AYUSHMAN BHARAT

AYUSH Health and Wellness Centres

Operational Guidelines

सत्यमेव जयते

Ministry of AYUSH
Government of India

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SOWA-RIGPA, HOMOEOPATHY-(AYUSH) &
MINISTER OF STATE FOR DEFENCE
GOVERNMENT OF INDIA

FOREWORD

The Union Cabinet approved establishment of 12500 Health and Wellness Centres by transforming existing AYUSH dispensaries and sub health centres. This is a historic decision and paradigm shift towards visualizing a holistic health approach for achieving "Community Health & Wellness" based on AYUSH principles and practices.

I am happy to publish the Operational Guidelines approved by the Union Cabinet for operationalization of AYUSH HWCs and also expect the mutual cooperation between the State Health Department and State AYUSH Department would enable to achieve "Holistic health" by operationalizing Yoga, appropriate use of medicinal plants, healthy lifestyle practices and choices for AYUSH medicines at the community level, in addition to existing activities, for reducing disease burden and out of pocket expenditure.

I would like to take this opportunity to congratulate all my officers and partner Ministries, Departments, States & Union Territories who contributed in finalising these guidelines for effective implementation of AYUSH Health and Wellness centres.

(Shripad Naik)

सत्यमेव जयते

वैद्य राजेश कोटेचा
Vaidya Rajesh Kotecha

सचिव
भारत सरकार
आयुर्वेद, योग व प्राकृतिक चिकित्सा,
यूनानी, सिद्ध, सोवा रिग्पा एवं होम्योपैथी (आयुष) मंत्रालय
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SECRETARY
GOVERNMENT OF INDIA
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PREFACE

This Operational Guideline is an outlook of service framework for the officers at the State and District level for effective implementation of AYUSH Health and Wellness Centres. This guideline is an outcome of discussion with the Ministry of Health and Family Welfare, State AYUSH departments, Health departments and other partners. This guideline is an initial framework for the expansion of various activities and services through AYUSH Health and Wellness Centres. Services such as "Identification of Prakriti (body-mind constitution of individual)", "Yoga", "Use of Medicinal Plants", "Healthy Living practices", "Basic OPDs interventions" ,"Evidence-based NCD protocols" multi sectoral convergence, and use of IT based solutions etc. would be key components of the programme.

The guidelines are indeed very comprehensive and indicative covering every aspect of AYUSH HWC. However, the States will use the guidelines to develop a State specific road map, and build shared accountability at district and sub district level so that there is a clear goal and focus to help us reach the target of operationalizing 12500 AYUSH Health and Wellness Centres by 2023-24.

I would also like to thank the team of Ayushman Bharat, National AYUSH Mission, State Government officials and other experts whose relentless efforts have made the launch of these guidelines possible. I thank all partner who contributed for developing this Operational Guideline of AYUSH Health and Wellness Centre and do believe that State/UTs will do value addition in coming future for the effective implementation of AYUSH Health and Wellness Centres.

I urge that the States take strong ownership of the programme and expedite to scale up and expand the scope of AYUSH Health and Wellness Centres.

(Rajesh Kotecha)

28th May, 2020
New Delhi

रोशन जग्गी
संयुक्त सचिव
ROSHAN JAGGI
JOINT SECRETARY

भारत सरकार
आयुर्वेद, योग व प्राकृतिक चिकित्सा,
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PROLOGUE

The National Health Policy 2017 has highlighted the mainstreaming of AYUSH Health Services for providing preventive and promotive health care services.

This Operational Guidelines prepared through multidisciplinary consultation are dynamic and are expected to subsequently evolved as per the need of the community and experiences learnt from implementation. These guidelines provide framework for providing 12 domain specific service delivery, laying focus on healthy practices to be followed on a daily basis which can help in prevention of diseases and enable the community to maintain a positive promotive health aiming at wellness through self care. I would like to urge the States to use these guidelines as a framework to move expeditiously towards transforming the existing sub health centres, and AYUSH dispensaries into dynamic, effective and efficient AYUSH Health and Wellness Centres for Comprehensive Primary Health Care.

There is a need to put these guidelines to practice in imparting training to HWC teams to build their capacities, reorient their approach to effectively perform and achieve the outcomes of the programme. The efforts of expert-team members and line Ministries put to bring out these set of guidelines are appreciable.

(Roshan Jaggi)

Operationalization of AYUSH Health and Wellness Centers under Ayushman Bharat

EXECUTIVE SUMMARY

1. Introduction

In the recent past, there is a paradigm shift in the approach from disease management towards achieving wellness. The AYUSH systems advocate holistic wellness approach aiming at prevention of diseases and promotion of health and wellbeing. A decision was taken on 30th Jan. 2019 that at least 12,500 Health and Wellness Centers(HWCs) under Ayushman Bharat will be upgraded by the Ministry of AYUSH. The Union Cabinet during its meeting on 20th March 2020 has approved the proposal to operationalise these 12,500 AYUSH HWCS through States/ UTs in Centrally Sponsored Scheme mode and under the broad umbrella of National AYUSH Mission (NAM) in a phased manner by 2023-24.

2. Objectives

The main objectives are to establish a holistic wellness model based on AYUSH principles and practices, to empower masses for "self-care" to reduce the disease burden, out of pocket expenditure and to provide informed choice to the needy public.

3. AYUSH Health and Wellness Centres

The health care facilities to be upgraded as AYUSH HWCS are AYUSH dispensaries and sub health centres (SCs). At upgraded AYUSH dispensaries, expanded AYUSH services will be initiated initially, and gradually the NHM components will be incorporated as per the feasibility. In case of SCs, AYUSH services will be in addition to already on-going National Health Programmes and other activities under National Health Mission. The mechanism of operationalisation of HWCs would be jointly workout by Department of AYUSH & Health in the State / UTs.

4. Key Principles of HWCs

Functional integration with existing establishment for providing comprehensive care by using standard protocols and guidelines, up-gradation of infrastructure, community mobilization for self-care, sensitization & capacity building of health care providers, expansion of services, inter & intra sectoral linkages and documentation with the help of IT platform are the highlights of the activities.

5. Components of AYUSH services

a) Preventive and promotive measures for self-care

b) Medicinal plants for self-care

c) Management of common ailments under 12 service delivery framework such as care in pregnancy and child birth, neonatal and infant health care, childhood and adolescent health care, family planning,

contraceptive and reproductive health care, communicable diseases, acute simple illness and minor ailments, non-communicable diseases, oral health care, elderly and palliative health care and mental health.

6. Institutional Mechanism

The AYUSH HWCs would be upgraded and operationalized through an institutional mechanism at National, State and District level. Already established framework of NAM and further linkages with line ministries & departments will enable to successfully plan and carryout public health activities. The collaboration with AYUSH standalone hospitals, collocated facilities, educational institutions, national level organizations, schools, social groups, private bodies, community groups, local bodies, Panchayati Raj Institutions are proposed.

7. Monitoring and Evaluation

The outcome will be measured through independent periodic assessment of key indicators such as infrastructure development, HR availability, provision of quality services, access to service, health outcomes. Supportive supervision and record checking at periodic intervals will be carried out manually and through IT based software.

8. Timeline and Financial Implication :

Target for operationalization of AYUSH HWCs in five years						
Year	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**Total**
No. of HWCs	1738	2700	3100	3700	1262	12500
Financial requirement (Rs. in Crore)						
Central Share	82.21	234.75	420.70	640.43	831.50	2209.58
State Share	44.27	126.40	226.53	344.85	447.73	1189.77
Total	126.47	361.15	647.23	985.27	1279.23	3399.35

Summary of Unit cost for upgradation of AYUSH Dispensary and Sub Health Centre

Sr. No.	Components	Rupees in Lakh per annum			
		For upgraded AYUSH Dispensary		**For upgraded Sub Health Centre**	
		Non-recurring cost	Recurring cost	Non-recurring cost	Recurring cost
1.	Infrastructure cost	5.00		5.00	
2.	Remuneration to Community Health Officer (CHO)	-	4.80	-	4.80
3.	Yoga instructor	-	0.96	-	0.30
4.	Yoga instructor (female)	-	0.60	-	-
5.	Team based incentives	-	1.00	-	1.00
6.	ASHA incentives	-	0.60	-	0.60
7.	Training of CHO	0.30	-	1.034	-
8.	Refresher training of CHO	-	0.05	-	0.10
9.	Refresher training of MPW, ASHA	-	0.20	-	0.20
10.	Laboratory services	1.00	0.30	1.00	0.30
11.	IT networking	0.35	0.05	0.35	0.05
12.	IEC	-	0.25	-	0.25
13.	Establishment of herbal garden	0.20	0.06	0.20	0.06
14.	AYUSH medicines (Maximum up to 2 lakh per HWC)	-	To be borne from NAM	-	To be borne from NAM
15.	Untied fund	-	0.50	-	0.50
	Total	**6.85**	**9.37**	**7.584**	**8.16**

The unit cost for upgradation of AYUSH dispensary is Rs. 16.22 lakh and for upgradation of the sub health centre is Rs. 15.744 lakh. The supply of essential AYUSH medicines will be met from NAM at upgraded AYUSH dispensaries and sub health centres.

Operationalization of AYUSH Health and Wellness Centers under Ayushman Bharat

OPERATIONAL GUIDELINES

1. Introduction

Comprehensive Primary Health Care is the major challenge in India's journey towards Universal Health Coverage (UHC). The WHO Traditional Medicine Strategy 2014–2023 emphasizes the importance of harnessing traditional knowledge for achieving universal health care. It recommends that member states should develop policies, regulations, and guidelines for mainstreaming the potential of Traditional &Complementary Medicines (T&CM) for improving health care delivery systems, progressing towards wellness and people-centric services.

The National Health Policy (NHP) 2017 has advocated mainstreaming the potential of AYUSH systems (Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa-rigpa and Homoeopathy) within a pluralistic system of integrative healthcare. At present, there is a highly receptive environment where the value of AYUSH systems in healthcare is widely recognized. In India, the experience with several programmes in the last few years has shown that the AYUSH systems have been successful in improving service delivery. Many reforms undertaken by the Ministry of AYUSH in the areas of education, R&D, Standardization & quality control of medicines and services, upgradation of healthcare facilities, public health initiatives, mainstreaming of AYUSH are yielding encouraging results. National AYUSH Mission launched during 2014 is successful in promoting AYUSH medical systems through upgradation of healthcare services, strengthening of educational systems and quality control of drugs.

In the recent past, there is a paradigm shift in the approach from disease management towards achieving wellness. Wellness is an active process of becoming aware of and making choices towards a healthy and fulfilling life. One can reach an optimal level of wellness by understanding how to maintain and optimize each of the dimensions of wellness such as physical, emotional, spiritual, occupational, environmental and social. For instance, Ayurveda advocates a self-care model known as "*swasthavritta*" meaning "establishing oneself in good habits". This aims at prevention of diseases and promotion of health for achieving a state of wellbeing. *Swasthavritta* encompasses *Dinacharya* (daily routine), *Ritucharya* (practices specific to season/weather conditions) and *Sadvritta* (behavioral code for mental health). Other AYUSH systems also have their own philosophy and practices for achieving wellness.

During February 2018, the Government of India has decided that Health & Wellness Centres (HWCs) would be upgraded by transforming existing Sub Health Centres and Primary Health Centres to deliver Comprehensive Primary Health Care and declared this as one of the two components of Ayushman

Bharat. The other component namely the Pradhan Mantri Jan Arogya Yojana (PMJAY) aims to provide financial protection for secondary and tertiary care to about 40% of India's households. Together, the two components of Ayushman Bharat will enable the realization of the aspiration for Universal Health Coverage.

During January 2019, it was decided that 10% of the total HWCs (12,500) under Ayushman Bharat will be upgraded by the Ministry of AYUSH. This formed the basis for the translation of policy articulations to an operational commitment. Already functional AYUSH dispensaries or sub health centres (SCs), identified by the States/UTs will be upgraded by the Ministry of AYUSH as AYUSH HWCs, for providing AYUSH based preventive, promotive, curative and rehabilitative care.

1.1 Vision

- To establish a holistic wellness model based on AYUSH principles and practices

1.2 Objectives

- To provide Comprehensive Primary Healthcare through AYUSH using team-based approach
- To establish a holistic wellness model based on AYUSH principles and practices focusing on preventive, promotive, curative, rehabilitative healthcare by establishing integration with existing public healthcare system
- To provide informed choice to the needy public by making AYUSH services available.

These Operational Guidelines are expected to serve as a framework for operationalizing the multiple components required for the delivery of Comprehensive Primary Health Care services by integrating AYUSH services. However, States have the flexibility to make necessary modifications based on their specific needs and capacities. These guidelines will be reviewed periodically and revised based on the experience from the field so as to provide updated guidance to programme implementers.

1.3 AYUSH Health and Wellness Centres

The Ministry of AYUSH has been given the task of developing 12,500 HWCs under Ayushman Bharat. This will be achieved in a phased manner through State Governments and Union Territories.The funding will be through the Centrally Sponsored Scheme of National AYUSH Mission (NAM).

