auxiliary Nurse Midwives (ANMs), community mobilization through ASHAs and Mahila Arogya Samitis (MAS), apart from providing medical care through the out-patient services. It is therefore of utmost importance that a specific guidebook with uniform information and directives on effective management of the U-PHC is published.

The paramount objective of the Guidebook is to strengthen the Preventive, Promotive and Curative Health care system for urban population, with a special focus to vulnerable population. It also goes beyond RMNCH and A services to provide comprehensive primary care including for NCDs in consonance with the healthcare needs of the urban poor. In addition it is expected that the Medical Officer at UPHC, the prime user of the document shall find this beneficial as it gives direct guidance for implementing health care services of urban population, especially the urban poor.

(Manoj Jhalani)

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FOREWORD

The Urban Primary Health Centre (U-PHCs) envisaged under the aegis of National Urban Health Mission (NUHM) plays a pivotal role in delivering necessary primary healthcare services to the urban population particularly the slum and vulnerable sections. In a country like India, where a substantial urban-rural gap exists, the healthcare needs remain different for the diverse population. It is therefore imperative to envisage healthcare facilities with structure and functionalities at best to fit to the needs of the urban population.

Further, it is important to mention that the human resources engaged under NUHM requires a clear and comprehensive understanding of the functioning of the U-PHCs. This will facilitate the staff to perform efficiently and effectively in the delivery of health services for the target population. Hence, interaction and coordination between different cadres of staff and convergence of their activities remain critical.

In the background of such thought, the idea to develop and publish a guidebook for operationalization of the U-PHC was conceptualised and nurtured. This guidebook is aimed at providing a uniform and broad-based understanding of the critical elements and functioning of the U-PHCs. It will be beneficial for the medical officers, staff members of U-PHCs and the program managers at city/district and state levels.

I sincerely believe this book shall bring clarity about the critical elements, functionalities and operationalization of U-PHCS at the state, city and district levels.

(Preeti Pant)

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LIST OF ABBREVIATIONS

ANC	Antenatal Check-ups
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BMI	Body Mass Index
BMWM	Bio Medical Waste Management
CMHO	Chief Medical and Health Officer
DOTS	Directly Observed Treatment, Short Course
GoI	Government of India
HBNC	Home Based Neonatal Care
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
IDSP	Integrated Disease Surveillance Programme
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IDSP	Integrated Disease Surveillance Programme
IPHS	Indian Public Health Standards
IUCD	Intrauterine Contraceptive Device
LHV	Lady Health Visitor
MAS	Mahila Aarogya Samiti
MIS	Management Information System
MO	Medical Officer
MOIC	Medical Officer In Charge
MoHFW	Ministry of Health and Welfare
NCD	Non Communicable Disease
NHSRC	National Health Systems Resource Centre
NLEP	National Leprosy Eradication Programme

NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke
NHM	National Health Mission
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
JnNURM	Jawaharlal Nehru National Urban Renewal Mission
NVBDCP	National Vector Borne Disease Control Programme
OCPs	Oral Contraceptive Pills
OPD	Outdoor Patient Department
PHCs	Primary Health Centres
RBSK	Rashtriya Bal Suraksha Karyakram
RCH	Reproductive & Child Health
RKS	Rogi Kalyan Samiti
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infections
STI	Sexually Transmitted Disease
TB	Tuberculosis
ULB	Urban Local Bodies
UPHC	Urban Primary Health Centre
U5MR	Under Five Mortality Rate

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1
INTRODUCTION

1.1 About National Urban Health Mission

Urban population in India has registered an increase of 32% in the last decade from 2001 to 2011 and is standing at 37.7 Cr as per the GoI census 2011[1]. Growth in urban population has led to a rapid increase in number of urban vulnerable poor, many of whom live in slums and other squatter settlements. The overall slum population is estimated to be 7.6 Cr, which is 20% of the total urban population.[2]

The urban poor suffer from poor health status. As per the NFHS-4 (2015-16) data, Under-5 Mortality Rate (U5MR) among the urban poor is 34 per 1000 live births, and Infant Mortality Rate (IMR) is 29 per 1000 live births. More than 49% of urban poor children are underweight and 36.1 % of urban poor children miss total immunisation before completing one year. Poor environmental condition in the slums along with high population density makes them vulnerable to lung diseases like asthma/bronchitis**,** tuberculosis (TB) etc. Slums also have a high-incidence of Water Borne (diarrhoea/dysentery) and Vector Borne Diseases (Dengue, Chikungunya) and cases of malaria among the urban poor are twice as high as other urbanites.

In order to effectively address the health concerns of the urban poor population, the Ministry of Health and Family Welfare, Government of India launched the National Urban Health Mission (NUHM) in the year 2013. The initiatives under the NUHM seek to strengthen the public health thrust in urban local bodies, besides providing health care for the urban poor. The focus of the NUHM is on alleviating the distress and duress of the urban poor in seeking quality health services. Thus, it is envisaged that during the mission period all 994 cities with a population of above 50,000, and all the district and state headquarters (irrespective of the population size) would be covered. This will be in partnership with the NRHM's efforts so far to ensure that there is no duplication of services. Urban areas with population less than 50,000 will be covered through the health facilities established under the National Rural Health Mission (NRHM). The NUHM aims to focus on:

- Urban poor population living in listed and unlisted slums.
- All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers and other temporary migrants.
- Public health thrust on sanitation, clean drinking water, vector control, etc.
- Strengthening capacity of all public healthcare providers including health personnel of urban local bodies.

1 Government of India (2011), Census 2011 (GoI), Ministry of Home Affairs, Office of Registrar General & Census Commissioner.

2 Government of India (2013), National Urban Health Mission-Implementation Framework, Ministry of Health & Family Welfare.

1.2 Specific Interventions under NUHM

I. Facility Level

a. **Establishment of UPHCs:** UPHCs are to be established for every 50,000 population, in close proximity to urban slums. All facilities should have a registered RKS for management and monitoring of service delivery and release and utilization of untied funds received by the facility.

b. **Establishment of UCHCs:** UCHCs are to be established for every 2.5 lakh population**.** Cases from UPHCs shall be referred to UCHCs where secondary care facilities will be available.

The UPHCs and UCHCs shall integrate services under all national disease control programs and provide the same to their catchment area in a seamless manner.

II. Community Level

a. **Urban ASHA:** One urban ASHA for every 200-500 urban vulnerable households shall ensure delivery of services to vulnerable households through home visits and provide an essential link between the community and the UPHCs.

b. **Mahila Aarogya Samitis:** These groups of community women, formed for every 50-100 households in slums and slum like settlements, shall provide a platform for convergent action and a mechanism for the community to voice their health needs. MAS may monitor Urban Health & Nutrition Days, Special Outreach Camps, deliveries and availability of referral transport. The MAS will be given an untied fund of Rs. 5000 every year which shall be deposited in MAS account opened in nearest bank. The management of Untied fund is completely in the hands of MAS.

c. **Outreach Services:** Regular outreach services shall be provided through Urban Health and Nutrition Days. Specialist services shall be provided at the community through Special Outreach Camps depending upon special needs of the vulnerable population.

III. Vulnerability Assessment

In order to understand the target population and their health needs, the UPHC shall conduct a vulnerability assessment. This may be conducted for all households/individuals in the UPHC's catchment area or only of the vulnerable population, as decided by the state. The frequency of assessment can vary from state to state as per the nature of vulnerable population, however, the guidelines recommend assessment to be made in every 6 months.

IV. Involvement of ULBs

NUHM aims to increase the participation of ULBs in planning and implementation of health services. For larger cities, including metro cities, NUHM is to be implemented through the Municipal Bodies. For smaller cities, NUHM will be implemented by the Health Department, with active involvement of the ULBs. In either case, there are some critical functions which require close collaboration between NUHM and ULBs to positively influence the wider determinants of health (this list is not exhaustive) such as Epidemic control (including control of vector borne diseases), Disease surveillance, Treatment and disposal of sewage, Solid waste management including carcass disposal, Drinking water supply, Sanitation and prevention of public health nuisances, Dangerous and offensive trade, licensing (in particular slaughter house management, health safety in cinemas, restaurants etc), Food safety, Road safety, including street lighting, Birth and death registration, Management of cremations and burials, Control of stray dogs – and rabies control, Air pollution, Convergence of slum redevelopment and affordable housing, Implementation of welfare schemes for vulnerable populations, especially the homeless. Irrespective of whether NUHM is implemented by the Health Department of the ULBs, the organization of primary healthcare services shall be the same.

1.3 Comprehensive Primary Health Care through the UPHC

Historically, Primary Health Care in India has been limited to package of selective services, leading to fragmentation of care and high out of pocket

expenditures particularly on services not related to maternal and child health or communicable diseases. This feature is exacerbated in urban areas where primary health care is accessed at tertiary and secondary care institutions, since the primary health infrastructure is not as structured as in rural areas. Urban areas furthermore have a large, and sometimes unregulated private sector with significant variation in cost and quality of services. All these factors challenge the provision of primary health care in urban areas.

In order to provide comprehensive primary healthcare services in urban areas, the National Urban Health Mission aims to establish urban primary healthcare centres (UPHCs) as hubs of preventive, promotive and basic curative care for its 50,000 population. In this well-defined catchment area, the UPHC is responsible for the primary health care and public health needs of the population. With its focus on continuity of care, the UPHC shall develop strong upward (with higher facilities) and downward (with community) linkages to develop a robust chain of referral, while effectively gate-keeping the health seeking behaviour of its population.

Thus, the UPHC shall be the epicentre from which the core Primary healthcare team operates and manages outreach sessions, special camps, home visits, oversee community mobilization through MAS, coordinate referrals and of course, provide healthcare at the facility. The package of 12 services that the UPHC is expected to provide spans preventive, promotive, curative, rehabilitative and palliative care for the following areas:

i. Care in pregnancy and child-birth (the latter would be provided based on the state context).
ii. Neonatal and infant health care services.
iii. Childhood and adolescent health care services including immunization.
iv. Family planning, Contraceptive services and Other Reproductive Health Care services.
v. Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments.
vi. Management of Communicable diseases: National Health Programmes.
vii. Screening and Management of Non-Communicable diseases.
viii. Screening and Basic management of Mental health ailments.
ix. Care for Common Ophthalmic and ENT problems.
x. Oral health care and Essential Dental Therapeutic Procedures (EDTP).
xi. Geriatric and palliative health care services.
xii. Burns & Trauma Care (that can be managed at this level) and Emergency Medical services.

With the Medical Officers, Public Health Managers (PHM), Staff nurse, supplemented by the ANMs and ASHAs, the team of the UPHC can provide the set of services defined above, with the requisite training. Population enumeration, ensuring life cycle appropriate services including screening for non-communicable diseases, treatment, referral and follow up would be key components.

In addition to basic health services, the UPHC should also address social and environmental determinants in its catchment area through the ASHA & MAS, supported by the ANM and PHM. The UPHC should also establish linkages with the ICDS system, homeless shelters, housing programmes, and other relevant stakeholders so as to enable non-medical services, particularly for its vulnerable population.

The UPHC also plays a critical role in referral and follow up. In urban areas given the proximity to secondary and tertiary care services, this is relatively easy but requires careful planning and management. The navigational role of the ASHA and ANM is also critical. The UPHC should also undertake planned specialist consultation. This assumes particular importance when the screening, early detection and management of non-communicable diseases is included into the package of services.

The NUHM aims to provide comprehensive primary health care through the Urban Primary Health Centers with robust upward and downward linkages.

The key principles of comprehensive primary health care for urban areas followed in developing these guidelines are:

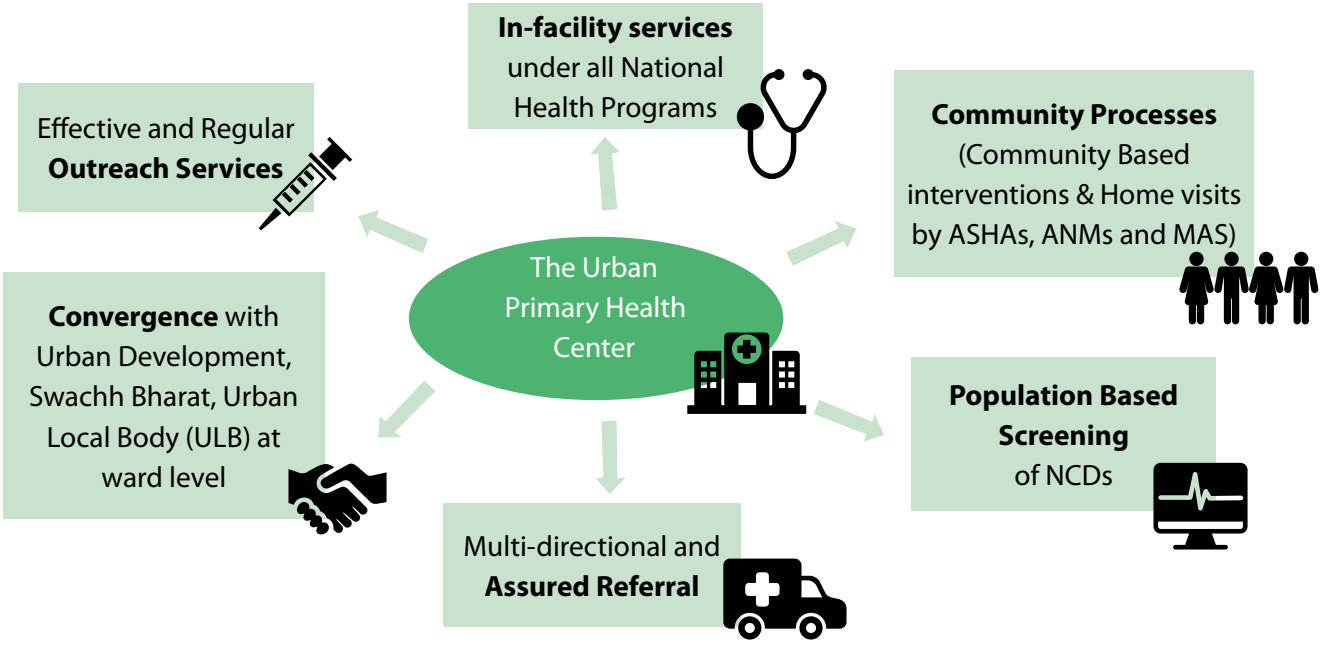
1. Universal provision of basic preventive and promotive care.
2. An assured minimum package of services is to be delivered to the population, as close to home as convenient and necessary, to ensure universal access with quality.
3. Increased focus on preventive and promotive care at the community level.
4. Improved management at UPHCs to reduce patient load at secondary and tertiary centers.
5. Reduction of out of pocket expenditure on drugs and diagnostics.
6. Provision of culturally appropriate health care & counselling through trained frontline health staff.
7. Integration and collaboration with Urban Local Bodies and other department for improved convergent actions for social and environmental determinants of health.
8. Enhanced focus on screening of non-communicable diseases, early identification of communicable diseases and early outbreak identification and management.
9. Special efforts to identify, reach out to and address healthcare needs of urban marginalized populations.

1.4 Objectives

The primary goal of the guideline is to improve the quality of service delivery and health outcomes by recommending a basic set of interventions to deliver primary health care services at the UPHCs. Specifically, the guidelines aim to:

1. Define the services to be delivered at the level of community, outreach, UPHC and referral linkages with UCHC.
2. Provide guidance for planning, organizing and managing service provision at the above levels.
3. Indicate the broad infrastructural and human resource requirements.
4. Define the job descriptions of all UPHC staff.
5. Guide on establishing ancillary and support services.
6. Define monitoring, supervision and reporting mechanisms.

Figure 1: UPHC as the Epicenter for Comprehensive Primary Health Care



1.5 Target Audience

The primary users of this document are all health functionaries at the UPHC who are responsible for providing service package through the UPHC, outreach and community based interventions. The detailed job descriptions of each functionary are given in Annexure III. This document will also be useful for program managers at state, district & city levels who have a key role in supporting UPHCs in organising their services.

1.6 Scope of the Guidelines

This document provides guidance for planning and organising health services by the UPHC. This entails two components: the planning and management of health services and defining the range of services to be provided. Accordingly, this document is divided into two components as follows:

The introduction deals with the management and planning aspects of the UPHC, namely:

1. Human resources at the UPHC.
2. Timings
3. Managing and governing UPHC.
4. Identifying and registering families in UPHC catchment area.
5. Organising outreach activities.
6. Ensuring social mobilisation, health communication activities.
7. Organising of general out-patient care.
8. Referral Mechanism.
9. Managing clinical support services- diagnostics and pharmacy.
10. Providing ancillary services- housekeeping and bio medical waste management.
11. Converging with nutrition, water and sanitation.
12. Ensuring infection control.
13. Establish Grievance Redressal.
14. Conducting patient feedback and exit interview.
15. Convergence with national programs – NPCDCS, RNTCP, NLEP, NVBDCP, RKSK, RBSK.

