INDIAN PUBLIC HEALTH STANDARDS

HEALTH AND WELLNESS CENTRE – SUB HEALTH CENTRE

2022

VOLUME-IV

Ministry of Health & Family Welfare

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डॉ. मनसुख मांडविया
DR. MANSUKH MANDAVIYA

सत्यमेव जयते

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

आज़ादी का अमृत महोत्सव

MESSAGE

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

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

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

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

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

(Dr. Mansukh Mandaviya)

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एक कदम स्वच्छता की ओर

MESSAGE

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

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

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

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

(Dr. Bharati Pravin Pawar)

"दो गज की दूरी, मास्क है जरूरी"

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Message

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

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

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

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

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

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

Place : New Delhi
Date : 21-09-2021

(Rajesh Bhushan)

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MESSAGE

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

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

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

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

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

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

(Vikas Sheel)

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FOREWORD

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

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

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

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

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

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

(Vishal Chauhan)

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FOREWORD

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

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

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

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

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

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

23/09/2021
(Dr. Harmeet Singh)

Dr. Himanshu Bhushan
Member Secretary

New Delhi
11th April 2022

The journey and the vision of IPHS 2022

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

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

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

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

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

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

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

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

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

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

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

(Dr. Himanshu Bhushan)

TABLE OF CONTENTS

ANNEXURES

LIST OF ABBREVIATIONS

AEFI	Adverse Events Following Immunization
AFB	Acid-Fast Bacillus
AFHC	Adolescent Friendly Health Clinics
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa Rigpa and Homeopathy
BCC	Behavioural Change Communication
BMWM	Bio Medical Waste Management
CDR	Child Death Review
CHC	Community Health Centre
CHO	Community Health Officer
COPD	Chronic Obstructive Pulmonary Disease
CPHC	Comprehensive Primary Health Care
DH	District Hospitals
DOTS	Directly Observed Treatment, Short-Course
EDL	Essential Drugs List
EML	Essential Medicines List
ENT	Ear, Nose, and Throat
ETP	Effluent Treatment Plan
FRU	First Referral Units
FSSAI	Food Safety and Standards Authority of India
GBV	Gender Based Violence
GOI	Government of India
HCG	Human Chorionic Gonadotropin
HD	High Definition
HIV	Human Immunodeficiency Virus
HRH	Human Resource for Health
HRMIS	Human Resource Management Information System
HWC	Health and Wellness Centre
ICDS	Integrated Child Development Services
ICT	Information and Communication Technology
ICTC	Integrated Counselling and Testing Centre

IEC	Information, Education and Communication
IFA	Iron Folic Acid
IPHS	Indian Public Health Standards
IT	Information Technology
IUCD	Intra Uterine Contraceptive Device
JAS	Jan Arogya Samiti
LCD	Liquid Crystal Display
LED	Light Emitting Diode
MAS	Mahila Arogya Samiti
MBPS	Mega Bits per Second
MCP	Mother and Child Protection
MDSR	Maternal Death Surveillance and Response
MDT	Multi Drug Therapy
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MO	Medical Officer
MPW	Multi Purpose Worker
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NBC	National Building Code
NCD	Non-Communicable Disease
NHP	National Health Policy
NIN	National Identification Number
NQAP	National Quality Assurance Program
NQAS	National Quality Assurance Standards
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
NRLM	National Rural Livelihood Mission
OOPE	Out of Pocket Expenditure
OPD	Out-Patient Department
ORS	Oral Rehydration Solution
OT	Operation Theatre
pH	Power of Hydrogen
PHC	Primary Health Centre
PHM	Public Health Manager
PLHA	Person living with HIV and AIDS
PMJAY	Pradhan Mantri Jan Arogya Yojana
PNC	Post Natal Care
PPTCT	Prevention of Parent To Child Transmission
PPE	Personal Protective Equipment
PPH	Postpartum Haemorrhage
PRI	Panchayat Raj Institution
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health

RLB	Rural Local Bodies
RTI	Respiratory Tract Infections
RWA	Resident Welfare Association
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goal
SDH	Sub District Hospitals
SHC	Sub Health Centre
SHG	Self Help Group
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOR	Terms of Reference
UCHC	Urban Community Health Centre
UHC	Universal Health Coverage
UHND	Urban Health and Nutrition Day
UHWC	Urban Health and Wellness Centre
ULB	Urban Local Bodies
UPHC	Urban Primary Health Centre
URI	Upper Respiratory Infection
VDRL	Venereal Disease Research Laboratory Test
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WCD	Women and Child Development
WIFS	Weekly Iron and Folic Acid Supplementation

READER'S GUIDE FOR HEALTH & WELLNESS CENTRE - SUB HEALTH CENTRE

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

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

- **Section 1:** The **Background** section provides a summary of the importance of strengthening of primary health care services in India and the basis for the establishment of health and wellness centres. It also includes the importance of having the Indian Public Health Standards (IPHS).
- **Section 2:** The section on **Introduction** includes the rationality behind revising the IPHS. It briefly describes how IPHS can accelerate India's progress towards achievement of UHC and Sustainable Development Goal - 3 (SDG 3) in alignment with the National Health Policy 2017.
- **Section 3:** This enlists the key **Objectives of the Indian Public Health Standards (IPHS)** for Sub Health Centres- Health and Wellness Centres and Urban Health & Wellness Centres.
- **Section 4:** It includes the **Types or categories of HWCs**, the purpose of establishing them and the population norms at which the HWCs are to be established in the rural as well as the urban areas.
- **Section 5:** It includes the **population norms** for all types of HWC-SHC and UHWCs.
- **Section 6**: It contains the **General Principles** to be adopted by the States and Union Territories to strengthen the service delivery and ensure better implementation of the National Health Programmes.
- **Section 7:** Defines the minimum **Criteria** for the health care and facility to be identified as '**IPHS Compliant**'.
- **Section 8:** The section on **Service Provision** includes the details of:

    a. The basis for establishing the health facilities, infrastructure requirement and the general appearance and upkeep of the facilities;

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

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

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

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

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

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

h. Quality Assurance Protocol to be adopted including a road map for healthcare facilities to achieve NQAS certification;

i. Ensuring accountability and governance in service delivery; and

j. Framework of implementation of IPHS.

BACKGROUND

1 SECTION

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

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

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

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

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

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

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

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

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

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

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

To meet all these national and international commitments, it is essential for public health facilities to deliver quality services through defined standards known as the Indian Public Health Standards (IPHS). It provides guidance on the health system components such as infrastructure, human resource, drugs, diagnostics, equipment, quality and governance requirements for delivering health services at these facilities.

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

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

NHP-2017 proposes key policy shift from selective primary care to assured comprehensive primary care with linkages to referral hospitals.

To address the morbidity burden and the social determinants, increased community participation, surveillance, health promotion, engaging with information technologies (IT) and for ensuring continuum of care; the Government of India implemented the holistic programme "Ayushman Bharat", which comprises of two inter-related components. The first component involves upgradation of all the Sub Health Centres (SHCs), Primary Health Centres (PHCs) and Urban Primary Health Care Centres (UPHCs) to Health and Wellness Centres (HWCs) for the delivery of comprehensive primary health care. The second component comprises of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) which aims to provide financial protection for secondary and tertiary care to socially vulnerable and low-income households. Thus, together, the two components of Ayushman Bharat will enable the country to achieve Universal Health Coverage and eventually "Health for All".

The HWCs will provide an expanded range of services beyond the selective package of health care for pregnant women, children, reproductive health and communicable diseases. These HWCs will also deliver Preventive, Promotive, Curative, Rehabilitative and Palliative care services close to communities with the principle being 'time to care' to be not more than 30 minutes from the farthest village. The HWCs are envisaged to provide clinical management for most common ailments, prompt referral to doctor or for specialist consultations at higher facilities and undertake follow-up of down referrals. To achieve this, an understanding for local

health needs, cultural traditions and social status of the population being catered by HWC are important parameters for effective service delivery.

For effective and quality delivery of comprehensive healthcare services, it is essential for public health facilities to adopt uniform standards and norms. To comply, the Indian Public Health Standards (IPHS) for Sub-Centres, Primary Health Centres, Community Health Centres, Sub-District and District Hospitals, were published in 2007 and revised in 2012 as the reference point to provide standardized public health care services and general principles for infrastructure planning and up-gradation of health facilities as per the population of the States and UTs. The defined uniform standards had been envisaged to deliver quality services to citizens with dignity and respect and provide guidance on the health system components such as infrastructure, human resource, drugs, diagnostics, equipment, quality and governance requirements for delivering seamless health services at these public facilities.

2
SECTION

INTRODUCTION

Primary health care is based on principles of social justice, equity and right to health and in recognition of the fundamental right to the highest attainable standard of health, echoing Article 25 of the Universal Declaration on Human Rights. It is an integral part of overall social and economic development in addition to catering to the healthcare needs of the country. HWC-SHCs/UHWCs strive to provide affordable, accessible, practical, quality and socially acceptable healthcare to the community and is universally available, regardless of their economic stature or payment capacity. Primary healthcare services in India are currently being delivered through Sub-Centres and Primary Health Centres in rural areas and Urban Primary Health Centres in urban areas.

Since the last revision of the IPHS in 2012, a number of new initiatives, interventions and programmes have been introduced in the public health system of India. The introduction of comprehensive primary health care through upgraded sub-centres and PHCs (now known as Health and Wellness Centres), and similarly, in urban areas, Urban Health and Wellness Centres, specialty UPHCs (polyclinics), are some of the new additions.

Focus on urban health came during RCH-I and continued in RCH-II as part of NRHM. However, it was in 2013, while reorganizing National Health Mission, that the National Urban Health Mission (NUHM) was launched with the aim to provide affordable primary healthcare through UPHCs, UCHCs and outreach services to the urban population in India. Recently, Urban HWCs have been planned to set up with a population norm of 15,000-20,000 in Urban areas to enable a robust decentralized delivery of primary health care services closer to people, thereby increasing reach of the public health systems to the vulnerable and marginalized.

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

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

In the public health sector, the Sub Health Centre (SHC) and Urban Health and Wellness Centre (UHWC) are the most peripheral and first points of contact between the primary health care system and the community in rural and urban areas, respectively. These health facilities act as an interface with the community at the

grass-root level, providing all the comprehensive primary health care services. The purpose of the SHC and UHWC is largely preventive and promotive, but they also provide a basic level of curative care.

To account for the above-mentioned developments and in light of newer advances in health, science, and technology, it is critical to update the IPHS by incorporating the stakeholder inputs on the existing standards' relevance and utility, so that the revised IPHS 2022 stay fit-for-purpose. Hence, the revised IPHS guidelines 2022, define the norms for public health facilities in rural and urban areas to set benchmarks towards achieving the goal of universal health coverage.

The IPHS 2022 guidelines have been framed for-

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

Additionally, the 2022 revised guidelines emphasize on the services to be delivered at each level of facility. The service delivery defined for each level of health facility will be the basis for developing other health system strengthening components viz. infrastructure, human resources, drugs, diagnostics/equipment, quality improvement, monitoring/supervision, governance, and leadership. These services are envisaged to be acceptable, accessible, affordable, and responsive to the needs of the population, especially the vulnerable and marginalized to maintain equity in the healthcare distribution.

The 2022 IPHS norms will retain the earlier approach of supporting government health facilities to attain a minimum acceptable functional standard (indicated as 'essential') while striving and aspiring for improvement (indicated as 'desirable') so as to accelerate India's progress towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3) in alignment with the National Health Policy 2017. The desirable services are over and above the essential services.

Indian Public Health Standards- Volume IV lays out norms for Health and Wellness Centre (rural HWC-SHCs and urban HWCs) for delivering the comprehensive primary health care services. It aims to support States with implementation of IPHS 2022 at public health facilities and includes the general principles to be followed while applying the norms. It considers health service provision holistically for a district and implementation of norms should be based on the local burden of disease and its projection in terms of likely future trends.

3
SECTION

OBJECTIVES OF IPHS FOR HWC-SHC AND UHWC

The broad objectives of the Indian Public Health Standards (IPHS) for HWC-SHC and UHWCs include the following:

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

TYPES/CATEGORIES OF HWCs

4 SECTION

In comparison with the IPHS guidelines of 2012, the revised IPHS 2022 guidelines classify the HWCs as:

1. **Health and Wellness Centres - Primary Health Centre:**
   a) HWC-PHC in rural areas
   b) HWC- UPHC in urban areas
2. **Health and Wellness Centres - Sub Health Centre:**
   a) Health and Wellness Centre - Sub Health Centre in rural areas
   b) Urban Health & Wellness Centre in urban areas

5
SECTION

POPULATION NORMS FOR HWC-SHC AND UHWC

i. HWC-SHC (rural): In rural areas, one Sub Health Centre is established for every 5000 population in plain areas and 3000 population in hilly/tribal/desert areas.

ii. UHWC (urban): In urban areas one Urban-HWC per 15,000-20,000 population caters predominantly to poor and vulnerable populations, residing in slums or other such pockets.

Population norm for HWC-SHC/UHWC			
S. No.	**Type of PHC facility**	**Plain (population)**	**Hilly/Tribal(population)**
1	HWC-SHC	5000	3000
2	UHWC	15,000- 20,000	-

GENERAL PRINCIPLES

6 SECTION

- IPHS defines the standards in the local context of the country and its implementation is the State's/UT's responsibility with technical support from MoHFW. IPHS does not define the implementation process. However, in the interest of rendering quality patient services, it suggests that in-house hiring of clinical and critical staff should be prioritized rather than those services which can efficiently be run even through outsourcing model like security, cleaning, laundry, etc.
- While planning and designing services at public health facilities, health needs of the entire district should be considered as a whole rather than focusing on individual facilities within that district. This holistic assessment should include estimating the burden of disease in the district based on previous years data generated/research papers/surveys, the local epidemiology and the specific needs and requirements of communities in different parts of the district. While placing services at various levels, the "continuum of care" approach needs to be ensured for the population.
- For each district/city, the final number of health facilities will be influenced by its population, time to care, geographical need, local epidemiology and burden of disease, community requirements and the health seeking behavior of the population. Every district should have a district health action plan, with all health facilities identified and mapped, and indicating the type and level of services they provide.
- Depending on the services provided at a particular facility, it may be deemed as a primary or secondary care service provider facility:
    - Health and Wellness Centres (HWC-SHC, UHWCs and PHCs), in both rural and urban areas will provide primary care services.
    - Multispecialty polyclinics nearer to the community will provide ambulatory specialist services, particularly in urban areas.
    - Community Health Centres in rural areas can be either FRU or non- FRU, depending on the range of services provided. In urban areas, CHCs will provide services at par with FRU.
    - District and Sub-District Hospitals will provide secondary care services.
- Implementation of all national programmes at individual facilities must be in line with the latest GoI/ state guidelines developed for that programme.
- Requirements of individual national health programmes (in terms of service delivery, infrastructure, human resources, drugs, and diagnostics) have been reviewed and included in IPHS. Therefore, achieving IPHS compliance would go a long way in fulfilling the requirements of various health programmes.
- The Urban-HWC would be the first port of call for residents in urban areas. It would be linked to the nearest UPHC-HWC (at population of 50,000) for administrative, financial, reporting, and supervisory purposes.
- All Rural and Urban-HWCs should have a National Identification Number (NIN-Id) and register on the AB-HWC portal.
- The specific set of services to be provided at a particular facility should be clearly identified from the list of services provided in the IPHS norms. Requirements of individual national health programs have

already been considered in this list. This will help to identify requirements for infrastructure, human resources for health, drugs, diagnostics, and equipment.

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

CRITERIA FOR IPHS COMPLIANCE

7 SECTION

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

The norms for service provision, infra-structural and human resource requirements, drugs, diagnostics and equipment, quality assurance, monitoring and governance will apply uniformly across all facilities in rural and urban areas. General guidance on these components is presented in the sections that follow.

The mechanism and criteria for IPHS certification can be accessed at the link given below.
https://nhsrcindia.org/IPHS2022

8
SECTION

SERVICE PROVISION

Health and Wellness Centres have an important role in the prevention of several disease conditions, including non- communicable diseases and health promotion. They go beyond first contact care and mediate an assured two-way referral service to primary and secondary level facilities.

The services envisaged- health promotion, early identification, ensuring treatment, follow-up, ensuring continuity of care by appropriate referrals.

They also play an important role in undertaking public health functions in the community leveraging the frontline workers and community platforms. They are envisaged to deliver people Centred, holistic, equity sensitive, quality response to people's health needs through a process of population enumeration, regular home and community interactions and improving people's participation. A community based participatory approach which ensures preventive and promotive actions for health is considered as one of the primary objectives of these Centres.

