सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

Regional Workshops on Operationalization of Ayushman Bharat Health and Wellness Centres

A Synthesis Report

August - October, 2019

REGIONAL WORKSHOPS ON OPERATIONALIZATION OF AYUSHMAN BHARAT HEALTH AND WELLNESS CENTRES

A Synthesis Report

(August – October, 2019)

Contents

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ABBREVIATIONS

AB-HWCs	Ayushman Bharat Health and Wellness Centres
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
CBAC	Community Based Assessment Checklist
CHO	Community Health Officer
CPHC	Comprehensive Primary Health Care
CPCH	Certificate Programme in Community Health
CSR	Corporate Social Responsibility
DMF	District Mineral Fund
DVDMS	Drug Vaccine Distribution Management System
EDL	Essential Drug List
ESR	Erythrocyte Sedimentation Rate
FLW	Frontline Workers
FP	Family Planning
FY	Financial Year
GoI	Government of India
HR	Human Resources
HSS	Health System Strengthening
HWC	Health and Wellness Centre
IEC	Information, Education and Communication
IPHS	Indian Public Health Standards
IT	Information Technology
IGNOU	Indira Gandhi National Open University
LRP	Learning Resource Package
LT	Laboratory Technician
MCSP	Maternal and Child Survival Program
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MPLAD	Members of Parliament Local Area Development
MPW	Multi-Purpose Health Worker
NCD	Non-Communicable Diseases
NHM	National Health Mission
NHSRC	National Health System Resource Centre
NUHM	National Urban Health Mission
PBS	Population Based Screening
PHC	Primary Health Centre
PIP	Programme Implementation Plan

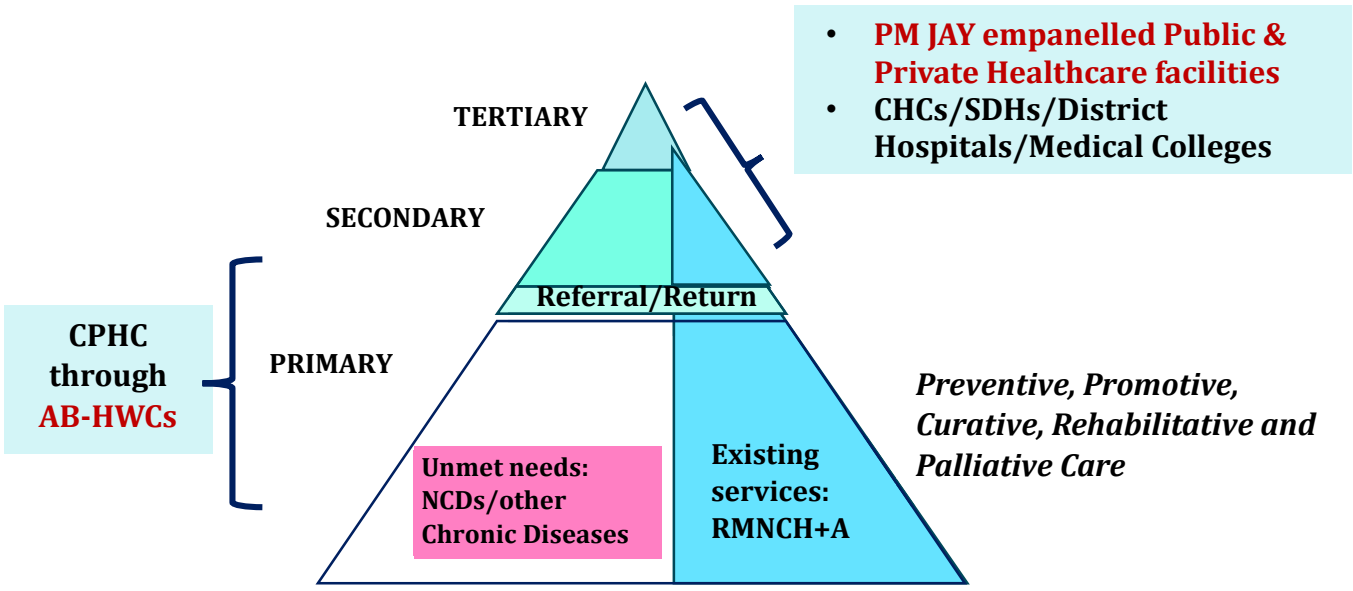
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPP	Public Private Partnerships
PRI	Panchayati Raj Institutions
PSC	Programme Study Centre
RDK	Rapid Diagnostic Kit
RMNCH+A	Reproductive Maternal Newborn Child and Adolescent Health
RPR	Rapid Plasma Reagin
SHC	Sub-Health Centre
SHP	School Health Programme
SN	Staff Nurse
TLC	Total Leukocyte Count
UHC	Universal Health Coverage
ULB	Urban Local Body
UPHC	Urban Primary Health Centre
USAID	US Agency for International Development
VHSND	Village Health Sanitation and Nutrition Day

INTRODUCTION

Universal Health Coverage (UHC) implies that all people and communities have access to promotive, preventive, curative, rehabilitative, and palliative quality healthcare services while ensuring that the use of these services does not expose the user to any financial hardship.

Launched in 2018, the 'Ayushman Bharat' programme, which translates into 'Long Live India' is a road map towards achieving UHC in India. The first component of this scheme is to roll out Comprehensive Primary Health Care (CPHC) through the 1.5 lakh Health and Wellness Centres by December 2022, by transforming the existing Sub Health Centres (SHCs) and Primary Health Centres (PHCs) in rural and urban areas – essentially by upgradation of the existing infrastructure and providing additional human resources – for provision of an expanded range of healthcare services.

The second component is the Pradhan Mantri Jan Arogya Yojna (PMJAY) which provides financial protection for secondary and tertiary care to 50 Crore population with coverage of upto Rs. 5 lakhs per family per year.



As a part of the National Health Policy 2017, Ministry of Health and Family Welfare (MoHFW) has envisaged provision of CPHC services, by integrating components of preventive, promotive and rehabilitative healthcare along with basic curative services. The paradigm shift from selective primary healthcare to a comprehensive approach is the backbone of Ayushman Bharat-Health and Wellness Centres (AB-HWCs).

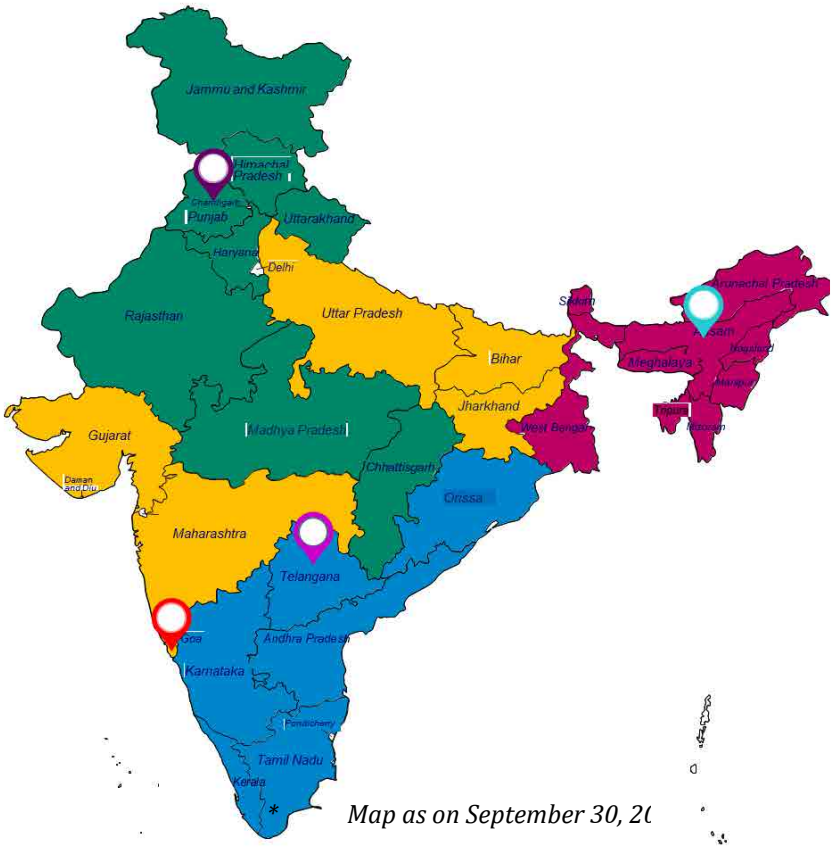
With an objective to provide regular mentoring and handholding support to the States/UTs, MoHFW with support from USAID's Maternal and Child Survival Program (MCSP) led by Jhpiego organized four regional workshops on operationalization of AB-

HWCs under the leadership of Secretary – MoHFW, Additional Secretary and Mission Director (AS & MD) – National Health Mission (NHM) and Joint Secretary (JS) – Policy, to review implementation of AB-HWCs across all states and union territories. The workshops were held to highlight the state specific best practices for cross learning, identify challenges and possible solutions for making CPHC a vibrant component of India's health system.

Objectives of the regional workshops

- To review the progress of operationalization of AB-HWCs
- To promote cross learning by experience sharing and highlighting state-specific best practices
- To create a culture of regional sharing between states with cultural proximity
- To pave the roadmap for planning and implementation of AB-HWCs for FY 2019 – 20

Regional workshops at a glance



Map as on September 30, 2(

First Regional Workshop held at Hyderabad, Telangana (August 6-7, 2019)

Participating states and UTs – Andaman and Nicobar Islands Andhra Pradesh, Karnataka, Kerala, Lakshadweep, Odisha, Puducherry, Tamil Nadu and Telangana

Second Regional Workshop held at Goa (August 19-20, 2019)

Participating states and UTs –Bihar, Daman and Diu, Dadra and Nagar Haveli, Goa, Gujarat, Jharkhand, Maharashtra and Uttar Pradesh

Third Regional Workshop held at Amritsar (September 5-6, 2019)

Participating states and UTs –Chandigarh, Chhattisgarh, Haryana, Himachal Pradesh, Jammu and Kashmir, Madhya Pradesh, Punjab, Rajasthan and Uttarakhand

Fourth Regional Workshop held at Guwahati (October 3-4, 2019)

Participating states and UTs – Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura and West Bengal

Participant profile

- Senior officials from Ministry of Health and Family Welfare (MoHFW) and National Health System Resource Centre (NHSRC) – Secretary – MoHFW, AS & MD – NHM, JS (Policy) JS (Urban Health), Executive Director, NHSRC and Directors, NHM
- Principal Secretaries and Mission Directors of participating States/ UTs
- State Nodal Officers for CPHC / AB-HWCs and Certificate in Community Health (CCH)
- Other senior officials and consultants from NHSRC
- Consultants from NHM and National Urban Health Mission (NUHM)
- Representatives from USAID, Jhpiego, Tata Trusts and other Development Partners
- Technical team managing IT Programmes

Flow of the workshops

Four regional workshops on operationalization of AB-HWCs were organized for one and a half days each. Before arriving for the workshop, a team from Government of India (GoI) and the state visited one or two districts of the participating states to observe the field level implementation (facility based and community interactions) of the AB-HWCs programme with a structured check-list / ToR. The team visited the SHC AB-HWC and the linked/first port of call PHC AB-HWCs as well.

