Ministry of Health and Family Welfare
Government of India

TECHNICAL & OPERATIONAL GUIDELINES

IMPLEMENTATION OF 15TH FINANCE COMMISSION (FC-XV) - HEALTH GRANTS THROUGH LOCAL GOVERNMENTS

31.08.2021

MINISTRY OF HEALTH AND FAMILY WELFARE

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Chapter 1: Overarching Principles for Planning and Implementation

1.1 Introduction

The Fifteenth Finance Commission (FC-XV) has recommended grants through local governments for specific components of health sector to the tune of Rs 70,051 crores and the same have been accepted by the Union Government. These grants for health through Local Governments will be spread over the five-year period from FY 2021-22 to FY 2025-26 and will facilitate strengthening of health system at the grass-root level.

The state wise annual resource envelope for each component over the next five years is already specified by the FC-XV report and is included as Appendix in the respective chapters.

Since the utilization of these FC-XV grants are to be completed on-time, to claim the subsequent instalments, the 28 States will be required to ensure completion of these activities in a time bound manner so that the FC-XV funds are efficiently utilized. **The funds released under the FC-XV grants for each Financial Year have to be utilized in the respective financial year.** States are required to ensure that optimal and effective utilization of funds are ensured at the District and Rural Local Bodies (RLB) / Urban Local Bodies (ULB) level.

1.2 Objective of the document

These technical and operational guidelines are intended for state and district programme managers, and the representatives of state and district rural and urban local bodies so that district specific plans may be drawn up specific to the need and context and consolidated into an actionable State Plan. The guidelines are structured as follows:

Chapter-1: lays out overarching principles for the use of the FC-XV grants for planning and gap analysis as per the needs identified by the Health Department in consultation with the Urban and Rural Local bodies; Chapter-2 lays out the guidance for establishing Urban Health and Wellness Centres (Urban-HWCs) and access to specialist services/polyclinics; Chapter-3 provides a detailed description for the Construction of Building less Sub Health Centres (SHCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs); Chapter-4 addresses the component related to the conversion of rural SHCs and PHCs to Health and Wellness Centres (HWCs); Chapter-5 focusses on the creation of Block Public health Units (BPHUs) and Chapter-6 provides direction on Support for Diagnostic Infrastructure to Primary Health Care facilities- SHCs, PHCs and urban PHCs (UPHCs).

Each chapter provides the description of each of the specific components, objectives of the component, the unit cost applicable for the component, factors to be considered while planning and the negative list for which the funds should not be utilized. As per the components, State, especially the Districts and Local Bodies are required to conduct comprehensive gap analysis as critical planning exercise before submitting the proposals for approval.

1.3 Components of XV-FC

Out of the total grants for health through Local Governments of Rs 70,051 crore, Rs 43,928 Crore has been allocated as tied grants for the 28 states through Rural Local Bodies (RLBs) and Rs. 26,123 Cr has been allocated as tied grants for Urban local bodies (ULBs). These grants are for strengthening primary care through the following specified components:

1.3.1 Rural Components

A. Building-less Sub-Centres, Primary Health Centres (PHCs), Community Health Centres (CHCs)
B. Conversion of rural PHCs and Sub-Centres to Health and Wellness Centres (HWCs)
C. Support for diagnostic infrastructure to the primary healthcare facilities
D. Block Level Public Health Units

Table 1: Year wise break up for the four components:

(Rs. In Crore)

Sr. No	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Building-less Sub Centres, PHCs, CHCs	1350	1350	1417	1488	1562	7167
2	Block level Public Health Units	994	994	1044	1096	1151	5279
3	Support for diagnostic infrastructure to the primary healthcare facilities	3084	3084	3238	3400	3571	16377
3.a	Sub-Centres	1457	1457	1530	1607	1687	7738
3.b	PHCs	1627	1627	1708	1793	1884	8639
4	Conversion of rural PHCs and Sub Centres into health and wellness centre	2845	2845	2986	3136	3293	15105
	Total Grants for primary health sector in rural areas	**8273**	**8273**	**8685**	**9120**	**9577**	**43928**

1.3.2 Urban Components

A. Support for diagnostic infrastructure to the primary healthcare facilities.

B. Urban Health and wellness centres (HWCs)

Table 2: Year wise break up for the two components:

(Rs. In Crore)

Sr. No	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Support for diagnostic infrastructure to the primary healthcare facilities – Urban PHCs	394	394	415	435	457	2095
2	Urban health and wellness centres (HWCs)	4525	4525	4751	4989	5238	24028
	Total Grants for primary health sector in urban areas	**4919**	**4919**	**5166**	**5424**	**5695**	**26,123**

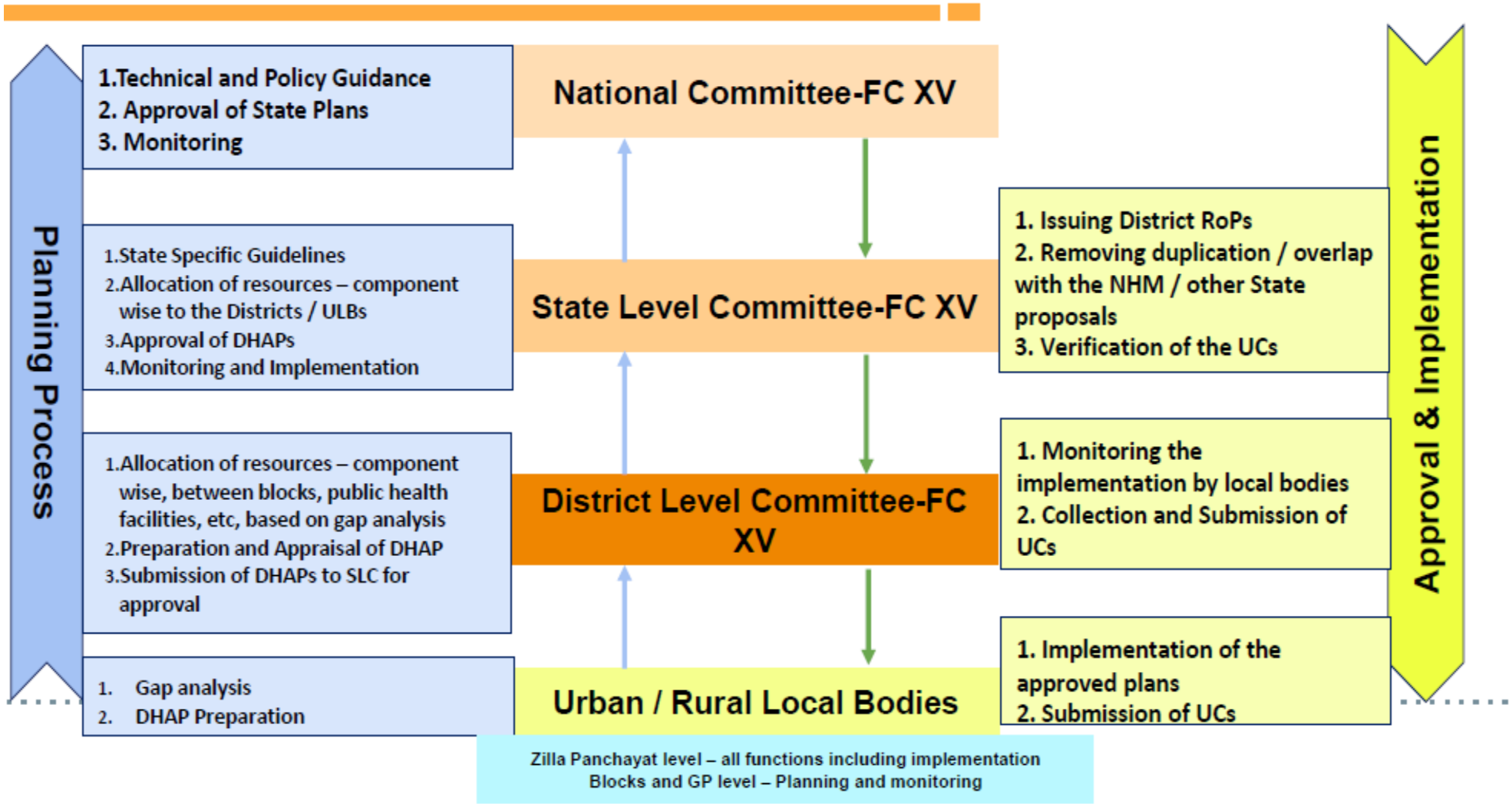
1.4 Planning and Budgeting

1.4.1 Pre-Planning

The key activities to be performed prior to preparation of the plan under XV-FC at State level will include:

i. **Developing the State specific guidance** for deciding the criteria for resource envelope and component wise target distribution among the districts / RLBs and ULBs. As per the DoE's guidance note (Annexure : Para 7 at page-7), at the district level, the Zilla Panchayats or Autonomous District Councils shall handle / implement the rural components of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector (not at Block Panchayat or Gram Panchayat level), because the components require technical experience as well as exposure in relevant subjects. However, rural local bodies below the district level (as the case may be), such as Block /Taluk level Panchayats, and Gram Panchayats / Village Councils must be involved in planning and monitoring of these components for the health facilities located in their jurisdiction. Similarly, at the district level, the urban local bodies shall handle / implement the urban components of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector.

Figure 1: Flow Diagram for Planning, Preparation, Implementation and Monitoring



ii. **Prioritization:** In planning district fund allocations, preferential allocations are to be made to the Aspirational / Tribal / Left Wing Extremism (LWE) / remote / Hill districts. However, within a particular district, allocations in each of the components should cover more units for effective utilization of the grant and this requires comprehensive gap analysis and the factors to be considered while planning are given at Table 3 of Para 1.4.2 of this chapter.

iii. **Indicating component wise physical targets and funds for each of the district/ULB to ensure that all the blocks are covered over a period of 5 years.** This is a crucial task at the State level which needs to be completed in pre-planning stage and communicated to all the districts with the specific directives / orders for allocation of funds component-wise.

iv. **Orientation and Capacity building:** The process of planning should be preceded by orientation and capacity building of the RLB and ULB at district and Block/Ward/Division levels so that they are actively engaged in preparing the plans, supporting implementation, and undertaking periodic reviews and monitoring. States should take necessary action in building capacities of Rural Local Bodies in planning, utilization and implementation of FC-XV grants. The ownership of the RLB and ULB is critical to ensure optimal use of the funds provided under FC-XV. It will also serve to strengthen decentralized planning, implementation and monitoring for the overall district.

v. **Gap Analysis:** District planning teams comprising of representatives of the District Programme Management Unit (DPMU) set up under NHM, Block Programme Management Unit (BPMU), Representatives of District and Block/Ward/Division level Local Bodies would be created and trained to prepare the District Health Action Plan for 15th Finance Commission (DHAP-FC-XV). As the NHM officials / representatives at Block and District level are actively involved in the preparation of annual PIP Proposals under NHM, they will be the critical team members to prepare the comprehensive gap analysis in coordination with the ULB and RLB representatives along with involving officials of Panchayat Raj and Municipal Administration Department, wherever required.

1.4.2 Key Principles

i. **State level five-year plan:** As the year-wise and component-wise grants are known to the States, the States have to prepare component-wise five-year plan as per the technical guidelines MoHFW, guidance from DoE and as per their local context. This will ensure proper

allocation of resources to the Districts in-advance – component wise, which will facilitate proper planning by the Districts for the current financial year and for the remaining four years. The factors that could be considered in allocation of resources to the Districts are explained in the Table 3 given below.

Table 3: Factors (component-wise) to be considered for inter-se allocation of resources to the Districts:

S.NO.	FC-XV Component	Factors to be considered for inter-se allocation of FC-XV grants to the Districts
1.	Block Public Health Unit	Number of Blocks in the State / District. States may prioritize the blocks in the Aspirational districts, including Tribal districts (as notified by MoTA) and Left Wing Extremism (LWE) affected districts (30 districts as informed by MHA), while doing inter-se allocation of resources among districts. Similarly, depending on the resources available, efforts may be made to saturate the blocks in the Hill districts of the Hill states/UTs (NE States, Himachal Pradesh, Uttarakhand, Jammu & Kashmir and Ladakh).
2.	Building-less SHCs, PHCs and CHCs	Number of Building-less SHCs / PHCs / CHCs in the District The States may prioritize the new constructions of healthcare facilities, **especially those Sub Health Centres, that have been converted into Ayushman Bharat Health and Wellness Centres (AB-HWCs)**, based on the grants of FC-XV available and few factors to be considered in this regard are: • Run-down / dilapidated building structures which are required to be re-built. • Construct new buildings, where services are being provided from rented buildings especially in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers. • New buildings in lieu of existing rented buildings that may not have adequate infrastructure/ space for carrying out the required activities. • New buildings, if required as per shortfall of population norms as per details given in RHS 2020. **States are informed that if the existing rented buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**

S.NO.	FC-XV Component	Factors to be considered for inter-se allocation of FC-XV grants to the Districts
3.	Conversion of Rural PHCs and Sub Centres into Health and Wellness Centre	Number of functional SHC-HWCs and PHC-HWCs in the District. District may apportion resources to the block panchayats in proportion to the number of functional SHC-HWCs as on date. Preferably, SHC-HWCs that are functional for more than one year can be selected for allocation of FC-XV resources.
4.	Diagnostic Infrastructure (Rural and Urban)	Number of SHCs, PHCs and UPHCs in the District. Actual allocation of resources is to be done after comprehensive gap analysis, for strengthening the Diagnostic Infrastructure at the SHCs, PHCs and UPHCs and building the diagnostic capacity in a Hub and Spoke model.
5.	Urban Health and Wellness Centres	Based on the vulnerability assessment and mapping of the urban areas, the slum / vulnerable areas will be prioritized where presently no primary health care facility exists The priority is to ensure that there is one Urban-HWC per 15,000-20,000 population catering predominantly to poor and vulnerable populations, resident in slum and slum-like areas. Decisions regarding the required number of Urban-HWCs, would depend on population density, presence of slums & similar habitations, vulnerable population, peri-urban areas and newly Notified Urban Areas and would be decided by the State Level Committee (SLC) based on justification provided by the ULB.

ii. **Five-year Plan:** Districts should also similarly, develop a comprehensive plan for 5 years, to utilize FC-XV grants in the given time frame. The template for the same will be enabled on the IT platform.

iii. **First-year Plan:** The state is required to plan for fund utilization for the 1st year keeping in view the limited timeline for its utilization and the necessity to complete the implementation of first year units / components before the end of financial year for effective utilization of FC-XV grants.

iv. **District Health Action Plan (DHAP)**: As per the resource allocation indicated to the district component wise and year wise, each District would prepare a District Health Action Plan for the FC-XV grants (DHAP-FC-XV) – year wise and component wise, covering all the rural and urban components, based on the financial allocation and specific physical targets communicated by the state. **For current financial year (FY 21-22), the districts have to prepare the plan duly keeping in mind the limited time-line and the necessity to complete the execution of works within the available time of the financial year.** The DHAP-FC-XV for each district, thus prepared, would

provide granular details on number of block/ward/division wise facilities that would receive the FC-XV funds on annual basis.

v. While preparing the **District Health Action Plan (DHAP)**, the districts should not only give emphasis on the technical guidance of FC-XV, but also a holistic assessment of the components should be undertaken including the systematic review of the burden of disease in that district, local epidemiology, rural demographic profile and the specific needs and requirements of communities in different parts of the district.

vi. **Unit Costs and Number of Units**: The unit costs for each component have been derived based on the upper limit and are also included in the respective chapters for each of the components. The States could plan for more number of functional units under each component, within the available resources, on the basis of comprehensive gap analysis.

vii. **Negative List**: State is required to strictly comply to the negative lists, which is specified for each of the components. States should not utilize the grants for the activities in the negative list.

viii. **Non-duplication:** States should ensure that there is no duplication or overlap of proposals, tasks, procurements, constructions, hiring of HR etc. for which funds have already been provided under NHM, State budgets, any other funds.

ix. **The fund under the FC-XV health grants should not be used by the State as the State's contribution for any CSS component or for any other mandate, apart from the components listed for the utilization of the health grants under FC-XV.**

x. **Centralized Procurement of medicines, Medical equipment, diagnostics and other consumables, etc:** As stated in the DoE's Guidance Note (Para 8 at Page 8), on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other consumables, etc, through a mechanism which include Central purchase at State level through established mechanisms like State Medical Services Corporations / Societies or State Health Society. For the centrally procured items, the State level Committee may also work out a mechanism for the payment of such centrally procurement items.

xi. **Collaboration with the other departments:** The RLBs / ULBs would 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.

xii. **Grievance Redressal:** The PRIs / ULBs will be required to monitor the implementation of the components for which the procurements / recruitments have been done centrally and any concern / issue should be raised in writing to the DLC.

xiii. **State level monitoring mechanism**: As the expenditure of FC-XV grants is to be completed within the same financial year, the States should fast track the preparation of the District plans and

subsequently, the State plan based on the gap analysis, appraise them in the SLC and send it to NLC for appraisal and approval.

xiv. **IT platform for approval and monitoring**: The State/SLC will send the progress reports on both physical and financial progress against the approved plan on quarterly basis to the Ministry of Health and Family Welfare, Govt. of India. A dashboard with the progress monitoring system (PMS) of 15th Finance Commission components is being prepared and would be made available to the States, to enable to send the proposals from the District level committee to State level committee for consideration and examination and further from State level committee to National level committee for appraisal and approval. This PMS would also be utilized to monitor the progress of all the components of FC-XV, both to track the physical as well as financial progress. The dashboard has to be updated by States regularly and the regular up-dation of the progress would be essential for release of subsequent instalments of FC-XV grants to the States.

xv. **Learning from NHM for implementation of some of the components of FC-XV grants:**

a. **Advantages of implementation of 3 components of FC-XV grants by the States:** As the States are already implementing three of the five components, namely, Building-less Sub Centres, PHC and CHC in rural areas, Conversion (provision of recurrent costs) of SHC/PHC to HWC, and support for diagnostic infrastructure in rural and urban areas, the Guidelines for these components including financial norms for various interventions, including Human Resource, recurrent costs if applicable, layouts in terms of specifications, operational details, etc., are already being used by states in planning for NHM and would serve as the basis for district planning.

b. **New Components for the States:** The components viz, Urban – HWCs, and Block Public Health Units (BPHU), are new interventions and States should orient all the stakeholders including health department, panchayat raj and municipal administration department officials and ULBs and RLBs to assist the planning process at the State and District level.

xvi. **Factors to be considered while planning component wise action plan:** Factors that are to be considered while planning have been given in detail in the respective chapters.

a. As the States / districts are already aware about the shortfalls / building-less SHCs, PHCs, in rural areas, number of the blocks and functional SHC and PHC level HWCs, the district level planning would be easier, based on the resource allocation to the districts, as allocated by the State.

b. Prioritizing blocks that are remote or cover larger proportion of marginalized populations, including tribal areas and similarly, prioritizing the facilities located in these backward areas of the district, has to be kept in mind to ensure the equitable access of intended services through FC-XV grants.

c. Similarly, the effective implementation of the component of the urban HWCs, depends on mapping the vulnerable areas within the territorial jurisdiction of the urban local bodies to finalize the location of such facilities in close collaboration with ULB.

xvii. Infrastructure works:

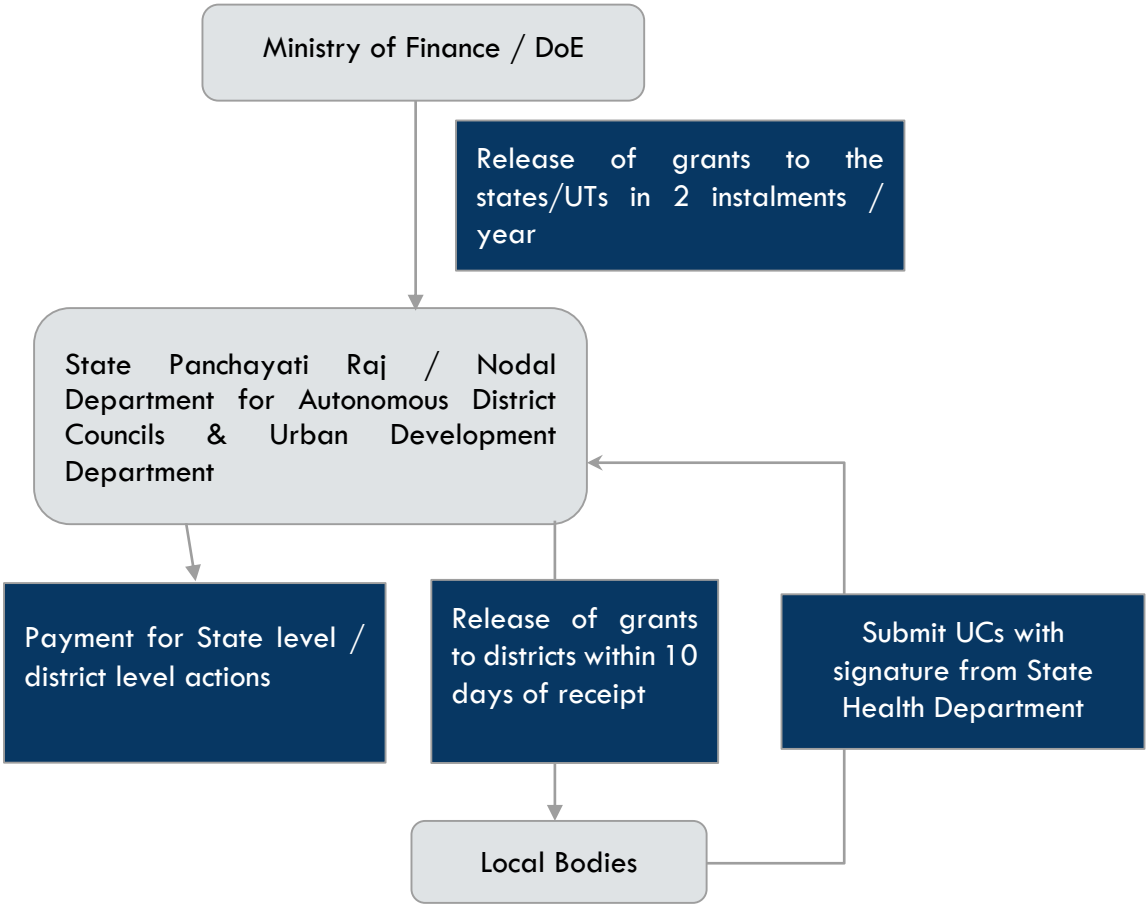
a. Out of the various components, the Building-less SHCs, PHCs, is the only component, where it is purely infrastructure work.
b. The component of conversion of SHCs and PHCs into HWCs does not include infrastructure related works.
c. In the component of BPHUs, the infrastructure support is provided for and the BPHU should ideally be located in the Block Medical Offices or Block CHC premises and have a linked laboratory also preferably located in the same premises for better synergy between clinical, programmatic and public health functions.
d. Similarly, in the urban HWCs component, the refurbishing of existing space for running the Urban HWCs is provisioned.
e. The component involving diagnostic infrastructure for SHCs, PHCs and UPHCs does not involve any civil or associated infrastructure work. This component covers the recurring expenditure for providing the diagnostic services at these facilities and non-recurring expenditure component for procurement of diagnostic equipment required. This activity can be taken up based on the principle of a Hub and Spoke Model and also on a PPP (Outsourcing) basis, wherever feasible.

xvii Recurring expenditure:

a. The component of BPHU involves creation of BHPU units under the non-recurring component and support of HR and other inputs under recurring component. Once the constructions of BPHUs are completed, the HR may be recruited for running these units and the FC-XV grants may be utilized accordingly. HR can be recruited earlier, if there is existing infrastructure / space available that can be utilized for BHPUs.
b. The component of Urban HWCs involves only recurring activities, except for minor infrastructure refurbishing of the existing space of the ULBs or government buildings for running the Centres. As soon as the premises are ready, the urban HWCs should start providing services from these premises and FC-XV grants may be utilized accordingly.
c. As the component of conversion of SHCs and PHCs are to be utilized only for the functional HWCs, the FC-XV grants may be utilized from the date of approval of the proposal of this component, as the grants are only meant for operational expenses of the functional HWCs.
d. For the component of diagnostic infrastructure at SHCs, PHCs and UPHCs, the FC-XV grants

may be utilized for recurring expenses for provision of diagnostic services at the functional SHCs, PHCs and UPHCs from the date of approval of these components. As there are substantial resources factored under this component, capital expenditure activities such as procurement of essential equipment, based on the gap analysis, will also be covered under this component of FC-XV grants. For the diagnostic component in rural and urban areas, a detailed gap analysis will need to be undertaken at each level of facility. After **ensuring that** the recurring expenses related to diagnostic services at SHCs, PHCs and UPHCs are provided for, the first charge of the remaining funds of this component should be to ensure provision of essential diagnostic tests at the Block and sub Block facilities (PHC-HWC and SHC-HWC in rural areas and U-PHCs). Once the needs of these facilities have been met, procurement of essential in-house diagnostic equipment for CHC/SDH and DH to address complex primary health care needs that cannot be undertaken at HWC- PHC/SHC or the Block level would also be permitted and taken up in a hub and spoke model.

1.4.3 Fund flow: The Figure 2 below represents the flow of funds for FC XV allocation:



1.5 Components and basis for allocation of resources to the districts

While detailed technical guidelines on each of the components is available separately, to help the State planning team, a brief on each component is provided below:

1.5.1 Rural Components

A. Building-less Sub Health Centres (SHCs), and Primary Health Centres (PHCs), Community Health Centres (CHCs)

The XV-FC has provisioned for supporting infrastructure to achieve the targets of the National Health Policy, 2017. The fund allocated under XV-FC may be utilised for construct buildings for the building less primary healthcare facilities and States / Districts may give priority to SHCs and PHCs depending on their local context. It is suggested to the Districts and States that SHCs may be given priority under this component, especially for those Sub Health Centres which are building less, operating in rented or rent-free panchayat/ Voluntary Society Buildings. The PHCs may be taken up after meeting the requirement of the SHCs. The facilities to be upgraded may be selected based on the following criteria:

a. Prioritization based on infrastructure availability:

i. Run-down / dilapidated building structures which are required to be re-built.

ii. Construct new buildings, where services are being provided from rented buildings especially in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers.

iii. New buildings in lieu of existing rented buildings that may not have adequate infrastructure/ space for carrying out the required activities.

iv. New buildings, if required as per shortfall of population norms as per details given in RHS 2020[3].

v. **States are informed that if the existing rented buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**

vi. Prioritising based on land availability: even among the above prioritized facilities, those SHCs for which site/land has already been acquired[1] are to be prioritised.

[1] Minimum estimated land required for SC-HWCs is 3000 sq. ft. and for PHC-HWCs is 15000 sq. ft.

b. Prioritising based on location: The new site (in case land has been acquired for multiple sites) located in Aspirational districts/ Tribal areas/ Left Wing Extremism (LWE) affected areas/ Hill areas are to be prioritised.

c. The prioritization should also take into consideration the local capacities available, so that the new buildings get completed in the stipulated time. In cases where two or more facilities are proposed for construction, the RLBs needs to indicate their priority.

d. **The maximum unit cost of construction of a new building is set at ₹ 55.5 lakhs for an SHC, ₹ 1.43 crore for a PHC. The district-wise allocation for this component may be done based on the proportion of building less SHCs and PHCs.**

B. Conversion of rural PHCs and Sub-Centres to Health and Wellness Centres (HWCs)

a. The XV-FC has provided grant in aid support to all 28 States for meeting the running cost of functional SHC and PHC level HWCs in the district. On examination of the funds available, it is suggested that **except in a few States (Odisha, Bihar, Rajasthan, Haryana**), funds available may not be sufficient for all the functional SHC and PHC level HWCs in the Districts as on date.

b. Accordingly, detailed guidelines on selection of HWCs for support under this component is given in the respective chapter. The district and State must ensure that there is no duplication of activity.

c. The proportion of rural PHCs and SHCs to be converted into HWCs may be made the basis for district-wise allocation.