The healthcare services to be provided at these Centres include health promotion, early identification, ensuring treatment adherence, follow-up care, ensuring continuity of care by appropriate referrals, optimal home and community follow-up, disease surveillance, and health promotion and prevention for the expanded range of CPHC services. The twelve packages envisaged under CPHC are:

1. Care in Pregnancy and Childbirth.
2. Neonatal and Infant Health Care Services
3. Childhood and Adolescent Health Care Services.
4. Family Planning, Contraceptive Services and other Reproductive Health Care Services
5. Management of Communicable Diseases: National Health Programme
6. Management of Common communicable diseases and outpatient care for acute simple illness and minor ailments
7. Screening, Prevention, Control and Management of Non-communicable Diseases
8. Care for Common Ophthalmic and ENT Problems
9. Basic Oral Health Care
10. Elderly and Palliative Health Care Services
11. Emergency Medical Services including Burns and Trauma
12. Screening and Basic Management of Mental Health Ailments

In addition to providing clinical services, HWCs are also to be utilized as a platform for teleconsultation and expanding the range of diagnostics. As defined in this guideline states can add more tests in hub & spoke model with a nearest CHC/UCHC if range of diagnostics is to be expanded particularly in urban areas.

To ensure continuum of care, assured referral with facility readiness to manage referred cases must be established with the PHC/UPHC and secondary level facilities in rural and urban areas. The referral transport network should have the requisite number of equipped ambulances (depending on population norms) and adequately trained human resources.

Apart from other services, an integration of Yoga and AYUSH services as appropriate to people's needs are required for provision of all-inclusive health services. The emphasis on health promotion (including the School Health and Wellness Ambassador Initiative) for public health action through active engagement and capacity building of community platforms, elected representatives and community volunteers is envisioned.

Besides facility-based services, HWCs play an important role in community outreach, which will be a part of the service package at HWCs (e.g., VHNDs/UHNDs). Need based outreach sessions can be conducted without any fixed periodicity (at required intervals), depending on national program requirements and for inter-departmental convergence activities from time-to-time basis in any particular area. Program specific outreach camps for screening and early detection of diseases such as TB, leprosy, fever, hypertension, diabetes, asthma, glaucoma, blindness, etc., special health drives, vaccination drives, health camps for disease specific awareness generation or other program related activities, convergence activities with other departments for health promotion/awareness generation by addressing social determinants of health such as sanitation, water, gender issues, violence, substance abuse, etc., public health surveillance, outbreak investigation in case of any outbreaks, epidemics and pandemics, Disaster mitigation/ disaster management activities in case of floods, droughts, earthquakes, landslides, etc., targeted interventions for migrants population sub groups residing in urban areas are some of the examples of such outreach sessions.

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

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

Service flow at UHWC

- The suggestive flow of services as mentioned below should be followed at UHWC for IPHS recognition-
- Enquiry → Registration → Waiting Area → Doctor's Consultation Room → Laboratory → Doctor's Consultation Room → Pharmacy → Exit.

Details of the services to be provided by HWCs are mentioned at ***Annexure 2.***

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

8.1. INFRASTRUCTURE

All the HWCs should be located such that they are easily accessible by the rural/urban communities which they target to serve. Planning and provision of HWC-SHC and UHWCs takes into account factors affecting access such as geographical spread, access within the community, road connectivity and the 'time to care' approach (within 30 minutes of reach).

The Urban HWCs should be located preferably within 1 kilometer radius from the periphery of under-served population in urban slums, vulnerable pockets, and temporary settlements in cities and peri-urban areas, which are the prime focus in the urban areas. Moreover, the HWCs should be prioritized in the aspirational, tribal, and backward blocks / districts. As far as practical, while choosing the location for construction/establishment of new Centres, places like landfill sites, water treatment plants, industrial areas, etc., should not be in the vicinity of HWC.

Selection of site for construction of HWC-SHC and UHWCs should take into account access issues such as geographical spread, access within the community, road connectivity and the 'time to care' approach (within 30 minutes of reach).

New infrastructure in rural areas should be planned, designed, and built taking account of future expansion – both with regards to the quantity and range of services to be provided.

The infrastructure for all facilities should follow the rules and regulations as laid down in the state by-laws and the associated National Building Code.

The UHWCs may function in rented building or any pre-existing public building in that area, provided the flow and range of services are possible with in the infrastructure available. If required, the existing infrastructure can be modified to suit the requirements. Sufficient space and infrastructure should be provisioned for the services being provided.

Old and dilapidated facilities may need to be demolished to build new infrastructure at the same site. However, while demolishing any old building, it should be ensured that alternate arrangements are made for effectively running the existing services. Factors to be considered while building a new facility or selecting a new site for a facility include:

- Accessibility to the community (with good road connectivity). Ideally, it should be located within the habitation while ensuring safety of health care providers.
- The facility is not in a low-lying flood prone area.
- It is adequately serviced by public utilities such as water, electricity and telephone connectivity, sewage, and storm-water disposal. In areas where these are not available, appropriate substitutes should be identified, alternative source of electricity like Solar panels or inverter for power backup to ensure constant electric supply for telephone and internet connectivity.
- Ensuring elderly and disabled friendly access.
- Minimizing exposure to air, noise, water and land pollution and vector-breeding / vector proof buildings.
- Reviewing land utilization in adjoining areas, the general topography, proximity to the local bus stands, railway station and other modes of transport and obtaining the necessary environmental (including seismic safety), fire safety and administrative clearance.
- The state and area specific by-laws and rules should be strictly adhered to.

Infrastructure planning of HWC-SHC and UHWC should ideally be as per standard layout plan **(Annexure 3).** While maps for the general lay-out, flow and suggested dimensions are provided for facility, these may have to be adapted to fit space constraints.

At times, the availability of land is a challenge, so the possibility of vertical expansion can be considered, especially in urban areas. **However, for a facility (HWC-SHC/UHWC) to be IPHS compliant, sufficient space along with services as prescribed in these guidelines should be provisioned for.**

For already existing facilities, the flow of services needs to be ensured as per the standard plan and if required, additional infrastructure to meet the deficiencies can be created. As far as practical, the principles suggested above can be built in for all new constructions and to the extent possible for existing infrastructure. Priority needs to be given for making infrastructure climate resilient, elderly and disabled friendly, etc.

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

Emphasis should be given to create a positive, client friendly ambience and environment around the facility. This includes due consideration to the provision of facilities for initial screening and holding area, patient registration, waiting areas, clear wayfinding and sign-posting, parking, gardens, washrooms, drinking water, elderly and disabled friendly facilities. Processes such as registration and drug dispensing should

be computerized. The facility should be environment friendly with scope for adequate natural light, water harvesting and solar energy, as appropriate. Adequate hand washing facilities near entrance, examination and patient waiting areas should be provided.

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

8.1.1. General Appearance and Upkeep

All the facilities should have a boundary wall with adequate lighting to ensure that the facility is clearly visible from the approach road and also to restrict entry of stray animals. Branding of the facility may be done as per the GoI norms. It should be free from seepage, cracks, and broken windowpanes. There should be no unwanted/outdated posters or hoardings on the walls of building and the boundary of the facility. It should have provision for easy access for disabled and elderly. The floors should be anti-skid and non-slippery.

8.1.1.1. Maintenance and upkeep

Periodic visits by public health engineers should take place to monitor the infrastructure and upkeep of the facilities.

8.1.1.2. Wayfinding/Signage

Adequate and clear signage should be displayed on the main and connecting roads to the facility. They should be in a font which is easily visible from a distance. A board clearly indicating the name of the facility should be placed at the front of the facility (including in the local language). Important information such as contact numbers (e.g., fire, police, ambulance, blood banks and referral centres) should be clearly visible. Visit schedule of primary health care team should be displayed.

The layout of the coverage area should be displayed near the entrance. The information regarding the nearest secondary care facilities could also be displayed at appropriate place. Safety, hazard and caution signs should be prominently displayed at relevant places. A fluorescent fire exit plan should be considered where appropriate. Tactile pathways should be made for visually disabled and elderly visitors.

8.1.1.3. Parking

Clear access for vehicles and ambulances should be maintained. Parking for disabled, elderly and ambulances should be reserved and 'no parking" for those areas should be marked.

8.1.1.4. Garden and green areas

Gardens, other green areas and open spaces give a positive, healing environment that reduces stress, anxiety and mental fatigue. So wherever possible, identify and promote greenery and open spaces. Herbal gardens should be promoted on the campus. Kayakalp guidelines may be referred to for maintenance of the gardens.

8.1.1.5. Environment friendly features

The facility should be environment friendly and energy efficient. Where possible, the use of rainwater harvesting, solar energy and energy-efficient bulbs/ equipment should be encouraged by converging resources from other ministries and local bodies (RLB/ULB). Kayakalp guidelines may be referred to for eco-friendly facilities.

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

8.1.1.6. Disabled and elderly friendly access

For an easy access of non-ambulant (wheelchair, stretcher), semi-ambulant, visually disabled and elderly people, infrastructural norms in line with the 'Guidelines and Space Standards for barrier-free built environment for Disabled and Elderly Persons' of the Government of India should be followed. Provisions of the 'Persons with Disability Act' should be implemented. These should be retrofitted in facilities currently lacking these provisions.

In order to support the needs of visually challenged visitors, it is also advised that tactile signs be placed with good contrast between letters and background. It is recommended to install one/two rows of tactile guiding blocks along the entire length of the proposed accessible route. Care shall be taken to ensure that there are no obstacles, such as trees, poles or uneven surfaces, along the route traversed by the guiding blocks. Provision of ramp with railing to be made for use of wheelchair/stretcher trolley, wherever feasible, should be ensured.

8.1.1.7. Disaster and emergency preparedness

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

Healthcare facilities shall be inspected by competent licensed engineers after every damaging earthquake to document damages (if any) to Structural Elements (SEs) and Non-Structural Element (NSEs) of the buildings, along with recommendations for detailed study and suitable retrofitting as found necessary. Protocols for these should be present in all facilities. Detailed norms for Disaster Preparedness and safe electricity are placed at ***Annexure 4.***

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

8.1.1.8. Fire safety

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

As a principle, none of the fire exit doors should be kept locked. These doors should be fire resistant and can be opened outwards with a push bar system on the doors. Fire detectors, extinguishers, sprinklers, and water connections for the water should be functional and easily accessible. Periodic monitoring and audit for fire safety including drills should be organized and conducted. The facility should have an identified nodal officer for ensuring fire safety.

All healthcare facilities should be so designed, constructed, maintained, and operated as to minimize the possibility of a Fire emergency requiring the evacuation of occupants, as safety of hospital occupants

cannot be assured adequately by depending on evacuation alone. Hence measures shall be taken to limit the development and spread of a fire by providing appropriate arrangements within the hospital through adequate staffing & careful development of operative and maintenance procedures consisting of:

(1) Design and Construction.

(2) Provision of Detection, Alarm and Fire Extinguishment.

(3) Fire Prevention

(4) Planning and Training programs for Isolation of Fire; and

(5) Transfer of occupants to a place of **comparative safety** or evacuation of the occupants to achieve **ultimate safety**.

8.1.1.9. Electric supply

The public health facilities should have access to adequate, and reliable electricity supply. Adequate number of electric points on various walls (at < 1.5 m height from the floor) need to be ensured for easy connection. Use of explosion proof plugs, plug connector and socket is essential to ensure safety against explosion.

New electrical appliances should have a minimum 3-star rating from Bureau of Energy Efficiency or equivalent recognized organization to minimize the energy input. Use of low-energy LED lighting or alternate low-energy option to save indoor lighting energy cost is recommended. Apart from the above, health care facility should ensure the following recommendations given by National Building Code 2016 (4.5.2-subdivision C-1):

- Appropriate power backup/inverter should be in place to ensure that there is no disruption of services, and cold chain for vaccine and diagnostics is properly maintained. Two number of earthing should be there at each electrical installation. Copper plate earthing should be preferred.
- Provision of surge protection/suppressor should be there. Surge suppressors are rated according to size of voltage spike they can handle, so only units of high enough joules rating to protect the equipment should be used.
- Load calculation should be proper, accordingly the distribution, electrical switch gear rating, circuitry, cabling, and electrical installation should be there.
- The size of cabling and wiring should be about 1.5 times or more to the actual electrical load calculated.
- Adequate power back up with another source such as DG, Photovoltaic etc. should be there in synchronization with the first source.
- For some places which are very important, provision of uninterrupted power supply should be ensured.
- Phase sequence should be proper as for motorized load.
- Load monitoring should be there to avoid any overloading.
- A lot of motorized as well as semiconductor material devices are there hence provision of power factor improvement should be there.
- All the connections and joints should be tight with proper size of thimbling.
- Balancing of electrical load should be proper and monitored via measuring devices.
- Suitable place should be selected for electrical installation.
- Sensitive equipment should be provided with proper rating UPS for extra safety against disturbances as voltage spike and noise.
- The Electrical Switch Room shall be housed in a dedicated room/ cupboard located on the ground floor and in association with an external wall and shall have internal access. The room shall be located

so that it does not present difficulties for services distribution from adjoining spaces or rooms, and it shall be located to provide for economic distribution of services. The main switchboard shall be of metal clad cubicle design as per approved standards and regulations. Each switchgear assembly shall have sufficient spare capacity. Electronic surge protection shall be provided on the incoming mains. **Periodic electrical audits by engineers should take place.**

8.1.1.10. Illumination

The minimum intensity required in general OPD area is 150 lux. Medicine store and laboratory should have an intensity of 300 lux. Emergency portable light units should be provided. These illumination requirements should be as prescribed by Bureau of Indian Standards (BIS).

8.1.1.11. Water Supply

Arrangement should be made for round the clock piped soft water supply along with an overhead water storage tank with a provision to store at least 3 days water requirement. It should have pumping and boosting arrangements. Drinking water can be harvested from spring, well or borehole and should be treated before consumption so that it becomes potable. Untreated water can be utilized for gardening and flushing of toilets etc. Requirement of water supply for firefighting needs to be considered while planning for total water capacity of a health facility.

8.1.1.12. Drainage and Sanitation

The construction and maintenance of drainage and sanitation system for wastewater, surface water, sub-soil water and sewerage shall be in accordance with the prescribed standards. This is particularly important in the UHWCs located in urban slum areas where availability of adequate drainage mechanism should be ensured within and around the health facility. Water harvesting is one of the most critical components to the challenge of climate change and thus should be focused upon. Reuse of wastewater in irrigation, cooking, cleaning and washing, etc. can be demonstrated in villages and urban slums for orientation of the community.

8.1.1.13. Waste management

All such waste which can adversely harm the environment or health of a person is considered as infectious and termed as Bio-Medical Waste (BMW). Every health care facility should ensure appropriate collection, transportation, treatment, and disposal of bio-medical waste as per the latest Bio Medical Waste Management Rules (BMWM). Each Healthcare facility should ensure that there is a designated central waste collection room situated within its premises for storage of bio-medical waste till the waste is picked. Availability of dedicated biomedical waste disposal facility/deep burial pit along with septic tank and soaking pit should be ensured in the health and wellness centres. Panchayat/ULB should make arrangements for disposal of general/municipal waste. It should also be ensured that disposal of human anatomical waste, soiled waste and biotechnology waste is done within 48 hours.

As per Biomedical Waste Management Rules & Guidelines 2016, deep burial pits need to be constructed only at such HWC-SHC/UHWCs where the common biomedical treatment plant is situated at a distance of more than 75 kms. Before disposal of biomedical waste in the pits the facility needs to ensure that biomedical waste is decontaminated and shredded. This will be carried out with prior approval from the prescribed authority and as per the Standards specified in Schedule-III.

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

Liquid waste management is another area which needs adequate attention and for smaller health care facilities the liquid waste and effluents can be treated in the area where it is generated, before disposal in drainage system. Other wastes consist of electronic equipment, used batteries, and radio-active wastes which are not covered under biomedical wastes but have to be disposed as and when such wastes are generated as per the provisions laid down under E-Waste (Management) Rules, Batteries (Management & Handling) Rules, and Rules/Guidelines under the latest Atomic Energy Act, respectively.

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

8.1.1.14. Infection Prevention & Control

With the rising need to practice infection and prevention control measures at individual, community and facility level, infrastructural design of the health and wellness centres should be such that it facilitates practicing infection prevention protocols like physical distancing, handwashing, mask distribution, PPE donning on & off, etc. Color-coded bins should be available in every service area including patient waiting areas so that waste can be segregated at source.

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

8.1.1.15. Infrastructure for Clinical Services

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

1. Screening and Holding Area

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

2. Registration

Every HWC should have facilities for computerized registration of cases coming to OPD. This can be done during OPD consultation by CHO or any other designated staff in SHC in rural areas and by ANM/Other support staff in UHWCs.

3. Waiting area

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

Adequate space should be allocated for persons using mobility devices, for example wheelchairs, crutches and walkers, white cane, etc., as well as those walking with the assistance of others. Waiting area for OPD should have a patient friendly ambience and can have colorful wall paintings.

Patient amenities in waiting areas should include:

Essential amenities

- Fans
- Clean drinking water
- Clean and gender sensitive toilets

Desirable amenities

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

Handwashing areas, mask distribution counters, bio-medical waste storage and disposal areas need to be clearly marked in the facility.