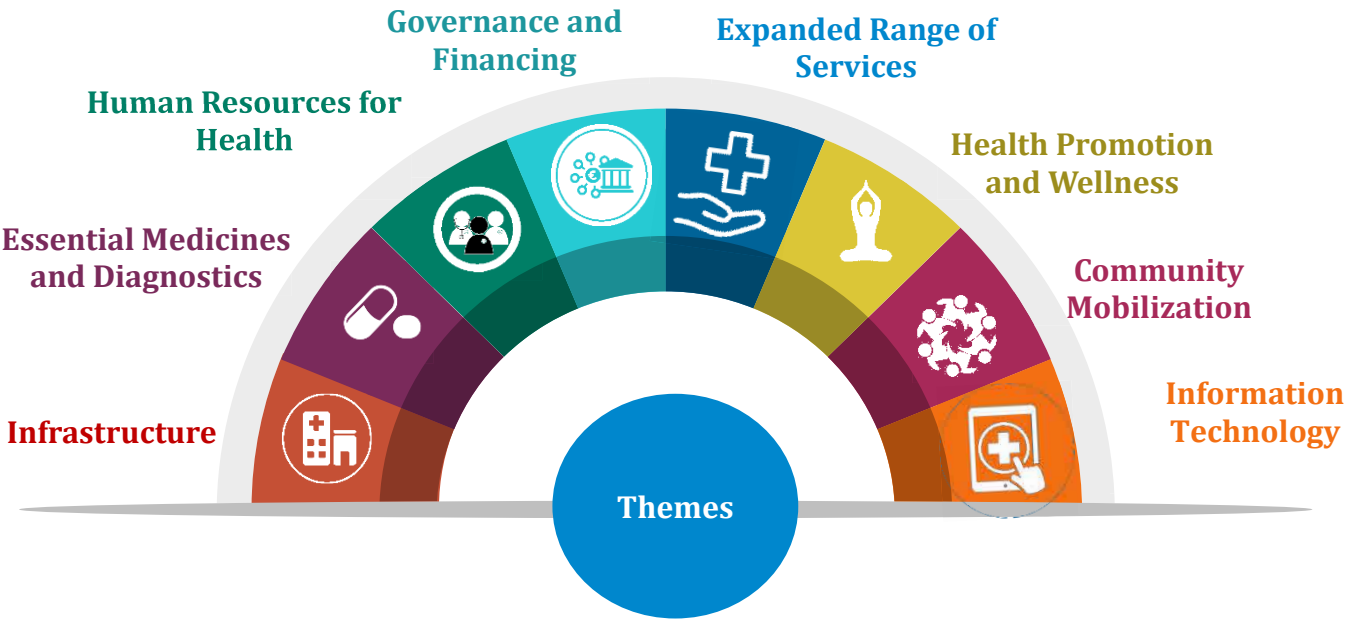
The field visits ensured that the teams had an on-ground understanding of the progress made in operationalizing AB-HWCs. The field teams comprised of senior national government officials, consultants from NHM, NUHM and NHSRC, representatives from Jhpiego and officials from participating states. During these visits, the team interacted with state and district level officials, health functionaries and beneficiaries using well defined terms of reference to get an in-depth understanding of the implementation status. The findings from the field visits were shared during the regional workshops.

The workshop structure comprised of group discussions, sharing of best practices and deliberations on the challenges and way ahead for strengthening CPHC in India. Each workshop commenced with group discussions among participating states to understand challenges in various functional criterion such as human resources, infrastructure, wellness, essential medicines, diagnostics etc. The groups also deliberated about the various solutions adopted by other states to not only overcome the challenges but also examined whether these solutions can be replicated or scaled-up across the country.

Day two of the workshop primarily focused on sharing GoI's vision on universalization of CPHC through AB-HWCs, understanding the progress made on operationalization of AB-HWCs across the states, developing roadmaps for planning and implementation of AB-HWCs in the respective states and lastly sharing state-specific best practices and providing a platform for cross learning.

Report outline

This report aims to capture the major discussions and key recommendations across major themes for strengthening the delivery of comprehensive primary healthcare. Each theme will cover the relevant best practices, challenges and recommendations. The themes are highlighted below:



INFRASTRUCTURE

INFRASTRUCTURE

Ensuring adequate infrastructure and human resources as per IPHS norms is essential for providing CPHC services through AB-HWCs. On the infrastructure front, States/UTs are being supported for infrastructure strengthening as well as branding of AB-HWCs. In this regard, model layout plans for constructing new AB-HWCs have also been prepared and shared with the states.

The GoI also emphasises on patient reception and registration centres, citizen charters, provision of waiting area for patients, other amenities in the waiting area, TV screens for health communication, facilities for people with disabilities, provision of privacy for patient examination/examination table, good quality lab, a pharmacy, a wellness room for conducting yoga/physiotherapy sessions, rehabilitative services, separate toilets for males and females etc. as important elements of infrastructure upgradation.

Essential requirements for strengthening a SHC to serve as a Health and Wellness Centre are:

- ✓ Well-ventilated OPD room with examination and office space for Community Health Officer
- ✓ Storage space for storing medicines, equipment, documents, health cards and registers
- ✓ Designated space for lab/diagnostics
- ✓ Separate male and female toilets
- ✓ Deep burial pit for Bio Medical Waste Management
- ✓ Proper system for drainage
- ✓ Assured water supply that can be drawn and stored locally
- ✓ Electricity supply linked to main lines or adequate solar source, inverter or back-up generator as apropriate
- ✓ Patient waiting area covered to accommodate at least 20-25 chairs
- ✓ Repairs of roofs and walls, plastering, painting and tiling of floors to be undertaken as per requirement
- ✓ Covered space/ room for Yoga, if adequate space for expansion is available
- ✓ Adequate residential facilities for the service providers
- ✓ Rain water harvesting facilities may be planned, if required

Best Practices across States

- **Developing model AB-HWCs layout designs – Maharashtra:** Three patient friendly model layout designs were developed by the state for AB-HWCs for bringing in uniformity in infrastructure, coloring and signage. Orientation workshops and onsite training were given to all state engineers and architects for execution of these designs.
- **Involving Panchayati Raj Institutions for infrastructural upgradation –Kerala:** For developing patient-friendly environment at AB-HWCs, the state involved PRIs for building rain-harvesting mechanisms, libraries at waiting areas and children friendly parks at the AB-HWCs.

- **Development of internal branding strategy for AB-HWCs – Chhattisgarh:** With an aim to extend uniform look and feel and to make beneficiaries comfortable even inside the premises, the state government of Chhattisgarh with support from MCSP led by Jhpiego, developed a comprehensive internal branding including facility branding and IEC materials to be displayed inside the facility. The package empowered the beneficiaries and service providers with strategic use of communication material and also to create a conducive environment at AB-HWCs.
- **Herbal gardens for treatment of waste water – Manipur:** The state had incorporated kitchen gardens with green-leafy vegetables, herbal gardens with medicinal plants and chlorination of waste water in their UPHC AB-HWCs.

Challenges

- Unavailability of comprehensive plan for transformation of existing SHCs and PHCs in rural and urban areas into AB-HWCs over a period till December 2022 across most of the states.
- Vision to build new facilities in place of SHCs and PHCs functioning in rented buildings and in dilapidated conditions has been lacking in the States/UTs.
- States/UTs initiated upgradation and branding of the low hanging/ easily doable facilities for achieving the short term targets; while doing so, quality of upgradation remained a matter of concern in most of the states.
- Most of the states have been able to address the gaps in ensuring availability of basic amenities such as electricity and water supply, however, few requirements as per the operational guidelines, specially, internet facility needs to be expedited by drawing optic fibre from the existing lines or through alternative sources.
- Absence of bio-medical waste management system at SHC AB-HWCs is a concern in most of the states.
- Despite availability of space, wellness activities have not been initiated in few states.
- Maximum infrastructure related gaps in UPHC-HWCs were observed in 5 States – Maharashtra, Uttar Pradesh, Tamil Nadu, Kerala and Gujarat.

Recommendations

- States need to ensure proper planning while selecting the facilities to be upgraded to AB-HWCs through a detailed gap assessment on various parameters of functionality.
- States and districts can leverage funds from alternate sources such as DMF, MPLAD, MLA Development Funds, MNREGA, CSR, ULBs, Gram Panchayats, etc. for repair and new construction work. Old dilapidated buildings should be considered for renovation only after careful review of available resources.
- When new construction is being planned, location of AB-HWCs should be decided through a consultative process involving community, gram panchayat members etc. and preferably located within the built up area of the village or gram panchayat or ward.

- States need to follow proper AB-HWC branding guidelines to main uniformity across. States can also plan for internal branding of AB-HWCs in line with that of Chhattisgarh.
- Identification of government buildings such as community halls of Urban Local Bodies or Corporations or other departments could be prioritized for operationalizing AB-HWCs after necessary renovation especially in urban areas.
- Private buildings could be taken on rent in urban areas, as an interim measure; however, the buildings identified should adhere to the specified infrastructure norms to serve as a AB-HWCs.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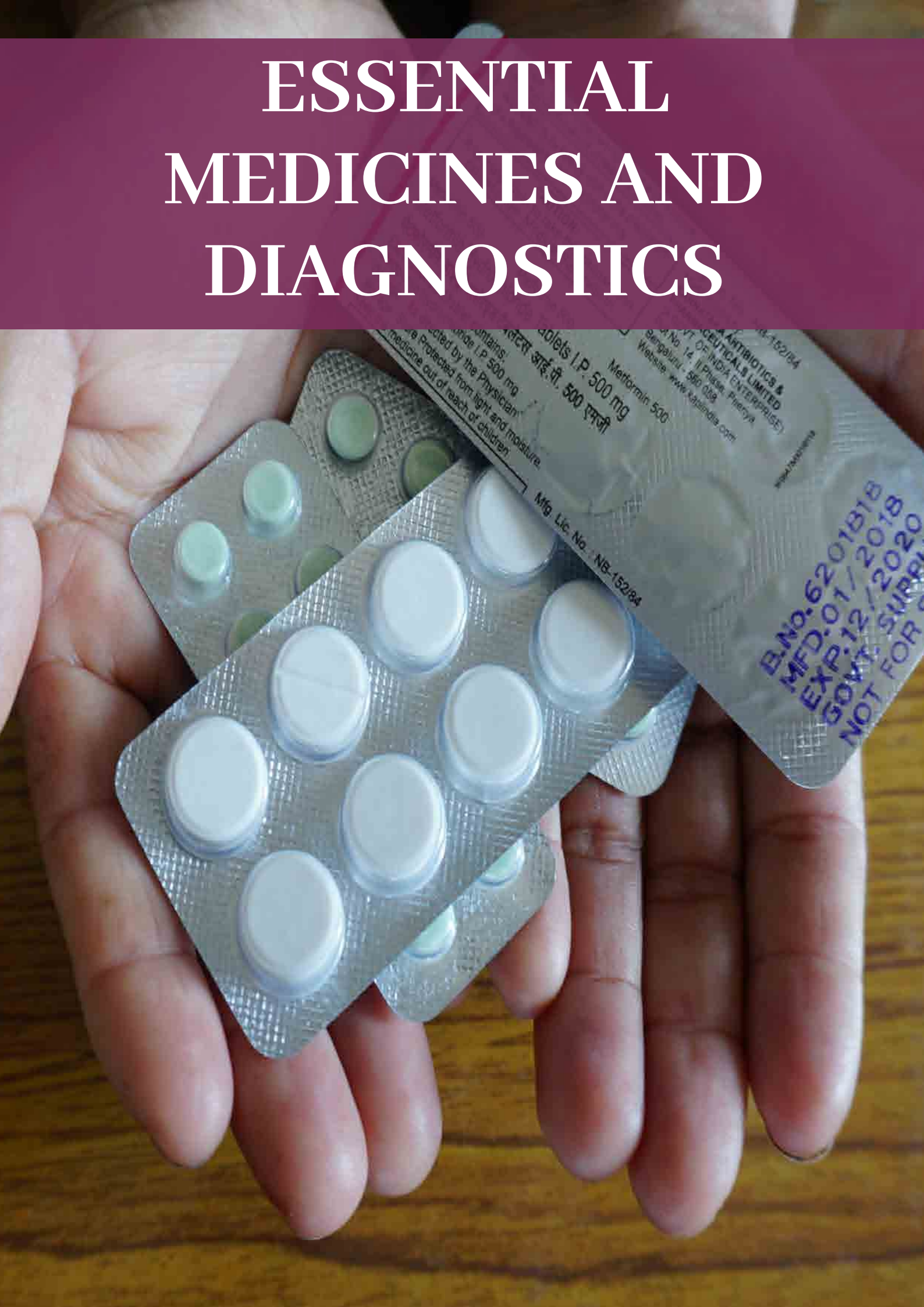
ESSENTIAL MEDICINES AND DIAGNOSTICS



