सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

REVISED
GUIDELINES FOR OPERATIONALIZING
FIRST REFERRAL UNITS

NOVEMBER 2025

National Health Mission
Ministry of Health & Family Welfare
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पुण्य सलिला श्रीवास्तव, भा.प्र.से.
सचिव
PUNYA SALILA SRIVASTAVA, IAS
Secretary

सत्यमेव जयते

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

MESSAGE

Strengthening the secondary level of care is a key priority for achieving an efficient and responsive public health system. While we have made significant progress in expanding primary healthcare services through Ayushman Arogya Mandirs, the need to reinforce the referral layer has become more critical. First Referral Units (FRUs) play an essential role in bridging this gap by providing timely emergency care, stabilization, and specialized services at the block level.

The *Revised Operational Guidelines for First Referral Units (FRUs), 2025,* provide a clear and updated framework for strengthening Community Health Centres to function as fully operational FRUs. These guidelines reflect the changing health needs of the population, the growing demand for emergency and critical care, and the need for improved maternal and newborn services. They also recognise the ongoing transition of District Hospitals into medical colleges, which requires CHC-FRUs to take on greater responsibility in managing secondary-level care and reducing pressure on tertiary care institutions.

From a policy perspective, these guidelines aim to ensure uniform standards of service delivery across the country. They align with IPHS 2022 and provide clear directions on infrastructure, human resources, emergency preparedness, blood storage, referral systems, and governance mechanisms. The guidelines also support integration with national programmes and encourage the use of digital health systems to improve efficiency, transparency, and continuity of care.

The Ministry expects all States and Union Territories (UTs) to adopt these guidelines and integrate them into their planning and implementation processes under the National Health Mission. States should prioritise strengthening FRUs based on local needs, service gaps, and patient load, and ensure regular monitoring of their performance.

These guidelines will help improve access to quality emergency and referral care, reduce avoidable referrals, lower out-of-pocket expenditure, and enhance public confidence in government health facilities. Their successful implementation will contribute significantly to achieving equitable and timely healthcare for all.

The Ministry will continue to provide policy guidance and necessary support to States and UTs to ensure effective operationalization of these guidelines. All authorities concerned are advised to take proactive steps for their phased implementation and sustained supervision.

Punya Salila

(PUNYA SALILA SRIVASTAVA)

Date : 25.11.25
Place: New Delhi

#StopObesity
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सत्यमेव जयते

आज़ादी का अमृत महोत्सव

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Ministry of Health & Family Welfare

MESSAGE

India's health sector is moving into a new phase where strengthening secondary care is essential for ensuring timely, equitable, and quality services for all citizens. Over the last several years, the National Health Mission has focused on expanding primary healthcare through Ayushman Arogya Mandirs and community-based interventions. As this foundation becomes stronger, it is now necessary to reinforce the block-level platform so that patients receive appropriate care without delay and unnecessary referrals are avoided.

First Referral Units (FRUs) are central to this effort. They provide 24×7 services for emergency obstetric and newborn care, trauma and accident management, acute NCD episodes, medico-legal cases, and other time-sensitive conditions. Their performance directly determines the effectiveness of the referral chain from primary to tertiary care. With District Hospitals being strengthened and many transitioning into medical colleges, CHC-FRUs must increasingly shoulder inpatient care, emergency stabilization, and essential surgical responsibilities. Strengthening all CHCs to function as reliable FRUs will also help decongest District Hospitals and ensure continuity of care at every level.

The *Revised FRU Guidelines 2025* provide a clear operational framework for this transformation. They align with IPHS 2022 and lay out actionable requirements across service delivery, infrastructure, human resources, diagnostics, digital health platforms, blood storage, quality assurance, and climate-resilient facility features. The guidelines underline the importance of readiness for trauma care, high-risk maternal and newborn services, acute medical emergencies, and stabilization before referral. They also highlight future-ready components such as task shifting, telemedicine, digital workflows, and preparedness for public health emergencies.

I expect States and UTs to use these guidelines to reorient their block-level planning and to prioritize FRU strengthening in a phased, evidence-based manner. Strengthened FRUs will reduce preventable deaths, bring specialist services closer to rural and remote populations, lower out-of-pocket expenditure, and improve public confidence in government health facilities. They will also make the referral system more efficient as District Hospitals evolve into medical colleges.

I urge all States and UTs to operationalize these guidelines with urgency, to map and close critical gaps, and to institutionalize supportive supervision and regular monitoring. A strong FRU network is essential for a responsive and resilient health system, and these guidelines provide a clear direction for achieving this goal.

Dated: 20th Nov, 2025

(Aradhana Patnaik)

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सत्यमेव जयते

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MESSAGE

India's public health system stands at a historic juncture. Over the past three decades, our national efforts—from the Child Survival and Safe Motherhood (CSSM) Programme to the National Health Mission (NHM)—have significantly expanded access to maternal, newborn, and emergency care. Yet, preventable deaths and delays in accessing timely emergency services continue to challenge our aspiration of equitable, universal health coverage. Strengthening emergency referral facilities is therefore not only a health systems priority, but a moral imperative.

The revised Guidelines for Upgradation of Community Health Centres (CHCs) into fully functional First Referral Units (CHC-FRUs) mark a pivotal policy shift. For the first time, India commits to universal CHC-FRU functionality across all rural and urban CHCs, ensuring that every block-level facility is equipped to provide 24×7 comprehensive emergency, surgical, obstetric, newborn, trauma, NCD-stabilisation, and medico-legal services. This step is essential as District Hospitals progressively transition into medical colleges, requiring CHCs to shoulder a strengthened secondary-care mandate and act as dependable first-line emergency and referral centres.

These guidelines bring together the most updated national standards—IPHS 2022, NQAS, FRU directives, programme guidelines, digital health frameworks and climate resilience—to provide a unified, actionable roadmap for States and UTs. They expand the traditional focus on maternal and newborn emergencies to encompass trauma care, acute NCD events, infectious disease outbreaks, adolescent health, family planning, mental health, palliative care, and geriatric services, pandemic preparedness reflecting India's evolving epidemiological realities. They also reinforce the critical role of CHC-FRUs within the Ayushman Bharat continuum of care, ensuring reliable referral pathways from Ayushman Arogya Mandirs for emergency and inpatient services.

A functional CHC-FRU is not merely an upgraded building—it is a guarantee of readiness: operational OTs, 24×7 skilled workforce, emergency diagnostics, digital linkages, a licensed blood storage unit, and the ability to save lives without delay. Achieving this across more than 5,000 CHCs will require sustained investment, governance reform, capacity building, and a relentless focus on quality, safety, and accountability.

I am confident that these revised guidelines will serve as a transformative tool for States and Districts to strengthen secondary healthcare, decongest higher facilities, and bring life-saving services closer to communities. I urge all health administrators, programme managers, clinicians, and implementing partners to adopt these guidelines with urgency and commitment. Together, we can build a resilient, responsive, and equitable referral care system that truly fulfils the vision of a healthier India.

(Saurabh Jain)

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MESSAGE

The National Health Systems Resource Centre (NHSRC), as the technical support institution to the Ministry of Health and Family Welfare and the National Health Mission, has consistently worked towards strengthening service delivery across the public health system. The *Revised First Referral Unit (FRU) Guidelines 2025* represent an important step in advancing secondary care readiness, improving emergency response, and ensuring continuity of care between primary, secondary, and tertiary levels.

FRUs occupy a critical position in India's health system. They provide 24×7 obstetric and newborn care, trauma management, emergency stabilisation, and essential surgical and medical services at the block level. Many State and District Hospitals are now being upgraded to medical colleges, and the need to decongest higher facilities has become more pressing. Strengthening CHCs to function as dependable FRUs is therefore essential for improving outcomes and ensuring timely care, especially in rural, tribal, and underserved regions.

NHSRC had the privilege of supporting the Ministry in coordinating technical inputs, reviewing existing frameworks, conducting field visits, and integrating feedback from States, programme divisions, and expert committee members. The revised guidelines incorporate updated IPHS 2022 norms, emergency care standards, blood storage and OT requirements, task shifting approaches, digital health platforms, climate-resilient infrastructure elements, and governance mechanisms. They also reflect the need for future-ready FRUs that can respond to emerging health threats, changing disease patterns, and increased service expectations owing to increased services at the Primary health care level.

Our aim while supporting the development of these guidelines was to ensure that they remain practical, implementable, and grounded in field realities. The document provides clear operational direction for service delivery, human resource planning, diagnostics, supply chain management, referral systems, and quality assurance. It also offers a roadmap for States to prioritise investments, strengthen monitoring, and move towards uniform standards of readiness across all FRUs.

NHSRC will continue to support States and UTs in adopting and operationalising these guidelines through capacity building, technical advisory support, development of tools, and on-site facilitation where required. We remain committed to working closely with the Ministry and all stakeholders to ensure that FRUs deliver timely, high-quality, and people-centred care.

I am confident that these revised guidelines will help States build a more responsive and resilient secondary-care platform and strengthen the referral system across the country. Their effective implementation will play a key role in improving maternal and newborn health, trauma outcomes, emergency care, and public trust in government health facilities.

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MESSAGE

The development of the *Revised First Referral Unit (FRU) Guidelines 2025* marks an important step in strengthening the secondary-care platform under the National Health Mission. Over the years, CHCs functioning as FRUs have played a crucial role in delivering essential care. With evolving health needs, growing patient expectations, and the pressure on District Hospitals, it has become necessary to upgrade the operational standards for FRUs across the country.

These revised guidelines are the result of a coordinated and collaborative effort involving senior officials, program divisions and NHM consultants at the MoHFW, experts, NHSRC, State representatives, and District teams. The revised document aligns with IPHS 2022 and provides updated directions on service delivery, infrastructure, diagnostics, emergency preparedness, blood storage, staffing requirements, digital systems, task shifting, and referral management and reflects the need for future-ready facilities.