4. Consultation room

The consultation room should have enough space to accommodate table and at least two chairs, where interaction with patients can be undertaken with confidentiality and dignity. It should be well lit and ventilated.

An examination table, curtains (wheeled, wall mounted, single piece), hand washing facilities should be provided, as needed.

5. Health and Wellness Area

Wellness area should be preferably located near the entrance of the facility and with a capacity to accommodate 18 - 20 persons at a time so that wellness activities can be carried out easily.

6. Clinical Laboratory

The laboratory should have equipment and reagents for conducting all tests enumerated to be provided at the level of Health and Wellness Centre. List of tests to be undertaken at the facility should be clearly displayed. Laboratory should not be a thoroughfare and various testing areas should be clearly marked. It should have facility for running water, testing and cleaning area and kept well maintained at all times.

7. Record keeping

Every HWC should plan to ensure safe upkeep of the necessary records preferably utilizing IT systems.

8. Day care beds

Outpatient health care services sometimes require the patient to be under medical supervision for a period of several hours for treatment or examination or observation. Later, during evening/at night the patients are either discharged or referred to higher facilities. For the same purpose, the HWC-SHC needs physical infrastructure for two-day care beds.

9. Store

The HWC should have adequate and spacious stores located away from patient traffic with facility for storing drugs, consumables, records, linen, furniture, equipment, and sundry articles. Guidelines for safe disposal of expired drugs and vaccines should be adhered to. The store should have small space for keeping 5-7 days stock of drugs and linen and there should be system of indenting medicines from the linked PHC/UPHC depending upon frequency as required.

10. Teleconsultation area

Adequate space and equipment as per guidelines should be made available. Allotted space along with internet/telephone connection will facilitate the effective delivery of telemedicine services. To optimize the use of space, the health and wellness room can be equipped with teleconsultation facilities. IT requirements should be set up to meet the needs of capturing, transmitting images, prescriptions, and diagnostic reports for teleconsultations. Video calling feature should be enabled in the existing IT system to connect with hubs identified for teleconsultation services. Minimum requirement for HWC infrastructure for teleconsultation

includes Telemedicine diagnostic kit, Desktop with headphone, Microphone and HD Web Camera, Printer, and last mile Connectivity (minimum 2 MBPS).

11. Support Services

i. Washrooms – Gender sensitive, clean and functional toilets with regular supply of running water.

ii. Decontamination and washing facilities – The facility should be available for both linen and equipment. Linkages with mechanized laundry at DH/CHC level can be established if required.

iii. Residential Area - All the staff should ideally be provided residential accommodation within the health and wellness centre compound, especially in rural areas. It is important to provide staff quarters to the incumbent staff so that the availability of services is ensured. Keeping the staff within the campus will also ensure accessibility and safety of the premises. Well-equipped transit accommodation facilities at larger facilities such as District Hospitals and geographically and strategically selected SDHs and CHCs can serve as a hub for health workers of all grades posted at nearby PHCs. Transport arrangements (such as employees led pooled shuttle service to and from the accommodation to the facility) will allow for staff to work at remote facilities while providing their families greater opportunities for quality education and employment. Alternatively, house rent allowance can be provided.

12. Oxygen Supply

The COVID 19 pandemic has affected not only secondary or tertiary level of care but also the primary level. Thus, oxygen support at HWC-SHCs/UHWCs through cylinder or concentrator is essential to manage COVID or other patients requiring the support. However, care should be taken to store the cylinder/concentrator carefully as per GoI guidelines.

Table: Oxygen delivery systems in HWC-SHC/UHWC

S. No.	Facility Type	Bed Capacity	B Type (1500 Lts Oxygen Capacity.) Oxygen Cylinder	Oxygen Concentrator (10 LPM)
1.	**HWC-SHC/UHWC**	2 (Day care)	3	1

Important Note regarding Oxygen delivery systems

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

8.2. HUMAN RESOURCES FOR HEALTH

Apart from providing preventive and promotive services, HWCs are also the fulcrum for services related to national/ state health programmes. Such services are envisaged to be delivered through a dedicated team of health care workers proficient in public health and primary health care services.

An accurate, timely, reliable, and complete Human Resource Policy at the State level backed by an efficient Human Resource Management Information System (HR-MIS) can be used for better human resource planning and effective utilization of the existing manpower. Information and monitoring regarding postings, deputation, transfers, training, promotion, leave, suspension, termination and retirement should be utilized for a transparent payment and transfer system.

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

HWC-SHC

The type of staff viz Community Health Officer (CHO), Auxiliary Nurse Midwife (ANM) and a Multi-Purpose Worker (MPW) (Male) or two ANMs, and support staff mentioned at Table has been selected taking into consideration services and programme requirements of the HWC-SHC.

Table : HR at HWC-SHC

S. No.	Human Resource required	Required Numbers
1.	Community Health Officer (CHO)	1
2.	Multipurpose Health Worker	1 Male +1 Female

Sanitation and security services can be hired/outsourced

There should be one ASHA per 1000 population or one ASHA per habitation in tribal, hilly and desert areas should be attached with the HWC as part of the entire team. The job responsibilities for each category of staff are placed at **Annexure 5.**

UHWC:

The Urban-HWC is to be staffed with a Medical Officer, a Staff Nurse/Pharmacist, Male-MPW and one support staff. Staff Nurses will also be supporting the doctors while examining the patients particularly the female patients to ensure their privacy and dignity. Ideally, the ANM and ASHA are responsible for the catchment area of a UPHC. Wherever available, they will be drawn from HWC-UPHC / UCHC for respective Urban-HWC while their salaries can continue to be drawn from their linked HWC-UPHC. In case where ANM, ASHA are not available, the state may engage new ASHA, ANM for Urban-HWCs depending on the local needs and resources available.

Table: HR at UHWC

S. No.	Human Resource	Required Numbers
1.	Medical Officer	1
2.	Staff Nurse	1
3.	MPW (Male)	1

S. No.	Human Resource	Required Numbers
4.	Sanitary Staff *	1
5.	Security Staff**	1

Sanitation and security services can be hired/outsourced*

One ASHA per 2000 population and one ANM per 10000 population should be attached as part of the entire team in urban areas.

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

Table: Minimum Performance Standards (HR)

S. No.	Staff	Break up of activities
1.	**Medical officer**	**OPD** = 75 patient /day Clinical, Emergency and other duties Supervision of Public Health and health programmes related activities.
2.	**CHO**	**OPD** = 20 patient /day Tele consultations= 40-50 per month Clinical, Emergency and other duties Supervision of Public Health and health programmes related activities.
3.	**Staff nurse**	As per INC norms (for OPD, IPD shifts and specialist services)
4.	**Pharmacist**	120 dispensations of prescription/day, maintain stock registers, store, inventory management

Note: Assuming 8 hours shift and 75% productivity and efficiency, it is estimated that there will be 6 hours of working time spread over 6 days in a week

8.2.1. Capacity Building

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

Special attention should be paid to training of CHO at the HWC-SHC as he/she not only serves as the lead of the HWC-SHC and a clinician but has to look after the overall health of the communities and ensure implementation of the National Health Programs in their catchment area.

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

8.2.2. Conduct and Behavioural Standards

The HRH placed in the public health facilities should adhere to the highest ethical and behavioral standards and provide patient care with utmost respect for the dignity of life. It is important that states orient

health professionals to discharge their duties in a professional and courteous manner, facilitating greater acceptability of HRH in the community as well. They should also be oriented to the concept of gender sensitivity and efforts should be made to ensure that gender sensitivity is inculcated in their conduct and actions.

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

8.2.3. Safety Measures for HRH

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

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

8.3. MEDICINES

Access to essential medicines is a major determinant of health outcomes and an integral, and often crucial component of health care. An approach to ensuring access to medicines closer to community has been promoted through the list of Essential Medicines. It is necessary for the states to prioritize which medicines should be made available based on the existing demographic profile and disease prevalence rate and update the state EML. All essential medicines should be available free of cost in all HWCs under 'Free Drugs Service Initiative' of GoI. For UHWC, the provisioning of medicines is to be ensured as per CPHC guidelines for Urban-PHCs. As the list of medicines is dynamic, the recommendations made under IPHS are as per National List of essential medicines. With the launch of universal NCD screening and comprehensive primary health care, long-term dispensing of medicines for the management of chronic illnesses such as diabetes and hypertension has been initiated.

Storage of medicines should be such that spoilage is minimized. Medicine stores should avoid dampness (for example, no leaking roofs) and basic principles like 'first expiry, first out' for drugs and vaccines should be followed. Storage of medicines in clinical areas should be avoided. For medicines and vaccines requiring cold-chain storage, adequate provisions can be made. Accurate record of stock should be maintained. Detailed List of Essential Medicines is attached as **Annexure 6.**

Updated list of Medicines as per EML is available at https://nhsrcindia.org/sites/default/files/202107/H%26WC%20SHC%20and%20PHC%20updated%20EML%20as%20on%20March%202020%20-.pdf

8.4. DIAGNOSTICS

Diagnostics are an integral part of the health care system and provide information needed by service providers to make informed decisions about care provision related to prevention, screening, detection, treatment and management. Limited availability and access to quality laboratory and radiology services are among the major challenges contributing to delayed or inappropriate responses to disease control and patient management.

The testing facility at the level of HWC-SHC includes diagnostics for screening of various conditions/diseases. Fourteen tests need to be ensured as per the list placed at ***Annexure 7.*** Since all UHWCs have MBBS doctors so it is desirable that the access/linkages to diagnostics should be as per the list indicated for UPHC-HWC. However, the fourteen types of diagnostics as defined for UHWC should be available in-house as essential diagnostics.

The turn-around time for test results should also be standardized, adhered to and monitored. For specialized, advanced and specific diagnostic tests, linkages with PHC, CHC, SDH and District Hospitals, in hub and spoke mechanism can be established. In all cases, transportation should be managed carefully to maintain integrity of the sample, giving due attention to temperature, preservation needs, special transport containers and time limitations. It is also important to ensure the safety of those handling the material before, during and after transportation.

8.5. EQUIPMENT

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

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

An effective equipment audit assesses the present equipment status and ensures better equipment procurement in the future. The audit should be done on a periodic basis and contain details like name, cost of equipment, date of purchase, manufacture and installation, name and address of supplier, department where installed, environmental control, spare parts inventory, technical manual, after sales service agreement, guarantee, warranty period, life of equipment, depreciation per year, up/down time, date of condemnation and replacement. Number of services delivered by each major equipment needs to be noted down, to analyse the value for the money invested in purchasing high-cost equipment.

Along with maintenance and monitoring programme, it is also essential that a condemnation policy is in place at all facilities so that the practice of out-of-use equipment and furniture being scattered around the

facility is mitigated. Condemnation should be done periodically by condemnation committee after careful examination of items. The list of items with code number, the date of purchase, repair, correct value and other relevant details should be thoroughly prepared by the committee.

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

8.6. QUALITY ASSURANCE

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

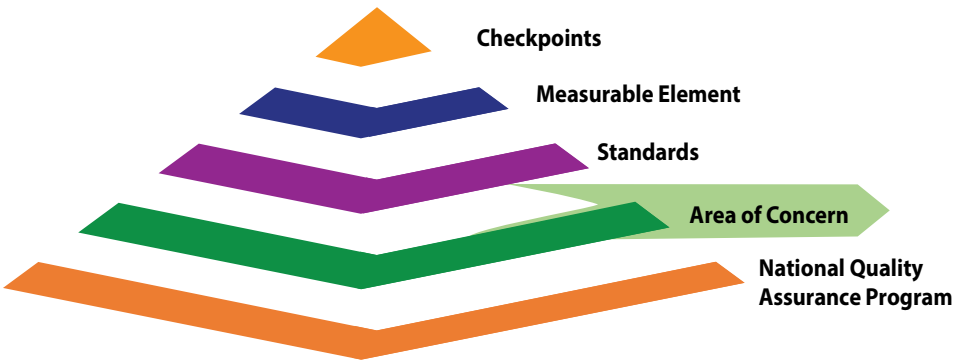
As a healthcare provider, while it is important to ensure provision of safe and evidence based clinical care, it is equally fundamental to provide the care that makes patients' and visitors' experiences rewarding. Ensuring 'Quality of Care' as a key component would require undertaking conscious and concerted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

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

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

NQAS are arranged broadly into eight (8) broad themes, named as area of concerns. For micro detailing of each standard, they are divided into Measurable Elements (ME) and further categorized into Checkpoints. These checkpoints are objective components and together they constitute a checklist which are scored to achieve a score (Figure Measurement system under NQAS). Health care facilities should refer to NQAS Assessors' guidebook and take initiative for the implementation.

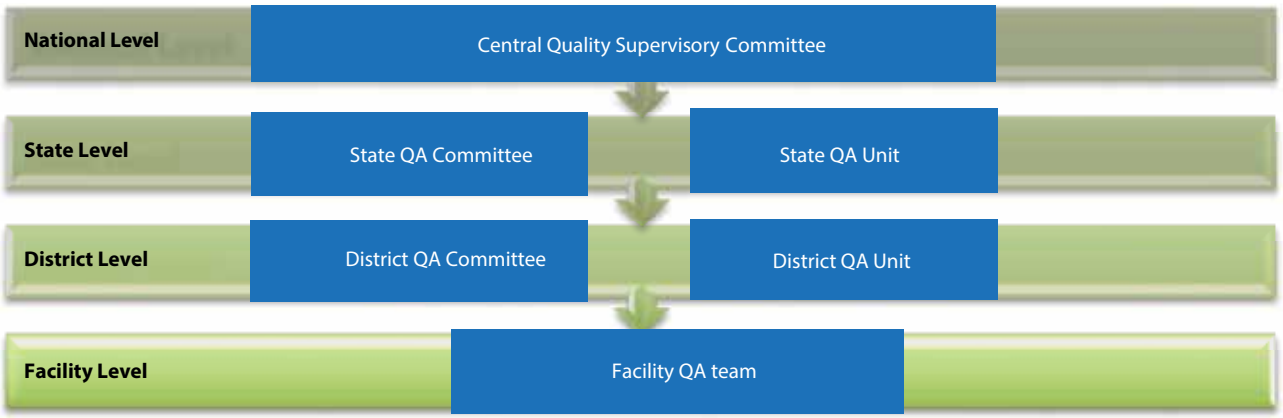
Figure: Measurement system under NQAS



A well-built institutional framework from facility (Quality team) to the National level (Central Quality Supervisory Committee) supports the seamless implementation of the standards (Figure Institutional

Framework under NQAS). Facilities which are able to meet the defined standards and criteria are certified and incentivized (subject to annual surveillance and ensure sustaining the changes). With this, National Quality Assurance Program (NQAP) envisages to instill the culture of Quality and Safety in our health systems.

Figure: Institutional Framework under NQAS



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

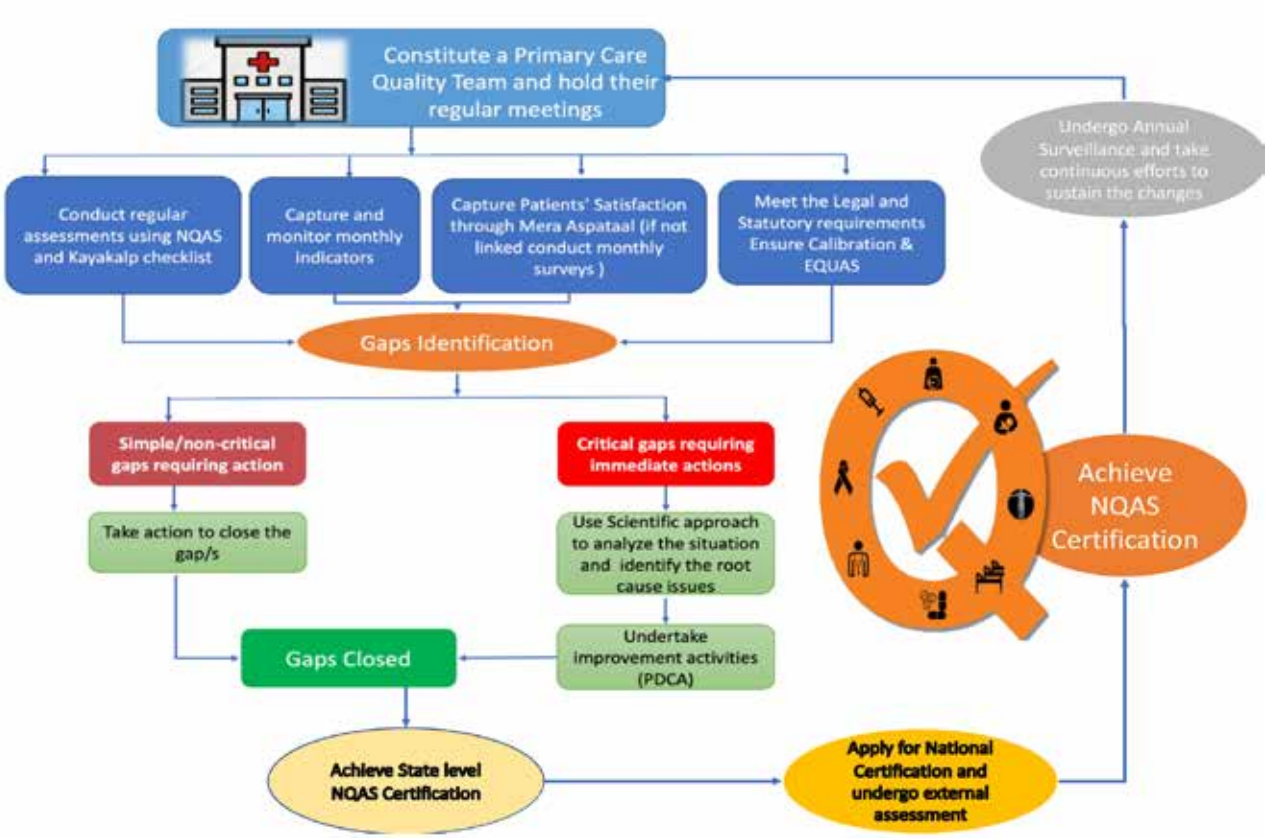
- Base-line assessment against NQAS
- Plan for gap closure
- Undertake Improvement activities
- Functional system of collating patients' satisfaction and its analysis
- Meeting regulatory requirement
- Analysis of facility level key performance indicators (KPIs)
- Quality certification, and
- Sustenance

Summary of the activities is given in Figure.