The second part of the Guideline: Administrative organisation of the UPHC describes the range of health services to be provided, namely:

1. Care in pregnancy and child-birth.
2. Neonatal and infant health care services.
3. Childhood and adolescent health care services including immunization.
4. Family planning, Contraceptive services and Other Reproductive Health Care services.
5. Management of Common Communicable Diseases and General Out-patient care.
6. Management of Communicable diseases: National Health Programmes.
7. Integration with RNTCP.
8. Screening and Management of Non-Communicable diseases - Integration with National Health Programme (NPCDCS).
9. Screening and Basic management of Mental health ailments.
10. Care for Common Ophthalmic and ENT problems.
11. Oral health care and Essential Dental Therapeutic Procedures.
12. Geriatric and palliative health care services.
13. Burns & Trauma Care (that can be managed at this level) and Emergency Medical services.

The guidelines for planning and management of each service will essentially focus on the scope, purpose, responsibility and the process/activities to be undertaken for each service.

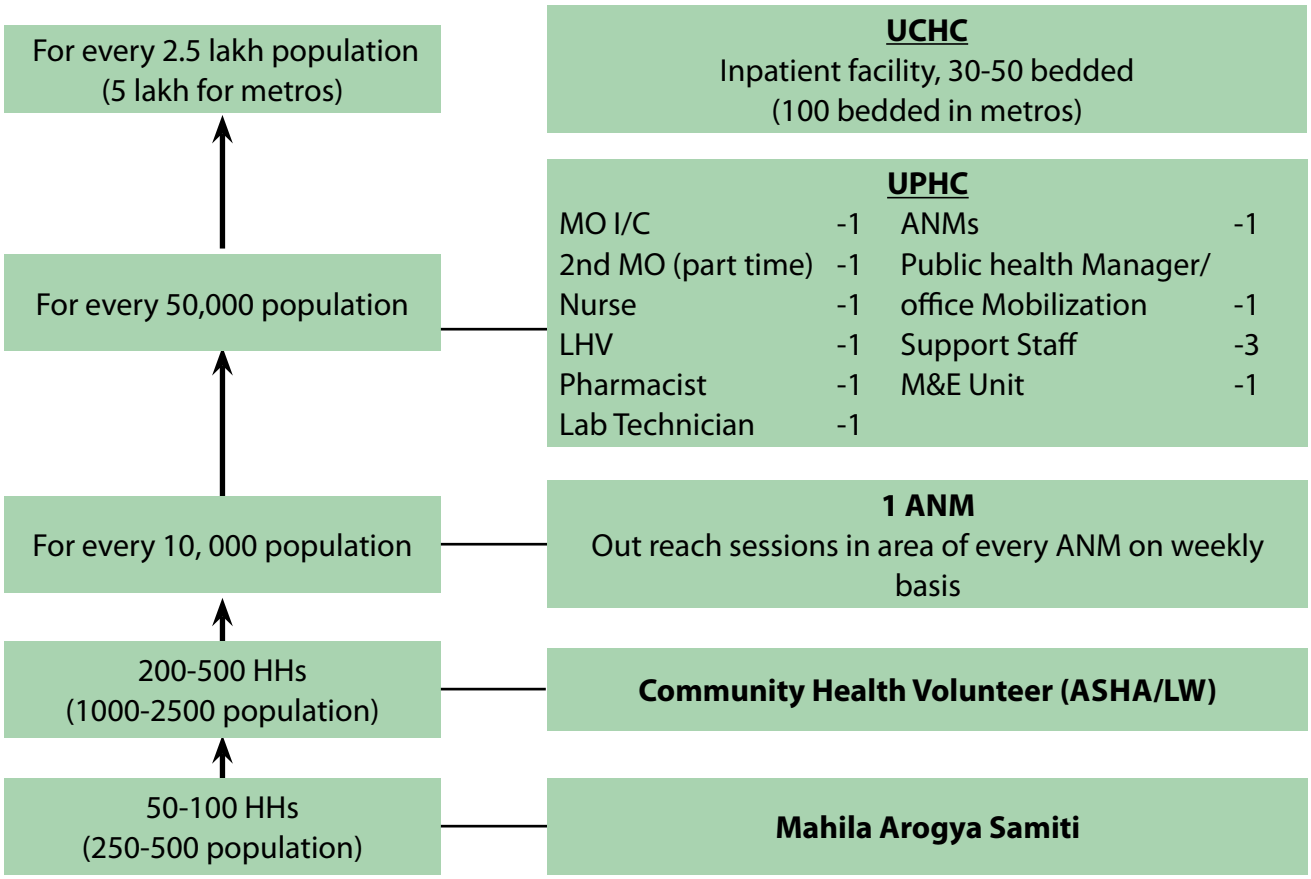
2
ADMINISTRATIVE ORGANIZATION OF THE UPHC

2.1 Human Resources at the UPHC

Scope: Defining number of staff required; Clarity on job descriptions, roles and responsibilities, and performance measures for each staff; Skill sets required and arrangements for training; Maintaining a positive work-force environment. This scope does not include details of selection, eligibility of each category of staff, the organisation of training, or the requirements of supervision and support from higher levels.

Purpose: A motivated, skilled work force is essential for health service delivery and the achievement of health outcomes.

Figure 2: Staff Structure at the UPHC



Activities:

1. Each UPHC should put in place the following minimum number of staff: 1 full time and 1 part time Medical Officer, nurse-1, pharmacist-1, laboratory technician-1, lady health visitor (Nurse Supervisor)-1, ANM-3-5 (depending on population catered), secretarial staff-1 and one Public Health Manager. In addition, there would be one ANM for every 10,000 population and one ASHA for every 2,000 population reporting to the UPHC.
2. The UPHC staff needs to adhere to the dress code as prescribed in each state.
3. Duty roster mentioning the duty timing and responsibility of each staff, should be prepared regularly.
4. More Medical Officers or nurses could be added in places where caseloads are high and all existing staff are fully utilised. Some of the outpatient care, especially follow-up care and repeat medications must be managed by the nurses so as to allow more time for doctors to see new patients or manage complications where clinical judgement is required.
5. Job responsibilities for Medical Officer and Public Health Manager, LHV/ANM supervisor, ANM and ASHA are given in Annexure III. Job Responsibilities of ANMs have been defined in "Operational Guidelines for Enhancing Performance of ANMs in the Urban Context".
6. The MOIC with assistance from the Nurse Supervisor is required to ensure that the skills with respect to standard treatment guidelines and care protocols are present in all the staff under them, and recommend for training anyone who is found to have significant gaps. This includes the skills of the laboratory assistant and the pharmacists. The MOIC and Nurse Supervisors themselves must be trained at the city or district level by appropriate resource teams and certified as having the necessary skills.
7. The MOIC, Nurse Supervisor and Public Health Manager are together responsible to ensure a positive practice environment for all those working at or under the UPHC. This would require public recognition and appreciation and if possible incentives for those doing their work well, polite supportive behaviour with junior staff as colleagues, ready assistance in problem solving on a day-to-day basis and a learning, creative atmosphere. Above all, it requires a partnership with the community that they serve- so that the work they do, leads to community satisfaction, which has a direct relationship with provider satisfaction as well. While material needs of staff – like adequacy of salaries – cannot be taken care of within the limits of a UPHC, much can be done to improve performance and provider satisfaction by creation of a positive practice environment.
8. The secretarial staff at UPHC level are expected to take care of all accounting and reporting activities. He/she should also assist the RKS and MAS in all their accounting and reporting related activities. He/she shall seek guidance from the block/district/municipal corporation level accountant for all accounting and reporting related assistance.

2.2 Timings

- The UPHC should be operational for 8 hours every day. Suggested timings include 12 pm – 8 pm or dual shifts from 8 am – 12 pm and 4 pm – 8 pm.
- Each UPHC should have morning and evening OPD. OPD timings may vary as per state norms.
- The laboratory timings need to match the OPD timings. The timings should cause as little inconvenience to the patients as possible. Patients should not have to make repeat visits for tests, collection of reports, post-test consultation etc.

2.3 Management and Governance of the UPHC

Scope

1. Management of the UPHC.
2. The role and functions of the Patient Welfare Committee.
3. Patients charter, public information including signage, grievance redressal.
4. Information management and reporting Ensuring quality of care.
5. Monitoring and reporting.
6. Financial management.

Purpose: The UPHC needs to provide quality services that are responsive to people's needs and demands and hold itself accountable for its performance. It must be able to measure the effectiveness of care it provides, improve the efficiency with which it is provided, and ensure quality of care.

Responsibility: MOIC, Nurse and Public Health Manager

Activities:

1. Management of the UPHC is through a management committee made up of the Medical Officer (s), the Nurse Supervisor or the senior nurse and the Public Health Manager. This committee should meet weekly.

Rogi Kalyan Samitis (Patient Welfare Committee)

2. Each UPHC shall also constitute a Patient Welfare Committee or Rogi Kalyan Samiti (RKS) as per guidelines. The guideline provides for public participation, both of elected members and of other public representatives.
3. Meeting of the RKS should be held at least once in two months. In between the meetings, the management committee acts as its secretariat in ensuring that the decisions of the RKS are implemented in the UPHC.
4. Reports to the RKS are made public documents to inform the achievements, shortcomings, challenges and finances of the UPHC. An annual review meeting is held preceded by the release of an annual report of the UPHC performance.

Public Consultations and Public information

5. Where new UPHCs are being created or any other social barriers that exclude access to vulnerable groups, discussions must be held in consultation with the community as to which location would be most useful.
6. The patients' charter is prominently displayed in UPHC waiting area. Signage as required must be displayed at the centre. All of these should be in the language spoken by most of the service users of that area.

Information Management and Reporting

7. Monthly compilation and analysis of health information should be collected by UPHC staff for the IDSP programme, the RCH programme, the various disease control programmes. The same must be uploaded on the various web-based databases of Govt. of India, including MCTS, HMIS, IDSP, and Nikshay, and as per State Govt. requirements.
8. Monthly health service information on out-patients categorised by diagnosis should be reported to districts.
9. Governance data on stockout of essential medicines, staff absenteeism and infrastructure upkeep is to be recorded.
10. Basic analysis of data should be performed either through HMIS or manually or through MS Office programmes.
11. The UPHC needs to integrate monitoring and reporting mechanisms for the routine and special outreach. For the monitoring and reporting of outreach sessions, the UPHC may refer to the **Operational Guidelines for Conducting Outreach Sessions in Urban Areas (2015) and Guidelines for ASHA and MAS in Urban Context (2015).**

Ensuring Quality of Care

12. The quality of care provided should be ranked and scored according to the

Quality of Care Framework (2013) prepared by NHSRC and released by the Ministry of Health and Family Welfare. The quality score and sub-scores should be included as part of the Annual Report.

13. Kayakalp Guidelines should also be followed for the good up keep of U-PHC premise by RKS and staff of U-PHC.

Financial Management

14. Financial management is an important contributor to the functioning of the UPHC and its community outreach programmes. Good accounting practices lead to timely utilisation certificates and transparency and integrity in financial expenditures.
15. Better allocation of available resources and innovative ways of raising resources is essential to close the gaps. In particular, the UPHC management can make good use of the untied funds received as grants and also try to raise money from urban local bodies and donations for improving the quality of services it provides.
16. MOIC/nominated person in his/her absence shall be accountable for discharging financial management responsibility.
17. The staff shall follow the **Financial Management Guidelines issued by the Govt. of India for NHM and all related letters/circulars**. Some of the important points to note are as follows:
    a. Books and records as mentioned in the financial management guidelines should be maintained. All vouchers and supporting documents should be maintained chronologically.
    b. Reporting to the block/district/ municipal corporation and submission of Utilisation Certificates (UCs) should be done on a timely basis.
    c. The UPHC shall be available for audit as and when required. Any issues pointed out by audit, shall be promptly attended to and resolved.

Characteristics of a Model UPHC

- The facility should have good visibility, with standardized colour coding of signage and exterior façade.
- Map at the entry of the UPHC and signage at the appropriate places may be placed for guiding the patients during their movement in the facility.
- Facility should be clean with pleasant surroundings.
- Should have patient friendly environment and waiting areas.
- Should be friendly for the differently-abled. Stairs should be complemented with ramp/lift for smooth access of services in the facility.
- Preference to senior citizens must be given at every level of interaction.
- Services rendered should be gender sensitive with zero tolerance for compromise in dignity and privacy.
- Separate washrooms, breast feeding corners, respectful behavior are some of the key indicators for gender sensitivity.
- Registration counter and emergency facilities with triaging should be in the most accessible area.
- Waiting area should be immediately adjacent to the consultation room.
- Sufficient wheel chairs and stretchers should be made available at the patient receiving area.
- All IEC displays should be relevant & easily visible. It should be properly framed and displayed, never pasted on wall.
- All displays and signage should be in a language easily understood by the local community.
- The option of co-locating the AYUSH centre with U-PHC may also be explored, thus enabling the placement of AYUSH doctor and other AYUSH paramedic staff in the U-PHC.

2.4 Identifying and Registering Families/Individuals in UPHC Catchment Area

Scope: All persons living in the catchment area of UPHC as per their health needs and demands.

Purpose: To understand the profile of the catchment population and their healthcare needs.

Responsibility: Medical Officer In Charge (MOIC) and Public Health Manager

Process:

a. ***Defining Area:*** MOIC should obtain a broad written mandate from the Nodal Officer in the Municipal Corporation / Chief Medical and Health Officer (CMHO) of the district, regarding the area to be covered.

b. ***Source of Data:*** The database of all households and individuals should be obtained from one of the following sources- Census, Election Commission's house lists, Pulse Polio lists or any other survey done in the state/city. Even one of these would be adequate but the preference is the order indicated above. If none are available, the MOIC along with Public Health Manager must ensure a formal house listing. Households should be given a unique number derived from any of the available lists *(refer b)*. If not, then house number may be allotted based on the house-listing. Aadhar number may also be recorded wherever available.

c. ***House Visits:*** A house listing team comprising of the ASHA/link worker/community organisations/NGOs is recommended to visit each house, as per the State's discretion and fill up the basic details of demographic data in a format. ANMs and PHMs need to supervise this activity. PHM also needs to analyse the report and bring out the areas of concern and actions required to address these gaps. Over a period of three months, each household to be catered by the UPHC should be visited on an appointed time by the ASHA along with the PHC staff to discuss the services available at the UPHC.

d. ***Data Collection:*** During this visit, the household level information must be updated using a simple questionnaire. The questionnaire must gather information related to vulnerable individual's risk factors and chronic illnesses

a. ***The information should capture basic demographic data:*** name of each member, age, sex, relationship with head of household, occupation and current need and access to primary healthcare services, number of under-five children, immunisation status, pregnant women with ANC history, eligible couples, and it would also include vulnerability category. The data base would include listing the migratory or homeless population based on the *Vulnerability Assessment Guidelines (2017)*. This could be done manually or in an electronic format. The visit should also include examinations like Blood Pressure measurements; glucometer readings for blood sugar are optional.

b. After the assessment, each family member should be given a **health card** for future reference and follow ups.

e. ***Data Management & Line-listing:*** Demographic database must be uploaded on the website. This would require a computer at the UPHC with internet connectivity. A tablet with every UPHC is also desirable. The Public Health Manager should undertake this task with the help of other staff. From the data base that is created, separate lists of eligible couples, pregnant women, infants, children aged one to four, and those with different specific chronic illness as included in the package are also generated, recorded and reported. Computerisation facilitates this process greatly. The lists of pregnant women and children less than one year should match with those on the

mother and child tracking system and/or HMIS and mismatches should be identified and corrected. The focus should be on the vulnerable population. These are the facility specific denominators that would be used for measuring performance.

Reporting:

a. The demographic database and the registered population database should be reviewed annually and checked with the field situation. The chronic illnesses database is also reviewed and updated along with any additional details available. The separate lists of eligible couples, pregnant women, infants, and children aged one to five, would be updated monthly and any changes needed on the demographic data base could be carried out on a quarterly basis (later with inter-operable systems it could happen on a real-time basis).

b. Relevant data as required and asked for should be uploaded on to the web-portal of the state government. States may decide to provide names and individual details to be uploaded or may only provide the aggregate number of registered population. If there is any change in this registered population database or in the demographic database, or in the data uploaded onto the state web-portal, the changes should be made as and when notified along with an audit trail which would record who made the change, when and what was the changed data.