Our primary objective in updating these guidelines is to ensure that FRUs can provide timely, competent, and uninterrupted care .Strengthened FRUs will reduce preventable deaths, lower out-of-pocket expenditure, and ensure that patients receive stabilization and treatment closer to home. They will also play a key role in easing the load on District Hospitals and improving the overall functioning of the referral chain.

As the coordinating division, NHM has worked closely with States to ensure that the revised norms are practical, implementable, and adaptable to different contexts. These guidelines give States a clear framework to map gaps, prioritize blocks, plan investments, and strengthen monitoring and supervision. Their effective implementation will depend on strong leadership at the State and district levels and consistent follow-up in line with NHM processes.

I encourage all States and UTs to integrate these guidelines into their planning exercises, including the preparation of PIPs, gap assessments, HR strategies, and quality improvement initiatives. A strong network of FRUs is essential for building trust in public health facilities.

The completion of these guidelines reflects the collective commitment of all stakeholders to strengthen secondary care. I look forward to their effective rollout and to seeing improved outcomes and stronger referral services across the country.

Dated:20th Nov, 2025

(Saroj Kumar)

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TABLE OF CONTENTS

Section 1: Introduction and Context **19**

1.1 The Imperative for Strengthening Emergency Referral Services: From CSSM to NHM 19

1.2 Policy Shift: Towards Universal CHC-FRU Functionality 20

1.3 Alignment with National Health Goals and Standards 20

1.4 Purpose and Structure of Revised Guidelines 21

Section 2: The CHC-FRU: Definition, Criteria, and Role **23**

2.1 Revised Definition of a Functional CHC-FRU 23

2.2 Essential Criteria for Designation and Functionality 23

2.3 Role within the District Health System and Referral Network 24

Section 3: Comprehensive Service Package **27**

3.1 Core Mandate: 24/7 Comprehensive Emergency Obstetric and Newborn Care (CEmONC) 27

3.2 Neonatal and Child Healthcare Services at FRUs 28

3.3 Family Planning and Contraceptive Services 29

3.4 Adolescent Health Services at FRUs 30

3.5 Expanded Emergency Response: Trauma Stabilisation, Management of NCD Emergencies 31

3.5.1 Strengthening Emergency and Trauma Care at CHC-FRU Level 32

3.5.2 Integration with National Emergency Response Framework 33

3.6 Essential Surgical, Medical, Oral Care 33

3.7 Integration with National Health Programmes 34

3.8 Strengthened Linkages: Mental Health, Palliative Care, Geriatric Care 35

3.9 Diagnostic Capacity (Laboratory and Imaging) 36

3.10 Blood Services (Storage and Transfusion) 36

3.11 Medico-Legal Service Provision 37

Section 4: Infrastructure, Equipment, and Technology Standards **39**

4.1 Physical Infrastructure Norms (IPHS 2022) 39

4.2 Essential Equipment and Consumables List 40

4.3 Support Services Infrastructure 40

4.4 Disaster Preparedness and Response 42

Section 5: Human Resources for Health (HRH): Norms and Capacity Building 43
5.1 Minimum Staffing Norms (IPHS 2022) ... 43
5.2 Strategies for Ensuring Specialist and Skilled MO Availability ... 44
5.3 Comprehensive Capacity Building Plan ... 45
5.4 Roles, Responsibilities, and Performance Expectations ... 46

Section 6: Quality Assurance, Governance, and Patient Rights 47
6.1 Mandatory Adherence to NQAS and Pathway to Certification ... 47
6.2 Strengthening Clinical Governance, Patient Safety, and IPC ... 48
6.3 Empowering Rogi Kalyan Samitis (RKS) for Oversight and Community Engagement ... 49
6.4 Upholding Patient Rights and Grievance Redressal ... 49

Section 7: Future-Ready CHC-FRUs: Integration and Adaptation 51
7.1 Leveraging Digital Health for Enhanced Care and Efficiency ... 51
7.2 Building Climate-Resilient Services and Infrastructure ... 52
7.3 Role in AMR Surveillance, Stewardship, and Pandemic Preparedness ... 53
7.4 NQAS Certification ... 54

Section 8: Implementation Framework and Strategic Recommendations 55
8.1 Phased Rollout Strategy for Universal Upgradation ... 55
8.2 Resource Planning and Financial Considerations ... 56
8.3 Interdepartmental Convergence ... 56
8.4 Strengthening Supply Chains and Logistics ... 57
8.5 Monitoring, Supervision, and Supportive Guidance ... 57
8.6 State/UT Level Adaptation and Action Planning ... 58
8.7 Role of Technical Partners and NHSRC ... 58

Section 9: Monitoring and Evaluation Framework 59
9.1 Purpose of Monitoring ... 59
9.2 Key Performance Indicators (KPIs) ... 59
9.3 Tools and Platforms for Monitoring ... 61
9.4 Reporting Responsibilities ... 61
9.5 Feedback and Course Correction ... 61

Section 10: Conclusion and the way forward 63

Section 11: Annexures and Operational Checklists 65
Annexure 1: FRU Facility Readiness Checklist (Aligned with IPHS 2022) ... 65
Annexure 2: Monthly Monitoring Template for Block Programme Management Unit (BPMU) ... 66

Revised Guidelines for Operationalizing First Referral Units (FRUs) | NOV 2025

Annexure 3: FRU Implementation Milestone Tracker (State/District Level) 66
Annexure 4: Role Matrix for FRU Implementation 67
Annexure 5: List of services available at CHC-FRU/UCHC-FRU 67
Annexure 6: List of Service Areas at CHC-FRU/UCHC-FRU 82
Annexure 7: Suggested Layout for a Model CHC-FRU/UCHC- FRU 85
Annexure 8: Disaster Management & Preparedness 94
Annexure 9: List of Human Resources for Health at CHC-FRU/UCHC-FRU 97
Annexure 10: Roles & Responsibilities of HRH at CHC-FRU/UCHC-FRU 100
Annexure 11: List of Diagnostic Tests and Equipment at CHC-FRU/UCHC-FRU 108
Annexure 12: List of Equipment at CHC-FRU/UCHC-FRU 110

Section 12: References **122**

LIST OF ABBREVIATIONS

ABBREVIATION	FULL FORM
AAM	Ayushman Arogya Mandir
AB-HWC	Ayushman Bharat – Health and Wellness Centres
ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account
AFB Stain	Acid-Fast Bacillus Stain
AFHC	Adolescent Friendly Health Clinic
ALS	Advanced Life Support
AMR	Antimicrobial Resistance
AMS	Antimicrobial Stewardship
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AST	Antimicrobial Susceptibility Testing
ATLS	Advanced Trauma Life Support
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy
BLS	Basic Life Support
BMO	Block Medical Officer
BMW	Bio-Medical Waste Management
BPHU	Block Public Health Unit
BPMU	Block Programme Management Unit
BSU	Blood Storage Unit
BWH	Birth Waiting Homes
CBWTF	Common BMW Treatment Facility
CCB	Critical Care Blocks
CCHFW	Central Council of Health and Family Welfare
CCU	Cardiac Care Unit
CDSR	Child Death Surveillance and Response
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Community Health Centre
CHO	Community Health Officer
COPD	Chronic Obstructive Pulmonary Disease
CPHC	Comprehensive Primary Health Care
CSR	Corporate Social Responsibility
CSS	Centrally Sponsored Scheme
CSSM	Child Survival and Safe Motherhood Program

ABBREVIATION	FULL FORM
CTG	Cardiotocography
D&C	Dilation and Curettage
DDC	District Development Committee
DEWAT	Decentralized Wastewater Treatment System
DH	District Hospital
DHAP	District Health Action Plan
DKA	Diabetic Ketoacidosis
DLC	Differential Leukocyte Count
DMHP	District Mental Health Programme
DPMU	District Programme Management Unit
DVDMS	Drugs and Vaccines Distribution Management System
DoNER	Ministry of Development of North Eastern Region
ECG	Electrocardiogram
ED	Emergency Department
EHR	Electronic Health Record
EmCrit	Emergency and Critical Care Training
EMR	Electronic Medical Record
EMTC	Emergency Medical Training Centre
ENT	Ear, Nose and Throat
ER	Emergency Room
ETP	Effluent Treatment Plant
EmONC	Emergency Obstetric and Newborn Care
FAST	Focused Assessment with Sonography for Trauma
FBNC	Facility-Based Newborn Care
FDSI	Free Drugs Service Initiative
F-IMNCI	Facility-Based Integrated Management of Neonatal and Childhood Illnesses
FP	Family Planning
FPLMIS	Family Planning Logistics Management Information System
FRU	First Referral Unit
FSTP	Faecal Sludge Treatment Plant
GDMO	General Duty Medical Officer
GPS	Global Positioning System
HAI	Hospital-Acquired Infection
HASD	Health Accounts Scheme Database
HDU	High Dependency Unit
HFR	Health Facility Registry
HMIS	Health Management Information System
HPR	Healthcare Professionals Registry
HRH	Human Resources for Health
Hb	Hemoglobin
IAPC	Indian Association of Palliative Care

ABBREVIATION	FULL FORM
ICU	Intensive Care Unit
IDSP	Integrated Disease Surveillance Programme
IEC	Information, Education and Communication
IHIP	Integrated Health Information Platform
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPC	Infection Prevention and Control
IPD	Inpatient Department
IPHL	Integrated Public Health Laboratory
IPHS	Indian Public Health Standards
ISQua	International Society for Quality in Health Care
IT	Information Technology
IUCD	Intrauterine Contraceptive Device
KPI	Key Performance Indicator
LBW	Low Birth Weight
LDR	Labour Delivery Recovery
LSAS	Life Saving Anesthesia Skills
LaQshya	Labour Room Quality
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDSR	Maternal Death Surveillance and Response.
MIS	Management Information System
MLC	Medico-Legal Case
MLCU	Midwifery-Led Care Unit
MMA	Medical Method of Abortion
MO	Medical Officer
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
MoHFW	Ministry of Health and Family Welfare
MoMA	Ministry of Minority Affairs
MoTA	Ministry of Tribal Affairs
NARS-Net	National AMR Surveillance Network
NBCC	Newborn Care Corner
NBSU	Newborn Stabilisation Unit
NCD	Non-Communicable Disease
NCDC	National Centre for Disease Control
NDMA	National Disaster Management Authority
NELS	National Emergency Life Support
NFHS	National Family Health Survey
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIKSHAY	National TB Elimination Programme Information System
NIMHANS	National Institute of Mental Health and Neurosciences