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

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

Figure: Road map for healthcare facilities to achieve NQAS certification



Patient Safety and Infection Control

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

- Hand washing facilities in all areas should be installed. Compliance with the correct method of hand hygiene by health care workers should be ensured.
- Safe clinical practices as per standard protocols to prevent health care associated infections should be instituted. *(**Annexure 9).***
- There should be proper written hand over system between health care staff.
- Safe Injection practices as per the prescribed protocol should be followed.
- Ensuring Safe disposal of Bio-Medical Waste as per rules should be adhered to.
- For reducing environmental pollution including those relating to Mercury, GoI Guidelines should be adhered to.
- Guidelines for Airborne Infection Control should be followed.
- Regular Training of Health care workers in patient safety, infection control and Bio-medical waste management should be scheduled and held.

8.7. IMPLEMENTATION OF IPHS

8.7.1. Governance

Effective governance of the public health system includes the establishment of institutional arrangements and policies along with their continuous monitoring to ensure proper implementation. Apart from promoting

good leadership, it also includes specific interventions such as building accountability in the system (e.g. performance appraisal, target setting and monitoring, social accountability, citizens' charter); patient centric services (patient feedback, reducing out-of-pocket expenditure, improving the patient experience, grievance redressal); compliance with statutory norms (Acts and regulations) and ensuring robust clinical governance (adherence to SOPs and standard treatment guidelines, and MDSR/CDR). Some aspects of governance relevant to public health facilities are described below:

8.7.2. Monitoring

It is assumed that rigorous monitoring, continuous support and encouragement by supervisors and higher levels of management and most importantly ownership by the staff will be strengthened as part of continuous quality improvement initiatives. Internal mechanisms include systematic and proper record keeping and timely reporting. An action plan with corrective measures, and timelines should be prepared and reviewed in subsequent meetings.

Health & Wellness Centres will provide a platform for co-ordination and holding meetings with Gram Panchayat for planning avenues and strategies for health promotion related to various dimensions of primary care.

Social Audits of service provided by HWC should be used for external monitoring.

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

Institutional structures operational for community-based monitoring such as social accountability, Village Health Sanitation and Nutrition Committees (VHSNC), UHNDs and Community Action for Health – monitor delivery of preventive, promotive and curative services as part of CPHC including through activities like social accountability. They are important to provide relevant inputs for decentralized health planning. Along with monitoring of services at the facility level, primary health centres should monitor and supervise activities of HWC-SC, VHNDs, ASHA, IEC/BCC, implementation of national health programs, timely payment of various entitlements through regular meetings, periodic visits by Medical Officer, LHV etc., checking and tracking of missed out and left out ANC/PNC, high risk pregnancies, vaccinations, cold chain etc. Periodic reporting of the HWC performance in the monthly review meeting is required.

8.7.3. Jan Arogya Samiti

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

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

8.7.4. Accountability

The CHO at SHC and MO at the UHWC must improve effectiveness and efficiency in the system by building mechanisms to strengthen answerability and accountability of service providers.

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

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

8.7.5. Patient Centric Services

All necessary efforts to ensure that patients and their attendants have a comfortable, respectful and hassle-free experience at the facility should be ensured. This includes an empathetic and compassionate attitude towards patients and relatives in a professional manner.

8.7.6. Grievance Redressal

No user fees are charged for national government funded programmes that are provided as a service guarantee for people accessing public sector health facilities.

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

8.7.7. Information and Communication Technology

Information and communication technology is essential to enable efficient service delivery at HWC. IT system has following functions in HWC.

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

8.7.8. Intersectoral Convergence

Convergence is central for the success of health promotion strategies and requires close coordination of health with other allied departments. While organizing health promotion activities on various dimensions of primary care at HWCs, support of other relevant departments can be taken.

Convergence should be undertaken with:

- Education department for School Health and Wellness Ambassador Initiatives
- ICDS for delivery of six services, viz. supplementary nutrition, pre-school education, nutrition and health education, immunization, health check-up and referral services at Anganwadi Centres, Village Health, and Nutrition Days act as a platform for interfacing between community and the health system.
- Panchayati Raj to address spread of outbreaks of communicable diseases such as dengue, chikungunya, malaria, for sanitation drives, vector control, controlling water coagulation through cleaning of drains etc. and ensure participation of community during the times of disaster.
- Ministry of Youth & Sports: Fit India and Age-appropriate fitness protocols
- FSSAI: Eat right tool kit and diet counselling
- AYUSH: for organizing regular yoga sessions and other wellness activities

The RLBs/ULBs would also ensure convergence with various schemes relating to the wider determinants of health and wellness such as urban development, drinking water, sanitation, education, nutrition being implemented by other ministries and departments.

Health & Wellness Centres will provide a platform for coordination and holding meetings with Zilla/ Block/ Gram Panchayat for planning avenues and strategies for health promotion related to various dimensions of primary care. Such phase wise meetings will also support in planning health education and communication strategies.

For effective delivery of services and health promotion, coordination activities should be strengthened between frontline workers of various programmes/institutions such as MGNREGA, ICDS, NRLM, Panchayati Raj and VHSNCs, e.g., a house wise nutritional plan consisting of recommended dietary allowance of each family should be prepared and monitored by the HWC team. Kitchen gardens to cover monthly requirement of balanced diet should be encouraged.

In Urban areas, the implementation of the components of UHWCs involves mapping the vulnerable population for which a close collaboration with ULBs would be instrumental in planning the location of the facilities in the vulnerable areas. Engaging Urban Local Bodies (ULB) in MAS would ensure planning and monitoring of health services through community participation and strengthen outreach, preventive and promotive functions including public health actions at UHWC.

The support of ULBs can be leveraged for formation of Resident Health Associations, a platform or federation of representatives of MAS (from poorer areas), Resident Welfare Association (RWA) such as Gully/Mohalla committees. The ULBs can mobilize the Residential Welfare Associations (RWAs) to undertake public health activities including health promotion activities about clean environments, lifestyle changes, healthy diets, etc. and also spread awareness on the diseases prevalent in the community viz seasonal, infectious etc. Community linkages with existing SHGs and Galli/Mohalla committees may also be utilized for the purpose.

In addition to above, engagement with private and not for profit sector for critical gap filling activities for UHWCs, such as capacity building, UHWCs management, provision of outreach services, diagnostic services, as appropriate to the local context, need and availability of the organizations to provide services etc. may be explored.

ANNEXURES

Logo Of State Government

CITIZENS' CHARTER

Logo Of NHM

Name Of the State

*Name & Type of The Facility: HWC-SHC/UHWC

Contact No: (MO/CHO): _____

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

Mission Statement & Objective:

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

General Information:

General beds

Staff

MO……

CHO……

Nursing staff……

Paramedical staff……

Any other*……

Services Available:

Services (as per Type of HWC)		Days	Timings
OPD services including special services		Mon-Sat (except on public holidays)	8.00am-2.00pm
Key services available during OPD			
General OPD			
Antenatal Care (ANC), PNC and Family Planning Services			
Immunization			
Emergency Services			
Dressing		24 x 7	
Basic Dental Services*			
Fixed Day services			
NCD Clinic			
Basic Geriatric & Palliative care			
Mental Health Care Services			
Basic Eye and ENT care			
DOTS services			
Adolescent clinics			
Laboratory	Routine Lab	Mon-Sat	00.00-00.00
	Referral Lab *(Hub & Spoke, if any)*	24 x 7	
Pharmacy		Mon-Sat	00.00-00.00
Ambulance Services			
Administrative Office Services		Mon-Sat	00.00-00.00
Medico-Legal Services			

Support Services: (In House/ Linked)

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

Other Basic Amenities:

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

Outreach Services:

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

Free Entitlements:

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

#Paid Services: *(If applicable)*

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

Financial Benefits:

Schemes	Benefits	
Janani Suraksha Yojana (JSY)		
Compensation for Family Planning procedures ○ Tubectomy ○ NSV ○ IUCD ○ Indemnity Scheme		
Revised National TB control Programme (RNTCP)		

***Expanded range of comprehensive service packages being implemented:**

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

(State specific Programs to be entered)

Referral Services:

Toll free number:

Details of nearest PHC-HWC *(for SHC-HWC)* ……

Details of nearest CHC……

Details of nearest FRU……

Details of nearest District Hospital……

Details of nearest Tertiary care hospital……

Tele-Consultation Services:

Tele-medicine, Tele-radiology

Tele-conferencing – ECHO, ZOOM

Patient Rights:

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

Patient Responsibilities:

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

Visitor's Policy:

Visiting time: Morning: Evening:

Only one person allowed to visit at a time *(Mention about pass system)

Respect visiting hours.

Complaints And Grievances:

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

Grievance Redressal:

Toll free number:

Designated officer: (with Mobile & Email)

Complaint Box

Funds:

*JAS detail

*Untied fund detail – Rs……/-

Note: The details of the nodal person can be displayed based on the program requirements

'*'marked points can be edited according to the conditions/services provided in the respective facility.

'@' Indicate amount, as applicable

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

ANNEXURE 2

Service Delivery Framework

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
1.	Care in pregnancy and childbirth	• Early diagnosis of pregnancy • Ensuring four antenatal care checks • Counselling regarding care during pregnancy including information about nutritional requirements • Identifying of high-risk pregnancies and follow up • Enabling access to Take home ration from Anganwadi Centre • Follow up to ensure compliance to IFA in normal and anemic cases • Facilitating institutional delivery and supporting birth planning • Post- partum care visits • Identifying high risk pregnancies, child births and post-partum cases and facilitating timely referrals	• Early registration of pregnancy and issuing ID number and Mother and Child Protection (MCP) card. • Antenatal check-up including screening for Hypertension, Diabetes, Anemia. Immunization for pregnant women-Td, IFA and Calcium supplementation • Identifying high risk pregnancies, postpartum cases for regular follow up, timely referral for institutional births and complication management. • Screening, referral and follow up care in cases of Gestational Diabetes, and Syphilis during pregnancy • Normal Vaginal delivery in specified delivery sites as per state context -where CHO or MPW (F) is trained as skill birth attendant. • Provide first aid treatment and referral for obstetric emergencies, e.g., eclampsia, PPH, Sepsis, and prompt referral.	• Antenatal and postnatal care of high-risk cases • Blood grouping and Rh typing and blood cross matching • Linkage with nearest ICTC/PPTCT Centre for voluntary testing for HIV and PPTCT services • Normal vaginal delivery and assisted vaginal delivery • Surgical interventions like Caesarean section, • Management of all complications including ante- partum and post-partum haemorrhage, eclampsia, puerperal sepsis, obstructed labour, retained placenta, shock, severe anaemia, breast abscess. • Blood transfusion facilities
2.	Neonatal and infant Health	• Home based new-born care through 7 visits in case of home delivery and 6 visits in case of institutional delivery	• Identification and management of high-risk new-born – low birth weight/preterm/ sick new-born and sepsis (with referral as required),	• Care for low-birth-weight new-borns (<2500gms) • Treatment of asphyxia and neonatal sepsis,

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
		• Identification and care of high-risk new-born – low birth weight/ preterm new- born and sick new-born (with referral as required), • Counselling and support for early breast feeding, improved weaning practices. • Iron supplementation • Adoption of safe and hygiene WASH practices • Growth Monitoring • Counselling for Early childhood growth and Development. • Identification of birth asphyxia, sepsis and referral after initial management • Identification of congenital anomalies and appropriate referral • Family /community education for 'prevention of infections and keeping the baby warm • Identification of ARI/Diarrhoea- identification, initiation of treatment- ORS and timely referral as required • Mobilization and follow up for immunization services	• Management of birth asphyxia • Identification, appropriate referral and follow up of congenital anomalies • Management of ARI/Diarrhoea and other common illness and referral of severe cases. • Screening, referral and follow up for disabilities and developmental delays • Complete immunization • Vitamin A supplementation • Identification and follow up, referral and reporting of Adverse Events Following Immunization (AEFI).	• Treatment of severe ARI and Diarrhoea/Dehydration cases • Vitamin K for premature babies • Management of all emergency and complication cases.
3.	Childhood and Adolescent health care services including immunization	• Growth Monitoring, IYCF continued and enable access to food supplementation- all linked to ICDS • Detection of SAM, referral and follow up care for SAM	• Complete immunization • Detection and treatment of Anaemia and other deficiencies in children and adolescents	• NRC Services • Management of SAM children, severe anaemia or persistent malnutrition • Severe Diarrhoea and ARI management

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
		• Prevention of Anaemia, iron supplementation and deworming • Prevention of diarrhoea/ ARI, prompt and appropriate treatment of diarrhoea/ ARI with referral where needed • Pre-school and School Child Health: Biannual Screening, School Health Records, Eye care, De-worming • Screening of children under national program to cover 4'D's Viz. Defect at birth, Deficiencies, Diseases, Development delay including disability **Adolescent Health** Counselling on- Improving nutrition • Sexual and reproductive health • Enhancing mental health / Promoting favourable attitudes for preventing injuries and violence Prevent substance misuse • Promote healthy lifestyle • Personal hygiene- Oral Hygiene and Menstrual hygiene • Peer counselling and Life skills education • Prevention of anaemia, identification and management, with referral if needed • Provision of IFA under National Program for Iron Supplementation	• Identification and management of vaccine preventable diseases in children such as Diphtheria, Pertussis and Measles • Early detection of growth abnormalities, delays in development and disability and referral • Prompt Management of ARI, acute diarrhoea and fever with referral as needed • Management (with timely referral as needed) of ear, eye and throat problems, skin infections, worm infestations, febrile seizure, poisoning, injuries/accidents, insect and animal bites **Adolescent Health** • Detection of SAM, referral and follow up care for SAM. • Adolescent health- counselling • Detection for cases of substance abuse, referral and follow up • Detection and Treatment of Anaemia and other deficiencies in adolescents • Detection and referral for growth abnormality and disabilities, with referral as required	• Management of all ear, eye and throat problems, skin infections, worm infestations, febrile seizure, poisoning, injuries/accidents, insect and animal bites • Diagnosis and treatment for disability, deficiencies and development delays • Surgeries for any congenital anomalies like cleft lips and cleft palates, club foot etc. **Adolescent Health** • Screening for hormonal imbalances and treatment with referral if required • Management of growth abnormality and disabilities, with referral as required • Management including rehabilitation and counselling services in cases of substance abuse • Counselling at Adolescent Friendly Health Clinics (AFHC)

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
4.	Family planning, contraceptive services and other reproductive care services	• Counselling for creating awareness against early marriage and delaying early pregnancy • Identification and registration of eligible couples • Motivating for family planning (Delaying first child and spacing between 2 children) • Provision of condom, oral contraceptive pills and emergency contraceptive pills • Follow up with contraceptive users • Other reproductive care services • Counselling and facilitation of safe abortion services • Post abortion contraceptive counselling • Follow up for any complication after abortion and appropriate referral if needed • Education and mobilizing of community for action on violence against women • Counselling on prevention of RTI/ STI • Identification and referral of RTI/ STI cases • Follow up and support PLHA (People Living with HIV/AIDS) groups • Ensure regular treatment and follow of diagnosed cases	• Insertion of IUCD • Removal of IUCD • Provision of condoms, oral contraceptive pills and emergency contraceptive pills • Provision of Injectable Contraceptives in MPV districts • Counselling and facilitation for safe abortion services • Medical methods of abortion (up to 7 weeks of pregnancy) on fix days at the HWC by PHC MO • Post abortion contraceptive counselling • Follow up for any complication after abortion and appropriate referral if needed • First aid for GBV related injuries – link to referral centre and legal support centre • Identification and management of RTIs/STIs • Identification, management (with referral as needed) in cases of dysmenorrhea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse	• Insertion of IUCD and Post-Partum IUCD • Removal of IUCD • Male sterilization including Non-scalpel Vasectomy • Female sterilization (Mini- Lap and Laparoscopic Tubectomy) • Management of all complications • Provision of Injectable Contraceptives • Medical methods of abortion (up to 7 weeks of pregnancy) with referral linkages MVA up to 8 weeks • Referral linkages with higher centre for cases beyond 8 weeks of pregnancy up to 20 weeks • Treatment of incomplete/ Inevitable/ Spontaneous Abortions • Second trimester MTP as per MTP Act and Guidelines • Management of all post abortion complications • Management of survivors of sexual violence as per medico legal protocols. • Management of GBV related injuries and facilitating linkage to legal support centre