ESSENTIAL MEDICINES AND DIAGNOSTICS

Provision of CPHC services through AB-HWCs rests on the availability of essential medicines and diagnostics for a range of healthcare needs of the population. This is one of the essential components of these transformed AB-HWCs as it will reduce the out of pocket expenditure and increase the footfalls in the public healthcare facilities duly enhancing the health seeking behaviour of the population.

In line with the paradigm shift envisaged, the AB-HWCs will provide a broader range of services and this necessitates expanding the list of essential medicines and diagnostic services currently available at these transformed SHCs and PHCs. Along with the medicines hitherto listed in essential list for the sub health centre, additional medicines like drugs for Hypertension, Diabetes, mental disorders etc. will be required at the AB-HWCs when the package of services will be incrementally introduced. The indicative list of medicines is as per National List of Essential Medicines 2015, will be updated periodically based on new protocols and states will have the flexibility to adapt the list as appropriate.

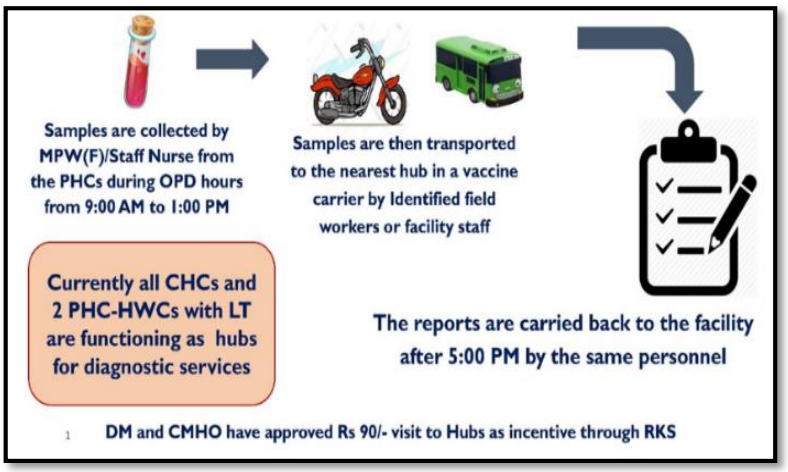
For a patient suspected of common chronic diseases such as Hypertension, Diabetes Mellitus, Epilepsy, etc. confirmation and initiation of treatment will be done by the Medical Officer at the PHC AB-HWC or a higher referral centre. However, for continuation of treatment as per the prescription by the Medical Officer, medicines will be dispensed at SHC AB-HWCs by Community Health Officers (CHOs) to avoid patient hardship and ensure that the clinical condition is monitored regularly i.e. treatment adherence, close to home without any additional travel involved.

Similarly, the AB-HWCs should have the capacity to deliver a minimum package of basic diagnostics and screening services as per the mandate. Diagnostic services as per the Guidelines for National Free Diagnostic Services initiative are to be ensured at these transformed AB-HWCs. In order to provide the essential diagnostics facilities at AB-HWCs, list of diagnostic tests has been expanded to 14 tests at SHC AB-HWCs and 63 tests at PHC AB-HWCs. For additional tests, hub and spoke model may be used or may be referred to nearest linkage facility.

Drugs and diagnostics at the AB-HWCs should be made available as per the specified clinical pathways and standard treatment guidelines initially for the seven packages and incrementally to be made available for all 12 services. Clear treatment protocols will ensure correct and efficacious use of drugs and diagnostics.

Best Practices across States

- **Hub and spoke model for PHC AB-HWCs - Madhya Pradesh:** Expanding diagnostics is one of the key elements for roll out of CPHC through AB-HWCs. Non availability of Lab Technicians and infrastructure at some PHC AB-HWCs in district Khandwa, made it extremely difficult to provide diagnostic services at the point of care. District administration of Khandwa taken an innovative approach to provide diagnostic services by following the hub and spoke model, creating seven hubs (Central Diagnostic Unit) at five CHCs and two PHCs (where lab technicians were available) to provide diagnostic services to 27 AB-HWCs. Samples are collected from the spokes during OPD hours, transported to the nearest hub by transporter (staff or field worker) and the reports are brought back to the spoke facilities in evening. This helped to minimize the movement of the patient and improved the timeliness of reporting.

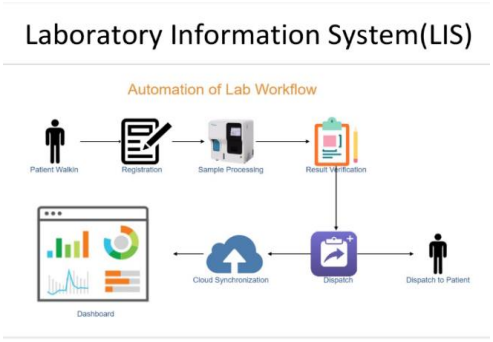


Hub & Spoke Model MP

- **Medical service corporations – Rajasthan and Tamil Nadu** have established a good system of e-procurement of drugs even at SHC AB-HWCs.
- **Fixed day indenting – Chhattisgarh:** In Chhattisgarh, to overcome the shortage of many essential drugs and consumables at the AB-HWCs due to erratic indenting behaviour of staff at HWCs and to ensure buffer stock maintenance, fixed day indenting approach was initiated at two facilities PHC AB-HWC Adenga and SHC AB-HWC Neerachindali of Kondagaon district. The SHC AB-HWCs placed the indents by 2nd of every month to the PHC AB-HWC and subsequently, the PHC placed the cumulative indent on 5th of every month at the state medical service corporation portal. In addition, EDL list was provided to the AB-HWCs for reference while indenting. Due to this, uninterrupted availability of essential drugs was ensured both at PHC and SHC AB-HWCs. Moreover, as SHC is submitting the indent to PHC on regular basis, the PHC is able to maintain buffer stock of essential medicines.
- **Hub and spoke model of selection of trained DMLTs as sample transporters – Tamil Nadu:** The state has developed a model where trained DMLTs will collect samples from 3-4 spokes (PHC AB-HWCs) and transport it to the hub (CHC/DPHL) based on prescribed tests. The transporters also support in conducting test or support Lab Technician at hub facility. Using trained DMLT as transporters helps in ensuring quality during sample collection during transportation.


- **Automation of lab workflow using Laboratory Information System - Tamil Nadu:** State has automated the diagnostic system using Laboratory Information System where cloud based recording and reporting mechanism has been used by the state.
- **State run diagnostic hub – Telangana:** To ease significant financial burden to the patients, health authorities in the state offer all major diagnostic tests free of cost at public healthcare institutions. There are more than 135 public health institutions in the Hyderabad city limits. Eight vehicles bring samples for testing from these health centres to the Central Hub and share the report with health Institutions.

State Run Diagnostic Hub - Telangana



Challenges

Medicines:

- Irregular supply of essential medicines at SHC AB-HWCs and shortage of medicines was a common feature.
- Limited capacity of the states for implementing and expanding Drug Vaccine Distribution Management System (DVDMS) upto SHC AB-HWCs.
- Prescription for chronic diseases has been done by PHC MOs, while dispensation and follow up was being done at SHC AB-HWCs. However, patients were able to get medicines for only 10-15 days in most SHC AB-HWCs due to limited availability of drugs.
- Medicine stock register not maintained properly in most of the AB- HWCs.
- Andhra Pradesh model of provision of supply of essential medicines through Vending Machines does not seem to be cost effective.
- Instructions from PHC Medical Officers on follow-up treatment are not properly documented at SHC AB-HWCs.

Diagnostics:

- Being the first port of call for all the Sub Health centres under it, the PHC AB-HWCs were unable to deliver expanded range of diagnostics due to lack of HR, infrastructure and non-availability of logistics.
- Improper and insufficient planning while executing Hub and spoke model resulting in provision of more number of high end tests at PHC AB-HWCs especially in Public Private Partnership (PPP) mode of provision of services against recommended diagnostics tests.
- There is limited availability of refrigerator at SHC AB-HWCs, which affects stocking of rapid diagnostic kits.
- No structured policy existed for procurement of reagents for diagnostics.
- No screening is being done for common cancers due to lack of capacities and logistics at AB-HWCs.