ABBREVIATION	FULL FORM
NMC	National Medical Commission
NPCBVI	National Programme for Control of Blindness and Visual Impairment
NPHCE	National Programme for Health Care of the Elderly
NPNCD	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke
NQAS	National Quality Assurance Standards
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NSSK	Navjaat Shishu Suraksha Karyakram
NTEP	National Tuberculosis Elimination Program
NTN	National Telemedicine Network
NUHM	National Urban Health Mission
OBGY	Obstetrics and Gynaecology
OOPE	Out-of-Pocket Expenditure
OPD	Outpatient Department
ORS	Oral Rehydration Solution
OT	Operation Theatre
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PFMS	Public Financial Management System
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PM-ABHIM	Pradhan Mantri – Ayushman Bharat Health Infrastructure Mission
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PMU	Project Management Unit
PNC	Post-Natal Care
PPE	Personal Protective Equipment
PPFP	Post-Pregnancy Family Planning
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPP	Public-Private Partnership
PRI	Panchayati Raj Institution
QA	Quality Assurance
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCHA+N	Reproductive, Maternal, Newborn, Child, and Adolescent Health + Nutrition
RTA	Road Traffic Accidents
SAANS	Social Awareness and Action to Neutralize Pneumonia Successfully
SAPCCHH	State Action Plan for Climate Change and Human Health
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal

ABBREVIATION	FULL FORM
SDH	Sub-District Hospital
SHC	Sub-Health Centre
SNCU	Special Newborn Care Unit
SOP	Standard Operating Procedure
SQAC	State Quality Assurance Committee
STEMI	ST-Elevation Myocardial Infarction
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infection
SUMAN	Surakshit Matritva Aashwashan
SWASTHYA	System for Wellness, Awareness, and Tracking Health in Youth & Adults
TB	Tuberculosis
TLC	Total leukocyte count
Tele-MANAS	Tele-Mental Health Assistance and Nationally Accessible Services
UCHC	Urban Community Health Centre
UHC	Universal Health Coverage
UHI	Unified Health Interface
UPS	Uninterrupted Power Supply
USG	Ultrasonography
WHO	World Health Organization
WHONET	World Health Organization Network
WIFS	Weekly Iron and Folic Acid Supplementation

SECTION 1: INTRODUCTION AND CONTEXT

1.1 The Imperative for Strengthening Emergency Referral Services: From CSSM to NHM

The journey towards strengthening emergency referral services in India's public health system has been evolutionary, marked by critical policy initiatives to reduce preventable mortality, particularly among mothers and newborns. The concept of the First Referral Unit (FRU) originated in 1992 with the implementation of the Child Survival and Safe Motherhood (CSSM) Programme. This initiative recognised the urgent need to upgrade existing Community Health Centres (CHCs) and Sub-District Hospitals to provide essential and emergency obstetric care (EmOC) closer to the communities they served. Under CSSM, central assistance was provided to states for identified facilities, primarily in equipment kits (including those for operation theatres and labour rooms), drug kits containing EmOC medicines, and funds for operationalising infrastructure and hiring critical workforce like Anaesthetists.

With the launch of the National Rural Health Mission (NRHM) in 2005, later subsumed under the broader National Health Mission (NHM) alongside the National Urban Health Mission (NUHM), the operationalisation of FRUs became an integral component of the national strategy. The NHM envisages achieving universal access to equitable, affordable, and quality healthcare services that are accountable and responsive to people's needs. Strengthening health systems, including infrastructure and human resources, particularly at the primary and secondary care levels, has been a core focus of NHM support to states and Union Territories (UTs).

Despite progress, the need for robust FRUs remains strong. Maternal mortality, though declining, is still above the SDG target of MMR <70 per lakh live births, with many deaths preventable through timely emergency care. Obstetric and neonatal complications, trauma and acute complications of NCDs require swift referral to well-equipped CEmONC and first-level referral facilities.

Although established decades ago, the FRU concept has faced persistent challenges in achieving consistent and widespread operationalisation. The initial focus, driven by the CSSM program, was heavily weighted towards emergency care in Maternal and Child Health. However, the evolving epidemiological landscape and the increasing recognition of other critical health emergencies, such as road traffic accidents and acute complications of NCDs and communicable diseases, demand a broader scope of services at the FRUs. The earlier approach of selecting and upgrading a limited number of facilities within a district to function as FRUs was pragmatic in resource-constrained settings but inherently restricted equitable and universal access to healthcare.

The revised guidelines, necessitated by the need to address historical gaps in FRU operationalisation, ensure they are equipped to handle the expanded scope of emergency and routine care today . Additionally, the ongoing conversion of District Hospitals into Medical Colleges under the Centrally Sponsored Scheme (CSS) has created a new urgency to strengthen CHCs to function as dependable First Referral Units. With district hospitals assuming a tertiary care and teaching mandate, the day-to-day secondary care load, including surgeries, deliveries, emergency and trauma management, and medico-legal services, as well as public health functions, must now be effectively handled at the block level. This calls for systematic investment in upgrading CHCs nationwide, decongesting higher facilities and enhancing community access.

1.2 Policy Shift: Towards Universal CHC-FRU Functionality

Community Health centers form an important link between primary, secondary and tertiary health care in the three-tiered public health delivery system. CHCs serve dual functions: as referral centres for Primary Health Centres and as direct-access facilities for specialist care, staffed with surgeons, obstetricians, gynecologists, physicians, and pediatricians. Strengthening the CHCs at the Block level by converting every CHC into FRU–CHC is an urgently needed step for improving health care delivery system. This document outlines the revised guidelines driven by a fundamental policy shift: the mandate to strengthen all existing and future Community Health Centres (CHCs), rural and urban, across India to function as fully operational First Referral Units (FRUs). Henceforth, these upgraded facilities will be referred to as CHC-FRUs.

The rationale for this universal approach stems from the core principles of equity and accessibility embedded within the NHM. Geographic barriers and delays in accessing emergency care contribute significantly to adverse health outcomes. The "golden hour" concept in trauma management underscores the critical need for immediate stabilisation. Similarly, timely intervention in obstetric emergencies, stroke, or acute cardiac events drastically improves survival rates and reduces long-term disability. Ensuring that every CHC functions as an FRU aims to bring comprehensive emergency services closer to the community, minimising travel time and ensuring that life-saving care is available to all citizens, irrespective of location. Typically, a block comprises about 100–120 villages, and a CHC functioning as an FRU caters to nearly 3-4 PHCs and around 20-25 SHC-AAMs, forming a critical link in the continuum of care. This contrasts sharply with the previous strategy, which recommended only 3–4 functional FRUs per district, potentially leaving a large population underserved. These guidelines, therefore, apply to all CHCs established under the public health system, providing a framework for their universal upgradation and sustained functionality as FRUs. The approach also aligns with the broader vision of Ayushman Bharat, which envisages a seamless continuum of care from the primary to the secondary level. By strengthening CHCs as FRUs, the system ensures that the 12 service packages of Ayushman Arogya Mandirs (AAMs) have clear and capable referral pathways, especially for emergency and inpatient care needs.

1.3 Alignment with National Health Goals and Standards

Strengthening all CHCs to FRU status is intrinsically linked to India's overarching health goals and standards. It directly contributes to the National Health Mission's objectives of reducing Maternal Mortality and Child Mortality, preventing and controlling communicable and non-communicable diseases, and ensuring universal access to integrated, comprehensive primary and secondary healthcare. NHM support has already led to a significant increase in the number of operational CHC-FRUs, from 940 in 2005 to 1588 by March 2025, alongside the operationalisation of over 12,000 24/7 PHCs, laying the groundwork for the universal expansion.

This strategy aligns seamlessly with the National Health Policy (NHP) 2017, which envisions attaining the highest possible health and well-being level through universal access to good quality healthcare services without financial hardship. It is also a critical step towards achieving Sustainable Development Goal 3 (SDG 3) – "Ensure healthy lives and promote well-being for all at all ages" – particularly targets related to maternal and child health, NCD mortality reduction, and achieving Universal Health Coverage (UHC). Also, as mandated under NHP 2017, CHCs must be strengthened to ensure effective emergency care and disaster preparedness. This includes training community first responders, developing disaster-resistant infrastructure, establishing mass casualty management protocols, and integrating CHCs into a unified emergency response system with ambulances and trauma centers to provide timely care during emergencies.

Crucially, these guidelines are built upon the foundation of existing national standards. The Indian Public Health Standards (IPHS) 2022 provide the definitive benchmarks for population norms,

infrastructure, human resources, services, equipment, quality, and governance requirements for public health facilities, including CHCs and FRUs. IPHS are designed to be the main driver for infrastructure planning and assessment reference point. The national goal, endorsed by the Central Council of Health and Family Welfare (CCHFW), is to achieve IPHS compliance (defined as scoring 80% or higher on assessment) for all health institutions by 2029. The IPHS 2022 update has clarified essential and desirable norms across health facilities for infrastructure, Human Resource (HR), services, and equipment. These norms must be read not as aspirational targets but as operational mandates. Furthermore, CHCs functioning as FRUs should also serve as platforms for testing innovations in digital health, referral tracking, and decentralised public health surveillance, which aligns with the goals of PM-ABHIM.