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
				• Management of hormonal and menstrual disorders and cases of dysmenorrhea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse • Provision of diagnostic tests services such as (VDRL, HIV) • Management of RTIs/STIs • PPTCT at district level
5.	Management of Communicable diseases and General Outpatient care for acute simple illness and minor ailments	• Symptomatic care for fevers, URIs, LRIs, body aches and headaches, with referral as needed • Identify and refer in case of skin infections and abscesses • Preventive action and primary care for waterborne disease, like diarrhoea, (cholera, other enteritis) and dysentery, typhoid, hepatitis (A and E) • Creating awareness about prevention, early identification and referral in cases of helminthiasis and rabies • Preventive and promotive measures to address Musculoskeletal disorders- mainly osteoporosis, arthritis and referral or follow up as indicated • Providing symptomatic care for aches and pains – joint pain, back pain etc	• Identification and management of common fevers, ARIs, diarrhoea, and skin infections. (Scabies and abscess) • Identification and management (with referral as needed) in cases of cholera, dysentery, typhoid, hepatitis and helminthiasis • Management of common aches, joint pains, and common skin conditions, (rash/urticaria)	• Diagnosis and management of all complicated cases (requiring admission) of fevers, gastroenteritis, skin infections, typhoid, rabies, helminthiasis, patitis acute • Specialist consultation for diagnostics and management of Musculoskeletal disorders, e.g.- arthritis.
6.	Management of Communicable diseases: National Health Programmes (Tuberculosis, Leprosy, Hepatitis, HIV-AIDS, Malaria, Kala-azar, Filariasis and Other vector borne diseases)	• Community awareness for prevention and control measures	• Diagnosis, (or sample collection) treatment (as appropriate for that level of care) and follow up	• Confirmatory diagnosis and initiation of treatment • Management of Complications,

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
		• Screening, Identification, prompt presumptive treatment initiation and referral as appropriate and specified for that level of care • Ensure compliance with follow up medication compliance • Mass drug administration in case of filariasis and facilitate immunization for Japanese encephalitis • Collection of blood slides in case of fever outbreak in malaria prone areas • Provision of DOTS/ensuring treatment adherence as per protocols in cases of TB	care for vector borne diseases – Malaria, Dengue, Chikungunya, Filaria, Kala Azar, Japanese Encephalitis, TB and Leprosy • Provision of DOTS for TB and MDT for leprosy • HIV screening, appropriate referral and support for HIV treatment. • Referral of complicated cases	• Rehabilitative surgery in case of leprosy
7.	Prevention, Screening and Management of Non-Communicable diseases	• Population empanelment, support screening for universal screening for population – age 30 years and above for Hypertension, Diabetes, and three common cancers – Oral, Breast and Cervical Cancer • Health promotion activities – to promote healthy lifestyle and address risk factors • Early detection and referral for – Respiratory disorders – COPD, Epilepsy, Cancer, Diabetes, Hypertension and occupational diseases (Pneumoconiosis, dermatitis, lead poisoning) and Fluorosis • Mobilization activities at village level and schools for primary and secondary prevention • Treatment compliance and follow up for positive cases	• Screening and treatment compliance for Hypertension and Diabetes, with referral if needed • Screening and follow up care for occupational diseases (Pneumoconiosis, dermatitis, lead poisoning); fluorosis; respiratory disorders (COPD and asthma) and epilepsy • Cancer – screening for oral, breast and cervical cancer and referral for suspected cases of other cancers • Confirmation and referral for deaddiction – tobacco/ alcohol/ substance abuse • Treatment compliance and follow up for all diagnosed cases • Linking with specialists and undertaking two-way referral for complication	• Diagnosis, treatment and management of complications of Hypertension and Diabetes • Diagnosis, treatment and follow up of cancers (esp. Cervical, Breast, Oral) • Diagnosis and management of occupational diseases such as Silicosis, Fluorosis and respiratory disorders (COPD and asthma) and epilepsy

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
8.	Screening and Basic management of Mental health ailments	• Healthy life style tips- balanced diet, exercise, stress management. • Screening using CIDT tool for mental illness • Community awareness about mental disorders (Psychosis, Depression, Neurosis, Dementia, Mental Retardation, Autism, Epilepsy and Substance Abuse related disorders) • Patient Health Questionnaires 2 to be included in CBAC form. • Identification and referral to the HWC/ PHC for diagnosis • Ensure treatment compliance and follow up of patients with Severe Mental Disorders • Support home-based care by regular home visits to patients of Severe Mental Disorders • Facilitate access to support groups, day care centres and higher education/ vocational skills	• Awareness and stigma reduction activities at individual level & psychoeducation for all groups of MNG conditions • Promotion of mental health through family enrichment programme • Detection and referral of patients with severe mental disorders • Confirmation and referral to deaddiction Centres • Dispense follow up medication as prescribed by the Medical Officer at PHC/ CHC or by the Psychiatrist at DH. • Counselling and follow up of patients with Severe Mental Disorders • Suicide risk assessment, suicide management by gatekeepers, referrals, and follow-up for suicidal ideation and behaviour. • Formulation of comprehensive plan for persons with Dementia. • Establish linkages with NGOs, Government departments, PRIs, ULBs to facilitate access to entitlements and referral linkages with faith healers and referral and integrated coordination with other programmes. • Management of Violence related concerns	• Awareness and stigma reduction activities at individual level • Diagnosis and Treatment of mental illness • Suicide risk assessment, suicide management, referral, follow up and emergency management of poisoning • Emergency care for seizures • Provision of out -patient and in-patient services • Counselling services to patients (and family if available)

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
9.	Care for Common Ophthalmic and ENT problems	• Community based services, Counselling and support for care seeking for blindness, other eye and ENT disorders • Health Promotion through appropriate IEC with special emphasis on prevention of ophthalmic and ENT problems. • Community screening for congenital disorders and referral and early identification of ENT related problems like sign of hearing loss in infants, children and adults. • Screening for blindness and refractive errors and ENT problems • AWC based screening for children from 6 to 18 year through RBSK. • Recognizing and treating acute suppurative otitis media and other common ENT problems	• Awareness about common ophthalmic & ENT problems and illness through IEC • Screening for visual acuity, blindness, cataract and for refractive errors • Identification and treatment of common eye problems – conjunctivitis, acute red eye, trachoma; spring catarrh, xeropthalmia as per the STG • Management of common colds, Acute Suppurative Otitis Media, injuries, pharyngitis, laryngitis, rhinitis, URI, sinusitis, epistaxis • Early detection of hearing impairment and deafness with referral • Diagnosis and treatment services for common diseases like otomycosis, otitis externa, ear discharge etc. • First aid for injuries/ stabilization and then referral. • Removal of Foreign Body. (Eye, Ear, Nose and throat) • Identification and referral of thyroid swelling, discharging ear, blocked nose, hoarseness and dysphagia	• Advocacy for ENT services. • Management of all Acute and chronic eyes, ear, nose and throat problems • Surgical care for ear, nose, throat and eye • Management of Cataract, Glaucoma, Diabetic retinopathy and Corneal ulcers and of referral cases from HWC-SHCs/UHWCs. • Diagnosis and management of blindness, hearing and speech impairment • Management including nasal packing, tracheostomy, foreign body removal etc. • Offering support services to hearing aid users e.g., day to day care such as change of batteries, Do's & Don'ts while handling the aid etc. • Counselling and referral of patients with complications and which require surgical treatment.
10.	Basic oral health care	• Providing awareness about oral health & hygiene, and health care seeking practices through IEC and planned interactive sessions in home visits, community meetings of the VHSNC, MAS and VHNDS/UHNDs and nutritional days in rural and urban area.	• Providing awareness about oral health & hygiene, and health care seeking practices through IEC and planned interactive sessions.	• Providing awareness to OPD patients about oral health & hygiene, and health care seeking practices through IEC and planned interactive sessions Diagnosis and management of oral cancer

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
		• Create awareness, early detection and referral for fluorosis, and other common oral problems like caries, gingivitis and tooth loss etc. • Creating awareness about ill effects of Substance Abuse like tobacco, beetle and areca nut, smoking, reverse smoking and alcohol • Co-ordinate various Oral Health Care training programs to school teachers, volunteers and other self- Help groups for imparting preventive and promotive oral health education. • Participate and coordinate the outreach activities. • Symptomatic care for tooth ache and first aid for tooth trauma, with referrals • Mobilization for screening of oral cancer on screening day	• Screening and early identification of common dental problems like gingivitis, periodontitis, malocclusion, dental caries, dental fluorosis and oral cancers, with referral • Oral health education about dental caries, periodontal diseases, malocclusion and oral cancers • Co-ordinate various Oral Health Care training programs to school teachers, volunteers and other self- Help groups for imparting preventive and promotive oral health education. • Management of conditions like apthous ulcers, candidiasis and glossitis, with referral for underlying disease • Participate and coordinate the outreach activities of PHC. • Symptomatic care for tooth ache and first aid for tooth trauma, with referral • Counselling for tobacco cessation and referral to Tobacco Cessation Centres. • Maintain records of all the identified oral diseases reporting in the OPD in a standardized recording format.	• Monitoring and ensuring quality care and smooth functioning of oral health services at HWCs. • Record keeping and maintenance of registries. • Conduct various Oral Health Care training programs to schoolteachers, volunteers and other Self- Help Groups. **Assured Services: -** • Management of malocclusion, trauma cases, Tooth abscess, caries • Topical application of fluoride for caries prevention.
11.	Elderly and palliative health care service	• Identification of high-risk groups • Support to family in palliative care • Home visits for care to home bound/ bedridden elderly, disabled elderly persons	• Home based care must be supported by a home visit by health care professional trained in palliative care and by linkages to day-to-day Centres and hospices to manage situations that are difficult to handle at home.	• Provide awareness by sensitizing care givers, on prevention of fall, malnutrition and neglect of care, social security schemes, social entitlements etc.

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
		• Support family in identifying behavioral changes in elderly and providing care • Linkage with other support groups and day care Centres etc. operational in the area. • Community mobilization on promotional, preventive and rehabilitative aspects of elderly. • Community awareness on various social security schemes for elderly • Identify and report elderly abuse cases, and provide family counselling	• The CHO will be provided with a "Palliative- Care Kit". • Arrange for suitable supportive devices from higher Centres to the elderly /disabled persons to make them ambulatory. • Palliative care team should provide out of hours care to those who require end of life care. • Referral for diseases needing further investigation and treatment, to PHC/CHC/DH • CHOs to undertake Comprehensive Geriatric Assessment twice in a year for cognitive decline, limited mobility, malnutrition, visual impairment, hearing loss, and depressive symptoms. • Develop elderly self-help groups named Sanjeevani & ensure involvement of active and mobile elderly in various activities like awareness generation, assessment of fit elders. • Undertake monthly visit to bedbound elderly. • Ensure mobile elderly & restricted mobile elderly attend yoga/activity sessions at HWCs. • Promote healthy behaviors. • Promote inter-generational bonding and involvement of elderly, ASHA & MPW to identify volunteers from youth groups.	• OPD: Diagnosis, treatment and referral for complications. • Drugs & Consumables: -Essential Drugs including Narcotics should be made available at PHC level. • Home care and End or Life Care. • Referral for those requiring secondary level of palliative care. • Rehabilitation through physiotherapy and counselling • Identify care givers and empower them to take care of bed bound elderly. • Ensure continuous psychosocial support to family members and other informal care givers of care dependent elderly patients. • Impart training to care givers. • Provide dietary advice like oral supplemental nutrition etc. for undernourished elderly. • Advanced Comprehensive Geriatric Assessment. • Provision of diagnostics, equipment, consumables, medicines and services for Elderly leveraging other National Health Programmes. • Referral of elderly patients requiring secondary & tertiary care to higher Centre.

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
			• Management of common geriatric ailments; counselling, supportive treatment • Pain Management and provision of palliative care with support of ASHA. • VHSNCs/JAS/MAS/RWA will ensure availability of benefits from various governments and non-governmental programs/schemes to the eligible patients/caregivers.	
12.	Emergency Medical Services, including for Trauma and Burns	• Providing awareness to the community for handling emergencies in health. • First aid for trauma including management of minor injuries, fractures, animal bites and poisoning	• Providing awareness to the community for handling emergencies in health. • Stabilization care with Triaging based on ABCD criteria and first aid before referral in cases of – poisoning, trauma, minor injury, burns, respiratory arrest and cardiac arrest, fractures, shock, chocking, fits, drowning, animal bites and hemorrhage, infections (abscess and cellulitis), acute gastrointestinal conditions and acute Genito urinary condition • Identify and refer cases for surgical correction – lumps and bumps (cysts/ lipoma/ hemangioma/ ganglion); anorectal problems, hemorrhoids, rectal prolapse, hernia, hydrocele, varicocele, epidymo-orchitis, lymphedema, varicose veins, genital ulcers, bed ulcers, lower urinary tract symptoms (Phimosis, paraphimosis), and atrophic vaginitis. • Facilitate referral and basic management with communication to higher Centre. • Administer Td if not immunized.	• Triage and management of trauma cases • Management of poisoning, • Management of simple fractures and poly trauma • Basic surgery and surgical emergencies (Hernia, Hydrocele, Appendicitis, Haemorrhoids, Fistula, and stitching of injuries) etc. • Handling of all emergencies like animal bite, Congestive Heart Failure, Left Ventricular Failure, acute respiratory conditions, burns, shock, acute dehydration etc.

S. No.	Health Care Services	Care at Community Level	Care at the Health and Wellness Centres-Sub Health Centres/ Urban Health and Wellness Centres	Care at the referral site** (PHC and upwards)
13.	Linkages with Outreach Public Health surveillance, VHNDs, UHND and special outreach.	• The PRIs/ULBs and frontline workers shall be oriented on identification and reporting of any abnormal morbidity and mortality in human beings and animals. • VHNDs, UHNDs, AWCs and other community level facility platform can be identified for organizing VHND. • Community linkages with existing SHGs and Galli/Mohalla committees may also be utilized for the purpose. • The PRIs, ULBs and community should be oriented to participate in VHNDs and UHNDs for availing specific services being organized. • While attending physical distancing and infection prevention protocols needs to be adhered. • Collaboration with Urban Local bodies to strengthen the outreach and preventive and promotive functions including public health actions and surveillance.	• Capacity building/sensitization/ • orientation of community/PRIs/ ULBs, frontline workers on public health issues, challenges and importance of timely reporting. • Facilitate testing of samples and timely submission of designated public health surveillance forms. • Planning for emergency preparedness and disaster management • Capacity building of PRIs/ULBs/ frontline workers as first responders during emergency. • Screening of early childhood diseases, through an active School Health Programme. • Identification of site for VHND/ UHND. • Service delivery through VHND/ UHND as per the GoI guidelines. • Need- based special outreach in urban areas.	• To support HWCs in their designated activities in public health importance including emergency preparedness and disaster management plan. • Timely management of all the referred cases.
14.	Services to be given by MO at UHWCs.	• In addition to the above the Medical Officer at UHWCs will also manage the clinical cases by proper diagnosis, treatment and follow up of patients. • He/she will supervise all the staff members working under UHWC, guide them, monitor their performance to ensure services are available to the community seamlessly.		