2.5 Organisation of outreach activities

Scope: Planning and implementation of Urban Health and Nutrition Days (UHND) and Special Outreach Camps.

Purpose: To reach out to vulnerable population with basic preventive health services, and refer them to the UPHC or higher center for further care [Detailed guidelines on organizing outreach activities have been released in **"Operational Guidelines for Outreach Activities in Urban Areas"**].

Responsibility: ANM and ASHA at the outreach venue; MOIC and PHM for planning and MAS for awareness generation.

Planning of Outreach Activities

1. Each UPHC shall determine the minimum requirement of outreach sessions it needs for immunisation sessions, health and nutrition days and for health camps with an NCD focus. Since a UPHC caters to approximately 50,000 population, and is expected to have five ANMs under it, it may decide on anywhere from 10 to 20 outreach sites such that there is one site close to every 2,500 to 5,000 population sub-group.
2. The timing of the outreach session is critical, and should be held at a time convenient to the community. The site and the timing – the day in the month and the time of the day, should be fixed in consultation with the MAS.

Improving Access to Vulnerable Section of Urban Poor

To target special interventions for the vulnerable groups in the cities, mapping of the vulnerable groups should be undertaken as a periodic exercise, ideally every six months. The vulnerable sections would include the rag pickers, street children, construction workers, sex workers, street vendors and other such migrant workers. It is also envisaged that dedicated drug distribution centres be opened for the identified vulnerable groups, through Non-Government Organisation (NGO)/Civil Society Organisations (CSOs), which will have provisions for emergency Over-The-Counter (OTC) drugs and contraceptives. Special attention should be paid to organising outreach sessions for these vulnerable communities.

3. Outreach locations could preferably be an ICDS centre, but it may also be a school, a community hall or rented room paid for by the ULB, or any private premises. Ideally it should have two to three rooms that can be temporarily taken over for three to four hours for one day in a month.
4. Vulnerability assessment/ health service needs assessment of the population, in the catchment area of the UPHC shall guide in deciding the location and nature of services to be provided through outreach.
5. Outreach activities should be organised in partnership with MAS in that area, the ASHAs working in that area and any community based organisation or NGO which is acceptable to the MAS and to the UPHC committee.

Urban Health and Nutrition Days:

6. The outreach sessions are so planned that an ANM organises one outreach session per week or additional sessions if required can be proposed as per the need. If there are five ANMs under a UPHC, there would be 20 outreach sessions held per month. On occasions the ANM may have to hold two such sessions per week, especially if some posts are vacant. If the vacancy is higher, the outreach sessions are planned for the most vulnerable groups, and the rest are required to come to the UPHC.
7. Though ASHAs, UPHC staff and MAS assist ANM in organising, the accountability for the camp is with the ANM of the allocated area.
8. The ANM should maintain a record of services provided in each outreach session. A simple line list of service user, the identity of the service user and the nature of service provided is adequate. Where it is a category of patient requiring follow-up like a pregnant woman, or an infant coming for immunisation, or an adult taking NCD medication, the required follow-up data is also recorded.

9. List of essential services at the UHND

Service	Essential Service Delivery
Maternal Care	Registration, three ANCs, identification and treatment for anaemia, referral to UPHC for one ANC, identification of risk factors, referral for institutional delivery, postnatal care follow-up, counselling.
Immunisation	Immunisation as per schedule.
Child Care	Identification of danger signs, referral, follow-up, distribution of ORS, paediatric cotrimoxazole, postnatal visits/ counselling for newborn care, identification and treatment of malnourished children.
Family Planning	Family planning, Counselling, distribution of OCP/CC, referral for sterilisation, follow-up of contraceptive related complications.
Adolescent Health	Counselling related to sexual concerns, pregnancy, contraception, abortion, menstrual problems, Tetanus immunisation as per UIP schedule, weight and height measurement, BMI calculation and appropriate nutritional counselling for underweight or overweight condition as may be. Examines blood for haemoglobin and treats anaemia till it normalises.
Vector-borne Disease	Slide collection, testing using RDKs, Counselling for practices for vector control and protection.
Tuberculosis, Leprosy, HIV	Detecting suspected cases of leprosy and TB.
Non-communicable Disease	Screening for non-communicable diseases, follow-up of under treatment patients and referrals as required.

Special Outreach

10. Special outreach for the vulnerable groups needs to be organised on a monthly basis. The special outreach should focus on the vulnerable groups who are hard to reach and for whom accessing health service is a major concern. The location of these sessions should be in the area where such population resides (Community Centre, School, Railway Station, railway tracks, city outskirts, Bus Stands, underpasses, outside place of worship etc.)

11. In the special outreach sessions, specialists from higher centers should be called for addressing health needs for locally endemic diseases and population sub group-specific problems, chronic and non-communicable diseases. Basic laboratory investigations (using portable/disposable kits) and drug dispensing services must be ensured by MOIC along with ANM. ASHA and MAS should ensure that camps are attended by those needing such care. Lab Tech, Pharmacist, Physiotherapists may also be participating in these sessions.
12. Records of outreach camp including patient details, services provided and referral details should be maintained systematically to enable follow up.

2.6 Social Mobilisation for Health through ASHA and MAS

Scope: The establishment, support and functions of MAS, support and functioning of ASHAs in the urban context, involvement and participation of other relevant community based organisations and partnerships.

Purpose: Most preventive and promotive actions and a considerable level of self-care and primary care occurs at the level of the community and family. To ensure a pro-active community and family participation through social mobilisation of health for NUHM.

Responsibility: Public Health Manager, ANM, ASHA and MAS

Activities:

1. Mahila Arogya Samitis should be constituted for every 500 population or approximately 100 households. These could have 10 to 20 members, who could be chosen by asking every 10 houses to choose two members.
2. MAS should meet at least once a month. It is the role of the ASHA to ensure this and she may need the help of other partners to manage it.
3. In practice, at the appointed time, the ASHA would call all MAS members and convene the meeting with clear agenda for the meeting, such as tobacco control, hypertension, diarrhoea in the neighbourhood or any organisational issues such as improving UPHC or outreach services, water and sanitation problems. Posters or leaflets designed may be used during each meeting. Twenty women in a group of 500 people (which is the MAS catchment population) being sensitised on some key messages is a very effective way of community mobilisation for a theme.
4. Site of meetings could be innovative. It could be one fixed place, or it could be in different houses by turn.
5. Agenda of all meetings should include some solidarity building activities, collecting information on key health events like births, deaths, specific illness episodes etc. and imparting information on the time of the next outreach session and special health camps, if these are scheduled.
6. At least once in three months there should be a meeting at the UPHC level of all the conveners of the MAS, the ASHAs under the UPHC area, and the ANMs. Potentially there are 100 MAS and 50 ASHAs and five ANMs in such a meeting. Alternately, the most active MAS from each ANM's area could be called. The agenda of the meeting would be to review MAS and ASHA functioning and planning activities for the next three to six months. The public health manager and the elected ward member(s) of that area should also attend.
7. On special occasions and themes, and when funds are available, these meetings could take the form of one or two day training programme. Observing special days like World Health Day, HIV day or World Malaria Day etc., could be one way of bringing focus on issues which are important health issues for that community.

8. In addition to the above, when dealing with MAS or community based organisations representing specific vulnerable groups, assistance should be taken from selected NGOs or academic departments of social work or departments of public health. Professional associations could also assist in providing training and support to the MAS members and ASHAs of that area and hold special health camps as needed, responsive to the needs of that vulnerable group.
9. All the above are also effective forms of health communication and measures to improve positive health practices and change behaviours which have adverse health consequences. This is supplemented by ASHAs making a home visit to every house in her service area and spending time on health communication and gathering health information.
10. Routine house visits take place at a frequency of one per month and are used for imparting key health messages and encouraging utilisation of services as relevant to the individuals in that household. The list of the ASHA's activities at the level of the family is part of the services described in **2.3 to 2.6** of this chapter**.**

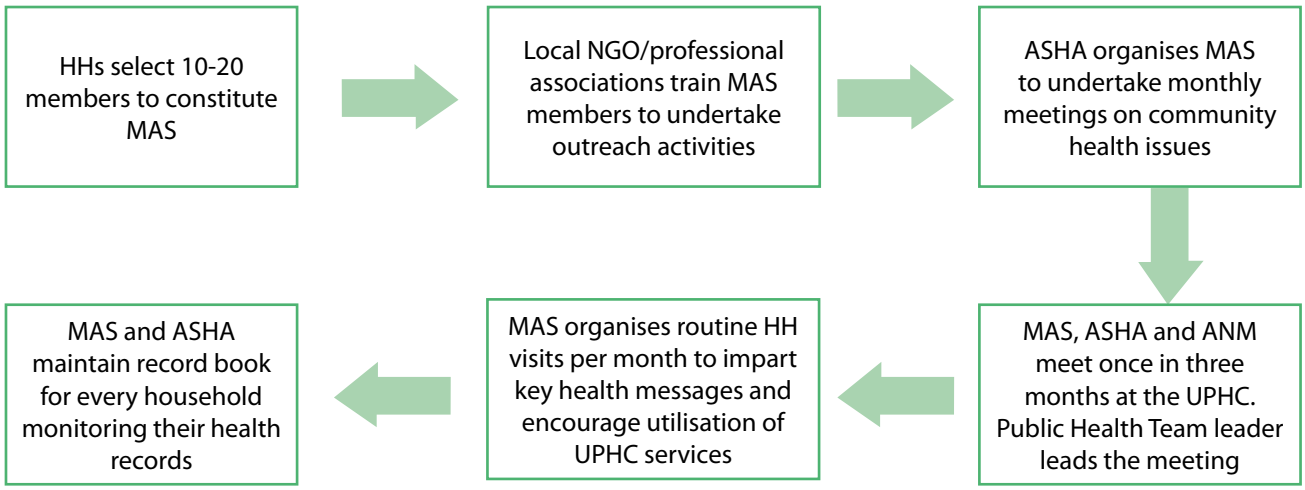
2.7 Organisation of General Out-patient Care

Scope: Patient registration, queue management, standards of time management, privacy and laboratory and pharmacy support. Purpose items 3, 6 and 7 listed below are specific to registered patients in the facility's catchment area whereas the rest relates to anyone seeking care at the UPHC irrespective of identity.

Purpose: The general out-patient care includes provision of health advice related to preventive, promotive and curative needs of patients. This would include:

1. Accurate and timely diagnosis and treatment or referral for illnesses.
2. Patient care as required at the facility level for maternal and newborn health, immunisation, child health, adolescent health or national disease control programmes as per protocol.
3. Screening for chronic diseases as per protocol, regular and assured follow up care for patients so that they can have requisite monitoring, access to routine prescribed medication, counselling and early detection and referral for complications.

Figure 3: Schematic Representation of Social Mobilization Process



4. Assured NCD screening services and its linkages with organized screening. Follow up of those detected with any morbidity or illness.
5. Facilitation of access to emergency transport and stabilisation care for medical or surgical emergencies. Ideally patients should bypass this stage and go directly to site of care, but the facility needs to be prepared for the same.
6. Identification of patients with symptoms of chronic complex illnesses - like cancer, psychosis, etc. and referral to a higher centre.
7. Response and feedback to referrals from frontline workers- ASHAs, ANMs etc. as needed.
8. Building a relationship of trust, confidence, understanding and satisfaction with the population served.

Key Responsibilities:

Activity	*Person In-charge*
Overall responsibility	MOIC
Registration, record and queue management	The staff at the registration counter
Consultation	MO, ANM/Nurse
Lab	Lab technician
Pharmacy	Pharmacist

Activities:

1. All patients should be registered according to category of care and if they are already registered previously, their number should be recorded in the registration book.
2. All registered patients need to be provided with a registration slip.
3. All patient details need to be recorded in the patient's card.
4. No person should be turned away without providing basic consultation, even if it is for referral to a higher centre.
5. Patients should be provided a queue number that would be used to call the patients for consultation.
6. Preference needs to be given to elderly, pregnant women, and other vulnerable groups. This could be done by separate queues or in some instances separate clinics with special waiting arrangements, till their number comes up.
7. All patients waiting for consultation treatment should be seated and should have access to safe drinking water and toilet facilities.
8. Records of patients treated under national programmes, and for regular chronic illnesses should be maintained for all visits. Records could be in the form of registers, case-sheets or digital records depending on the existing systems.
9. To manage the consultation time adequately, preliminary tests such as Blood Pressure examination, height and weight examination may be done by the nursing staff prior to consultation.
10. Consultation should cover previous health history, living conditions and family history. Following consultations, MO should provide a diagnosis, treatment and follow-up plan and ask patients if they have any questions regarding the consultation provided.
11. There should be adequate privacy for patients to discuss their health problems without being overheard, and to be examined without being seen by the waiting public or others.
12. The patient should be referred for laboratory tests based on the symptoms, if any diagnostic services are required.
13. The patient needs to be directed for follow up consultation after the diagnostic reports are made available, to facilitate further line of treatment as needed.
14. The patient needs to be directed to the pharmacy if any medicine has been prescribed under the initial consultation by the MO.
15. Special clinics may be organised in the afternoon or evening, on some specified

days, to enable a more focused follow up on some categories of chronic illness or for adolescent clinics etc. Schedule of such clinics should be displayed at the UPHC and actively disseminated during outreach activities by the ASHAs/ANMs and during UHNDs.

2.8 Referral Mechanism

Scope: Establishing a two-way referral mechanism to ensure continuity of care.

Purpose:

1. To enhance the system's ability to transfer patients between different providers and levels of the health care system, along with detailed records and documentation of the case.
2. To provide follow up care after referral consultant or supervise adherence to long term treatment plan as advised at the higher centre.

Responsibility: Medical Officers, Staff Nurse, ANM

Process:

1. Urban Community Health Centre (U-CHC) should be set up as a satellite hospital for every 4-5 UPHCs. UCHC would cater to a population of 2,50,000. It would provide in-patient services and would be a 30-50 bedded facility. For metros, U-CHCs would be set up with a population of above five lakhs, wherever required.
2. UCHCs are designated to provide specialist services. So, every UCHC should have defined linkages with the ground level facilities ie. UPHCs. This will help in effective management and follow-up of the patients requiring specialized care.
3. UCHCs can also plan to send specialist to the feeding UPHCs on monthly/ fortnightly basis. This will help in providing specialist services closer to people and would also assist in their timely review and follow ups. (Referring a patient from U-PHC to higher facility can be referred from **Section 7.16 of 'Referral Unit', NUHM Framework**).
4. Existing hospitals including ULB maternity homes, state government hospitals and medical colleges other than private hospitals, will be deemed to act as referral points for different types of healthcare services such as maternal health, child health, diabetes, trauma care, orthopaedic complications, dental surgeries, critical illness, surgical cases etc.
5. It is also expected that the collaboration with District Hospitals/Area Hospitals/ Sub-District hospitals and local Medical Colleges may be promoted for strengthening the training support and supplement human resource at the U-PHC level.
6. In addition to specialized clinical facilities at the above mentioned hospitals, UPHC need to identify centers providing services such as de-addiction for substance abuse, mental health services, rehabilitation, domestic violence help center, nutritional rehabilitation center (NRC) and others as per population needs. Such multi-directional referral pathway is very important to ensure that all health needs of the community are met.
7. Wherever public sector coverage is inadequate, reputed private sector institutions may be considered. The empanelled/accredited facilities could be reimbursed for the services provided as per the pre-decided rates, negotiated with them at the time of empanelling/ accrediting them and indicated in the city level urban health Programme Implementation Plans (PIPs) subject to approval at the appropriate level. This will not only ensure flexibility to adapt to different conditions in different cities but also increase the range of options for the beneficiaries. For all such PPP models, robust monitoring indicator and mechanism needs to be defined in the MOU.