Complementing the structural and input standards of IPHS, the National Quality Assurance Standards (NQAS) provide the framework for assessing and improving care and outcomes. NQAS, which is ISQua-accredited (International Society for Quality in Healthcare) provides Quality Certification (QC) to the healthcare facilities, including FRU CHCs. Therefore, the universal CHC-FRU policy does not necessitate the creation of entirely new standards. Instead, it mandates the rigorous implementation of the existing, updated IPHS 2022 and NQAS frameworks within the context of providing safe, patient-centric comprehensive emergency and referral services at every CHC. The primary challenge these guidelines aim to address is bridging the gap between these established national standards and the current operational capacity of many CHCs, which requires significant investment in resources, systems strengthening, and capacity building.

1.4 Purpose and Structure of Revised Guidelines

The revised guidelines provide a comprehensive, standardised, and actionable framework for States and Union Territories (UTs) to effectively plan, implement, monitor, and sustain the upgradation of all CHCs to functional FRU status. They aim to ensure the consistent availability of quality routine, emergency and referral care across the country, contributing significantly to improved health outcomes. These guidelines consolidate requirements from various sources, including IPHS 2022, NQAS, previous FRU directives, and specific program guidelines, and supersede earlier FRU operationalisation guidelines where provisions differ.

Recognising the diversity across states and regions, the guidelines provide a national framework while allowing for flexibility in implementation to suit local contexts and needs, a principle embedded within IPHS and Rogi Kalyan Samiti (RKS) guidelines.

The subsequent sections of this document are structured as follows:

Section 2: Defines the CHC-FRU, outlines essential criteria for functionality, and clarifies its role in the district health system.

Section 3: Details the comprehensive package of services mandated for a functional CHC-FRU.

Section 4: Specifies the standards for infrastructure, equipment, and technology, including digital health integration and climate resilience.

Section 5: Outlines the human resource norms, staffing strategies, and capacity-building requirements.

Section 6: This section focuses on quality assurance mechanisms (NQAS), governance structures (including RKS), patient safety, and patient rights.

Section 7: This section addresses integrating future-ready components like digital health, climate adaptation, AMR surveillance, and pandemic preparedness.

Section 8: Provides an implementation framework, including rollout strategy, resource planning,

supply chain management, monitoring, and state-level adaptation.

Section 9: Presents the monitoring and evaluation framework. It defines key performance indicators (KPIs), data sources, digital tools, and reporting responsibilities at facility, district, and state levels. It also outlines mechanisms for feedback, course correction, and performance-based reviews.

Section 10: Concludes with key takeaways, a call to action for state and district health authorities, and the way forward for institutionalising CHC-FRUs as foundational units of a responsive, resilient, and patient-centred secondary healthcare system.

Section 11: Provides a comprehensive set of annexures and checklists to aid facility planning, readiness assessments, service monitoring, human resource tracking, and layout guidance. These tools are designed for easy use by implementers at facility and district levels.

Section 12: Lists all key references and documents used in formulating these guidelines, including relevant MoHFW guidelines, national health missions, IPHS standards, quality assurance frameworks, and digital health policies.

SECTION 2: THE CHC-FRU: DEFINITION, CRITERIA, AND ROLE

2.1 Revised Definition of a Functional CHC-FRU

A functional Community Health Centre-First Referral Unit (CHC-FRU) is a Community Health Centre located in a rural or urban area that fully meets the Indian Public Health Standards (IPHS) 2022 criteria for an FRU. It must be capable of providing, on a 24/7 basis, a comprehensive package of routine, emergency and referral services for a continuum of care. This includes but is not limited to, Comprehensive Emergency Obstetric and Newborn Care (CEmONC), Medical Termination of Pregnancy (MTP) services and Family Planning (FP) services, essential surgical interventions, emergency management of trauma, acute NCD and communicable disease complications, critical newborn care. The facility must have a functional blood storage and transfusion facility, 24/7 Oxygen availability and necessary diagnostic support (including X-ray and Ultrasound).

In addition to their clinical mandate, there is a need to strengthen the public health functions of CHC-FRUs through the Block Public Health Units (BPHUs), with a clearer and more emphatic role in mentoring and supportive supervision of linked PHCs and Sub Health Centres (SHCs). Strengthening the upward and downward referral network between facilities is essential.

This definition distinguishes a CHC-FRU from a non-FRU CHC, as defined in IPHS 2022. While a non-FRU CHC provides essential primary and secondary level care, including normal deliveries and stabilisation of common emergencies, it lacks the mandated 24/7 availability of specialists (or appropriately trained MOs acting in their capacity), a fully functional operation theatre capable of handling emergency surgeries like Caesarean sections, and an operational blood storage unit – all of which are defining characteristics of an FRU. ***The ability to perform emergency surgeries including C-sections and provide blood transfusions is a critical differentiator.*** These guidelines' definitions and criteria are explicitly derived from and aligned with the IPHS 2022 standards for FRU CHCs and FRU Urban CHCs (UCHCs).

Furthermore, the CHC-FRU is vital in the care continuum envisioned under Ayushman Arogya Mandirs (AAMs). It is expected to receive referrals and manage escalated cases related to the full spectrum of the 12 service packages, ranging from non-communicable diseases, communicable diseases, mental health, and elderly care to palliative and rehabilitative services. These guidelines, therefore, go beyond the traditional CEmONC definition and incorporate the requirements for handling broader clinical and emergency conditions aligned with evolving community needs and health system goals up to 2030.

2.2 Essential Criteria for Designation and Functionality

For a CHC to be designated and considered functionally operational as a CHC-FRU, it must meet the following mandatory criteria, largely based on IPHS 2022 requirements and the core FRU concept:

1. 24/7 Availability of Emergency Services: The facility must be equipped and staffed to handle emergencies round the clock.

2. Functional Operation Theatres (OTs): Two fully equipped and operational OTs capable of handling emergency surgeries, including Caesarean sections and other life-saving procedures, available 24/7. (one additional OT in 100 bedded UCHC FRU should be provisioned)

3. Emergency Obstetric Care & Surgical Capability: Demonstrated capacity to manage CEmONC, including performing Caesarean sections and managing major obstetric complications 24/7.

4. Anaesthesia Services: Anaesthesia services are available 24/7, either by a qualified Anaesthetist or an MBBS Medical Officer trained and certified in Life-Saving Anaesthesia Skills (LSAS).

5. Specialist/Skilled MO Availability: 24/7 availability (in-house or through a robust, documented on-call system or supported by telemedicine) of key specialists: Obstetrician & Gynaecologist, Paediatrician, Physician, Surgeon, Anesthesiologist, Ophthalmologist, ENT specialist and Orthopedician. Without specialists, appropriately trained and certified MBBS MOs (e.g., CEmONC, LSAS trained) must be available to provide equivalent emergency functions.

6. Newborn Care: The ability to provide essential and emergency newborn care, including resuscitation at birth, management of low birth weight/preterm babies, sepsis management, and stabilisation of sick newborns 24/7.

7. Functional Blood Storage Unit (BSU): An operational BSU licensed as per Drugs and Cosmetics Rules, with 24/7 availability of blood and capability for safe blood transfusion.

8. Essential Laboratory Services: 24/7 functional laboratory capable of performing essential investigations required for emergency management.

9. Referral Transport: Assured availability of functional referral transport (ambulance) owned or through a reliable contractual arrangement, for the timely transfer of patients requiring higher-level care.

In addition to these essential criteria, CHC-FRUs should be digitally enabled for emergency teleconsultation and support from tertiary hubs under the National Telemedicine Network (NTN) and e-Sanjeevani platforms. Given the increasing burden of trauma, NCDs, and geriatric care, FRUs must also be equipped for initial critical care management, oxygen therapy, and monitoring before referral. While infrastructure and HR availability may vary, states are encouraged to build these capabilities to make FRUs future-ready progressively.

Beyond these service capabilities, achieving and maintaining compliance with IPHS 2022 standards, aiming for a score exceeding 80%, is the benchmark for assessing overall functionality. The web-based IPHS dashboard facilitates self-assessment and monitoring.

Historical experience, reveals that many designated FRUs lacked the necessary specialists, blood storage, or consistent 24/7 service availability to be truly functional. Therefore, these revised guidelines emphasise operationalisation and sustained functionality. The focus must shift from achieving static targets to ensuring dynamic, reliable service delivery.

2.3 Role within the District Health System and Referral Network

The CHC-FRU is a cornerstone of the district health system's referral network. It is the designated first point of referral for all emergencies arising from the SHCs and PHCs, within its catchment area. Its primary role is to provide immediate, life-saving stabilisation and comprehensive management for obstetric, neonatal, paediatric, surgical, medical, and trauma emergencies.

The CHC-FRU functions as a critical gatekeeper, capable of definitively managing many

common emergencies, thereby reducing the burden on higher-level facilities. For complex cases requiring specialised interventions beyond its scope (e.g., advanced trauma surgery, neurosurgery, specialised cardiac care, intensive care beyond its capacity), the CHC-FRU plays a vital role in stabilising the patient and facilitating timely and appropriate referral to the District Hospital (DH), Medical College Hospital, or other specialised tertiary care centres.

The CHC-FRU, being part of the continuum of care, receives patients referred back from tertiary centres for continued management or follow-up. It provides outreach support and technical guidance to the PHCs and SHCs within its area. Effective functioning requires robust two-way communication and clearly defined referral protocols. District Health Action Plans (DHAP), developed under the NHM framework, may meticulously map these referral pathways, ensuring that emergency transport systems are aligned and patients are directed to the nearest functional CHC-FRU capable of providing the required care. Information regarding the location and services available at functional CHC-FRUs must be widely disseminated within the community.

As AAMs begin delivering the full range of 12 service packages under Comprehensive Primary Healthcare, they will increasingly refer cases requiring inpatient care, diagnostics, surgical intervention, and specialist management. The FRUs, as block-level hubs, must be geared to receive these referrals, offer comprehensive management, and ensure back-referral for follow-up care and community reintegration.