The Ministry of AYUSH, in consultation with States/ UTs and Ministry of Health & Family Welfare has proposed two following models for upgradation as AYUSH Health & Wellness Centres:

i. Upgradation of AYUSH dispensaries
ii. Upgradation of existing sub health centres (SCs)

The AYUSH dispensaries will be priorotised for upgradation as AYUSH HWCs, however, in some UTs and North- eastern States, where the number of AYUSH dispensaries is negligible or if the State Department of Health desires, the sub health centres would be considered for upgradation by the Ministry of AYUSH. At upgraded AYUSH dispensaries, the entire range of AYUSH services will be rolled out initially

and gradually the NHM components may be incorporated as per the feasibility and cooperation extended by the Department of Health of the particular State/ UT. Till the provision for such components are made available at upgraded AYUSH dispensaries, the needy persons will be referred to nearby SC/PHC for various National programmes such as immunization, ante-natal care. In case of upgraded SCs, AYUSH services will be in addition to already on-going National Health Programmes and other activities under the National Health Mission (NHM).

The funding for both the above models would be through National AYUSH Mission. The responsibility to upgrade and operationalize AYUSH dispensaries will rest with the Department of AYUSH. The upgraded sub health centres will be operationalized by the State health departments and the fund flow in this case will be made from State AYUSH society to State health society. The supply of essential AYUSH medicines will be through NAM and an indicative list of AYUSH Medicines to be made available at HWCs is at **Appendix 1**.

A close coordination and written agreement between AYUSH and Health Departments containing detail planning is required at State level to successfully operationalise AYUSH HWCs.

The health care facilities will be selected by States/UTs for upgradation as AYUSH HWCs as per the following criteria:

- Need based location, where comprehensive health care facility is relatively lacking.
- Already functional centres with the availability of minimally required manpower preferably an AYUSH physician.
- Availability of infrastructure to suit HWC requirement, including space for the practice of Yoga & demonstrative herbal garden/potted plants for about 15 species.
- Covering maximum of upto 5000 population in plain areas and 3000 in hilly/ remote areas.
- Institutional support in the area for training and referral such as PHCs/ AYUSH Hospitals/ co-located facility at Community Health Centres (CHC) /District Hospitals (DH)/ AYUSH integrated hospitals/Teaching Hospitals/National level institutions/ Allopathic facilities.
- Popularity of the particular AYUSH system such as Ayurveda, Unani, Siddha, Homoeopathy in the area.
- Identification of health facilities for upgradation should be a joint exercise of Department of Health and Department of AYUSH to avoid overlapping of catchment areas of different HWCs and also to have a consensus on their operationalization.

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

2. Key Principles of HWCs

I. Transform existing AYUSH dispensaries and sub health centres to AYUSH Health & Wellness Centers to ensure universal access to an expanded range of Care.

ii. Primary health care services, enable the integration of AYUSH services as appropriate to people's needs.

iii. Ensure a people-centered, holistic, equity sensitive response to people's health needs through a process of population empanelment, regular home and community interactions and people's participation.

iv. Enable the delivery of quality care that spans health risks and disease conditions through a commensurate expansion in the availability of medicines & diagnostics, use of standard treatment and referral protocols and advanced technologies including IT systems.

v. Instil the culture of a team-based approach to delivery of quality health care encompassing preventive, promotive, curative, rehabilitative and palliative care.

vi. Ensure continuity of care with a two-way referral system and follow up support.

vii. Emphasize health promotion and promote public health action through active engagement and capacity building of community platforms and individual volunteers.

viii. Implement appropriate mechanisms for flexible financing, including performance-based incentives and responsive resource allocations.

ix. Facilitate the use of appropriate technology for improving access to health care advice and treatment initiation, enable reporting and recording, eventually progressing to electronic records for individuals and families.

x. Institutionalize participation of civil society for social accountability.

xi. Partner with not for profit agencies and private sector for gap filling in a range of primary health care functions.

xii. Facilitate systematic learning and sharing to enable feedback and improvements and identify innovations for scale-up.

xiii. Develop strong measurement systems to build accountability for improved performance on measures that matter to people.

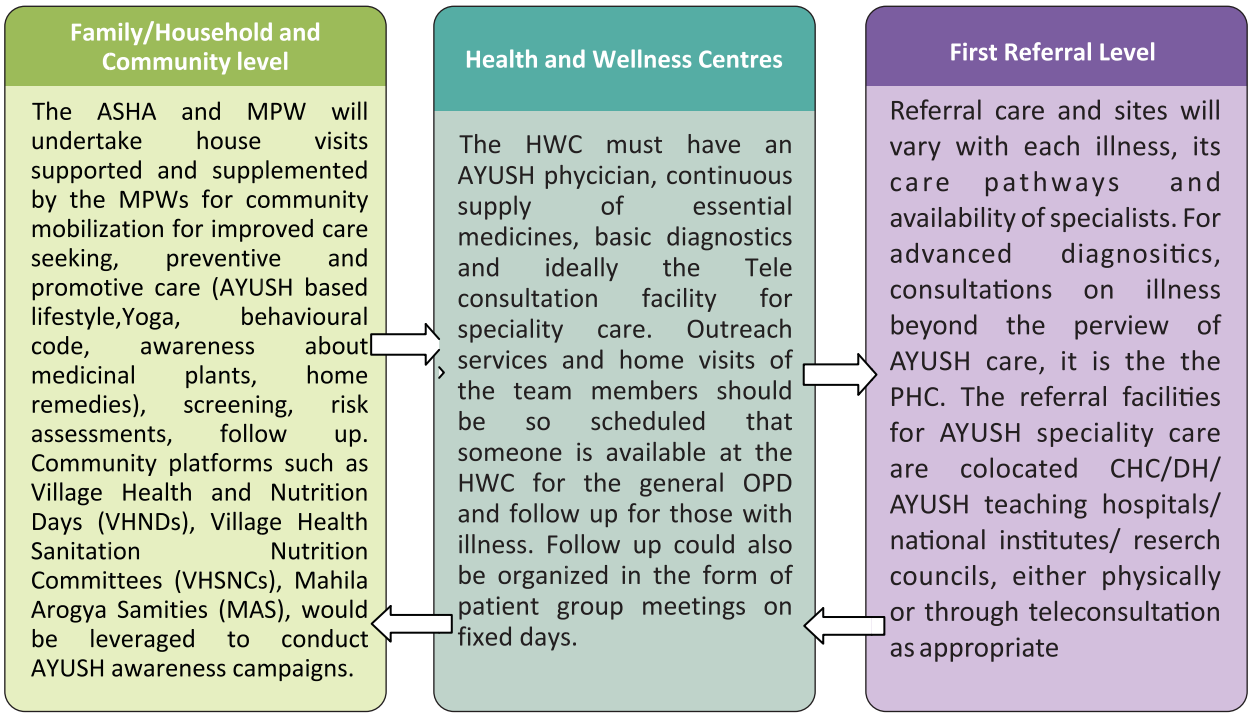
3. Service Delivery

The HWC will be considered functional once the delivery of services is initiated. The expanded AYUSH services will be initiated at upgraded AYUSH dispensaries and NHM activities may be integrated as and when the Department of Health takes a decision on this. At upgraded sub health centres, entire range of AYUSH services will be rolled out alongwith already existing NHM activities. The service delivery including preventive, promotive, curative, rehabilitative health care would be at three levels i.e., (i) family/household and community levels through outreach OPDs, health mela, village panchayat, village & home visits, school & anganwadi visits; (ii) health and wellness centres; and (iii) referral facilities/sites.

delivery of services closer to the community and close monitoring would enable increased coverage and help in addressing issues of marginalisation and exclusion of specific population groups.

The needy patients will be appropriately referred to PHCs [First Referral Unit (FRU)], AYUSH dispensaries, co-located facilities at CHC/DH/ AYUSH integrated hospitals, state teaching hospitals, National level institutions, etc. as per pre-devised referral criteria. Needy patients will also be referred to Allopathic centres and vice versa. The continuum of care will be ensured through referral to higher centers of care and reverse referral to HWCs for follow up.

The AYUSH HWCs would deliver an expanded range of services as per the preventive &promotive guidelines and standard treatment guidelines that will be issued periodically.



4. AYUSH Wellness Interventions

The AYUSH wellness model for integration in Ayushman Bharat will include three components:

(1) Preventive and promotive measures for self-care

(2) Medicinal plants for self-care and

(3) Management of common ailments.

These guidelines will provide the details of Ayurveda services and similarly the guidelines for other AYUSH systems viz. Yoga & Naturopathy, Unani, Siddha and Homoeopathy have been shared with the States/UTs, separately. Yoga would be an essential activity of all AYUSH HWCs.

4.1 Preventive and promotive measures for Self-care :

4.1.1 **Know your health-***Prakriti* is a comprehensive understanding of psycho somatic constitution of an individual based on physical, psychological and social identity by using validated methods and tools. This identity will form the basis for advocacy of diet and lifestyle customized to the individual as preventive & promotive measures. Identification of *Prakriti* will be advocated through trained Ayurveda physicians at HWCs, PHCs, DHs, close by Ayurveda colleges and national level institutes. This may be undertaken both at institutional and community level through camps and at schools. It has been proposed that the *Prakriti* will be mentioned in the health card of the individual.

4.1.2 **Dinacharya (daily routine)-***Dinacharya* is set of rules to be followed to stay connected to the rhythms of nature. Feasible components of *Dinacharya* focusing on time to wake up, sleep, massage, exercise, behavioural code, oral-nasal-eye care, suppressible and non-suppressible natural urges, Yoga, etc. will be used in the intervention as per the detail advocacy modules.

4.1.3 **Ritucharya (seasonal routine)**- Awareness about easy to follow healthy practices specific to season/weather conditions for preventing seasonal illnesses will be advocated.

4.1.4 **Dietetics-** Mass awareness programmes will be conducted on Ayurveda dietetics by considering locally prevalent traditional practices and resources in the region. Dietetics will play major role in the maintenance of healthy *Agni* (factors responsible for digestion & metabolism). There are healthy cooking methods and eating rules for the people to follow so as to stay healthy. The detail guidelines on dietetics have been made available in the training documents.

4.1.5 **Yoga-** Yoga will be taught to the public for general health promotion as community based intervention, by qualified Yoga instructor.

- Group-specific yoga practices viz. pregnant women, lactating mother, school children, adolescents, elderly, diabetics etc. regularly in HWCs, community centres, schools.
- The standard audio visual support will also be taken for making the sessions interesting and to ensure follow ups.

4.1.6 **Medicinal plants for Self care** An Indicative list of 16 plants **(Appendix 2)** is prepared for growing in the pots, kitchen gardens, home streets, parks, schools, village common land- in the region. The community will be encouraged to grow important medicinal plants and awareness about their use in simple illnesses will be the focus of this components. The help of National / State medicinal plants boards, horticulture departments will be taken to roll out this activity.

4.1.7 **Management of common ailments** Medicines/home remedies for prophylaxis during the outbreak of communicable diseases, management of simple ailments through lifestyle modification, Yoga, diet, home remedies and medicines will be made available as per 12 service delivery framework envisaged under HWCs.

4.1.7.1 Service Delivery Framework

So as to expand the range of services at transformed HWCs, 12 service delivery areas have been already decided under Ayushman Bharat Health & Wellness Centres. The following are Ayurveda interventions proposed under 12 service delivery areas, similarly, the guidelines for other AYUSH systems would be shared with the States/UTs as and when they are operationalized. The interventions mentioned here are simple, evidence based and commonly used for the said indications. All the medicines are pharmacopoeial formulations, selected from the Essential Drug List (EDL) of Ministry of AYUSH and therefore the quality standards of the medicines and the framework for quality control of medicines are already in place.

The services of particular system of medicine will be decided as per the choice of the beneficiary and suitability of the interventions to the individual, which may be stand alone or add on to the standard care as per the need assessed by the attending physician. The cases beyond the limits of AYUSH systems or if the patient warrants for further investigations or standard specialty/critical care or interventions such as immunization, surgery, standard drugs (e.g. Tuberculosis) would be referred to the linked higher level facilities. Similarly, referrals will be made for AYUSH specialty care for therapeutic procedures such as *Panchakarma*.