***Activities*:**

1. UPHC needs to identify a contact person/ desk in each referral center to inform and take information regarding the patients referred, to ensure that they receive the necessary consultation that can enable follow up by UPHC.
2. All referrals should be in writing on a referral slip (Given in Annexure IV).
3. At the site of registration, the referring facility and provider should record the information in digital form or if not digitized, then in a referral register. A feedback referral form could be attached to the OPD slip at the time of referral. The following information must mandatorily be sent along with the patient:

Identity Details:	Medical/Clinical Details
◆ Full name of patient (and name of person responsible in case of minors ◆ Name of the person responsible in case of minors – (name, address and phone number) ◆ Age and sex of the patient ◆ Address and telephone number (if available) of patient ◆ ID of the patient	◆ Date and time of referral ◆ Diagnosis, if known ◆ Treatment given ◆ Reason for referral ◆ Name of physician or facility where the patient is referred ◆ Name of the doctor/ nurse and the UPHC making the referral ◆ Contact details of MO/ MOIC and the UPHC making the referrals

4. To establish an effective linkage, digital platforms can also be used for sending patients information to the referred clinician/ facility, or conveyed by fax/email.
5. Irrespective of providing the information in writing, the health provider should also inform the patient on reasons for referral and risks of non-referral. They should also provide details on how to reach the receiving facility, location and transport, whom to see, what is likely to happen, and follow-up on return. A handout/card could be prepared at the UPHC mentioning the details of the higher facility where the patient is referred.
6. All relevant diagnostic results (laboratory, radiological studies, previous referral information, etc.) should accompany the Patient Referral Form.
7. The UPHC staff would communicate and if possible schedule an appointment with the receiving clinic/hospital to ensure advance notice of the referral given and that the patient is expected. This is mandatory if the referral is an emergency. For emergency referral, transport needs to be made available as per established practice or availability in the State. Toll free nos. 102/108 or any other can be used for calling ambulances if available. All referred cases needs to be given a referral card or slip. It shall be the responsibility of UPHC staff and ambulance staff to ensure safety in transit, monitoring, and documentation.

Following activities should be carried out at the secondary (UCHC/District Hospital)/tertiary level for the referred patients:

1. At the referred facility, the patient should be guided by the registration desk/helpdesk staff to meet the appropriate provider. In large hospitals, to encourage referral and to slowly shift to UPHC as gate-keeper, the registration-cum-helpdesk for referred patients should be separate from that for other patients. To qualify for this preferential treatment, the patient should be coming in with the UPHC referral slip duly signed by the MOIC/MO.
2. Providers at the referred facilities shall receive the referred patient, along with the referral note from the UPHC which could be in digitised form or on paper. They would assess them and provide the necessary interventions.

The details of referral process are explained in Section 7 of NUHM training Module.

2.9 Management of Clinical Support Services: Diagnostics Lab and Pharmacy

Scope: Management of laboratory and pharmacy services as required for a UPHC.

Purpose: Organisation of appropriate laboratory and pharmacy services is essential to support quality of care and effectiveness in service delivery by the UPHC.

Responsibility: Laboratory technician, Pharmacist, MOIC

Laboratory

1. The UPHC needs to be staffed by a qualified laboratory technician. In the absence of a qualified technician, certain essential but simple tests can be performed by multi-skilling other staff.
2. If U-PHC does not have a Lab Technician, atleast provision for collecting sample can be made for diagnostic tests in partnership with empanelled private diagnostic centres. However, monitoring and audit mechanisms must be established clearly and robustly while entering PPPs.
3. Simple tests of larger volume should be done in the UPHC, but technically more demanding tests which are of lesser volume could be outsourced to a suitable laboratory under a contract or to the government hospitals linked with the UPHC.
4. The minimum laboratory services that a UPHC should provide are:
    - Routine blood tests (Hb%, platelets count, total RBC, WBC, bleeding and clotting time).
    - Routine urine tests (sugar, albumin, microscopy).
    - Diagnosis of RTIs/STIs with wet mounting, grams stains, etc.
    - Sputum testing for mycobacterium (**as per guidelines of RNTCP**).
    - Blood smear examination malaria.
    - Blood for grouping and Rh typing.
    - RDK for Pf malaria in endemic districts.
    - Rapid tests for pregnancy.
    - RPR test for syphilis/YAWS surveillance (endemic districts).
    - Rapid test kit for faecal contamination of water.
    - Estimation of chlorine level of water using orthotoludine reagent.
    - Blood sugar.
    - Blood lipids, blood biochemistry for urea, creatinine and liver function tests could be done locally if auto-analyser available or outsourced.
5. The laboratory should adhere to minimum quality standards as defined in Quality Assurance Standards for UPHCs. Quality checks may require cross checking of a sample of tests done in a reference laboratory, which may be done once in six months. For malaria and tuberculosis every positive slide and small percentage of negative slides (about 5 to 10%) should be sent monthly for a quality test **(as per the guidelines of the national programme).**
6. The working area should have defined protocol for patient entry, sample collection, testing areas, report collection etc.
7. All staff should be in hospital attire and practice infection prevention protocols. It should never be a thorough fare and entry must be restricted.
8. INQUAS and EQUAS must be in place for all critical equipment and tests.
9. A standard should be established for the time within which the laboratory — whether in house or outsourced — will provide the results and the format and routes (SMS, paper, email etc.) by which it would be provided to all.
10. Laboratory timings should match with the OPD timings. It should be kept in mind that patients do not have to make repeated visits to the facility for tests, collecting reports, post test consultation etc.

11. Disposal of used syringes, cotton and other waste items must be disposed as per the biomedical waste management guidelines.

Pharmacy

1. The UPHC pharmacy should, at all times, maintain stock supply of essential drugs as listed for UPHC. The list of drugs for minimum service delivery can be referred to in **Annexure II, Essential Drugs for UPHC, (IPHS Guidelines for PHC, Revised 2012).**
2. The essential drug list has to be displayed prominently at the visible place of the facility.
3. Every UPHC should have a separate Main Drug storage and a separate Service Area storage. Drugs should be issued periodically from Main store to the Service Area stores, in order to avoid bulk storage at 1 Service Area. Indent of drugs & other supplies should be based on consumption. Normally, each service area of UPHC should be given a stock for 5 to 7 days only, to avoid bulk storage in service areas.
4. The threshold level for placing the order/ indent for refill should be a stock level, equivalent to three months utilisation in the previous year. At no time should the stock levels fall below a one month of supply for any drug/ consumable. This buffer is required in anticipation of a sudden spurt in demand as would happen in an epidemic.
5. The pharmacy should maintain records of all medicines and drugs at its facility along with proper inventory mechanisms (First Expiry First Out - FEFO). Expired drugs should be removed from the shelves and returned for disposal as soon as they expire. Soon to expire (within 3 months) drugs should be sent back to the district/ULB store so that they can be used in a high volume facility.
6. The UPHC pharmacy should also ensure that the ANMs and ASHAs under the UPHC have adequate drug stocks. For this purpose, each of them should have a simple stock card which shows the number of drugs they have for the beginning of the month, the number that was added and the number spent, as also the numbers disposed due to expiry or damage. Progressively UPHCs should maintain Computerized Inventory Management System.
7. Stock and issue register with details of medicine needs to be maintained in the facility. As per the norm, random quality check of the medicine from the stock should also be conducted at regular interval.

2.10 Ancillary Services: Housekeeping and Waste Management

Scope: Measures to ensure cleanliness in all internal and external areas of the UPHC including- biomedical waste management, infection control practices, sanitation, environmental hygiene, odour control; pests, rodents and animal control.

Purpose: To provide processes, instructions and methodology for management of housekeeping and biomedical waste management, with the aim of patient and public safety through reduced infections, and better patient experience in terms of comfort and satisfaction.

I. For House-keeping

Responsibility: Responsibility of sanitary staff under overall supervision of MOIC and PHM.

1. The minimum cleaning frequency and methods need to be defined and maintained as a reference document.
2. The procedures would, for example, specify that UPHC premises should be cleaned once a day, consulting rooms should be cleaned thrice a day, the toilets should be cleaned thrice a day, linen washed twice a week, and soiled linen should be replaced at once or with change of patients.
3. For each activity, it would specify additional quality standards: For example,
   a. Sweeping and mopping with dis-infectant materials.

   i. At least twice a day, additionally when needed.
   ii. Mopping should be done in one direction.

b. Wash the walls with a brush, using detergent and water.
c. Do high dusting with a wet mop.
d. Clean fans and lights with soap and water.
e. Disinfect all work surfaces by wiping with disinfectant.
f. Clean the cupboards, shelves, beds, lockers, intravenous fluid stands, stools and other fixtures, with detergent and water.
g. Change curtains periodically or whenever soiled, and send them regularly for laundry.
h. Clean the patients' beds (if any) every week with detergent and water. Use 1% hypochlorite when soiled with blood or body fluids.
i. Collect the waste category-wise, from all the departments (OPD, Injection room, laboratory, pharmacy and other places), and store them at the designated location.
j. Clean the kidney basins, basins, bed pans, urinals, etc. with detergent and water, and disinfect them with Phenyl, especially when these have been used for infected patients.
k. Clean the floor of bathrooms with a broom and detergent thrice a day and then with disinfectant solutions. During out-patient hours, clean them hourly.
l. Clean the toilets with a brush, using detergent disinfection with Phenyl.
m. Stains may be removed using Hydrochloric acid.
n. Clean the wash-basins with detergent powder every morning. During out-patient hours, clean them every hour
o. Segregate, store and dispose bio-medical waste as per guidelines.
p. Check for cobwebs, wild growth of vegetation, and nests/beehives in the building once a week and remove as and when required.
q. Store and dispose non-functional furniture, equipment, instruments, stationeries and other junk material, as per instructions.

4. Based on these work specifications, either the work is outsourced through bidding, or the necessary sanitation staff is hired and appropriately instructed and trained.
5. Provide the necessary sanitary equipment and consumables to keep the premises clean including safety equipment like gloves and boots.
6. The person appointed for supervision should have a checklist with dates; the staff should sign against each item, stating when it was done and the supervisor counter-signs it.
7. There should be a well maintained janitor's room for keeping cleaning and house keeping equipments.

II. Waste management at the UPHC

Key Responsibilities:

Activity	*Person In-charge*
Overall responsibility	MOIC
Daily Monitoring	Staff Nurse or any other staff delegated by MOIC
Segregation	All staff handling waste
Collection, Transportation & Storage	Housekeeping Staff
Disposal	Outsourced Agency/ Housekeeping Staff

Activities:

1. **Segregation of Waste:** This shall be done at point of generation as per **Biomedical Waste (Management & Handling) Rules 2016** in different colour coded bins with liners. Infectious waste must not mix with non-infectious waste. Adequate number of bins and liners for proper segregation and collection of biomedical waste should be provided at point of use. Needles and other sharp items should be handled and disposed as per standard protocols to avoid accidental sharp injuries. There are also protocols for liquid waste, blood spillage, laboratory waste and contaminated plastic that must

be adhered to. For liquid waste management, clean the liquid waste spill by adding equal or more quantity of bleaching powder solution. Leave the area for 30 minutes and then wipe the area with a swab/cloth. Discard the swab/cloth after cleaning, into the red bin meant for plastics and other waste. If possible, dispose the liquid waste into the drains.

2. **Collection of waste:** Waste should be collected by housekeeping staff from the respective department in two shifts, morning and evening (or as required) preferably when there are minimum OPD patients/visitors, except, if applicable, in labour room where the waste should be collected after every delivery case. Waste should be collected in two shifts or when waste bin is ¾ full, whichever is earlier.
3. **Transportation of waste:** Daily waste should be transported to disposal site in closed container through a pre-defined route avoiding crowded area. A large plastic bag should be used to line the wheelable bin to prevent any liquid leaks from the waste bags from soiling the bin. This plastic bag should be replaced in each shift.
4. **Safe disposal of waste**: The disposal of waste is done by the outsourced agency hired for waste management. Anatomical waste (yellow bag) is disposed in deep burial pits constructed as per specifications of BMW Management and Handling Rules. Sharps in puncture proof box should be disinfected and disposed in sharp pits. Contaminated solid waste (red bag) should be disinfected, mutilated and then disposed with general waste. General waste is collected from the facility and disposed by Municipal Corporation in landfills.
5. **Common bio-waste disposal:** Given space constraints, a common arrangement for waste disposal for all public health facilities in the defined urban area may be explored.
6. **Monitoring and quality control:** MOIC should take rounds of UPHC to assess the process flow and compliance of bio-medical waste regulations once a week. Observations should be recorded and corrective and preventive action should be taken. If required under MIS or another authority, reporting should be done in the prescribed format and within time.

For more details on Infection Control and BMW Management, **Infection Control and Environmental Plan- Guidelines for Healthcare workers on Waste Management and Infection Control may be referred to.**

2.11 Infection control

Scope: To enable health functionaries to implement the infection control programme effectively in order to protect themselves and others from the transmission of infections. This includes:

- Hand washing and antisepsis (hand hygiene).
- Use of personal protective equipment when handling blood, excretions, secretions etc.
- Appropriate handling of patient care equipment and soiled linen.
- Prevention of needle stick/sharp injuries.
- Environmental cleaning and spills-management.
- Appropriate handling of waste.

Purpose: To provide process, instructions and methodology for infection control for provider, patient and public safety in terms of reduced infections and better patient experience.

Responsibility: MOIC, Staff Nurse, Sanitary Staff

1. All aspects of bio-waste management and good housekeeping contribute to infection control **(Refer 3.13 on Housekeeping and bio-medical waste management**). *In addition, the following need to be observed:*
2. Disposable masks should be issued to patients who are coughing or sneezing while in the waiting queue at UPHC.
3. Hand washing and antisepsis should be done:
   a. After handling any blood, body fluids,

secretions, excretions and contaminated items.

b. Before and after examining a newborn or pregnant woman or immune-compromised patient, or doing any interventional procedure.

c. Between contact with different patients- which would mean hand washing after seeing one patient and before seeing the next one.

d. Between tasks and procedures on the same patient to prevent cross contamination.

e. Immediately after removing gloves.

4. Use of personal protective equipment like gloves, protective eye wear, mask, apron, gown, boots/shoe covers and hair cover:

   a. The health care worker is at a risk of exposure to blood, body fluids, excretions or secretions and hence, should choose their equipment and items of personal protection accordingly to protect himself or herself.

   b. Should avoid any contact with contaminated (used) personal protective equipment and surfaces, clothing or people outside the patient care area.

   c. Discard the used personal protective equipment in appropriate disposal bags, and dispose off, as per the policy (**BMWM protocol**).

   d. Do not share personal protective equipment with others.

   e. A health worker needs to change personal protective equipment completely, and thoroughly wash hands each time before attending to another patient or another duty.

5. Patient Care Equipment:

   a. Handle patient care equipment soiled with blood, secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment.

   b. Handle, transport and process used linen that is soiled with blood, body fluids, secretions or excretions with care, to ensure that there is no leaking of fluid.

   c. Ensuring sterilisation of all reusable equipment; they should be reprocessed appropriately before being used on another patient.

   d. Decontaminate, wash and clean instruments before sending them for sterilisation.

   e. After the instruments are sterilised, handle them with sterile gloves and store the sterile instruments in special areas meant for storing them.

6. Use of Disinfectant:

   a. Store bleaching powder in dry, dark and cool places and the bleaching powder container should always be kept closed.

   b. While preparing 1% bleaching powder solution, add 1 tablespoon of bleaching powder in 1 litre water and stir the solution well.

   c. After the solution is ready, pour the solution in the waste bin meant for disinfection of used plastics and sharps.

   d. Bleaching powder solution needs to be prepared every day.

7. Prevention of needle stick/sharps injuries:

   a. Place the used disposable syringes and the needles, scalpel blades and other sharp items in a puncture-resistant container, with a closable lid located close to near usage area.

   b. Take extra care when cleaning sharp reusable instruments or equipment.

   c. Never recap or bend needles.

   d. Sharps must be appropriately disinfected and/or destroyed as per protocol.

   e. Healthcare providers, especially those dealing with injectables or blood samples regularly should be immunised against Hepatitis B infection.

8. Cleaning floors:
    a. Wear personal protective gears like gloves and apron while cleaning the floors.
    b. The UPHC floor must be cleaned regularly with hot water and soap/floor cleaner.
    c. Mop/cloth needs to be disinfected after every use.