C. Support for diagnostic infrastructure to the primary healthcare facilities

a. The XV-FC health grants are to strengthen the diagnostic infrastructure at Sub-Health centres (SHCs), and Primary Health Centre (PHCs) to achieve the IPHS and CPHC norms so that the intended comprehensive primary healthcare could be delivered.

b. The DHAP and the State plan should ensure that all the required clinical and public health diagnostic services are provided to the community either by strengthening in-house service delivery capacities or by expanding the same under the PPP mechanism, as deemed appropriate and suitable at the Block, District and State level keeping in view the capacity and inclination of the private providers in hard-to-reach areas and difficult terrains.

c. Presently 14 tests at Sub Health Centre/ Health & Wellness Centre level and 63 tests at PHC level are to be conducted as per guidelines on free diagnostics initiative. The team responsible for gap analysis and planning should look in to following components:

   i. Availability of Health Services, lab services and caseload
   ii. Gap in terms of infrastructure for providing diagnostic services as per CPHC guideline
   iii. Availability of Human Resources for providing services as per IPHS

iv. Availability and functionality of the diagnostics and lab equipment including storage
v. Availability of IT infrastructure
vi. Availability of rapid/point of care test kits, reagents, and other consumables and their optimal storage conditions
vii. Gap in the existing Logistic Management System
viii. Equipment maintenance mechanism
ix. Distance / Travel time from Hub/ availability of transport services
x. Need for capacity building of existing HR

d. **For equipping a new / greenfield SHC or PHC with the required diagnostic infrastructure, a maximum of ₹ 3.91 lakhs for each SHC and a maximum of ₹ 25.86 lakhs for each PHC could be proposed.** For the existing / brownfield SHCs and PHCs in rural areas, the grant could be used depending on the gap analysis and comprehensive diagnostic plan of the district. So, the unit rate for each SHC / PHC may vary as per the identified gaps in the facility but should not exceed the maximum limits specified under FC-XV grants.
e. After saturating all the diagnostics related requirements of SHCs and PHCs, States and the districts may plan to utilise the balance amount for strengthening the diagnostics infrastructure at the CHC/ SDH/ district hospital level in a Hub and Spoke model to support the SHCs and PHCs and with the approval from National Level Committee.
f. The initial district-wise allocation may be done based on proportion of SHCs and PHCs in the district.

D. <u>Block Level Public Health Units:</u>

a. Support is being provided under XV-FC to establish Block Public Health Units (BPHUs) across all the blocks of 28 states. The BPHUs will have three major components:
    i. Public Health Unit for providing public health functions such as surveillance and detection of outbreaks.
    ii. Block Public Health Lab for providing advanced diagnostics services for clinical and public health functions.
    iii. Hub for data compilation, analysis, and feedback, through a Health Management Information System and IHIP.
b. The BPHU will serve as the referral unit for the Health and Wellness Centres (Sub Health Centre/Primary Health Centre) in the block.
c. A comprehensive plan is to be prepared for the following activities under this component of XV-FC:
    i. Infrastructure requirement

ii. Requirement for IT Support
iii. Requirement for equipment for Block Public Health Lab
iv. HRH for BPHU

d. A maximum of ₹ 80.96 lakhs of Capital expenditure per BPHU and a maximum of ₹ 20.14 lakhs of recurring/operational expenditure per BPHU (applicable once the constructions / non-recurring activities are completed either in the same financial year or in the subsequent year) is prescribed. Details are given in the respective chapter.
e. The proportion of blocks in the district would be the basis of district wise allocation of budget and targets.

1.5.2 Urban Components

A. Support for diagnostic infrastructure to the primary healthcare facilities: The XV-FC grant will provide support for strengthening the diagnostic services in the urban PHCs. The range of diagnostic tests has been expanded in alignment with the guidelines of comprehensive primary healthcare services under Ayushman Bharat.

a. For each urban PHC, support will be provided for the following components:

i. Procurement of diagnostic equipment
ii. Setting up IT support
iii. Procurement of kits
iv. Sample transportation
v. Equipment Maintenance
vi. Monitoring
vii. Capacity Building
viii. Miscellaneous cost

b. For equipping a new / greenfield UPHC with the required diagnostic infrastructure, a maximum of ₹ 25.86 lakhs for each UPHC could be proposed. For the existing / brownfield UPHCs in urban areas, the grant could be used depending on the gap analysis and comprehensive diagnostic plan of the district. So, the unit rate for each UPHC may vary as per the identified gaps in the facility but should not exceed the maximum limits specified under FC-XV grants.
c. The proportion of existing and new Urban PHCs may be made the basis of district-wise/ULB wise allocation of budget and targets.

B. Urban Health and Wellness Centres (Urban HWCs): To strengthen the health systems to deliver comprehensive primary healthcare through Ayushman Bharat-Health and Wellness Centres (AB-HWCs) in urban areas, health grant has been recommended for:

a. **Urban Health and Wellness Centres**: The urban HWCs are expected to increase its reach in the urban areas and cover the vulnerable and the marginalized by acting as satellite centres

to be established under the UPHCs. Each UPHC that caters to a population of approximately 50,000, is expected to have 2-3 UHWCs under it, depending on the vulnerable population of the urban local body and as per the detailed guidance given in the Chapter 2.

b. **Provision of specialist services at Urban health facilities / Polyclinics:** The Polyclinics are envisioned to ensure continuum of care by providing specialty services closer to the community. In urban areas, currently 5-6 UPHCs are catering to a population of 2.5-3 lakhs; one of the UPHCs, among these 5-6 UPHCs would be identified to be upgraded as a Polyclinic with availability of specialist services on a rotation basis. For areas with functional Urban CHCs (UCHCs) providing specialist services, separate polyclinics may not be required.

As the 15th FC grants are to plug the critical gaps in the Primary Health care, SLC may proportionately allocate the budget and targets between Metros, million plus cities, Other cities, towns, etc., (except those having a population of less than 50,000 population) giving priority to unserved and underserved slum or slum like populations.

1.6. Roles and Responsibilities:

The summary of the National, State and District Level Committee roles and responsibilities are listed below:

Table 4: Roles and responsibilities for planning, implementation and monitoring:

Level	Planning	Implementation	Monitoring
National level Committee	• Guidance to States for flow and utilization of grants, with a timeline of deliverables and outcomes • Appraisal and approval of state proposals	• Provide technical guidance related the XV-FC grants	• Review progress
State Level Committee	• District wise resource allocations as worked out by the State Health Department • Set target and physical deliverables for the districts	• Identify of local bodies based on State specific structure • Delegation of powers to RLBs/ ULBs • Provide all the assistance for implementation of FC XV – Health Grants to the districts.	• Review progress • Facilitate Collection and sending of the UCs of FC-XV grants to GoI • Ensuring timely submission of progress reports
District Level Committee	• Validate district specific gap assessment report prepared by the district planning team • Prioritising within district • Ensuring there is no duplication of activity within FC grants or any other source of fund	• Provide overall guidance to RLB/ULBs on implementation • Mobilize the District Health team to support RLB/ULB in planning and provide technical support	• Mobilize the District Health team to support RLB/ULB in planning and provide technical support • Review progress • Coordinate with Local Bodies for collection of

Level	Planning	Implementation	Monitoring
	• Finalise the Costing of plan of the district as per the guidelines	• Appraise the proposals received from RLB/ULB and recommend to SLC	**UCs** and submitting to the State • Check and prevent any duplication • Ensuring timely submission of progress reports

1.7. Financial Approvals and fund transfer

1.7.1 Fund Releases and submission of UCs and releases of subsequent instalments: The details are already communicated to the States by the DoE vide letter dated 16th July 2021. Copy is attached with this document at Annexure. It is reiterated that timely completion of the activities and submission of UCs and providing the physical and financial progress in the Progress Monitoring System are crucial to get the subsequent instalments of the FC-XV grants. The allocation of the funds state-wise and component wise have been provided in the respective chapters of the components for ease of reference for the States and Districts.

1.7.2 Pooling of funds: Functions such as engaging competent human resources for health, procurement of medicines, equipment, diagnostics & consumables, contracting agencies to provide diagnostic services (as in the Hub and Spokes model), etc are critical for implementation of above components. Efficient use of funds for these activities, are dependent on economies of scale, standardized processes, including quality assurance, and require complex technical expertise. **(DoE's Guidance Note at Annexure (Para 8 at Page 8) and reiterated again at sub-point 10 under para 1.4.2 of this Chapter)**

1.7.3 State level / District level HRH services: Most of the State Health Departments have developed effective modalities for recruitment of Human Resources for Health such as Medical Officers, Nurses, Lab Technicians, Pharmacists and other para-medical staff, through mechanisms such as a State / District level agency of government or through empanelled agencies. Under National Health Mission, States/UTs are supported to deploy such agencies. States have been undertaking these human resource recruitments through these empanelled agencies, which have established transparent and systematic procedures.

1.7.4 Procurement Cell: The RLBs / ULBs would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement. Such a strategy would eventually create capacities within the ULBs to handle these responsibilities independently.

1.7.5 Utilization of savings: In case of savings under the head of both non-recurring and recurring expenditure under any component, states could propose utilization of these savings, for the same component in the next year.

1.8 Monitoring and Reporting

The State/SLC will send the progress reports on both physical and financial progress against the approved plan on quarterly basis to the Ministry of Health and Family Welfare, Govt. of India. A dashboard will be prepared to monitor the activities of 15th FC grants, which would track the physical as well as financial progress. The dashboard would be updated by States regularly.

1.9 Timelines

The targeted time frames for the preparation and appraisal of the plans under 15th FC are as follows:

Table 5: Targeted time-lines for activities:

Activity	Time frame
Issuance of technical guidelines to the States on planning of 15th FC grants by MoHFW	31st August 2021
Orientation of the State Health Departments by MoHFW	By 3rd September 2021
Orientation to the District teams including health, Panchayat raj and municipal administration department by the State Health Department	By 10th September 2021
Orientation of the RLBs and ULBs of the States by the State Health Departments in coordination with State Panchayat Raj and Municipal Administration Departments	By 10th September 2021
Conduct of first SLC and arrival of the district wise allocation of all the components of FC-XV grants and Communicating to the Districts	By 10th September 2021
Gap Analysis and preparation of DHAPs for FY 21-22 and sending to the State level committee for approval	By 15th September 2021
Consideration of the District Health Action Plans by the State level committee and forwarding to the National level committee	By 20th September 2021
Appraisal and approval by NLC	By 30th September 2021

Appendix 1.1: Total XV FC Health Grants – State wise

		Year wise Allocation (In Cr.)					
S. No.	**State**	2021-22	2022-23	2023-24	2024-25	2025-26	**Total**
1	Andhra Pradesh	490	490	514	540	567	2601
2	Arunachal Pradesh	49	49	51	54	56	259
3	Assam	280	280	293	308	323	1484
4	Bihar	1133	1133	1190	1249	1312	6017
5	Chhattisgarh	339	339	356	373	392	1799
6	Goa	31	31	33	35	37	167
7	Gujarat	629	629	661	694	728	3341
8	Haryana	305	305	320	335	352	1617
9	Himachal Pradesh	98	98	103	108	114	521
10	Jharkhand	446	446	469	492	517	2370
11	Karnataka	552	552	579	608	638	2929
12	Kerala	559	559	587	616	647	2968
13	Madhya Pradesh	923	923	969	1018	1069	4902
14	Maharashtra	1331	1331	1397	1467	1541	7067
15	Manipur	44	44	46	49	51	234
16	Meghalaya	59	59	61	64	68	311
17	Mizoram	31	31	33	35	36	166
18	Nagaland	57	57	60	63	66	303
19	Odisha	462	462	485	510	535	2454
20	Punjab	401	401	421	443	465	2131
21	Rajasthan	833	833	875	918	964	4423
22	Sikkim	21	21	22	23	24	111

		Year wise Allocation (In Cr.)					
S. No.	**State**	2021-22	2022-23	2023-24	2024-25	2025-26	**Total**
23	Tamil Nadu	806	806	846	889	933	4280
24	Telangana	419	419	441	463	486	2228
25	Tripura	85	85	90	94	99	453
26	Uttar Pradesh	1830	1830	1921	2017	2118	9716
27	Uttarakhand	150	150	158	165	174	797
28	West Bengal	829	829	870	914	960	4402
	Total	13,192	13,192	13,851	14,544	15,272	**70,051**

Appendix 1.2: District wise allocation of resources of all the components of FC-XV grants by the States for FY 21-22

Code	Activities	Amount in Crores		
		District 1	Districts 2,3,4, ...	District 'last'
	Total FC-XV grants for FY 21-22			
FR	**Rural components**			
FR.1	**Building-less Sub Health Centres, PHCs, CHCs**			
FR.2	**Block Public Health Units**			
FR.3	**Support for diagnostic infrastructure to the primary healthcare facilities**			
FR.3.1	No. of SHC			
FR.3.2	No. of PHC			
FR.4	**Conversion of rural Sub Health Centres and PHCs to HWCs**			
FU	**Urban Components**			
FU.1	**Support for diagnostic infrastructure to the primary healthcare facilities**			
FU.2	**Urban health and wellness centres (HWCs)**			

Appendix 1.3: Summary Budget Sheet Template for Districts /States for FY 21-22

Code	Activities	No. of Units			Unit Cost	Budget Proposed (In Lakhs)			State Remarks
		In Aspirational Districts	In Non-Aspirational Districts	Total		In Aspirational Districts	In Non-Aspirational Districts	Total	
	Total FC-XV grants								
FR	**Rural components**								
FR.1	**Building-less Sub Health Centres, PHCs, CHCs**								
FR.1.1	No. of SHCs taken up for this financial year								
FR.1.2	No. of PHCs taken up for this financial year								
FR.1.3	No. of CHCs taken up (not applicable in most of the States)								
FR.2	**Block Public Health Units**								
FR.2.1	No of BPH units sanctioned for capital works								
FR 2.2	No of BPH units supported for recurring expenditure								
FR.3	**Support for diagnostic infrastructure to the primary healthcare facilities**								
FR.3.1	No. of SHCs supported for recurring expenditure for provision of diagnostic services								Individual SHC will have its own unit cost

Code	Activities	No. of Units			Unit Cost	Budget Proposed (In Lakhs)			State Remarks
		In Aspirational Districts	In Non-Aspirational Districts	Total		In Aspirational Districts	In Non-Aspirational Districts	Total	
FR 3.2	No. of SHCs supported for capital expenditure for procurement of diagnostic equipment based on the gap-analysis								Individual SHC will have its own unit cost depending on the gap analysis
FR.3.3	No. of PHCs supported for recurring expenditure for provision of diagnostic services								Individual PHC will have its own unit cost
F.R.3.4	No. of PHCs supported for capital expenditure for procurement of diagnostic equipment based on the gap-analysis								Individual PHC will have its own unit cost depending on the gap analysis
FR.4	**Conversion of rural Sub Health Centres and PHCs to HWCs**								
FR.4.1	No. of functional SHC-HWCs, whose operational expenses being met from this support								
FR.4.2	No. of functional PHC-HWCs, whose operational expenses being met from the support								
FU	**Total Urban**								
FU.1	**Support for diagnostic infrastructure to the primary healthcare facilities**								
FU.1.1	No. of Urban PHCs supported for recurring								Individual UPHC will have its own unit cost

Code	Activities	No. of Units			Unit Cost	Budget Proposed (In Lakhs)			State Remarks
		In Aspirational Districts	In Non-Aspirational Districts	Total		In Aspirational Districts	In Non-Aspirational Districts	Total	
	expenditure for provision of diagnostic services								
	No. of Urban PHCs supported for capital expenditure for procurement of diagnostic equipment based on the gap-analysis								Individual UPHC will have its own unit cost depending on the gap analysis
FU.2	**Urban health and wellness centres (HWCs)**								
FU.2.1	No. of Urban HWCs, being established in the ULB or other government or rented premises								
FU.2.2	No. of urban health facilities (UPHCs / Urban CHCs) where specialist services are to be provided / Poly Clinics								Unit cost depends on the no of Urban HWCs under this selected urban health facility

Chapter-2: Urban Health and Wellness Centres (Urban-HWCs) and Access to specialist services / Polyclinics

2.1 Introduction

- The National Urban Health Mission (NUHM) was set up in 2013, as a sub mission of the National Health Mission, to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections through facilitating equitable access to available health facilities by rationalizing and strengthening the existing capacity of health delivery.
- Under Ayushman Bharat, Urban Primary Health Centres (UPHCs) are being strengthened as Health and Wellness Centres (UPHC-HWCs) to deliver Comprehensive Primary Health Care (CPHC). Currently, this is done through enabling Urban PHCs, covering a population of 50,000. Outreach functions in this population, are undertaken by five ANMs and 20-25 ASHAs, with a normative coverage of **a population of 10,000 served** by a team of one ANM and five ASHA.
- Healthcare needs and aspirations of urban residents are different from those in rural areas. The current strategy of relying on outreach teams of ANM and ASHA alone to provide selective services is not sufficient. State experiences demonstrate that provision of health care services by trained service providers from facilities closer to poorer, and vulnerable urban communities is likely to improve access to an expanded range of services, reduce OOPE, improve disease surveillance, and strengthen referral linkages. At the same time, state experiences also show that the establishment of "poly clinics" in selected Urban Primary Health Centres, enables reach of specialist services to poor communities, thus building trust in the public health system.
- The COVID-19 pandemic has highlighted that public health action (such as surveillance, contact tracing, community mobilization and other containment measures) in urban areas need substantial strengthening. It has also shown that such public health action is ineffective if focused only on slum and slum like areas. Action for outbreaks needs to address the entire urban population across all sections. Decentralizing primary health care particularly in urban areas would enhance disease surveillance and improve reporting for epidemic/outbreaks and risk factor mitigation through focused health promotion and wellness activities.
- A paradigm shift in urban primary health care is envisaged, based on the learning from the management of the COVID-19 pandemic, which has affected urban areas disproportionately. As part of this shift, Universal Comprehensive Primary Health Care would be provided through setting up ***Urban Health and Wellness Centres (Urban-HWCs)*** and

strengthening selected Urban Primary Health Centre - Health and Wellness Centres (UPHC-HWCs) for provision of specialist services/polyclinics. Such Urban-HWCs would enable decentralised delivery of primary health care to smaller populations, closer to their homes, thereby increasing access to care especially for the vulnerable and marginalised.

2.2 Urban Health and Wellness Centres (Urban HWCs):

The Urban-HWCs are envisaged to deliver comprehensive primary health care to the community, and public health related actions and would also enable strengthening the care continuum for upward and downward linkages, improve access to high quality care, minimize the out of pocket expenditure incurred on health care services, and decongestion of secondary and tertiary health care facilities. Decentralizing primary health care in urban areas would enable improved disease surveillance and reporting for epidemic/outbreaks and Risk factor mitigation through health promotion and wellness activities. The three components of Urban HWCs are detailed as below;

2.2.1 Establishing urban-HWCs to provide comprehensive primary health care and undertake public health action.

i. Support under this component of FC-XV is to establish Urban HWCs to decentralize primary health care below the existing UPHC level HWCs.

ii. The unit of planning for establishment of Urban HWCs would be the city / major urban local body. In the million plus cities, subdivisions into two or more segments could facilitate such planning.

iii. The location and population coverage of the Urban HWCs could be flexible depending on population densities and presence of vulnerable and marginalized population sub-groups. The principle of Urban HWC location would be such that it becomes the first port of call for individuals and families in urban areas and is linked to the nearest UPHC level HWCs for administrative, reporting, and supervisory purposes and where there is no existing UPHC level HWCs, new Urban -HWC can be planned as per gap.

iv. Given the challenges of acquiring land for construction of new facilities, utilization of infrastructure already created through other government initiatives and Urban Local Bodies, as well as rented commercial spaces/residential facilities would be explored. The use of Mobile Medical Units, and evening OPDs will be considered as alternate service delivery modes. In addition, states may plan for use of community infrastructure such as community and charitable institutions. NGO run clinics may also be explored.

v. Urban HWCs would provide outpatient care for a range of expanded services. Public health functions related to surveillance and early outbreak management as well as interventions for screening and prevention of chronic communicable and non-communicable diseases, would also be undertaken by the team at the UHWC.

vi. These Urban HWCs would be staffed with a Medical Officer, a Staff Nurse and two support staff, and will provide both facility based and outreach services, largely for ambulatory care. Outreach services would be undertaken by the ANM (MPW-F), and ASHA. The outreach team will be expanded by the addition of a Male-MPW, with specific responsibilities for disease surveillance, addressing public health actions, and health promotion and prevention efforts, including WASH, wellness promotion, attention to lifestyle changes, through convergence with ULBs/Residents associations, etc.

vii. States could explore outsourcing/contracting out of Urban HWCs through well designed and monitored Public Private Partnerships (PPP) with NGOs and not for profit private sector in urban areas but ensure that there is no fragmentation between curative care, public health activities and health promotion and prevention for the target population. The Private/NGO partner must ensure delivery of preventive, promotive, and curative care as well as all public health functions related to surveillance, management of outbreaks, etc.

viii. With the creation of Urban Health and Wellness Centres to cover smaller population cohorts, the existing Urban Primary Health Centre level Ayushman Bharat Health and Wellness Centres (UPHC level HWCs) would, in addition to providing clinical services and provide administrative control, serve as a hub for teleconsultation, surveillance, reporting, capacity building, monitoring and supervision, of the Urban HWCs in its coverage area. UPHC level HWCs will also be linked to the component of strengthening public health surveillance in Metropolitan areas.

2.2.2 Ensuring continuum of care by linking with secondary and tertiary care through appropriate mechanisms.

a. Services for specialist consultation (Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology, Psychiatry/Psycho-social care), would be provided on a rotational basis at UPHC-HWCs or at Urban CHCs. Such poly clinic services would be limited to outpatient care to minimize the need for specialised equipment at every UPHC level AB-HWCs. Access to specialist services / Polyclinics is envisaged for every 2.5-3 lakh population depending on the local context. The select UPHCs-HWCs or urban CHCs for specialist / Polyclinic services would be strengthened with equipment, laboratory services for diagnosis, disease surveillance, public health etc.

b. These Poly clinics could also serve as a referral point and link with a telemedicine hub at a medical college, thereby reducing the congestion at secondary and tertiary level hospitals.

c. Linkages for secondary and tertiary care for all, would be through the Urban HWCs and District Hospitals. Given that most states have insurance schemes including AB-PMJAY, referrals for those eligible would be to government facilities/empanelled private health facilities.

2.2.3 Promoting community engagement through various platforms and ensure universal reach of public health interventions, including action on wellness promotion and social and environmental determinants.

a. COVID-19 has demonstrated that mechanisms of community engagement that span all sections of society and economic classes are essential. A good public health system should be equipped for universal reach. Currently the mechanism for community engagement- the ASHA and Mahila Arogya Samities (MAS) are in place only in slum and slum like areas, and do not reach the homes of middle- and upper-income classes.

b. Urban areas are characterized by heterogeneous population that often live in close juxtaposition. Thus, it is common to find slums coexisting near the homes of the wealthy. A uniform mechanism of community engagement across all these sections is not possible, no matter how active and well intentioned, by ASHA and MAS

c. ASHA and MAS however are a key mechanism to reach the vulnerable and marginalized. They will continue to be strengthened including their linkages with Urban Local Bodies (ULB) which have positive potential to impact the social and environmental determinants of health. Where Self Help Groups are established through programmes such as the National Urban Livelihood Missions/State level or NGO led SHGs, they would also be actively involved.

d. For other sections, location based *Resident Health Associations (Sthanniya Swasthya Sabhas)* would be formed, preferably with the locus being a public health facility. Such associations would be a platform or federation comprised of representatives of MAS, (from poorer areas), Resident Welfare Association (RWA) such as Gully/Mohalla committees. This would ensure that information about public health activities, and awareness about lifestyle changes, healthy diets, smoking/alcohol cessation, are disseminated across all residents in an area, irrespective of socio-economic status.

e. Urban HWCs would be monitored and supported by the UPHC-HWCs. Support is also provided for engaging the services of specialists on a periodic basis, at the selected UPHC-HWCs, based on local need and demand. It is envisaged that the Urban-HWCs

would create a mechanism for representatives of Service Providers and Resident Welfare Associations (RWAs) to converge into a Sthaniya Swasthya Sabha to discuss and disseminate public health related issues on a monthly / quarterly basis.

f. Health promotion and wellness activities are an important component of UHWC services. Such associations would also lead the process of wellness promotion in coordination with the local public health facility and ULB so that safe spaces are created/earmarked for urban residents to undertake regular physical activity such as walking, cycling, exercise, yoga, etc.

g. The Sthaniya Swasthya Sabhas would also be the fulcrum for managing public health actions for "well to do" sections of society in towns/cities including taking up drives for vector control awareness and Public Health actions for containing disease outbreaks, (like COVID related containment measures, home isolation, support to home isolated cases, etc.).

2.3 Objectives:

i. Establish Urban-HWCs to provide decentralized comprehensive primary health care and improve public health action especially focussing on the slums & similar habitations, vulnerable population and areas with limited access to public health interventions.

ii. Strengthen Public Health Surveillance, timely reporting, and analysis.

iii. Promote community engagement to ensure universal reach of public health interventions, including action on social and environmental determinants of health.

iv. Increase access to specialist services polyclinics, which are close to the community to minimize patient hardship, reduce time to care and improve continuum of care.

2.4 Factors to be considered

a. Administrative and institutional related activities towards utilization of funds by ULB would be governed by the Key Principles detailed in Chapter 1.

b. The priority is to ensure that there is one Urban-HWC per 15,000-20,000 population catering predominantly to poor and vulnerable populations, residents of slum and slum-like areas. This will be linked to the UPHC-HWCs at the population of 50,000. All the HWC-UPHCs and the Urban-HWCs are required to have a National Identification Number (NIN-ID) and register on the AB-HWC portal.

c. Since the aim is to strengthen the ownership and accountability of the ULBs for delivery of primary health care and essential public health functions, the state would work closely with the ULBs through the State Department of MA&UA to map the areas under each ULB to prioritize the location of the UPHC-HWCs.

d. All ULBs would be allocated a number of Urban-HWCs, based on the FC-XV allocation for the State. State /Municipal Corporation may need to leverage other funding sources if additional number of Urban-HWC are needed.

e. Decisions regarding the required number of Urban-HWCs, would depend on population density, presence of slums & similar habitations, vulnerable population, peri-urban areas and newly Notified Urban Areas would be decided by the State Level Committee (SLC) based on justification provided by the ULB. It will be essential that these areas are classified and placed under the Rural or Urban designations and provide services as mandated.

f. The Urban-HWC would be the first port of call for individuals and families in urban areas and would be linked to the nearest UPHC –HWCs for administrative, financial, reporting, and supervisory purposes.

g. The timings of Urban-HWC would be as per the schedule fixed by States considering the local needs of urban population.

h. **Urban-HWC should not be located in areas which are within 3- 5 kms distance of an UPHC-HWCs, Urban-CHC, SDH or a DH or any State level Dispensaries / Public Health Facilities.** This would ensure that this new initiative of Urban-HWC is focused on hitherto uncovered areas.

i. The ceiling of the unit cost for the Urban-HWC is fixed. State could decide to increase the number of units which can be made operational within the given funds, if the cost of setting up the unit is lower than the unit cost support provided or through the supplementation of resources by ULBs. ULBs should actively contribute through the provision of space in existing ULB owned buildings, community buildings owned by ULBs/RWAs, space available with NGOs/Charitable organizations, space in markets, shopping complexes, etc to ensure that these Urban-HWCs are enabled to provide primary health care services to the community.

j. State may explore engagement with private and not for profit sector for critical gap filling activities such as capacity building, Urban-HWCs management, provision of outreach services, diagnostic services, as appropriate to the local context, need and availability of the organizations to provide services etc. The contracting in/ contracting out / outsourcing of services should be complementary to Public sector services and should be well designed with monitor able indicators.

2.5 Support for this component under FC-XV

The XV-FC Health Grants to Local Governments - Urban Local Bodies provides Rs. 24, 028 crores to ULBs for setting up ***Urban HWCs***, across the country over five years. State-wise and year-wise

allocation is given at Appendix-1. Detailed unit cost particulars (Rs. 75 lakhs per urban HWC including the provision of specialist services at select higher level Urban primary health care facilities/U-CHCs, are given at Appendix-2. Detailed Guidance note on Urban HWCs is given at Appendix-3 and on provision of polyclinic /specialist services is given at Appendix-4.

2.6 Guidance for identification of facility, approvals and operationalization

2.6.1 Allocation by the State to Districts: Based on the resource available and number of functional UPHCs in the State / ULBs, the State will allocate resources to the Districts / ULBs. States must ensure that that the grant under this component is released to all the Districts / ULBs of the State. As the resources available under this component are substantial, the efforts should be made to saturate the ULBs in the Aspirational, Tribal and backward areas / blocks / districts of the State and accordingly, allocation is to be made. If any ULB has not been allocated support under this Urban-HWC component of FC-XV, the State Level Committee must provide a strong justification for such exclusion.