Recommendations

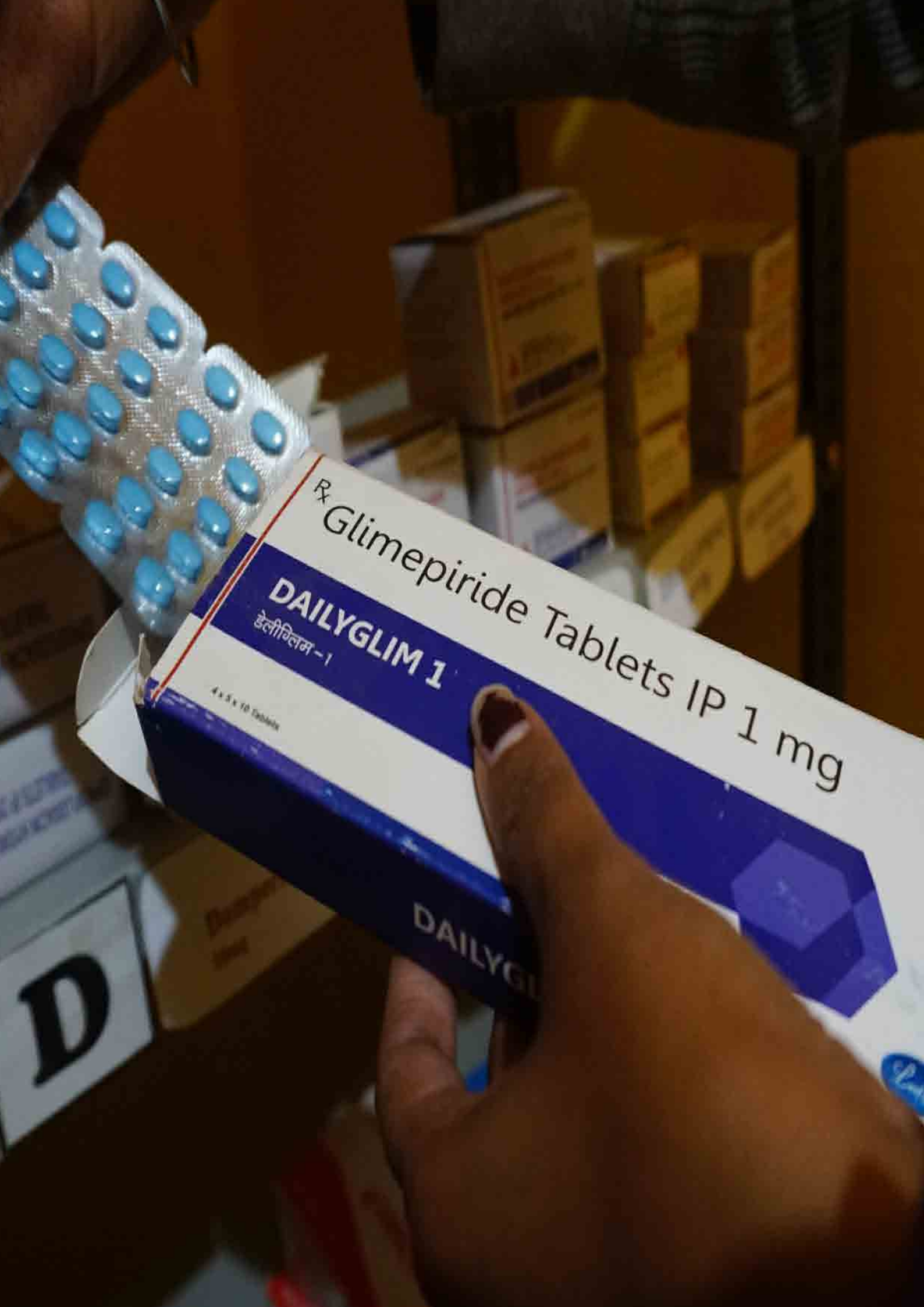
Medicines:

- Planning and designing of strategy for implementation IT enabled drug inventory management (DVDMS) at all transformed PHC AB-HWCs and subsequently, extending till SHC AB-HWCs.
- Finalization of Essential drug list for transformed PHC and SHC AB-HWCs as per the recommendations of the Operational Guidelines for AB-HWCs.
- Ensuring availability of essential medicines including medicines for Hypertension, Diabetes and Mental illness at SHC AB-HWCs for top-up required by the chronic patients and increasing the list of essential medicines as and when new services are introduced incrementally.
- Maintaining buffer stock of at least three months for fast moving and NCD drugs at SHC AB-HWCs.
- To tackle the problem of irregular, erratic and delayed supply of drugs at SHC AB-HWCs, state can adopt mechanism of monthly fixed day indenting
- State may plan structured training of CHOs on drug management and reporting duly having appropriate registers to be maintained at SHC AB-HWCs.

Diagnostics:

- Planning and designing of strategy for provision of expanded range of diagnostics facility at SHC and PHC AB-HWCs, which includes identification of Hub and spoke facilities, provision of auto analyzers at PHCs, mechanism for sample transportation, incentivization of HR, dispatch of results through IT mode, etc.
- There is need to strengthen identified Hub facilities in terms of HR, infrastructure, Equipment, reagents etc. for providing recommended diagnostics tests.
- State may plan structured training of Lab Technicians on expanded diagnostics test

- State need to ensure availability of rapid diagnostics kits at SHC and PHC AB-HWCs for provision of Kit based diagnostic tests.
- State may plan for initiation of cancer screening and diagnosis at AB-HWCs through capacity building of staff and availability of consumables.
- For provision of high end diagnostics tests, state may plan for alternate mechanisms like strategic purchasing from the private sector or strengthening in-house capacity or adoption of a hybrid model; however, strict monitoring and quality check mechanism need to be followed.
- There is need to focus on periodic calibration of laboratory instruments, procurement and supply of reagents on regular basis and strengthening recording and reporting mechanism.
- State may plan to automate the diagnostic system using Laboratory Information System as implemented in Tamil Nadu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HUMAN RESOURCES FOR HEALTH

HUMAN RESOURCES FOR HEALTH

As we move towards improved and patient-centered Comprehensive Primary Health Care (CPHC), having robust and responsive human resources for health is essential. In an effort to promote CPHC, GoI decided to have a key addition to the primary healthcare team at the SHC AB-HWCs, in the form of Community Health Officers (CHOs) who are trained for six-months on a Certificate Programme in Community Health. The CHO will lead the team of existing multipurpose workers and ASHAs to provide the expanded range of services including screening, early detection and address issues of changing lifestyles and treatment adherence.

Besides the addition, it is also envisaged to build a robust primary healthcare team at the AB-HWCs for delivering CPHC services through multi-skilling of frontline workers and service providers at various levels. Presently, the team is being trained on early detection of chronic conditions like Hypertension and Diabetes along with three common cancers and use of IT enabled platform for reporting and ease of follow-up, besides skill upgradation for enhanced community outreach. As and when, newer services are introduced incrementally at the AB-HWCs, members of the primary healthcare team will undergo the required training and skill enhancement for provision of quality healthcare. Efforts are also being made for establishing mechanisms for supportive supervision and mentoring of the primary healthcare team.

In order to motivate the primary healthcare team, Performance Linked Payments (PLPs) have been proposed for CHOs and their team, based on the performance of AB-HWCs. Similarly, states are being pursued to develop well defined career progression pathways for CHOs – an emerging cadre in the system to improve their retention.

As PHC and UPHC AB-HWCs will be the first referral point from SHC AB–HWCs, the primary healthcare team at PHC and UPHC level of AB-HWCs will also need to be initially trained for screening and management of common NCDs and gradually, they will be need to undergo multiskilling for provision of an expanded range of healthcare services like Oral, Ophthalmic, Mental, Geriatric, Palliative, ENT, primary management of trauma and emergency cases, etc. as and when these are introduced incrementally at the AB-HWCs.

Best Practices across States

- **Streamlining CHO recruitment and curriculum- Karnataka:** State has been successful in streamlining CHO recruitment process by decentralizing the recruitment process to district level, partnering with digital agencies for online processing of admission, exams and fee deposition, and strict adherence to timelines after advertisement of posts. Karnataka has also harnessed medical colleges as 'Centre of Excellence' in trainings as Programme Study Centres (PSCs) for the Certificate

Programme in Community Health. Additionally, state has designed a practical skill test thereby, reinforcing the acquisition of skills required by the CHOs at AB-HWCs.

- **Virtual training of CHOs - Uttar Pradesh:** For meeting the huge targets of CHO production and creating a strong mentorship environment, alternate strategy of making trained CHOs available has been adopted by the state in collaboration with KGMU, SIHFW and Jhpiego through virtual training platform. The virtual training pilot is currently underway at five identified Regional Health and Family Welfare Training Centres (RHFWTCs) of the state.
- **CHO performance monitoring system- Assam:** Assam has developed an in-house online system for tracking monthly performance of CHOs with support from Jhpiego to ensure transparency in performance linked payments of CHOs. Performance of CHOs on all indicators is analysed at state level using this single platform, and accordingly the performance based incentives are disbursed.
- **Utilizing existing cadres as CHOs - Assam and Chhattisgarh:** States like Assam and Chhattisgarh have deployed existing cadres of professionals (Rural Health Practitioners in Assam and Rural Medical Assistants in Chhattisgarh) who have been trained for three and half years in medicine, national programs and field activities in place of CHOs.
- **Fixed-day weekly services by Staff Nurses - Kerala:** In order to ensure provision of a comprehensive package of services at the AB-HWCs, staff nurses (who are equivalent of CHOs) in Kerala are following a fixed day weekly schedule as depicted in the table below. Adherence to this weekly schedule has remarkably improved health outcomes in the catchment area of AB-HWCs.

Day	Fixed-day service
Monday	Woman Wellness Clinic
Tuesday	Field visit of priority households
Wednesday	Screening of children <5 years for 4Ds; follow-up of children w/ 4Ds
Thursday	Chronic diseases clinic - Patient groups and peer support
Friday	School visit: Adolescent outreach clinic
Saturday	FHC Duty – Pre-check and patient care; restocking of consumables
Sunday	Weekly off

- **Arogya Samanvay – Gujarat:** A pilot project of having a 21-days integrated model of Certificate Programme in Community Health training of CHOs is being undertaken with the plan of a state-wide scale-up eventually. This project has been launched to integrate services of Ayurveda and Yoga in the conventional healthcare system for prevention of illnesses and complications of NCDs, promotion of health through lifestyle modifications, diet, practice of yoga and meditation.
- **Use of alternate accreditation universities- Maharashtra and Uttar Pradesh:** Maharashtra is imparting the Certificate Programme in Community Health through

its state university i.e., Maharashtra University of Health Sciences to meet the huge demand for CHOs. By doing this, Maharashtra has developed a capacity of training 6300 candidates per batch. Similarly, to expedite CHO production, Uttar Pradesh has roped in KGMU for conducting examination and certification of CHOs.

- **Quality Assurance of CHO training – Uttar Pradesh:** In order to train the required number of CHOs, UP has operationalized a total of 55 PSCs till date. To ensure quality CHO training at scale, the state with support from Jhpiego has implemented a Mentoring and Quality Assurance (MQA) model using structured tools. This model has helped the state in improving the quality of training as well as has enhanced the pass percentage of CHOs to 80%.

Challenges

- Performance Linked Payments to primary healthcare team especially CHOs, are yet to be streamlined. Apart from a few states like Chhattisgarh, Uttarakhand and Punjab, irregular or nil disbursement of PLPs was observed in most of the states.
- Disparity between remuneration of CHOs and MPWs (F) is causing dissatisfaction among CHOs.
- Massive gaps in the quality and duration of the trainings being imparted at the state and district level were observed.
- VIA trainings of staff nurses for screening of cervical cancer are not being undertaken in most of states.
- Vacant HR positions at PHC AB-HWCs especially staff nurses, LTs and pharmacists are a matter of concern in states like Maharashtra, Himachal Pradesh, Madhya Pradesh, Chandigarh, Puducherry, Rajasthan, Uttarakhand, Bihar and Jharkhand.
- Non-availability of dedicated community health volunteers like ASHAs in states like Tamil Nadu led to poor outreach services and linkages in urban areas.