I. Care in Pregnancy and Child-birth

Care at community level

- Preventive pregnancy care (*Garbhini Charya)* – food and way of life for the woman and family, particular food preparations
- Cultivation of medicinal plants / home remedies
- Yoga

Care at the HWC

- Anemia
- Morning sickness
- Minor ailments like gastro intestinal complaints, general weakness etc.
- Yoga

Care at referral site

- Availability of specialist
- Delivery point-vaginal/ assisted vaginal and caesarean section
- Management of all complications including ante-partum and post-partum haemorrhage, eclampsia, puerperal sepsis, obstructed labour, retained placenta, shock, severe anaemia, breast abscess
- Essential neonatal care

II. Neonatal and Infant Health Care Services

Care at community level

Family and individual counselling

Care at the HWC

- Whole body *Snehana* (gentle massage) of the baby everyday with Coconut oil, Gingely oil, Mustard oil, medicated oil
- Augmentation of lactation for feeding mother

Care at referral site

- Care for low birth weight new-borns
- Treatment of asphyxia and neonatal sepsis
- Treatment of severe Acute Rspiratory Infections (ARI) and diarrhoea / dehydration cases
- Vitamin K for premature babies
- Childhood and adolescent health care services including immunization
- Management of all emergency and complication cases

III. Childhood and Adolescent Health Care Services

Care at community level

- Focus on schools
- Promoting healthy eating habits, lifestyle
- Yoga, prayer, sleeping and waking up on proper time, daily routine, hygiene, etc.
- Keeping away from electronic gadgets
- Keeping away from junk food
- Counselling for child hood and adolescent changes
- Sex-education, acne, hair loss, obesity etc.
- Medicinal values of plants / kitchen items

Care at the HWC

- For general health promotion in children with frequent infections or other problems
- Eating & digestive problems
- Chronic and recurrent Upper Respiratory Infection

For Adolescent Girls

- Primary Dysmenorrhoea
- Home remedies for Primary Dysmenorrhoea
- Dysfunctional Uterine Bleeding (DUB)
- Yoga

Care at referral site

- Nutrition Rehabilitation Centers (NRC)
- Management of severe malnutrition/ anaemia
- Severe diarrhoea and ARI management
- Management of all ear, eye and throat problems, skin infections, worm infestations, febrile seizure, poisoning, injuries/accidents, insect and animal bites
- Diagnosis and treatment for disability, deficiencies and developmental delays
- Surgeries for any congenital anomalies like cleft lips and cleft palates, club foot etc.
- Screening for hormonal imbalances and treatment with referral if required
- Management of growth abnormality and disabilities, with referral as required
- Management including rehabilitation and counselling services in cases of substance abuse
- Counselling at Adolescent Friendly Health Clinics (AFHC)
- *Abhyanga, shirodhara*

IV. Family Planning, Contraceptive Services and other Reproductive Health Care Services

Presently no specific AYUSH interventions are proposed for Family Planning and Contraceptive Services.

Reproductive health services

- Preconception counselling of couple for achieving healthy progeny
- Primary Dysmenorrhoea
- Home remedies for Primary Dysmenorrhoea
- DUB
- Leucorrhoa
- For Anemia
- Yoga

Care at referral site

- Insertion /removal of IUCD, male sterilization including non-scalpel vasectomy, female sterilization, management of all complications
- Provision of Injectable Contraceptives
- Medical methods of abortion with referral linkages
- Treatment of incomplete/ Inevitable/ Spontaneous Abortions
- Second trimester MTP as per MTP Act and Guidelines and management of complications, management of survivors of sexual violence as per medico legal protocols. management of GBV related injuries and facilitating linkage to legal support centre

- Management of hormonal and menstrual disorders – dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain
- Provision of diagnostic tests services such as (VDRL, HIV)
- Management of RTIs/STIs
- Prevention of mother-to-child transmission (PPTCT) of HIV (PPTCT) at the district level

V. Management of Communicable Diseases : National Health Programmes

Care at community level

Help in IEC about prevention and surveillance under National Health Programmers

Care at the HWC

- Prevention during out break
- Treatment of common cold
- Chronic upper respiratory tract infection
- Arthritis (sequel of Chikungunya, Dengue)
- Recovery from debility
- Morbidity management and disability prevention of lymphatic filariasis and other lymphedema : skin wash, *phanta* soaking, bacterial entry point care using modern dermatology drugs, Indian Manual Lymph Drainage (*vimplapana/ udwarthana*), pre and post oil massage yoga postures, compression bandaging

Care at referral site

- Diagnosis and management of all complicated cases of fever (requiring admission) , gastroenteritis, skin infections, typhoid, rabies, helminthiasis, acute hepatitis
- Specialist consultation for diagnostics and management of musculo-skeletal disorders, e.g.- arthritis
- *Abhyanga, sthanika basti*

VI. General Out-patient Care for Acute Simple Illnesses and Minor Ailments

The AYUSH services will be provided to all the health conditions mentioned in the Framework 1, 2, 3, 4, 5, 7, 8, 9, 10 & 12, and in addition, the following areas will also be covered.

- GI disorders (acid peptic disorders, dyspepsia, dysentery, IBS, constipation)
- Liver diseases (Jaundice, hepatitis, fatty liver)
- Haemorrhoids and anal fissure
- Skin diseases (eczema, psoriasis)

- Osteoarthritis
- Respiratory problems (bronchial asthma/ COPD)
- Chronic urinary tract infection/ uncomplicated urinary calculi
- Headache
- Yoga

Care at referral site

- All *Panchakarma* procedures
- Confirmatory diagnosis and initiation of treatment
- Management of complications
- Rehabilitative surgery in case of leprosy

VII. Screening, Prevention, Control and Management of Non-communicable Diseases

Care at community level

- Yoga
- Identification of Prakriti of the population for preventive and curative measures

Support the National Programme through activities such as

- IEC on need for prevention, screening and benefits of early diagnosis
- Tobacco, substance use
- Diet and healthy lifestyle for harmony and health
- Identification of risk factor, screening and advice
- Watch on compliance

Care at the HWC

- Individualized diagnosis to suggest preventive and curative measures
- Inclusion of elements of *Agni Dipana* and *Amapachana* (to aid proper digestion/assimilation)
- Yoga
- Diet & lifestyle recommendations for pre-hypertension
- Pre-diabetes & diabetes
- Obesity, lipid disorders

➢ **As stand alone or add on**

Care at referral site

- All *Panchakarma* procedures
- Diagnosis, treatment and management of complications of hypertension and diabetes diagnosis, treatment and follow up of cancers
- Diagnosis and management of occupational diseases such as silicosis, fluorosis and respiratory disorders (COPD and asthma) and epilepsy

VIII. Care for common Ophthalmic and ENT Problems

Care at community level

Counseling/screening/education about preventive aspects, home remedies

Care at the HWC

- Chronic and recurrent upper respiratory tract infections (prevention & management)

Care at referral site

- Provision for *Nasya, Tarpana*
- Management of all acute and chronic eyes, ear, nose and throat problems
- Surgical care for ear, nose, throat and eye
- Management of cataract, glaucoma, diabetic retinopathy and corneal ulcers
- Diagnosis and management of blindness, hearing and speech impairment
- Management including nasal packing, tracheostomy, foreign body removal etc.

IX. Basic Oral Health Care

Care at community level

Awareness about oral hygiene, preventive dental care

Care at the HWC

- Preventive oral health treatment of pyorrhea and periodontitis

Care at referral site

- Diagnosis and management of oral cancer
- Management of malocclusion, trauma cases, tooth abscess, dental caries
- Surgical and prosthetic care

X. Elderly and Palliative health care services

Care at community level

- Family counseling
- Help in organizing group interactions
- Involve religious institutions
- Health education related to healthy ageing
- Palliative care-focus on quality of life, symptom management, psychological and moral support
- Yoga

Care at the HWC

- Yoga
- Dinacharya, Ritucharya
- Regular use of BalaTaila for external application in muskulo-skeletal pain/ whole body massage/ application on scalp
- Rasayana for general health
- Benign prostate hyperplasia
- Care of elderly women specifically for urogenital problems

* **Note:** Management of osteoarthritis**,** respiratory, gastrointestinal, reproductive, skin, ano rectal, urological problems, metabolic diseases etc. will be done as mentioned under the other framework .

Care at referral site

- All *Panchakarma* procedures
- Diagnosis, treatment and referral for complications
- Surgical care/ rehabilitation through physiotherapy and counselling

XI. Emergency Medical Services including Burns and Trauma

Care at community & HWC level

- First aid before referral

Care at referral site

- Triage and management of trauma cases
- Management of poisoning
- Management of simple fractures and poly trauma
- Basic surgery and surgical emergencies (hernia, hydrocele, appendicitis, haemorrhoids, fistula, and stitching of injuries etc.)
- Handling of all emergencies like animal bite, congestive heart failure, left ventricular failure, acute respiratory conditions, burns, shock, acute dehydration etc.

XII. Screening and Basic Management of Mental Health Ailments

Care at community level

- Identifying risk factors, screening
- Counsel on psychological healthcare (*Achara rasayana*), family and community support
- Yoga

Care at the HWC

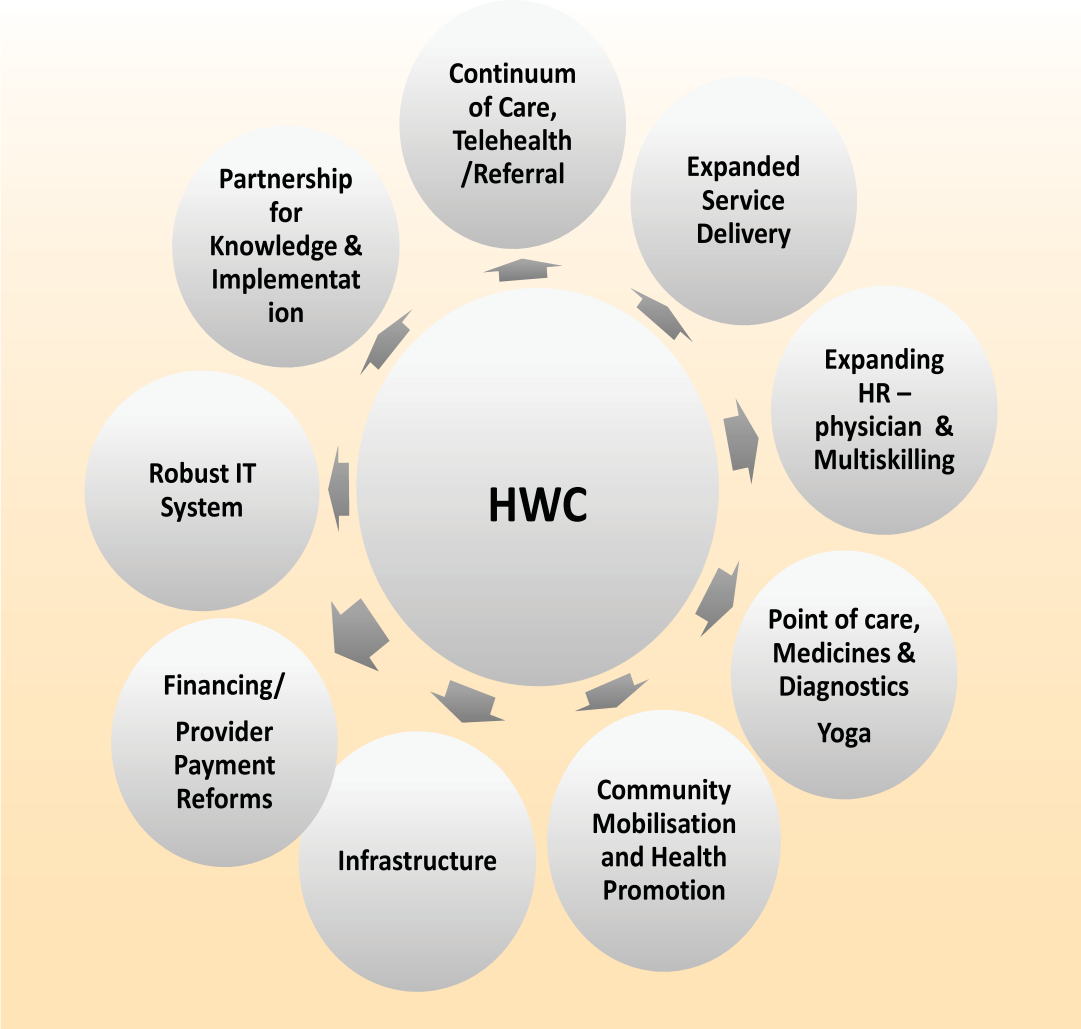
- Yoga and meditation as preventive, supportive and management
- Counseling on Ayurveda lifestyle
- Insomnia, mild anxiety, depression

Care at referral site

- *Abhyanga, Shirodhara* procedures
- Diagnosis and treatment of mental illness
- Provision of out –patient and in-patient services
- Counselling services to patients (and family if available)

5. Key Elements of HWC

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



5.1 HWC Team : The HWCs would be equipped and staffed by an appropriately trained primary health care team, comprising of multi-purpose workers, ASHAs at the norm of one per 1000 thousand and axillary nurse midwife (ANM) led by a community health officer (CHO). Upgraded AYUSH dispensaries may have pharmacist, nursing staff or technicians, in addition to house keeping staff. A qualified/certified Yoga instructor would be deployed at all HWCs on a part time basis to provide continuous and customised Yoga training to the community at HWC and various other identified public places. The CHO would be a qualified AYUSH physician, deployed on the basis of services of the particular system made available at HWC like Ayurveda, Unani, Siddha, and Homoeopathy. The CHO will take clinical decision in his particular stream of medicine and provide mentorship to the team. The HWC team with the help of nearby AYUSH dispensaries, standalone hospitals, AYUSH wings, educational institutions and National level organizations will roll out the AYUSH interventions.

5.2 Logistics : Adequate availability of essential medicines, diagnostics and equipment have been proposed to support the expanded range of services, to resolve more and refer less at the local levels, and to enable dispensation of medicines for chronic illnesses, advocacy of self-care practices including Yoga, as close to communities as possible.

5.3 Infrastructure : Sufficient space for outpatient care, for dispensing medicines, diagnostic services, adequate spaces for display of communication material of health messages, audio visual aids and appropriate community spaces for wellness activities, practice of Yoga and demonstration of medicinal plants in the garden or display of potted plants.