ANNEXURE 3

Layout Plans

HWC-SHC without Labour Room and with Residential Facility


1
2
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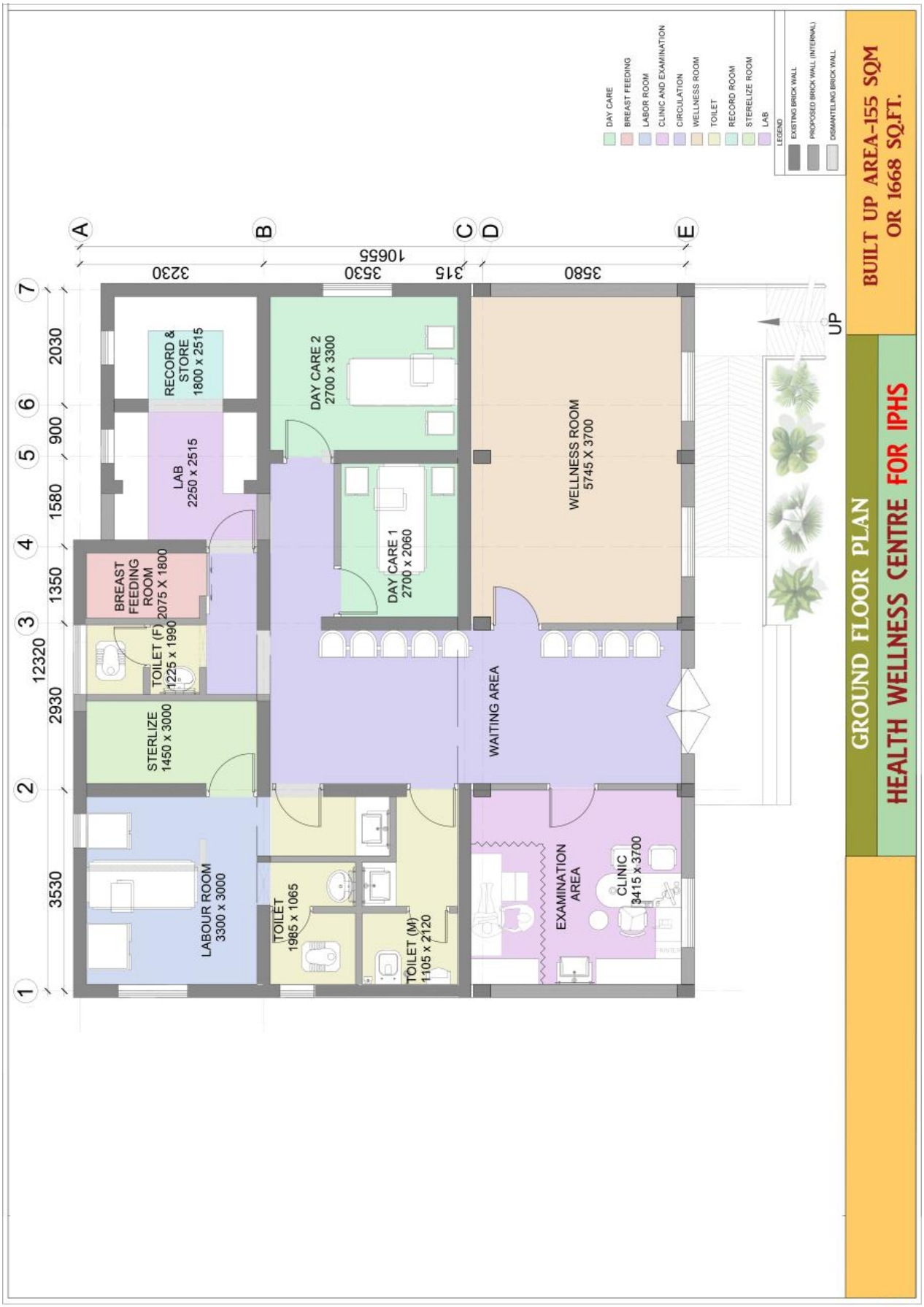
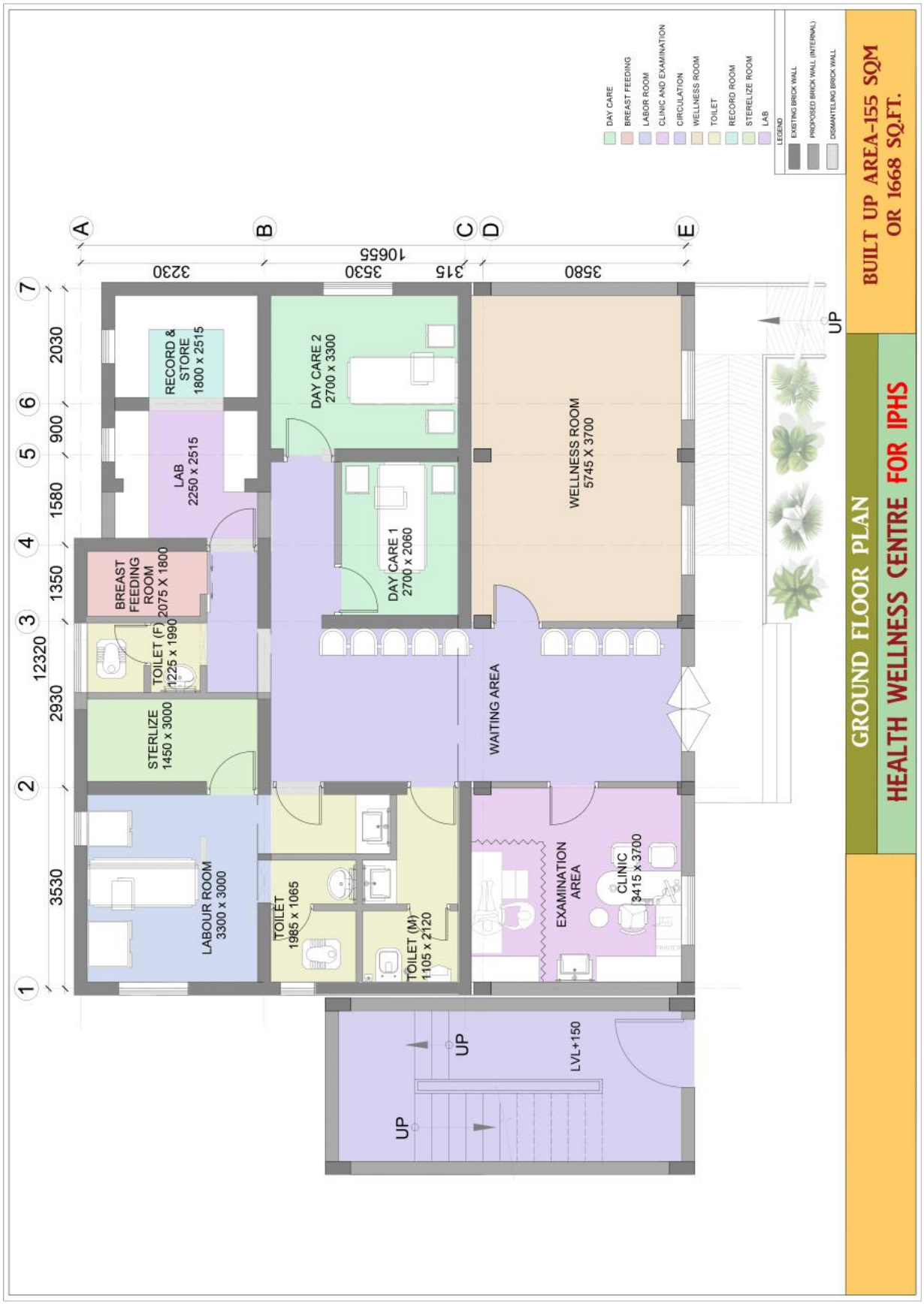
4
5
6
7
12320
3530
2930
1350
1580
900
2030
A
B
C
3230
6760
3535
2300
TOILET
1200 x 3000
BEDROOM
2850 X 3000
TOILET
1200 x 1985
LIVING AREA
2745 X 4395
UP
DN
BEDROOM
3500 X 3415
TERRACE
KITCHEN
2130X 2285
DINING
2700 X 2400
BED ROOM
TOILET
LIVING & DINNING
TERRACE
KITCHEN
CIRCULATION
LEGEND
EXISTING BRICK WALL
PROPOSED BRICK WALL (INTERNAL)
PROPOSED BRICK WALL (EXTERNAL WITH SLAB)
DISMANTELING BRICK WALL
FIRST FLOOR PLAN
HEALTH WELLNESS CENTRE FOR IPHS
BUILT UP AREA-86 SQM
OR 925 SQ.FT.

HWC-SHC without Labour Room and without Residential Facility

HWC-SHC with Labour Room and without Residential Facility



HWC-SHC with Labour Room and with Residential Facility

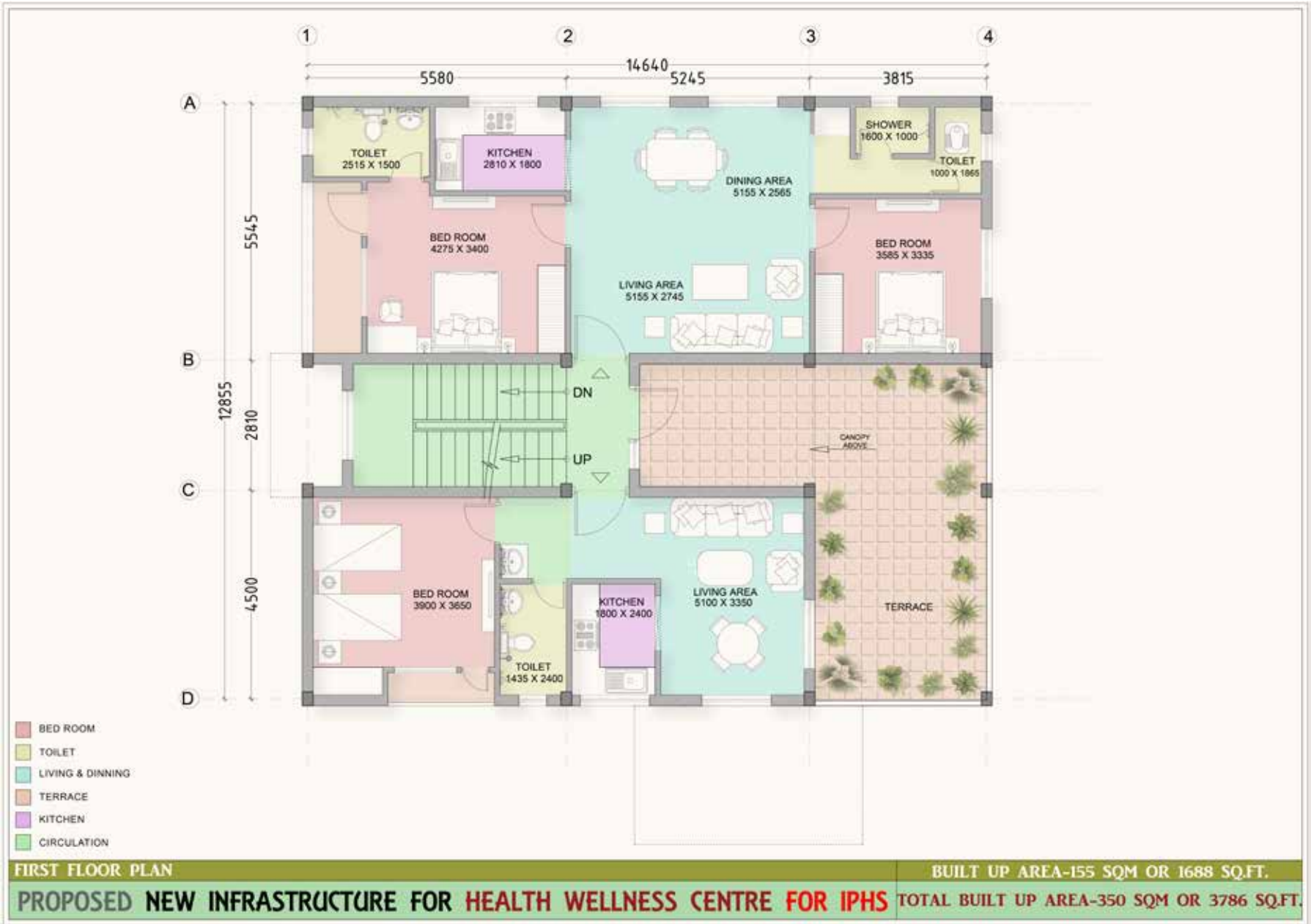


FIRST FLOOR PLAN

HEALTH WELLNESS CENTRE FOR IPHS

BUILT UP AREA-130 SQM
OR 1399 SQ.FT.

HWC-SHC New Construction


1
2
3
4
14640
5580
5245
3815
A
B
C
D
5545
2810
4500
12855
TOILET
2515 X 1500
KITCHEN
2810 X 1800
DINING AREA
5155 X 2565
SHOWER
1600 X 1000
TOILET
1000 X 1865
BED ROOM
4275 X 3400
LIVING AREA
5155 X 2745
BED ROOM
3585 X 3335
DN
UP
CANOPY
ABOVE
BED ROOM
3900 X 3650
TOILET
1435 X 2400
KITCHEN
1800 X 2400
LIVING AREA
5100 X 3350
TERRACE
BED ROOM
TOILET
LIVING & DINNING
TERRACE
KITCHEN
CIRCULATION
FIRST FLOOR PLAN
BUILT UP AREA-155 SQM OR 1688 SQ.FT.
PROPOSED NEW INFRASTRUCTURE FOR HEALTH WELLNESS CENTRE FOR IPHS
TOTAL BUILT UP AREA-350 SQM OR 3786 SQ.FT.

The Detailed layout plan for HWC- SHC can be accessed through the link provided:
https://nhsrcindia.org/IPHS2022

ANNEXURE 4

Disaster Management & Preparedness

Fire safety Norms

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

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

Expected Levels of Fire Safety in Hospitals

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

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

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

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

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

Open space

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

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

Instructions for Fire Safety for Hospital Staff Instructions for Personal Safety

All Hospital Staff should know:

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

Matters to be reported to the Fire Officer

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

Instructions for Fire Incidents

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

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

Safe electricity

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

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

Earthquake Safety Provisions

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

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

Post-Earthquake Assessment of Hospital Structures

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

ANNEXURE 5

Roles & Responsibilities of HWC-SHC Staff

Community Health Officer (CHO)

The CHO would broadly be expected to carry out public health functions, ambulatory care, management and provide leadership at the HWC-SHC. They would be responsible for the following:

1. Ensure that all households in the service area are listed, empaneled and a database is maintained- in digital format/ paper format as required by the state.
2. Provide clinical care as specified in the care pathways and standard treatment guidelines for the range of services expected of the SHC.
3. Clinical care provision would include coordinating for care/ case management for chronic illnesses based on the diagnosis and treatment plan made by the Medical Officer/specialists who will initiate treatment for chronic diseases, dispense drugs as per standing orders by the medical officer.
4. Such coordination could be facilitated through processes such as telehealth. However, CHOs can also provide medicines as per the provisions of Schedule K, Item 23.
5. Focus attention in screening for chronic conditions on screening, enabling suspected cases confirmed and initiating treatment based on appropriate STGs or on basis of plans made by medical officer/ specialists. As a team, ensure adherence, along with counselling and support as needed for primary and secondary prevention efforts. Such chronic conditions would include both non -communicable diseases and the chronic communicable diseases of tuberculosis, leprosy and HIV.
6. Coordinate and lead local response to diseases outbreaks, emergencies and disaster situations and support the medical team or joint investigation teams for disease outbreaks.
7. Support the team of MPWs and ASHAs in their tasks, including on the job mentoring, support and supervision and undertaking the monitoring, management, reporting and administrative functions of the HWC such as inventory management, upkeep and maintenance, and management of untied funds.
8. Support and supervise the collection of population-based data by frontline workers, collate and analyse data for planning and reporting of data to the next level in an accurate and timely fashion. Use HWC and population data to understand key causes of mortality, morbidity in the community and work with the team to develop a local action plan with measurable targets, including a particular focus on vulnerable communities.
9. Coordinate with community platforms such as the VHSNC/MAS/SHGs and work closely with PRI/ ULB, to address social determinants of health and promote behaviour change for improved health outcomes.
10. Address issues of social and environmental determinants of health with extension workers of other departments related to gender-based violence, education, safe potable water, sanitation, safe collection of refuse, proper disposal of wastewater, indoor air pollution, and specific environmental hazards such as fluorosis, silicosis, arsenic contamination, etc.

Medical Officer (MO) of UHWC

1. **Clinical Work**
   - The Medical Officer will be organizing and performing duties necessary for the routine Outpatient services and also ensure emergency cases are attended and taken care of.
   - He/she will screen cases needing specialized medical attention, refer them to referral institutions and will cooperate and coordinate with other institutions providing medical care services in his/ her area.

- He/ she will attend all calls from the in-patients, while he/ she is 'on-call duty'
- As a member of the health care team, he/she will exemplify an example in attitude toward patients and staff, thereby, performing duties with respect, dignity, privacy, and modesty to the patients.
- He/ she will be friendly, courteous and sympathetic while working with patients and ensure privacy and confidentiality of the patients.
- He/she will perform any other duties which a Medical Officer is expected to perform in view of his position and any other duties which will be assigned as and when required.