Recommendations

- **Developing a new, robust and responsive cadre of Community Health Officers:** For augmenting the capacity of SHC AB-HWCs for providing the expanded package of services closer to the community, having a new cadre of CHOs is essential. States can decide to take the traditional route of using IGNOU or can explore other public/ state/ medical universities for a rapid scale-up, as done by Uttar Pradesh and Maharashtra. States need to develop a transparent mechanism for selecting a large pool of candidates to improve training quality.

  States can institutionalize District Level Committee of Observers to monitor the quality of CHO trainings. States should also ensure smooth deployment of the newly graduated CHOs with proper induction on their roles and responsibilities at SHC AB-HWCs. Additionally, states can leverage IT platforms like ECHO for continued professional development and mentoring of CHOs. States should also make efforts

towards creating a favorable policy environment for CHOs by developing well defined career pathways, recruitment rules and retention policies.

- **Integrated curriculum for nursing graduates:** To ensure continuous availability of CHOs, the Indian Nursing Council has agreed to integrate the Certificate Programme in Community Health in the existing B.Sc. Nursing curriculum, so that the nursing graduates will be directly eligible for deployment as CHOs (after due selection process), without the six-months training. States need to coordinate with their respective State Nursing Councils for ensuring that the integrated curriculum is introduced in all public and private nursing colleges of the state.
- **Team building:** The concept of team-based approach for healthcare delivery is fundamental for provision of comprehensive primary healthcare. Value-based mentoring on sharing of tasks, delegating responsibility to other team members and collaborative practice are hallmarks of team-based care. Upskilling of existing frontline workers for the expanded role as well as clear delineation of roles and responsibilities among all members of the primary healthcare team will improve their functioning as an effective unit. This in turn, will streamline the functioning of AB-HWCs as they move from a reactive, passive and treatment oriented health-care model to a more responsive, proactive and preventive one.
- **Gap assessment of HR at AB-HWCs:** States should aim at conducting proper gap assessments at the targeted AB-HWCs to understand HR availability and requirement. This can help the states in HR planning by rationalization, inter and intra district transfers and recruitment of additional HR. States may also plan for implementation of HR-MIS to strengthen the HR processes.
- **Multi-skilling of Frontline Workers (FLWs) and other staff in AB-HWCs:** States should earmark budgets in their state PIPs for multi-skilling of all the staff in AB-HWCs and FLWs, along with provisions for their incentives. The trainings must be preceded by a meticulous training needs assessment or an assessment of gaps in skills and competencies of the existing health workforce. States may forge partnerships with academic and training organizations to help deliver such multi-skilling trainings on an ongoing basis. Alternatively, based on the training load, states could look at conducting trainings in a decentralized manner or may explore use of platforms like ECHO, MOOC, SatCom, ZOOM etc. for a wider reach.

GOVERNANCE AND FINANCING

GOVERNANCE AND FINANCING

Governance in the context of health has become one of the essential factors for establishing stronger health systems leading to better health outcomes. There is an established evidence demonstrating that effective and sustainable governance systems are the foundation for building robust health systems to achieve improved health impacts. An increasing number of low- and middle-income countries are attempting to strengthen their health systems and expand access to affordable and high-quality healthcare. But many face barriers, including lack of proper vision and political decision, inefficient use of resources and weak governance structures besides inherent shortages in the healthcare delivery systems. Poor governance, further, undermines the vitality of the healthcare delivery system and makes it less effective, less efficient, less equitable, and less responsive to serving population.

Transformation of existing primary healthcare facilities into Ayushman Bharat Health and Wellness Centres will warrant significant increase in the allocation of resources. GoI recommended to look for alternative sources of funds which can be mobilized to support infrastructure strengthening and service delivery at AB-HWCs for provision of CPHC. These funding sources can be other ministries like Rural Development (NREGA), WCD, Tribal, Mines, MPLADS Funds, MLA Development Funds, CSR, PSUs, Crowdsourcing, Innovation funds and Panchayat/ ULBs.

Best Practices across States

- **Establishing CPHC cell for timely action for operationalization of AB-HWCs - Assam**: In January 2019, state has established CPHC cell headed by the Mission Director. The key roles of CPHC cell was regular mentoring and supportive supervision, gap analysis, sharing field findings in CPHC meetings and expedite the process for filling the gaps. This cell helps to create strong governance system and bring accountability among stakeholders which enabled the state to operationalize 939 HWCs against the target of 878 facilities for FY 2018-19.
- **Empowering village health committees for operationalization of AB-HWCs - Nagaland**: For upgrading SHCs into AB-HWCs, Government of Nagaland involved Village Health Committees in upgradation of facilities. These committees have ensured to maintain funding transparency and monitoring of construction.
- **Leveraging funds through alternative sources - Chhattisgarh:** Recognizing the potential of AB-HWCs in bringing a remarkable improvement in provision of care in Chhattisgarh, many districts collaborated closely with other stakeholders to mobilize alternate funds to fill the gap. Many districts tapped onto the PRI funds for aiding the construction activities, District Mineral Funds (DMF) to procure portable labs to ensure access to free diagnostics, an essential component of AB-HWCs.

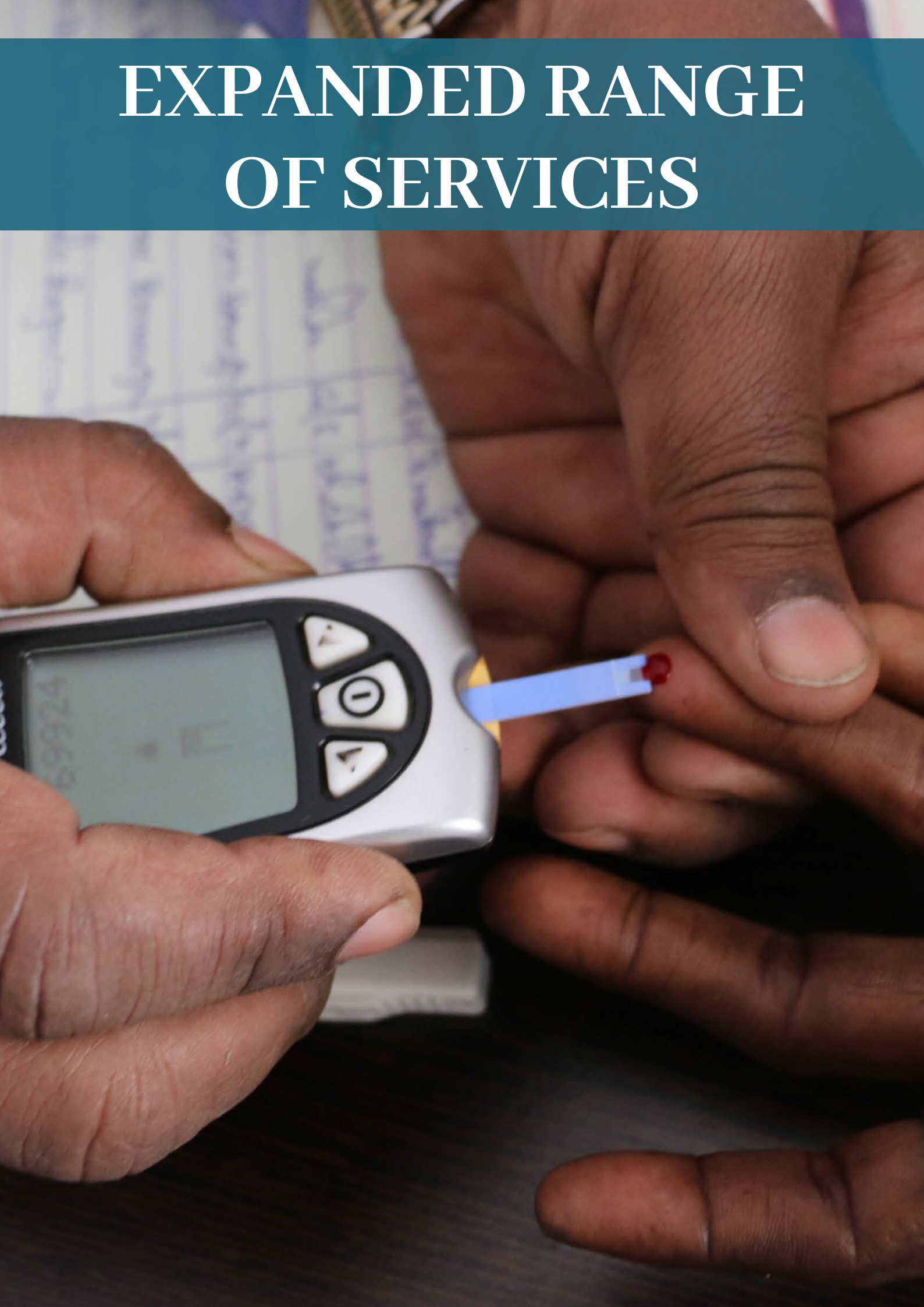
Challenges

- Political will on delivery of quality healthcare system with cost effective interventions on the understanding that investment in health is an economic investment for the States is wanting in most of the States.
- Governance rests primarily with the States. There is considerable heterogeneity in healthcare systems across States in terms of their organizational arrangements, political will, public-private interactions and ultimately, their health outcomes.
- Lack of a clearly laid out road map towards transformation of all its SHCs and PHCs in rural and urban areas into AB-HWCs by December 2022 was observed in most of the States.
- Lack of strategies to leverage alternate source of funding for strengthening health systems and expand access to affordable and high-quality healthcare.
- Tenure of the leaders of the administration is very short in most of the States to have the required momentum continued for ensuring operationalization of AB-HWCs as per the target.
- Capacity and exposure of the middle management of the healthcare delivery system requires to be updated tremendously.

Recommendations

- **Engage stakeholders and bring them on a common platform for better collaboration and co-ordination:** Governance is a collective process of making decisions to ensure continuous vitality and performance of health systems. Formation of governance mechanisms through AB-HWC committees at state and district levels enables different sets of stakeholders to come together to take key decisions for improving health outcomes.
- **Cultivate accountability for long term sustainability:** To facilitate decision-making environment and to ensure transparency and accountability, State and District leadership have to keep track of the work-in-progress which in-turn increases ownership and accountability among the stakeholders
- **Enable a shared strategic direction to build efficient health systems:** States need to establish a strategic direction for provision of comprehensive primary healthcare and bring every stakeholder on the same platform to guide the process forward.
- **Develop strategies to leverage alternate source** of funding for strengthening health systems and expand access to affordable and high-quality healthcare
- **Creative public demand for quality and affordable healthcare**: Awareness towards supply of assured availability of quality and affordable healthcare delivery at public healthcare facilities should be created so as to ensure the required political will for continued support required for strengthening healthcare delivery system in the System.