2.6.2 Apportioning by the Districts: Depending on the grants available to the District / ULBs, district /ULB will plan for the number of Urban HWCs that can be supported under this component of FC-XV. The District Level Committee, as elaborated in the Guidance Note to the States dated 9th July 2021 and as explained in Chapter-1, will take necessary actions. As the resources available under this component are substantial, Districts /ULBs may give preference to the areas where poor and vulnerable populations reside and slum and slum-like areas of the ULBs and accordingly, identification of locations for Urban- HWCs are to be finalized.

2.6.3 DLC will finalize the number of Urban-HWCs that can be covered with the financial allocation made by the State for this component of FC-XV.

2.6.4 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-I (or may be given in this chapter as well) to the State.

2.6.5 A Software is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and effective monitoring

2.6.6 After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV. **As per DOE guidance Note dated 16th July, 2021, (DoE's Guidance Note at Annexure (Para 8 at Page 8) and reiterated again at sub-point 10 under para 1.4.2 of Chapter 1), on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other**

consumables, etc., through a mechanism which may include centralized purchase at State level to ensure purchase of quality products at reasonable/competitive prices in an efficient manner after following the due processes/procedures and practices with the prior approval by the National Level Committee".

i. As the component involves multiple activities such as Infrastructure upgradation /provision of essential drugs and diagnostics / team based incentives and remuneration to HR and other HR related components, besides the operational diagnostic expenditure of PoC tests and independent monitoring, as per the decision of the State, DLC should ensure that the funds under this component are to be sent by the Urban Local Bodies **in-time** or **in-advance** to the State level agency (either State Health Society) or to the District level agency (District Health Society), as per the local context. This will ensure timely payment of remuneration and incentives to the primary healthcare team working at these SHC level HWCs. State level decision on the mobilization of funds from the ULBs to District or State level agency should be fully followed by the concerned Urban Local Bodies and DLC should monitor the compliance.

ii. Some States may opt for releasing the money to the Urban Local Bodies excluding the funds required for State level / District level agency activities for this component, as per their context as decided at the State level.

   a. Concerned Urban Local Bodies should be actively involved in the planning and monitoring of all the functional urban-HWCs. To the extent possible, the city level institutional arrangements should be utilized for this purpose.

   b. Capacity of the urban local bodies for all components of the FC-XV will need to be improved, by the state by undertaking the requisite trainings through state level institutions as per the plan in this regard (Detailed plan will be communicated separately). Since the aim is to strengthen the ownership and accountability of the ULBs for delivery of primary health care and essential public health functions, the state/District would work closely with the ULBs through the Department of Municipal Administration Institute.

2.6.7 The ULBs and DLC are required to focus on optimal utilisation of the grant for recurring expense incurred in the AB-HWC especially for Human Resources, their

training skills, salary and incentives, range of health care package of services to be offered, drugs, equipment, IT infrastructure, community structures and independent monitoring, all as defined in the CPHC guidelines.

2.6.8 **Negative List for this component of FC-XV:** The funds under this component cannot be utilized Repair and Renovation works already undertaken under the NHM Funds.

Appendix 2.1: Grants for Urban Health and Wellness Centres as indicated in XV Finance Commission

		2021-22	2022-23	2023-24	2024-25	2025-26	Total
S. No.	**State / UTs**	**Grants in 15th FC**	**Grants in 15th FC**	**Grants in 15th FC**	**Grants in 15th FC**	**Grants in 15th FC**	**Grants in 15th FC**
1	Andhra Pradesh	102.88	102.88	108.02	113.48	119.17	546.43
2	Arunachal Pradesh	5.24	5.24	5.50	5.78	6.07	27.83
3	Assam	69.93	69.93	73.43	77.10	80.95	371.34
4	Bihar	185.43	185.43	194.71	204.44	214.66	984.67
5	Chhattisgarh	133.88	133.88	140.58	147.60	154.99	710.93
6	Goa	20.48	20.48	21.50	22.58	23.71	108.75
7	Gujarat	260.73	260.73	273.76	287.45	301.83	1384.50
8	Haryana	139.33	139.33	146.30	153.62	161.30	739.88
9	Himachal Pradesh	1.41	1.41	1.48	1.56	1.64	7.50
10	Jharkhand	119.21	119.21	125.17	131.42	138.00	633.01
11	Karnataka	122.93	122.93	129.08	135.54	142.31	652.79
12	Kerala	322.22	322.22	338.34	355.25	373.01	1711.04
13	Madhya Pradesh	427.83	427.83	449.22	471.68	495.27	2271.83
14	Maharashtra	774.13	774.13	812.84	853.48	896.16	4110.74
15	Manipur	9.83	9.83	10.32	10.84	11.38	52.20
16	Meghalaya	23.30	23.30	24.47	25.69	26.98	123.74
17	Mizoram	12.01	12.01	12.61	13.24	13.90	63.77
18	Nagaland	22.61	22.61	23.74	24.93	26.18	120.07
19	Odisha	89.19	89.19	93.65	98.34	103.25	473.62
20	Punjab	241.75	241.75	253.83	266.52	279.85	1283.70
21	Rajasthan	106.49	106.49	111.82	117.41	123.28	565.49
22	Sikkim	8.19	8.19	8.60	9.03	9.48	43.49
23	Tamil Nadu	356.48	356.48	374.30	393.01	412.67	1892.94
24	Telangana	133.60	133.60	140.28	147.29	154.66	709.43
25	Tripura	41.68	41.68	43.76	45.95	48.25	221.32
26	Uttar Pradesh	424.55	424.55	445.83	468.07	491.47	2254.47
27	Uttarakhand	81.57	81.57	85.65	89.93	94.42	433.14
28	West Bengal	287.92	287.92	302.31	317.43	333.30	1528.88
	Total	**4,524.80**	**4,524.80**	**4,751.10**	**4,988.66**	**5,238.14**	**24,027.50**

Appendix 2.2: Indicative Unit cost particulars of Urban Health and Wellness Centres (Urban HWCs)

a. Components of Urban HWCs

Non-Recurring components	Recurring Components
Arrangements of premises / Rental / upgradation of Infrastructure	Drugs
Tele-consultation	Human Resource *(GDMO-1, Staff Nurse-1, MPW (M)-1, Support staff-2)*
Basic equipment's and furniture (excluding diagnostics support for UPHCs)	Capacity building for HR
	Team Based Incentives
	Drugs
	Quality Assurance activities for Infection Prevention control
	Operational expenses for running UHWC (other than rent, untied grants, consumables etc.)
	IEC/Branding
	Wellness Activities
	Untied fund
	Tele-consultation
	Monitoring
	Other items (convergence, Provision of specialist services, consumables, etc.)
@ 70 lakhs per Urban-HWC per annum for both recurring and non-recurring component	
@ Rs. 5 lakh/Urban-HWC for Polyclinic services	

b. Indicative Unit cost particulars

	Items	Budget outlay (in Rs.)	Remarks
One-time cost	Arrangements of premises / Rental / up-gradation of Infrastructure	25,00,000	Wherever ULB provides the building on free of cost, this component may be utilized for other activities to create more urban HWCs. • If the rented premises are arranged, max ceiling of Rs.1 lakh per premises per month may be adopted.
	Tele-consultation	1,00,000	
	Basic equipment and furniture (excluding diagnostics support for UPHCs)	2,00,000	

	Items	Budget outlay (in Rs.)	Remarks
Recurring cost	Human Resource *(GDMO, Staff Nurse, MPW (M), Support staff)*	20,00,000	
	Capacity building of Human Resource	1,00,000	
	Team Based Incentives	2,00,000	
	Drugs	12,00,000	
	Quality Assurance activities for Infection Prevention control	1,00,000	
	Operational expenses for running UHWC (other than rent, untied grants, consumables etc.)	1,20,000	This activity may be added for operational expenses for UHWCs @ Rs. 10,000/mon
	IEC/Branding	75,000	
	Wellness Activities	1,00,000	This activity may be added for wellness activities
	Untied fund	1,00,000	This activity may be added for untied fund @ Rs. 1 lakh/UHWC
	Teleconsultation	5,000	
	Monitoring	1,00,000	
	Other items (convergence, Provision of specialist services, consumables, etc.)	1,00,000	This activity may be added for undertaking other activities such as provision of specialist services, convergence etc.
Total of urban HWC components		70,00,000	
	For Polyclinic services @ Rs. 5 lakh/UHWC*	5,00,000	
	Grand Total	**₹75,00,000**	

*-To be pooled at the level of Urban PHC or Urban CHC where the specialist services are being provided

Appendix 2.3: Guidance on establishing Urban Health and Wellness Centre (Urban-HWCs)

2.3.1 Infrastructure:

a. For establishment of Urban-HWCs, infrastructure already existing with other government initiatives or Urban Local Bodies (ULB) or rented commercial spaces, residential flats, community halls, govt. housing etc. may be utilized, as support for new construction of urban-HWCs is not envisaged under the scheme e.g. buildings provided by ULBs for "Basti Dawakhana" in Greater Hyderabad Municipal Corporation of Telangana, space and basic infrastructure/ furniture provided by ULBs for "Atal clinics" in Jharkhand.

b. The service areas/space are to be earmarked and signs posted for the following: registration, waiting area, OPD, pharmacy, treatment/injection, counselling, wellness, separate toilets etc. The choice of the building should ensure that the quality of services is not compromised. The premises are required to be disabled friendly and necessary infrastructure should be in place.

2.3.2 Functions: The Urban-HWC would perform the following functions:

a. Facility based services: Urban-HWC will deliver comprehensive range of primary health care services i.e. preventive, promotive and curative as described in the Operational Guidelines for Comprehensive Primary Health Care through Health and Wellness Centres issued in 2018[2].

b. Community based services:

i. The Urban-HWC team in collaboration with ULB would enable household survey/ population enumeration for slums & similar habitation, low-income groups, homeless and other categories of vulnerable population through MPW, Urban ASHA, MAS or through mobilizing other volunteers.

ii. Allocation of areas/demarcation of population for enumeration between frontline workers Urban ASHA and MPW should be undertaken for universal population coverage.

iii. The Urban-HWC will provide outreach services (UHND) through MPW (F)/MPW (M), ASHA & supported by MAS on a targeted basis for slums & similar habitations and vulnerable population in a defined geographic area of the Urban-HWC.

iv. The ULB would facilitate the Residential Welfare Associations (RWAs) to undertake public health activities including health promotion activities about clean environments,

[2]http://nhsrcindia.org/sites/default/files/Operational%20Guidelines%20For%20Comprehensive%20Primary%20Health%20Care%20through%20Health%20and%20Wellness%20Centers.pdf

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.

v. The ULBs would 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.

c. Public Health Functions, including preventive and promotive care

i. ASHA and MAS are a key mechanism to reach the vulnerable and marginalized population. They will continue to be strengthened including their linkages with Urban Local Bodies (ULB) and strengthen the outreach and preventive and promotive functions including public health actions.

ii. For other sections, ULBs would enable the formation of *Resident Health Associations* preferably with the locus being a public health facility. Such associations would be a platform or federation comprised of representatives of MAS, (from poorer areas), Resident Welfare Association (RWA) such as Gully/Mohalla committees. This would ensure that information about public health activities, as well as awareness about lifestyle changes, healthy diets, weather events like heat strokes, etc. are disseminated across all residents in an area, irrespective of socio-economic status and area of residence or work.

iii. Engagement of the Primary Health Care team at the Urban-HWC with schools for screening of early childhood diseases, through an active School Health Programme may also be promoted. These linkages are essential under the Ayushman Bharat – School Health and Wellness Ambassador Initiative and the same can be leveraged for engaging with the teachers and students.

iv. Public health functions related to regular surveillance, timely IDSP reporting and early outbreak management with contact tracing, referrals and follow-up as well as interventions for screening and prevention of chronic communicable and non-communicable diseases will be undertaken by Urban-HWCs supported by the ULBs, under the overall supervision of the linked HWC-UPHC.

v. Preventive and Promotive healthcare services such as awareness on healthy lifestyles, wellness activities like yoga, meditation, physical exercise and other activities would be provided at the Urban-HWC. These centres will also provide guidance on "Eat Right" and engaging with the community on their eating practices.

vi. Health promotion activities would be organized every month at Urban-HWCs as per Annual health calendar issued by MoHFW with a list of health-related days. Other activities may also be included based on the local health needs, to ensure that

communities are empowered on social issues like gender-based violence, harmful effects of alcohol and tobacco and substance abuse.

d. Access to specialist services/Polyclinics:

Tele-consultation services would be made available in all Urban-HWCs for availing specialist consultations. The state in collaboration with ULB would decide on the level of facility to serve as a hub (UPHC/UCHC/District Hospital/Medical Colleges/Existing hubs which have been developed as hubs can be linked or expanded to provide these services). Some States are experimenting with Specialist Clinics like AMA Clinic in Odisha and evening specialist services in Karnataka at the HWC-UPHC level.

e. Human Resources: The Urban-HWC is to be staffed with a Medical Officer, a Staff Nurse/Pharmacist, Male-MPW and two support staff. Ideally, the ANM and ASHA are responsible for the catchment area of an Urban-PHC wherever available will be drawn from HWC-UPHC / U-CHC for respective Urban-HWC while deriving their salary 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. Savings are more likely in urban HWCs, as diagnostic services to these Urban HWCs may be provisioned under the component of Diagnostic Infrastructure at Urban PHCs.

Table 6: Human Resources:

Type of staff	No. required
Medical Officer (new recruitment)	1
Staff Nurse (new recruitment)	1
One MPW (Male) (new recruitment)	1
Guard (Outsourced)	1
Cleaning Staff (Outsourced)	1
Total	5

f. Training and Capacity Building: The staff posted at Urban-HWC would be oriented/trained in the competencies to deliver primary health care and public health functions, as well in the use of Digital and IT systems to access online training and real time reporting of data. They would also be trained in undertaking vulnerability assessment and community-based processes to enhance reach to marginalized communities.

g. Medicines, Diagnostics and Equipment: The provisioning of medicines and diagnostics is to be made as per CPHC guidelines for Urban-PHCs. The EDL for each facility to be made as per govt. guidelines and the existing e-aushadi mechanism, shall be used for drug management. The hub and spoke model shall be adopted for diagnostics at Urban-HWCs.

The budget available under FC-XV for diagnostic services could be utilized. The details of the services which are being provided at these centres (diagnostics and medicines as well) are to be displayed at the centre.

h. Monitoring and Supportive Supervision: The Urban-HWC Medical officer would report to the Medical Officer of the linked Urban-PHC, who would undertake periodic review meetings to ascertain effective implementation and ensure early collective action. The ULBs would also be involved in such review meetings.

i. Citizen charter: 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 and other citizen friendly information. Patients' rights should be ensured, and they should also be made aware of their responsibilities (e.g. to keep the facility clean and avoid spitting in corners, avoiding over-crowding by attendants, respecting visiting hours etc.). Important contact numbers (such as fire, police, ambulance, blood banks and referral centres) must be clearly visible.

Appendix 2.4: Establishing specialist services / polyclinic at higher urban primary healthcare facilities to ensure access to specialist services/Polyclinics

In selected Urban-PHCs based upon the context of the local area, state would make arrangements to provide selected specialist services on a periodic basis, so as to bring these services closer to the people. The timings are required to be displayed along with the days of the visit. It will be important to provide the same as per the needs of the community and the requirements which they list. The funds for these activities will be pooled from the urban HWCs @5 lakhs per urban HWCs for the provision of specialist services at the selected UPHC or UCHC.

2.4.1 Operationalization:

a. The XV-FC provides for provision of specialist healthcare services by strengthening all HWC-UPHCs or a selected UCHC, depending upon geographic location, density, available infrastructure, disease burden, community needs etc.
b. In addition to the existing Urban-PHC functions, these would provide specialist care on rotational basis (day care/ambulatory) to the urban population residing in catchment area of all associated UPHCs and Urban-HWCs
c. A separate Urban-PHCs with specialist services may not be required wherever U-CHC is functional and providing Specialist services. The same U-CHC may be strengthened to ensure specialist services are being provided in the area.

2.4.2 Referral linkages can be established between the Urban CHC, UPHCs and Urban-HWCs to ensure continuum of care and assured care. This can be supplemented through teleconsultations for services which can be provided without the patient having to visit the higher centre physically

2.4.3 Infrastructure:

- Strengthening of existing infrastructure of UPHCs for provision of specialist services should be based on services planned (not under this component of FC-XV but through regular NUHM support or through Urban Local Bodies support). Improvements of the premises should preferably be ensured with support from the ULBs. New construction for specialist services at the select UPHCs is not envisaged under this component of FC-XV.
- Separate earmarked space to be made available for specialists OPD, registration, Dental, refraction, physiotherapy, laboratory, treatment/Injection, examination, pharmacy, imaging services etc.

2.4.4 Service Provision: The HWC-UPHCs with specialist services would provide the following services:

i. Outpatient specialist care, with provision for 2 day-care observation beds.
ii. Fixed day rotational specialist OPD services for Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology and Psychiatry. Dental, physiotherapy and optometrist services etc. may be planned as per local needs and requirement.
iii. Laboratory tests for the specialties concerned along with point of care testing would be provided.
iv. For improvement of diagnostic infrastructure to provide specialist services at the select UCHC or UPHC (where human resource is available for performing the tests), the resources under the component of Diagnostic Infrastructure for UPHCs of FC-XV may be utilized, both, by equipping these facilities with the required infrastructure / equipment and support for sample transport under a hub and spoke model.
v. The select UCHC / UPHC for providing specialist services can be a hub for UPHCs/ Urban HWCs for providing Tele-consultation services.
vi. The medicines required to provide the specialist services at these UPHCs / urban CHCs would be supported under Free Drugs Services Initiative or ULB support.
    a) Timings: The timings of U-PHCs with specialist services would be decided by the States as per the need of the community and availability of staff to be positioned at these centres. Evening OPDs should be encouraged.
    b) Human Resource: In addition to HR available at UPHCs, the following is the indicative list of specialists and other support staff required for provision of specialist services at the select Urban-PHCs / urban CHCs.

Table 7: Human Resources:

Type of staff	No. required
Specialist each for Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology and Psychiatry*	6
Dentist (May be on fixed days)	1
Staff Nurse	2
Optometrist	1
Physiotherapist,	1
Integrated counsellor	1
Multipurpose Worker/Guard (Outsourced)	1
Cleaning staff (Outsourced)	1
Total	**14**

*- The State can be given the option to engage additional specialists based on local needs and context. **These specialists can also be in-sourced on a per hour / per patient basis.**

2.4.5 Training and Capacity Building:

The staff posted at these select UPHCs / urban CHCs for providing specialist services should be given orientation/training on various program activities, public health surveillance, etc. Besides this, they would also be trained on various IT applications. U-PHCs with specialist services would function and report on e-hospital/e-shushrut application of NIC and C-DAC and other portals such as AB-HWC, HMIS, RCH, NCD, IHIP, etc.

2.4.6 Referral Services:

i. Clear referral pathways with mapping of the Speciality Services (type of services and timings for which they are available) need to be established between Urban-HWCs, UPHCs and UPHCs / urban CHCs providing specialist services.
ii. The select UPHCs / urban CHCs providing specialist services shall provide assured referral linkages with higher centres like Maternity Homes, SDH, DH and Medical College Hospital in the City/District. Besides this, specific institutions like de-addiction centre, rehabilitation facilities, old age homes and specialized counselling Centres should be identified to enable ease of access to services. It will be required to provide the details of the nodal persons from each of these centres to the UPHCs with specialist services staff.

2.4.7 Citizen charter: 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 and other citizen friendly information. Patients' rights should be ensured, and they should also be made aware of their responsibilities (e.g. to keep the facility clean and avoid spitting in corners, avoiding over-crowding by attendants, respecting visiting hours etc.). Important contact numbers (such as fire, police, ambulance, blood banks and referral centres) must be clearly visible.

Chapter-3: Construction of Building-less Sub centres, PHCs and CHCs

3.1 Introduction

The Sub Centres and Primary Health Centres provide the first level of healthcare close to the community. The National Health Mission has supported not only construction of these peripheral facilities but also encouraged the states to operate such facilities in rented buildings where government buildings or land for construction was not available. In addition, a few States are also providing services from Rent Free Panchayat / Voluntary Society Buildings to ensure care closer to the community and as per the given population norm.

The FC-XV[3] report (Para 7.145, page 215) states that "*an assessment of infrastructure gaps in rural PHCs/Sub centres based on Rural Health Statistics, 2019, shows that 885 PHCs and 33,886 Sub centres do not have the necessary infrastructure to meet the targets of the National Health Policy, 2017. The Commission proposes to provide support for necessary infrastructure for 27,581 HWCs at the Sub Health Centre level and 681 HWCs at the Primary Health Centre level in rural areas in close collaboration with rural local bodies (Annex 7.10 D).*"

3.2 Factors to be considered

Despite the best efforts by the States, there are still gaps in terms of functional public health facilities in existing government owned building. Some of the civil infrastructure is in a dilapidated status. So, taking cognizance of this fact, FC-XV has provisioned certain amount for each state to meet this gap to the extent possible within the resources allotted. Therefore, the States may utilize these funds for **new constructions of the building-less facilities** as per the allocations made under the FC-XV grants. The States may prioritize the **new constructions of Sub Health Centres** based on the funds available under the FC-XV:

i. **Run-down / dilapidated building structures** which are required to be re-built.
ii. Construct new buildings, where services are being provided from **rented buildings** which lack required space and infrastructure to provide the comprehensive package of services, lab infrastructure and space to conduct wellness activities; Priority may be given to Sub Health Centres, especially in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers.
iii. New buildings in lieu of Rent-Free Panchayat / Voluntary Society Building, especially where space and infrastructure is inadequate to provide the entire range of 12 CPHC

[3] https://fincomindia.nic.in/ShowContentOne.aspx?id=9&Section=1

services, lab infrastructure, for wellness activities.

iv. New buildings, if required as per shortfall of population norms (details given in RHS 2020[3])

v. **States are informed that if the existing rented buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**

The SLC /DLC shall mandate the quality check of the constructed facilities as per the norms set by the State in accordance with the other construction works undertaken. The SLC should ensure third party monitoring and quality checks to ensure that the works undertaken meet the required quality parameters and are constructed as per the terms and conditions decided by the State.

3.3 Support for this component under FC-XV

The Fifteenth Finance Commission (FC-XV) has provided grants of **Rs.7,167 crores** cumulatively for all **28 states for a five-year duration from FY 21-22 to FY 25-26** for supporting infrastructure of Sub Health Centres, Primary Health Centres and Community Health Centres which are functional in building-less - rented or rent-free panchayat/ vol. society building.[4] Details of the funds allocated for each financial year are given in **Appendix-1**

3.3.1 Unit cost for the Building-less SHC / PHC / CHCs under this component of FC-XV is given below:

- Unit cost per SHC is 55.5 lakhs
- Unit cost per PHC is 1.43 Cr
- Unit cost per CHC is 5.75 cr

A Guidance note to the States to effectively plan for construction of buildings for the Building-less SHCs / PHCs / CHCs are given in Appendix-2.

3.4 Guidance for identification of facility, approvals and operationalization

3.4.1 Allocation by the State to Districts: Depending on the resources available under this component of FC-XV and the building less facilities in the State, it is suggested to the States that priority shall preferably be given to building-less SHCs / SHC-HWCs in the first instance and if more resources are available after saturation of all the SHCs level building-less institutions, then building-less PHCs / PHC-HWCs may be taken up. Accordingly, the State can allocate resources to the Districts based on the number of

[4] https://fincomindia.nic.in/ShowContentOne.aspx?id=9&Section=1

such building-less SHCs in a district. As the resources available under this component are limited, the efforts should be made to saturate the provision of infrastructure to the building-less SHCs / PHCs of Aspirational, Tribal and backward areas / blocks / districts of the State and accordingly, **allocation of resources amongst the districts** is to be made. Depending on the resources available, State has to finalize a five-year plan for the total number of building-less facilities that can be covered under this component of FC-XV and then work out its year-wise phasing.

3.4.2 Apportioning by the Districts: Depending on the grants available to the District, district will identify the building-less SHCs / PHCs. The District Level Committee, as elaborated in the DoE's Guidance Note to the States dated 16th July 2021 and as further explained in Chapter-1, will take necessary actions. As the resources available under this component are limited, Districts may saturate the provision of infrastructure to the building-less SHCs / PHCs of Aspirational, Tribal and backward areas / blocks of the District and accordingly, identification of building-less facilities may be taken up. The choice of prioritizing a 'building-less' SHC or PHC and their location, would rest with the **District Level Committee. As per the DoE's guidance note (Para 7 at page-7), at the district level, the Zilla Panchayats or Autonomous District Councils shall handle / implement all rural components including this component in close coordination with the District Health Department under the overall supervision of the District Collector (not at Block Panchayat or Gram Panchayat level), because the components require technical experience as well as exposure in relevant subjects. However, rural local bodies below the district level (as the case may be), such as Block /Taluk level Panchayats, and Gram Panchayats / Village Councils must be involved in planning and monitoring of these components for the health facilities located in their jurisdiction.**

3.4.3 Selection of sites for construction should be such that its benefits reach larger segments of vulnerable populations such as SC / ST population dominated blocks/areas, and remote areas. Land should be available for the selected facilities and land purchase cost should not be covered with this component. To the extent possible, lands available with the local bodies / government land revenue department should be utilized. The land allocated should be ideally with-in the community to improve access to care.

3.4.4 The States /District may pool in additional funds from other sources like District Mineral Fund (DMF), CSR funds, etc. as supplementary financial resources for addition of extra-facilities in the select public healthcare facilities or to cover more number of building-less facilities in the district / State, duly conforming to the requirements and

mandates under each fund.

3.4.5 Also, timely completion of construction is important for effective utilization of **funds under this component of FC-XV, t**he process of land transfer and other revenue records up-dation should be completed by the district at the earliest, much before the arrival of approval from the State.

3.4.6 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-I to the State.

3.4.7 A software package is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

3.4.8 After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV

i. As the component is only for infrastructure work, as per the decision of the State, the activity may be done through the engineering wing of the State level department or through Zilla Parishad engineering wing. **As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

3.4.9 Local Bodies (District and Block) should be actively involved in the monitoring of the progress of the construction work. To the extent possible, the institutional arrangements such as JAS / VHSNCs should be utilized for this purpose.

3.4.10 The DLC will also ensure that monitoring of the construction is under-taken, and UCs are submitted on time.

3.4.11 **Negative List for this component of FC-XV:** The funds under this component cannot be utilized for the following:

i. Repair and Renovation works already undertaken under the NHM Funds.
ii. This amount should not be used for the construction of a single room /wellness area or any other single project like boundary wall, toilets, water tanks etc.
iii. Construction of boundary walls, entrance, pavements, footpaths etc.

Appendix 3.1: Grants for Building-less Sub-centres, PHCs, CHCs as indicated in XV Finance Commission

State	2021-22	2022-23	2023-24	2024-25	2025-26	Total (Rs. In crore)
Andhra Pradesh	1.17	1.17	1.23	1.29	1.36	6.22
Arunachal Pradesh	1.06	1.06	1.10	1.16	1.22	5.60
Assam	13.32	13.32	3.98	14.69	15.41	70.72
Bihar	329.29	329.29	345.6	363.00	381.10	1748.27
Chhattisgarh	10.75	10.75	11.28	11.85	12.45	57.08
Goa	1.54	1.54	1.61	1.70	1.78	8.18
Gujarat	1.17	1.17	1.24	1.29	1.36	6.23
Haryana	29.51	29.51	30.97	32.53	34.15	156.67
Himachal Pradesh	2.68	2.68	2.81	2.96	3.11	14.24
Jharkhand	118.54	118.54	124.41	130.67	137.19	629.35
Karnataka	10.06	10.06	10.56	11.09	11.64	53.41
Kerala	0.50	0.50	0.52	0.55	0.58	2.64
Madhya Pradesh	30.03	30.03	31.52	33.10	34.75	159.44
Maharashtra	50.07	50.07	52.55	55.21	57.96	265.87
Manipur	2.03	2.03	2.12	2.24	2.35	10.78
Meghalaya	3.21	3.21	3.37	3.54	3.72	17.06
Mizoram	0.56	0.56	0.58	0.61	0.64	2.95
Nagaland	1.03	1.03	1.08	1.13	1.19	5.46
Odisha	72.83	72.83	76.43	80.28	84.29	386.66
Punjab	20.26	20.26	21.26	22.33	23.45	107.57
Rajasthan	191.39	191.39	200.87	210.98	221.51	1016.14
Sikkim	0.53	0.53	0.55	0.58	0.60	2.79
Tamil Nadu	71.21	71.21	74.73	78.50	82.41	378.05
Telangana	2.81	2.81	2.96	3.11	3.26	14.95
Tripura	0.25	0.25	0.26	0.27	0.29	1.32
Uttar Pradesh	333.68	333.68	350.22	367.84	386.18	1771.59
Uttarakhand	1.43	1.43	1.49	1.57	1.65	7.57
West Bengal	49.04	49.04	51.46	54.05	56.75	260.33
All States	**1,349.95**	**1,349.95**	**1,416.76**	**1,488.12**	**1,562.35**	**7,167.14**

Appendix 3.2: Note on Infrastructure Planning and Design requirements:

This document lists the **guiding principles for building new health infrastructure** with the **model layout plans** and **suggestive area** required for building new health facilities. The states may modify the layout for these facilities and plan for their construction and operationalization as per the FC XV allocation of grants to the State, based on the local context.