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

3. **Administrative Work**
   - He/she will supervise the work, scrutinize the programmes of his/her staff and suggest changes if necessary to suit the priority of work of staff working under him/her.
   - He/she will hold monthly staff meetings to evaluate the progress of work and suggest steps to be taken for further improvements
   - He/she will ensure the maintenance of the prescribed records and registers at UHWC level and will issue various kinds of certificates in the capacity of a medical officer.
   - He/she will ensure that the problems and grievances of the staff are solved promptly.
   - He/she will ensure the confidentiality of the patients
   - He/she will take actions timely for legal matters, medico-legal cases, RTIs, court cases and expeditions implementation of orders of the courts.
   - He/she will organize training programmes including continuing education for the staff of PHC and ASHA under the guidance of the district health authorities and Health & Family Welfare

Training Centres and will ensure that the staff working under his office regularly gets appropriate training.

- He/she will assess the performance of the staff and arrange for retraining if required.
- He/she will ensure appropriate utilization of funds as per the guidelines and GFR (General Financial Rules) provisions.
- He/she will ensure auditing procedures are completed well in advance, and audit reports are furnished to all the concerned authorities.
- He/she will dispose of all of the obsolete / condemned items and vehicles as per the Government orders in force.
- He/she will monitor and guide the activities of Hospitals/ UHWCs committees, patient welfare societies of hospitals, village health & sanitation committees.
- He/she will ensure inter-sectoral/ inter- departmental coordination; involvement of community leaders, various social welfare agencies and people for effective provision of patient centric healthcare.
- He/ She will be involved in 'performance audit' of staff as per the guidelines of 'Performance Audit'.
- He/ She will facilitate, coordinate, supervise, monitor and implement the provisions of all the health sector Acts and the Rules.

Staff Nurses of UHWC

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

- S/he will take care that case papers are not allowed to be handled by anyone except the doctor-in-charge of the patient. This is specifically for medico-legal cases.
- S/he will provide assistance and instructions to the patients and their relatives.
- S/he will be responsible -To provide antenatal, intra-natal, postnatal care as taught in the nursing curriculum.
- S/he will perform any other duties which a Staff Nurse is expected to perform in view of his position and any other duties which will be assigned as and when required.

2. Administrative work

- S/he will ensure that all articles are sterilized, all equipment, gadgets, electrical connections, light, fan etc. are maintained.
- S/he will ensure that the specimens are collected, labelled and dispatched.
- S/he will ensure to escort the patient to and from the department.
- S/he will ensure that the reports are received and given to the patients as well as the doctor is informed.
- S/he will ensure that the patient's problems are listened to and help them to solve them through various means.
- S/he will ensure the confidentiality of the patients.
- S/he will ensure that the cultural and religious differences of the patients are respected.
- S/he will supervise the students and ancillary staffs.
- S/he will ensure that all records, outcome indicators as per LaQshya guidelines are maintained.
- S/he will ensure to make the ward clean and tidy, including the bed.
- S/he will keep all articles well-arranged and maintain the inventory.
- S/he will maintain all records and mandates.
- S/he will assist the ward sister in orientation programme of new staff and students and in the supervision of work of Group D allotted in the ward for maintenance of cleanliness and sanitation.
- S/he will accompany with doctors and senior nursing officers during 'ward round'.
- S/he will help ward sister in indenting and checking of drugs, supplies and maintaining inventories.
- S/he will perform the functions of the ward sister during her/his absence
- S/he will assist in orientation of new staff nurses.
- S/he will support and guide the ASHAs working in the HWC area.
- S/he will participate in staff education and staff meeting.
- S/he will maintain good interpersonal relations with all other staff.
- S/he will give information about MLC cases to Head / Officer in charge.
- S/he will co-operate in activities related to the National Health Programmes.
- S/he will ensure safe disposal of biomedical waste.
- S/he will keep herself/himself up to date with nursing knowledge by taking part in in-service education programmes.
- S/he will perform any other duty that may be assigned to her/him from time to time including field work.

Multi-Purpose Worker-Female (MPW-F) /Auxiliary Nurse Mid Wife (ANM) of HWC-SHC

1. **Clinical Work**

   A. Under the supervision of CHO, the MPW-F/ANM to perform the following functions:

   - General OPD services and managing cases at HWC-SHC
   - Early registration of pregnancy: issuing of ID number and Mother and Child protection card
   - Antenatal check-up and identifying high risk pregnancies, child births and post-partum cases.
   - Screening, referral of suspected cases and follow up care in case of gestational diabetes and syphilis during pregnancy, STI/RTI, eye, ENT, TB, leprosy, non-communicable diseases, vector borne diseases, common mental conditions, substance use and Epilepsy cases, delays in development and disability and other congenital anomalies.
   - Identification and support in management of anaemia, nutritional deficiencies, and vaccine preventable diseases in children and their complete immunization including identification and follow up, referral and reporting of Adverse Events Following Immunization (AEFI)
   - Undertake Diagnostic Services- Pregnancy Test, Haemoglobin, Urine Test, Blood Sugar, and other point of care diagnostic services specified for different service packages.
   - Provide first aid treatment for obstetric emergencies, e.g., eclampsia, PPH, Sepsis and prompt referral (Type B SHC) and supporting medical team for handling other emergency situations by coordinating
   - Midwifery Services in Sub Centres only where institutional deliveries have been allowed by the state governments and provide appropriate treatment or refer to higher centres in cases where ASHA is not able to manage with home-based care.
   - Reviewing completed CBAC for cancer symptoms/epilepsy/COPD and refers as appropriate.
   - Ensuring patient's compliance for treatment.

2. **Public Health Work**

   A. Undertake household survey with ASHAs for detailed mapping, enumeration and enrolment of population being covered in HWC and in urban areas where ASHAs are currently not available, to identifying population at risk, estimating RCH needs etc.

   B. Counselling and Health Education to the community on:

   - Danger signs during pregnancy, and teaching them importance of institutional delivery, early and exclusive breastfeeding, seeking postnatal care, weaning and complementary feeding, consuming nutritious diet and where to go for delivery.
   - Importance of complementary feeding, its components, on consuming supplementary nutrition at AWCs and consuming iron-rich diet in children to avoid anaemia.
   - Childhood and adolescent healthcare services including nutrition, personal hygiene, sanitation, menstrual hygiene management, healthy living etc. in the community through home visits and through VHSNDs.
   - Family Planning/Education of children/Dangers of sex selection/Age at marriage/ Information on/Disease outbreak/Disaster management/Adolescent Health.
   - Care during communicable and vector-borne disease infections.
   - Lifestyle modifications needed for non-communicable diseases like Hypertension and Diabetes and importance of regular follow up visits to Health and Wellness Centre or other facilities for NCDs and ensuring adherence to treatment plans.

- Oral Health education especially to antenatal and lactating mothers, school children and adolescent, first aid and referral of cases with oral problems.
- Motivation for quitting and referrals to Tobacco Cassation Centre at District Hospital/Medical College.
- Activities for prevention and early detection of hearing impairment/deafness, visual impairments at the level of health facility, community and schools.
- Sensitization of community regarding entitlements provided by government under various national programs

3. Field/Home visits

- Prioritize visit to pregnant women who did not attend their regular ANCs in the monthly ANC clinics/ VHSND, bring them back to the system -motivate them for institutional deliveries.
- Visits to postpartum mothers for home-based services and providing care - either as indicated by ASHA after a home visit, or if ASHA is not there, or if they failed to attend VHSND.
- Identify children who missed their immunization sessions and ensure that they get vaccinated during next immunization session/campaigns.
- Visit sick new-born/low-birth weight babies and children who need referral but are unable to go, as indicated by ASHA and malnourished children who did not go for the medical reference - ensure they get care at a higher centre.
- Motivate Families with whom ASHA is having difficulty in motivating for changing health-seeking behavior, adopting family planning methods and who did not come to VHSND.
- Patients having chronic illnesses, who have not reported for follow up at the sub centre or VHSND and encourage them to attend special-day clinics
- Prioritized visits in areas where Fever Treatment Depots/ASHAs have not been deployed - Collecting blood smears or performs RDTs from suspected malaria cases during domiciliary visits and maintains records. Providing treatment to positive cases.
- Distribution and utilization of LLIN Bed Nets; facilitate and ensure quality spray in households and insecticide treatment of community-owned bed nets.
- Verbal autopsy and/or at least preliminary inquiry into any maternal or child death.
- Surveillance for unusually high incidence of cases of any communicable disease and notify CHO and PHC-MO.
- Ensuring regular testing of salt at household level for presence of Iodine through Salt Testing Kits by ASHAs.

4. Administrative Work

A. In ensuring that the untied funds are utilized as per the rules and guidelines.

B. Supportive and Supervisory function to ASHA in:

- Replenishment of drugs in her kit.
- Survey in the community for nutritional deficiency among those who had experienced trauma/ disaster/disease outbreak and spreading awareness on nutrition, lifestyle modification diet post trauma/disaster/disease outbreak.
- In coordinating for building convergence with Women's Group, Self Help Groups (under MoRD, GoI) for generating awareness, counselling to promote behaviour change - at community level and relief camps.

- In coordinating for building convergence with ICDS (AWW) and conduct growth monitoring at AWC, counselling on nutrition, referral of cases (low weight babies, PW with nutritional deficiency)
- Attending VHSND during disaster - in relief camps for awareness generation on nutrition, growth monitoring along with other service delivery.
- In community level care for emergency & coordination for first aid stabilization and follow-up visit to patient.
- In organizing special "Day Clinics" to enhance attendance for ambulatory outpatient services.
- Support ASHA to ensure home based care for new born and young children.
- Assisting ASHA: Assist the ASHA/similar village health volunteer to motivate the TB patients in taking regular treatment

5. Functions of Reporting and Record Maintenance:

- Register entries and housekeeping work, data entry; report preparation and review meetings.
- Support CHO in enabling every HWC to have a folder for every family.
- Attending monthly meetings at PHC
- Ensure timely documentation and registration of all births and deaths under the jurisdiction of Sub Centre.
- Attend VHSNC meetings and ensure that the minutes of the meetings are recorded and maintained.
- Making and timely submission of reports for various programs i.e. RCH Portal, NCD, HMIS, IDSP, NIKSHAY etc.

Multi-Purpose Worker-Male (MPW-M) of HWC-SHC

1. Clinical Work

Under the supervision of CHO, the MPW-M performs the following functions:

- General OPD services and managing cases at HWC-SHC that are referred by ASHAs /or visit the health centre with any illness or problem.
- Identification, referral and follow-up: Mobilize community members including children and guide them to nearest screening camps, health facilities/Referral centre, for registration, early identification of gestational diabetes and syphilis during pregnancy, STI/RTI, eye, ENT, TB, leprosy, non-communicable diseases, vector borne diseases, common mental conditions, substance use and Epilepsy cases, delays in development and disability and other congenital anomalies.
- Referring of adolescents with anaemia, underweight, issues related to nutrition etc. to AB-HWCs. Follow-up of sick and malnourished children regarding their nutrition intake, especially those discharged from NRCs.

2. Public Health Work

- Counselling and Health Education to the community on:
  a. Importance of institutional delivery, early and exclusive breastfeeding, seeking postnatal care, weaning and complementary feeding, consuming nutritious diet and where to go for delivery.
  b. Importance of complementary feeding, its components, on consuming supplementary nutrition at AWCs and consuming iron-rich diet in children to avoid anaemia.

c. Childhood and adolescent healthcare services including nutrition, personal hygiene, sanitation, vaccination, healthy eating behaviour, in the community through home visits and through VHSNDs.

d. Activities for prevention and early detection of hearing impairment/deafness, visual impairments at the level of health facility, community and schools.

- Motivate adolescents to attend VHSND sessions related to adolescent health.
- Sensitization of community regarding entitlements provided by government under various national programs
- Information and prevention of RTIs, STIs, HIV/AIDS through health education in the community.
- Aware the community and adolescents regarding the various government programmes for adolescents' health Nutrition such WIFS, school deworming programme etc.
- Awareness Generation: Utilize meetings of the Village Health Nutrition and Sanitation Committee/Mahila Arogya Samiti (VHSNC/MAS) to raise awareness about the needs of palliative care patients, and mobilize individual and community level support, including accessing assistance available through other Government programmes, assess symptoms

3. Administrative Work

- Facilitate opening of Bank Account, Aadhar card registration of patients and ensure entry in portals such as Nikshay / TB notification register at health facility for DBT transfer.
- Maintain a record of cases in his area, who are under treatment for tuberculosis and leprosy
- Co-ordinate and participate in the outreach activities of PHC/CHC/ District Mobile dental clinic.
- Attending monthly meetings at PHC
- Supportive and Supervisory function to ASHA.
- Support ASHA in active case detection of cases in the community and referral of suspected cases with skin patches to MO.
- Assist the ASHA/similar village health volunteer to motivate the TB patients in taking regular treatment
- In organizing special "Day Clinics" to enhance attendance for ambulatory outpatient services.

ANNEXURE 6

List of Essential Medicines for HWC-SHC/UHWC

S. No.	Medicine Name
Anesthetics Agent	
1	Oxygen gas for inhalation
2	Lignocaine Topical form 5% (Plain Lignocaine Injection can be kept at SC if enough case load is there)
Analgesics, antipyretics, non-steroidal anti-inflammatory medicines, medicines used to treat gout and disease modifying agents used in rheumatoid disorders	
3	Aspirin (Acetylsalicylic acid) Tablet 75 mg (Not to be used in suspected dengue patients and other clinical conditions without prescription)
4	Diclofenac Tablet 50 mg Diclofenac Injection 25 mg/ml
5	Ibuprofen Tablet 200 mg (Not to be used in suspected dengue patients and other clinical conditions without prescription)
6	Paracetamol tablet 250 mg, Paracetamol Syrup 125 mg/5 ml Paracetamol Syrup 250 mg/5 ml
Anti-allergic and medicines used in anaphylaxis	
7	Levocetirizine 5 mg Tablet Levocetirizine Oral Liquid
8	Hydrocortisone Succinate Injection 100 mg
9	Pheniramine Injection 22.75 mg/ml
10	Adrenaline Injection 1mg/ml (Should be part of all emergency drugs)
Anti-dotes and other substances used in poisoning	
11	Atropine Injection 1 mg/ml (Ampoules should be made available)
12	Activated Charcoal
Anti-convulsant/ Anti-epileptic/ Anti-psychotic	
13	Magnesium Sulfate Injection (50% solution), 2 ml ampoule
14	Diazepam Tablet 5 mg Diazepam Tablet 10 mg Diazepam rectal suppository* (Controlled medicine)
15	Midazolam Nasal Spray* (For emergency purpose)
16	Phenobarbitone Tablet 30 mg Phenobarbitone Tablet 60 mg Phenobarbitone Oral liquid 20 mg/5 ml
17	Phenytoin Tablet 50 mg Phenytoin Tablet 300 mg
18	Sodium valproate Tablet 200 mg Sodium valproate Tablet 500 mg Sodium valproate Syrup each 5 ml contains 200 mg
Intestinal Anthelmintics	
19	Albendazole Tablet 400 mg Albendazole Oral liquid 200 mg/5 ml
Anti-filarial	
20	Diethylcarbamazine Tablet 100 mg Diethylcarbamazine Oral liquid 120 mg/5 ml

S. No.	Medicine Name
Anti-bacterial	
21	Amoxicillin Capsule 250 mg, Amoxicillin Capsule 500 mg Amoxicillin Oral liquid 250 mg/5 ml Amoxicillin Dispersible Tablet 250 mg
22	Gentamicin Injection 10 mg/ml Gentamicin Injection 80 mg/m
23	Tab Co-trimoxazole [Sulphamethoxazol 80 mg +Trimethoprim 400 mg] Tab. 20 mg trimethoprim + 100 mg sulphamethoxazole Co-trimoxazole Oral Liquid [Sulphamethoxazole 200 mg + Trimethoprim 40 mg/5 ml]
24	Doxycycline Capsule 100 mg
25	Metronidazole Tablet 200 mg Metronidazole Tablet 400 mg
26	Norfloxacin tab/ oral Liquid
Anti-leprosy medicines	
27	As per Program Guidelines (Adults and Pediatrics)
Anti-tuberculosis medicines	
28	As per Program Guidelines (Adults and Pediatrics)
Anti-fungal medicines	
29	Clotrimazole Ointment Clotrimazole Cream 1% Clotrimazole Vaginal Tablet Clotrimazole Drops 1% Clotrimazole Oral Solution
30	Miconazole Ointment
31	Fluconazole 150 mg Tablet
Anti-malarial medicines	
32	As Per Program Guidelines (Adults and Pediatrics)
Medicines used in Palliative care	
33	Lactulose Oral liquid 10 g/15 ml
34	Povidone Iodine Lotion and Ointment
Anti-anaemic medicines	
35	Ferrous salt 100 mg + Folic acid 500 mcg Tablet Ferrous salt 20 mg + Folic acid 100 mcg Table Ferrous salt 60 mg + Folic acid 500 mcg Table Ferrous salt 45 mg + Folic acid 100 mcg Table Ferrous sulphate + Folic acid Syrup
36	Folic acid Tablet 5 mg Folic acid Tablet 400 mcg
37	Vitamin K Injection 1 mg/ml
Cardiovascular medicines (Medicines used in angina)	
38	Isosorbide-5- mononitrate Tablet 5 mg
39	Atenolol Tablet 50 mg
40	Metoprolol Tablet 25 mg Metoprolol SR Tablet 25 mg
41	Isosorbide dinitrate Tablet 5 mg (Sublingual)
Anti-hypertensive medicines	
42	Amlodipine Tablet 2.5 mg Amlodipine Tablet 5 mg
43	Enalapril Tablet 5 mg
44	Telmisartan Tablet 40 mg
45	Hydrochlorothiazide Tablet 12.5 mg Hydrochlorothiazide Tablet 25 mg
Hypolipidemic medicines	
46	Atorvastatin Tablet 10 mg
Medicines used in Dementia	
47	Alprazolam Tablet 0.25 mg Alprazolam Tablet 0.5 mg