EXPANDED RANGE OF SERVICES



EXPANDED RANGE OF SERVICES

India has witnessed significant improvement in the delivery of maternal and child health services during the past decade by strengthening provision of RMNCH+A services at primary, secondary and tertiary level. While mortality and morbidity due to communicable diseases and RMNCH+A still remains an unfinished agenda, the non-communicable diseases and injuries are increasingly affecting the health of the people. Among the multitude of factors, lack of comprehensive primary healthcare services at the level of community is considered to be the one of the crucial factors responsible for poor health outcomes in the country.

Essentials for delivering expanded package of services

- ✓ Adequate, appropriate, motivated and responsive human resources
- ✓ HR trained for provision of additional services
- ✓ Medicines, diagnostics, equipment, and consumables based on type of services envisioned
- ✓ Treatment protocols with standardized forward and backward referral pathways
- ✓ Well-coordinated primary healthcare team, including ASHAs, to ensure treatment compliance and regular follow up
- ✓ Adequate community awareness on availability of expanded package of services

The true essence of AB-HWCs is to provide comprehensive healthcare at the level of community while safeguarding principles of universal health coverage. Currently, the existing primary healthcare facilities are providing limited services under RMNCH+A and few national health programs. The recommended expanded range of services is depicted in the picture below:

Expanded Package of Services

Strengthening primary healthcare facilities to provide all the above mentioned services across all functional AB-HWCs is a long-term goal. In this regard, it has been decided to incrementally roll out new services in a phased manner. As the training modules on common NCDs for service providers were available and most of the states had some experience in implementing Population based Screening (PBS) for common NCDs, so services for prevention, screening and management of NCDs were introduced initially at all the functional AB-HWCs. However, many states have taken initiatives to introduce additional services at their AB-HWCs through state specific innovations and some of these initiatives are summarized in the section below:

Best Practices across States

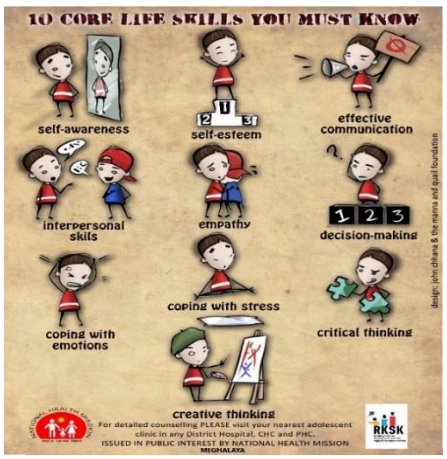
- **Innovative approaches for NCD screening:** While most of the states have rolled out NCD services at AB-HWCs, few states initiated **NCD screening on campaign mode** (Odisha, Chhattisgarh, Madhya Pradesh) or **involvement of self-help groups** in increasing the awareness about NCD screening (Arunachal Pradesh); Jharkhand and Meghalaya have provided **NCD Screening kits** to MPWs-F to facilitate population based screening at community level.

NCD Screening Kit

- **Deputation of counsellors to Sneha Clinics- Karnataka:** Realizing the importance of **adolescent health services,** Karnataka deputed counsellors to **Sneha Clinic -** clinics for adolescents, for providing quality counselling services at AB-HWCs.
- **Expanded range of services - Tamil Nadu:** Tamil Nadu has taken a number of measures for expanding healthcare services at AB-HWCs. These include- **mental health counselling** services at facility or through toll free number 104; home based **geriatric and palliative care** through dedicated Palliative Care Nurse; **polyclinic** – provision of Fixed day specialized services (Ophthalmic, ENT, Dentistry, Ortho and

Physiotherapy, Psychiatry, Obstetrics and Gynecology, Dermatology, Pediatric, General medicine) at UPHC AB-HWCs in public private partnership (PPP) mode.

- **Weekly geriatric clinics -Telangana:** State is organizing weekly geriatric clinics at SHC AB-HWCs, PHC AB-HWCs and Basti-Dawakhanas (urban health facilities below UPHC level and recognized as AB-HWCs), for providing palliative care through NGOs.
- **Healthcare for elderly population -Maharashtra:** Maharashtra has modelled provision of healthcare services for elderly at AB-HWCs in Chandrapur District through a team of trained MOs, MPWs and ASHAs. The services include- weekly clinics, physiotherapy services, diagnostic services, health education sessions, and referral services.
- **Provision of ophthalmic services at AB-HWCs**: **Maharashtra** collaborated with Netradan Trust to ensure ophthalmic care, referral and follow up at AB-HWCs; **Karnataka and Chhattisgarh** have deputed an ophthalmic assistant to PHC AB-HWCs to conduct regular OPD services and refer the suspected/high risk cases to higher centres for further management. Owing to its considerable truck driver population, **Haryana** organized camps for identifying and treating ophthalmic problems in truck drivers at UPHC AB-HWCs. **Tripura** initiated **tele-ophthalmology** services at block level for early diagnosis, treatment and timely referral of complicated cases.
- **Community/ Local self-government owned palliative care services: Kerala (through its Family Health Centres) and Tripura** have taken efforts to roll out palliative care services. In Kerala, the service providers and community stakeholders have been trained to provide facility and home based palliative care. The required resources (catheters, colostomy bags, Ryles tube, drugs, mobility support and honorarium) have been made available to ensure quality services. Similarly, Tripura ensured skill upgradation of its Community Health Officers for home-based palliative care by training them on palliative care during the six-month Certificate Course in Community Health.
- **Generating awareness among adolescents - Meghalaya:** A month long campaign was conducted in the state to address adolescent health issues like- teenage pregnancy, substance misuse, vulnerability to RTIs/STIs, nutrition and physical fitness, mental health and wellbeing, oral health, skin diseases and NCDs. Several activities including screening camps, fun-fests, sports activities, cyclothon, beauty contest, dancing and singing competitions, road shows and rallies were conducted during the campaign to increase awareness on AB-HWCs by engaging adolescents.





RKSK celebrations with the theme of Health and Wellness

Challenges

- **Multiskilling activities**: Many states have deviated from the prescribed training guidelines which in turn affects the quality of training. Examples include- **Puducherry** – Only one-day VIA training being given to ANMs; **Telangana**- primary healthcare Teams were given only one-day training on population based Screening for NCDs; **Andhra Pradesh –**ASHAs given only one-day training on NCDs; **Jammu and Kashmir** - NCD trainings were not being conducted as per guidelines and VIA trainings not yet started; **Gujarat** was yet to start formal trainings on common cancers; **Rajasthan, Bihar and Himachal Pradesh** were yet to start trainings on NCDs.
- **Strengthening RMNCHA+N services**: All RMNCHA+N services are not being provided in **Himachal Pradesh**: Routine immunization sessions are being provided as fixed-day facility-based services in **Chandigarh and Jammu and Kashmir**; No fixed day for conducting VHSNDs and outreach RI sessions in **Arunachal Pradesh**.
- **Follow-up and failure to ensure treatment compliance** at the community level emerged as a major challenge across all states except Kerala and Tamil Nadu. This is particularly more important for chronic diseases and NCDs to ensure continued treatment and regular checkups.
- **Referral protocols and standard treatment workflows** for CHOs are not available in many of the states.
- **Streamlining referral linkages**- Referral linkages among the transformed primary healthcare facilities and higher referral facilities for managing the complicated cases are currently missing in most of the states. The major issues include lack of coordination among service providers, inability of higher level facilities (block PHCs or CHCs) to manage referrals for expanded range of services and missing focus on strengthening the referral facilities for ensuring continuum of care. Most of the states are yet to identify suitable mechanisms for streamlining referral linkages.
- **Piecemeal approach in operationalization of AB-HWCs**: Due to lack of adequate number of CHOs, many of the states are unable to transform all the SHCs under a functional PHC AB-HWC into AB-HWCs.
- **Missed opportunity**: Inability to ensure uninterrupted and regular supply of medicines, diagnostics, equipment and consumables leading to shortages will affect the continuum of care as well as the utilization of AB-HWCs by community.

Recommendations

- To begin with, states need to focus on strengthening delivery of RMNCH+A services, screening and management of common communicable diseases and common NCDs, at all their functional AB-HWCs. Additional services from the package of 12 recommended services can be introduced incrementally, based on the need and capacity of providers, after providing required resources and skill upgradation.
- Ensuring regular PLPs to the primary healthcare team of AB-HWCs will be a motivating factor. Additional indicators for PLPs may be added, once the additional packages are rolled out at all the AB-HWCs.
- Expansion of services must go hand in hand with strengthening existing services especially RMNCH+A services and the national health programs.
- Cross learning from the states who have implemented additional services successfully at the primary healthcare level.
- Facility and specialist service mapping for providing secondary and tertiary care at public healthcare facilities (CHCs, SDHs, DHs and State Medical College Hospitals) for continuity of care.
- Roll out of Telemedicine services at all PHC AB-HWCs for initiating specialist consultations.
- Streamlining Referral linkages by tracking referrals, setting up help desks at receiving facilities, priority management of referral cases and nominating focal persons at the referring and receiving facilities.

HEALTH PROMOTION AND WELLNESS

HEALTH PROMOTION AND WELLNESS

Government of India has taken many significant initiatives to ensure Healthy Population through improved intersectoral convergence and peoples participation. With increasing life expectancy, it is more important to create an enabling environment for building a healthy India which is free of disease or disability. And in this direction, Ayushman Bharat Health and Wellness Centres (AB-HWCs) are being established to deliver Comprehensive Primary Health Care (CPHC). CPHC ensures highest possible level of health and well-being for all at all ages, through a set of preventive, promotive, curative and rehabilitative services. By acting as the first contact to community for comprehensive services, AB-HWCs are positioned to provide quality healthcare services without anyone having to face financial hardship by improving access and lowering the cost of healthcare delivery. Evidences have also shown that efforts to improve provision of wellness activities will directly improve wellbeing of the community and thereby reducing catastrophic expenditure on healthcare.

Preventive and promotive health is one of the essential components of AB-HWCs. Some of the major initiatives taken by The Ministry of Health and Family Welfare (MoHFW) in this regard are detailed below:

- **Training of Service Providers**: ASHAs and other frontline workers (MPW - M & F) are being trained for creating awareness among the community and motivating individuals to adopt healthy life style.
  - ✓ The primary healthcare team, in partnership with VHSNCs, are oriented and enabled to organize wellness campaigns at village level such as marathon and traditional /local games during the Fit India Campaign on fixed days.
  - ✓ "*Health Talks*" by the primary healthcare teams to highlight benefits of healthy life style for improved health outcomes.

Primary healthcare team including CHOs, ANMs, ASHAs in collaboration with local elected representatives are acting as change agents for health promotion and wellness at the community level.

- **Annual Health Calendar**: The MoHFW is also providing support to states to implement an "*Annual Health Calendar*" with series of wellness activities throughout the year on selected health days. During these health days, special events like health talks, patient support group meetings, rallies, sports events like marathon, walkathon, cycling, traditional games etc. are organized to promote adoption of healthy lifestyle. The states may also plan to organize localized competitions like TB Free Villages based on the availability of resources, locally and culturally acceptable practices with a focus on local disease burden and social issues
- **Physical Activities:** The AB-HWCs are also envisaged to promote wellness activities by regularly organizing events such as yoga or other physical exercise like aerobics, Zumba etc. Nearly 20,000 operational AB-HWCs are undertaking yoga activities and

over 3 lakh sessions have been conducted across the country so far. This has been planned in partnership with AYUSH Ministry where a trained yoga instructor is engaged to conduct yoga sessions either at the AB-HWCs or at an identified site in the vicinity of AB-HWCs. The minimum Yoga protocol, developed by AYUSH and MoHFW, is being used as a base document to guide the counselling and yoga sessions.