2.12 Convergence with ICDS, Water and Sanitation Departments

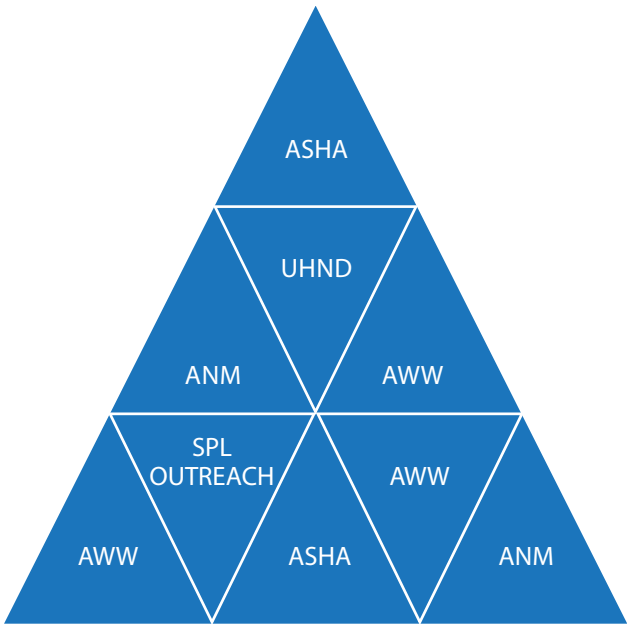
Scope: It provides a framework for convergence of all health and allied services at the UPHC level.

Purpose: To ensure coordinated planning and delivery of urban services for all departments.

Responsibility: Medical Officer, Public Health Manager, ANM, ASHA and MAS

Convergence with ICDS

1. All Anganwadi Centres (AWCs) in the catchment area must be identified and mapped.
2. UPHC needs to establish a functional liaison between the ANM, ASHA and the Anganwadi worker (AWW) in the area.
3. At the community and outreach level, the frontline (ANM, ASHA and AWW) workers will jointly provide nutrition services. These would include:
    - Diagnosis and nutrition advice to malnourished children, pregnant women and adolescent girls and boys.
    - Diagnosis and management of anaemia and Vitamin A deficiency.
    - The outreach camps or the Urban Health and Nutrition Day (UHND) can be organised at the AWC, where the AWW takes the lead responsibility in organising and mobilising women and children through ASHA and MAS.
    - The UPHC staff must ensure the full immunisation coverage and provision of RMNCH+A services at the community level.
    - Effective referrals to NRC should be ensured for severe and acute malnourished children.
4. Children, women or adolescents, if diagnosed as malnourished/anaemic in the UHND or in the UPHC, should be attached to their nearest AWC for ensuring services.
5. The ANM/ASHA will be responsible for coordination with the AWW and will also monitor the service received by these beneficiaries and their performance.



Convergence with Swachh Bharat Mission and Urban Local Body

Efforts should be made to work closely with the Urban Local Body by participating regularly in the Ward Co-ordination Committee meeting and getting ward Counsellor engaged in the RKS. U-PHC will also participate actively in the activities related to Swachh Bharat Mission in its catchment area.

Convergence with Water and Sanitation Department

1. The Medical officer and PHM needs to identify the officials responsible for water, sanitation, garbage disposal in their ward or locality and develop functional linkages with them.
2. At the level of ward, locality, zone (as

appropriate as per the states context) a coordination committee may be established to address issues of public health, vector control, solid waste management, sanitation etc. in the UPHC catchment area. The committee may include representatives of the Public Health Engineering Department (PHED)/Jal Nigam/Municipal Corporation, Resident Welfare Association, MAS, and other bodies as applicable.

3. ASHAs and ANMs needs to identify issues of water supply, water quality, garbage collection, drainage and sanitation faced by the community and report to the PHM. The PHM and MO should take up these issues with the ward level officials or personnel responsible for these services in the area. They should also act as advocates of the community to improve the basic services in their catchment area.
4. The Committee should find local solutions for environmental sanitation with collaborative efforts.
5. In addition, UPHCs must have sufficient stock of chlorine tablets/drops and all ASHAs should be given adequate supply.

2.13 Public Private Partnership

Scope: Partnership between government and private agencies to provide services close to people at affordable costs.

Purpose:

a. To enhance the system's ability to provide effective services in collaboration with private providers.
b. To guide stakeholders in understanding contracting mechanisms under Public Private Partnership.

Responsibility: Government officials, private entity

Process:

PPP is a form of contract between a government and a private entity, wherein these two bodies jointly provide public services in line with the pre-defined terms of contract. While primary healthcare is the mandate of the State, PPPs may be considered in the urban areas to compensate for the lack of structured primary healthcare facility and to leverage the large number of private providers available.

In process of entering a PPP, following three things needs to be kept in mind:

- Rationale for entering a PPP mode.
- Factors to be considered while planning a PPP model.
- Outcome indicators for proper monitoring.

Major challenges in providing primary healthcare in urban context are HR constraints, limited outreach, limited range of services and infrastructural limitations. Hence, PPPs can be used as a tool to deliver various services under NUHM; Clinical services at UPHCs, specialist outreach services, community outreach services, diagnostic services, mobile health units etc. Withdrawing Specialists or Doctors from public health facilities for outreach tends to make such facilities non-functional. Under such conditions, ongoing private doctors to conduct outreach could be considered.

To establish a successful PPP, state needs to conduct a situational analysis, identify appropriate private partner to bridge the gaps in service delivery, identify the type and scope of PPP model, prepare RFPs and SLAs taking into consideration the healthcare needs and local conditions with key performance indicators (KPIs) and finally develop a robust and reliable mechanism to monitor the performance and service delivery standards. The RFP and SLA guidelines have been issued by the MoHFW.

PPP model for UPHC management: A cluster of UPHCs or a single PHC in an urban area can be provided to the private partner for operation and maintenance. A set of key performance indicators (KPI) are to be shared among the two partners including, both quantitative as well as qualitative indicators. An incentive can be added to the fixed payment, based on the performance against the KPIs.

Two types of outreach under NUHM namely, UHND and special outreach can be conducted by private specialists through competitive bidding under PPP.

The District Health Society or Urban Local Body would invite tender for the engagement of private service providers.

Critical Success Factors for Private Sector Participation in Primary Care are effective governance structure, sharing of responsibilities based on capabilities, incentivizing performance, effective monitoring, timely payments and standardizing practices for PPPs in similar activities. Defining the roles, responsibilities and scope of work along with monitoring mechanisms are important prerequisites before MOU is signed.

2.14 Grievance Redressal

Scope: Addressing the complaints and grievances of patients regarding the service provided at the UPHC level.

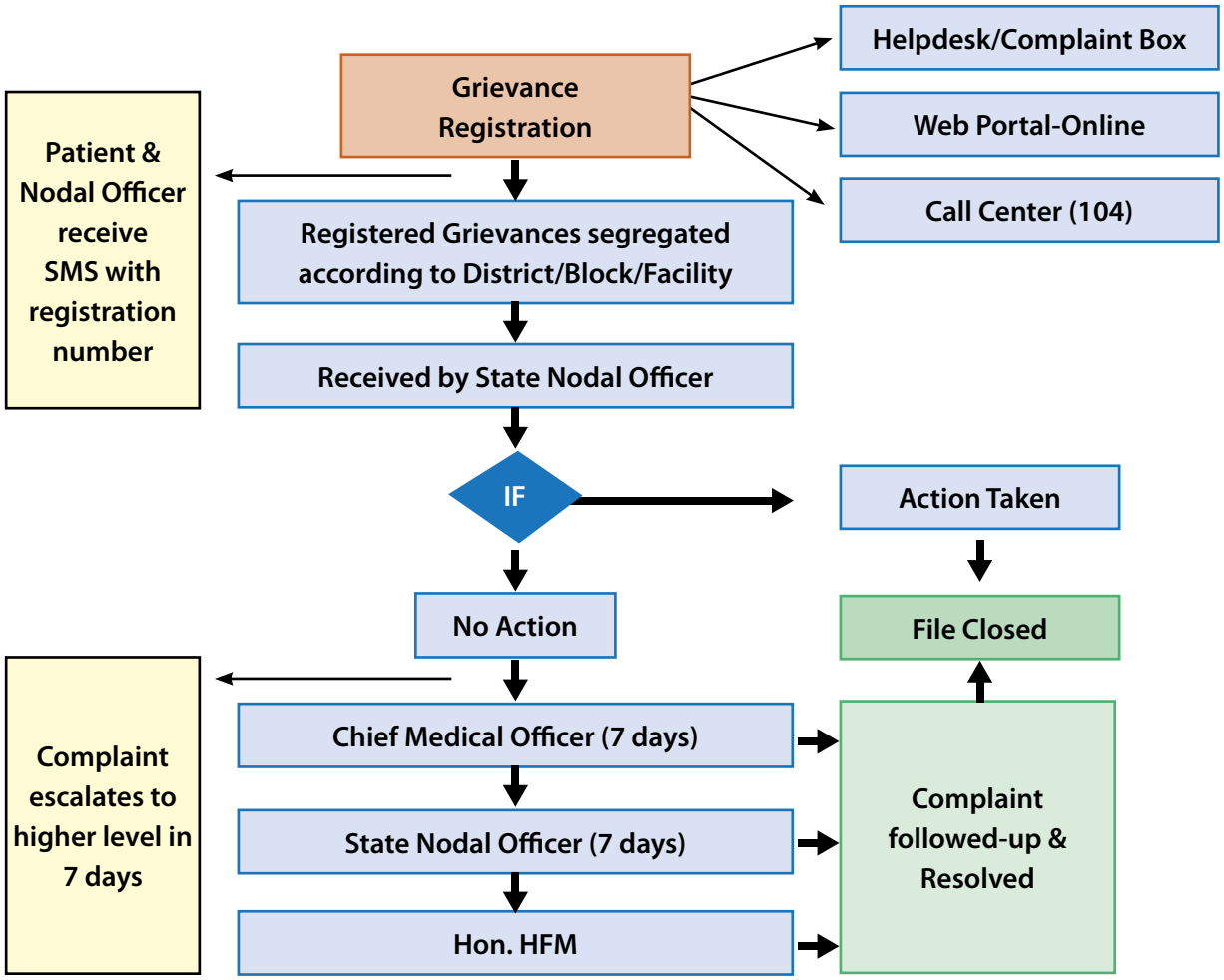
Purpose: The UPHC needs to provide quality services that are responsive to people's needs and demands and hold itself accountable for its performance. It must be able to measure the effectiveness of care it provides, improve the efficiency with which it is provided and ensure quality of care.

Responsibility: Official designated at each level (state, district and facility)

Activities:

1. Grievance Redressal System in UPHCs shall be established as per the Grievance Redressal Guidelines for NHM (2017).
2. As per the GRS guidelines, each state shall have a centralized set-up, operated through a call center (104), to address grievances and

Figure 4: Grievance Redressal Flowchart as per Grievance Redressal Guidelines (2017)



provide medical advice. The system enables tracking, investigating and resolution of complaints in a timely manner.

3. UPHCs under NUHM should also be linked to the centralized system. Each UPHC shall have a nodal officer designated for grievance redressal.
4. The State Program Officer for NUHM should maintain a directory with details of each UPHC in-charge. The Directory should be handed over to the 104 call center for facilitating complaint resolution.
5. In each UPHC there should be a clear display of GR helpline number and methods by which a grievance can be registered. The process of redressal and timeline should also be displayed.
6. The UPHCs from which frequent complaints are received may be invited for the review, inquired into further, and appropriate corrective action taken.
7. RKS of the UPHC should review the number of grievances registered and number resolved every month for their UPHC.

2.15 Patient Feedback and Exit Interviews

Scope: To enable patients to provide feedback on the service received at the UPHC.

Purpose: Patient feedback/exit interview will help the UPHC to strengthen the quality of service provisioning, be more responsive to patient needs and meet the expectations of the patients and reduce out-of-pocket expenditure.

Responsibility:

- MOIC: For use of information and oversight.
- Public Health Manager: Organisation and oversight over the feedback system.
- Help-desk in charge (if this is established) or else registration clerk: Collection of feedback.

Activities:

1. Two forms of feedback collection are envisaged: A semi-structured interview that is administered by the registration clerk or the help-desk and a questionnaire that literate persons can fill up without guidance and drop into a box kept for the purpose.
2. Questionnaire should be decided by the Public Health Manager in consultation with the MOIC. Questions will include timeliness of care, subjective satisfaction with care, health outcomes as perceived, out-of-pocket expenditure and provider to patient relationship.
3. All UPHCs needs to conduct exit-interviews of out-patients for collection and analysis of their feedback. This will help in understanding their out-of-pocket expenditures, problems in accessing health service and overall satisfaction with care provided in the facility.
4. On each day, at least 5 persons who are leaving the facility are contacted and requested to fill the questionnaire and drop it into the box kept for the purpose. A separate box/ file must be placed for submitting the filled-in feedback forms.
5. If the person is not literate, the help-desk in charge could conduct it as an interview. The selection should be random but at least half of it should be women and one third could be women or men with young children.
6. Anonymity needs to be maintained. The patients must not be forced to disclose their identity.
7. The Public Health Manager supervised by the MOIC is responsible for analysing the feedback and preparing a comprehensive report. The report should be shared with the RKS and the city/ district health society.

A comprehensive report on the specific actions taken and support needed for improving the service should also be prepared.

3
UPHC SERVICES

Services under NUHM are envisaged at four levels:

- Community level: Home visits, MAS meetings, other community based fora or group meetings.
- Outreach: Activities held as part of UHND, Special Outreach and NCD Screening Days.
- UPHC: Services provided within UPHC premises.
- UCHC: Services provided within UCHC premises.

While in some cases, the services provided at different levels overlap, in most cases there is a clear distinction in the limits of each level. The following summary table provides NUHM services at the four levels of care. Which services to be provided at UCHCs are mentioned in the last column. Details of services available in the last column in UCHC are for referral purpose. However this guideline details services for the first three levels only.

Detailed description of services at all levels, are given on following pages.

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
1	Care in Pregnancy: Maternal Health	Early diagnosis of pregnancy, support throughout pregnancy, motivation for institutional delivery, nutrition information, hygiene, enabling Take Home Rations (THR) for pregnant woman through AWW, offering pregnancy test kit to those who need, identify high risk births, anemia cases, facilitating referrals, helping birth planning, identification of postpartum complication, postpartum support.	Early registration of pregnancy, Issue of Maternal & Child Health Card (MCH Card) after registration, regular Ante natal check-ups with 7 components ie (As per ANC & Skilled birth attendant Guideline), screening for hypertension, diabetes, anemia, immunization for mother – TT, iron-folic acid calcium supplementation, MCH card, Identification and referral of high risk pregnancy & postnatal high risk cases.	ANC by MO to include minimum lab investigations: haemoglobin, urine albumin and sugar, RPR test for syphilis, blood grouping and Rh typing, and HIV testing, clinical examination to rule out other co-morbidities notably diabetes, hypertension, heart disease, TB, other risk factors and growth retardation,high risk ANC, PNC, high risk PNC, early assessment of complicated delivery cases and referral, IV Antibiotics. At Delivery Points: ■ Normal vaginal delivery (if resources are available to conduct delivery as per protocol); Pre-referral management (obstetric first-aid) in obstetric emergencies that need expert assistance (training of staff for emergency management to be ensured).	Normal vaginal delivery, assisted vaginal delivery, C-section, ante partum and post-partum haemorrhage, eclampsia, puerperal sepsis, obstructed labour, hospitalisation and surgical interventions, including blood transfusion. Safe abortions. Complications requiring specific competencies like MRP (Manual Removal of Placenta), maneuvers for stopping PPP etc. should only be attended if specialists or properly trained doctors are there.
		■ ASHA visits every pregnant woman at least once a month. In high risk pregnancies, she makes a referral to UPHC, or organises a home visit by the ANM. ■ Post partum visit should be ensured on 0th, 3rd, 7th and 14th days of delivery. ■ At least one ANC, preferably during the 3rd visit, must be done by a doctor (medical ANC), preferable at the UPHC where the woman is registered. ■ At delivery points, Minimum 48 hours of stay after delivery. This requires a clean bed, clean toilets, and arrangements for food and privacy for breastfeeding. ■ Initiation of breastfeeding within one hour of birth. ■ Recognition of gender based violence during pregnancy (and also at all other times).			

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
2	Neonatal and infant health (0-1 yrs of age)	6 household visits in neonatal period for improved newborn care practices, Home based new born care, identification and care of low birth weight/ preterm newborn (with referral as required), counselling and support for exclusive breastfeeding, complementary feeding, improved weaning practices; nutrition counselling; Education of prevention of infections; identification of ARI/ diarrhoea and treatment (ORS).	Complete immunization, Vitamin A supplementation, height and weight measurement. Care of common illnesses of new born, Identification of congenital anomalies, and appropriate referral .	If birth occurs at UPHC: Initiation of breast-feeding within an hour of birth; Screening for birth defects (as per the RBSK protocol) 7 appropriate referral; Essential new born care : wiping the baby, weighing the baby, prevention of hypothermia by wrapping the baby, examination to rule out health problems, cord care. Immunisation Management of Birth asphyxia, severe ARI, diarrhoea management, acute gastroenteritis with dehydration, pneumonia case management, Treatment and stabilization and referral of severe cases, Weekly immunization sessions.	Congenital anomalies, Management of complicated paediatric/ neo-natal cases, hospitalisation, surgical interventions, blood transfusion. Management of severe acute malnutrition (SAM). Hospitalisation, treatment and rehabilitation of severe undernutrition.
		▪ Monthly visit by ASHA to all families with children below one year of age; information on immunization sessions, All ASHAs must be given the HBNC kit for providing care to neonates at home. ▪ Convergence with ICDS essential, ANM to maintain & update MCTS register, linelisting of children who missed immunization, display of immunization schedule, maintenance and monitoring of vaccine cold chain.			