3.2 Guiding principles for infrastructure planning

While planning the new construction of the health facility, it is imperative to consider following points which would enable the state and districts to place the required design elements thereby delivering quality services that are integrated with essential primary and secondary care service:

a. The new facility should ideally be located centrally to allow for access to a large proportion of the catchment area. It can also be built near the Panchayat Office, Primary Health School / Anganwadi Centre etc.

b. Every health facility should ensure availability of essential infrastructure as per Operational Guidelines for Comprehensive Primary Health Care: Health and Wellness room (for HWCs), emergency room & wards (for PHCs and CHCs), examination room, laboratory services, storage and dispensing facilities for drugs as the core areas.

c. The infrastructure for SC-HWCs, PHC-HWCs and CHCs should follow the rules and regulations as laid down in the state by-laws and the associated National Building Code and are friendly for differently abled, patient friendly with appropriate culture and gender sensitive amenities.

d. There should be availability of drinking water, hand-washing area, separate female and male toilets, parking area, waiting area, laundry facilities and waste disposal as per BMWM Rules, 2018.

   i. All new infrastructure should be environment friendly with scope for enough natural light, water harvesting, solar energy, etc.

   ii. Availability of an open area for management of any disasters or emergency cases.

   iii. The facilities should be in line with the national and state disaster management plan / National Disaster Management Plan for hospital safety, 2016 issued by NDMA, GoI.

   iv. Regular piped water supply and reliable electricity for service delivery should be made available at the site of new construction. This should be ensured in collaboration with the concerned departments and if required, facilitation should be done at the district level. The water storage along with the required equipment also needs to be provided.

v. New electrical appliances should have a minimum 3-star rating from Bureau of Energy Efficiency or equivalent recognized organization to minimize the energy input. When choosing the technology, guidelines and standards issued by the Ministry of New and Renewable Energy must be adhered to (Gazette of India April 16, 2018, No 1456).

vi. To ensure compliance with safety norms, all new hospital buildings should comply with provisions prescribed for seismic zone IV and V and mitigation measures to be undertaken as per National Building Code if such buildings are situated in these zones.

vii. The infrastructure should be planned, designed and built to take account of future expansion – both with regards to the quantity and range of services to be provided, either through expanding it vertically or horizontally.

viii. Citizen Charter should be displayed near the entrance of the building indicating various services, their timings, responsibilities of patients and providers, details of referral vehicles and facilities, number of diagnostics and drugs being provided free and other citizen friendly information should be displayed prominently.

ix. The process and flow of services should be properly organized, in order to minimize patient discomfort and ensuring safety. The IPHS 2012 and CPHC guidelines would be followed for SHC, PHC and CHC or updated as per the latest available guidelines of GoI.

x. HWCs should offer space for health education, conducting yoga sessions, community meetings on health awareness, and a display of key health messages related to public health.

xi. The infrastructure should be planned, designed and built to take account of future expansion – both with regards to the quantity and range of services to be provided, either through expanding it vertically or horizontally.

3.3. Layout Plan: The flow of services should be in alignment with the IPHS 2012 guidelines or the most recent ones released by GoI and as given in the Appendix 3).

The essential areas to be planned for all health care facilities:

i. Waiting area - For patient registered at registration counter, there should be seating arrangement for them while they wait for their consultation. Adequate seating arrangement/ chair should be available.

ii. Consultation room – Room of Community Health Officer / Medical Officer and Specialists, should have enough space to accommodate desks and chairs, where

interaction with patients can be undertaken with confidentiality and dignity. It should be well lit and ventilated.

iii. Examination room (This can be combined with the Consultation room if there is a space constraint). It should be co-located with consultation room or Can be clubbed with the consultation room with due privacy features for the patient. It should have adequate space for accommodating an examination table (wheeled, wall mounted, single piece), space for free movement around examination table, curtains for privacy and wall mounted cupboard where essential equipment, etc. can be kept.

iv. Record keeping: Every HWC must plan to ensure safe upkeep of the necessary records preferably utilizing IT systems.

v. Day care beds: The facility may sometimes require the patient to be under medical supervision for a period of a few hours at Sub-Centre and PHC-HWCs.

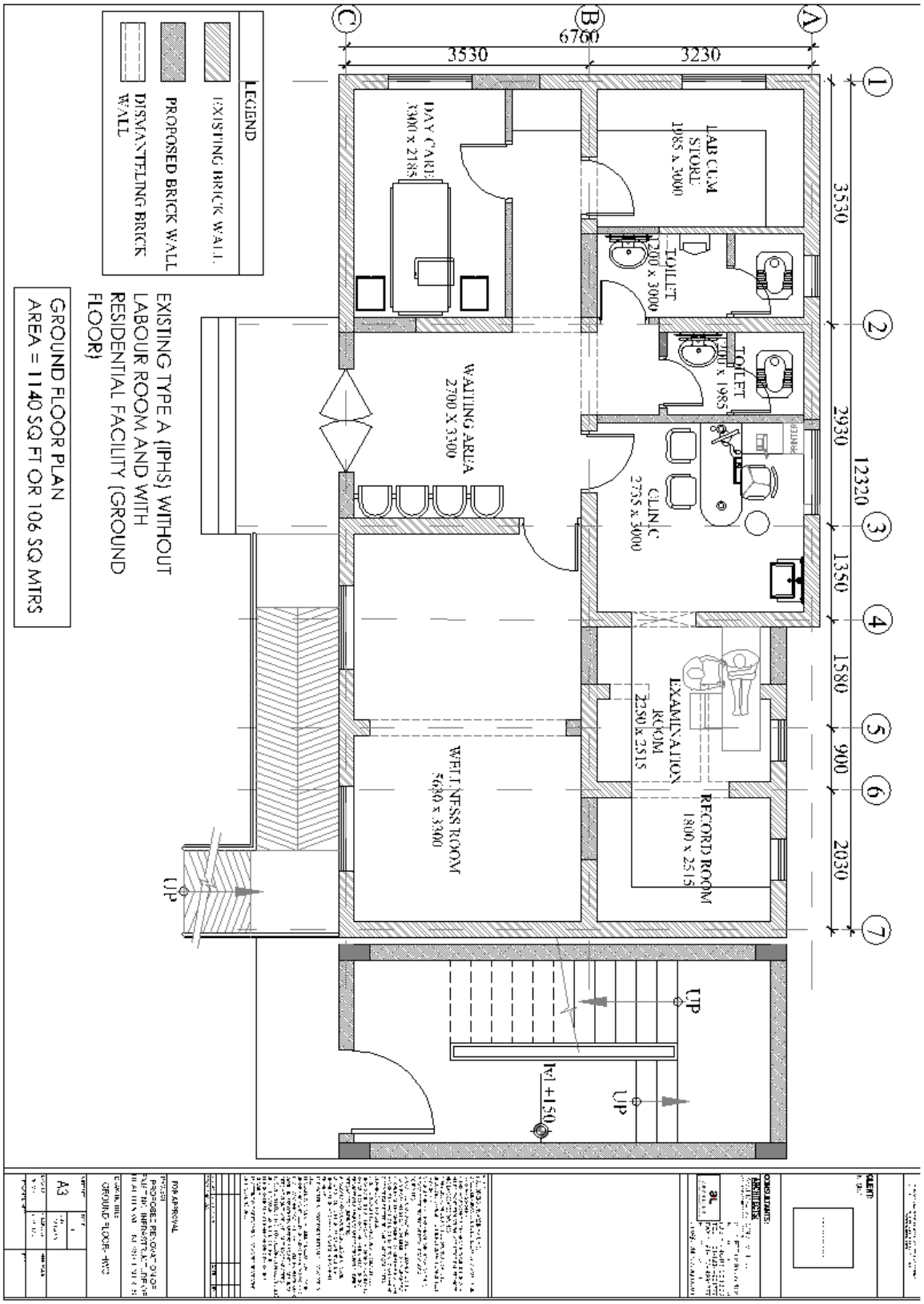
vi. Store: Adequate and spacious stores located away from patient traffic with facility for storing drugs, consumables, records, linen, furniture, equipment and sundry articles. GoI Guidelines for safe disposal of expired drugs and vaccines should be adhered to.

vii. Support services – Drinking water / Handwashing facilities: Washroom facility, laundry facilities and waste disposal as per BMWM Rules, 2018 should be part of planning.

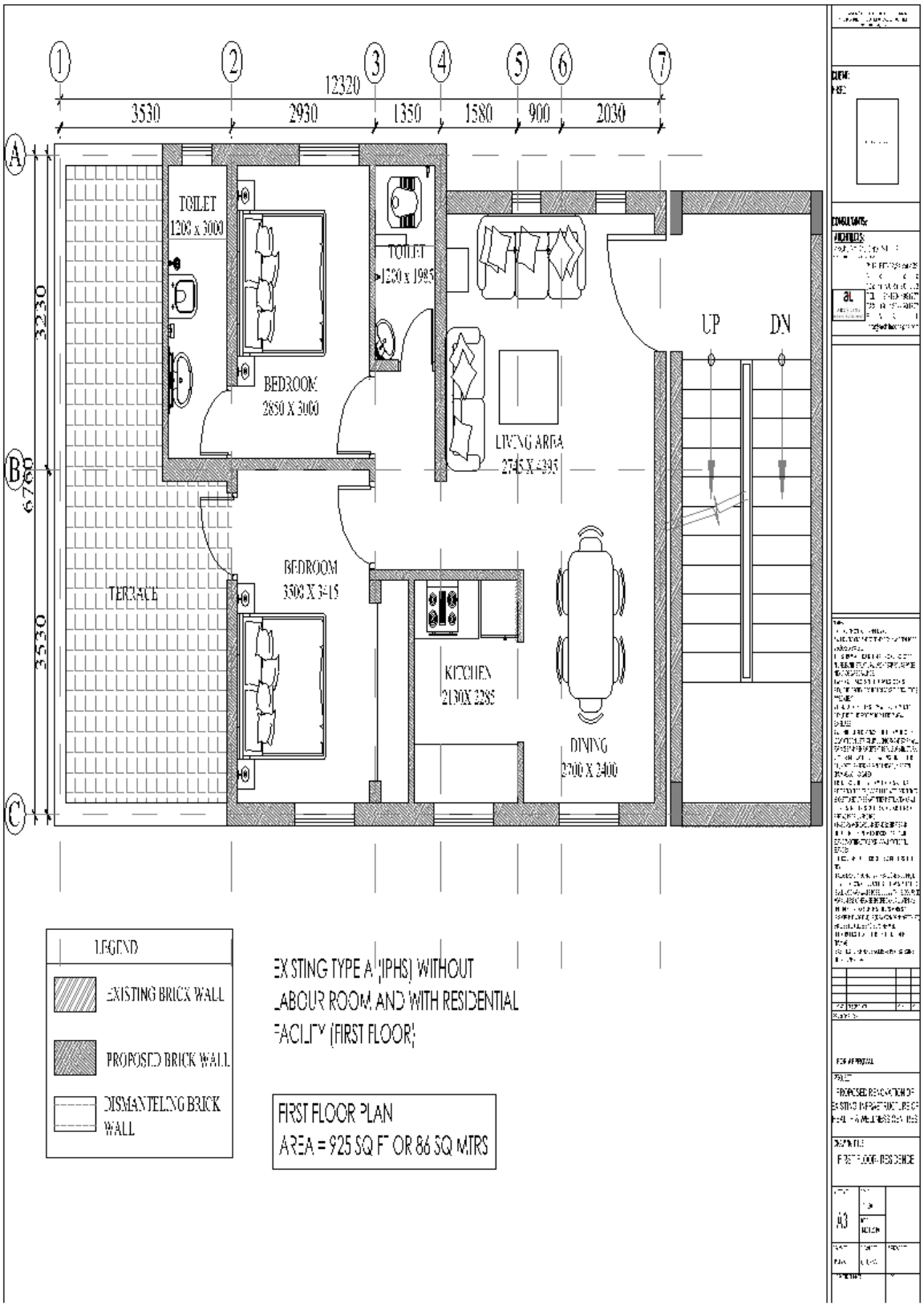
Table 8: Suggestive area for facility:

S.No.	Type	Suggestive Area in sq. ft
1.	Primary Health Centre	
	PHCs / PHC level HWCs	**8,369.8**
2.	SHC – HWC with residential facilities	**3,766.0**
	SHC - HWC building without Residence	**2,098.0**
3.	Community Health Centre (30 bedded)	**22,596.0**

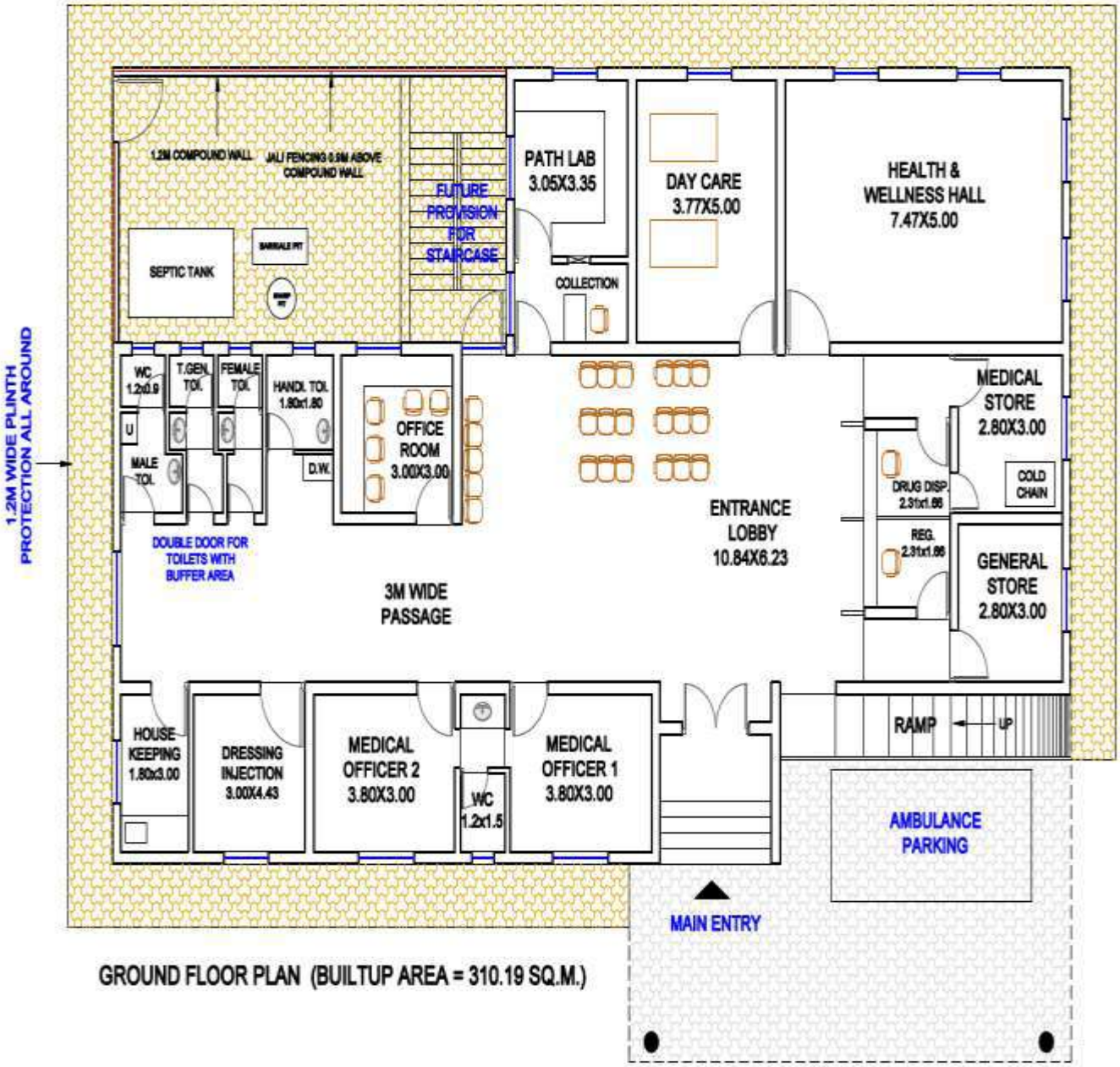
a. Suggested Layout plan for Sub Centre- Health and Wellness Centre (ground floor)



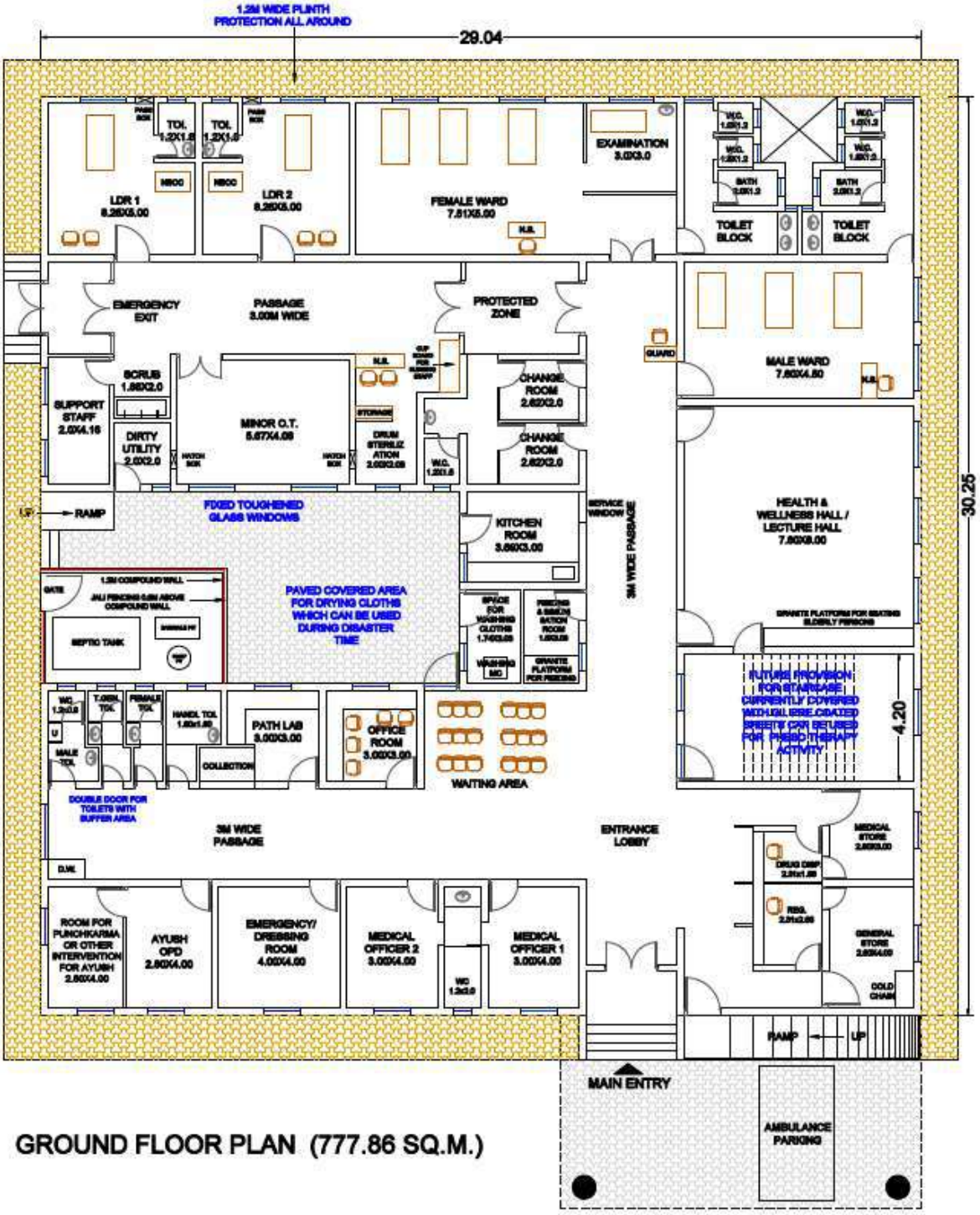
b. Suggested Layout plan for Sub Centre- Health and Wellness Centre (first floor)



c. Suggested Layout plan for Primary Centre- Health and Wellness Centre

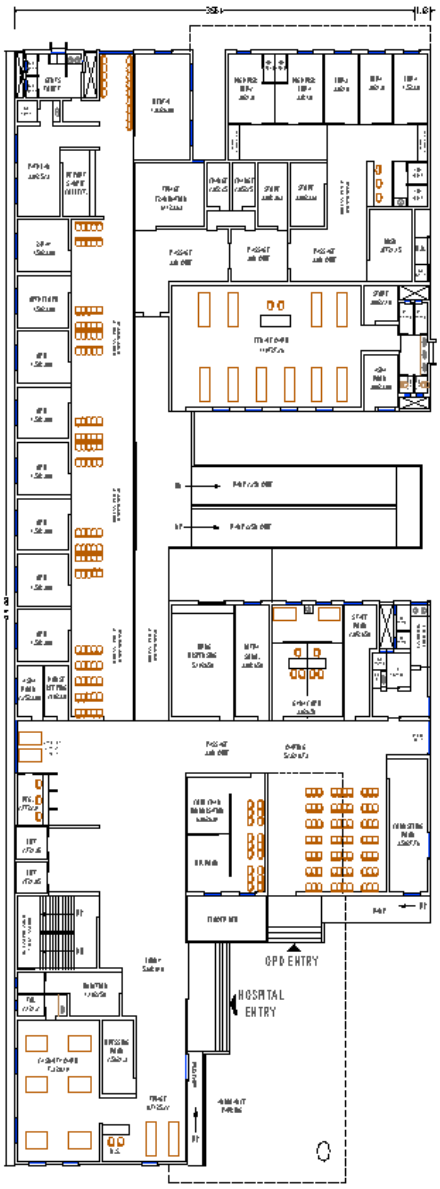


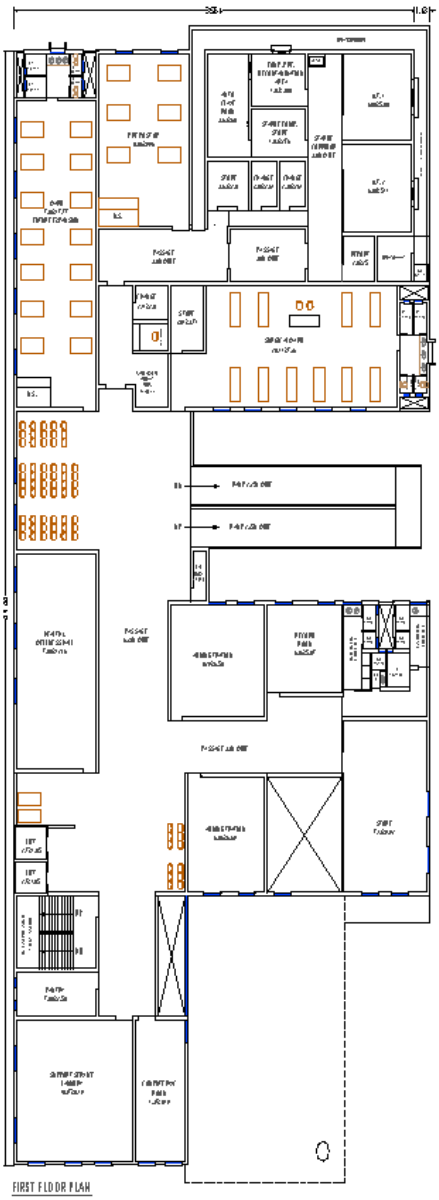
d. Suggested Layout plan for Primary Centre- Health and Wellness Centre



GROUND FLOOR PLAN (777.86 SQ.M.)

e. Suggested Layout plan for 30/50/100 bedded Community Health Centre





PROPOSED PLAN OF CHC 30/50/100 BEDDED FOR IPHS

SANGRAM GAIKWAD AND ASSOCIATES
ARCHITECTS ENGINEERS INTERIOR DESIGNERS & VALUERS

Chapter-4: Conversion of Rural Sub Health Centres and Primary Health Centres to AB-HWCs

4.1 Background

- Ayushman Bharat- Health and Wellness Centres (AB-HWCs) are intended to deliver Comprehensive Primary Health Care (CPHC) which is universal and free. It is envisaged that 1,50,000 SHCs and PHCs in rural and urban areas will be transformed as AB-HWCs by December 2022.
- The COVID19 pandemic has further highlighted the need to strengthen primary health care system and build local capacities in rural areas to integrate public health actions into Primary Health Care and ensure uninterrupted delivery of essential services particularly during the pandemic.
- Operational Guidelines on *Ayushman Bharat Comprehensive Primary Health Care through Health and Wellness Centres (2018)* provide detailed guidance on the conversion of SHCs and PHCs into HWCs. Further, AB-HWCs are being implemented by the States since 2018 and hence, these existing operational guidelines with the necessary time-to-time updates provided by the Ministry are to be followed by the States while implementing this component of the FC-XV. Link to the guidelines is : https://abhwc.nhp.gov.in/download/document/45a4ab64b74ab124cfd853ec9a0127e4.pdf

4.2 Factors to be considered

4.2.1 To enable the States to achieve the target of 1.5 lakhs of functional HWCs by December 2022, so far, under the National Health Mission (NHM), sanctions have been given to convert more than 1.5 lakhs SHCs and PHCs into HWCs, including the approvals in the RoP 21-22. Hence, States have been sanctioned financial support for meeting the non-recurring expenditure to convert the SHCs and PHCs into HWCs. Further, under RoP-21-22, financial approval was provided for a few months to meet the recurring expenditure of functional HWCs, keeping in view that the grants under the FC-XV are to be available to the states for this component and have to be fully utilized by the States within this fiscal year.

4.2.2 Hence, the grant-in-aid under this component of Fifteenth Finance Commission (FC-XV) shall preferably be utilized by all 28 States **ONLY** for ***recurring*** expenditure for the Sub Health Centres and rural PHCs that have been transformed into AB-HWCs. This grant may also be utilized for one-time cost for building additional facilities to undertake wellness activities depending on the Resource Envelope available. This will ensure optimal utilization of the FC grants under this component.

4.2.3 It is also to highlight that FC-XV allocations to a State / District will not cover the requirement of recurring expenditures of **all the functional SHC and PHC level HWCs** in a State / District and hence, the State especially, the Districts have to plan in such a way that the selected SHC and PHC-HWCs continue to be supported under FC-XV for five years from FY 21-22 onwards to ensure continued support to these selected functional AB-HWCs. **For the remaining SHC and PHC level HWCs, State/District may continue to obtain the support from NHM funds as well other sources. One HWC should not be funded from both FC-XV funds and NHM. All components of a particular HWC should be funded entirely and exclusively from one source- viz: either FC-XV or NHM.**

4.2.4 Based on the data uploaded by the States in HWC portal on the functional SHC and PHC level HWCs as on 14th August 2021, and the unit costs for operationalizing HWCs, it is estimated that the grant available under FC-XV for this component for present FY 21-22 will be sufficient **ONLY** to cover the recurring expenditure of significant proportion of functional SHC-HWCs in 25 States. **In the remaining 3 States, (Orissa, Bihar, Rajasthan)**, the grant available under FC-XV for this component is sufficient to cover the recurrent expenditure of **ALL** the functional SHC-HWCs as on date, besides covering the recurring expenditure of some proportion of PHC level HWCs functional as on date.

4.2.5 Further, though the FC recommends an upper limit of unit cost of 9.7 lakhs for SHC level HWCs and 5.6 lakhs for PHC level HWCs, to retain the uniformity of support under NHM and FC-XV for meeting the recurring expenditure of HWCs, the unit cost for meeting the recurring expenditure of SHC level HWCs is fixed at Rs.7.81 lakhs per HWC per annum and unit cost for meeting the recurring expenditure of PHC level HWCs is Rs.4.29 lakhs as per Operational Guidelines on *Ayushman Bharat Comprehensive Primary Health Care through Health and Wellness Centres (2018)*. The difference in the amounts can be used to fund more numbers of HWC.