SECTION 3: COMPREHENSIVE SERVICE PACKAGE

The service package for a functional CHC-FRU is comprehensive, encompassing not only the traditional focus on maternal and child health emergencies but also expanded capabilities for management of trauma, NCD emergencies, and other critical care needs, aligned with IPHS 2022 and national program priorities.

3.1 Core Mandate: 24/7 Comprehensive Emergency Obstetric and Newborn Care (CEmONC)

The cornerstone of FRU services remains the provision of CEmONC, which is to be available round-the-clock. This package, based on IPHS 2022, the original FRU concept, and CEmONC training objectives, includes:

- **Delivery Services:** Management of normal and assisted (e.g., vacuum, forceps) vaginal deliveries 24/7 along with post-partum contraceptive services
- **Surgical Interventions:** Capability to perform emergency Caesarean sections and manage obstetric complications requiring surgery (e.g., ruptured uterus, ectopic pregnancy) 24/7.
- **Management of Obstetric Emergencies:** Prevention and management of Post-Partum Haemorrhage (PPH), eclampsia/pre-eclampsia using anticonvulsants (Magnesium Sulphate) etc. Availability of Magnesium Sulphate is a key indicator.
- **Management of Retained Products/Placenta:** Manual removal of placenta and management of retained products of conception (e.g., Manual Vacuum Aspiration - MVA, Dilatation & Curettage - D&C).
- **Newborn Care:** Essential newborn care includes thermal care, early initiation of breast feeding along with feeding support to mothers, infection prevention, childhood immunisation and screening. Crucially, this includes emergency newborn care: basic neonatal resuscitation (bag and mask ventilation), stabilisation and management of common neonatal problems like low birth weight (LBW), prematurity, birth asphyxia, and neonatal sepsis.
- **Blood Transfusion:** Availability and capability for safe blood transfusion services 24/7.
- **Pregnancy Monitoring and High-Risk Care:** FRUs are integrated with the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) program, ensuring that high-risk pregnant women are identified, tagged, and provided with focused antenatal care sessions at the FRU.
- **Midwifery-Led Care Unit (MLCU) & Physiological Birthing:** In a phased manner, FRUs may establish MLCUs and midwifery care services to promote physiological birthing practices, including support for alternative birthing positions, ensuring women-centered care.
- **Linkage with Birth Waiting Homes (BWH):** FRUs maintain active linkages with birth waiting homes, providing expectant mothers from remote or hard-to-reach areas with accommodation and care before delivery, enhancing timely access to emergency obstetric services.

Ensuring the quality of these services is paramount. Facilities must actively participate in quality improvement initiatives like LaQshya, which focuses on improving the quality of care in

Labour Rooms and Maternity Operation Theatres. Furthermore, facilities designated under the Surakshit Matritva Aashwasan (SUMAN) initiative, which aims to provide assured, dignified, and quality healthcare for mothers and newborns with zero tolerance for denial of service, must meet these CEmONC standards if designated at that level.

3.2 Neonatal and Child Healthcare Services at FRUs

Newborns and children are among the most vulnerable population groups and require timely, specialised care to prevent avoidable deaths and long-term morbidity. First Referral Units (FRUs) play a crucial role in providing comprehensive neonatal and child healthcare services, ensuring early identification, treatment, and referral of sick children and high-risk newborns after initial management.

FRUs should ensure the following services for newborns and children:

Newborn Care Services

- Skilled care at birth through Navjaat Shishu Suraksha Karyakram (NSSK) trained staff
- Kangaroo Mother Care and the promotion of exclusive breastfeeding
- Newborn Stabilization Units (NBSU): It is a 4 bedded unit for stabilization and management of small and sick newborns. In this unit, babies with mild illness such as birth asphyxia, hypothermia, jaundice, sepsis, along with stabilization and appropriate referral of sick babies.
- Screening and adequate management of common congenital conditions.
- Universal Immunization birth doses (BCG, OPV, Hep B)

Child Health Services (OPD)

- Screening, early detection, and treatment of common childhood illnesses as per IMNCI/F-IMNCI protocols
- Management of Childhood Pneumonia under the SAANS initiative, including oxygen therapy, antibiotics and referral support
- Diarrhoea/Dehydration management through ORS–Zinc supplementation and nutrition & hygiene counselling at ORS-Zinc corners.
- Malnutrition management using IMNCI/F-IMNCI protocols, with linkage to Nutrition Rehabilitation Centres (NRCs) for severe cases. Tribal / Aspirational districts may have a higher prevalence of severe malnutrition, necessitating the establishment of the Nutritional Rehabilitation Centres at the CHC-FRU level. Effective linkages of the NRCs with the community based ICDS facilities to be ensured.

Paediatric Ward (IPD)

Routine and emergency care for sick children, including inpatient management of common childhood illnesses (pneumonia, diarrhoea, malaria, fever etc) by the Paediatrician or trained Medical Officers supported by teleconsultations. For this,

- Availability of 4–6 pediatric beds (minimum), including thermal protection and feeding support
- Protocol-driven management of pediatric pneumonia, diarrhoea, sepsis and acute malnutrition

- Screening and management of common congenital disabilities, early developmental delays and ensuring community linkages for follow-up of high-risk children.

3.3 Family Planning and Contraceptive Services

Family planning and reproductive health are critical public health interventions that help reduce maternal and child mortality by preventing high-risk pregnancies, enabling healthy birth spacing, and meeting the national targets under the Family Planning 2030 commitments. As part of the Comprehensive Primary Health Care (CPHC) framework, CHC-FRUs must ensure universal access to the full range of contraceptive and reproductive health services.

Scope of Services

- **Counselling and Informed Decision making:** Provide confidential counselling to all clients on the full range of modern contraceptive methods, including side effects, reversibility, and ensuring informed decision making without coercion.
- **Contraceptive Services:**
  - » Spacing methods: IUCD (PPIUCD and interval IUCD), oral contraceptives, injectable contraceptives, condoms, and emergency contraceptive pills.
  - » Permanent methods: Female sterilisation (tubectomy/minilap) and male sterilisation (NSV), either through scheduled camps or on a regular basis.
- **Post pregnancy Family Planning (PPFP) including Postpartum & Post Abortion Family Planning:** Counselling for Contraceptive basket of Choice and awareness about Healthy Timing and Spacing between pregnancies.

Medical Termination of Pregnancy (MTP): Comprehensive Abortion Care (CAC) services shall be provided as per national guidelines, ensuring safety, privacy, and informed choice. Trained providers must deliver services with appropriate counselling, follow-up, and referral linkages.

- Safe abortion services as per the MTP Act (amended 2021), including:
  - » Medical abortion (MA) up to 9 weeks of gestation.
  - » Manual Vacuum Aspiration (MVA) for early surgical termination.
  - » Second-trimester MTP where trained obstetricians and facilities are available.
- **Infertility Management (Basic):** Counselling and referral for primary infertility cases.
- **Management of RTI/STI:** Screening and syndromic management of reproductive tract and sexually transmitted infections, with referrals to higher facilities if needed.
- **Cervical Cancer Screening:** Provision of VIA, Pap smear, HPV testing, and treatment of precancerous lesions, as applicable.

Infrastructure and HR Requirements

- Dedicated counselling space ensuring confidentiality, equipped with adequate IEC materials promoting family planning choices and rights, including cancer awareness.
- Installation of 4-5 Self-care kit (condom box) on strategic location like waiting area, Immunization room, OPD/IPD, Counseling Room, Drug dispensing area etc.
- Functional labour room for postpartum family planning services. Dedicated OT for

sterilisation procedures in line with IPHS norms.

- MTP room equipped as per GoI norms, with MVA kits available.
- At least one trained provider for IUCD insertion and one trained in minilap/Vasectomy & NSV procedures.
- FP counsellor (desirable) to support informed choice and post-abortion/postpartum counselling.

Service Delivery Norms

- Sterilisation services to be offered at least once a week; IUCD, oral, and injectable contraceptives to be available on all OPD days.
- Safe abortion and postpartum family planning services integrated with routine obstetric and gynaecological care.
- Documentation of all family planning acceptors in standard registers and digital systems (HMIS/FP-LMIS).
- Documentation of all failures, complications and deaths due to contraceptive methods should be maintained at the FRUs.
- Strict adherence to infection control, post-procedure observation, and follow-up protocols.
- Ensure no coercion or incentive-based bias in counselling and service delivery.

Referrals and Linkages:

- Cases requiring advanced infertility care, complications following sterilisation or abortion, or other reproductive health conditions that cannot be managed at CHC-FRU must be referred to higher-level facilities with complete documentation.
- Strong coordination with ASHAs and ANMs for community-based demand generation, counselling, and follow-up.

Training and Quality Assurance:

- All providers must be certified under GoI-approved family planning training modules and the MTP Act.
- Regular refresher and quality assurance training to be conducted for FP and MTP service providers.

3.4 Adolescent Health Services at FRUs

Adolescents form a significant part of India's population. The common health problems faced by Adolescents include anaemia, menstrual health problems, emotional stress, high risk pregnancies, high risk behaviour, accidents and violence. FRUs must serve as referral centers for the health needs of Adolescents and must be equipped to respond to these issues and provide confidential, safe, and adolescent-friendly services.