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
3	Child Health & Adolescent Health	Growth monitoring, prevention through IYCF counselling, access to food supplementation through ICDS; Detection of SAM, referral and follow up care; Prevention of anaemia, use of iodized salt, de-worming; Prevention of diarrhoea, prompt treatment and referral if needed. Pre-school and school children: biannual screening, eye care, de-worming, school health records Adolescent health: anemia detection, peer counselling, sexual health education, personal hygiene, encourage adolescent health days.	**Child Health:** Prompt management of ARI and fever; acute diarrhoea; detection and treatment of anaemia and de-worming; Early detection of growth abnormalities, developmental delays and disability. **Adolescent health:** Detection and treatment of anaemia and other nutritional deficiencies; bi-annual de-worming and adolescent counselling & referral as per need.	Immunization, management of SAM, severe anaemia, persistent malnutrition and nutritional deficiencies; severe diarrhoea and ARI management; Diagnosis of disability and developmental delays and referral, Skin infection. Convergence with RBSK & ICDS, Confirmation of any type of deficiencies/disease/ developmental delays upto 6 years. Diagnosis and treatment of childhood illnesses, Referral of acute deficiency cases and chronic illnesses. Outbreak investigation if there are more than five cases seen from one cluster of any of infections within a week.	Treatment of childhood illnesses and infections, Treatment of disability and developmental delays.
		1. The ASHA/ANM/MAS must mobilise both girls and boys for counselling and treatment. In urban areas adolescent males have significant health problems as they are engaged in labour work and other kinds of physical occupations. So they must be provided health check-ups related to their living conditions and appropriate counselling related to sexual concerns, drug abuse, mental health, etc. 2. Similarly, adolescent girls attending the clinic must be provided information, counselling and services related to sexual concerns, pregnancy, contraception, abortion, menstrual problems and menstrual hygiene, drug abuse, mental health, nutrition etc. responsive to their requests.			

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
4	Family Planning Services	Health communication and preventive education for early marriage, identify eligible couples, motivation for family planning – delaying first child and birth spacing, information and access to spacing methods - OCP, ECP, condoms; Referral for sterilisation, follow-up of contraceptive related complications. Counselling for family planning, access to all spacing methods RTI/ STI: Knowledge of and referral for RTI/STI, follow-up for ensuring adherence to treatment regime of cases undergoing treatment.		Counselling for family planning, Medical examination required before start of OCPs, access to all spacing methods including IUCD insertion, referral for sterilisation, management of contraceptive related complications. Medical Abortion in the first trimester if indicated, after necessary medical examination (where resources available as per protocol). RTI/STI: opportunistic screening of RTI/STI, wet mount test, diagnosis and treatmentUTI treatment, menstrual disorder. First aid for gender based violence – link to referral center and legal support services. Laboratory tests for VDRL and for HIV if UPHC is designated for same, otherwise to refer to designated referral facility.	IUCD, Vasectomy, tubectomy, manual vacuum aspiration, safe abortions, Sterilisation operations, infertility treatment. Complications in contraceptive usage, hormonal and menstrual disorders, infections etc. RTI/STI: Management of complicated cases, hospitalisation (if needed).
		■ Empowering girls and women to understand that they have the right to decide the number of children and social reasons for delaying the first child, spacing the second and limiting to a smaller family size. ■ ANM and ASHA should take the lead in counselling the woman immediately after marriage, and during and after pregnancy on reasons and choice of contraception.			
5	Management of common communicable diseases	Identification and referral for testing at UPHC, symptomatic care for fevers, diarrhoea, aches and pains. Skin infections, abscesses – identify, refer.	Diagnosis and management of fevers, ARI, diarrhoea, skin infections. Management of aches, pains, rash, gastritis, acute febrile illness; Referral for severe and complicated cases, Acute febrile illness, indigestion, gastritis.	Diagnosis and management of all fevers, infections etc.	Management of complicated cases, hospitalization.

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
6	Management of communicable diseases (National Health Programs)	TB, HIV, Leprosy, Malaria, Kala Azar, Filariasis, other vector borne diseases: Prevention, identification, use of RDT, prompt treatment initiatives, vector control measures; education for prevention; identification, use of RDT, Follow up on medication compliance. Mass drug administration in Filariasis prevention, immunization of Jap B, RDK testing for malaria, Counseling for leprosy on treatment compliance. Vector Borne Diseases: Identification of suspected cases, Slide collection, testing using RDKs. Counselling for practices for vector control and personal protection. Community education.	Identification, examination and referral to UPHC for suspected cases.	Diagnosis and treatment/ management plan, referral of acute and chronic cases, Report to IDSP. Lab testing for all vector borne diseases; Drug dispensation for TB. Maintenance or records for all cases of TB, leprosy. Establish diagnosis if fever persists for more than 5 days. UPHC to serve as DOTS center, regular follow up to ensure compliance to drug regimen.	Diagnosis and treatment of complicated or severe cases, hospitalization.
		■ Visit the family and neighbouring families to ensure that no contacts have similar symptoms. This is particularly important for TB and leprosy. For vector borne and water borne diseases, an active case detection survey in neighbouring houses is required. In HIV, it requires testing for spouse but care is needed on issues of confidentiality and prevention of stigma. ■ Facilitate the visit of the public health response team from the UPHC to take community level action in case of vector borne or water borne diseases. ■ Examine every case of fever. If fever persists beyond five days, then always try and establish a diagnosis. ■ If there is a cluster of infection cases then always ask support for higher diagnostics like ruling out Swine flu. ■ Every UPHC is necessarily a part of IDSP, and is hence required to file three reports on a weekly basis- L form which is the report of cases tested and cases found positive for infectious diseases, from the laboratory; P forms,which are presumptive (not necessarily confirmed) cases of any of the notifiable infectious disease; and S forms which are cases suspected and reported by ANMs. Ensure maintaining a copy of these reports sent and analyse them periodically to understand the communicable disease situation in the UPHC catchment population/ area.			

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
7	Screening & Management of Non-Communicable diseases				
	NCD (Hypertension, Diabetes, Cancers – oral, breast, cervical)	**Hypertension:** Screening, primary & Secondary Prevention. **Diabetes:** Screening, primary & Secondary Prevention. **Cancers:** awareness generation regarding signs and symptoms . Counselling on mitigation of risk factors. **Silicosis, Flourosis:** Preventive action and early case identification. **COPD:** Prevention and early detection, referral. **Epilepsy:** Early case identification and referral.	**NCD Screening Day** **Hypertension:** BP measurements, medication, enable specialist consultation, follow up. **Diabetes:** Blood sugar test, medication, follow up diagnostics, enable specialist consultation, diet counselling, Refer persons with >140/90 BP and >140 random sugar to UPHC. **Cancer:** Screening of oral cancer, clinical breast examination, (with adequate privacy), early referral, follow up. Counselling regarding risk factors, diet management as appropriate for all NCDs. **Silicosis, Flourosis:** Early case identification. **COPD:** identification	Comprehensive NCD screening for 30+ patients who missed screening day. **Hypertension:** Medical management. **Diabetes:** Medical management, provision of regular drug supply for diabetes and hypertension. **Cancer:** Cervical cancer screening using acetic acid. Diagnosis and treatment plan for HT and DM cases. Referral for complicated and severe cases. Systematic recording of NCD cases. **COPD:** diagnosis, treatment plan **Epilepsy:** diagnosis, treatment plan.	Diagnosis and treatment/ management of all NCDs, hospitalization if needed. Integration with RNTCP for TB elimination with urban areas. Integration with NPCDCS at community and facility levels.
		▪ Population enumeration and listing of target population (all 30+ individuals). ▪ Risk assessment of 30+ persons through prescribed format. ▪ Inform all 30+ about advantages of screening, screening day and ensure they attend, esp high risk persons. ▪ Ensure treatment compliance for those on medication through visits. Referral of at-risk cases to UPHC. ▪ NCD Screening to be organized weekly for every 10,000 population. ▪ Implementation of NCD Screening to be supported by District NCD Cell for planning, monitoring and reporting. ▪ Once diagnosis for HT & DM is established, patients to be given at least a months supply of medication. ▪ First follow up at the end of the first three months after diagnosis, and sooner if required. ▪ An annual specialist consultation at the nearest nodal CHC with an NCD clinic, is also recommended.			

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
8	Mental Health	Screening of mental illness using screening questions and tools, Identification of cases, referral and follow up; community education and sensitization on mental health issues, substance abuse.	Detection & referral of mental illness, community education and preventive measures against substance abuse.	Initial screening and referral. Referral to de-addiction centers, if needed. Management of violence related concerns.	Psychiatric services, including hospitalisation, if needed.
9	Dental Care	Education on oral hygiene Identification of cases, referral special outreach camps for diagnosisand treatment, counselling and oral health education.	Dental hygiene, screening for cavities, gingivitis, dental caries, ulcers. Treatment or referral.	Diagnosis, treatment of infections and referral; essential dental therapeutic procedures.	Treatment for tooth abscess, dental caries, scaling, extraction, etc. Referral for further care.
10	Eye/ENT	Identification of glaucoma, trachoma, and referral to UPHC. Early identification of squint, lazy eye in children, other eye disorders; Identificationof cases of hearing impairment (if reported by family/ community), referral for testing.	Eye care in newborn, screening for visual acuity, cataract, refractive errors. Nose, throat infections.	Treatment for conjunctivitis, Management of colds, identification of cases and referral.	Diagnosis and management of infections, disorders, further referral of complicated cases, hospitalisation (if needed).
11	Geriatric & Palliative Care	Support to family in palliative care, counselling to the elderly on keeping healthy, active, appropriate diet, recreational activities.	Management of common geriatric ailments, counselling, supportive treatment. Pain management and provision of palliative care with support of ASHA.	Diagnosis, treatment plan, referral for specialist care.	Diagnosis and management of geriatric conditions, referral for advanced treatments required.
		In view of increasing geriatric population in urban areas, UPHCs should organize special outreach sessions or weekly geriatric clinics at the UPHC..			

S.No.	Area	Community Level	Outreach Level	UPHC Level	UCHC Level
12	Trauma Care (burns & injuries)	First aid and referral. First aid and first responder training for school teachers, community volunteers, ASHAs and AWW.	First aid and referral	emergency resuscitation, documentation for MLC (if applicable) and referral. Management of animal bites, insect bites, rodent bites, stabilization care and treatment in poisoning and trauma of any nature; Management of injury, simple fractures and burns and abscess management.	Treatment, Case - management and hospitalisation, physiotherapy and rehabilitation.
		■ All UPHC staff should be trained in first aid, first responder care. UPHC should be equipped with necessary equipment and drugs for stabilization of patients of trauma, fracture, respiratory distress, burns, poisoning, fall and other accidents common in urban areas. ■ They should also have an emergency response system in place, in case of a hazard in the community eg: building collapse, fire, demolition etc. ■ UPHC must be able to arrange for emergency transport quickly when needed. All wheelchairs and stretchers at the UPHC should be functional and placed appropriately for quick and easy access.			

Annexure – I

MINIMUM REQUIREMENTS FOR U-PHC

Layout

Room	
Ward*	Consultation room
Out-patient department	Dressing room
Waiting area	Labour room
Store	Laboratory
Nursing station	Pharmacy
* for maternity homes and bedded U-PHCs	

Basic Amenities

Utility	
Beds	Hand washing including availability of water and soap in dressing rooms
Private area for expansion	Wheelchair, stretcher etc.
24*7 electricity supply	Fire safety equipment- fire extinguisher, sand buckets
Drinking water facilities	Computer with internet connection for MIS purpose
Fans, coolers/warmers	Maintenance of registers for monitoring and record keeping
Separate Toilets for men and women	

List of Furniture

Furniture Item	
Writing tables (officer) with table sheets	Inverter for fridge
Armless chairs	Lamps
Basin with stands	Mattress for beds
Bed sheets	Medicine box
Bed stead iron for treatment room	Notice board

Furniture Item	
Bedside table	Office chairs
Benches for waiting area	Pillows with covers
Bio-medical bins with liners	Revolving stool (examination)
Buckets and mugs	Rubber sheeting
Cloth screen - three-fold	Side wooden racks
Computer table with chair	Steel almirah - big
Curtains	Steel almirah - small
Dustbins	Stretcher on trolley
Examination beds	Towels
Foot steps	Wheelchairs
Generator(7.5 KV)	Wooden screen
Inverter for computer	

List of Essential Equipment and Instruments

Item	
Adult weighing scale	Kidney tray for emptying contents of MVA syringe
Anterior wall retractor	Kidney trays
Artery forceps (large and small)	Measuring tape
B.P. (digital) apparatus	MVA syringe and cannula of sizes
Baby weighing scale	Nebulizer
Bowl for antiseptic solution for soaking cotton swabs	Needle destroyer
Bowls - stainless steel	Oxygen concentrator
Clinical digital thermometers	Oxygen cylinder on trolley with spanner and flow meter
Cold boxes (large and small)	Percussion (knee) hammer
Computer with internet facility	Probe for ear wax removal
Deep freezer (small with voltage stabiliser)	Refrigerator
Dressing trolley	Resuscitation self-inflating bags (Ambu's) and masks of different sizes
Ear specula	Scissors
Ear syringe	Sims speculum
ECG machine	Single panel X-ray view box
Emergency tray and equipment	Sponge holding forceps
Forceps chelate 9"	Spot light
Forceps plain 6"	Stainless steel tray with cover
Forceps toothed 6"	Sterilizer
Head light	Stethoscope
Height measuring scale	Suction Apparatus
Ice box	Syringes of different sizes
Ice lined refrigerator (small)	Torch with batteries
Ice packs	Tray containing chlorine solution for keeping soiled instruments
Instrument trolley	Tuning fork
IUCD kit	Vaccine carriers with four icepacks

IV giving sets with intracaths	Volsellum uterine forceps
IV stand	Desirable: Dental chair & accessories only if dental surgeons are posted.

Laboratory Requirement for U-PHC

Name of the Item	
Haematology analyser	Vacutainers
Semi-auto analyser	Tourniquets
Colorimeter	Microscope (preferably binocular)
Test tubes	Centrifuge machine
Glass slides and cover slips	Hot air oven or incubator or water bath
Glass beaker	Burette (used to measure amount of alkali/acid for titration)
Glass flask	General laboratory stands, racks, filter papers
Pipettes	Reagents, chemicals etc.
Syringes and needles	Refrigerator
Gloves and masks	Bio-medical waste management buckets
Lancets	Urine containers

Annexure – II

ESSENTIAL DRUG LIST FOR UPHC

(Note: Essential Drug List for U-PHC can be referred from State)

The following list is suggestive and not exhaustive. Requirement may be decided as per facility load.