- Through **Eat Right India- Sahi Bhojan Behtar Jeevan** (Right diet leads to better quality life) initiative, Eat-Right toolkit and Food Safety kit (Magic Box) have been developed in partnership with FSSAI. The primary healthcare team at SHC AB-HWCs and PHC/UPHC level AB-HWCs are to be trained to use the tool kits and spread awareness amongst the community on eating healthy and safe food. The major features are:
  - ✓ **Eat Right** movement in which the entire AB-HWC team of Community Health officer, ANM, and ASHA are to be trained on various aspects of nutrition including Food Fortification, Limiting the consumption of foods high in fat, sugar and salt, Hygiene and Sanitation, Food Safety and Safe Food Practices and use of local foods. There are also to be used as aids for the team while explaining these concepts to the community.
  - ✓ **Food Adulteration Detection Kits or Magic Boxes.** These kits will be placed at PHC/UPHC level AB-HWC and the community members can come and check and detect food adulteration with the help of Lab Technicians at AB-HWCs.
- **School Health Programme**: The MoHFW and Ministry of Human Resource Development (MHRD) have jointly drafted comprehensive School Health Programem (SHP) guidelines to foster the growth, development and educational achievement of school going children by promoting their health and wellbeing. Through this, there are active efforts for ***screening of adults*** for early detection of high risk individuals with unhealthy lifestyle habits and at the same time promoting for healthy lifestyle changes. The programme is planned to be implemented by two teachers identified in every school as "**Ayushman Bharat -Health and Wellness Ambassador".**
- **Changes in School Curriculum:** A 24-hour curriculum has been designed by NCERT (National Council of Educational Research and Training) in conjunction with various experts from health department. The Health and Wellness Ambassador will transact age appropriate, culturally sensitive activity based sessions for one hour per week in a year to promote joyful learning. As part of the AB-HWC, Ayushman Ambassadors will be created from among the children attending schools. The Ayushman Ambassadors will be trained to create awareness about health lifestyle among the peers at school and at the community level.

Best Practices across States

- **PRI Involvement in palliative care- Kerala:** State has trained their ANMs for 3 months on palliative care in every PHC/ Panchayat and the ANMs provided home base palliative care for 16 days in a month at the community level. ANMs provide outpatient services for the rest of days at the facility level. The project is owned by

Local Self-Government and implemented through MO in/charge of the health institution.

- **Yoga and meditation for pregnant women- Odisha:** The state has integrated Yoga and meditation for the antenatal care of pregnant women for improving the health and well-being of mother and child.
- **Provision of yoga at AB-HWCs- Gujarat:** Yoga is being conducted at SHC and PHCs AB-HWCs on a daily basis by trained CHOs/ MPW-M/ ANMs and weekly twice by trained ANMs at UPHCs in the state.
- **Saptdhara to Swasthya -Gujarat:** Saptdhara provide cultural platform to generate awareness for better acceptance of health programs to achieve SDGs. It seeks to health issues by using traditional skills as means to propagate health education in communities with their participation.
- **Aarogya Samnvay (integration of allopathy and ayurveda)- Gujarat:** Along with treatment of disease, emphasis is given on prevention of disease and promotion of health through integration approach.
- **Expanded wellness activities- Goa:** The state has initiated laughter clubs in the catchment areas of AB-HWCs as a part of wellness activities.
- **Wellness beyond Yoga- NE states:** The NE states have engaged local youth and taken up locally acceptable sports formats like football, volleyball and dances like aerobics, Zumba as wellness activities.
- **Herbal garden at PHCs- Meghalaya:** State health department in collaboration with AYUSH mission has initiated herbal gardens at PHCs in Meghalaya.

Challenges

- States are unable to plan and design their wellness strategy for expanding scope of wellness under AB-HWCs. The activities to strengthen preventive and promotive healthcare are not given equal importance as of activities to strengthen curative services.
- Lack of clearly laid out Wellness Plan at AB-HWCs by the states.
- Unable to streamline Yoga services due to limited availability of certified yoga trainers and limited space at facility level.
- Social and environmental determinants of health like water, sanitation and nutrition are also not focused by the states.
- Unable to rope in non-governmental/ faith based organizations and other players who are experienced in rolling out wellness activities at community level
- States are yet initiate activities towards creating awareness on the importance of primordial prevention and adoption of healthy lifestyle habits among the school students

- No efforts taken towards co-opting PRIs, ULBs, MLAs and MPs for their support to use their Local Area Development Funds in creating open gyms and other public spaces for wellness activities.
- Failure to rope-in strong Self Help Group (SHG) system of the states in both rural and urban areas

Recommendations

- **Social Movement**- Ayushman Bharat Health and Wellness Centres to lead a social movement for wellness activities by promoting community participation, engagement and ownership
- The **Vision Document** to operationalize AB-HWCs to incorporate comprehensive plan **and strategy for wellness** based on the local context and disease burden
- **Widen the scope of wellness** beyond yoga by inclusion of culturally relevant and locally feasible activities like- Sahi Bhojan, Behtar Jeevan – Eat Right Campaign; TB Free villages/ Healthy villages; Celebration of Health days; promoting medicinal Plants and their use; Health Talks; Counselling clinics/ Laughter clubs; aerobics, walkathons, cyclathons and Zumba
- **Promote intersectoral convergence** and collaboration among Health, Education, WCD, MoHUA, Rural Development, PRIs, NRLM, NULM, Smart cities to create an enabling environment for practicing regular wellness activities.
- **Planning in advance for celebration of health days** to create awareness across the community.
- **Capacity building** of frontline health workers on soft skills to improve community engagement.
- **Sustainable yoga through community engagement**: States may identify local people in the community for their training and capacity building on yoga. After the training, they can be utilized as yoga instructor in AB-HWCs on rotational basis and to create behavioral change in the community.
- The primary healthcare team at AB-HWCs HWC can be motivated to lead as a "role model" by adopting active healthy life style. A competition among the healthcare teams to incentivize and motivate them can be planned.
- Involving Indian Medical Association, Nursing Association and similar other associations can be included as part of social media campaign and through events organized at meeting of these organizations to be led at state level by respective Health Departments and at central level by MoHFW.

COMMUNITY MOBILIZATION

COMMUNITY MOBILIZATION

Community Mobilization is the cornerstone and absolutely essential for universalization of Comprehensive Primary Health Care (CPHC) at all levels. Community Action for Health has shown concrete improvement in health indicators in some states with intensive processes under the NHM. This clearly suggests that there is a need for upscaling and strengthening the efforts for communitization under AB-HWCs. The objective of community mobilization is to generate supply side push combined with demand side pull and active feedback from healthcare users. Increased community participation in healthcare clearly empowers governance and accountability at all levels.

Population enumeration and population based screening are being undertaken in all functional AB-HWCs for identification and early detection of diseases at the community level. Efforts are being made to engage community through frontline staff including ANMs and ASHAs along with local elected representatives. Platforms like VHSNDs and outreach camps are also being utilized for identification and referral of at-risk population to the AB-HWCs and higher facilities for confirmed diagnosis and management.

Community level activities will also be conducted for creating awareness and generating demand for CPHC services available at AB-HWCs. States may leverage digital technology and local NGOs for community mobilization efforts, resulting in increased uptake of healthcare services at AB-HWCs.

Best Practices across States

- **Campaign mode screening for NCDs - Odisha:** State conducted a month long campaign for screening of male and female population aged above 30 years. Special IEC/BCC strategy was deployed for the campaign to improve awareness on NCDs and focus on community engagement through use of existing platforms like Gram Kalyan Samitis, patient support groups and activities like Swasthya Kanthas (health walls). These efforts resulted in NCD screening of about 3 million beneficiaries.
- **Expansion of population based screening to universal screening for NCDs – Himachal Pradesh:** The state has gone beyond the mandate of NCD screening of 30 plus population and has initiated the screening of 18 plus population for common NCDs.
- **Community awareness programme - Manipur:** The state is conducting community awareness programs at all SHC AB-HWCs before their inauguration for acquainting the local community with the healthcare services to be rendered by AB-HWCs. These awareness programs are conducted by the newly posted CHOs by engaging village chiefs and local PRI members. These awareness programs have resulted in

building a good rapport with community, thereby, enabling accountability right from the beginning and high footfalls at the AB-HWCs.

- **Construction of wellness room and community kitchen - Nagaland:** The state has engaged local Village Health Councils (VHCs) for construction of wellness room at AB-HWCs to ensure transparency and community ownership. Villagers have also constructed one kitchen at AB-HWCs as a sign of community participation and have supported timely completion of infrastructural upgradation.

- **Innovative approach for population based NCD screening - Jharkhand:** State has distributed NCD kits comprising of all essential instruments and consumables required for NCD screening to ANMs for conducting Fixed day village wise NCD screening. Village level micro plans are developed for NCD screening for easy mobilization of the eligible population and also reducing travel time for the community to less than thirty minutes.

Challenges

- Limited capacity and lack of a clear strategy for community mobilization at the state and district levels.
- Preventive and promotive services involving community are yet to gain momentum in urban and tribal areas. Even in rural areas, the SHC AB-HWCs are still perceived as centres for maternal and child healthcare services.
- Limited ownership and poor health seeking behavior of the community (urban poor, tribal and remote population).
- Low pace of population based screening for common NCDs especially in urban areas due to various constraints.
- NCD screening limited to Hypertension and Diabetes in most of the states and screening for common cancers is yet to start due to limited capacities and infrastructure.
- Limited supply of hardware and software at the field level is affecting the digitization of population enumeration and NCD screening data into the designated applications/ portals.
- Lack of follow up and gate keeping mechanisms at community level.

Recommendations

- Planning and designing a comprehensive community mobilization strategy based on the local context. The strategy may include a mix of community engagement materials, behavioural communication tools and job aids and may focus on some key aspects such as:
  - ✓ Increasing visibility and awareness generation on AB-HWCs
  - ✓ Facilitating change in community through community engagement
  - ✓ Strengthening facility level activities for enhancing health seeking experience
- Active engagement of community in ensuring accountability of healthcare providers and quality of care at AB-HWCs through existing community platforms like VHSNCs, panchayats, MAS, Rogi Kalyan Samitis etc.
- Leverage technology for generating community awareness on the additional services at AB-HWCs.
- Engagement with local NGOs, PRI members and development partners for concerted community mobilization efforts.
- Involvement of MAS members/ local SHGs in community mobilization and outreach activities especially in urban areas in absence of ASHAs.
- Planning for training load and training calendars for capacity building activities for service providers and frontline staff on population enumeration and population based screening.
- Assured availability of hardware, software and capacity building support for digitization of population enumeration and NCD screening data.