Every FRU should offer a dedicated Adolescent Friendly Health Clinic (AFHC). These clinics should function daily and have a trained MO and a counsellor providing health services and counselling support to boys and girls in the 10–19 age group. FRUs should ensure the following services for adolescents:

- **General Health Services:** Treatment for common conditions like skin infections, menstrual problems, reproductive tract infections, anaemia, and minor injuries.
- **Nutritional Support:** Screening for undernutrition/obesity, diet counselling and promotion of a healthy lifestyle with counselling on prevention of NCDs/Obesity.
- **Anaemia Management:** Regular screening for anaemia among adolescents using haemoglobin estimation methods, with appropriate management and referral.
- **Counselling Services:** One-to-one or group counselling sessions on issues like growing up, body image, mental health, handling exam stress, substance use, prevention of violence and reproductive health. These sessions must be private and non-judgmental.
- **Menstrual Hygiene:** Distribution of sanitary pads under the Menstrual Hygiene Scheme and counselling on safe practices including disposal.
- **Mental Health:** Early Identification of signs for depression, anxiety, or behavioural issues. Referrals should be made to district-level specialists or consultations can be supported through telemedicine, if required.
- **Referral Services:** Adolescents who need specialised care must be referred to district hospitals or medical colleges. All referrals must be tracked for follow-up.
- **Peer Educator Linkages:** FRUs should develop linkages with Peer Educators under the Rashtriya Kishor Swasthya Karyakram (RKSK) for referral of adolescents requiring further support at FRU.

The adolescent health services at FRUs must be linked with national programmes like RKSK, ICDS and the School Health and Wellness Programme under Ayushman Bharat. FRUs should also organise monthly review meetings with Medical Officers and CHOs of AAM-PHCs and AAM-SHCs to track service delivery and outreach activities for adolescents.

Infrastructure and HR Requirements: AFHC should be as per RKSK Guidelines

- A separate counselling room with privacy and seating space.
- A trained Adolescent Health Counsellor.
- IEC materials on nutrition, reproductive health, and mental well-being are in local languages.
- Registers and reporting formats to capture adolescent data separately.

FRUs must ensure that all services are adolescent-friendly, confidential, and stigma-free. All staff should be trained to be sensitive to adolescents' needs and treat them with respect and dignity.

3.5 Expanded Emergency Response: Trauma Stabilisation, Management of NCD Emergencies

In light of the rising burden of NCDs, trauma, and acute medical conditions, FRUs are now required to move beyond their traditional maternal and neonatal emergency care focus. The new mandate encompasses round-the-clock capability for **multi-dimensional emergency care,** consistent with India's evolving disease profile and aligned with **IPHS 2022.**

- **Trauma Care/ Stabilisation: CHC-FRUs must possess the capability for basic trauma care including stabilisation**, acting as a vital link in the trauma care chain. This involves applying Advanced Trauma Life Support (ATLS) principles and adhering to relevant Standard

Treatment Guidelines (STG).

- **Non-Communicable Disease (NCD) Emergencies:** NCD emergencies such as acute stroke, hypertensive emergencies, diabetic ketoacidosis (DKA), and ST-Elevation Myocardial Infarction (STEMI) require timely recognition, initial stabilisation, and rapid referral. CHC-FRUs should be equipped and staffed to provide essential emergency evaluation, basic stabilisation, and prompt coordination of referral using the Hub-and-Spoke model. This includes ensuring availability of essential diagnostics (e.g., ECG, glucose tests), emergency drugs, trained staff, and efficient ambulance linkages.
- **Other Acute Care:** Management of other common medical and surgical emergencies that fall within the scope of available specialists and resources, should be managed as per the STGs.

3.5.1 Strengthening Emergency and Trauma Care at CHC-FRU Level

Given the increasing burden of trauma-related morbidity and mortality, especially from road traffic accidents(RTAs) and occupational injuries, CHC-FRUs must be capable of delivering immediate trauma care. This is crucial given:

- The rising incidence of accidents & emergencies in peri-urban, rural, and remote areas.
- The shift of District Hospitals (DHs) towards medical college status has led to higher caseloads and calls for level specific care at all levels.
- The strategic need is to ensure that life-saving care is available closer to the community and in line with the principles of equity and accessibility.

Therefore, every CHC-FRU should establish and maintain a dedicated Emergency and Trauma Care Unit. This unit must operate 24/7, be adequately staffed, and be equipped to manage

- Stabilization (including airway and ventilation management) of Burns, Injuries & Polytrauma (e.g., application of splints, spinal immobilization, haemorrhage control).
- Poisoning, animal and snakebite cases.
- Stroke and cardiac emergency care (e.g., thrombolysis if feasible, referral if needed) .

All CHC-FRUs must have:

- A designated Emergency Room (ER) or Casualty Ward with a minimum of 4–6 beds (depending on catchment size) and an isolation ward with minimum 1-2 beds (depending on the catchment area) for highly infectious cases.
- A triage area with trained nurses and medical officers.
- Essential emergency equipment, including defibrillators, portable ventilators, ECG, oxygen supply, emergency drug tray, crash cart, suction apparatus, and patient monitors.
- Protocols for stabilization and timely referral using functional 108/102 emergency transport services.
- Establish Referral Linkages with nearby Critical Care Units, trauma centres for referrals, particularly in accident-prone corridors or industrial areas.

Dedicated medical emergency beds (minimum 2–4) must be earmarked, especially in high-volume CHCs.States may also explore Public-Private Partnership **(PPP) or contractual**

emergency specialists to fill HR gaps in critical geographies.

This level of readiness will significantly reduce preventable deaths from trauma and acute emergencies while decluttering district hospitals and enabling a **functional, resilient referral system**

3.5.2 Integration with National Emergency Response Framework

CHC-FRUs must be integrated into the broader national emergency response ecosystem. This includes linkage with platforms such as the **112 emergency response system, ambulance tracking systems, and State-level emergency operations centres.** This ensures seamless coordination for timely referrals, especially in time sensitive NCD and trauma emergencies.

Furthermore, CHC-FRUs should be mapped on digital dashboards and health facility registries (e.g., ABHA-linked HFR under ABDM), indicating their real-time functional status (especially for critical care beds, oxygen, trauma capability, etc.) to assist call centres, referral managers, and users/citizens.

Training under the **National Programme for NCDs (NP NCD)** should include simulation drills for hypertensive crises, DKA, acute coronary syndromes, and stroke triage. Wherever feasible, **teleconsultation support** for NCD emergencies (e.g., tele-stroke or remote cardiology advice) may be piloted and scaled-up using platforms like **e-Sanjeevani-HUB.**

Documentation and Protocol Display

To ensure consistency in managing emergencies and trauma, **Standard Treatment Guidelines,** issued by MoHFW, must be **visibly displayed** in the Emergency Department (ED), doctors' duty room, and nursing stations. Visual job aids, flowcharts, and laminated protocols in vernacular language (wherever required) can reduce decision time and ensure adherence, especially during night shifts or in facilities with frequent HR turnover. Training should be aligned with the National Emergency Life Support (NELS) curriculum.

3.6 Essential Surgical, Medical, Oral Care

CHC-FRUs are expected to provide routine secondary-level care while the current FRU model has successfully addressed emergency obstetric care, with a high focus on quality of services, there is a need to utilize the strengthened CHC- FRUs to handle the routine surgical and medical cases along with high burden of Trauma and RTA cases including but not limited to Trauma stabilization (e.g., fracture splinting, wound debridement, securing hemostasis), Minor surgical procedures (e.g., incision & drainage, foreign body removal) etc

Surgical Care

CHC-FRUs are expected to provide both elective and emergency surgical services as per IPHS norms, based on the availability of specialists such as General Surgeons, Obstetricians/ Gynaecologists, Anaesthetists, Ophthalmologist, ENT specialists. Facilities must be equipped to perform a wide range of minor surgical procedures including incision and drainage of abscesses, wound suturing, foreign body removal (skin, eye, ear, nose), dressing of burns and injuries, and management of animal bites with appropriate prophylaxis. A well-equipped minor OT or procedure room should be available, with all necessary surgical instruments, proper sterilisation facilities, and essential emergency medicines.

In addition, CHC-FRUs should be capable of delivering key common surgical interventions, such as appendectomy, hernia and hydrocele repair, treatment of haemorrhoids and fistula, foreign body removal, Caesarean sections, sterilisation procedures etc, and Medical Termination of

Pregnancy (MTP) services.

Medical Care

Inpatient management of common medical conditions by the physician or medical officers includes communicable/infectious diseases (malaria, typhoid, pneumonia, TB), exacerbations of chronic conditions (COPD, asthma), seizures, animal/snake bites, poisoning, and acute gastroenteritis etc. FRUs should be able to admit and manage the wide spectrum of medical conditions.

Oral care

CHC FRUs will provide a comprehensive range of oral health services including screening and diagnosis of oral cancers, patient counselling, and education on Oral Self-Examination to promote early detection. In alignment with the National Oral Health Programme, CHC FRUs will deliver essential dental services such as routine and emergency extractions, fillings, root canal treatments, and dental health education.

Human Resource and Support

A trained duty doctor and staff nurse must be present 24/7 to attend to cases. All medical officers should follow Standard Treatment Guidelines (STGs) and display them in the OPD and emergency areas for easy reference. Protocols for managing common emergencies must also be placed on record.

Essential drugs such as paracetamol, antibiotics, antihistamines, rehydration salts, antiseptics, and analgesics must always be available through the Free Drugs Service initiative.

Documentation and Monitoring

FRUs should maintain all the necessary registers and integrate all outpatient and emergency data into the Health Management Information System (HMIS). Cases requiring medico-legal attention (RTAs, assault injuries etc) must also be properly documented as per protocol.

- Daily medical rounds with the participation of Medical Officer, Staff Nurse, and Pharmacist/ Lab personnel.
- Weekly mortality review meetings for maternal, neonatal, and general deaths
- Maintenance of a *register of complications* and audit of referred cases

3.7 Integration with National Health Programmes

CHC-FRUs are crucial hubs for the delivery and monitoring of various National Health Programmes:

- **RMNCAH + N:** Provide comprehensive services related to Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition including antenatal care (ANC), intranatal care (deliveries), postnatal care (PNC), family planning (including laparoscopic sterilisation), safe abortion services, child immunisation, nutrition and adolescent health services.
- **Communicable Diseases:** Participate in programs like the National Tuberculosis Elimination Programme (NTEP), National Vector Borne Disease Control Programme (NVBDCP - Malaria, Dengue, etc.), National Leprosy Eradication Programme (NLEP), and Integrated Disease Surveillance Programme (IDSP).
- **Non-Communicable Diseases:** Function as sites for NCD Clinics under the National Programme for Prevention and Control of Non-Communicable Diseases (NP NCD), providing screening, follow up, diagnosis, treatment initiation, and management of common NCDs like HTN, DM, COPD/ Asthma. It should serve as First referral unit for screening and suitable management of Common cancers (Oral Cancer: Dentist, Cervical Cancer: Gynecologist and

Breast Cancer: Surgeon/ Gynecologist).