Drug list			
1.	Acetyl Salicylic Acid Tablets 150mg	2.	Fluconazole Tablets 50mg
3.	Acyclovir 200mg	4.	Folic Acid & Ferrous Sulphate Tablets (Large)
5.	Albendazole 400mg	6.	Folic Acid & Ferrous Sulphate Tablets (Small)
7.	Amoxycillin Capsules 250mg	8.	Folic Acid Tablets 5mg
9.	Amoxycillin Trihydrate Dispersible Tablets 125mg	10.	Glibenclamide Tablets 5mg
11.	Ascorbic Acid Tablets (Chewable)	12.	Glimepiride Tablets 1mg
13.	Atenolol Tablets 50mg	14.	Glipizide Tablets 5mg
15.	Atorvastatin Tab 10mg	16.	Ibuprofen Tablets 400mg
17.	Azithromycin Tablets 500mg	18.	Inj. Ranitidine
19.	Bisacodyl Tablets 5mg	20.	Levocetirizine Tablets 5mg
21.	Calcium Gluconate Tablets 500mg	22.	Metformin HCL Tablets 500mg
23.	Cefadroxil Kid Tablets 125mg	24.	Methyldopa Tablets 250mg
25.	Cefadroxil Tablet 500mg	26.	Methylergometrine Maleate Tablet 0.125mg
27.	Cefiximine Tablets 200mg	28.	Metronidazole Tablets 200mg
29.	Chlorine Tablets 0.5gm	30.	Norfloxacin Tablets 400mg
31.	Chloroquine Phosphate Tablet 250mg (150mg base)	32.	Norfloxacin Kid Tablets 100mg
33.	Chlorpheniramine Maleate Tablets 4mg	34.	Ofloxacin Tablets 200mg
35.	Ciprofloxacin Tablets 250 mg	36.	Omeprazole Capsules 20mg
37.	Clotrimazole Vaginal Tablets 100mg	38.	Pantoprazole Tablets 40mg
39.	Dexamethasone Tablets 0.5mg	40.	Paracetamol Tablets 500mg
41.	Diazepam Tablets 5mg	42.	Primaquine Phosphate Tablets 2.5mg
43.	Diclofenac Sodium Tablets 50mg	44.	Primaquine Phosphate Tablets 7.5mg
45.	Dicyclomine Tablets 20mg	46.	Tab Fenoxidenadine 120mg
47.	Diethyl Carbamazine Citrate 50mg	48.	Tab Ranitidine 150mg
49.	Domperidone Tablets 10mg	50.	Tab Tinidazole 500mg
51.	Doxycycline Capsules 100mg	52.	Vitamin A & D Capsules
53.	Eteophylline with Theophylline Tablets	54.	Zinc Sulphate Dispersible Tablets 20mg
55.	Fluconazole Tablets 150mg		

Miscellaneous

Miscellaneous			
1.	Albendazole Suspension 200mg/5ml	2.	Inhaler Beclomethasome
3.	Anti-Rabies Vaccine	4.	Inhaler Salbutamol
5.	Azithromycin Oral Suspension 200mg/5ml	6.	Injections for Emergency Treatment
7.	Betamethasone Valerate Cream	8.	Insulin Preparations
9.	Chloroquine Phosphate syrup (60ml)	10.	Levocetirizine Dihydrochloride Syrup
11.	Clotrimazole Cream 1%w/w	12.	Metronidazole Suspension 100mg/5ml
13.	Dicyclomine HCL Oral Solution 10mg/5ml	14.	Neomycin, Bacitracin &Polymyxin - B Oint
15.	Domperidone Suspension 1mg/ml	16.	Paracetamol Syrup 125mg/5ml
17.	Folic Acid & Ferrous Sulphate Syrup 100ml	18.	Povidone Iodine Ointment 5%
19.	Framycetin Sulphate Cream	20.	Povidone Iodine Solution 5%
21.	Gamma Benzene Hexachloride Application	22.	Reagent Strips for estimation of Albumin & Glucose In Urine
23.	Gentamicin Eye Drops 0.3% w/v	24.	Salbutamol Syrup 2mg/5ml
25.	Gentian Violet Topical Solution	26.	Silver Sulphadiazine Cream 1 %
27.	I.V. Fluids	28.	Vitamin A solution 1Lac IU/1ml
29.	Ibuprofen Suspension 100mg/5ml		

Emergency Drugs

1. Drugs & Injectable as per requirement
2. Fluids & Plasma Expanders
3. Oxygen Cylinders/Oxygen Concentrator
4. Essential Equipment – Suction Machine, Ambu Bag, ECG Machine, etc.
5. Suture Kit

Surgical

1. Absorbent Gauze (20mt x 90cm)
2. Absorbent Cotton Wool
3. Adhesive Tape 5cmx10mtr
4. Adhesive Tape 7.5cmx10mtr
5. Bandage Cloth (20mt x 90cm)
6. Disposable Hypodermic Needle Size:22x1"
7. Disposable Hypodermic Needle Size:23x1"
8. Disposable Hypodermic Needle Size:24x1"

Disposable Syringe 2 ml and 5 ml (Without Needle)

Annexure – III

JOB RESPONSIBILITIES OF UPHC STAFF

1. Medical Officer

The Medical Officer (MO) of Urban Primary Health Centre (UPHC) is responsible for implementing all activities grouped under Health and Family Welfare delivery system in UPHC area. The MO will be solely responsible for the proper functioning of the UPHC, and activities in relation to National Health Programmes. The detailed job functions of MO working in the UPHC are given below. Refer IPHS for PHC and programme documents for role and responsibilities related to National Health Programmes.

Curative Work:

- The Medical Officer shall organise the dispensary, outpatient department and shall allot duties to the ancillary staff to ensure smooth running of the OPD.
- He/she shall make suitable arrangements for the distribution of work in the treatment of emergency cases which come outside the normal OPD hours.
- He/she shall organise laboratory services for cases where necessary and within the scope of his laboratory for proper diagnosis of suspected cases.
- He/she shall make arrangements for rendering services for the treatment of minor ailments at community level and at the UPHC through the Frontline Health Workers and others.
- He/she shall attend to cases referred to him/her by Female Health Workers, ASHA, Voluntary Health Workers where applicable, Dais or by the School Teachers.
- He/she shall screen cases needing specialised medical attention including dental care and nursing care and refer them to referral institutions.
- He/she shall provide guidance to the Health Workers, Health Guides and School Teachers in the treatment of minor ailments.
- He/she shall cooperate and coordinate with other institutions providing medical care services in his/her area.
- He/she shall visit each Sub-Centre in his/her area at least once in a month on a fixed day not only to check the work of the staff but also to provide curative services. This will be possible only if more than one Medical Officer is posted in PHC.
- He/she shall organise and participate in the "Urban Health and Nutrition Day" at Anganwadi Centre once in a month.

Preventive and Promotive Work:

The Medical Officer shall ensure that all the members of his/her Health Team are fully conversant with the various National Health and Family Welfare Programmes including NUHM to be implemented in the area allotted to each health functionary.

He/she shall further supervise their work periodically both in the clinics and in the community setting to give them the necessary guidance and direction.

He/she shall prepare operational plans and ensure effective implementation of the same to achieve the laid down targets under different National Health and Family Welfare Programmes. The MO shall provide assistance in the formulation of health and sanitation plan through the ANMs and coordinate with the elected public representatives in his/her PHC area.

He/she shall keep close liaison with civil administrative officers and his/her staff, community leaders and various social welfare agencies in his/her area and involve them to the best advantage in the promotion of health programmes in the area.

Wherever possible, the MO shall conduct field investigations to delineate local health problems for planning changes in the strategy for the effective delivery of health and family welfare services. He/she shall coordinate and facilitate the functioning of AYUSH doctor in the PHC.

Training:

- He/she shall organise training programmes including continuing education for the staff of PHC and ASHA under the guidance of the district/city health authorities and Health and Family Welfare Training centres.
- He/she shall ensure that staff is sent for appropriate trainings.
- He/she shall maintain and update a data base of staff and the trainings undergone by the them.
- He/she shall provide opportunity to the staff for using the knowledge, skills and competencies learnt during the training.
- He/she shall ensure appropriate infrastructure for trainings like venue, training aids, training material and other logistics.
- He/she shall organise training programmes for ASHAs with focus on developing appropriate skills as per local need.
- He/she shall also make arrangements/provide guidance to the Health Worker (Female) in organising training programmes for ASHAs.

Administrative Work:

- He/she shall supervise the work of staff working under him/her.
- He/she shall ensure general cleanliness inside and outside the premises of the UPHC and also proper maintenance of equipment under his/her charge.
- He/she shall ensure to keep up to date inventory and stock register of all the stores and equipment supplied to him/her and shall be responsible for its correct accounting.
- He/she shall get indents prepared timely for drugs, instruments, vaccines, ORS and contraceptive etc. sufficiently in advance and shall submit them to the appropriate health authorities.
- He/she shall check the proper maintenance of the transport given in his/her charge.
- He/she shall scrutinise the programmes of his/her staff and suggest changes if necessary to suit the priority of work.
- He/she shall get prepared and display charts in his/her own room to explain clearly the geographical areas, location of peripheral health units, morbidity and mortality, health statistics and other important information about his/her area.
- He/she shall hold monthly staff meetings with his/her own staff with a view to evaluating the progress of work and suggesting steps to be taken for further improvements.
- He/she shall ensure the regular supply of medicines and disbursements in Sub-Centres and to ASHAs.
- He/she shall ensure the maintenance of the prescribed records at PHC level.
- He/she shall receive reports from the periphery, get them compiled and submit them regularly to the district/city health authorities.

- He/she shall keep notes of his/her visits to the area and submit every month his/her tour report to the district/city health authorities.
- He/she shall discharge all the financial duties entrusted to him/her.
- He/she shall discharge the day to day administrative duties and administrative duties pertaining to new schemes.

2. Public Health Manager

The role of Public Health Manager (PHM) at a UPHC is envisaged as the nodal person responsible for all non-clinical activities at the UPHC. He/she will assist the Medical Officer in provisioning of services at the UPHC level and outreach locations. Key roles and responsibilities of PHM are as below:

Planning and budgeting – Overall management and functioning of healthcare facility

- He/she shall have a significant managerial role relating to planning and budgeting, organising staffing, directing, coordinating, and monitoring/reporting to ensure optimal utilisation of the facility.
- He/she shall be nodal person for all activities and programmes.
- He/she shall provide financial oversight in planning and budgeting.
- He/she shall compile the overall profile of facility regarding geographical coverage, target population, demographic and socio-economic indicators and update periodically.
- He/she shall ensure efficient functioning of OPD and shall strive to reduce patient waiting time.
- He/she shall refer to IPHS for assessing the functional status of health facilities and to bring up the UPHC to the comparable level.

Management of health human resource, training and capacity building

- Plan and organise training and capacity building of staff posted at the UPHC.
- Participate in community mobilisation processes like selection of ASHAs and formation of MAS and ensure their training.
- Assist Medical Officer in monitoring and supervision of staff on daily basis, like punctuality, maintenance of record, analysis of data etc.

Management of infrastructure, equipment and all support services

- He/she shall coordinate to ensure timely completion of civil work in the UPHC if any.
- He/she shall assist Medical Officer in examination of tender document for civil work in UPHC.
- He/she shall ensure that all equipment and instruments are in good condition and calibrated.
- He/she shall monitor and manage Annual Maintenance Contract.
- He/she shall ensure timely delivery of supplies to the UPHC.

Quality assurance and Infection Control and Environment Management

- The PHM shall assist in gap analysis of existing services, preparation of action plan to fill identified gaps and implementation of the guidelines.
- He/she shall ensure bio-medical waste management practices as per the guidelines.
- He/she shall facilitate periodic meeting of Quality Assurance Committee/team and prepare agenda notes and action taken report for the same. He/she shall also maintain minutes of the meeting.
- He/she shall ensure that protocols for service delivery of National Health Programmes are being followed.

Grievance redressal

- The PHM shall ensure display of the Charter of Patient's Rights focusing NUHM component in UPHC.

- He/she shall facilitate periodic meetings of Rogi Kalyan Samiti for improvement of the management and service provisions of the UPHC as per the RKS guidelines issued from time to time.

Community mobilisation, special outreach and referral support

- The PHM will be the nodal officer in charge of selection of ASHAs and all activities with respect to their payment of incentives and grievances.
- He/she shall be responsible of training of ASHAs and replenishment of their kits.
- He/she shall ensure periodical meeting of MAS, utilisation of MAS fund and submission of quarterly report.
- He/she shall provide supportive supervision to ANMs for community mobilisation events and special outreach camps.
- He/she shall facilitate referrals if advised during special outreach camps.

Supply chain management

- The PHM shall ensure to keep up-to-date inventory and stock register of the stores and equipment, drug supplied and shall be responsible for its accounting.
- He/she shall ensure timely preparation of indents for drugs, linen, vaccines, ORS, consumables, instruments, contraceptives sufficiently in advance and shall ensure submission of the same to the appropriate authority.

Management of support services

- He/she shall assist Medical Officer in management of support services like security, laundry, transportation, diet etc.
- He/she shall ensure convergence and coordination of national and state health programmes.
- The PHM shall ensure bringing convergence amongst all National Health Programmes in the catchment area as well as reporting of progress on programme indicators to appropriate authority.

Disease surveillance and epidemic control

- The PHM shall coordinate with existing mechanism of disease reporting under IDSP to ensure timely reporting to appropriate authority. This will require networking, liaison and coordination with multiple stakeholders like UPHC staff, private and other public health providers, community, officials of other departments.

IEC activities and public health education

- The PHM shall work towards spreading awareness regarding seasonal occurrence of diseases, and preventive measures. He/she shall make use of special health days, special campaigns, available IEC/BCC materials to increase awareness especially among poor and vulnerable communities.

Data collection, HMIS reporting and analysis

- The PHM shall ensure timely reporting and uploading of HMIS data and other reports.
- He/she shall ensure quality of data being submitted. To ensure the quality and timeliness, he/she shall train/handhold staff of the UPHC.
- PHM shall do a monthly analysis on outputs/inputs for cost effectiveness and share the same with UPHC Staff and district authorities.

3. Lady Health Visitor or Nurse

Supervision and Guidance

- She shall supervise and guide the Multi-purpose Health Worker (Female), and guide ASHA in the delivery of health care service to the community.
- She shall strengthen the knowledge and skills of the Health Worker (Female).
- She shall help the Health Worker (Female) in improving her skills in working in the community.

- She shall help and guide the Health Worker (Female) in planning and organising her programmes of activities.
- She shall assess fortnightly the progress of assessment report work of the Health Worker (Female) and submit with respect to their duties under various National Health Programmes.
- She shall carry out supervisory home visits in the area of the Health Worker (Female) with respect to her duties under various National Health Programmes.
- She shall supervise referral of all pregnant women for ANC check-ups at the UPHC.

Team Work

- She shall help the health workers to work as part of the Health Team.
- She shall coordinate her activities with other health personnel.
- She shall coordinate the health activities in her area with the activities of workers of other departments and agencies and attend meetings at PHC level.
- She shall conduct regular staff meetings with the health workers in coordination with the other health personnel.
- She shall attend staff meetings at the Urban Primary Health Centre.
- She shall assist the Medical Officer of the Primary Health Centre in the organisation of the different health services in the area.
- She shall participate as a member of the health team in mass camps and campaigns in health programmes.
- She shall facilitate and participate in activities of the UHND.

Records and Reports

- She shall scrutinise the maintenance of records by the Health Worker (Female) and guide her in their proper maintenance.
- She shall review reports received from the Health Workers (Female), consolidate them and submit monthly reports to the Medical Officer of the Primary Health Centre.

4. Auxiliary Nurse Midwives (ANM)

Responsibilities of ANM for outreach sessions:

- Unlike rural areas, Sub-Centres will not be set up in the urban areas as distances and mode of transportation are much better here. Outreach services will be provided through the Female Health Workers (FHWs), essentially ANMs with an induction training of three to six months, who will be headquartered at the Urban PHCs.
- The ANMs will report at the UPHC and then move to their respective areas for outreach services (including school health) on designated days. They will be provided mobility support for providing outreach services.
- On other days, they will conduct immunisation and ANC clinics etc. at the UPHC itself.
- Responsible for providing preventive and promotive healthcare services at the household level through regular visits and outreach sessions.
- Each ANM will organise a minimum of one routine outreach session in her area every month. Outreach sessions shall be planned to reach out to the vulnerable sections like slum population, rag pickers, sex workers, brick kiln workers, street children and rickshaw pullers.
- Special outreach sessions (for slum and vulnerable population) – Once in a week the ANMs covering slum/ vulnerable populations shall organise one special outreach session in partnership with other health professionals (doctors/ pharmacists/ technicians/ nurses - government or private). It will include screening and follow-up, basic lab investigations (using portable/ disposable kits), drug dispensing, and counselling.

5. Laboratory Technician

- Lab maintenance: General lab maintenance, including equipment, glassware, sterilization of equipment, disposal of specimen and infected material as per protocol, hygiene maintenance in lab.
- Ensure proper flow of patients, sample, maintenance of testing area. Ensuring adherence to infection prevention protocols, maintaining entry restriction to the lab.
- Investigations: Conduct tests as mentioned in 2.9 *(page 19)* and any other tests as specified by the medical officer, collection of sample, preparation of reagents, stains, media and other processes necessary for lab tests.
- Reporting & Record Keeping: maintain necessary records of investigations done in defined registers such as lab tests, tests referred, lab stock & store register, lab indent register. Prepare monthly reports of the lab tests done.
- Inform MO of any unusual observations, positives test, and any patterns observed in samples received.