4.2.6 If for any reasons specific to their local context, States need to utilize the grant under this component of FC-XV for non-recurring / one-time expenses such as infrastructure strengthening, Lab and IT infrastructure, cost for 6 months certificate course of CHOs, etc, then the unit cost mentioned in the Operational Guidelines (Rs.9.7 lakhs and Rs.5.6 lakhs for SHC-HWC and PHC-HWC respectively) is to be utilized by the States. At the same time, care should be taken that there is no duplication w.r.t to the sanctions already given under NHM support.

4.2.7 Further, present Operational Guidelines, do not allow the co-located Sub Health Centres, to be converted into HWCs and hence, the FC-XV grant should not be utilized for such purposes either.

4.2.8 Finally, it is re-iterated that optimal utilization of the funds under this component of FC-XV is to be ensured. **As stated earlier, costs for recurring expenditure of SHC-HWC or PHC-HWC should NOT be supported with multiple funding sources- (FC-XV, NHM or any other State funds).**

4.3 Support for this component under FC-XV

- As reiterated above, all the AB-HWCs (both SHC and PHC levels) in a State whether supported through NHM, FC-XV or other funding sources would follow the same processes, standards, monitoring indicators, performance benchmarks and quality parameters as laid out in the Operational Guidelines on Ayushman Bharat Comprehensive Primary Health Care through Health and Wellness Centres (2018) and other updates provided by the GOI.
- A financial allocation of Rs 15,105 crore has been made for this purpose by FC-XV as detailed in Appendix-1 of this chapter. Unit cost particulars (a maximum of Rs. 7.81 lakhs per year for a SHC-HWC and Rs. 4.59 lakhs for a PHC-HWC per year) are given at Appendix-2 of this chapter.

4.4 Guidance for identification of facility, approvals and operationalization

i. Allocation by the State to Districts: Based on the resource available and number of functional SHC / PHC HWCs, the State will allocate resources to the Districts. Criterion for prioritizing the districts as given in Chapter-I need to be followed. States must ensure that the grants under this component are allocated to all the Districts of the State.

ii. Apportioning by the Districts: Depending on the grants available to the District, district will identify the functional AB-HWCs for providing support under this component (for meeting the recurring expenditure of functional HWCs). The District Level Committee, as elaborated in the DoE's Guidance Note to the States dated 16th July 2021 and as explained in Chapter-1, will take necessary actions to plan and execute the required activities and identify the blocks in which HWC would be located.

iii. District will finalize the number of SHC-HWCs that can be covered with the financial allocation made by the State for this component of FC-XV (since for this FY 21-22, some support has already been provided by NHM for two to four months).

iv. The SHC-HWCs that are functional since 2018 onwards will be eligible and accordingly, SHC-HWCs in all the block panchayats will be selected by the DLC.

v. To ensure easier processing, District can apportion the number of the facilities (SHC-HWCs) under this component of FC-XV to the block panchayats of the Districts based on the operational SHC-HWCs as on date. Preferably, SHC-HWCs that are functional for more than one year can be selected for allocation of FC-XV resources.

vi. Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-1 to the State.

vii. Software is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

viii. After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV. **As the allocation under this component incudes substantive funding for HR related components, the operational diagnostic costs of PoC tests and independent monitoring, DoE's Guidance Note (Para 8 at Page 8) which has been reiterated again at sub-point 10 under para 1.4.2 of Chapter 1) may be referred for further action to ensure timely payment of remuneration and incentives of the primary healthcare team working at these SHC level HWCs.**

ix. **State level / District level HRH services:** Most of the State Health Departments have developed effective modalities for recruitment of Human Resources for Health such as Medical Officers, Nurses, Lab Technicians, Pharmacists and other para-medical staff, through mechanisms such as a State / District level agency of government or through empanelled agencies. Under National Health Mission, States/UTs are supported to deploy such agencies. States have been undertaking these human resource recruitments through these empanelled agencies, which have established transparent and systematic procedures.

x. **Procurement Cell:** The RLBs / Zilla Panchayats would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement. Such a strategy would eventually create capacities within the ULBs to handle these responsibilities independently.

xi. **As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

xii. Local Bodies (District and Block) should be actively involved in the monitoring of all the functional SHC and PHC level HWCs, without restricting such monitoring to those HWCs, which are supported under this component of FC-XV. To the extent possible,

the institutional arrangements such as JAS / VHSNCs should be utilized for this purpose.

xiii. Capacity building of the local bodies for all components of the FC-XV will be improved as per the plan in this regard (Detailed plan will be communicated separately). Since the aim is to strengthen the ownership and accountability of the RLBs for delivery of primary health care and essential public health functions, the state/District would work closely with the RLBs through the Department of Panchayati Raj.

xiv. The PRIs and DLC are required to focus optimal utilisation of the grant for recurring expense incurred in the AB-HWC especially for Human Resources, their training skills, salary and incentives, range of health care package of services to be offered, drugs, equipment, IT infrastructure, community structures and independent monitoring, all as per CPHC guidelines defined norms. (Costing Norms attached in Appendix 3).

xv. **Negative List for this component of FC-XV:** The funds under this component cannot be utilized for the following:

   i. Repair and Renovation works already undertaken under the NHM Funds.
   ii. Construction of boundary walls, entrance, pavements, footpaths etc.
   iii. Purchase of Solar panels etc.
   iv. Purchase of electronic items like TVs, cameras etc. which are not listed as part of the guidelines.
   v. Purchase of IT hardware: (these are covered under the non-recurring costing of the HWCs as per CPHC guidelines).
   vi. Cost of Diagnostic Infrastructure including purchase of refrigerators, etc (except for 30,000/- which is provided for Point of Care Diagnostics as recurring expenditure).

Appendix 4.1: Financial requirement for conversion of Rural PHCs and SCs into Health and Wellness Centres

		2021-22	2022-23	2023-24	2024-25	2025-26	Total
Sr. No.	**State**	**Amount available under 15th FC**	**Amount available under 15th FC**	**Amount available under 15th FC**	**Amount available under 15th FC**	**Amount available under 15th FC**	**Amount available under 15th FC**
1	Andhra Pradesh	124.67	124.67	130.55	137.45	144.32	661.66
2	Arunachal Pradesh	6.67	6.67	7.01	7.36	7.72	35.43
3	Assam	80.70	80.70	84.74	88.98	93.42	428.54
4	Bihar	195.81	195.81	205.60	215.88	226.68	1039.78
5	Chhattisgarh	90.13	90.13	94.64	99.37	104.34	478.61
6	Goa	4.00	4.00	4.20	4.41	4.63	21.24
7	Gujarat	160.01	160.01	168.01	176.41	185.23	849.67
8	Haryana	46.61	46.61	48.94	51.38	53.95	247.49
9	Himachal Pradesh	44.13	44.13	46.34	48.65	51.08	234.33
10	Jharkhand	68.71	68.71	72.14	75.75	79.54	364.85
11	Karnataka	188.86	188.86	198.30	208.22	218.63	1002.87
12	Kerala	105.43	105.43	110.70	116.23	122.04	559.83
13	Madhya Pradesh	197.76	197.76	207.64	218.03	228.93	1050.12
14	Maharashtra	191.95	191.95	201.54	211.62	222.20	1019.26
15	Manipur	8.73	8.73	9.17	9.63	10.11	46.37
16	Meghalaya	9.29	9.29	9.75	10.24	10.75	49.32
17	Mizoram	7.36	7.36	7.73	8.11	8.52	39.08
18	Nagaland	8.19	8.19	8.60	9.03	9.49	43.50
19	Odisha	125.33	125.33	131.60	138.18	145.09	665.53
20	Punjab	46.70	46.70	49.04	51.49	54.06	247.99
21	Rajasthan	263.19	263.19	276.35	290.17	304.67	1397.57
22	Sikkim	2.96	2.96	3.10	3.26	3.42	15.70
23	Tamil Nadu	148.61	148.61	156.04	163.85	172.04	789.15
24	Telangana	85.09	85.09	89.34	93.81	98.50	451.83
25	Tripura	17.89	17.89	18.78	19.72	20.71	94.99
26	Uttar Pradesh	387.35	387.35	406.72	427.05	448.40	2056.87
27	Uttarakhand	35.52	35.52	37.29	39.16	41.11	188.60
28	West Bengal	192.98	192.98	202.63	212.76	223.40	1024.75
	Total	**2,844.63**	**2,844.63**	**2,986.49**	**3,136.20**	**3,292.98**	**15,104.93**

Appendix 4.2 Conversion of SHCs and PHCs into HWCs in Rural Areas: Unit Cost

A. Unit cost for SHC-HWCs (Only Recurring Cost (as per CPHC guidelines)

Recurring items	Amount per SHC per annum (lakhs)
Remuneration to CHOs	4.80
Team Based Incentives to primary healthcare team at SHCs (ANMs, ASHAs & CHOs)	1.00
ASHA Incentives for delivery of expanded range of services @1000 per month (ceiling)	0.60
Refresher Training of CHOs and Multi-skilling of MPWs and ASHAs	0.30
IEC	0.25
IT support	0.05
Recurring cost for diagnostics	0.30
Independent Monitoring costs for performance assessment	0.51
Total per SHC per annum (lakhs)	**7.81**

B. Unit cost for Rural PHC-HWCs (Only Recurring Cost (as per CPHC guidelines)

Recurring items	Amount per SHC per annum (lakhs)
Training of Medical officers (two) @10k per MO, Staff Nurses (two) @7500 per SN and Multi-skilling of MPWs and ASHAs for co-located SHC	0.55
Team Based Incentives to primary healthcare team at PHC level HWCs	2.00
ASHA Incentives for delivery of expanded range of services @1000 per month (ceiling)	0.60
IEC	0.50
IT support	0.05
Recurring cost for diagnostics	0.30
Independent Monitoring costs for performance assessment	0.29
Total per SHC per annum (lakhs)	**4.29**

(Source-Ayushman Bharat Comprehensive Primary Healthcare through Health and Wellness Centres Operational Guidelines 2018)

Chapter-5: Block Public Health Units

5.1 Background

- Every block in the country is envisaged as having a CHC/ Block PHC/ SDH at the Block Headquarter (HQ) which serves as a hub for referral from the SHCs and PHCs of the block. However, the situation across states is variable, with the Block CHC functioning as just another PHC in some states. In some other states, on the other hand, the Block CHC also serves as a First Referral Unit (FRU). Currently, the block health facility is only equipped to provide selected clinical services, a limited range of public health functions and administrative control of the health institutions within the block.
- The present reporting channel for outbreaks or disease patterns is not routed through the block facility leading to fragmentation of care, reduced effectiveness and accountability for public health activities and response to public health emergencies.
- The COVID-19 pandemic highlighted the need for strengthening and enhancing a coordinated public health response at block and sub block levels thus ensuring an optimal focus on public health actions and increased attention to social and environmental determinants which impact health.
- The pandemic also highlighted the need for the block facility to be upgraded and equipped to provide a range of comprehensive primary care services and also essential secondary care services.
- There is therefore a need to augment the existing capacity of the facility at the Block level to meet the requirements of public health surveillance and response (early identification, management and creating evidence for research/ resource allocation), and referral support for HWCs at SHC and PHC level.

5.2 Block Public Health Unit (BPHU)

The BPHU would encompass the service delivery facility (CHC/PHC/SDH), a Block Public Health Laboratory, and a Block HMIS Cell. The goal of the Block Public Health Unit is to protect and improve the health of the population in the block. Decentralization at this level would enable a focus on reaching remote areas and unreached populations. It is envisaged that the Block Headquarter level facility (variously referred to as Community Health Centres (CHCs)/ Sub- Divisional Hospitals (SDHs)/Block Primary Health Centres (PHCs), (the nomenclature may vary across states) ***would be strengthened*** to become a Block Public Health Unit.

5.2.1 **The Block Public Health Unit** shall be responsible for developing a Block Level Plan, that sets block specific targets for national health programmes, and improves population health outcomes, including focus on social and environmental determinants of health. Its key functions are to:

i. Support and supervise peripheral facilities (Health and Wellness Centres) in implementation of public health and service delivery functions to undertake population-based screening for early identification of morbidities, health promotion and health education activities, involve and orient Panchayats/ULBs for social and environmental action adopting health lifestyles including yoga and various other wellness activities.

ii. Augment capacity of the Block facility to provide an expanded range of public health services and serve as the referral point for the HWC in the block, thereby reducing patient hardship and minimizing costs of care.

iii. Enable health system preparedness and ensure early and timely response during outbreaks, other public health emergencies, including disaster and violence.

iv. Ensure early identification for prevention and control of various infectious/emerging infectious diseases.

v. Maintain provision of essential services in the event of public health emergencies and outbreaks.

vi. Public Health Functions of BPHU would focus on planning and coordinating all health functions such as public health surveillance, early identification, vector control measures, school health programmes, supporting HWC in preventive functions such as population based screening- for chronic communicable and non-communicable diseases, RBSK, community health awareness campaigns, including the Annual Health Calendar, enabling avenues for increased physical activity and support to Eat Right and Fit India related activities.

5.2.2 **The Block Public Health Laboratory** of the BPHU will provide comprehensive diagnostic facilities for infectious and non-infectious diseases to enable public health surveillance and support in generating evidence and confirmation of potential disease outbreaks (***Improve disease surveillance (both human and animal) to support in generating evidence/forecasting potential outbreaks)***. The BPHL will be established within the premises of Block Public Health Unit. BPHL would serve as a diagnostic hub for all the HWCs functional under its jurisdiction within the block. Its key functions are to:

i. Conduct all Point of Care Tests (POCT) as applicable for CHC/SDH level, support collection, storage, and transportation of samples for various public health activities as required, including serve as hub for the diagnostic functions of the HWC in the block.

ii. Undertake surveillance, reporting and analysis of crucial epidemiological information (particularly source of infection, mode of transmission, period of infectivity) and confirmation of outbreaks.

iii. Maintain data of environmental surveillance by collaborating with concerned departments.

iv. Support the identification of initial cases associated with an outbreak, and actively coordinate with the rapid response teams engaged in outbreak investigations.

v. Undertake epidemiological surveillance, risk factor identification, and assessment of severity of outbreaks to help plan an appropriate response.

vi. The Block Public Health Laboratory to provide comprehensive diagnostic facilities for both clinical (as per IPHS) and public health functions. The diagnostic facilities will enable public health surveillance (including zoonotic-related illnesses and environmental surveillance for water and food as per one-health approach), generating evidence and confirmation of potential disease outbreaks, at block level, and be aligned with the Integrated Health Information Platform (IHIP) for surveillance and public health information.

5.2.3 The Block HMIS Cell will collect, compile and analyze clinical, programme and public health data to ensure effective monitoring, enable early detection of outbreaks, and serve to hold service providers accountable (***Improved public health data reporting and follow-up action)***. It has the following functions:

i. Undertake Data recording and compilation from peripheral facilities for decentralized reporting and analysis to support planning and monitoring of disease trends.

ii. Use data to identify pockets of higher morbidity/mortality and enable focused interventions to address these.

iii. Enable strong local surveillance and enable early detection of outbreaks.

iv. Generate reports for information and timely and appropriate corrective action by service providers and public health managers.

v. The Block HMIS Cell will collect, compile and analyse clinical/service delivery, programme and public health data of the entire block, to ensure effective monitoring, and early corrective action of programmes.

vi. The Block HMIS cell will compile, analyse data from peripheral facilities and provide feedback to the peripheral facilities, thus improving service delivery, and support in planning and monitoring of disease trends. They will also conduct a disease outbreak enquiry based on the data analysis and ensure containment measures have been put in place.

vii. The BPHU will monitor and ensure coordinated implementation and outputs of all National Health Programmes.

viii. The cell will ensure data quality and maintenance of timely reporting. The cell would also link with the district HMIS unit and be integrated with the IHIP. The system will be utilised to report, record and use the data for decision making and facilitate the health planners, PRIs in developing health plans and monitoring the activities.

ix. The BPHU would also leverage Electronic Health Records (EHR) through the National Digital Health Mission (NDHM) and enable individualized tracking of beneficiaries and longitudinal records through the life cycle for the population in the catchment area.

x. Thus, the BPHU is envisaged as having following functions:

   a. Public Health Functions such as surveillance, and early detection of outbreaks, emergency preparedness and planning,
   b. Clinical service delivery through the block health facility,
   c. Advanced Diagnostics services through a Block Public Health Laboratory for clinical and public health functions, and
   d. Serve as a hub for data compilation, analysis and feedback, through a Health Management Information System and IHIP.

5.3 Objectives of the Block Public Health Unit:

i. Improve healthcare within the block by strengthening integration between clinical and public health services.

ii. Improve disease surveillance (both human and animal) to support in generating evidence/forecast of potential outbreaks.

iii. Improved public health data reporting and follow-up action for clinical and public health functions.

iv. Enable decentralized planning for service delivery and public health activities for the block, with the support from the rural local bodies.

v. Serve as the referral point for service delivery and as focal hub for the SHC-HWCs and PHC-HWCs in the block to reduce crowding at higher level facilities and provide comprehensive primary health care (delivery of clinical and public health services).

vi. Strengthen disease surveillance (both human and animal) to support evidence generation/forecast of potential outbreaks through robust data reporting using HMIS and IHIP towards strengthening the One Health approach.

vii. Undertake preparatory activities for emergencies to which the area is prone in tandem with NDMA, NDRF, Medical Relief, Local bodies etc.

viii. In the event of emergencies and disease outbreaks, the BPHU would serve as the coordinating hub for community engagement and risk communication, organizing frontline workers & volunteers as first responders, collecting relevant health information, and providing health interventions, including essential services.

ix. Create a platform for multi-sectoral convergence (with WCD, ICDS, Water and Sanitation, School Education, Department of Social Justice and Empowerment, IMD (Ministry of Earth Sciences) to address social and environmental determinants of health.

x. Assume accountability for service delivery and public health outcomes within the block, including the Rogi Kalyan Samities (RKS) and the Jan Arogya Samities (JAS).

5.4 Factors to be considered

Since the grant is channelized through PRIs, wherever the health facility in a block is co-terminus with governance structure of rural local bodies, both the planning and decision making can be better coordinated. If planned as per population norms of the IPHS, the Sub Health Centres and PHCs would be co-terminus with the wards/Panchayats. VHNSCs would work under the umbrella of PRIs, and BPHU would develop better coordination with the standing committees of health under PRIs. The team at the BPHU would coordinate with the Panchayati Raj Institutions (PRIs) / Rural Local Bodies and the SHC-HWC and PHC-HWC health teams to develop Block Health Plans based on the disease burden, health need of the community, available infrastructure, and staff. The team would also coordinate with other departments like ICDS, education, and water and sanitation, National Disaster Management Authority (NDMA) to enable action on environmental and social determinants and improved responsiveness to outbreaks and emergencies.

i. Monitoring: Integrated Public Health Labs (IPHLs) at the District level will mentor and handhold BPH Labs of the BPHUs and ensure regular training and capacity building of the staff.

ii. Accountability: BPHU would support, supervise, and monitor the existing community-based platforms such as VHSNC and JAS in planning and supporting multi-sectoral action on social and environmental determinants of health in co-ordination with the AB-HWCs PHCs and SHCs. BPHUs would also support JAS at the HWC level in facilitating and enabling quality health care services in the community by being responsive to the citizens' varied needs and requirements. The BPHU will also support resolution of any

issues arising at the AB-HWCs and escalate any issue requiring decision with the higher authorities at the District Level.

iii. Decentralized Planning: The BPHU would serve a key role in decentralised planning to achieve Health for All. The District Health Action Plan (DHAP) can be prepared using the morbidity and mortality data available with HMIS unit, through a participatory, inclusive, and transparent process. Such a plan should contribute to the integrated plan for districts, keeping in view the long-term vision as a 5-year plan at the district level.

iv. Infrastructure and Equipment: Based on gap analysis, support will be provided to states for creating additional space required in the block health facility to accommodate the expanded functions of BPHU. Equipment, including equipment for IT services, etc. required for Block Public Health Unit, after gap analysis against IPHS for the clinical services being provided at the block level facility, can be proposed by the state.

v. Human Resources: The existing HR of the facility and the BPMU, would be part of the BPHU. The BPHU will be supported by a team with clinical and public health skills which will coordinate with the Block Program Coordination Committee (BPCC). Public health professionals (with multidisciplinary qualifications), data analyst/statistician, and a laboratory technician will be added to the existing public health unit. The total recurring cost of BPHU is inclusive of this additional HR for supporting BPHUs. The HR at the designated health facility shall be as per Indian Public Health Standards (IPHS) and public health unit will have its existing HR and add-on as proposed above.

vi. Capacity Building: To cater to the training needs of the healthcare staff including frontline workers, 'Integrated Govt. Online training' (iGOT) portal on the Ministry of HRD's DIKSHA platform can be utilized for capacity building on components such as Planning, Infection Prevention and Control Practices, Data Management & Report Writing, public health surveillance, monitoring and supervision, various program components etc. Other clinical trainings will continue as per the program guidelines.

5.5 Support for this component under FC-XV

A financial allocation of **Rs.5,279 crore** has been made for this purpose by FC-XV as detailed in Appendix-1 of this chapter. The Composite Unit Cost per BPHUs is:

a. Total capital cost (infrastructure for Block Public Health Unit, equipment for Block Public Health Lab and health facility, IT infrastructure for Lab and HMIS Unit)- 80.96 Lakhs

b. Total recurring cost (human resource, consumables, monitoring, etc) of Block Public Health Unit with Labs- 20.14 Lakhs

Unit cost particulars are given at Appendix-2 of this chapter. Besides, a table of various activities of three components of BPHU is also given.

5.6 Guidance for identification of facility, approvals and operationalization

5.6.1. It is envisaged that the process to complete the non-recurring / capital portion of the BPHU will take nine to twelve months. The State will utilize this time-period to complete the process of engagement of required HR under three components of HR. Accordingly, in the first year (FY 21-22), recurring expenditure is not to be factored-in and while planning for subsequent years, the recurring expenditure is to be charged first, before proceeding to plan to establish new BPHU units in the districts. Accordingly, the indicative number of blocks that can be covered over the five years period is given at Appendix 3. This is arrived with the presumption that all the Blocks require full set of activities under non-recurring components to establish BPHUs.

5.6.2. Allocation by the State to Districts: Based on the resources available to cover the number of blocks in the State, the State will allocate resources to the Districts proportionate to the number of blocks that can be covered with the available resources in the five-year period (as per above formula). States must ensure that that the grant under this component is released to all the Districts of the State. State may plan to saturate the blocks in the tribal and backward areas / blocks / districts of the State with the BPHU units and accordingly, allocation may be made. Further, after the completion of comprehensive gap analysis of infrastructure and HR availability in all the blocks of the districts, State may plan to cover more blocks than originally envisaged in an effort to cover more blocks with the available resources, as there will be savings.

5.6.3. Apportioning by the Districts: Depending on the grants available to the District, district will identify the blocks, within the districts, for providing support under this component. The District Level Committee, as elaborated in the Guidance Note to the States dated 9th July 2021 and as explained in Chapter-1, will take necessary actions.

i. Blocks located in the tribal /backward / remote areas of the districts may be given preference.

ii. District would undertake gap analysis of the infrastructure requirement at each selected block for all the three components of the BPHU and accordingly arrive at the requirement of non-recurring and recurring component of the BPHU per block. This would be compiled to reach the district requirement.

iii. Preferably, blocks with good infrastructure set-up and complete / near-complete HR availability should be given preference in the first few years for this component for the system to stabilize and also to enable the other blocks to learn from them.

5.6.4 Accordingly, District will finalize the number of blocks with block level requirement for recurring and non-recurring components under BPHU.

5.6.5 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-1 to the State.

5.6.6 A software package is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

5.6.7 After the State level and National level approval, the districts may start utilizing the resources under this component of FC-XV.

5.6.8 **As per DOE guidance Note dated 16th July, 2021, (DoE's Guidance Note (Para 8 at Page 8) and reiterated again at sub-point 10 under para 1.4.2 of Chapter 1)**, on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other consumables, etc, through a mechanism which include Central purchase at State level to ensure purchase of quality products at reasonable/competitive prices in an efficient manner after following the due processes/procedures and practices with the prior approval by the National Level Committee".

5.6.9 **DoE's Guidance Note (Para 8 at Page 8) and at sub-point 10 under para 1.4.2 of Chapter 1 may be referred.**

i. **State level / District level HRH services:** Most of the State Health Departments have developed effective modalities for recruitment of Human Resources for Health such as Medical Officers, Nurses, Lab Technicians, Pharmacists and other para-medical staff, through mechanisms such as a State / District level agency of government or through empanelled agencies. Under National Health Mission, States/UTs are supported to deploy such agencies. States have been undertaking these human resource recruitments through these empanelled agencies, which have established transparent and systematic procedures.

ii. **Procurement Cell: The RLBs / Zilla Panchayats** would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement. Such a strategy would eventually create capacities within the ULBs to handle these responsibilities independently.

5.6.10 **As per DoE's Guidance Note dated 16th July 2021 (Annexure: Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

5.6.11 Local Bodies (District and Block) should be actively involved in the monitoring of BPHUs including the functional SHC and PHC level HWCs under them. To the extent possible, institutional structures such as RKS should be utilized for this purpose.

5.6.12 Capacity of the local bodies for all components of the FC-XV will be improved by the state through undertaking the requisite trainings through state level institutions.

5.6.13 The PRIs and DLC are required to make optimal use of the grant for recurring expense incurred in the AB-HWC especially for Human Resources, their training skills, salary and incentives, range of health care package of services to be offered, drugs, equipment, IT infrastructure, community structures and independent monitoring, all as per CPHC guidelines defined norms.

5.6.14 **Negative List for this component of FC-XV:** The funds under this component cannot be utilized for the following:

i. Repair and Renovation works of Block level facilities already undertaken under the NHM Funds.
ii. Construction of boundary walls, entrance, pavements, footpaths etc.
iii. Purchase of Solar panels etc.
iv. Purchase of electronic items like TVs, cameras etc.