- **Other Programmes:** Support implementation of programmes like the National Programme for Control of Blindness & Visual Impairment (NPCBVI), Anaemia Mukt Bharat, Iodine Deficiency Disorders Control Programme, etc., as relevant to the CHC level.
- **PM-JAY Linkages:** Function as empanelled providers under Pradhan Mantri Jan Arogya Yojana (PMJAY), offering cashless secondary-level services, reducing out of pocket expenditure, and strengthening referral pathways at the block level.

CHC-FRUs must act as nodal platforms for implementing key national health programmes under NHM. They should coordinate closely with AAMs to ensure seamless delivery of the 12 CPHC service packages. Digital tools like HMIS, IDSP portal, and population-based screening data should be used for planning and review. Co-location of program units (e.g., IDSP, NCD clinics), periodic staff training, and integrated review meetings at the block level are essential for improving convergence and accountability.

3.8 Strengthened Linkages: Mental Health, Palliative Care, Geriatric Care

To provide truly comprehensive care, CHC-FRUs should integrate basic services and establish strong referral linkages for specialized needs:

Palliative and Geriatric Medical Care

With increase in India's ageing population and increasing NCD burden, FRUs should begin integrating:

- Palliative care for cancer patients and those with NCDs with complications.
- Home-based care linkages via CHOs or ANMs & ASHAs.
- Dedicated OPDs for geriatric care (2 days per week) with minimum services encompassing vision testing, screening for hearing loss, oral health and hygiene services, support for locomotor diseases, and screening/support for common Mental Illnesses including depression, Memory deficit etc.
- **Mental Health:** Training of health care providers (MOs, Nurses, Counsellors) to build up their skills in providing counselling support for mental health illnesses along with psychological first aid (PFA) skills to handle emergencies. The capacity building should enable early identification and adequate management of common mental disorders (depression, anxiety) and stabilization of emergencies before referral. Establish linkages with programs such as Tele-MANAS for mental health, tele-consultations and delineate clear referral pathways to the District Mental Health Programme (DMHP) team/ facilities.
- **Palliative Care:** Provide basic palliative care for patients identified with serious, life-limiting illnesses. This includes assessment and management of pain and other distressing symptoms, utilizing essential palliative care medicines (including oral morphine where legally permissible, available, and staff are trained), providing basic psychosocial and spiritual support, and counselling families. Establish referral linkages with specialized palliative care centres or community/home-based care teams. Training modules for CHOs and potentially MOs/Nurses are available and in the process of training. The focus is on improving the quality of life and ensuring dignity, including at the end of life.
- **Geriatric Care:** Implement basic geriatric assessment tools to identify vulnerability and specific needs among elderly patients (>60 years). Manage common geriatric syndromes (e.g., fall risk, incontinence, cognitive decline screening) within the facility's capacity. Ensure

the facility environment is age friendly. Link patients with services under the National Programme for the Health Care of Elderly (NPHCE), including rehabilitation services. Focus on a continuum of care encompassing preventive, promotive, curative, and rehabilitative aspects.

Integrating these services represents a move towards more holistic, patient-centered care at the FRU level. While CHC-FRUs may not provide specialist-level care in these domains, their role in early identification, initiation of basic management (especially symptom control in palliative care), and effective referral is crucial for improving patient outcomes and reducing the burden on specialized services. This necessitates incorporating relevant training modules and protocols into the standard functioning of the CHC-FRU.

In line with the 12-service package under the Comprehensive Primary Health Care (CPHC) approach, CHC-FRUs must integrate additional services that respond to the evolving disease burden and demographic transitions. These include structured linkages with programs such as Tele-MANAS for mental health consultations, availability of palliative care services for chronic and terminal illnesses, and establishment of geriatric clinics. Each FRU should identify dedicated spaces and designate trained personnel or establish teleconsultation networks to deliver these services efficiently.

Moreover, the FRU should develop an internal mechanism to track referrals made and follow-up care provided for such specialized services, ensuring continuity of care. This includes maintaining records, conducting patient satisfaction surveys, and coordinating with district-level programs for specialist inputs, in-person or through digital platforms under ABDM.

3.9 Diagnostic Capacity (Laboratory and Imaging)

Functional diagnostics are essential for supporting the service package:

Laboratory Services:

With the expansion of service packages under Ayushman Arogya Mandirs and the expected rise in caseloads due to increased referral and diagnostic demand, FRUs must also be equipped for point-of-care diagnostics tests. (details in Annexure 11). Linkages with Integrated Public Health Laboratories (IPHL) under PM-ABHIM should be established for advanced diagnostics and quality assurance.Integration with **IPHLs under PM-ABHIM** must go beyond quality assurance, including **specimen transport linkages, digital lab reporting, and district-level turnaround time monitoring**

Imaging Services

Functional X-ray and Ultrasonography (USG) services are essential as per IPHS. The capacity to perform Focused Assessment with Sonography for Trauma (FAST) is desirable for trauma management at FRU. FRUs, especially those serving high-traffic or remote regions, should be considered for portable ultrasound services and tele-radiology tie-ups, especially where radiologists are not posted. The availability of ultrasound must also ensure gender-sensitive protocols and registration under adherence to PCPNDT guidelines. Where feasible, basic echocardiography should be planned for the 2025–2030 horizon.

3.10 Blood Services (Storage and Transfusion)

A defining feature of FRU is its blood service capacity:

Blood Storage Unit (BSU): A mandatory, functional, and licensed BSU operating 24/7 is required. This requires appropriate refrigeration, inventory management, and trained personnel adhering

to guidelines by GoI and Drugs and Cosmetics Rules. In districts where FRUs are distant from District Blood Banks, states should explore **hub-and-spoke models** for blood component delivery and adopt **digital blood inventory management systems** (e.g., e-Rakt Kosh) at all BSUs. Each BSU must maintain a **stock-out alert mechanism** and participate in **monthly audits of blood usage, wastage, and cross-matching times.**

Transfusion Capacity: The facility must be able to perform safe blood transfusions round-the-clock when indicated, particularly for obstetric haemorrhage, severe anaemia, and trauma. Capacity building must also include training for MOs and nurses in timely identification and managing transfusion reactions. Facilities must ensure SOPs for **medico-legal aspects of transfusion , and blood usage for trauma and maternal emergencies.**

3.11 Medico-Legal Service Provision

CHC-FRUs, being emergency care providers, must be equipped to handle Medico-Legal Cases (MLCs) appropriately and efficiently:

- **Identification and Registration:** Medical Officers must be trained to identify potential MLCs (including trauma, assault, poisoning, burns, sexual offences, brought dead cases under suspicious circumstances, criminal abortions, attempted suicide, etc.) and register them appropriately in the MLC register. Treatment remains the priority, but documentation should proceed concurrently.
- **Examination and Documentation:** Conduct thorough medico-legal examinations following standard procedures. Documentation must be meticulous, legible, and objective, avoid abbreviations or overwriting (corrections must be authenticated), and capture all relevant findings, history, and identification marks. Use standardized forms where available.
- **Consent:** Obtain written informed consent for examination and treatment. Specific procedures apply for unconscious patients (consent from next of kin) or minors. Document refusal of examination/treatment.
- **Evidence Collection and Handling:** Collect, preserve, pack, seal, and label medico-legal evidence (e.g., clothing, swabs, gastric lavage fluid, blood samples) as per established protocols. Maintain chain of custody and hand over samples promptly to the investigating police officer, obtaining a receipt.
- **Reporting and Communication:** Prepare medico-legal reports accurately and objectively. Intimate the jurisdictional police station promptly upon identifying an MLC. Provide reports and records to authorized legal authorities upon request.
- **Dying Declaration:** Understand the procedure for facilitating or recording a dying declaration if a patient is deemed capable and death is imminent, following legal requirements (e.g., certifying fitness, presence of witnesses, avoiding leading questions).
- **Record Keeping:** Maintain all MLC-related documents (registers, case sheets, reports) securely and confidentially, often for extended periods (potentially lifetime or until case closure) as per state/national guidelines.
- **Training:** Regular medical and nursing staff training on medico-legal procedures, documentation, and ethical responsibilities is essential.

SECTION 4: INFRASTRUCTURE, EQUIPMENT, AND TECHNOLOGY STANDARDS

Ensuring that CHC-FRUs can deliver a comprehensive service package requires adherence to rigorous standards for physical infrastructure, equipment, and, increasingly, technology integration. These standards are primarily based on IPHS 2022, supplemented by requirements for the expanded scope of services and future readiness.