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

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

5.6 Capacity Building : The service providers will be trained in a set of primary healthcare and public health competencies through an accredited training programme that combines theory and practicum with on the job training. Other service providers at HWC will also be trained appropriately to deliver the expanded range of services. Three categories of capacity building are :

S.No	Category	Duration of Training	Objective
1	Training of Trainers	2 days orientation of AYUSH Master Trainers	To prepare master-trainers for imparting trainings at different levels
2	Induction Training to CHO	• 15 days one time induction training on AYUSH HWC component for CHO at upgraded dispensary • 6 month certificate course for CHO manning sub health centre upgraded as AYUSH HWC which will also include AYUSH component	To orient and equip them for role as leader of HWC Team
3	Multi-skilling of MPWs (F&M) and ASHAs	2-3 days	Multi-skilling of staff for expanded services
4	Refresher Training of HWC Team	2-3 days	To provide continuum orientation for skill upgradation

The broad components of the training are available at **Appendix 3.**

5.7 Functional Integration : To successfully plan and run the integrated services with different National Programmes under NHM, the close cooperation between the frameworks of Department of Health & Dept. of AYUSH in the States/UTs will be ensured. A bilateral MOU will be signed for sharing the experience, existing facility, manpower, support the activities including integrated training, healthcare services, supply of essential medicines/ vaccines/ chemicals/ reagents/ equipment, and to run different vertical health programmes of National Health Mission including Digitization/Telemedicine/IT Platforms. Depending on the selected facility, the deployment and duties of manpower such as ANM, MPW, AYUSH physician etc. will be assigned as per the requirement for implementation of both NHM and AYUSH services. The issues such as line of command, mechanism of fund flow etc. will be addressed in the MoU.

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

5.9 Community Mobilization : Action on social and environmental determinants would require intersectoral convergence and build on the accountability initiatives so that there is no denial of health care and universality and equity are respected.

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

5.11 Record Maintenance and Reporting : Proper maintenance of records of services provided at HWCs and the morbidity/mortality data is necessary for assessing the health situation in the area. In addition, all births and deaths under the jurisdiction should be documented and sex ratio at birth should be monitored and reported.

5.12 Routine Monitoring Mechanism : Supportive supervision and record checking at periodic intervals will be carried out by the Officer at PHC/ District AYUSH Officer etc. (at least once in a month). The facilities such as access to service, registration and referral procedures, transportation of emergency cases, management of funds, staff behaviour, toilets, and drinking water will be evaluated, documented and reported.

5.13 Quality Assurance and Accountability : This can be ensured through regular skill development training of HWC team (at least one such training in a year). In order to ensure quality of services and patient satisfaction, it is essential to encourage community participation. To ensure accountability, the Citizens' Charter should be available in all centres.

6. Expanded Service Delivery

6.1 HWC Data Base : Population enumeration and empanelment implies the creation and maintenance of database of all families and individuals in an area served by HWC. This is planned such that every individual is empanelled to HWC. This also involves active communication to make residents aware of this facility. In the catchment areas where there are no HWCs set up by the Department of Health, this activities may be taken up by AYUSH HWCs. With the full support of Department of Health, the frontline workers would create population-based household lists and undertake registration of all individuals and families residing within the catchment area of a Health & Wellness Centre. It is this registration that is referred as empanelment and it is right of any resident in that area. Care should not be denied to those who are not enrolled to seek care at the HWC. An active process of enrollment is encouraged to ensure that there is an active contact between the HWC team and the entitled population.

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

Family Health Folders and an individual Health Records will be created through the ASHAs and the MPWs and stored in the HWC. A digital format of the family health records will be implemented in a phased manner depending on the state of readiness for connectivity and resource availability. Population-Based Records/Data Base already available should be leveraged to initiate HWC based digital records of demographic information of individuals.

The above two activities will be taken up by the HWCs set up by the department of health. However if the catchment area of AYUSH HWC is not covered by any other HWC, the AYUSH HWC may take up this task if the department of health desires so. In that case, the AYUSH HWC will require complete operational support of health department and cooperation of peripheral health workers such as ASHA, ANM. In such scenario the data generated in a particular geographical area will be mutually shared between the health and AYUSH departments.

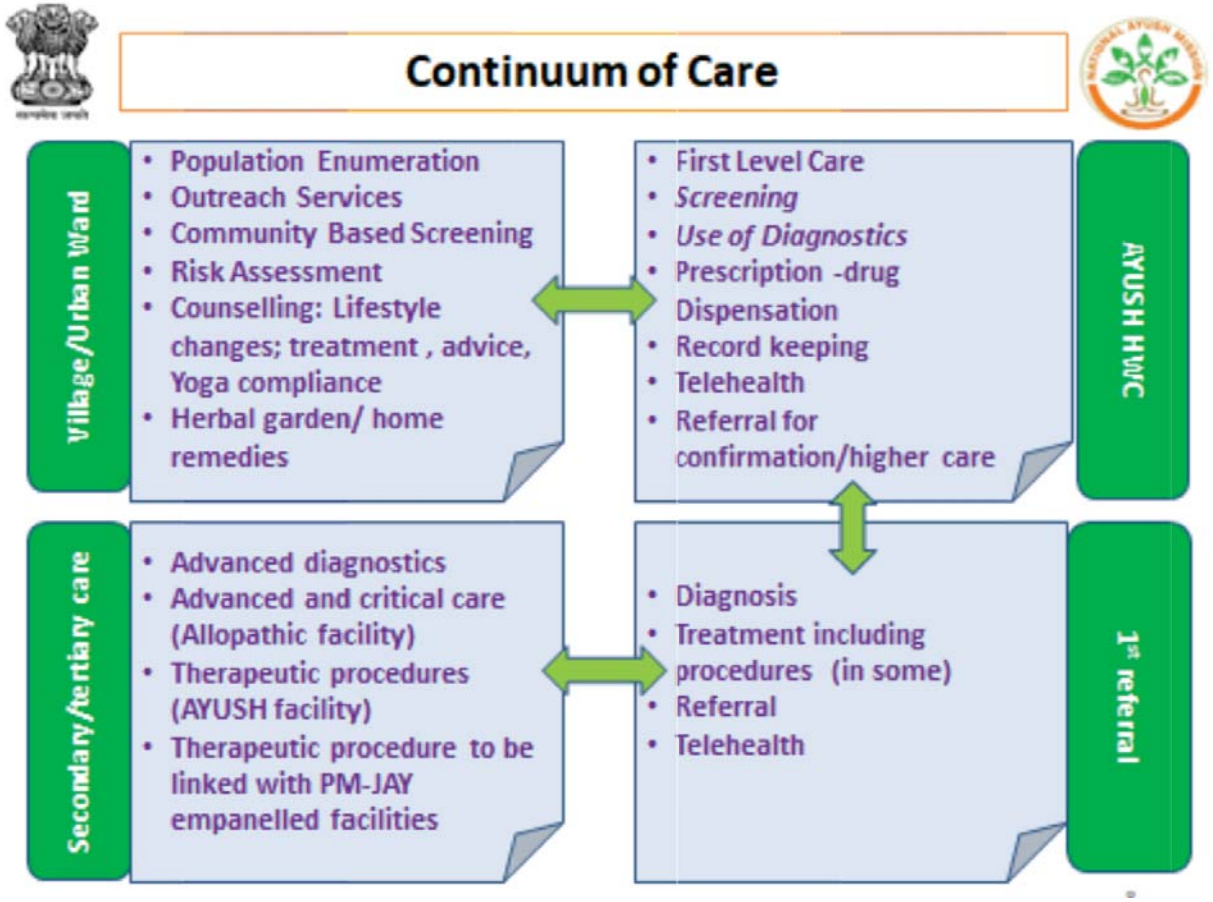
6.3 Continuity of Care and Patient Centric Care : Continuity of care is one of the key tenets of primary health care. Continuum of care spans for the individuals from the same facility to her/his home and community, and across levels of care-primary, secondary and tertiary. Care must be ensured from the level of the family through the facility level. Linkages need to be developed with department of health for sharing mobile health units, ambulance services and higher level facilities and IT solutions.

6.3.1 **Community/Household :** The ASHA/ANM would undertake home visits to ensure that the patient is taking actions for risk factor modification, provides counselling and support, including reminders for follow up appointments at HWC and collection of medicines.

6.3.2 **HWC :** Dispensation of medicines, repeat diagnostics as required, identification of complications and facilitating referrals at a higher-level facility/teleconsultation with a specialist as required are undertaken at the HWC, including maintenance of records. The last activity would

enable HWC team to identify stable patients, and to organize community level supportive activities to improve adherence to care protocols and reduction of exposure to risk factors.

6.3.3 **Higher-Level Facility :** PHCs, AYUSH dispensaries, collocated facility at community health centres (CHC)/ district hospital (DH)/ AYUSH integrated hospitals, teaching hospitals, national level institutions, allopathic facilities as per the need and vice-versa will be the referral points. Systems need to be in place so that a medicine prescribed by a specialist is made available to the patient at the HWC where she/he is empanelled. Periodic meetings (whether in person or through virtual platforms) between HWC team and the specialists/ medical officers referred to, are also essential to ensure that they all function as one team and ensure care continuum. The upgradation of higher-level facility may also be planned wherever essential.



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

a. Provision of patient centred and respectful care.

b. Enable essential amenities at HWC.

c. Adhere to standard treatment guidelines and clinical protocols for care provision.

d. Achieve Indian Public Health Standards with regards to HR, infrastructure, equipment, service delivery and supplies.

e. Implement the National Quality Assurance Standards for public health facilities, by focusing on eight critical areas – a) Service provision, b) Patient rights, c) Inputs d) Support services, e) Clinical services, f) Infection control, g) Quality management and h) Health outcomes.

6.5.1 General Population

This group is targeted for primary prevention.

- Identification of Prakriti for advocacy of preventive & promotive measures
- Education on lifestyle modifications such as healthy diet, regular exercise yoga, behavioral ethics etc.
- Promotion of medicinal plants cultivation and home remedies
- Organizing sanitation drives for clean surroundings to prevent the spread of communicable diseases-malaria, gastroenteritis etc.
- Nutrition counselling in adolescents and women in reproductive age group to address issues of low birth weight in new-borns, promotion of early initiation of breastfeeding to prevent childhood illnesses.
- Including section on healthy diets and arranging a special session to promote healthy nutrition habits in school going children etc.
- Community yoga training at the HWC, school, panchayat bhawan or even anganwadi centre.

6.5.2 Population at Risk

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

6.5.3 Individuals with Symptoms

This is for individuals and population groups who show obvious signs of a disease condition. Home visits by frontline functionaries for early identification of symptoms, prompt referral and follow up of cases like high-risk pregnancies, high-risk newborn, malnourished children, and passive surveillance for malaria etc.

6.5.4 Population with Known Disorders

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

While not all inputs can be provided immediately, the state needs to have a road map for HWC strengthening, in which some inputs can be added in an incremental manner.

7 Inter-sectoral Convergence

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

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

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

- Swachh Bharat Abhiyan
- Addressing tobacco, alcohol and substance abuse
- Action against gender violence
- Social evils
- Reduced stress and improved safety in the work place
- Reducing indoor and outdoor air pollution
- Partnership with other Govt. and Non- Governmental organisations, local bodies, groups.

States will need to develop strategies and institutional mechanisms in each of the above areas, to create "SwasthNagrik Abhiyan" –a social movement for health in the form of Jan Andolan.

8 Institutional Framework

The AYUSH HWCs would be developed and operationalized through an institutional mechanism at National, State and District level. Already established framework of NAM and further linkages with line ministries & departments will enable to successfully plan and carryout public health activities. The linkages with AYUSH standalone hospitals, collocated facilities, educational institutions, National level organizations, schools, social groups, private bodies, community groups, local bodies, Panchayati Raj Institutions are proposed **(details are available at Appendix. 4).**

A sample MoU for entering into formal agreement with such bodies has been shared with States/ UTs.

9 Roles and Responsibilities

The objective of the scheme can be achieved only if there is proper coordination between the team. Each person has to understand his roles and responsibilities and the probable list & duties are given under. These may slightly vary depending on various service available in the particular facility.

9.1 Ministry of AYUSH

- Overall responsibility of implementation by providing essential support to State Govt.
- Provide funds as per the norms of Centrally Sponsored Scheme
- Preparing AYUSH training modules/ standard treatment guidelines/referral protocols to suit the requirement at HWC/ referral level

- Preparing documentation tools, IEC materials
- Detail guidelines (pictorial/ video) for Yoga
- National Medicinal Plant Board (NMPB) will provide the guidelines on good cultivation practices and ensure supply the saplings with the help of State Medicinal Plant Boards
- Provide any other support required for the States/UTs from time to time

9.2 State Government/ UT/ Department of AYUSH

- Sharing of funds as per the norms of Centrally Sponsored Scheme
- Close networking between department of AYUSH & Health and other departments for inter-sectoral convergence
- Identify the facility in consultation with dept. of Health & AYUSH
- Propose the action plan
- Selection & deployment of manpower
- Uninterrupted supply of medicines
- Operational support such as training, monitoring etc.
- Implementation, monitoring, data management, timely reporting
- Periodic submission of timely progress and UCs

9.3 MoHFW/ Department of Health

- Help in planning and implementation of NHM components in upgraded AYUSH HWCs
- Support in conducting certificate course, regular capacity building of HWC staff
- Help in community mobilization for AYUSH services through ASHAs/ ANMs
- Help in assessment of performance based incentives in overlapping catchment areas
- Appropriate management of referrals
- IT interface- sharing of technical know how and infrastructure
- Data sharing/ help in data generation/ monitoring/evaluation
- Any other areas based on the requirement in future, as per mutual agreement.