Appendix 5.1: Financial allocation for establishing BPHUs

		2021-22	2022-23	2023-24	2024-25	2025-26	Total (Rs in Cr)
S. No.	State / UTs	Funds available	Funds available	Funds available	Funds available	Funds available	Total Funds available
1	Andhra Pradesh	134.42	134.42	141.14	148.20	155.61	713.79
2	Arunachal Pradesh	22.94	22.94	24.09	25.29	26.56	121.82
3	Assam	5.31	5.31	5.58	5.86	6.15	28.21
4	Bihar	49.47	49.47	51.94	54.54	57.27	262.69
5	Chhattisgarh	13.56	13.56	14.24	14.95	15.70	72.01
6	Goa	2.41	2.41	2.53	2.66	2.79	12.80
7	Gujarat	50.31	50.31	52.82	55.46	58.24	267.14
8	Haryana	28.58	28.58	30.00	31.50	33.08	151.74
9	Himachal Pradesh	1.85	1.85	1.95	2.05	2.15	9.85
10	Jharkhand	24.44	24.44	25.66	26.95	28.29	129.78
11	Karnataka	38.23	38.23	40.15	42.15	44.26	203.02
12	Kerala	30.59	30.59	32.12	33.72	35.41	162.43
13	Madhya Pradesh	28.99	28.99	30.44	31.96	33.56	153.94
14	Maharashtra	70.83	70.83	74.37	78.09	82.00	376.12
15	Manipur	14.09	14.09	14.79	15.53	16.31	74.81
16	Meghalaya	9.25	9.25	9.72	10.20	10.71	49.13
17	Mizoram	5.23	5.23	5.49	5.77	6.06	27.78
18	Nagaland	14.89	14.89	15.63	16.42	17.24	79.07
19	Odisha	29.08	29.08	30.53	32.06	33.66	154.41
20	Punjab	30.18	30.18	31.69	33.28	34.94	160.27
21	Rajasthan	27.40	27.40	28.77	30.21	31.72	145.50
22	Sikkim	6.44	6.44	6.76	7.10	7.45	34.19
23	Tamil Nadu	77.47	77.47	81.35	85.42	89.69	411.40
24	Telangana	118.52	118.52	124.45	130.67	137.21	629.37
25	Tripura	11.67	11.67	12.26	12.87	13.51	61.98
26	Uttar Pradesh	76.53	76.53	80.36	84.37	88.59	406.38
27	Uttarakhand	2.22	2.22	2.33	2.44	2.57	11.78
28	West Bengal	69.22	69.22	72.69	76.32	80.14	367.59
	Total	**994.12**	**994.12**	**1043.85**	**1096.04**	**1150.87**	**5279.00**

Appendix 5.2: Unit cost for establishing the Block Public Health Unit Components

i. **Block Public Health Unit:**

BLOCK PUBLIC HEALTH UNIT			
S. No.	Particulars	Cost per Block Public Health Unit (in Rs.)	Total (in Rs.)
1	**Infrastructure**		
1.1	Area (sq. ft.)	1000	
1.2	Cost (2000 per sq. ft.) (one time)	20,00,000	20,00,000
2	IT Equipment		
2.1	Set up Cost (one time)	2,00,000	2,00,000
	Total non-recurring		22,00,000
2.2	**Recurring cost**	**4,000 per month**	**48,000**
3	Monitoring and Supervision	2,000 per month	24,000
4	**Human resource (all HR will be as existing IPHS & BPMU some add on HR is reflected here for one year)**		
4.1	Epidemiologist/Entomologist	42,500 per Epidemiologist (1 per Unit)	42,500
4.2	Public Health Personnel	42,500 per specialist (1 per Unit)	42,500
4.3	Veterinary Doctors (Hiring/linkages with veterinary department)	42,500 per doctor (1 per Unit)	0
4.4	Lab Technician	24000 per technician (1 per Unit)	24,000
	HR Cost per month		1,09,000
	HR Cost per Year		13,08,000
	Recurring cost per year (HR+ Others)		**13,80,000**

ii. Block Public Health Laboratory

BLOCK PUBLIC HEALTH LABORATORY			
S. No.	Particulars	Unit cost (in Rs.) * Unit	Total cost (in Rs.)
1	**Infrastructure (already available at CHC as per IPHS)**		
1.1	Area (sq. ft.)	1,000	
1.2	Cost (2000 per sq. ft.)	20,00,000	20,00,000
2	Equipment as per IPHS 2012 are presently available, additional equipment indicated below is required		
2.1	Hemoglobinometer electronic	6,500 (2 per Unit)	13,000
2.2	a) Semiautomated Biochemistry analyser OR b) Fully automated Biochemistry analyser	13,00,000	13,00,000
2.3	Hematology analyser	5,00,000	5,00,000
2.4	Spirometer	4,500 (4 per Unit)	18,000
2.5	Rotor/shaker	15,000	15,000
2.6	ESR analyser	1,50,000	1,50,000
2.7	TrueNat (Chip based Real time micro PCR)	7,00,000	7,00,000
	Total		**46,96,000**
2.8	Consumables including masks, PPE, etc. Bio medical waste		58,500
3	Human resource (all HR will be as per IPHS, some add on HR is reflected here)		
3.1	Lab Technician	24,000 per technician (2 per unit)	24,000
	HR Cost per month		24,000
	HR Cost per Year		2,88,000
	Recurring Cost per year (HR+ Others)		**3,46,500**

iii. HMIS Unit

S. No.	Particulars	Cost per Block HMIS Cell (in Rs.)	Total (in Rs.)
1.1	Infrastructure		
1.2	Area (sq. ft.)	500	
2	Cost (2000 per sq. ft.)	10,00,000	10,00,000
2.1	IT Equipment		
2.2	Set up Cost	2,00,000	2,00,000
3	**Total**		**12,00,000**
	Recurring cost	4,000	48,000
3.1	Human resource *(supported by existing staff some add on HR is reflected here)*		
	Data Manager	20,000 per manager (1 per Unit)	20,000
	HR Cost per month		20,000
	HR Cost per Year		2,40,000
	Recurring Cost per year (HR+ Others)		**2,88,000**

iv. Composite Unit cost per BPHUs

Total capital cost (in Rs) of the Block PH Unit with Labs	**80,96,000**
Total recurring cost (in Rs) of Block PH Unit with Labs	**20,14,500**

v. Table of Recurring and Non-recurring activities under three Components of the BPHUs

Components	Block PH Unit	Block HMIS Cell	Block PH labs
Non-Recurring	Support for infrastructure IT equipment Furniture and others	Support for infrastructure IT equipment Furniture and others	Support for infrastructure Equipment as per IPHS 2012 -Hemoglobinometer -Electronic Semi-automated Biochemistry analyser or Fully automated Biochemistry analyser -Hematology analyser -Spirometer

			-Rotor/shaker -ESR analyser -TrueNat (Chip based Real time micro PCR)
Recurring	HR - Human resource (all HR will be as existing IPHS & BPMU) Epidemiologist / Entomologist Public Health Personnel Veterinary Doctors (Hiring / linkages with veterinary department) / Lab Technician	Human resource *(supported by existing staff and besides, exclusive Data manager and other supporting staff are proposed*	Consumables including masks, PPE, etc. Bio medical waste. Human resource (all HR will be as per IPHS) Lab Technician and other critical cadres

Appendix 5.3: Indicative number of Block Public Health Units, based on the resources available

		2021-22		2022-23		2023-24		2024-25		2025-26		Total (Rs in Cr)		Total No of Blocks in the State (as per LG code)	Blocks, yet to be covered after FC XV Grants
S. No.	State / UTs	Funds available	Units Possible	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Total Funds available	Total Units		
1	Andhra Pradesh	134.42	166	134.42	124	141.14	102	148.2	86	155.61	73	713.79	551	668	117
2	Arunachal Pradesh	22.94	28	22.94	21	24.09	18	25.29	14	26.56	13	121.82	94	114	20
3	Assam	5.31	6	5.31	5	5.58	4	5.86	4	6.15	3	28.21	22	230	208
4	Bihar	49.47	61	49.47	46	51.94	37	54.54	32	57.27	27	262.69	203	534	331
5	Chhattisgarh	13.56	16	13.56	13	14.24	10	14.95	9	15.7	8	72.01	56	146	90
6	Goa	2.41	2	2.41	3	2.53	2	2.66	1	2.79	2	12.8	10	12	2
7	Gujarat	50.31	62	50.31	46	52.82	39	55.46	32	58.24	27	267.14	206	250	44
8	Haryana	28.58	35	28.58	26	30	22	31.5	19	33.08	15	151.74	117	142	25
9	Himachal Pradesh	1.85	2	1.85	2	1.95	1	2.05	1	2.15	1	9.85	7	81	74
10	Jharkhand	24.44	30	24.44	22	25.66	19	26.95	16	28.29	13	129.78	100	264	164
11	Karnataka	38.23	47	38.23	35	40.15	29	42.15	25	44.26	21	203.02	157	228	71
12	Kerala	30.59	37	30.59	29	32.12	23	33.72	20	35.41	16	162.43	125	152	27
13	Madhya Pradesh	28.99	35	28.99	27	30.44	23	31.96	18	33.56	16	153.94	119	313	194

		2021-22		2022-23		2023-24		2024-25		2025-26		Total (Rs in Cr)		Total No of Blocks in the State (as per LG code)	Blocks, yet to be covered after FC XV Grants
S. No.	State / UTs	Funds available	Units Possible	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Total Funds available	Total Units		
14	Maharashtra	70.83	87	70.83	66	74.37	54	78.09	45	82	38	376.12	290	352	62
15	Manipur	14.09	17	14.09	13	14.79	11	15.53	9	16.31	8	74.81	58	70	12
16	Meghalaya	9.25	11	9.25	9	9.72	7	10.2	6	10.71	5	49.13	38	46	8
17	Mizoram	5.23	6	5.23	5	5.49	4	5.77	3	6.06	3	27.78	21	26	5
18	Nagaland	14.89	18	14.89	14	15.63	11	16.42	10	17.24	8	79.07	61	74	13
19	Odisha	29.08	35	29.08	28	30.53	22	32.06	18	33.66	16	154.41	119	314	195
20	Punjab	30.18	37	30.18	28	31.69	23	33.28	19	34.94	17	160.27	124	151	27
21	Rajasthan	27.4	33	27.4	26	28.77	21	30.21	17	31.72	15	145.5	112	352	240
22	Sikkim	6.44	7	6.44	7	6.76	5	7.1	4	7.45	3	34.19	26	32	6
23	Tamil Nadu	77.47	95	77.47	72	81.35	59	85.42	49	89.69	43	411.4	318	388	70
24	Telangana	118.52	146	118.52	110	124.45	90	130.67	75	137.21	65	629.37	486	589	103
25	Tripura	11.67	14	11.67	11	12.26	9	12.87	7	13.51	7	61.98	48	58	10
26	Uttar Pradesh	76.53	94	76.53	71	80.36	58	84.37	49	88.59	42	406.38	314	828	514
27	Uttarakhand	2.22	2	2.22	2	2.33	2	2.44	2	2.57	1	11.78	9	95	86
28	West Bengal	69.22	85	69.22	64	72.69	53	76.32	44	80.14	38	367.59	284	346	62
	Total	**994.12**	**1214**	**994.12**	**925**	**1,043.85**	**758**	**1,096.04**	**634**	**1,150.87**	**544**	**5,279**	**4,086**	**6,855**	**2,769**

Chapter-6: Support for Diagnostics Infrastructure to the primary healthcare facilities- Sub-centres, PHCs and Urban PHCs

6.1 Background

- The Fifteenth Finance Commission (FC-XV) recommended grants to provide support for diagnostic infrastructure in Sub-Health centres, PHCs and Urban PHCs with the vision of providing **Comprehensive Primary Health Care** near to the community. This will strengthen the comprehensive primary care services at the grass roots encompassing preventive, promotive, basic curative, rehabilitative and palliative health care.
- Availability of quality, free diagnostics at public health facilities is one of the most effective ways for achieving the goal of providing universal health coverage as recognized by National Health Policy 2017. Ministry of Health and Family Welfare, Government of India, released *Operational Guidelines for the Free Diagnostics Service Initiative under NHM in 2015* (link of the resource - https://nhm.gov.in/New_Updates_2018/NHM_Components/Health_System_Stregthening/Drugs_&_logistics/Operational_Guidelines_Free_Drugs_Service_Initiative.pdf) in to address the urgent need for accessible and quality diagnostics in public health facilities. An expanded basket of tests was recommended and a hub and spoke model was suggested to enable provision of laboratory services from district till primary care level.
- Further, a detailed Guidance Document for Implementing Laboratory Services in States under NHM-Free Diagnostics Service Initiative was shared with the States in August 2019 (Link of the resource - https://nhm.gov.in/New_Updates_2018/NHM_Components/Health_System_Stregthening/Comprehensive_primary_health_care/letter/Guidance_document_for_Free_Laboratory_Services.pdf)
- The range of diagnostics tests has been further expanded in alignment with the guidelines of comprehensive primary health care services under Ayushman Bharat. Presently, 14 tests at Sub Health Centre/ Health & Wellness Centre level and 63 tests at PHC/UPHC level need to be conducted as per guidelines on free diagnostics initiative (See Appendix 1). The tests encompass haematology, serology, biochemistry, clinical pathology, microbiology and any other test for improved public health surveillance/clinical condition.
- The States may undertake the delivery of the expanded diagnostic tests in a hub and spoke model also including the BPHUs in their ambit. This can be achieved by either strengthening the in-house service delivery capacities or by expanding the same under

the PPP mechanism, as deemed appropriate and suitable at the Block, District and State level duly keeping in view the capacity of the private providers in hard to reach areas and difficult terrains.

- The FC-XV recognised that in the efforts to achieve the ideal of universal health coverage, rural and urban local bodies can play a key role in the delivery of primary health care services especially at the "cutting-edge" level. Strengthening the local governments in terms of resources, and capacity building can enable them to play a catalytic role in health care delivery, including in the time of crisis like the current COVID-19 pandemic.

6.2 Status on Free Diagnostics Service Initiative under NHM

The Free Diagnostic Service initiative has been implemented in 33 States/UTs. States/UTs have already adopted different models (In-house/ In-house with hub and Spoke/ Hybrid model detailed below) contextual to their needs. The detail of these models are as follows:

i. In-house model of service delivery: The laboratory services are provided through in-house laboratories of the respective health laboratory services. The reagents supply, equipment repair and maintenance are required to be ensured at all times. The States can also explore the reagent rent model at the higher labs with an adequate case load to ensure that the same is cost-effective.

ii. In-house system with Hub and Spoke Model of Service delivery: In hub and spoke model, the samples are collected at peripheral facilities/collection centres and safely transported to a central laboratory which acts as the Hub. The Hub can be block level Community Health Centres/Sub District Hospital /District Hospital Lab/Medical College/or a public laboratory set up for the purpose. Sampling of patients is carried out by laboratory technicians at the spoke health facilities. Samples are transported by the laboratory technicians/courier of the spokes / hubs either to sample aggregating points located at select PHCs, and CHCs, or directly to the hub laboratory. Samples should be picked up once a day from PHCs and travelling time to receiving hub laboratory should not exceed 2 hours (starting from where pick-up was started).

iii. Hybrid model of service delivery: In this model, States/UTs undertake all high volume and low-cost tests not requiring highly skilled manpower within public health facilities and all high cost, technologically demanding and lower frequency diagnostic services through outsourced mode as a way of gap filling. Sample collection and transportation will be similar to hub and spoke model.

6.3 Objectives of the support under this component of FC-XV

i. To ensure the availability of a minimum set of diagnostics appropriate to the level of care as per **Comprehensive Primary Health Care** package for HWCs and as per IPHS norms.
ii. To strengthen/ fully equip laboratories at primary healthcare facilities in both rural and urban areas
iii. To ensure adequate availability and training of the Human Resources at HWCs in performing laboratory functions and equipment maintenance
iv. To facilitate early detection, prevention and containment of any chronic /infectious disease – towards strengthening the public health surveillance, reporting and analysis
v. To leverage the approved technology for expeditious use of Point of Care diagnostics
vi. To contribute towards achieving Universal Health Coverage
vii. Reduce high Out of Pocket Expenditure (OOPE) incurred by patients on diagnostics.

6.4 Factors to be considered

6.4.1 The core objective of this component under FC-XV is to equip all the primary healthcare facilities such as SHCs, PHCs and Urban PHCs with all the diagnostic infrastructure, for effective delivery of comprehensive primary health care near to the community. Depending on the context and requirement, additional diagnostic needs for effective delivery and management of cases at these primary healthcare facilities may be attended through referring the samples to the diagnostic facilities at the higher public healthcare facilities or referring the patients wherever warranted (such as X-ray). In the process, the diagnostic infrastructure at the higher public healthcare facilities also have to be commensurately improved to attend these tasks. Strategically, the Block Public Health Unit component of the FC-XV has the lab components, at the Block level to cater to the higher-level diagnostic needs.

6.4.2 The funds provided under this diagnostic infrastructure component of FC-XV are substantial and thus, allow the states to plan not only to ensure access to essential diagnostic tests but also expand the range of tests available so that the HWCs at Sub Health Centre & Primary Health Centres of rural and urban areas are able to provide better quality of care based on accurate diagnosis. This will also strengthen the credibility of the public in the public health system.

6.4.3 While the FC-XV funds are meant to support diagnostic infrastructure at the levels of SHC, PHC and UPHC, the needs for the range of diagnostic tests in the community vary. Further, not all tests can be made available at these primary healthcare facilities, given

the complexity of test, need for qualified HR, space to locate such equipment and requirement of maintenance of the diagnostic equipment. Thus, the Block Public Health Laboratory/Laboratory at Block facility/SDH, District Public Health Laboratory/DH Laboratory could also be strengthened based on local need and availability of qualified HR, for provision of diagnostic services to the people accessing the primary healthcare facilities (SHCs, PHCs and UPHCs) through sample transportation and referral of patients especially for the tests such as Blood and Urine cultures, etc.

6.4.4 Based on the analysis of the funds available under this component, it is arrived that the State is supported with substantially high financial assistance under this component of diagnostic support. As the financial assistance is given separately for SHC, PHC and UPHC for diagnostic infrastructure, the financials available are sufficient for catering to the requirements of both recurring expenditure of these SHCs, PHCs and UPHCs in the State for the next five years and further, the financials available will also cater to improve the diagnostic infrastructure of these SHCs, PHCs and UPHCs with all the required diagnostic equipment and upgradation (except the HR support), not only to effectively provide all the 12 packages of CPHC services at these facilities, but also, effectively equip these facilities with the diagnostic-care-continuum with the Block and District level public health care facilities.

6.4.5 As these SHCs, PHCs and UPHCs are presently having varied level of diagnostic infrastructure, one-size-fit-all unit costing method is not suitable for this component of FC-XV. A detailed gap-analysis of these facilities with the required diagnostic infrastructure, duly factoring-in the available HR and diagnostic-care-policy of the State, is a pre-requisite to effectively utilize this component of FC-XV. A comprehensive gap analysis is required for all the facilities to strengthen the hub and spokes for timely testing and reporting in a time-bound approach to plan for the necessary procurement. While undertaking the facility level gap analysis, the equipment, human resources which are in position as per the latest IPHS need to be taken into consideration **for avoiding duplication**. The facility should be reviewed comprehensively for the functions it is required to perform and the equipment which is available. The current case load of the facility can be considered for augmenting the existing equipment if needed based on a sound rationale.

6.4.6 In this regard, it is instructed that while planning and submitting proposals under this component of FC-XV, State is required to categorize support areas among the following:

i. Diagnostic and Laboratory Equipment including storage

ii. Software/ IT Infrastructure including the option to print diagnostic reports or send via e-mail / electronic media.

iii. Rapid/point of care test Kits, reagents, etc. and their optimal storage conditions

iv. State specific diagnostic kits for early detection of disease conditions like Filaria / Kala-Azar / Leprosy in specific endemic areas or blocks or districts

v. Sample Transportation (Cost and Mode of sample transportation to hub – reducing the Turn Around Time)

vi. Diagnostic Equipment Maintenance and time bound repairs

vii. Monitoring of the Equipment uptime, Cost-effective utilization and replenishment of the reagent

viii. Capacity Building of all teams (For early identification and counselling for testing to obtain the lab results and providing treatment / follow-up)

ix. Misc. (other consumables for sample collection, processing and safe disposal, disinfectants; boxes for sample transportation, internet connection).

6.4.7 The states should strive to plan and operationalize all essential diagnostic tests to cater to the needs of the population to deliver Comprehensive Health Care services along with the diagnostic needs for conducting active and passive public health surveillance.

a. The selected facilities (SHC, PHCs and U-PHCs) will ensure basic diagnostic facilities with linkages for advanced testing facilities at Block Public Health Units / Block level facilities or SDHs +/ DHs or specially, Integrated District Public Health Laboratories at the District level. It is imperative that these linkages are established and accounted for during the planning phase and communicating the same between the hub and spoke facilities.

b. Since the role of SHC-HWCs and PHC-HWCs in rural and urban areas is to ensure seamless continuum of care, if the requirement for such a test is approved by the treating Medical officer/Specialist via direct examination/teleconsultation, the HWC would issue a referral slip for doing diagnostic tests at the designated centres (higher level public health care facility or outsourced private diagnostic facilities).

i. High volume and low-cost tests not requiring highly skilled manpower should preferably be done within the public health facilities and not be outsourced.

ii. High cost, low volume tests requiring expensive equipment and technologically complicated processes, could be outsourced, with adequate checks and balances as safeguards to prevent abuse. For

higher end, low volume tests, such as the blood and urine cultures, etc, the following options are suggested:

- Where there is space in the CHCs/SDHs/DHs, the states could procure the equipment directly, engage qualified HR and offer the diagnostic service directly.
- If the facility is able to provide space, and procure/maintain equipment, but not able to hire qualified HR, they could contract-in private operators to manage these facilities within the government health facility where services are offered on a cashless basis to beneficiaries referred through the Public health facilities.
- If there is no space within the DH/SDH, state could contract out such high-end diagnostic tests to private providers/encourage private providers to set up facilities for such tests within a district to service a cluster of districts, thereby reducing patient hardship and OOPE.

iii. Sample transport: States/UT adopting 'Hub & Spoke' or Hybrid model should ensure safe transport of the sample from all spokes to associated hubs / lower to higher facility. The process of collection and transport has been described in detail in IPHL guidelines. The chain for transport collection and testing should be established keeping in view the distances and the time taken for transportation, availability of public transport, identification of available runners.

iv. Test reports should be given as printed reports to the patients for all tests done as well as sample drawn within the health facility (including rapid tests/point-of-care tests). The intimation that the reports are ready (to collect from the institution where the sample has been taken) will be sent through SMS to the patient along with the link for the soft copy of the reports wherever possible. This service will be in-addition to the right of the patients to receive the hard copy of reports where the sample was given.

v. For the effective management of samples and associated investigation data, surveillance and for timely reporting, digitalization is important. Laboratory Information Management System (LIMS) will allow the spokes to track samples, inventory management (consumables and reagents) and timely communication of the test results. Hubs will be able to collect, store and

analyze the data collected from the spokes for timely actions. This data will be fed directly into IHIP.

vi. Given the increasing availability of digital technology, radiology investigations, (X-Rays and USG) could be undertaken at the level of PHC-HWCs at rural and urban areas with establishment of systems for capturing, transmission and reporting of tests where in house expertise is not available. In this regard, Tele-radiology is already in use in number of States.

vii. Equipment Maintenance: In the in-house model, at the time of procurement, the state government should ensure that the vendor provides the following as complimentary services:

   a) 3-5 years of AMC and CMC;
   b) supply of reagents for 5 years / reagent rental model
   c) annual / bi-annual calibration of equipment (based on the use)
   d) monitoring of equipment uptime and downtime; this is required to be linked with the repair and maintenance contract which is provided to the vendor
   e) initial and annual refresher training of laboratory technicians and diagnosticians on the equipment and its upkeep, software, reporting, imitating breakdown for repairs, disinfection / IPC protocols and biomedical waste management.
   f) Including calibration of equipment on a regular basis
   g) Improve the quality of equipment for large scale screening loads.

viii. Quality Assurance: To ensure reliable and accurate testing, it is important to adhere to quality procedures and protocols. The process of quality assurance would be in accordance to the NQAS program of GoI.

ix. Infection Prevention Control measures: The IPC maintenance should be given due importance keeping in view of the cross-infections / contamination from the samples collected.

x. Grievance Redressal System: Patients can file complaints or give feedback regarding laboratory services including sample collection, reporting etc. using integrated grievance redressal mechanism as per the guidelines of GRS and health helpline (104) through help desk/call centre/web portal.

xi. A system of regular monitoring and periodic review by the district/block units will be ensured on the following indicators to assess the performance. The District/Block Team can undertake onsite visits besides monitoring

performance using online portal. The suggested Monitoring Indicators are as given below:

a) Total number of tests being performed at the lab against the list of essential tests (HWCs-SHC-14/ PHC-63 tests)
b) Total samples rejected / not fit for testing – along with reason
c) Repeat sampling rate – and the time taken to complete the repeat sampling process
d) Test results outside biological reference interval
e) Average turnaround time of test reports and identification of any outliers
f) Number of facilities reporting in LIMS as per the protocols
g) No. of trained HR/LTs/Staff nurses
h) Tests which are being outsourced despite in-house capacity and the reasons

6.5 Guidance for identification of facility, approvals and operationalization

6.5.1 The FC-XV grant is to improve substantially the diagnostic infrastructure in Sub Health Centres (SHCs), Primary Health Centres (PHCs) and Urban Primary Health Centre (U-PHCs) in 28 States under the vision of comprehensive primary health care. A specific amount of Rs. 18,472 Crore has been committed to support diagnostic infrastructure in HWC - sub centres, PHCs and urban PHCs. State-wise budget allocated for support of diagnostic infrastructure in SHCs / SHC-HWCs, PHCs / PHC-HWCs and urban PHCs / UPHC-HWCs are given in the Appendix 2.a, 2.b and 2.c respectively. (*as per Annex 7.10 A-I, A-II & A-III of XV-FC report)*.

6.5.2 The unit cost of establishing new / green field diagnostic infrastructure for SHCs and PHCs in urban and rural areas is calculated to be Rs.3.91 lakhs and Rs.25.86 lakhs for SHCs and PHCs respectively. The support available under this component, if divided among the number of SHCs, PHCs and UPHCs presently functional in the States, is pretty higher than these unit costs per facility. Hence, as re-iterated above, the financial grant under this component has to be utilized – both for recurring expenditure for the provision of diagnostic services at these facilities and improving the diagnostic infrastructure of these facilities to meet the CPHC and IPHS norms.

6.5.3 The support under this component of FC-XV is being provided across various areas like diagnostic equipment for Point of Care Tests, software/ IT Infrastructure, rapid test kits, reagents, etc., sample transportation to hub, equipment maintenance, monitoring,

capacity building and other miscellaneous costs (includes sample storage, test kits, etc.). The cost is not fixed for every facility as fund required for each facility may vary as per the gap analysis.

6.5.4 Allocation by the State to Districts: Based on the resource available and number of functional SHC, PHCs and UPHCs, the State will allocate resources to the Districts. Criterion for prioritizing the districts as given in Chapter-1 need to be followed. States must ensure that that the grants under this component is released to all the Districts of the State. As the resources available under this component are substantial, efforts should be made to saturate the diagnostic requirement of Aspirational, Tribal and backward areas / blocks / districts of the State and accordingly, allocation is to be made.

6.5.5 Apportioning by the Districts: Depending on the grants available to the District, districts have to do a detailed planning.

a. First, districts have to arrive at the recurring expenditure towards provision of diagnostic services at these SHCs, PHCs and UPHCs and this requirement has to be met from the grant under this component of the FC-XV

b. As explained above, as substantial resources are available under this component, the remaining resources are to be proposed for improving the diagnostic infrastructure (non-recurring expenditure) under two broad categories.

    1. Basic diagnostic infrastructure mandatorily available in all SHCs, PHCs and UPHCs
    2. Improved diagnostic infrastructure to be made available depending the availability of HR and other logistic arrangements

6.5.6 All the Districts have to do a detailed gap-analysis facility-wise against the standard list of equipment warranted at the SHCs, PHCs and UPHCs and accordingly, arrive at the list of two categories of diagnostic infrastructure / equipment as mentioned above

1. Basic diagnostic infrastructure / equipment that are immediately required to be provided at these facilities.
2. Advanced diagnostic infrastructure / equipment

6.5.7 Districts have to compile these lists of equipment under two different categories and depending on the resources available, the allocation of resources are to be made for both recurring expenditure and non-recurring expenditure for provision of both types of diagnostic infrastructure (basic and advanced).

6.5.8 The District Level Committee, as elaborated in the DoE's Guidance Note to the States dated 16th July 2021 and as explained in Chapter-1, will take necessary actions.

6.5.9 To ensure equity, facilities located in tribal / backward areas are to be saturated first.

6.5.10 District will be having some of the facilities where due to recent sanctions and execution of diagnostic infrastructure works no allocation may be required from the grant of this component under FC-XV.

6.5.11 Similarly, if the district is adding new public healthcare facilities to cater to needs based on population norms, then the grants of this component of FC-XV may be utilized for providing diagnostic infrastructure to those facilities.

6.5.12 Accordingly, the District will finalize the number of SHCs / PHCs / UPHCs requiring diagnostic infrastructure works (with facility wise requirement) and the strengthening of hub level diagnostic infrastructure upgradation (for this FY 21-22, some support has already been provided by NHM) and accordingly, arrive at the financial requirement of the above, including for the recurring expenditure and based on the financial allocation made by the State for this component of FC-XV, the district may plan for sending the proposals to the State accordingly.

6.5.13 As explained above, with the resources of grant available under this component of FC-XV, all the districts will be in a position to improve the diagnostic infrastructure of the SHCs, PHCs and UPHCs in the districts, including those under construction presently, to the CPHC and IPHS standards.

6.5.14 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter- 1 to the State.

6.5.15 Software is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

6.5.16 After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV.

6.5.17 **As stated in the DoE's Guidance Note (Para 8 at Page 8), on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other consumables, etc, through a mechanism which include Central purchase at State level and for the centrally procured items, the State level Committee may also work out a mechanism for the payment of such centrally procurement items.**

6.5.18 **<u>Procurement Cell</u>: The RLBs / Zilla Panchayats and Urban Local Bodies would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement.** Such a strategy would

eventually create capacities within the ULBs to handle these responsibilities independently.

6.5.19 **As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

6.5.20 Local Bodies (District and Block) should be actively involved in the monitoring of execution of these diagnostic infrastructure works at SHCs, PHCs and UPHCs, including at the higher-level facilities (where improvement has been attended for referral diagnostic tests), which are supported under this component of FC-XV. To the extent possible, the institutional arrangements such as JAS / VHSNCs should be utilized for this purpose.

6.5.21 Capacity building of the local bodies for all components of the FC-XV will be improved as per the plan in this regard (Detailed plan will be communicated separately). Since the aim is to strengthen the ownership and accountability of the RLBs for delivery of primary health care and essential public health functions, the state/District would work closely with the RLBs through the Department of Panchayati Raj Institute.