6. Pharmacist

- Drug storage and dispensation: drug dispensation and distribution, maintain continuous supply of drugs and consumables, proper storage of drugs to ensure potency and quality, ensure hygiene in the pharmacy, display of EDL in UPHC.
- Procurement and management of drugs, and ensuring no stock-outs in the facility.
- Inventory management, ensuring timely indents, stock maintenance and making and raising indents.
- Reporting and record keeping: maintenance of stock and store registers, utilization drug records software such as E-Aushadhi, prepare monthly reports.
- Random sampling and testing of medicine stocks.

7. ASHA

- Each slum/community shall have one frontline community worker called ASHA. ASHA, similar to ASHA under NRHM, covering about 1,000 - 2,500 beneficiaries, between 200 - 500 households based on spatial consideration, shall preferably be co-located at the Anganwadi Centre functional at the slum level, for delivery of services at the doorstep.
- She shall remain in charge of each area and serve as an effective demand generating link between the health facility (Urban Primary Health Centre) and the urban slum populations. She shall maintain interpersonal communication with the beneficiary families and individuals to promote the desired health seeking behaviour. She shall be responsible for the MAS (community groups) for which they are designated.
- The ASHA shall help the ANM in delivering outreach services in the vicinity of the doorsteps of the beneficiaries. Preferably some suitable identified place for ASHA may be arranged in the slums which may be AWW centres, clubs, community premises set up under the JnNURM, Sub Health Posts set up in IPP cities, municipal premises etc., or even her own residence.
- Essential services to be rendered by the ASHA may be as follows:
  - Actively promote good health practices and community support.
  - Facilitate awareness on essential RCH services, sexuality, gender equality, age at marriage/pregnancy; motivation on contraception adoption, medical termination of pregnancy, sterilisation, spacing methods. Early registration of pregnancies, pregnancy care, clean and safe delivery, nutritional care during pregnancy, identification of danger signs during pregnancy; counselling on immunization, ANC, PNC etc.

- Act as a depot holder for essential provisions like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, oral pills and condoms, etc.
- Identify target beneficiaries and support the ANM in conducting regular monthly outreach sessions and tracking service coverage.
- Facilitate access to health-related services available at the Anganwadi/ Primary Urban Health Centres/ULBs, and other services being provided by the ULB/State/ Central Government.
- Encourage formation and promotion of MAS in her community.
- Arrange to escort/accompany pregnant women and children requiring treatment to the nearest Urban Primary Health Centre, secondary/tertiary level healthcare facility.
- Ensure reinforcement of community action for immunisation, prevention of water borne and other communicable diseases like TB (DOTS), malaria, chikungunya and Japanese encephalitis.
- Carry out preventive and promotive health activities with AWW/ MAS.
- Maintain necessary information and records about births and deaths, immunisation, antenatal services in her assigned locality as also about any unusual health problem or disease outbreak in the slum and share it with the ANM in charge of the area.

8. Mahila Arogya Samiti

- Supporting and contributing to mapping and listing of slum households; also preparing of resource map in the communities for identifying vulnerable and socio-economically disadvantaged group.
- Monitoring and facilitating access to essential public services and ensuring that all the people in the community or geographical area of MAS, particularly marginalised, vulnerable groups and disabled are receiving the services related to health, water, sanitation, nutrition and education.
- Organising local collective action for preventive and promotive health activities in the locality and amongst the families that are part of the group.
- Supporting ANM, AWW and ASHA in organising the Urban Health Nutrition Day and immunisation sessions. Mobilising pregnant women and children, particularly from marginalised families, and coordinate with ASHA and ANM in organising outreach sessions (both routine and special) activities in the community.
- The Mahila Arogya Samiti (MAS) is also responsible for community health planning which should be done on a monthly basis.
- Informing the UPHC or its functionaries in the event of any disease outbreak, which could be a single unusual disease, or a cluster of three to five cases of a common disease happening within two weeks to a month.
- Providing feedback to UPHC on the services being provided.
    - Maintaining records of births and deaths in the slum cluster.
    - Managing untied funds for Rs. 5,000 given annually to MAS.

Annexure – IV

REFERRAL FORM

Referral Form **Original / Copy** **Name of facility:**						
Referred by:	Name: Position:					
Name & Address of UPHC:		Date of referral:				
Referred to Facility Name and Address:						
Patient's Name						
Identity Number		Age:	Sex:	M	F	
Patient's address						
Clinical history						
Findings						
Treatment given						
Reason for referral						
Documents accompanying referral						
Print name, sign & date	Name:	Signature:	Date:			
Note to receiving facility: On completion of patient management please fill in and detach the referral back slip below and send with patient or send by fax or mail.						

-------✂----------receiving facility - tear off when making **back referral**----------✂--------

Back referral from Facility Name		Tel No.	Fax No.		
Reply from (person completing form)	Name:		Date:		
	Position:	Specialty:			
To Initiating Facility: (enter name and address)					
Patient Name					
Identity Number		Age:	Sex:	M	F
Patients address					
This patient was seen by: *(give name and specialty)*		Date:			
Patient history					
Special investigations and findings					
Diagnosis					
Treatment / operation					
Medication prescribed					
Please continue with: *(meds, follow-up, care)*					
Refer back to:		Date:			
Print name, sign & date	Name:	Signature:	Date:		

Annexure – V

REFERRAL REGISTER FOR UPHC

S.No.	Date of referral	Name of the Patient	Sex (M/F)	Identity No. (if NA, then address)	Referred to (name of facility / specialty)	Reason for Referral	Date Back referral received	Follow-up required YES / NO	Follow-up completed YES / NO	Appropriate referral YES / NO

Annexure – VI

HISTORY TAKING/RISK ASSESSMENT FORM FOR NON-COMMUNICABLE DISEASES

General Information	
Name of ASHA	Village
Name of ANM	Sub Centre
PHC	Date
Personal Details	
Name	Any Identifier (Aadhar Card, UID, Voter ID)
Age	State Health Insurance Scheme: (Y/ N) _____
Sex	Telephone No.
Address	

Part A: Risk Assessment				
Question	Range		Circle any	Write score
1. What is your age? (in complete years)	30-39 years		**0**	
	40-49 years		**1**	
	≥ 50 years		**2**	
2. Do you smoke or consume smokeless products such as Gutka; or Khaini ?	Never		**0**	
	Used to consume in the past / Sometimes now		**1**	
	Daily		**2**	
3. Do you consume Alcohol daily?	No		0	
	Yes		**1**	
4. Measurement of waist (in cm)	**Female**	**Male**		
	<80 cm	<90 cm	**0**	
	81-90 cm	91-100 cm	**1**	
	>90 cm	>100 cm	**2**	
5. Do you undertake any physical activities for minimum of 150 minutes in a week?	At least 150 minutes in a week		**0**	
	Less than 150 minutes in a week		**1**	
6. Do you have a family history (any one of your parents or siblings) of high blood pressure, diabetes and heart disease?	No		**0**	
	Yes		**2**	
Total Score				

A score above 4 indicates that the person may be at risk for these NCDs and needs to be prioritized for attending the weekly NCD day

Part B: Early Detection: Ask if patient has any of these symptoms			
B1: Women and Men	Yes/No	B2: Women only	Yes/No
Shortness of breath		Lump in the breast	
Coughing more than 2 weeks		Blood stained discharge from the nipple	
Blood in sputum		Change in shape and size of breast	
History of fits		Bleeding between periods	
Difficulty in opening mouth		Bleeding after menopause	
Ulcers /patch /growth in the mouth that has not healed in two weeks		Bleeding after intercourse	
Any change in the tone of your voice		Foul smelling vaginal discharge	
In case the individual answers Yes to any one of the above mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available.			

Part C: Early Detection: Circle all that apply
Type of fuel used for cooking: Firewood/crop residue/cow dung cake/coal/kerosene
Occupational exposure: Crop residue burning/burning of garbage-leaf/working in industries which smoke, gas and dust exposure such as brick kilns and glass factories etc.

Annexure – VII

REGISTER FOR OPD REGISTRATION COUNTER

S.No	Date	Registration number		Full Name, Addres and Phone Number	Father/ Husband / Guardian	Age & Sex (M/F/O)	Religion	Caste	Consulting Room Number	BPL (Y/N)
		New patient	Old patient					(Gen/ OBC/ST/ SC)		
1										
2										
3										
4										
5										
6										
7										
8										

*To be kept at the UPHC Registration Counter

Annexure – VIII

OPD SLIP

Date:	Timing*: 12 Noon - 8 PM (Single Shift) OR 8 AM - 12 PM & 4 PM - 8 PM (Double Shift) **State Specific time can also be indicated*
Registration No.	Name: Age: Sex: M/F/O
New:	
Old:	
Department / Room Number :	Token/Queue No.
Provisional Diagnosis:	Final Diagnosis:
Present Complaint:	
Investigation:	Clinical examination:
Treatment:	
Follow-Up:	

Annexure – IX

OPD REGISTER*

**To be maintained 1 in each OPD room*

**All HMIS information will be taken from this register*

S. No.	Date	Registration No.	Name	Age	Sex	Complaints	Investigation	Height/ Weight	Diagnosis		Treatment Advise	Remarks	
									Provisional	Confirmed		Admission	Referral To
1													
2													
3													
4													
5													
6													
7													
8													

Annexure – X

BED HEAD TICKET

Bed Head Ticket			MCTS Number (if pregnant women):		
Registration No.			Date: Time:		
Name:	Age:	Sex:			
JSY (Y/N)*	BPL (Y/N)				
*In case of pregnancy, Bed-Head ticket, prescribed by MH Division of GoI should be followed.					
Name of Father/ Husband/ Guardian:			Address: Mobile No.		
Provisional Diagnosis:			Final Diagnosis:		
Date of Discharge/LAMA/Referral:**			Place of Referral:		
			Reasons for Referral:		
			Condition at the time of Referral:		
Past Medical History:					
Past Surgical History:					
Present Complaint:					
H/O Allergy:					
General Examination					
BP:	Pulse:	Icterus:	Pallor:	Respiration:	Oedema:
Systemic Examination					
Chest:	Abdomen:	CVS:	CVS:	Others:	
Previous Investigations:			Previous Treatment if any:		
Investigation Advised:			Treatment Advised:		

Note: Copy of Discharge Card/ Referral Slip to be Annexed

CONTINUATION SHEET			
Date & Time	Complaints	Examination notes / Investigations	Treatment / Advise

Note: Copy of Discharge Card/ Referral Slip to be Annexed

TREATMENT SCHEDULES AND RECORDS FOR NURSING STAFF:

Note: Copy of Discharge Card/ Referral Slip to be Annexed

Annexure – XI

INDOOR REGISTER

S.No	Date	Registration No. (BPL-Y/N)	I P No.	Name & address-Phone	Age & Sex (M/F/O)	Religion	Caste (Gen/ OBC/ ST/SC)	BPL-(Y/N)	DOA & Time	Ward & Bed No.	Diagnosis	Advice on Admission	DOD & Time (Discharge/ Death)	Treatment at discharge	Remarks
MCTS Number (if pregnant women):															

Annexure – XII

LABOUR ROOM REGISTER

LABOUR ROOM REGISTER				MCTS NO* :	
1	Name	9	Aadhar Number:	17	Delivery:
2	Age:	10	Facility Registration Number (OPD/ IPD):	18	Normal (mention gestation in weeks)/Assisted/C-Section)
3	W/o or D/o:	11	Date of Registration:	19	Live Birth/Still Births/Abortions (mention gestation in weeks)
4	Address:	12	Whether JSY Beneficiary (Y/N):	20	If any complication during delivery
5	Mobile Number (Family/Others):	13	Parity (GPLA):	21	Maternal conditions[3]
6	Religion:	14	LMP & EDD:	22	Foetal/Neonatal conditions[4]
7	Caste SC/ST/Others:	15	Past History, if any, Specify[1]:	23	PPIUCD inserted (Y/N)
8	MCTS Number	16	Past Obstetric History[2]:		
Past obstetric history					
24	Any identified Complication/high risk during ANC specify[5]				
25	If diagnosed with Pre-term labour, Please give reason				
26	Ante natal corticosteriod given or not	Given (Y/N) / / I Dose (Time) / / II Dose (Time) /			
27	Complication during present pregnancy, specify				
Pregnancy outcome					
28	Date and time of delivery				
29	Outcome (LB/Still birth/Abortion)				
30	Gestation age in weeks at the time of delivery				
31	Delivery conducted by (write name and designation)				
32	Type of delivery: normal/assisted (specify)/LSCS/ others				
33	Any Medical/surgical interventions (eg. Injectable drugs, ARM etc.) given, Specify				
34	Indication for the intervention				
35	Post-delivery identification tag no. of newborn & mother				
36	Sex (M/F)				
37	Weight (in grams)				
Essential newborn care or Routine care of the newborn					
38	Did the baby cry immediately after birth?				
39	Did the baby require resuscitation? (Y/N)				
40	Essential Newborn Care (ENBC) provided: (Y/N)				
41	Time of initiation of Breastfeeding				
42	Birth doses (BCG/OPV/ Hep. B/Vit. K), Please specify				
43	If any congenital anomaly, specify				
44	PPTCT drugs given (Yes/No/Not applicable)				
45	PPIUCD inserted (if applicable) (Yes/No)				
46	If referred, reason and place for referral, along with time of referral				
47	Death of the mother or new born - please specify				

** If MCTS number is not generated, then the MCTS number is to be generated by the treating health facility. Findings of the ANC are to be uploaded in MCTS portal by the treating facility.*

[1] Tuberculosis, Diabetes, Hypertension, heart disease, epileptic or any convulsion, STI/RTI (HIV & Hepatitis B), asthma, any other specify.

[2] Past Obstetric history - H/O of any past surgery/previous LSCS, repeated abortions, infertility treatment, H/o Still birth, any other (specify), H/o Eclampsia, Hemorrhage, Obstructed labour, Prolonged labour, other (specify).

[3] Hemorrhage (APH/PPH), Infection, Eclampsia, Others (please specify).

[4] Low birth weight/Pre-term, Sepsis, Asphyxia, Any other complications.

[5] Hypertension, Diabetes, convulsion, severe headache, oedema, APH, any other please specify.

Annexure – XIII

PATIENT DISCHARGE CARD*

		MLC/Non-MLC
Registration No.	Name:	Age / Sex :
Address:	Mobile No:	
Date of Admission:	Time:	Doctor:
Date of Discharge:	Time:	Doctor:
Diagnosis:		
Investigation findings:		
Treatment advised:		
Follow up:		

***Note:** Copy of Discharge card/Referral slip to be annexed with the Bed-head ticket

Annexure – XIV

GENERATOR USAGE REGISTER

Location of Generator							
Date	Starting time	Closing time	Working hours / minutes	Total working hours for the day	Breakdown Hours	Signature of operator	Signature of Supervisor

Annexure – XV

RCH-I: TRACKING OF ELIGIBLE COUPLES

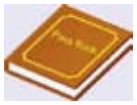
Note: Formats of RCH Registers Section I, II & III used for tracking eligible couples, pregnant women & children respectively, will remain the same as used in NRHM.

1	2	3		4			5			6	7
Sr. No.	MCTS ID No. of Woman	Name of Woman	Name of Husband	Aadhaar No. and Bank Details of Woman			Aadhaar No. and Bank Details of Husband			Mobile No. of the Husband/ Woman/ Family (Specify)	Page Number
				Aadhaar No. / NA	Bank Account No./NA	Name of Bank & Branch/ NA	Aadhaar No. / NA	Bank Account No./NA	Name of Bank & Branch/NA		
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

Annexure – XVI

RCH-II: TRACKING OF PREGNANT WOMEN

Note: Formats of RCH Registers Section I, II & III used for tracking eligible couples, pregnant women & children respectively, will remain the same as used in NRHM.

1	2	3	4	5			6		7
							JSY Beneficiary Details		
Sr. No.	MCTS ID No. of Pregnant Woman	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA 	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	Page Number

Annexure – XVII

RCH-III: TRACKING OF CHILDREN

Note: Formats of RCH Registers Section I, II & III used for tracking eligible couples, pregnant women & children respectively, will remain the same as used in NRHM.

1	2	3	4		5		6	7
Sr. No.	MCTS ID No. of Child	Date of Registration	Name of Child	Sex of Child (M/F)	Name		Mobile No. of mother / father/ any other contact No.	Page Number
					Mother	Father		
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Design & Layout: JS MEDIA (www.jsmedia.in)

Ministry of Health and Family Welfare
Government of India