9.4 HWC Team

- Responsible for the activities at the local level such as community out reach for preventive/ promotive care, awareness generation/ screening/diagnostic camps/medicinal plant cultivation, inter-sectoral convergence, providing clinical service, documentation and timely reporting
- Propose annual action plan in time
- Placing timely proposal for medicines, IEC materials and other requirement.

9.5 Referral Points

- Mange the referred cases as per the need
- Arrange for further referrals or consultation with specialists as per the need
- Use telehealth whenever required
- Refer back to HWC for follow up so that continuum of care is maintained
- Propose upgradation plan including provision for AYUSH therapies such as Panchakarma where ever required

9.6 Specific Roles of CHO

The AYUSH physician will be deployed by the State Govt. on regular or contractual basis, as per the specific requirement of the medical system. He/she would broadly be expected to carry out public health functions, ambulatory care, management and provide leadership at the HWCs. They would be responsible for the following:

- Ensure that all households in the service areas are listed, empanelled and a database is maintained- in digital format/ paper format as required by the state
- Ensure Prakriti assessment of the entire population above 18 years of age in phased manner
- Provide clinical care as specified in the care pathways and standard treatment guidelines for the range of services expected of the HWC
- Dispense allopathic drugs as per the prescription of Medical Officer at PHC or specialist
- He/she may take clinical decision and prescribe AYUSH medicines as per the qualification in the particular stream
- Higher care through referral or facilitated through telehealth
- Focus attention in screening for chronic conditions on screening, enabling suspected cases confirmed and initiating treatment based on appropriate guidelines or on basis of plans made by specialists. As a team, ensure adherence, along with counselling and support as needed for primary and secondary prevention efforts. Coordinate and lead local response to diseases outbreaks, emergencies and disaster situations and support the medical team or joint investigation teams for disease outbreaks
- Support the team of MPWs and ASHAs on their tasks, including on job mentoring, support and supervision, undertaking the monitoring, management, reporting and administrative functions of the HWC such as inventory management, upkeep and maintenance, and management of untied funds
- Support and supervise the collection of population based data by frontline workers, collate and analyse data for planning and report the data to the next level in an accurate and timely fashion. Use HWC and population data to understand key causes of mortality, morbidity in the community and work with the team to develop a local action plan with measurable targets, including a particular focus on vulnerable communities
- Coordinate with community platforms such as the VHSNC/MAS/SHGs and work closely with PRI/ ULB, to address social determinants of health and promote behaviour change for improved health outcomes
- Address issues of social and environmental determinants of health with extension workers of other departments related to gender based violence, education, safe potable water, sanitation, safe collection of refuse, proper disposal of waste water, indoor air pollution, and on specific environmental hazards such as fluorosis, silicosis, arsenic contamination, etc.
- Guide and be actively engaged in community health promotion including behaviour change communication

9.7 Additional Duties of ASHA/ANM other community workers

The ASHAs, MPW and other community workers will be assigned following AYUSH specific activities, in addition to their routine NHM duties: To provide information on availability of AYUSH services in their vicinity.

- To ensure Prakriti analysis of every individual above 18 years of age in the catchment area
- To ensure regular Yoga at the community
- Advocacy of AYUSH IEC campaigns- lifestyle, diet, behavioral codes
- Cultivation of medicinal plants
- Referral and follow up of patients under AYUSH care

9.8 Additional Duties of multipurpose worker

- Coordinate and monitor community level AYUSH activities
- At HWC he/she will help AYUSH physician in providing clinical services including diagnostics, dispensation of medicines and record keeping

9.9 Yoga Instructor

- Conduct minimum 32 Yoga sessions with minimum of one hour per session at HWC, schools and at community level each month as per the sessions scheduled by CHO (20 sessions at HWCs and remaining 12 sessions at outreach level)
- Out of 32 Yoga sessions, atleast 2 hours of IEC program to be conducted in the community in a month
- Capacity building of ASHAs and ANM/MPW or any other volunteer in aspect of Yoga
- Help CHO, ANM and ASHAs for conducting aware campaigns
- Help in documentation and reporting related to Yoga component including monitoring ASHA/ANM
- Conduct at least two Yoga awareness campaigns in a year at community level

9.10 Yoga Instructor (Female)

- To conduct 20 Yoga classes with minimum of one hour per session for female group wherever required, as per the sessions scheduled by CHO
- Coordinate with the other Yoga Instructor for successful advocacy of yoga component in the community

9.11 Additional duties of Safai Karmachari/ any other house keeping staff

- Maintenance of herbal garden at HWC like watering, deweeding etc.
- Timely replacement of plants

9.12 Roles of SPMU & DPMU

- All managerial and administrative function of administrator
- Compilation of reporting of data / information from District to State and from State to national level
- Ensuring timely submission of monthly, quarterly and yearly progress report

- Preparation / finalisation of yearly action plan for districts / State and submission to the national level
- Other managerial and administrative work assigned by senior officer for smooth functioning
- The staff will be responsible for overall coordination and linkages at all levels of implementation and service delivery

10 Monitoring and Evaluation

Dedicated MIS/ AHMIS monitoring and evaluation cell would be established at Centre/ State level. It is therefore proposed to have a Health Management Information System (HMIS) Cell at National level with HMIS Managers at State level. The physical records, electronic data updated on CPHC-portal from time to time and other IT enabled applications would be used for arriving to conclusions on the functionality of AYUSH HWCs.

The regular evaluation of the National AYUSH Mission shall be carried out to know the implementation progress and bottlenecks and scope for improvement. Third party evaluation will also be taken up after two years of implementation.

National Ayushman Bharat Cell would frequently visit the States and generate reports based on observations. Checklist of outcome indicators would be provided to Common Review Mission of MoHFW for including AYUSH-HWCs for evaluation.

10.1 Deliverables and outcomes

A. Short-term output indicators:

I. Number of AYUSH dispensaries upgraded as AYUSH HWCs
ii. Number of sub health centres upgraded into AYUSH HWC
iii. Number of HWCs having AYUSH services
iv. Number of AYUSH HWCs with regular Yoga activities
v. Number of CHOs trained for Standard Treatment Protocol
vi. Number of MPW, ASHA underwent AYUSH training
vii. Number of beneficiaries seeking AYUSH services
viii. Herbal gardens successfully developed under HWC
ix. Number of beneficiaries complying with preventive and promotive activities
x. Number of households making use of home remedies at household level

B. Long-term outcome indicators:

The following outcome indicators would be assessed in comparison with the control HWC (developed by MoHFW), where AYUSH services are not made available :

I. Integration of AYUSH in implementation of SDG 3, as mandated by NITI Aayog measured on the basis of uninterrupted availability of AYUSH services (at HWC/ outreach), number of beneficiaries seeking services, compliance to yoga /advises, number of plants grown

ii. Reduced burden on secondary and tertiary health facilities

iii. Enhanced accessibility to achieve universal health coverage for affordable treatment measured through the number of people utilising the services

iv. Reduced out of pocket expenditure due to "self-care" model measured through documenting consumer's perception in representative samples

v. Validated holistic wellness model in healthcare areas measured on the basis of overall outcome in the wellness status

vi. Improved health and wellness status of larger population of country due to strengthening of preventive and promotive aspects of health, measured through prevalence of diseases

May refer to **Appendix 5** for indicative list of Program Monitoring Indicators.

11 Infrastructure and Branding

The first step for each state is to develop a road map with number of Health and Wellness Centres that will be created in a phased manner and also develop robust and objective annual plans with specific targets for the state and district level to improve access to the facilities, keeping in mind local context and capacity, focusing on following component.

Ensuring adequate infrastructure for the delivery of comprehensive primary health care would need to cater to a population size as per IPHS norms for sub health centers - one per 5000 population in all areas and one per 3000 in tribal, hilly and desert areas. The areas where currently sub healthcenters are catering to much larger population, their numbers need to be increased. Planning for infrastructure upgrade succeeds the finalization of number and type of facilities designated as Health and Wellness Centres.

Patient reception and registration centers, citizen charters, electronic display boards for services, provision of sitting arrangement of patients, other amenities in the waiting area, TV screens for health communication, facilities for people with disabilities, provision of privacy for patient examination area/ examination table, good quality lab, pharmacy, a wellness room for conducting physiotherapy/Yoga sessions, rehabilitative services, separate toilets for males and females, space for display of medicinal plants etc. may be included in infrastructure upgrade. Essential requirements for strengthening a facility to serve as a Health & Wellness Centres are :

- A well-ventilated clinic room with examination space and office space for community health officer
- Storage space for medicines, equipment, documents, health cards and registers
- Designated space for lab/diagnostics
- Separate male and female toilets
- Deep burial pit for bio- medical waste management
- Proper system for drainage, assured water supply that can be drawn and stored locally
- Electricity supply linked to main lines or adequate solar source, inverter or back-up generator as appropriate
- Patient waiting area covered to accommodate at least 20-25 chairs.
- Repairs of roofs and walls, plastering, painting and tiling of floors to be undertaken as per requirement
- Space/room for Yoga if adequate space for expansion is available

- Garden/ space for display of 15 medicinal plants
- Adequate residential facilities for the service providers
- Rain water harvesting facilities may be planned if required

The concerned Medical Officer and a representative from the engineering wing at the district level will do a joint site inspection and complete gap analysis for repair/renovation in existing buildings. The analysis should be based on the essential requirements stated above and will support in estimating necessary financial resources. To save time and optimize resources, identification of government buildings available with other departments could be prioritized for operationalising HWCs after necessary renovation. Old dilapidated buildings should be considered for renovation only after careful review of resources required.

Though financial provision for repair and new construction are made available under the National AYUSH Mission, resource mobilization for new construction could also be explored from different government programmes such as Members of Parliament/Members of Legislative Assembly, Local Area Development Scheme, Labour component support available under Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA), District Mineral funds wherever applicable, Untied funds available with Local Self Governments in urban and rural areas, District Innovation Funds and other State Government development programmes. Support from corporate social responsibility and philanthropic organizations may also be explored.

It has been proposed to follow the specifications, colour code and illustrations used by the Ministry of Health & Family Welfare for AYUSH HWCs also. Additionally, illustrations of AYUSH services have been finalized for using on the walls of Health & Wellness Centres alongwith NAM Logo.

NAM Logo

AYUSH HWC illustration

12 Timeline

Proposed activities	Timeline				
	1st year	2nd year	3rd year	4th year	5th Year
Preparatory Phase- Planning & approval, modules/manuals/protocols/ recruitment & training, documentation tools, IT system, supply of medicines, operationalise AYUSH HWCs	✔				
Intervention- implementation of services		✔	✔	✔	✔
Periodic third party evaluation			✔	✔	✔

13. Cost norms and Budgetary Requirement

The funding pattern for developing Health & Wellness Centres (HWCs) by the Ministry of AYUSH will be under Centrally Sponsored Scheme. The Ayushman Bharat will be part of National AYUSH Mission and the same financial guidelines shall be followed for implementing the programme.

Fund requirement for upgrading and operationalizing AYUSH HWCs would vary depending on the type of facility to be taken up for upgradation i.e. sub health centres and AYUSH dispensaries. In addition to the existing fund flow to these centres, additional funds would be admissible under the following components for developing and operationalizing HWCs:

Sl. No.	Component
i.	Infrastructure strengthening
ii.	Man power (remuneration of HWC team)
iii.	Performance linked payment to HWC team
iv.	Training & capacity building
v.	Laboratory services
vi.	IT networking
vii.	IEC
viii.	Establishment of herbal garden
ix.	Contingency
x.	Admin cost

A. Cost norms for AYUSH Dispensaries to be converted into AYUSH HWCs

(Annual requirement / HWC)

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
i	Infrastructure strengthening	Infrastructure including civil work, repair, renovation, addition, alteration, equipment and furniture	5.00	-	Provision of space for outpatient care, dispensing medicines, diagnostic services, display of IEC material including audio visual aids, wellness activities, including Yoga & physical exercises. It includes provision for boundary-walling, drinking water, electricity, internet, branding etc. Indicative list of equipment/ furniture at **Appendix 7.**
ii	Man power (remuneration of HWC Team)	Community Health Officer (CHO) - Rs. 40000/- per month. [Rs. 25000/- per month as a fixed remuneration and Rs. 15000/- per month as Performance Linked Payment (PLP)].	-	4.80	There will be no provision of contractual CHO for those AYUSH dispensaries where regular AYUSH physicians are in position. However, for others, the provision of CHO on contractual basis shall be for a maximum period of one year or till the vacancy is filled up by State/UTs. CHO would be qualified AYUSH physician in the particular stream of selected service such as Ayurveda, Unani, Siddha, and Homoeopathy. Performance Linked Incentives @Rs.5000 per month may be provided for regular Medical Officer posted at AYUSH Dispensaries acting as CHO. Guidelines for regulating the payment of PLP are attached in **Appendix 6.**

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
		Yoga instructor (Part time)-1 male @ Rs.8000/- per month.	-	0.96	For conducting yoga sessions at AYUSH HWC/ Community level.
		2nd Yoga Instructor (Female) for conducting Yoga classes for women.	-	0.60	Payment to ASHA/ trained female person as a Yoga instructor @ Rs.250/ hour for maximum 20 hours/month (as desired by some States that male instructor is not acceptable to the women folk).
iii	Man power (performance linked payment)	Team based incentives (for HWC team).	-	1.00	For additional services to be performed by HWC team for AYUSH. The guideline for regulating the payment of PLP is attached at **Appendix 6**.
		ASHA incentives for maximum upto 5 ASHAs/ HWC @Rs.1000 per ASHA/ month.	-	0.60	For additional work of AYUSH Health and Wellness Centres. Care to be taken not to duplicate the incentives paid by MoHFW.
iv	Training & capacity building	Certificate course/ training on the standard treatment protocol.	0.30 per trainee	-	One time induction training of 2 weeks duration for capacity building as team leader and to perform expanded range of services such as community based population enumeration, screening, IT enabled programmes etc. Six months certificate course planned by MoHFW may be required only when NHM activities are integrated at these HWCs.
		Refresher training of physician.	-	0.05	Reorientation and updation of skills.