INFORMATION TECHNOLOGY

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Use of Information Technology (IT) to its full potential can bring radical changes in the delivery of healthcare in both urban and rural areas. Realizing the importance of IT, Government of India is taking significant efforts to streamline its use across primary, secondary and tertiary levels of healthcare. In this regard, it is mandated to have a robust IT system at Ayushman Bharat-Health and Wellness Centres (AB-HWCs). When made fully operational, the IT system is envisaged to facilitate following key activities:

Essential components of IT System:

- ✓ Functional laptop/desktop at PHC/ UPHC level AB-HWCs
- ✓ Functional tablet with CHO and MPW at SHC AB-HWCs
- ✓ Functional smartphone for ASHAs
- ✓ Internet connectivity
- ✓ Use of NCD application and MO portal
- ✓ Daily entry of service statistics in AB-HWC portal
- ✓ Teleconsultation services

- Population enumeration and empanelment of all individuals and families residing in the catchment area of AB-HWCs.
- Assist healthcare providers in providing care and regular follow up as per standard treatment guidelines, managing referrals, easy maintenance of health records and undertaking health promotion activities by using effective IEC/BCC materials.
- Support facility in-charges in maintaining adequate supply of logistics, medicines, equipment, diagnostics and consumables.
- Provide a platform for capacity building and continuous learning of primary healthcare team.
- Roll out of tele-consultation services to bridge gaps in the continuum of care.

Best Practices across States

- **Follow up of NCD cases - Tamil Nadu**: State owned application uses color coding in the NCD portal for follow up cases. It has an inbuilt feature of sending alerts and messages to the diagnosed cases for regular follow up and maintaining healthy lifestyle.
- **Tele-consultation - Andhra Pradesh:** With general practitioners and nurses already available at the UPHC AB-HWCs, state is leveraging IT to provide specialty services through tele-consultation. Additionally, e-health records, which are crucial to ensure continuum of care, are accessible throughout the state.
- **Tele-ophthalmology- Tripura:** State is providing eye care to beneficiaries by linking the PHC AB-HWCs to IGM Hospital (medical college hospital) through Tele-ophthalmology. Currently, these services are available across 44 AB-HWCs.
- **E-Arogya - Dadra and Nagar Haveli**: Cloud based health ecosystem named e-Arogya is functional across all public health facilities of Dadra and Nagar Haveli.

- **Tele-Consultation** facility is available at PHC AB-HWCs using hub and spoke model in public-private-partnership mode in Jharkhand.
- **Odisha** had incentivized the entry of population based screening data (CBAC, family folder, individual health card) in CPHC IT application.
- **Chhattisgarh** state has ensured NCD application, NCD MO Portal and AB-HWC portal are put into use at all operational AB-HWCs. The portals were found to be updated on a daily basis during the field visit.

Challenges

- Limited use of AB-HWC portal/ NCD app by CHOs and MOs at AB-HWCs was reported in Arunachal Pradesh, Karnataka, Haryana and Andhra Pradesh mainly due to issues such as poor availability of internet, user ID and password related issues, non-availability of tablets and lack of training or orientation of the service providers.
- Non-availability/partial availability of IT system was found in Assam, Karnataka, Punjab, Bihar, Haryana, Chandigarh, Chhattisgarh, Dehradun, Goa, Manipur, Puducherry and Tripura due to delay in procurement and/or distribution of tablets/ computer/ laptop, lack of internet connectivity, camera for teleconsultation and smartphone for ASHAs.
- Lack of on-site mentoring to end users on the operational aspects or troubleshooting mechanisms of the IT equipment and applications.
- Lack of regular reviewing of IT system by state leadership and lack of any state level data validation mechanisms leading to poor quality data being fed into the system.
- Availability of internet connectivity especially in rural and tribal areas.
- Distribution of tablets without loading required apps leading to delay in initiation of IT application based services.
- No protocols in place or the service providers are not aware about the actions to be taken in case of damage or loss or breakdown of IT equipment.
- As the IT applications and equipment are still in nascent stage, service providers are obligated to use both the manual and digital formats. This leads to duplication of work and unnecessary storing of physical formats at health facilities.

Recommendations

- Situational analysis of IT infrastructure across public healthcare facilities in the States and ensuring availability and functionality of essential IT equipment across all functional AB-HWCs.
- Procurement and timely distribution of all necessary IT equipment to AB-HWCs.
- Developing time-bound action plan in consultation with appropriate technical partners (TATA trust in case of NCD application/MO portal) to train and orient all the service providers. Care has to be taken to ensure there is no time gap between training/orientation of service providers on use of IT equipment/application and distribution of the IT equipment.

- Institutionalizing review mechanisms for IT systems during the state and district level review meetings. The performance indicators derived from the IT applications need to be used in these meetings which can in-turn improve the quality of information entered by service providers.
- Incentives to expedite the process of digitalization of all data and records.
- Development and dissemination of standard protocols for maintenance of IT equipment.


Flush toilet with running water
Flush toilet without
Pit toilet with running
Pit toilet without water
Other
SAMSUNG

WAY FORWARD

WAY FORWARD

Ayushman Bharat or "Long Live India" – flagship programme of the Health Ministry with its two inter-connected components of AB-HWCs and PMJAY - was launched with a larger vision of achieving UHC in India. This initiative has been designed on the lines of the global sustainable development goals with an underlining commitment to "leaving no one behind". The initiative aims to undertake path breaking interventions to holistically address all aspects of health care (including prevention, promotion and ambulatory care), at primary, secondary and tertiary level. This bold vision requires concerted and committed efforts from all stakeholders to work together and make accessible, affordable and quality primary health care a reality in India.

Since public health is handled by the states, planning by states becomes imperative and all the states/UTs should develop a clear Road Map for delivery of CPHC services through AB-HWCs as discussed below:

- **Move towards a structural reform of health systems:** Provision of CPHC services through AB-HWCs requires a larger systemic change. There is a need to move from ad-hoc mechanisms to a more comprehensive and structured planning and vision to bring out a structural reform in the health systems.

- **Rigorous financial planning:** As recommended in the National Health Policy, 2017, the states should strive to allocate two-third of their health budget to primary health care. This is a key step towards ensuring availability of adequate financial resources for strengthening delivery of comprehensive primary healthcare through AB-HWCs. In addition, alternate sources can also be explored for leveraging funds such as MPLADs, MLA-LADs, MLA-Development Funds, CSR funding, ULBs and PRI funding, inter-sectoral convergence with MNREGA etc.

- **Strengthening infrastructure at all levels for better functioning AB-HWCs:** Besides strengthening existing public health facilities for basic amenities such as regular water supply and electricity, it is important to do need analysis on the infrastructure requirement of different levels of public healthcare facilities as per population norms. The newly transformed facilities should have sufficient space for toilets, additional room as per the norms, space for medicine dispensing, laboratory investigations and patient waiting areas as per the approved layout plans.

- **Assigning population to AB-HWCs:** Success of CPHC lies in definite assignment of population to the primary health care facility. In the context of AB-HWCs, as far as rural areas are concerned, service area population under SHC AB-HWCs needs to be assigned to them. While in case of urban areas, despite allotting the service area population to the urban healthcare facilities, the focus should be on community outreach activities for vulnerable and urban poor population. After each household is

assigned to the nearest AB-HWC, family folders need to be created for each household at SHC AB-HWCs and the individuals will have to be given a health diary, to update treatment given at the AB-HWCs and higher facilities on referral, till IT based solutions are developed. States should also plan to harness digital technology by digitizing the family folders and health diaries. PHC level AB-HWCs should be the first port of call for all types of OPD treatment for every person seeking care through the public system while the subsequent monitoring and dispensation of medicines for chronic conditions should be the responsibility of SHC AB-HWCs.

- **Ensuring continuum of care as a key principle:** It is essential to focus on ensuring continuum of care across the AB-HWCs operationalized. There is a need to establish bidirectional referral linkages to ensure continuum of care. As a first step, the AB-HWCs should be mapped to all public health facilities, especially for secondary and tertiary care.

- **Building a robust primary healthcare team at AB-HWCs:** Primary healthcare teams are the foundation for ensuring the delivery of quality healthcare services to the community. It is essential that all facilities have adequate staff posted across the levels as per IPHS norms. It is also important to plan for capacity building and multiskilling of the staff so that they are better equipped to address the health needs of the population and deliver the expanded range of services. Capacity building on the expanded range of services needs to be planned. Further, it is essential to develop the cadre of the CHOs and plan for their career progression and performance based incentives to ensure retention and motivation of the trained CHOs.

- **Ensuring availability of free essential medicines and diagnostics:** Essential medicines and diagnostics form the foundation for providing primary healthcare through AB-HWCs, which will increase footfall at AB-HWCs, thereby, resulting in the reduction of Out of Pocket Expenditure (OOPE) of the service area population. There is a need to ensure continuous supply of generic medicine at all facilities including maintaining a buffer stock of essential medicines. States also need to ensure availability of prescribed diagnostic tests at AB-HWCs to reduce the OOPE on lab investigations. Further, is it important that the states adopt DVDMS to ensure IT based monitoring till SHC AB-HWCs.

- **Moving from curative to preventive health care:** Wellness is an important component of AB-HWCs as we need to move from traditional curative care to preventive and promotive care. It is important that the AB-HWCs are looked upon as wellness centers rather than centers of disease management. States need to explore various wellness activities beyond yoga, such as walking, regular physical exercise, cycling, marathons at local level, open gyms, awareness on Right Eating Habits, provision of kits for checking food adulteration at PHC level, regular health promotion activities, conduct of fit health professional competitions, recognizing fit citizens from

the community, incentivization of good habits and practices, no-junk-food at schools campaign, etc. The proposed School Health and Wellness Ambassadors also needs to be rolled out and emphasized.

- **Community action for health and wellness:** Finally, to achieve CPHC, it is important to involve and engage communities from the start. Community action is central and essential to achieve the larger goal of health for all. It has been proven that community action for health helps in concrete improvement of health indicators. Involvement of local community groups and NGOs for strengthening outreach will go a long way in enabling an increased demand for services. The supply side push must be complemented with demand side pull and active feedback from healthcare users.

- **Building robust IT system including Tele-Consultation**: Technical advancements have to be leveraged to systematically monitor our progress and tide over the constraints of specialists and human resources. Techniques such as tele-Consultation and ECHO are to be used extensively. Data collection and analysis will provide lot of insights on the policy implementation and determine the necessary corrective measures to be taken.

As the country gears towards achieving UHC, a well-articulated design, derived through consensus, and building on existing institutional and implementation platforms and structures are essential aspects for India to demonstrate the critical role of primary healthcare in achieving Universal Health Coverage. Provision of comprehensive primary healthcare services through Ayushman Bharat Health and Wellness Centres will accelerate India's journey towards Universal Health Coverage.

GLIMPSES FROM THE WORKSHOPS

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Disclaimer: All information provided in this report is updated as on September 30, 2019

Published by:
Ministry of Health and Family Welfare
Nirman Bhawan, Maulana Azad Road
New Delhi - 110011
www.mohfw.gov.in / www.mohfw.nic.in

Developed with support from:
USAID MCSP/Jhpiego

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