6.5.22 District may utilize the resources under this component of FC-XV for infrastructure upgradation / repairs / refurbishment of existing labs /diagnostic facilities including for required furniture and electrical works.

6.5.23 **Negative List for this component of FC-XV:** The funds under this component cannot be utilized for the following:

i. High End equipment such as PET SCAN / CT SCAN to the higher-level facilities.
ii. Construction of boundary walls, entrance, pavements, footpaths etc.
iii. Purchase of Solar panels etc.
iv. Purchase of electronic items like TVs, cameras etc. which are not listed as part of the guidelines.
v. Paying of the electricity bills of the facilities.

Appendix 6.1: Support for diagnostic infrastructure for SHCs

S. No.	State / UTs	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	54.76	54.76	57.5	60.37	63.39	**290.78**
2	Arunachal Pradesh	2.84	2.84	2.98	3.13	3.28	**15.07**
3	Assam	46.93	46.93	49.28	51.74	54.33	**249.21**
4	Bihar	157.11	157.11	164.96	173.21	182.02	**834.41**
5	Chhattisgarh	39.19	39.19	41.15	43.21	45.37	**208.11**
6	Goa	1.61	1.61	1.69	1.78	1.92	**8.61**
7	Gujarat	67.49	67.49	70.87	74.41	78.13	**358.39**
8	Haryana	25.48	25.48	26.75	28.09	29.49	**135.29**
9	Himachal Pradesh	15.38	15.38	16.15	16.8	17.81	**81.52**
10	Jharkhand	49.83	49.83	52.33	54.94	57.69	**264.62**
11	Karnataka	71.85	71.85	75.44	79.22	83.18	**381.54**
12	Kerala	39.61	39.61	41.6	43.68	45.86	**210.36**
13	Madhya Pradesh	102.61	102.61	107.74	113.13	118.78	**544.87**
14	Maharashtra	103.91	103.91	109.11	114.56	120.29	**551.78**
15	Manipur	3.95	3.95	4.15	4.36	4.58	**20.99**
16	Meghalaya	6.05	6.05	6.23	6.68	7.01	**32.02**
17	Mizoram	2.72	2.72	2.86	3.08	3.15	**14.53**
18	Nagaland	3.19	3.19	3.35	3.52	3.69	**16.94**
19	Odisha	61.72	61.72	64.81	68.05	71.45	**327.75**
20	Punjab	26.23	26.23	27.54	29.11	30.36	**139.47**
21	Rajasthan	100.45	100.45	105.47	110.75	116.28	**533.4**
22	Sikkim	1.3	1.3	1.36	1.43	1.5	**6.89**
23	Tamil Nadu	64.16	64.16	67.36	70.73	74.27	**340.68**
24	Telangana	34.93	34.93	36.68	38.51	40.44	**185.49**
25	Tripura	7.16	7.16	7.61	7.89	8.28	**38.1**
26	Uttar Pradesh	255.7	255.7	268.48	281.91	296	**1357.79**
27	Uttarakhand	13.6	13.6	14.28	14.99	15.74	**72.21**
28	West Bengal	97.39	97.39	102.26	107.37	112.74	**517.15**
	Total	**1,457.15**	**1,457.15**	**1,529.99**	**1,606.65**	**1,687.03**	**7,737.97**

Appendix 6.2: Support for diagnostic infrastructure for PHCs

S. No.	State / UTs	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	57.61	57.61	60.49	63.55	66.92	**306.18**
2	Arunachal Pradesh	6.96	6.96	7.31	7.68	8.06	**36.97**
3	Assam	50.65	50.65	53.18	55.84	58.56	**268.88**
4	Bihar	172.79	172.79	181.42	190.5	200.22	**917.72**
5	Chhattisgarh	41.06	41.06	43.11	45.22	47.53	**217.98**
6	Goa	1.17	1.17	1.23	1.29	1.39	**6.25**
7	Gujarat	71.88	71.88	75.48	79.25	83.21	**381.7**
8	Haryana	28.05	28.05	29.45	30.64	32.4	**148.59**
9	Himachal Pradesh	28.54	28.54	29.96	31.46	33.04	**151.54**
10	Jharkhand	52.55	52.55	55.17	57.93	60.83	**279.03**
11	Karnataka	103.58	103.58	108.76	114.2	119.91	**550.03**
12	Kerala	49.58	49.58	52.06	54.66	57.39	**263.27**
13	Madhya Pradesh	108.75	108.75	114.18	119.89	125.89	**577.46**
14	Maharashtra	111.96	111.96	117.56	123.44	129.61	**594.53**
15	Manipur	4.38	4.38	4.6	4.83	5.08	**23.27**
16	Meghalaya	6.04	6.04	6.34	6.46	6.99	**31.87**
17	Mizoram	2.87	2.87	3.02	3.22	3.22	**15.2**
18	Nagaland	6.14	6.14	6.44	6.76	7.1	**32.58**
19	Odisha	65.5	65.5	68.78	72.41	75.83	**348.02**
20	Punjab	28.88	28.88	30.32	31.84	33.51	**153.43**
21	Rajasthan	116.25	116.25	122.06	128.16	134.57	**617.29**
22	Sikkim	1.41	1.41	1.48	1.56	1.64	**7.5**
23	Tamil Nadu	69.25	69.25	72.71	76.35	80.17	**367.73**
24	Telangana	35.6	35.6	37.49	39.48	41.21	**189.38**
25	Tripura	5.26	5.26	5.63	5.8	6.09	**28.04**
26	Uttar Pradesh	281.53	281.53	295.61	310.39	325.91	**1494.97**
27	Uttarakhand	12.52	12.52	13.14	13.8	14.49	**66.47**
28	West Bengal	106.02	106.02	111.32	116.88	122.73	**562.97**
	Total	**1,626.78**	**1,626.78**	**1,708.3**	**1,793.49**	**1,883.5**	**8,638.85**

Appendix 6.3: Support for diagnostic infrastructure for UPHCs

S. No.	State / UTs	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	14.29	14.29	15.21	15.84	16.63	**76.26**
2	Arunachal Pradesh	3.07	3.07	3.3	3.38	3.55	**16.37**
3	Assam	12.66	12.66	13.3	13.96	14.66	**67.24**
4	Bihar	43.2	43.2	45.36	47.63	50.01	**229.4**
5	Chhattisgarh	10.23	10.23	10.74	11.27	11.84	**54.31**
6	Goa	0.24	0.24	0.26	0.27	0.28	**1.29**
7	Gujarat	17.63	17.63	18.51	19.44	20.41	**93.62**
8	Haryana	7.01	7.01	7.36	7.73	8.12	**37.23**
9	Himachal Pradesh	4.24	4.24	4.45	4.67	4.91	**22.51**
10	Jharkhand	13.1	13.1	13.75	14.44	15.16	**69.55**
11	Karnataka	16.02	16.02	16.82	17.66	18.55	**85.07**
12	Kerala	11.05	11.05	11.61	12.19	12.8	**58.7**
13	Madhya Pradesh	27.17	27.17	28.53	29.96	31.46	**144.29**
14	Maharashtra	27.96	27.96	29.35	30.82	32.36	**148.45**
15	Manipur	1.12	1.12	1.17	1.23	1.29	**5.93**
16	Meghalaya	1.51	1.51	1.59	1.67	1.75	**8.03**
17	Mizoram	0.44	0.44	0.46	0.48	0.51	**2.33**
18	Nagaland	1.02	1.02	1.08	1.13	1.19	**5.44**
19	Odisha	18.36	18.36	19.28	20.24	21.26	**97.5**
20	Punjab	7.21	7.21	7.57	7.95	8.35	**38.29**
21	Rajasthan	27.81	27.81	29.2	30.66	32.19	**147.67**
22	Sikkim	0.15	0.15	0.15	0.16	0.17	**0.78**
23	Tamil Nadu	18.75	18.75	19.69	20.67	21.7	**99.56**
24	Telangana	8.86	8.86	9.31	9.77	10.26	**47.06**
25	Tripura	1.27	1.27	1.33	1.4	1.47	**6.74**
26	Uttar Pradesh	70.37	70.37	73.89	77.58	81.46	**373.67**
27	Uttarakhand	3.26	3.26	3.42	3.6	3.78	**17.32**
28	West Bengal	26.49	26.49	27.82	29.21	30.67	**140.68**
	Total	**394.49**	**394.49**	**414.51**	**435.01**	**456.79**	**2,095.29**

Annexure: Department of Expenditure Guidelines Dated 16th July 2021

File No.15 (2) FC-XV/FCD/2020-25
Ministry of Finance
Dept of Expenditure
Finance Commission Division

Block No. 11,5th Floor,
CGO Complex, Lodhi Road,
New Delhi-110003
Dated:-16/07/2021

To

The Chief Secretary,
(All State Governments)

Subject:- Operational Guidelines for implementation of the recommendations of the Fifteenth Finance Commission (FC-XV) on Health Sector grants contained in Chapter 7 (Empowering Local Governments) of FC-XV Final Report.

Sir,

The recommendation of the Fifteenth Finance Commission (FC-XV) contained in Chapter-7 (Empowering Local Governments) of FC-XV Final Report inter-alia, include grant-in-aid for Health Sector to be channelized through Local Governments during the award period 2021-22 to 2025-26.

2. In this regard, the undersigned is directed to forward herewith a copy of the Operational Guidelines for implementation of the recommendations of the FC-XV on Health Sector grants for further necessary action.

Yours faithfully,

Encl.: as above

(Abhay Kumar)
Director(FCD)

Copy to:-

(i)The Secretary, Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.
(ii)The Secretary, Ministry of Panchayati Raj, Krishi Bhavan, New Delhi.
(iii) The Secretary, Ministry of Housing & Urban Affairs, Nirman Bhawan, New Delhi.

No. 15(2)FC-XV/FCD/ 2020-25
Government of India
Ministry of Finance
Department of Expenditure
(Finance Commission Division)
....

Operational Guidelines for implementation of the recommendations of the Fifteenth Finance Commission (FC-XV) on Health Sector grants contained in Chapter 7 (Empowering Local Governments) of FC-XV Final Report.

Introduction

The Fifteenth Finance Commission (FC-XV) in Chapter 7 (Empowering Local Governments) of its Final Report has recommended a total grant amounting to Rs. 4, 27, 911 crore for local governments for the award period 2021-22 to 2025-26 out of which the Commission has inter-alia decided to provide grants amounting to Rs. 70,051 crore to strengthen and plug the critical gaps in the health care system at the primary health care level. FC-XV has also identified interventions that will directly lead to strengthening the primary health infrastructure and facilities in both rural and urban areas.

2. In the Eleventh Schedule to the Constitution, Health and Sanitation including hospitals, Primary Health Centers & Dispensaries, Family Welfare are listed for Panchayats. Similarly, in the Twelfth Schedule to the Constitution, Public Health, Sanitation conservancy and solid waste management are listed for Municipalities. In order to achieve the objective of Universal Health, rural and urban local bodies can play a key role in the delivery of primary health care services especially at the 'cutting edge' level. Strengthening the local governments in terms of resources, health infrastructure and capacity building can enable them to play a catalytic role in health care delivery including in crisis times. Therefore, involving Panchayati Raj institutions as supervising agencies in these primary health care institutions would strengthen the overall primary health care system and involvement of local governments would also make the health system accountable to the people.

3. In the light of aforesaid, the Fifteenth Finance Commission has decided to provide a part of the grants earmarked for the third tier for support to primary healthcare. State-wise and year-wise total fund allocation on health Sector spread over the award period of five years starting from 2021-22 to 2025-26 is given in the **Annexure (I).** The components identified by the Fifteenth Finance Commission for upgradation of primary health care infrastructure in Rural and Urban areas along with the summary of the amount earmarked year-wise are given below:

For Rural Areas

(Rs. in crore)

S. No.	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	***Support for diagnostic infrastructure to the primary healthcare facilities***	**3084**	**3084**	**3238**	**3400**	**3571**	**16377**
	(i) Sub centres	*1457*	*1457*	*1530*	*1607*	*1687*	*7738*
	(ii) PHCs	*1627*	*1627*	*1708*	*1793*	*1884*	*8639*
2	***Block level public health units***	**994**	**994**	**1044**	**1096**	**1151**	**5279**
3	***Building-less Sub centres, PHCs, CHCs***	**1350**	**1350**	**1417**	**1488**	**1562**	**7167**
4	***Conversion of rural PHCs and sub centres into health and wellness centre***	**2845**	**2845**	**2986**	**3136**	**3293**	**15105**
	Total Health Grants	**8273**	**8273**	**8685**	**9120**	**9577**	**43928**

For Urban Areas:-

(Rs. in crore)

S. No.	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	*Support for diagnostic infrastructure to the PHC facilities in Urban PHCs*	394	394	415	435	457	2095
2	*Urban health and wellness centres (HWCs)*	4525	4525	4751	4989	5238	24028
	Total Health Grants	4919	4919	5166	5424	5695	26123

4. Brief details about each recommended component is given hereunder;

(i) Support for diagnostic infrastructure to the primary healthcare facilities in Rural and Urban Areas

Under the vision of comprehensive primary health care, FC-XV has provided support for diagnostic infrastructure in Sub-Centers & Public Health Centres(PHCs) in rural areas and for Urban PHCs. Diagnostic services are critical for the delivery of health services, and these grants are intended to fully equip the primary health care facilities so that they can provide some necessary diagnostic services. *(State-wise & Year-wise grants allocated for diagnostic infrastructure in Sub-Centers and PHCs in Rural Areas are provided in Annexure-II & III and for Urban PHCs in Annexure-VII).*

(ii) Block level public health units :-

Block public health units (BPHU) would integrate the functions of service delivery, public health action, strengthen laboratory services for disease surveillance, diagnosis and public health and serve as the hub for health-related reporting. The BPHUs will also improve de-centralised planning and the preparation of block plans that feed into district plans. In addition, they will improve accountability for health outcomes. Given that the block health facility is co-terminus with the Block Panchayat /Panchayat Samiti/Taluka Panchayat, this has the potential to facilitate convergence with the panchayati raj institutions and the child development project officer of the Integrated Child Development Scheme (ICDS) programme. The FC-XV proposes to provide support to BHPUs in all the 28 States. *(State-wise & Year-wise grants allocated for Block level public health units in Rural Areas are provided in Annexure-IV).*

(iii) Urban Health and Wellness Centres

Universal comprehensive primary health care is planned to be provided through urban Ayushman Bharat-Health & Wellness Centres (AB-HWCs) and polyclinics. Such urban HWCs would enable de-centralised delivery of primary health care to smaller populations, thereby increasing the reach to cover the vulnerable and marginalised. It is envisaged that the urban HWCs would create a mechanism for representatives of the Medical Administrative Staff and Resident Welfare Associations to disseminate information on public health issues at least once a month. FC-XV has recommended financial support for setting up urban HWCs in close collaboration with urban local bodies *(State-wise & Year-wise grants allocated for Urban Health and Wellness Centers are provided in Annexure-VIII).*

(iv) Building-less Sub centres, PHCs, CHCs

After assessing infrastructure gaps in the rural PHCs/Sub-Centres based on Rural Health Statistics, FC-XV has recommended financial support for development of necessary infrastructure for 27,581 HWCs at the sub-centre level and 681 HWCs at the

PHC level in rural areas in close collaboration with rural local bodies. (State-wise & Year-wise grants *allocated for Building-less Sub centres, PHCs, CHCs are provided in Annexure-V*).

(v) Conversion of Rural PHCs and Sub Centres into Health and Wellness Centre

The Union Government has envisaged the creation of 1,50,000 HWCs by transforming existing sub-centers and PHCs as the basic pillar of Ayushman Bharat to deliver comprehensive primary health care. 15th Finance Commission propose to provide support for necessary infrastructure for the conversion of rural PHCs and sub-centers into HWCs so that they are equipped and staffed by an appropriately trained primary health care team, comprising of multi-purpose workers (male and female) and ASHAs and led by a mid-level health provider. PHCs linked to a cluster of HWCs would serve as the first point of referral for many disease conditions (State-wise & Year-wise grants *allocated for Conversion of Rural PHCs and Sub Centers into Health and Wellness Centre are provided in Annexure-VI*).

5. **Institutional mechanism for administration of the Health Sector grants**:-

(i) At the **national level**, a Committee called National Level Committee (**NLC**) headed by the Secretary, Ministry of Health & Family Welfare (MoHFW), and comprising Principal Secretaries of Health of all States shall be set up to draw a time line of deliverables and outcomes for each of the five years along with a definite mechanism for flow and utilisation of these grants. Composition of the NLC and the Terms of Reference shall be decided by the Ministry of Health and Family Welfare (MOH&FW) for which the nodal Ministry will issue separate orders. NLC shall consider and if found fit, approve the State level plans received from State Level Committees. It shall also issue necessary technical guidance to the States from time to time which shall include items to be procured/services to be provided under each recommended component, their specifications, price range, names of the standard brands available in the market

etc. etc. along with the formats in which proposals/information from State Level Committees (SLCs) / District Level Committees (DLCs) is required to be sought.

(ii) Similarly in each State, a **State Level Committee** (**SLC**) headed by the Chief Secretary and comprising officials of the State Department of Health, Panchayat Raj (or nodal for Autonomous District Councils) and Urban Affairs and select representatives from all three tiers of rural and urban local bodies shall be set up. Based on the Action Plans received from District Level Committee (DLC), SLC shall prepare a State Plan for presentation/consideration/approval to NLC. Composition of the SLC and the Terms of Reference along with the Role and Responsibilities shall be as decided by the Ministry of Health and Family Welfare (MOH&FW) for which the nodal Ministry will issue separate orders/advisory to the States.

(iii) Similarly, in each district, a **District Level Committee (DLC)** shall be set up under the District Collector/Deputy Commissioner. The Committee will comprise of officials of Health, Panchayati Raj and Urban Affairs and select representatives from all three tiers of rural and urban local bodies in the District. Chief Medical Officer of the District shall be the convener of the Committee. Responsibilities of the Committee shall be as decided by the Ministry of Health and Family Welfare (MOH&FW) and the State Government concerned (SLC) for which the nodal Ministry/State Government will issue separate orders/advisory to the States. Based on the plans received from nominated local body entities, the DLC shall prepare a District Level Plan for submission to State Level Committee for consideration/approval.

6. Thereafter, subsequent steps shall be taken at both the Union and State levels in line with plans agreed upon in the National Level Committee / State Level Committee. The Committees shall meet as frequently as required for the early disposal and smooth working of the proposed mechanism so that the objective of the Fifteenth Finance

Commission recommended Health Sector grants are fulfilled in a fair and transparent manner. The persons charged with this responsibility at each level of the Union and State Governments will ensure strict adherence to timelines and outcomes as set out in the agreed policy.

7. **Implementing entities for the Fifteenth Finance Commission recommended Health Sector grants to Local Bodies**:-

The components identified by the Fifteenth Finance Commission for strengthening primary health care infrastructure and facilities in both rural and urban areas are mostly technical in nature and require experience as well as exposure in the relevant subject. Since, in all States, local bodies have not hitherto handled primary public health functions directly therefore, suddenly transferring the responsibility of the delivery of primary health care services to the local bodies especially at the lower levels during these critical times may not produce the desired results. Further, Fifteenth Finance Commission has also recommended that representatives of the urban local bodies and all three levels of Panchayati Raj institutions (wherever applicable) should be involved by entrusting them, in a phased manner, with the responsibility of supervising and managing the delivery of health services.

Therefore, at district level, Zilla Parishad/ Autonomous District Councils shall handle / implement the rural component of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector. The district level Rural Local Bodies/ Zilla Parishad is better equipped in terms of having a health and engineering resources, that could undertake the functions entailed. However, it is emphasized that Rural Local Bodies below the District level(as the case may be) such as Block/Taluk Level Panchayats and Gram Panchayats/Village Councils must be involved in planning and monitoring of these components for the health facilities located in their jurisdiction.

For implementing urban components of health sector grants, the Urban Local body concerned will be entrusted with implementation of these components. The urban bodies shall handle/implement the urban components of health sector grants (as per component-

wise details in para-3 above) in close coordination with the District Health Department under the overall supervision of the District Collector.

8. **Procurement of medicine, medical equipment, diagnostics and other consumables etc.** :-

Procurement of medical equipments/items of stores for providing diagnostic services etc. are essential part of the health services. Like other items of stores, they are also dependant on the economies of scale, standard processes, quality assurance and require technical expertise in addition to adherence to the Rules, practices and procedures on the subject. As local bodies hitherto have largely not handled such public health functions, therefore, the State Level Committee (SLC) may decide about the procurement of the approved components of medical equipment, diagnostics etc. under 'Support for diagnostic infrastructure' component through a mechanism which may include central purchase(at State level) with the aim to ensure purchase of quality products at reasonable/competitive prices in an efficient manner after following the due processes, procedures and practices with the prior approval by the National Level Committee. For the centrally (at State level) procured items, it must be ensured that the selected vendors/companies do deliver the items of store at the intended destination (where these are required to be installed/utilized). State Level Committee may also work out a mechanism for the payment for centrally procured items of stores to the concerned vendors/companies.

9. **Convergence of FC-XV recommended Health Sector Grants**:- The Fifteenth Finance Commission in Chapter 7 of its Final Report for the period 2021-22 to 2025-26 has inter-alia recommended Health Sector Grants (HSG) to strengthen and plug the critical gaps in the health care system at the primary health care level. The Fifteenth Finance Commission has assessed the gaps in the existing health care interventions made through different programmes /schemes like National Health Mission and Aysuhman Bharat. After assessment, the Fifteenth Finance Commission has identified interventions that will directly lead to strengthening the primary health infrastructure and facilities in both rural and urban areas. The implementing local bodies/entities may utilise the health sector grant

components in convergence with any other scheme aided by the Union Government with similar outcomes or with other type of funds available with them. While avoiding duplication, the ultimate aim for convergence should be to cover maximum population/area within the jurisdiction of the concerned local body or to improve the quality of the assets proposed to be constructed for the purpose. However, 15th Finance Commission recommended health sector grant should not be used as a State share/contribution towards any particular scheme.

10. **Role of State Health Department** :–

(i) State Health Department (SHD) in collaboration with the State Panchayati Raj Department shall work out the District-wise distribution of funds / resources, including physical deliverables and targets - for all the components (separately for rural and Urban) of the *Fifteenth Finance Commission – Health Grants through Local Governments* as per the public healthcare facilities available in the districts, based on the technical guidance provided by the National Level Committee (NLC) and submit it to State Level Committee for consideration / approval.

(ii) The district-wise allocations for health sector grants as a whole may be done keeping in view the rural population factor and ensuring preferential allocation to the aspirational /Tribal districts/ insurgency affected areas/Hill areas with the aim to make health facilities available to even far flung areas/backward areas.

(iii) State Health Department shall compile the Annual District Health Action Plan-FC-XV (DHAP) received from the District Level Committee (DLC) and after examination will place it before State Level Committee for consideration. It is the responsibility of State Health Department to ensure, before forwarding the Fifteenth Finance Commission proposals to State Level Committee that there is **no duplication between the proposals** submitted to the State Level Committee under Fifteenth Finance Commission grants and proposals for funding under National Health Mission or any other schemes of the Govt. of India/State Government.

(iv) The State Health Department shall forward the **approved** District Health Action Plans / compiled State Action Plan to National Level Committee for concurrence/approval.

(v) After approval by State Level Committee & National Level Committee, State Health Department shall communicate the approved District Health Action Plan to the Panchayati Raj Department (for rural grant components) and the Urban Development Department (for Urban grant components) alongwith other relevant details for smooth implementation of the approved plans/components along with the activities/works to be executed by each entity as decided by the State Level Committee and place the same in public domain within 2 weeks of approval by National Level Committee. The State Health Department shall also inform each District Level Committee / Zila Panchayats/ Urban Local bodies about the works/activities approved for their districts alongwith the year-wise budget for further action at their level.

(vi) The State Health Department shall get monthly progress (physical and financial) from all District Level Committes-FC-XV and submit the progress quarterly to the State Level Committee for review and directions.

(vii) State Health Department shall work in close coordination with State Panchayat Raj(PR) Department / Urban Development Department(UDD) in implementation as well as decision making for Fifteenth Finance Commission recommended Health Grants through Local Governments. On the basis of Utilization Certificates collected from different entities, State Health Department alongwith the Panchayat Raj Department shall prepare a joint Utilization Certificate with the signatures of the Secretaries of both the Departments and submit the same to the State Finance Department for onward transmission to the Department of Expenditure, Ministry of Finance and the Ministry of Health & Family Welfare.

(viii) With the permission of the Chairman, State Level Committee, State Health Department shall convene State Level Committee meetings as frequently as required and shall also function as the Secretariat for State Level Committee.

11. **Role of State Panchayat Raj(PR) Department and Urban Development Department(UDD)** :-

(i) State Panchayat Raj Department/Nodal Department for Autonomous District Councils and Urban Development Department(UDD) shall release funds to the local bodies (and to the agency decided by SLC for procurement, if any) and work in close coordination with State Health Department. They will provide all the assistance for implementation of Fifteenth Finance Commission recommended Health Grants through Local Governments ear-marked for Rural Local Bodies/Urban Local Bodies.

(ii) On the basis of information received from State Health Department, State Panchayat Raj Department/ Urban Development Department shall communicate the resource allocation, physical deliverables and targets on a year wise basis, to all the concerned Rural Local Bodies/Urban Local Bodies and shall also seek their Annual proposals in the form of District Health Action Plan (DHAP-FC-XV) from the District/Zila Panchayats and Urban bodies(for their concerned components) .

(iii) State Panchayat Raj Department/ Nodal Department for Autonomous District Councils and Urban Development Department shall pursue with all the Rural Local Bodies/Urban Local Bodies for the proper implementation of the approved District Health Action Plans.

(iv) State Panchayat Raj Department/ Urban Development Department, in active collaboration with the State Health Department, shall take necessary actions for capacity building of the Rural Local Bodies/Urban Local Bodies (officials and elected members) for effective implementation and will utilize all their available resources and institutions for the purpose.

(v) State Panchayat Raj Department/ Urban Development Department shall collect the Utilization Certificates of the amount released to nominated entities (Rural Local Bodies/Urban Local Bodies). It has the responsibility to submit the Utilization Certificates of Fifteenth Finance Commission -Health Grants, with the joint signature of the State Health Department to the State Finance

Department, which will be subsequently submitted to the Department of Expenditure, Ministry of Finance and the Ministry of Health & Family Welfare

12. **Role of District Level Committee (DLC-FC-XV) :-**

(i) District Level Committee (DLC) shall be responsible for providing overall guidance to the Rural Local Bodies/Urban Local Bodies on the implementation of the Fifteenth Finance Commission – *Health Grants through Local Governments*, including preparation of the proposals, component wise as per the Guidelines on the subject and ensuring timely completion of each project.

(ii) The District Level Committee would appraise the proposals received from the Rural Local Bodies/Urban Local Bodies, as per the guidelines on the subject and recommend to the State Level Committee for consideration.

(iii) After receipt of final approved District Health Action Plan -FC-XV from State Level Committee through State Health Department, the District Level Committee shall guide the concerned Rural Local Bodies/Urban Local Bodies and monitor the implementation of the approved activities of various components of District Health Action Plan -FC-XV.

(iv) District Level Committee shall also take necessary steps to guide and handhold the Rural Local Bodies/Urban Local Bodies including capacity building of Rural Local Bodies/Urban Local Bodies (all tiers available within their jurisdiction).

(v) The District Level Committee would mobilize the district health team, (and the state health Department if required) to support Rural Local Bodies/Urban Local Bodies in planning and to provide technical support required in implementation and monitoring.

(vi) The District Level Committee would meet on a monthly basis to review progress and identify issues coming in the way of smooth delivery of primary health care to the intended population and take appropriate remedial measures.

(vii) The District Level Committee shall ensure that the concerned Rural Local Bodies/Urban Local Bodies submit the Utilization Certificates to the Panchayat Raj Department/ Urban Development Department so that further action on these Utilization Certificates can be taken at the appropriate level.

13. Role of Rural & Urban Local Bodies :-

(i) Zila/District Panchayats or District Councils or Municipal Corporations (in case of Urban Local Bodies) shall in collaboration with the District health Department, assess the existing gaps in the health care delivery system within rural and urban areas and prepare a programme for fixing such gaps after taking existing interventions through different centrally sponsored programmes or state sponsored programmes into consideration. On the basis of interventions/components recommended by the Fifteenth Finance Commission as per details given above in para -3 above and District-wise allocations worked out by the State Level Committee, Zila/District Panchayats or District Councils or Municipal Corporations shall prepare annual programmes for a five year period after taking required inputs from all tiers available in the State through their representatives.