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
		Multi-skilling of MPWs and ASHAs	-	0.20	Reorientation and updation of skills.
v	Laboratory services	To establish and successfully run the laboratory.	1.00	0.30	Basic lab services like rapid test for anaemia, pregnancy, blood glucose, malaria etc. Patients requiring other tests will be referred to linked higher level health centres.
vi	IT networking – HWC	Cost of one laptop (Tablets for ASHA/ANM are already provided through NHM and duplication is avoided).	0.35	0.05	One laptop for CHO for Tele-consultation /reporting/ IT related work. Recurring cost of Rs. 5000/- on account of internet services.
vii	IEC	Creating awareness among the masses through audio-visual means, posters/ booklets/ slogan-writing/ street plays.	-	0.25	Rs.5 per capita, for population of catchment areas upto maximum of Rs. 25,000 per HWC.
viii	Promotion of Medicinal plants/home remedies	Establishment of herbal garden in HWCs or within available place in catchment areas.	0.20 Establish-ment of herbal garden.	0.06 Maintenance of herbal garden. Includes honorarium for Safai Karmachari/ identified staff.	Cost for development and maintenance for the herbal garden. To educate the community about the cultivation of medicinal plants and their use in common ailments.

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
ix	Contingency	Untied funds	-	0.50	Expenses on water, electricity, meetings, Stationary, patient transportation in emergency, any other exigencies.
		Sub total (i – ix)	**6.85**	**9.37**	
		Grand total	**Rs. 16.22 lakh per HWC**		

B. Cost norms for Sub-Health Centres to be converted into AYUSH HWCs

(Annual requirement / HWC)

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
i	Infrastructure strengthening	Infrastructure including civil work, repair, renovation, addition, alteration equipment and furniture	5.0	-	Provision of space with facility for outpatient care, dispensing medicines, diagnostic services, display of IEC material including audio visual aids, wellness activities, including Yoga & physical exercises. It includes provision for boundary-wall, drinking water, electricity, internet, branding, etc. Indicative list of the equipment/ furniture is attached in **Appendix 7.**

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
ii	Man power (remuneration of HWC Team)	Community Health Officer (CHO)– Rs. 40000 per month. [Rs. 25000/- per month as a fixed remuneration and Rs. 15000/- per month as Performance Linked Payment (PLP)].	-	4.80	There is provision of CHO on contractual basis after completion of six months training in certificate course on contract basis. Looking at scarcity of Ayurveda practitioner in some North Eastern States/UTs, initially AYUSH physician such as Ayurveda, Unani, Siddha, Homoeopathy may be deployed. CHO would be qualified AYUSH physician in the particular stream of selected services such as Ayurveda, Unani, Siddha, Homoeopathy.
		Yoga instructor (Part time) - 1 @ Rs. 2500/- per month. Max. 10 classes in a month @ Rs. 250/- per hr.	-	0.30	For conducting yoga sessions at AYUSH HWC/ Community level.
iii	Man power (performance based incentive of HWC Team)	Team based incentives for HWC team.	-	1.0	For additional services to be performed by HWC team for AYUSH. The guidelines of MoHFW need to be followed.
		ASHA incentives for maximum upto 5 ASHAs/ HWC @ Rs. 1000 per ASHA/ month.			For additional work of AYUSH Health and Wellness Centres. Care to be taken not to duplicate the incentives paid by MoHFW.

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
iv	Training & capacity building	Certificate course/ training of CHO on the standard treatment protocol.	1.034 Per trainee	-	One time induction training (6 months).
		Refresher training of physician/CHOs.	-	0.10	Reorientation and updation of skills.
		Multi-skilling of MPWs and ASHAs.	-	0.20	Reorientation and updation of skills.
v	Laboratory services	To establish and successfully run the laboratory.	1.00	0.30	Basic lab services like rapid test for anaemia, pregnancy, blood glucose, malaria etc. Patients requiring other tests will be referred to linked higher level health centres.
vi	Medicines	For the procurement of essential AYUSH medicines required for AYUSH HWC.	-	As per the actual requirement with the upper ceiling of 2.0 per centre per year.	To be met from NAM budget head of medicines.
vii	IT networking – HWC	Cost of one laptop. (Tablets for ASHA/ANM are already provided through NHM and duplication is avoided).	0.35	0.05	Two tablets for ANM/MPW and one laptop for CHO for tele-consultation / IT related work. Recurring cost of Rs. 5000/- on account of internet services.

Sl. No.	Head	Sub Head-wise break up (Rs. in lakhs)	Classification of Budget		Remarks
			Non-Recurring (Rs. in lakhs)	Recurring (Rs. in lakhs)	
viii	IEC	Creating awareness among the masses through audio-visual means, posters / booklets/ slogan-writing / street plays.	-	0.25	Rs. 5 per capita, for population of catchment areas upto maximum of Rs. 25,000 per HWC.
ix	Promotion of Medicinal plants / home remedies	Establishment of herbal garden in HWCs or within available place in catchment areas.	0.20 Establishment of herbal garden.	0.06 Maintenance of herbal garden. Including honorarium for Safai Karmachari/ identified staff.	To educate the community about the cultivation of medicinal plants and their use in common ailments during IEC activities. (An indicative list is available at **Appendix 2)**
x	Contingency	Untied funds	-	0.50	Expenses on water , electricity, meetings, Stationary, patient transportation in emergency any other exigencies.
		Sub total (i – x)	**7.584**	**8.16**	
		Grand Total	**Rs. 15.744 Lakh per HWC**		

Summary – Cost Norms

Component-wise breakup of non-recurring and recurring financial implication for five years												Rupees in Crore		
Year	AYUSH Dispensaries	Sub-centres	Total Units	Non-Recurring (NR) cost (AYUSH dispensary)	Non-Recurring (NR) cost (sub health Centre)	Total Non-Recurring (NR) cost*	Recurring (R) cost (AYUSH dispensary)	Recurring (R) cost (sub health Centre)	Total Recurring cost**	Total Cost (NR+R)	Admin Cost (4%)	Central Share (estimated 65%) of total	State Share (estimated 35%) of total	Total Budget
2019-20	1390	348	1738	95.22	26.39	121.61	00	00	00	121.61	4.86	82.21	44.27	126.47
2020-21	2200	500	2700	150.70	37.92	188.62	130.24	28.4	158.64	347.26	13.89	234.75	126.40	361.15
2021-22	2500	600	3100	171.25	45.50	216.75	336.38	69.2	405.58	622.33	24.89	420.70	226.53	647.23
2022-23	3000	700	3700	205.50	53.09	258.59	570.63	118.16	688.79	947.38	37.90	640.43	344.85	985.27
2023-24	910	352	1262	62.33	26.70	89.03	937.00	204.00	1141.00	1230.03	49.20	831.50	447.73	1279.23
Grand Total	10000	2500	12500	685.00	189.60	874.60	1974.25	419.76	2394.01	3268.61	130.74	2209.58	1189.77	3399.35

*Non-Recurring cost @ Rs 6.85 lakh per Dispensary and @ Rs. 7.584 lakh per Sub Health Centre
**Recurring cost @Rs. 9.37 lakh per Dispensary and @ Rs. 8.16 lakh per Sub Health Centre

Unit cost for upgradation of AYUSH Dispensary is Rs. 16.22 lakh and unit cost for upgradation of Sub Health Centre is Rs. 15.744 lakh.

- The financial requirement for strengthening of SPMU and DPMU would be met from Admin cost i.e. 4 % of the total budgetary ceiling.
- The Mission Directorate of NAM may be authorized to make amendments in the Guidelines, whenever required, as per the operational requirements within the overall scope of the Scheme.

14. Phasing Out Plan

The operationalization of AYUSH HWCs shall proceed as per following phases and funds will be released subject to fulfillment of terms and conditions mentioned in guidelines as under:

Phase I:

Year	AYUSH Dispensaries	Sub Centres	Total	Conditions imposed/Remarks
2019-20	1390	348	1738	Nil
2020-21	2200	500	2700	

Phase II:

Year	AYUSH Dispensaries	Sub Centres	Total	Conditions imposed/Remarks
2021-22	2500	600	3100	Phase II will be sanctioned after 100% of the HWCs sanctioned in 2019-20 and 50% of HWCs sanctioned in 2020-21 are made operational.

Phase III:

Year	AYUSH Dispensaries	Sub Centres	Total	Conditions imposed/Remarks
2022-23	3000	700	3700	Phase III will be sanctioned after 100% of the HWCs sanctioned in 2020-21 and 50% of HWCs sanctioned in 2021-22 are made operational.

Phase IV:

Year	AYUSH Dispensaries	Sub Centres	Total	Conditions imposed/Remarks
2023-24	910	352	1262	Phase IV will be sanctioned after 100% of the HWCs sanctioned in 2021-22 and 50% of HWCs sanctioned in 2022-23 are made operational.

These are National targets. The States/UT wise target shall be decided in the beginning of each financial year.

15. Performance Linked Payments

This has been envisaged to improve the quality of services delivery by incentivizing providers to ensure better health outcomes for the population in the catchment area. This shift in payment mechanism, in our context, would also address perceived challenge of poor performance of the providers in public health facilities. This would be achieved by linking one proportion of the salary with the performance/service delivery and providing team based incentives based on improvement in health outcomes.

The performance of the persons or team involved in the activities of both Department of Health & AYUSH will be jointly assessed for providing incentives. The guidelines for the same are available at **Appendix 6** in case of upgraded AYUSH dispensaries and for upgraded sub health centres, the norms of MoHFW will be followed.

Appendix 1 - Indicative List of AYUSH Medicines at HWC

A. Poly Herbal formulations-36

1. Abhayaristha	19. Khadiraristha
2. Ajamodadi Churna	20. Kumaryasava
3. Amalaki Rasayana	21. Kutajavaleha
4. Amritaristha	22. Lodhrasava
5. AnuTaila	23. Nalpamaradi Taila
6. Aravindasava	24. Narayana Taila
7. Ashokaristha	25. Punarnava Mandura
8. Avipattikara Churna	26. Rajapravrittini Vati
9. BalaTaila	27. Sanjivani Vati
10. Bilvadi Leha	28. Saubhagya Shunthi Paka
11. Dashamularistha	29. Sitopaladi Churna
12. Dashana Sanskara Churna	30. Trikatu Churna
13. Drakshavaleha	31. Trinpanchamula Kvatha
14. Gokshuradi Guggulu	32. Triphala Churna
15. Jatyadi Taila	33. Triphala Guggulu
16. Kaishora Guggulu	34. Varunadi Kashaya
17. Kanakasava	35. Vasavaleha
18. Kantakari Avaleha	36. Yogaraja Guggulu

B. Single plants (powder)- 14

1. Amalaki (*Phyllanthu semblica*)	8. Guduchi (*Tinospora cordifolia*)
2. Ashvagandha (*Withania somnifera*)	9. Kalamegha (*Andrographis paniculata*)
3. Bala (*Sida cordifolia*)	10. Katuki (*Picrorrhiza kurroa*)
4. Bhumyamalaki*(Phyllanthus niruri)*	11. Nimba (*Azadirachta indica*)
5. Bilva (*Aegle marmelos*)	12. Shatavari (*Asparagus racemosus*)
6. Brahmi *(Bacopa monnieri)*	13. Shunthi (*Zingiber officinale*)
7. Gokshura (*Tribulus terrestris*)	14. Yastimadhu (*Glycyrhiza glabra*)

*** Note:** The States/UTs may make modifications in the list as per the popularity and requirement at local level. The quality of all procured medicines should be ensured.