S. No.	Medicine Name
Dermatological medicines (Topical)	
48	Silver sulphadiazine Cream 1%
49	Betamethasone Cream 0.05%
50	Calamine Lotion
51	Benzyl benzoate ointment/lotion
52	Mupirocin (anti -bacterial cream)
53	Potassium Permanganate 0.1%
54	Zinc Oxide Cream 10%
Disinfectants and antiseptics	
55	Ethyl alcohol (Denatured) Solution 70%
56	Hydrogen peroxide Solution 6%
57	Methylrosanilinium chloride (Gentian Violet)
58	Bleaching powder Containing not less than 30% w/w of available chlorine (as per I.P)
59	Gama Benzene Hexachloride
60	Framycetin sulphate (Ointment)
Ear, nose and throat medicines	
61	Ciprofloxacin Drops 0.3 % Ciprofloxacin Tablet 250 mg Ciprofloxacin Tablet 500 mg
62	Boro-Spirit ear drop
63	Ear wax solvent drops (combination of Benzocaine, Chlorbutol, Paradichlorobenzene and Turpentine Oil)
Gastrointestinal medicines	
64	Ranitidine Tablet 150 mg Ranitidine Injection
65	Omeprazole capsule 20 mg
66	Ondansetron Tablet 4 mg Ondansetron Oral liquid 2 mg/5 ml Ondansetron Injection 2 mg/ml
67	Ispaghula Granules/ Husk/ Powder (Herbal Medicine)
68	Oral rehydration salts (ORS)
69	Zinc sulphate Dispersible Tablet 20 mg Zinc Sulphate Syrup
70	Dicyclomine Tablet 10 mg Dicyclomine Injection
71	Dioctyl sulfosuccinate sodium
72	Magnesium Hydroxide liquid
73	Senna Powder (Herbal Medicine)
74	Domperidone Tablet Domperidone Syrup
Contraceptives	
75	Ethinylestradiol (A) + Levonorgestrel Tablet 0.03 mg (A) + 0.15 mg (B)
76	Copper bearing intra-uterine device IUCD 380 A & IUCD 375
77	Male Condom
78	Ormeloxifene Tablet 30mg
79	Emergency contraceptive Pill Levonorgestrel 1.5 mg
80	Medroxyprogesterone Acetate Injection 150 mg
81	FP Commodities: PTK
Medicines used in Diabetes Mellitus	
82	Glimepiride Tablet 2 mg
83	Metformin Tablet 500 mg Metformin SR Tablet 500 mg
84	Glibenclamide Tablet 2.5 mg/ Glibenclamide Tablet 5 mg

S. No.	Medicine Name
Thyroid and Anti-thyroid medicines	
85	Levothyroxine Tablet 25 mcg Levothyroxine Tablet 50 mcg Levothyroxine Tablet 100 mcg
Vaccines	
86	As per Current National Programme Guidelines
87	Rabies vaccine
Oxytocics & Abortificent Medicine	
88	Misoprostol Tablet 200 mcg (Should be use with caution)
Medicines acting on the respiratory tract	
89	Budesonide Respirator solution for use in nebulizer 0.5 mg/ml (Nebulizer Essential)
90	Salbutamol Tablet 2 mg Salbutamol Oral liquid 2 mg/5 ml Salbutamol Respirator solution for use in nebulizer 5mg/ml (Nebulizer Essential)
91	Normal Saline Drops
92	Dextromethorphan oral Syrup
93	Hyoscinebutylbromide Tablet 10 mg
Solutions correcting water, electrolyte disturbances and acid-base disturbances	
94	Ringer lactate Injection
95	Sodium chloride injection 0.9%
96	Dextrose 5% Dextrose 25%
Vitamins and minerals	
97	Ascorbic acid (Vitamin C) Tablet 100 mg
98	Calcium Carbonate Tablet 500 mg
99	Cholecalciferol Tablet 60000 IU
100	Pyridoxine Tablet 25 mg Pyridoxine Tablet 50 mg Pyridoxine Tablet 100 mg
101	Vitamin A Oral liquid 100000 IU/ml
102	B Complex Tablet
Ophthalmological Medicines	
103	Sodium Cromoglycate 2% Eye drop
104	Methylcellulose eye drops
Diuretics	
105	Furosemide Injection (Lasix) Furosemide Tablet 40 mg

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

ANNEXURE 7

List of Diagnostic Tests & Equipment for Gap Analysis at HWC-SHC and UHWC

S. No.	Types of Tests	Method/Equipment Required
1.	**Essential**	**Essential**
	Hemoglobin, HCG, Urine test, Blood Sugar, Malaria test, HIV, Dengue, Cervical Cancer, Iodine, Water testing for fecal contamination and chlorination, HbsAg test for Hep B, Filariasis, Syphilis, Sputum for AFB, Sickle cell rapid test *	Technique – Sahli's Hemoglobinometer, Digital Hemoglobinometer, (Paper based Hb test), Rapid card test, Multiparameter urine strip (Dipstick), Glucometer (Strip based), VIA method, Testing Kit, Sample collection, Filaria Strip test
	NESTROFT, Solubility Test	NESTROFT, Solubility Test
	Desirable**	**Desirable****
	HaemChip	HaemChip
2.	**Desirable**	**Desirable**
	Matching, Peripheral blood film, Reticulocyte count, Absolute eosinophil count, Bleeding time and clotting time, Sickling Test for screening of Sickle cell anemia, NESTROFT Test for screening of Thalassemia*, DCIP test for screening HbE hemoglobinopathy*, Screening test for G6PD enzyme deficiency, Urine test for pH, specific gravity, leucocyte esterase, glucose, bilirubin, urobilinogen, ketone, protein, nitrite, Urine for microalbumin, Stool for ova and cyst, Stool for Occult Blood, RPR/ VDRL test for syphilis, Typhoid test (IgM), Glucose Tolerance test (GTT), S. Bilirubin (T), S. Bilirubin direct and indirect, Serum creatinine, Blood Urea, SGPT, SGOT, S. Alkaline Phosphatase, S. Total Protein, S. Albumin & AG ratio, S. Globulin, S. Total Cholesterol, S. Triglycerides, S.VLDL, S.HDL, S. LDL, S. Uric acid, Glycosylated haemoglobin (HbA1C), Serum Calcium, Wet mount and Gram stain for RTI/STD, Gram staining for clinical specimen, Throat swab (Albert stain) for Diphtheria, Stool for hanging drop for Vibrio Cholera, Visual Inspection Acetic Acid (VIA), rK39 for Kala Azar, TB – Mantoux, Troponin – I, Pap smear	3 Part Hematology analyzer, Manual with reading using ESR analyzer, Blood group kit (manual), Microscopy, Manual with microscopy/Solubility test/Cover slip test, Rapid card tests for combined P. Falciparum and P. vivax, Turbidometer/ Nephelometer, Manual Kit, Semi Automated Biochemistry analyzer, HbA1C Analyzer, Wet mounting, gram staining

** For endemic areas only, **These services to be linked with Hub for UHWCs*

Note: The Desirable will be over and above the tests and Equipment mentioned as essential.

ANNEXURE 8

List of Equipment and Consumables for HWC-SHC/UHWC

S. No.	Equipment	HWC-SHC		UHWC	
		E	D	E	D
Emergency					
1.	Ambu Bag (Paediatric size) with Baby mask, Suction Machine, Oxygen Administration Equipment, I/V Stand, Tongue Depressor, Oxygen Cylinder with trolley, Mouth Gag, Nebulizer	E		E	
OPD					
2.	Digital Sphygmomanometer, Sphygmomanometer Aneroid 300 mm, with cuff IS: 7652, Kelly's haemostat Forceps straight 140 mm, Vulsellum Uterine Forceps curved 25.5 cm, Cusco's/Graves Speculum vaginal bi-valve small, medium and large, Sims retractor/ depressor, Sims Speculum vaginal double ended ISS Medium, Uterine Sound Graduated, Flashlight/Torch Box-type pre-focused (4 cell), Weighing Scale, Adult 125 kg/280 lb, Weighing Scale, Infant (10 Kg), Weighing Scale, (baby) hanging type, 5 kg, Clinical Thermometer oral & rectal, Stethoscope, Foetoscope, Measuring Tape, BP Apparatus (Digital), Mouth Mirror, Snellen vision chart, Near vision chart, Stadiometer, Tuning fork.	E		E	
Minor Treatment					
3.	Basin 825 ml. SS (Stainless Steel), Basin deep (capacity 6 liters), Tray instrument/Dressing with cover 310 x 195x63mm, Torch (ordinary), Dressing Drum with cover 0.945 liters stainless steel, Sterilizer, Surgical Scissors straight, 140 mm, Sponge holder, Plain Forceps, Toothed Forceps, Needle Holder, Suture needle straight -10, Suture needle curved, Kidney tray, Artery Forceps, straight, 160 mm Stainless steel, Dressing Forceps (spring type), 160 mm, stainless steel, Cord cutting Scissors, Blunt, curved on flat, 160 mm,	E		E	

S. No.	Equipment	HWC-SHC		UHWC	
		E	D	E	D
	Examination Lamp, Gauze Cutting Scissors Straight, Foam Mattress.				
Immunization Services					
4.	Vaccine Carrier, Ice pack box, Tracking Bag and Tickler Box (Immunization)	E		E	
***ANM Room**					
5.	Syringe (10 cc, 5 cc, 2 cc) and AD Syringes (0.5 ml and 0.1 ml) for immunization, Disposable gloves, Mucus extractor , Disposable delivery Kit, Dry cell/Battery, Disposable lancet (Pricking needles), Disposable Sterile Swabs, Routine Immunization Monitoring Chart, Blank Immunization Cards/Joint MCH Card (one per pregnant mother) and Tally Sheets (one per immunization session), IV canula and Intravenous set, Chlorine tablets, Sanitary napkins, Salt – Iodine test kit, Kits for testing residual chlorine in drinking water, Mackintosh Sheets – 5 meters, Wooden spatula, Suture Material, Online UPS 1 KVA with 60 minute backup. ***Only for HWC-SHC.**	E		E	
Miscellaneous					
6.	Fire Extinguisher, Buckets Big (Plastic), Buckets Small (Plastic), Dust bins- Blue, Dust Bins – Red, Dust Bins – Yellow, Dust Bins- Black, Black Disposal bags, Red Disposal Bags, Yellow Disposal Bags, Blue Translucent Container, Sharps Container, Hand Towels, Bed Sheet for Examination Tables, Cleaning material, detergent, Insecticide treated nets.	E		E	
Furniture /Non-Consumables					
7.	Chairs for patient waiting area, Footstep, Office Chair, Office Table, Screen Separators with stand, Steel Almirah / Cupboard/storage chests, Stool for attendants.	E		E	

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

ANNEXURE 9

Cleaning Protocols at HWC-SHC/UHWC

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

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

Cleaning frequency, level of cleaning/ disinfection and evaluation/ auditing frequency according to the type of functional area risk category Functional Area Risk Category	Frequency of cleaning	Level of cleaning/ disinfection (As per Spaulding's Classification)	Method of cleaning/ Disinfection	Evaluation/ auditing frequency
Moderate risk areas • Consultation Room • Health & Wellness Room • Counselling Room • Inpatient ward/ Day-Care room • Toilets	Floors, walls and Surfaces: Routine cleaning once in four hours with aldehyde free high-level disinfectant (HLD) like 70% isopropyl alcohol Spot Cleaning: As required	Cleaning and low-level disinfection	Routine Cleaning with soap and detergent plus disinfection with aldehyde free high-level disinfectant (HLD) like 70% isopropyl alcohol **Spot Cleaning:** As required after disinfection with 0.5% chlorine solution.	Once in a month or once in two months if cleanliness of high standards is maintained as certified by Officer I/C Sanitation and Infection Control Team
	Intensive deep cleaning: Weekly/ Holidays		All Equipment and instruments to be disinfected and cleaned with aldehyde free high-level disinfectant like peracetic acid and autoclaving accept heat sensitive Equipment & instruments.	
Low risk areas • Corridors • Waiting halls / Waiting Rooms/ Registration Area • Stores (Medicine Store, Linen Store) • Pharmacy	**Floors, walls and Surfaces:** Routine cleaning for areas working round the clock at least once in a shift or in areas having general shift at least twice in the shift with water and Soap/ Quaternary Ammonium Compound Spot Cleaning: As required Intensive deep cleaning: Weekly/ Holidays	Cleaning with water and detergent	Routine physical removal of soil, dust or foreign material followed by cleaning with water and Soap/ Quaternary Ammonium Compound. Spot Cleaning: As required after disinfection with 0.5% chlorine solution	Once in three months

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

General Cleaning Practices for All Healthcare Settings

Before Cleaning

- Check for additional (isolation) precautions signs
- Follow precautions as indicated
- Remove clutter before cleaning
- Follow the manufacturer's instructions for proper dilution and contact time for cleaning and disinfecting solutions
- Gather materials required for cleaning before entering the room
- Visibly check and ensure all cleaning equipment itself is clean
- Clean hands before entering the room
- Prepare chemical dilutions and put on gloves before beginning cleaning.

During Cleaning

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

After Cleaning

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

ANNEXURE 10

Service Area Wise Protocol

Service Area (Please Mark): (OPD/ Side Lab/ Labour Room / Day Care IPD Area/ Any other etc.)

Room No:

Timings:

Staff in the room:

Designation	Name
MO	
CHO	
Nurses	
Other Health Care Staff	
Sanitation staff	
Security Guard	

Activities (Key services provided):

1.

2.

3.

List of equipment and its maintenance:

S. No.	Equipment's/ Material	Quantity	Frequency of Utilization	Cleaning material & frequency	Responsible person

Toll Free number of BMMP:

Nodal person at the facility with contact details:

Records and Registers:

S. No.	Name of the Register	Key Information Recorded in The Register	Frequency of Updating	Person Responsible	Designation of Authority Responsible for Verification of Register

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

1.
2.

Performance

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

Performance Bar Graph:

Cleaning Protocols:

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

ANNEXURE 11

Checklist for Daily Rounds

S. No.	Observe/Monitor and Guide Date	1	2	3	4	5	6	7	8	9	10
1.	Display of duty roster and presence of staff accordingly in their respective duty station										
2.	Staff is in proper uniform & maintains decorum										
3.	Department/Service Area wise protocols and performance displayed in respective service areas.										
4.	Clinical practices as per the SoPs in each service area										
5.	Privacy during patients' examination is maintained in all service areas										
6.	Quality of performance by Nursing and other junior staff										
7.	Infection control protocols are adhered										
8.	BMW is segregated properly										
9.	Adherence to handing over-taking over protocols in all areas.										
10.	Availability of stock required in every service area (Drugs & Consumables etc.)										
11.	Necessary Equipment are available and functional in every service area										
12.	Sterilization of the instruments is as per protocols in										
	12.2 Labour Room										
	12.3 casualty										
	12.4 Any other service areas.										
13.	Only sterilized/autoclaved instruments are used in service areas										
14.	Records of sterilization are maintained										

S. No.	Observe/Monitor and Guide Date	1	2	3	4	5	6	7	8	9	10
15.	Cleanliness and check the cleaning checklist for completion in the below mentioned areas (OPD, Wards, Labor room, OT, Lab. & diagnostic rooms, Injection & dressing room, Toilets etc.) as per cleaning protocols.										
16.	Presence of junk or unnecessary item in service areas										

Round taken by (Please tick and sign):

1. MO/CHO/Health Facility In charge:
2. Staff Nurse
3. Any Other:

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

A. COMMITTEE MEMBERS

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

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

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

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

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

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

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

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

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

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

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

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

B. MINISTRY OF HEALTH AND FAMILY WELFARE

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

C. NITI Ayog

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

D. OTHER INVITED MEMBERS

1. MOHFW Representatives

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

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

2. State Representatives

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

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

3. Institutional Experts

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

S No	Name	Designation	Organisation
38.	Dr. Vandana Kumar	Consultant	WHO India
39.	Dr. Sushant Agarwal	Consultant QI	ADB, NHSRC

4. NHSRC

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

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

5. RRCNE

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

6. Administrative and Secretarial Support

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

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Ministry of Health and Family Welfare
Government of India