(ii) Annual / five year plan thus finalized, shall be submitted to the District Level Committee in the format as prescribed by State Level Committee / National Level Committee for their scrutiny/ approval and further transmission to State Level Committee for necessary action.

(iii) On the basis of the approval received, the Zila /District Panchayats/ Autonomous District Councils or Urban Local Bodies shall implement the activities/projects, in close coordination with the District Health Department, and ensure timely completion, submit UCs to the District Level Committee and Panchayati Raj Department/Urban Development Department (as the case may be).

14. **Release of Grants**:-

On the basis of recommendations received from the Ministry of Health & Family Welfare, Department of Expenditure, Ministry of Finance, Govt. of India shall release Fifteenth Finance Commission recommended health grants to the State Finance Department on PFMS as per the State-wise & component-wise allocation given in **Annexure-II & VIII**. Subsequent installment of the these grants shall be released to the concerned States during the award period of five years on the basis of recommendation received from the Ministry of Health & Family Welfare, submission of Grant Transfer Certificates in the format prescribed at Annexure-IX. A separate Account may be opened for the purpose of monitoring health sector grant transactions. This will also enable in simplification of the processes and ensure no duplication happens with any other scheme for the same subject. The same also needs to be linked with the PFMS.

15. **Distribution of health Sector grants by the States**:-

State Finance Department shall transfer the grant to the Panchayat Raj Department/ Urban Development Department or nodal Department for Autonomous District Councils within ten working days without any deduction.

Panchayat Raj Department/ Urban Development Department or nodal Department for Autonomous District Councils shall transfer the grant to the Zila/District Panchayats/ District Councils or Urban Local Bodies or other tiers in the Panchayati Raj system **based on the items / projects approved by the State Level Committee for execution at their level**.

16. **Mode of payment by the executing entities**:-

Payments made to suppliers/vendors/companies by any executing entity shall be transferred through PFMS or any electronic system fully integrated with PFMS. Therefore, every entity shall have to register either their existing or new bank account with the PFMS or the system integrated with PFMS. Grant transfer and utilization shall be centrally verified through PFMS, therefore, it must be ensured that there is no discrepancy. State Level Committee and District Level Committees shall ensure that all executing entities have linked their bank account with the PFMS.

17. **Capacity Development of the Representatives of local bodies:-**

Consequent upon the enactment of the 73rd & 74th Constitution Amendment Acts, (and as per the Legislation passed by each State), Panchayats were primarily given the responsibility for the delivery of basic services. Involvement of local bodies/third tier in the delivery of primary health care is a new responsibility proposed for transfer in a phased manner and hitherto not managed by the rural local bodies in most of the States. Health being a sensitive subject and the responsibilities required in the delivery of health services require some basic knowledge on the subject. Therefore, Ministry of Health & Family Welfare in coordination with the Ministry of Panchayati Raj / Ministry of Housing and Urban Affairs and the concerned State Governments may consider Capacity Development of the Representatives of local bodies so as to equip them with the new challenges and the new responsibilities being assigned to them.

In order to make the new initiative a success, National Level Committee may consider organizing a short duration training programme for a select group of local body representatives of all the States to be know as 'Training of Trainers' which can further train representatives upto all the available tiers in a State within their jurisdiction or through any other mechanism that National Level Committee may deem fit for their capacity development.

18. **Allocation of State-wise and component-wise health Sector grant for the award period 2021-22 to 2025-26.**

Allocation of State-wise, year-wise and component-wise health Sector grant for the award period 2021-22 to 2025-26 is provided in Annexure-I to VIII.

19. **Accounting procedure**:- A budget line at Budget Stage 2021-22 has been provided under major head 3601, Sub- major head(07). Health Sector Grant being a new addition in the local body grants therefore, new Minor Head for Health Sector grant & Sub-heads is being opened for each component separately. Similarly, while booking expenditure, actual expenditure incurred shall be booked under these newly created Sub-heads under Minor head (Health Sector grant).

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Annexure-I

Total Health Grants for the award period 2021-22 to 2025-26

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	490.00	490.00	514.00	540.00	567.00	**2601.00**
2	Arunachal Pradesh	49.00	49.00	51.00	54.00	56.00	**259.00**
3	Assam	280.00	280.00	293.00	308.00	323.00	**1484.00**
4	Bihar	1133.00	1133.00	1190.00	1249.00	1312.00	**6017.00**
5	Chhattisgarh	339.00	339.00	356.00	373.00	392.00	**1799.00**
6	Goa	31.00	31.00	33.00	35.00	37.00	**167.00**
7	Gujarat	629.00	629.00	661.00	694.00	728.00	**3341.00**
8	Haryana	305.00	305.00	320.00	335.00	352.00	**1617.00**
9	Himachal Pradesh	98.00	98.00	103.00	108.00	114.00	**521.00**
10	Jharkhand	446.00	446.00	469.00	492.00	517.00	**2370.00**
11	Karnataka	552.00	552.00	579.00	608.00	638.00	**2929.00**
12	Kerala	559.00	559.00	587.00	616.00	647.00	**2968.00**
13	Madhya Pradesh	923.00	923.00	969.00	1018.00	1069.00	**4902.00**
14	Maharashtra	1331.00	1331.00	1397.00	1467.00	1541.00	**7067.00**
15	Manipur	44.00	44.00	46.00	49.00	51.00	**234.00**
16	Meghalaya	59.00	59.00	61.00	64.00	68.00	**311.00**
17	Mizoram	31.00	31.00	33.00	35.00	36.00	**166.00**
18	Nagaland	57.00	57.00	60.00	63.00	66.00	**303.00**
19	Odisha	462.00	462.00	485.00	510.00	535.00	**2454.00**
20	Punjab	401.00	401.00	421.00	443.00	465.00	**2131.00**
21	Rajasthan	833.00	833.00	875.00	918.00	964.00	**4423.00**
22	Sikkim	21.00	21.00	22.00	23.00	24.00	**111.00**
23	Tamil Nadu	806.00	806.00	846.00	889.00	933.00	**4280.00**
24	Telangana	419.00	419.00	441.00	463.00	486.00	**2228.00**
25	Tripura	85.00	85.00	90.00	94.00	99.00	**453.00**
26	Uttar Pradesh	1830.00	1830.00	1921.00	2017.00	2118.00	**9716.00**
27	Uttarakhand	150.00	150.00	158.00	165.00	174.00	**797.00**
28	West Bengal	829.00	829.00	870.00	914.00	960.00	**4402.00**
	Total	**13192.00**	**13192.00**	**13851.00**	**14544.00**	**15272.00**	**70051.00**

Annexure-II

Support for diagnostic infrastructure to the primary healthcare facilities- Sub centres

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	54.76	54.76	57.50	60.37	63.39	**290.78**
2	Arunachal Pradesh	2.84	2.84	2.98	3.13	3.28	**15.07**
3	Assam	46.93	46.93	49.28	51.74	54.33	**249.21**
4	Bihar	157.11	157.11	164.96	173.21	182.02	**834.41**
5	Chhattisgarh	39.19	39.19	41.15	43.21	45.37	**208.11**
6	Goa	1.61	1.61	1.69	1.78	1.92	**8.61**
7	Gujarat	67.49	67.49	70.87	74.41	78.13	**358.39**
8	Haryana	25.48	25.48	26.75	28.09	29.49	**135.29**
9	Himachal Pradesh	15.38	15.38	16.15	16.80	17.81	**81.52**
10	Jharkhand	49.83	49.83	52.33	54.94	57.69	**264.62**
11	Karnataka	71.85	71.85	75.44	79.22	83.18	**381.54**
12	Kerala	39.61	39.61	41.60	43.68	45.86	**210.36**
13	Madhya Pradesh	102.61	102.61	107.74	113.13	118.78	**544.87**
14	Maharashtra	103.91	103.91	109.11	114.56	120.29	**551.78**
15	Manipur	3.95	3.95	4.15	4.36	4.58	**20.99**
16	Meghalaya	6.05	6.05	6.23	6.68	7.01	**32.02**
17	Mizoram	2.72	2.72	2.86	3.08	3.15	**14.53**
18	Nagaland	3.19	3.19	3.35	3.52	3.69	**16.94**
19	Odisha	61.72	61.72	64.81	68.05	71.45	**327.75**
20	Punjab	26.23	26.23	27.54	29.11	30.36	**139.47**
21	Rajasthan	100.45	100.45	105.47	110.75	116.28	**533.40**
22	Sikkim	1.30	1.30	1.36	1.43	1.50	**6.89**
23	Tamil Nadu	64.16	64.16	67.36	70.73	74.27	**340.68**
24	Telangana	34.93	34.93	36.68	38.51	40.44	**185.49**
25	Tripura	7.16	7.16	7.61	7.89	8.28	**38.10**
26	Uttar Pradesh	255.70	255.70	268.48	281.91	296.00	**1357.79**
27	Uttarakhand	13.60	13.60	14.28	14.99	15.74	**72.21**
28	West Bengal	97.39	97.39	102.26	107.37	112.74	**517.15**
	Total	**1457.15**	**1457.15**	**1529.99**	**1606.65**	**1687.03**	**7737.97**

Annexure-III

Support for diagnostic infrastructure to the primary healthcare facilities- PHCs

(Rs corore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	57.61	57.61	60.49	63.55	66.92	**306.18**
2	Arunachal Pradesh	6.96	6.96	7.31	7.68	8.06	**36.97**
3	Assam	50.65	50.65	53.18	55.84	58.56	**268.88**
4	Bihar	172.79	172.79	181.42	190.50	200.22	**917.72**
5	Chhattisgarh	41.06	41.06	43.11	45.22	47.53	**217.98**
6	Goa	1.17	1.17	1.23	1.29	1.39	**6.25**
7	Gujarat	71.88	71.88	75.48	79.25	83.21	**381.70**
8	Haryana	28.05	28.05	29.45	30.64	32.40	**148.59**
9	Himachal Pradesh	28.54	28.54	29.96	31.46	33.04	**151.54**
10	Jharkhand	52.55	52.55	55.17	57.93	60.83	**279.03**
11	Karnataka	103.58	103.58	108.76	114.20	119.91	**550.03**
12	Kerala	49.58	49.58	52.06	54.66	57.39	**263.27**
13	Madhya Pradesh	108.75	108.75	114.18	119.89	125.89	**577.46**
14	Maharashtra	111.96	111.96	117.56	123.44	129.61	**594.53**
15	Manipur	4.38	4.38	4.60	4.83	5.08	**23.27**
16	Meghalaya	6.04	6.04	6.34	6.46	6.99	**31.87**
17	Mizoram	2.87	2.87	3.02	3.22	3.22	**15.20**
18	Nagaland	6.14	6.14	6.44	6.76	7.10	**32.58**
19	Odisha	65.50	65.50	68.78	72.41	75.83	**348.02**
20	Punjab	28.88	28.88	30.32	31.84	33.51	**153.43**
21	Rajasthan	116.25	116.25	122.06	128.16	134.57	**617.29**
22	Sikkim	1.41	1.41	1.48	1.56	1.64	**7.50**
23	Tamil Nadu	69.25	69.25	72.71	76.35	80.17	**367.73**
24	Telangana	35.60	35.60	37.49	39.48	41.21	**189.38**
25	Tripura	5.26	5.26	5.63	5.80	6.09	**28.04**
26	Uttar Pradesh	281.53	281.53	295.61	310.39	325.91	**1494.97**
27	Uttarakhand	12.52	12.52	13.14	13.80	14.49	**66.47**
28	West Bengal	106.02	106.02	111.32	116.88	122.73	**562.97**
	Total	**1626.78**	**1626.78**	**1708.30**	**1793.49**	**1883.50**	**8638.85**

Annexure-IV

Financial Requirement for establishing Block Level Public Health Units

(Rs cerore)

SL No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	134.42	134.42	141.14	148.20	155.61	**713.79**
2	Arunachal Pradesh	22.94	22.94	24.09	25.29	26.56	**121.82**
3	Assam	5.31	5.31	5.58	5.86	6.15	**28.21**
4	Bihar	49.47	49.47	51.94	54.54	57.27	**262.69**
5	Chhattisgarh	13.56	13.56	14.24	14.95	15.70	**72.01**
6	Goa	2.41	2.41	2.53	2.66	2.79	**12.80**
7	Gujarat	50.31	50.31	52.82	55.46	58.24	**267.14**
8	Haryana	28.58	28.58	30.00	31.50	33.08	**151.74**
9	Himachal Pradesh	1.85	1.85	1.95	2.05	2.15	**9.85**
10	Jharkhand	24.44	24.44	25.66	26.95	28.29	**129.78**
11	Karnataka	38.23	38.23	40.15	42.15	44.26	**203.02**
12	Kerala	30.59	30.59	32.12	33.72	35.41	**162.43**
13	Madhya Pradesh	28.99	28.99	30.44	31.96	33.56	**153.94**
14	Maharashtra	70.83	70.83	74.37	78.09	82.00	**376.12**
15	Manipur	14.09	14.09	14.79	15.53	16.31	**74.81**
16	Meghalaya	9.25	9.25	9.72	10.20	10.71	**49.13**
17	Mizoram	5.23	5.23	5.49	5.77	6.06	**27.78**
18	Nagaland	14.89	14.89	15.63	16.42	17.24	**79.07**
19	Odisha	29.08	29.08	30.53	32.06	33.66	**154.41**
20	Punjab	30.18	30.18	31.69	33.28	34.94	**160.27**
21	Rajasthan	27.40	27.40	28.77	30.21	31.72	**145.50**
22	Sikkim	6.44	6.44	6.76	7.10	7.45	**34.19**
23	Tamil Nadu	77.47	77.47	81.35	85.42	89.69	**411.40**
24	Telangana	118.52	118.52	124.45	130.67	137.21	**629.37**
25	Tripura	11.67	11.67	12.26	12.87	13.51	**61.98**
26	Uttar Pradesh	76.53	76.53	80.36	84.37	88.59	**406.38**
27	Uttarakhand	2.22	2.22	2.33	2.44	2.57	**11.78**
28	West Bengal	69.22	69.22	72.69	76.32	80.14	**367.59**
	Total	**994.12**	**994.12**	**1043.85**	**1096.04**	**1150.87**	**5279.00**

Annexure-V

Grants for Building-less sub-centres, PHCs, CHCs

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	1.17	1.17	1.23	1.29	1.36	**6.22**
2	Arunachal Pradesh	1.06	1.06	1.10	1.16	1.22	**5.60**
3	Assam	13.32	13.32	13.98	14.69	15.41	**70.72**
4	Bihar	329.29	329.29	345.6	363.00	381.10	**1748.28**
5	Chhattisgarh	10.75	10.75	11.28	11.85	12.45	**57.08**
6	Goa	1.54	1.54	1.61	1.70	1.78	**8.17**
7	Gujarat	1.17	1.17	1.24	1.29	1.36	**6.23**
8	Haryana	29.51	29.51	30.97	32.53	34.15	**156.67**
9	Himachal Pradesh	2.68	2.68	2.81	2.96	3.11	**14.24**
10	Jharkhand	118.54	118.54	124.41	130.67	137.19	**629.35**
11	Karnataka	10.06	10.06	10.56	11.09	11.64	**53.41**
12	Kerala	0.50	0.50	0.52	0.55	0.58	**2.65**
13	Madhya Pradesh	30.03	30.03	31.52	33.10	34.75	**159.43**
14	Maharashtra	50.07	50.07	52.55	55.21	57.96	**265.86**
15	Manipur	2.03	2.03	2.12	2.24	2.35	**10.77**
16	Meghalaya	3.21	3.21	3.37	3.54	3.72	**17.05**
17	Mizoram	0.56	0.56	0.58	0.61	0.64	**2.95**
18	Nagaland	1.03	1.03	1.08	1.13	1.19	**5.46**
19	Odisha	72.83	72.83	76.43	80.28	84.29	**386.66**
20	Punjab	20.26	20.26	21.26	22.33	23.45	**107.56**
21	Rajasthan	191.39	191.39	200.87	210.98	221.51	**1016.14**
22	Sikkim	0.53	0.53	0.55	0.58	0.60	**2.79**
23	Tamil Nadu	71.21	71.21	74.73	78.50	82.41	**378.06**
24	Telangana	2.81	2.81	2.96	3.11	3.26	**14.95**
25	Tripura	0.25	0.25	0.26	0.27	0.29	**1.32**
26	Uttar Pradesh	333.68	333.68	350.22	367.84	386.18	**1771.60**
27	Uttarakhand	1.43	1.43	1.49	1.57	1.65	**7.57**
28	West Bengal	49.04	49.04	51.46	54.05	56.75	**260.34**
	Total	**1349.95**	**1349.95**	**1416.76**	**1488.12**	**1562.35**	**7167.13**

Annexure-VI

Financial requirement for Conversion of Rural PHCs and SCs into Health and Wellness Centre

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	124.67	124.67	130.55	137.45	144.32	**661.66**
2	Arunachal Pradesh	6.67	6.67	7.01	7.36	7.72	**35.43**
3	Assam	80.70	80.70	84.74	88.98	93.42	**428.54**
4	Bihar	195.81	195.81	205.60	215.88	226.68	**1039.78**
5	Chhattisgarh	90.13	90.13	94.64	99.37	104.34	**478.61**
6	Goa	4.00	4.00	4.20	4.41	4.63	**21.24**
7	Gujarat	160.01	160.01	168.01	176.41	185.23	**849.67**
8	Haryana	46.61	46.61	48.94	51.38	53.95	**247.49**
9	Himachal Pradesh	44.13	44.13	46.34	48.65	51.08	**234.33**
10	Jharkhand	68.71	68.71	72.14	75.75	79.54	**364.85**
11	Karnataka	188.86	188.86	198.3	208.22	218.63	**1002.87**
12	Kerala	105.43	105.43	110.70	116.23	122.04	**559.83**
13	Madhya Pradesh	197.76	197.76	207.64	218.03	228.93	**1050.12**
14	Maharashtra	191.95	191.95	201.54	211.62	222.2	**1019.26**
15	Manipur	8.73	8.73	9.17	9.63	10.11	**46.37**
16	Meghalaya	9.29	9.29	9.75	10.24	10.75	**49.32**
17	Mizoram	7.36	7.36	7.73	8.11	8.52	**39.08**
18	Nagaland	8.19	8.19	8.60	9.03	9.49	**43.50**
19	Odisha	125.33	125.33	131.6	138.18	145.09	**665.53**
20	Punjab	46.70	46.70	49.04	51.49	54.06	**247.99**
21	Rajasthan	263.19	263.19	276.35	290.17	304.67	**1397.57**
22	Sikkim	2.96	2.96	3.10	3.26	3.42	**15.70**
23	Tamil Nadu	148.61	148.61	156.04	163.85	172.04	**789.15**
24	Telangana	85.09	85.09	89.34	93.81	98.5	**451.83**
25	Tripura	17.89	17.89	18.78	19.72	20.71	**94.99**
26	Uttar Pradesh	387.35	387.35	406.72	427.05	448.4	**2056.87**
27	Uttarakhand	35.52	35.52	37.29	39.16	41.11	**188.60**
28	West Bengal	192.98	192.98	202.63	212.76	223.40	**1024.75**
	Total	**2844.63**	**2844.63**	**2986.49**	**3136.20**	**3292.98**	**15104.93**

Annexure-VII

Support for diagnostic infrastructure to the primary Healthcare facilities - UPHCs

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	14.29	14.29	15.21	15.84	16.63	**76.26**
2	Arunachal Pradesh	3.07	3.07	3.30	3.38	3.55	**16.37**
3	Assam	12.66	12.66	13.30	13.96	14.66	**67.24**
4	Bihar	43.20	43.20	45.36	47.63	50.01	**229.40**
5	Chhattisgarh	10.23	10.23	10.74	11.27	11.84	**54.31**
6	Goa	0.24	0.24	0.26	0.27	0.28	**1.29**
7	Gujarat	17.63	17.63	18.51	19.44	20.41	**93.62**
8	Haryana	7.01	7.01	7.36	7.73	8.12	**37.23**
9	Himachal Pradesh	4.24	4.24	4.45	4.67	4.91	**22.51**
10	Jharkhand	13.10	13.10	13.75	14.44	15.16	**69.55**
11	Karnataka	16.02	16.02	16.82	17.66	18.55	**85.07**
12	Kerala	11.05	11.05	11.61	12.19	12.80	**58.70**
13	Madhya Pradesh	27.17	27.17	28.53	29.96	31.46	**144.29**
14	Maharashtra	27.96	27.96	29.35	30.82	32.36	**148.45**
15	Manipur	1.12	1.12	1.17	1.23	1.29	**5.93**
16	Meghalaya	1.51	1.51	1.59	1.67	1.75	**8.03**
17	Mizoram	0.44	0.44	0.46	0.48	0.51	**2.33**
18	Nagaland	1.02	1.02	1.08	1.13	1.19	**5.44**
19	Odisha	18.36	18.36	19.28	20.24	21.26	**97.50**
20	Punjab	7.21	7.21	7.57	7.95	8.35	**38.29**
21	Rajasthan	27.81	27.81	29.20	30.66	32.19	**147.67**
22	Sikkim	0.15	0.15	0.15	0.16	0.17	**0.78**
23	Tamil Nadu	18.75	18.75	19.69	20.67	21.70	**99.56**
24	Telangana	8.86	8.86	9.31	9.77	10.26	**47.06**
25	Tripura	1.27	1.27	1.33	1.40	1.47	**6.74**
26	Uttar Pradesh	70.37	70.37	73.89	77.58	81.46	**373.67**
27	Uttarakhand	3.26	3.26	3.42	3.60	3.78	**17.32**
28	West Bengal	26.49	26.49	27.82	29.21	30.67	**140.68**
	Total	**394.49**	**394.49**	**414.51**	**435.01**	**456.79**	**2095.29**

Annexure-VIII

Grants for Urban Health and Wellness Centres (UHWCs)

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	102.88	102.88	108.02	113.48	119.17	**546.43**
2	Arunachal Pradesh	5.24	5.24	5.50	5.78	6.07	**27.83**
3	Assam	69.93	69.93	73.43	77.10	80.95	**371.34**
4	Bihar	185.43	185.43	194.71	204.44	214.66	**984.67**
5	Chhattisgarh	133.88	133.88	140.58	147.60	154.99	**710.93**
6	Goa	20.48	20.48	21.50	22.58	23.71	**108.75**
7	Gujarat	260.73	260.73	273.76	287.45	301.83	**1384.50**
8	Haryana	139.33	139.33	146.30	153.62	161.30	**739.88**
9	Himachal Pradesh	1.41	1.41	1.48	1.56	1.64	**7.50**
10	Jharkhand	119.21	119.21	125.17	131.42	138.00	**633.01**
11	Karnataka	122.93	122.93	129.08	135.54	142.31	**652.79**
12	Kerala	322.22	322.22	338.34	355.25	373.01	**1711.04**
13	Madhya Pradesh	427.83	427.83	449.22	471.68	495.27	**2271.83**
14	Maharashtra	774.13	774.13	812.84	853.48	896.16	**4110.74**
15	Manipur	9.83	9.83	10.32	10.84	11.38	**52.20**
16	Meghalaya	23.30	23.30	24.47	25.69	26.98	**123.74**
17	Mizoram	12.01	12.01	12.61	13.24	13.90	**63.77**
18	Nagaland	22.61	22.61	23.74	24.93	26.18	**120.07**
19	Odisha	89.19	89.19	93.65	98.34	103.25	**473.62**
20	Punjab	241.75	241.75	253.83	266.52	279.85	**1283.70**
21	Rajasthan	106.49	106.49	111.82	117.41	123.28	**565.49**
22	Sikkim	8.19	8.19	8.60	9.03	9.48	**43.49**
23	Tamil Nadu	356.48	356.48	374.30	393.01	412.67	**1892.94**
24	Telangana	133.60	133.60	140.28	147.29	154.66	**709.43**
25	Tripura	41.68	41.68	43.76	45.95	48.25	**221.32**
26	Uttar Pradesh	424.55	424.55	445.83	468.07	491.47	**2254.47**
27	Uttarakhand	81.57	81.57	85.65	89.93	94.42	**433.14**
28	West Bengal	287.92	287.92	302.31	317.43	333.30	**1528.88**
	Total	**4524.80**	**4524.80**	**4751.10**	**4988.66**	**5238.14**	**24027.50**

Annexure –IX

GRANT TRANSFER CERTIFICATE FOR THE FIFTEENTH FINANCE COMMISSION RECOMMENDED HEALTH SECTOR GRANTS (contained in Chapter 7) **DURING ITS AWARD PERIOD 2021-22- TO 2025-2026.**

Name of State:-

S. No.	Components of Health Sector Grants	Year/ Installment	Amount received from GOI (Rs. in lakh)	Date of Receipt (00/00/00)	Date of transfer by SFD to Local Body Nodal Department	Amount transferred (Rs. in lakh)	Amount transferred by Nodal Depart. to Local Bodies
1	Support for diagnostic infrastructure to the Sub centres in rural areas.						
2	Support for diagnostic infrastructure to the PHCs in rural areas.						
3	Block level public health units in rural areas.						
4	Building-less Sub centres, PHCs, CHCs in rural areas.						
5	Conversion of rural PHCs and sub centres into health and wellness centre in rural areas.						
6	Support for diagnostic infrastructure to the primary healthcare facilities in Urban PHCs						
7	Urban health and wellness centres (HWCs).						

Certified that the grants have been utilized / proposed to be utilized for the purpose for which these have been provided and if any deviation is observed, the same will be intimated.

Signature with seal of
Secretary (Nodal department)

Countersigned:
Signature with seal of the Finance Secretary

List of Contributors:

Ministry of Health and Family Welfare	
Name	**Designation**
Mr. Rajesh Bhushan	Secretary, HFW
Ms. Vandana Gurnani	AS&MD, NHM
Mr. Vikas Sheel	Additional Secretary
Ms. Preeti Pant	Joint Secretary, NUHM
Mr. Vikas Chauhan	Joint Secretary, Policy
Dr. N.Yuvaraj	Director – NHM
Dr. Sachin Mittal	Director – NHM
Dr. Rajani R. Ved	Advisor
Ms. Asmita Jyoti Singh	Senior Consultant, NHM
Dr. Rakshita Khanijou	Consultant HSS,WHO
Ms. Rajni Tomar	NUHM, Sr Consultant, ADB
Ms. Seema Pati	NUHM, Sr Consultant, ADB
Ms. Isha Rastogi	NUHM, Sr Consultant, ADB
Ms. Ramya Ramakrishnan	Consultant, IIC/Jhpeigo
Mr. Nilav Kumar Pyne	Consultant, IIC/Jhpeigo

National Health Systems Resource Centre	
Name	**Designation**
Maj Gen (Prof) Atul Kotwal, SM, VSM	Executive Director
Dr (Flt Lt) M A Balasubramanya	Advisor, CP-CPHC Division
Dr. Himanshu Bhushan	Advisor, PHA Division
Air Cmde(Dr.) Ranjan Choudhury VSM	Advisor, HCT Division
Ms. Mona Gupta	Advisor, HRH Division
Dr Ashoke Roy	Director, RRC-NE
Dr Neha Singhal	Senior Consultant, CP-CPHC Division
Dr. Anantha Kumar Srinivasaiyer	Senior Consultant, CP-CPHC Division
Dr Suman Bhardwaj	Senior Consultant, CP-CPHC Division
Mr Arun Srivastava	Consultant, CP-CPHC Division
Dr Anwar Mirza	Consultant, CP-CPHC Division
Dr Atul Rairker	Consultant, CP-CPHC Division
Ms. Ima Chopra	Consultant, CP-CPHC Division
Dr Vijaya Salkar	Junior Consultant, CP-CPHC Division
Dr Swarupa Kshirsagar	Junior Consultant, CP-CPHC Division
Dr. Neha Dumka	Lead Consultant, Knowledge Management Division
Mr. Prasanth KS	Senior Consultant, PHA Division
Dr. Smita Shrivastava	Senior Consultant, PHA Division
Mr. Ajit K Singh	Sr. Consultant, PHA Division
Dr. Aashima Bhatnagar	Consultant, PHA Division
Dr. Poonam	Consultant, PHA Division
Dr. Ashutosh Kothari	Consultant, PHA Division
Ms. Neelam Tirkey	Consultant, PHA Division
Dr. Aditi Joshi	Jr. Consultant, PHA Division
Ms. Diksha Rathee	Jr. Consultant, PHA Division
Dr. Diksha Dhupar	Senior Research Associate, PHA Division

National Health Systems Resource Centre	
Name	**Designation**
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