Appendix 2 - Indicative List of Plants for Herbal Garden

1. Amalaki (*Phyllanthus emblica*)
2. Ashvagandha (*Withania somnifera*)
3. Bala (*Sida cordifolia*)
4. Bhumyamalaki *(Phyllanthus niruri)*
5. Brahmi *(Bacopa monnieri)*
6. Guduchi (*Tinospora cordifolia*)
7. Haridra (*Curcuma longa*)
8. Kumari (*Aloe vera*)
9. Mandukaparni (*Centella asiatica*)
10. Nimba (*Azadirachta indica*)
11. Shatavari (*Asparagus racemosus*)
12. Shunthi (*Zingiber officinale*)
13. Tulsi (*Ocimum sanctum*)
14. Eranda *(Ricinus communis)*
15. Nirgundi *(Vitex negundo)*
16. Vasa *(Adhatoda vasica)*

*** Note:** The States/UTs may make modifications in the list as per the regional suitability.

Appendix 3 - Training Component

Facility	Human Resource	Skill Requirements	Training Requirements
Community Level	ASHA/1000 population or ASHA/500 population for tribal and hilly areas/ ASHA for 2500 population in urban areas	• Skill to say about importance of diet and lifestyle (along with Yoga) • Skills to address about personal and social hygiene with respect to daily routine, seasonal regimens, including basic sanitation and healthy living environment • Skills to tell about common ailments management through home remedies and promotion of cultivation of medicinal plants • Skills for identification, referral follow up care and ensuring treatment compliance related to diseases • Skills for appropriate referral to AYUSH	• 2-3 days of induction training • 2-3 days of skill based training • 2-3 days of training on common ailments • Supplementary trainings - refresher training and training on newer topics for about 10 days every year
AYUSH HWC	Multipurpose worker	• Skill to focus on healthy diet and lifestyle along with Yoga practices • Skill for management of common ailments through home remedies. • Skill of cultivation of medicinal plants • Pregnancy test, hemoglobin, urine test and blood Sugar • Reporting, inventory management, record maintenance and untied fund management • On the job mentoring support to ASHAs on a regular basis **Additional Skills:** • Screening for common NCDs and timely referral and provision of follow up care enabling periodic monitoring of BP, Blood sugar for patients on treatment • Support provision of first level of care for mental health, elderly care, palliative care, ENT, Ophthalmic care, etc. • Support to formation and handholding of Patient Support Groups • dispensing of medicines as appropriate at the HWC level • IT solutions	• 2-3 days of skill based training in modules 1, 2 and 3 • 2-3 days of training for basic diagnostic procedure • Training on National Health Programmes as per programme guidelines • 3 days of training on universal screening, prevention and management of non-communicable diseases • One-day joint training with ASHAs on universal screening of NCDs days training on reporting and recording information using digital applications

		• Skills to use digital applications wherever applicable for reporting, inventory management, record maintenance and use population based analytics • Maintaining Family Health Folders and Individual Health Records (having Prakriti mentioned on it as an when such provision is made)	• 3-5 days training can be planned every year based on the expansion of range of services
	AYUSH Physician (CHO)	• Skills for provision of preventive, promotive, curative, rehabilitative and palliative care for expanded range of services, referral **Additional Skills:** • Laboratory skills • Promotion of Yoga practices and cultivation of medicinal herbs. • Skills to use digital applications wherever applicable for reporting, inventory management, record maintenance • Maintaining Family Health Folders and Individual Health Records • Supportive supervision of field level functionaries	• 6 month certificate programme in community Health for NHM components at upgraded SCs • At AYUSH dispensaries, 15 days training for AYUSH care and NHM training as and when the services are expanded. • 5-7 days supplementary training on new health programmes, new skills and refreshers every year • 3 days training on use of IT application and telehealth • Regular monitoring/ training through ECHO platform

Appendix 4 - Institutional Mechanism for AYUSH HWCs

The AYUSH HWCs would be developed and operationalized through an institutional mechanism at National, State and District level. Already established framework of NAM and further linkages with line ministries & department will enable to successfully plan and carryout public health activities. The structure available at all levels of service planning and delivery are mentioned below.

1. National Level

The institutional framework of NAM has provision for bringing together representatives from inter-linked sectors such as Health, Agriculture and Horticulture Departments during discussion on Annual Plans for convergence of actions, to avoid the overlapping of different schemes and to save the public resources.

The Ayushman Bharat Cell at Ministry of AYUSH has been established under NAM for implementation and monitoring of AYUSH HWCs. At central level, there are National Institutes and AYUSH Research Councils under the administrative control of Ministry of AYUSH. The Ministry also seeks the help of Ministry of Health & Family Welfare, its subordinate bodies and private partners. Further there are Committees at National level as mentioned below:

Mission Directorate:

Sl. No.	Designation	Status
1.	Secretary (AYUSH)	Chairperson
2.	AS & FA or his nominee	Member
3.	AS&MD, NHM, Department of Health	Member
4.	Mission Director, Horticulture	Member
5.	J.S. dealing with ASU & H drugs/Institutions	Member
6.	Advisers of Ayurveda, Homoeopathy, Unani, Siddha	Member
7.	Adviser of Ayushman Bharat cell	Member
8.	Joint Secretary (Ministry of AYUSH)	Member Secretary

Any other expert may be co-opted as deemed necessary with the approval of Chairperson. This committee shall be responsible for approving State Annual Action Plan (SAAP) based on recommendation of the appraisal committee.

Apprisal Committee :

Sl. No.	Designation	Status
1	Joint Secretary (AYUSH)	Chairperson
2	JS dealing with ASU &H drugs/Institutions	Member
3	CEO/Dy. CEO, NMPB	Member
4	Mission Director, Horticulture or his representative	Member
5	Representative from NHM, Dept. of Health	Member
6	Representative of IFD	Member
7	Additional Drug Controller General of ASU & H Drugs / Sr. Technical officer dealing DCC	Member
8	Advisers/Joint Advisers/Dy. Advisers of Ayurveda, Homoeopathy, Unani, Siddha, and Medicinal Plants	Member
9	Director/Dy. Secretary i/c of NAM	Member Secretary

Any other expert may be co-opted as deemed necessary with the approval of Chairperson. This committee shall be responsible for appraising the State Annual Action Plan (SAAP) and submit to the governing body for approval.

2. State Level

States/UTs will have following structure as an institutional mechanism:

- State Programme Management Unit (SPMU) under NAM
- District Programme Management Unit (DPMU) under NAM
- HWC team-appropriately trained Primary Health Care team, comprising of Multi-Purpose Workers, ASHAs and led by an AYUSH physician
- Referral points such PHCs, CHC, Medical/AYUSH colleges
- Linkages- AYUSH dispensaries, standalone hospitals, collocated facilities, teachers & students of educational institutions, National level organizations, schools, social groups, private bodies etc.
- Community groups, Local bodies, Panchayati raj Institutions
- Mission at State level will be governed and executed by a State AYUSH Mission Society, constituted with following members

Governing Body:

Sl. No.	Designation	Status
1	Chief Secretary	Chairperson
2	Principal Secretary/Secretary I/c of AYUSH/ (Health & F.W.)	Member Secretary
3	Principal Secretary/Secretary (AYUSH Medical Education)	Member
4	Principal Secretary (Finance)	Member
5	Principal Secretary (Planning)	Member
6	Principal Secretary Forests & Horticulture dealing with Medicinal Plants	Member
7	Mission Director, NHM	Member
8	Commissioner(AYUSH)/Director General (AYUSH)/Director Ayurveda, Unani, Homoeopathy, Siddha	Member
9	Nodal Officer, State Medicinal Plants Board	Member
10	State ASU &H Drug Licensing Authority	Member

Any other expert may be co-opted as deemed necessary with the approval of Chairperson.

Executive Committee:

Sl. No.	Designation	Status
1	Principal Secretary/Secretary I/c of AYUSH/ (Health & F.W.)	Chairperson
2	Principal Secretary/Secretary (AYUSH Medical Education)	Vice-Chairperson
3	Commissioner (AYUSH) /Director General (AYUSH)/Director-Ayurveda, Unani, Homoeopathy, Siddha	Member Secretary
4	Mission Director, NHM	Member
5	Representative of State Finance/Planning Department	Member
6	Representatives of Forest & Horticulture Department	Member

7	Nodal Officer, State Medicinal Plants Board	Member
8	ASU &H State Licensing Authority	Member
9	Senior Technical officers dealing with Ayurveda, Homoeopathy, Unani, Siddha, Yoga and Naturopathy and Medicinal Plants	Member
10	State AYUSH Programme Manager	Member

Any other expert may be co-opted as deemed necessary with the approval of Chairperson.

3. District Level

The guideline for constitution of District AYUSH society has been shared with the States and UTs so as to strengthen the activities at grass root level.

Appendix 5 - Program Monitoring Indicators for Upgraded AYUSH Dispensary

Note:

- Subject to revision based on the range of services to be provided at the health facility
- Indicators for upgraded sub health centres would be finalised jointly with Dept. of Health

Indicator A- sent by District to State and National Level	**Indicator B –available at District**	**Source**
Out- patient visits at AYUSH HWCs and outreach camps	Out- patient visits at HWCs and outreach camps	Electronic and physical records
No of people underwent Prakriti analysis	Prakriti analysis done at AYUSH HWC	CPHC App/ registers
Hospitalization Rate (per 100,000 Population) in each district/state	1) Beds per lakh population 2) Bed Occupancy Ratio	HMIS/ AHMIS
Annual primary care empanelment rate - proportion of families in district who are registered with Health & Wellness Centers	Same indicator by each HWC facility	Management Information System (MIS) /CPHC/ IT System
Child malnutrition rate by district	• Severe Acute Malnutrition (SAM), Moderately Acute Malnutrition (MAM) rates • Mild, moderate and severe malnutrition rates	Integrated Child Development Services (ICDS) – MIS
Exclusive breast-feeding for six months after birth	Breastfeeding within first hour	HMIS
Patients with hypertension under primary care	• % of population of 30 years and above screened for HT • % of those screened positive for HT who were examined at PHC/ CHC • % of those who were initiated on treatment at PHC or above who are still under treatment, uninterrupted for last 3 months • % of those currently on treatment who have achieved blood pressure control	HMIS/ AHMIS
Patients with diabetes mellitus under primary care	• % of population of 30 years and above screened for DM • % of those screened positive for DM who were examined at PHC/ CHC	HMIS/ AHMIS

	• % of those who were initiated on treatment at PHC or above who are still under treatment, uninterrupted for last 3 months % of those currently on treatment who have achieved blood sugar control	
Individuals screened for common cancers	• % of population of 30 years and above screened for oral cancer • % of women of 30 years and above screened for breast cancer • % of women of 30 years and above screened for cervical cancer • % of those who were screened positive for each of the cancers that underwent biopsy at CHC/ DH • % of those who underwent treatment for each of the cancers who are screened periodically	HMIS/ AHMIS
Cardiovascular mortality in the 15 to 60 years age group	Mortality disaggregated by gender	RGI
Leprosy : Annual new case detection Rate / 100,000 population Prevalence rate/100,000 New cases with grade II disability Treatment Completion Rate	• Proportion of new cases detected • Multi bacillary case incidence • Child Cases. • Grade II disability • Child case with disability	HMIS/ National Leprosy Eradication Programme (NLEP)
Case detection rate for tuberculosis	Treatment completion rate MDR rate	TB-MIS
Annual parasite index for malaria	Also % PF, SPR	Malaria-MIS
Rate of patients with chronic NCDs on regular medication or other follow up at the HWC	Rates for specific diseases- HT, diabetes, COPD/ asthma, epilepsy, mental illness, etc. where specialist initiates but regular follow up and medication locally	HMIS
Average medical Out of Pocket (OOP) Cost of Care for hospitalization	Also break up of cost of care in medicines, diagnostics etc. in public and private facility	Based on exit interviews on fixed protocol
Average OOP cost of care on Out patient care	Break up of cost of care in medicines, diagnostics etc. in public and private facility	Based on annual community survey on fixed protocol

Self care components adopted by the community	• Participation in Yoga classes • Number People trained in Yoga • Medicinal plants grown • Number of people following preventive and promotive measures	Physical and electronic records
Intersectoral convergence	• Number of meetings held with various departments • Public outreach activities • Attendance of public • Public perception	Physical and electronic records
Wellness in the community	• All morbidity & mortality indicators mentioned above • Availability of toilets, drinking water • Out of pocket health care cost, feeling of wellbeing etc.	Cross sectional survey of population
Integration between AYUSH & Health departments	• Number of meetings held • Sharing of manpower • Infrastructure & data sharing • Number of cross referrals • Uninterrupted service delivery	Physical and electronic records

Appendix 6 - Performance Linked Incentives for AYUSH HWC team at upgraded AYUSH dispensary : A Guidance Note

Note : The PLP at upgraded sub health centres will be as per MoHFW guidelines.

Background :

Comprehensive Primary Health Care through Health and Wellness Centres identify Performance Linked Payment(PLP) as a strategy to improve motivation levels, strengthen quality of services, enhance accountability for population health outcomes and serve as a mechanism to identify performance and skill gaps, at the Health and Wellness Centers. The PLP are provided for the team of frontline functionaries and the CHO, who will play a key role in enabling continuum of care. This guidance note is expected to enable the states to roll out Performance Linked Payment for the primary care team at the HWC that include CHO (team leader), two Multi-Purpose Workers or equivalent Staff decided by the State/UT and ASHAs in the catchment population of the HWC.

The individual incentive will made on a monthly basis and the team based incentive is made annually. Team and individual performance will be assessed on the basis of data obtained from existing information systems. However, states also have the flexibility to undertake independent monitoring, to validate the information systems. This may be done through partnerships with research organizations, NGOs, State Health System Resource Centres and AYUSH colleges or by training the existing staff at district and block level to undertake population- linked surveys to monitor progress on outcomes on a periodic basis. The key features and suggested indicators to guide performance linked payment mechanism for AYUSH HWC team is explained below:

1. **Level of Incentive Distribution**: AYUSH-Health and Wellness Centres
2. **HWC Team-**CHO, Two Multi-Purpose Workers or equivalent Staff decided by the State/UT and ASHAs as per the population of the HWC-service area.
3. **Periodicity**: Every month for individual incentive and annual for team
4. **Indicators for performance measurement and source of verification:** The performance of the team will be assessed on indicators that will be a mix of service utilization and coverage of population for essential services (**Table 1**).

Key criteria for selection of indicator cover essential activities under AYUSH HWC. Monthly performance of the functionaries will be assessed on a set of indicators. The list of indicators may be updated periodically linked on the- experience gained from the implementation of performance linked payments, progress on outcomes and roll out of new service packages.

5. **Distribution of incentive amount for each HWC-SHC team-** The monthly incentive to HWC team could follow the distribution listed below:
   - Rs 15,000/ CHO/month for the contractual CHOs
   - Rs. 5000//month for regular dispensary Medical Officer for additionally assigned duties
   - Rs.5000/month for maximum of 5 ASHAs (Subject to a maximum of Rs 1000/month/ASHA)
   - Rs. 1,00,000/ per year for AYUSH HWC team equally distributed among CHO, ANM, MPW, ASHA or any other staff as per the situation in the particular HWC, on the basis of same 10 performance indicators

Considering the above distribution, the maximum amount of incentive for 5 ASHAs would be Rs. 60000/- per year. The maximum amount allocated to contractual CHO would be Rs. 1,80,000/annum, Rs. 60000/- for regular Medical Officer.

6. **Incentive amount to be allocated for the indicators-** For ease of implementation in the early stages, all indicators are weighted equally. The contractual CHO would receive Rs. 1500/-per indicator/month, upto a maximum of Rs. 15,000/ten indicators/month. (regular dispensary MO will get Rs.500/- per indicator/month, upto a maximum of Rs.5000/- ten indicators/ month)Similarly, the incentive of Rs.1000/month/ASHA will be equally for ten indicators (100 per indicator/ASHA/month for 10 indicators in one month. While in upgraded sub health centres, Performance-linked payment shall be as per MOHFW PLP guidelines.

7. **Service delivery output for incentive payment-** Performance linked payment that is to be disbursed for each indicator will correspond the level of achievement. The indicators will be measured against three levels of performance viz. 30% to 50%, 51% to 70% and 71% to 100%. No incentives would be paid if performance is below 30% of expected target.

8. **Key principles to assess performance:**
   - Indicators for performance measurement of the AYUSH HWC team should be easily verifiable. The selection of indicators is such that report for these indicators can be verified from the existing information systems such as AHMIS, RCH Portal/Registers, NCD Application of the CPHC IT system, AHMIS, NIKSHAY, IDSP reports, meeting records submitted to PHC Medical Officer/ District AYUSH officer or physical records may be used till the time IT application is functional
   - Ensuring that data is fed accurately and regularly in the information system at each level is a collective and individual responsibility of the HWC team

9. **Process:**

   The District AYUSH Medical Officer or any suitable representative identified by the States under whose jurisdiction the HWC is assigned will be responsible for assessing the performance of the HWC team. He/ She will
   - Ensure that CHOs/MPWs are trained in using the CPHC IT system for online auto compilation and transmission of performance data for HWC team. However, till the time such a system is in place, CHO will use the data entered in the respective information system to submit performance reports on service delivery outputs for the particular month in a standard format developed by the state
   - Ensure release of performance- linked incentives within one month of submission of performance report by CHOs
   - Use the performance monitoring mechanism to identify the areas of improvement for the primary care team at the HWC and provide the necessary handholding and support to improving the performance and overall service delivery at HWCs
   - Undertake monthly visits to every HWC for field level monitoring and use these visits to handhold and mentor HWC team

10. **Mode of Validation:**

a. **Local**- Designated Officer will assess and validate the records submitted by CHO with the reports from information systems - RCH portal/registers, NCD application of the CPHC IT system/registers, NIKSHAY (online tool for monitoring TB control programme), Integrated Disease Surveillance Programme (IDSP) reports, meeting records submitted for performance-linked payment/AYUSH portal/physical data.

b. **External- (i)** Existing mechanisms of 104 Call Centre etc. can also be used to validate team performance data reported by CHOs. **(ii)** States can also opt to assess service use and satisfaction by random surveys of service users through telephone surveys, **(iii)** States may also opt for nominating an independent committee comprising of officials and civil society representative to validate the quantity and quality of service delivered by HWCs. This committee can evaluate the performance quarterly or bi annually to ensure that no conflict of interest arises, during the process of performance- linked payment.

11. **Ensuring timely payments:**

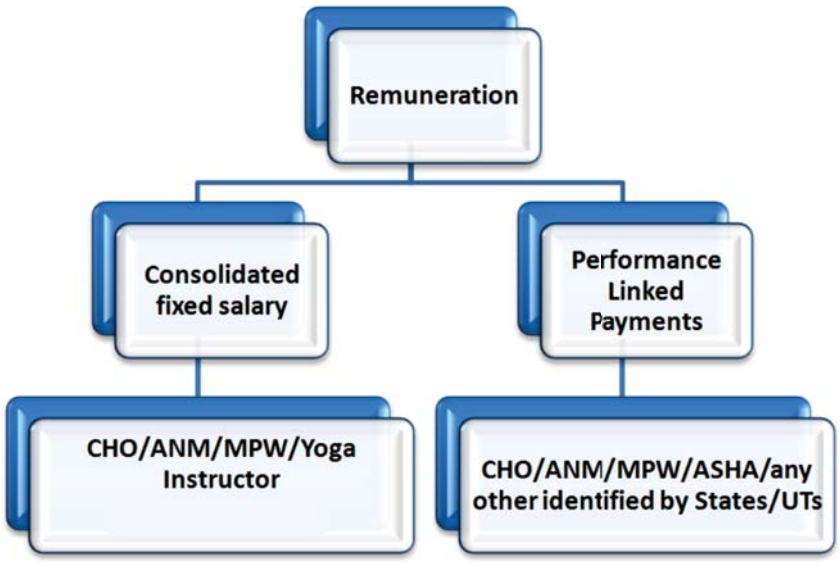
Though external validation is essential to check fraudulent reporting; in any given circumstance monthly payment of incentives to CHOs and frontline functionaries should not await call centre linked validations.

12. **Possible action for false reporting by CHOs:**

CHO as team leader would be accountable for submitting performance reports of HWC team. He/she should be given one warning if an instance of false reporting of performance indicators is identified from the call-linked validation of performance reports. Any repeat of falsification could result in deducting the amount from their salaries, and a third instance could lead to termination of service contracts of CHO if continuous false reporting is observed despite warning.

13. **Fixed remuneration and PLP:**

The HWC staff, deployed on contractual basis will have 60 % fixed remuneration and 40% as performance linked incentive. So as to become eligible for fixed remuneration the staff need to perform following main duties. For the regular staff the PLI will be applicable in addition to the salary as specified in this guideline.



A. Fixed roles and responsibilities of HWC staff:

Main Duties of CHO

1. Attend daily OPD in HWC and in the community as per the schedule
2. Overall planning and monitoring of community level activities including Yoga & herbal garden
3. Participate/ organize meetings
4. The CHO as a team leader and in-charge of HWC, will broadly be expected to carry out public health functions, ambulatory care and management
5. Ensure that all households in the service areas are listed, empanelled, a database is maintained-in digital format/ paper format as required by the state
6. Prakriti analysis of every population in the catchment area above 18 years of age

Duties of ASHA/MPW

1. To ensure Prakriti analysis
2. To ensure regular Yoga by the community
3. Advocacy of AYUSH IEC campaigns AYUSH lifestyle, diet, behavioral codes
4. Cultivation of medicinal plants
5. Referral and follow up of AYUSH cases

B. Performance Linked Payment:

Performance linked incentives given to CHO, ASHAs, ANM/MPW or any other equivalent staff identified by States/ UTs on the assessment of 10 indicators :

Table 1: Suggestive list of indicators to assess monthly performance of HWC team for service utilization

Sl. No.	Assessment Indicator	Definition	Source of Verification/ Reporting	30% to 50 % performance	75 % performance	100 % performance
1.	Number of OPD cases in the month	No. of OPD cases including new and old cases	• NCD-CPHC app • OPD register	200 to 300 OPD/month	301 to 400 per month	More than 400 OPD/month
2.	No of people underwent Prakriti Parikshan	100 cases of Prakriti Assessment per month Denominator - Total no. of individuals above 18 years of age in the catchment area	• CPHC app • Registers	30% to 50% of the estimated (100 target)	51 to 70 % of the estimated (100 target)	More than 71 % of the estimated (100 target)

Sl. No.	Assessment Indicator	Definition	Source of Verification/ Reporting	30% to 50 % performance	75 % performance	100 % performance
3.	No. of individual empanelled in AYUSH facility	Numerator - No. of individual empanelled by ASHAs// ANMs/CHO. Denominator - Total no. of Individuals in catchment area of HWC	NCD application/NCD registers	Defined target/month - 8% of total population in the HWC catchment area shall be the monthly target for activity		
				30% to 50 % of defined target	51% to 70% of the defined target	More than 71 % of the defined target
4.	Proportion of above 30 years individuals screened for Hypertension (HT)	Numerator - No. of individuals screened for Hypertension Denominator- Total population above 30 years of age	NCD application/ Registers	Defined target/month - 8% of total population in the HWC catchment area shall be the monthly target for activity		
				30% to 50 % of defined target	51% to 70% of the defined target	More than 71 % of the defined target
5.	Proportion of individuals above 30 years screened for Diabetes	Numerator - No. of individuals screened for Diabetes Denominator- Total population above 30 years of age	NCD application/ Registers	Defined target/month - 8% of total population in the HWC catchment area shall be the monthly target for activity		
				30% to 50 % of defined target	51% to 70% of the defined target	More than 71 % of the defined target
6.	Proportion of Patient of DM on AYUSH treatment	Numerator - No. of HTN patients who received follow up care Denominator - Total no. of HTN/ patients	NCD application/ Registers	20% to 30% of patients who received treatment	31 to 40% of patients who received treatment	41% and above received treatment
7.	Proportion of Patient of HTN on AYUSH treatment	Numerator - No. of HTN patients who received follow up care Denominator - Total no. of HTN/ patients	NCD application/ Registers	20% to 30% of patients who received treatment	31 to 40% of patients who received treatment	41% and above received treatment

8.	People counseled for the life style modification- 6 campaigns of 7 days duration in a year	No of group sessions held at the community level for AYUSH lifestyle counseling (Minimum 20 person /session)	Registers	Up to 3 sessions (50% incentives)	At least 4 sessions held (75% incentives)	6 sessions held then (100% incentives)
9.	Distribution of Medicinal Plants to the household	Numerator - No. of families received medicinal plants Denominator – Total number of families	Registers	Defined Target - 8% of total families in the HWC catchment area shall be the monthly target for activity, assuming 1200-1500 families per HWC Catchment area.		
				30% to 50 % of defined target	51% to 70% of the defined target	More than 71 % of the defined target
10.	Organizing /participating intersectoral meetings , involving public	Numerator - No. of meetings attended Denominator - Total no. of meetings	Self- reported in CPHC-NCD application/ Registers	HWC team will organize/ participate in atleast one meeting for getting full performance- linked incentive		

Note:

1. Performance linked incentives are given to CHO, ASHA, ANM, MPW or any other staff identified by the State/UT
2. The target for some indicators such as number of OPD may vary from place to place and therefore the State/District authorities will decide the target for each AYUSH HWCs
3. The same 10 indicators will be used for calculating both individual incentives and team based incentives
4. All the 10 indicators carry equal weightage for deciding individual based and team based payment of incentives
5. The list of the indicators may be updated periodically based on the availability of the services

Appendix 7 - Indicative list of the equipment in AYUSH HWC

Equipment for carrying out basic Panchakarma procedures at OPD level

1. Swedana/sudation chamber
2. Nadisweda yantra
3. Bastiyantra
4. Nasya karma set
5. Yoga neti pot
6. Yoga mats

Other Minor equipment

7. Stethoscope
8. Blood pressure apparatus (digital)
9. Thermometer
10. Weighing machine
11. Kidney trays
12. Swab holder
13. Sterilised gloves
14. Sterilised gauze
15. Sterilised tampons
16. Sterilised cotton
17. Dressing tray with gloves, bandage, cloth etc.

Furniture

As per the need of the centre such as

18. Wheel chair
19. Trolleys
20. Stretcher
21. Computer table & chair

सत्यमेव जयते

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