4.1 Physical Infrastructure Norms (IPHS 2022)

Compliance with the infrastructure norms in the IPHS 2022 guidelines for CHCs/UCHCs is mandatory for all facilities being upgraded to or functioning as CHC-FRUs. Key aspects include:

- **Bed Strength:** The essential bed strength varies based on the facility type and location, as defined in IPHS 2022:
  - » Rural FRU CHC: Minimum 30 essential beds. A 50-bedded configuration is desirable, particularly if additional specialist services like ophthalmology or orthopaedics are offered.
  - » Urban FRU UCHC (Non-Metro Cities): Minimum 50 essential beds.
  - » Urban FRU UCHC (Metro Cities - population > 1 million): Minimum 100 essential beds.
- **Layout and Space Allocation:** Facilities must adhere to the functional space requirements and suggested layouts in the IPHS 2022 CHC guidelines (Annexure 7). This includes adequate, well-demarcated space for critical areas such as:
  - » Emergency/Casualty Department (with triage, resuscitation, and observation areas).
  - » Operation Theatre Complex (including pre-op post-op areas).
  - » Labour Delivery Recovery (LDR) Complex (designed as per NQAS standards).
  - » Newborn Care Corner (NBCC) within the Labour Room/ Labour OT and 4 bedded Newborn Stabilization Unit (NBSU) and functional linkage with level II care facility (FBNC guideline).
  - » Intensive Care Unit (ICU) / High Dependency Unit (HDU): Required in higher bed strength facilities (e.g., 100-bedded UCHC) or where critical care services are planned, adhering to relevant space and design norms.
  - » Blood Storage Unit (BSU).
  - » Laboratory and Medical Imaging (X-ray, USG) sections.
  - » The Outpatient Department (OPD) has adequate waiting areas and consultation rooms.
  - » Inpatient Department (IPD) wards (Male, Female, Paediatric, Maternity).
  - » Pharmacy / Drug Dispensing Counter (DDC).
  - » Administrative areas, Stores, etc.
- **Accessibility:** The facility must be easily accessible by public transport and ambulance services. Infrastructure must be barrier-free and friendly for elderly patients and Persons

with Disabilities, complying with the Rights of Persons with Disabilities Act, 2016.

- **Future Expansion:** Site selection and layout planning should incorporate considerations for potential expansion of services or bed capacity.

4.2 Essential Equipment and Consumables List

The availability of functional equipment is non-negotiable for FRU services.

- **Compliance:** Facilities must ensure the availability of all essential equipment as per IPHS CHC 2022 guidelines and specific guidelines for services like CEmONC, trauma care, and NCD management.(details in Annexure 12)
- **Critical Equipment:** This includes, but is not limited to:
  - » **Operation Theatre:** Anaesthesia machine with ventilator, multi-parameter monitors, defibrillator, electrosurgical unit, OT table and lights, essential surgical instrument sets (for general surgery, C-section, MTP, etc.).
  - » **Labour Delivery Recovery Room:** Delivery tables/beds, radiant warmers, neonatal resuscitation kits (Adult and Newborn Ambu bag, masks, laryngoscope), foetal doppler/ CTG machine, multi-parameter monitors.
  - » **Emergency/Casualty**: Resuscitation equipment (ventilator - transport/basic, defibrillator, monitors), ECG machine, pulse oximeters, infusion pumps, emergency drug trolleys, and immobilization devices (splints, collars, spine boards).
  - » **Newborn Care**: Radiant warmers, phototherapy units, Neonatal Laryngoscope set, Self-inflating bag & mask (neonatal), Suction Pump, infusion pumps, Transcutaneous Bilirubinometer, glucometer with strips, pulse oximeters, KMC chairs and oxygen delivery systems.
  - » **Blood Storage Unit:** Validated blood bank refrigerators with temperature monitoring and alarm systems.
  - » **Laboratory:** Microscopes, centrifuges, basic analysers (haematology, biochemistry), incubators
  - » **Imaging:** Functional X-ray machine (fixed or mobile) and Ultrasound machine
- **Equipment Maintenance**: A robust system for preventive maintenance, calibration, and timely equipment repair must be established, with dedicated budgets and potentially Annual Maintenance Contracts (AMCs).
- **Supply Chain Management:** Reliable systems must be in place to ensure the uninterrupted availability of essential drugs, consumables (sutures, dressings, IV fluids, syringes, gloves etc), reagents for laboratory tests, and other logistics. Linkages with systems like the Drug & Vaccine Distribution Management System (DVDMS) should be leveraged.

4.3 Support Services Infrastructure

Functional support services are the backbone of clinical operations:

- **Utilities**
  - » **Electricity:** Assured, stable 24/7 electricity supply is mandatory. Adequate power backup (generators with sufficient fuel supply, potentially US for critical equipment) must cover essential areas like OT, LR, Emergency, BSU, Laboratory, and critical care areas.
  - » **Water:** Round-the-clock supply of safe, potable piped water with adequate storage

capacity is essential. Norms suggested for district hospitals (approximately 450-500 litres per bed per day) can serve as a guide and be adjusted for the context of CHC. Water quality monitoring should be regular.

- **Referral Transport and Linkages:** An effective referral transport and linkage system is central to the functionality of an FRU-CHC, ensuring seamless patient movement across different levels of care. The FRU-CHC must maintain robust upward linkages with the designated Sub-District Hospital (SDH) or District Hospital (DH) for specialized and advanced interventions, while also sustaining downward linkages with non-FRU CHCs and Primary Health Centres (PHCs) to facilitate timely referrals and back-referrals for continuity of care.

  Each FRU should have at least one functional ambulance, preferably a Basic Life Support (BLS) vehicle, and where feasible, an Advanced Life Support (ALS) ambulance linked to higher centres for transfers of critical patients. Ambulance services may be owned or arranged through reliable contractual partnerships with round-the-clock availability. Integration with state-wide or district-level centralized ambulance networks (such as 108 services) is essential for rapid mobilization, reducing referral delays, and optimizing emergency response times. A referral register and communication protocol must be maintained at both sending and receiving facilities to ensure accountability, feedback, and patient tracking. Strengthening digital connectivity through telemedicine support or digital referral systems can further enhance coordination, particularly in remote areas. This integrated referral mechanism not only improves clinical outcomes but also reinforces the FRU-CHC's role as a pivotal node within the district health delivery continuum.

- **Waste Management:** Strict adherence to the Bio-Medical Waste (BMW) Management Rules, 2016 (and subsequent amendments) is mandatory, which includes proper segregation at source using colour-coded bins, appropriate collection, transportation, treatment, and disposal, either through in-house facilities (like autoclaves, shredders where appropriate) or linkage with a Common BMW Treatment Facility (CBWTF). General waste management and safe liquid waste disposal/sewage treatment are also required. In addition, a separate drainage system for effluents generated from various service areas to an Effluent Treatment Plant (ETP) must be in place so that all effluents are treated before discharge. Provision of an ETP, based on estimated effluent load and separate from sewage treatment, is mandatory for health facilities with more than 10 beds under the BMW Rules. A Faecal Sludge Treatment Plant (FSTP) using the Decentralised Wastewater Treatment System (DEWATS) method is also recommended as a greener and climate-resilient option, allowing treated wastewater to be reused for gardening/landscaping and dried sludge to be used as manure.

- **Sanitation and Hygiene:** Maintaining high standards of cleanliness and hygiene throughout the facility is crucial for infection prevention and patient experience, which includes functional, clean, and gender-segregated toilets for patients and staff, regular cleaning schedules, and adherence to protocols promoted under initiatives like Kayakalp.

- **Pharmacy Services:** A well-organized Drug Dispensing Counter (DDC) with adequate space for storage (following proper storage conditions) and drug dispensing must be available. Adherence to principles of rational drug use and the Free Drugs Service Initiative (FDSI), ensuring the availability of essential medicines free of cost, is expected.

- **Communication Systems:** Reliable internal and external communication systems, including functional telephone lines and internet connectivity, are essential for coordination, referrals, and telemedicine.

- **Laundry and Linen:** Provision of clean linen is essential. As per IPHS, mechanized laundry services are ideally located at the SDH/DH level. However, larger FRUs (>50 beds) may need dedicated arrangements if outsourcing is not feasible or reliable.

- **Dietary Services:** Hygienic kitchen and dietary services are required for admitted patients,

following IPHS norms.

- **Security:** Adequate security arrangements must be in place to ensure the safety of patients, staff, and assets.
- **Patient Feedback System:** Create mechanisms for capturing patient feedback, at least at the time of discharge and take timely and appropriate action on such feedback. (Mera Aspataal, Jan Sunwai and Jan Sanwad must be encouraged)

Biomedical Waste Management and Infection Control Equipment

In addition to patient care equipment, FRUs must be equipped with functional and compliant systems for biomedical waste segregation, transport, and disposal. Every CHC-FRU must have:

- Colour-coded bins and bags as per BMW 2016 rules.
- Needle destroyers and hub cutters are available at all service delivery points.
- Autoclaves or linkage to CBWTF.
- Hand hygiene stations and sanitiser dispensers in all wards, OT, and OPD.
- Routine audits for infection prevention and control (IPC) must be institutionalized.

4.4 Disaster Preparedness and Response

- **Structural Safety:** Compliance with seismic and other relevant safety codes to withstand local hazards.
- **Fire Safety**: Strict adherence to the National Building Code fire safety norms, with installation and maintenance of fire detection and suppression systems (extinguishers, hydrants where applicable), clear evacuation routes, and regular fire drills.
- **Emergency Plans:** Develop and update facility-level disaster management plans to address floods, heatwaves, cyclones, and earthquakes, including strategies to maintain essential services during emergencies (As per IPHS CHC guidelines 2022 Annexure 5).

Environmental Safety

- **Waste Management:** Implement scientific, biomedical and general waste management protocols to avoid contamination and disease transmission.
- **Pollution Control:** Minimise air, water, and soil pollution from facility operations.

SECTION 5: HUMAN RESOURCES FOR HEALTH (HRH): NORMS AND CAPACITY BUILDING

Human resources are critical to the functionality of FRUs, as even the best infrastructure remains underutilised without an adequate and skilled workforce. As CHCs transition into full-service FRUs providing continuum of care for the 12 service packages under CPHC, staffing norms must be reviewed and realigned to address newer responsibilities such as critical care, medico-legal services, mental health, geriatric, and palliative care. The availability of adequate, skilled, and motivated personnel is therefore the most critical determinant of CHC-FRU functionality. Achieving universal upgradation will require strict adherence to IPHS norms, strategic deployment, and continuous capacity building.

5.1 Minimum Staffing Norms (IPHS 2022)

Compliance with the HRH norms specified in the IPHS 2022 guidelines for FRU CHCs/UCHCs, corresponding to the designated bed strength (30, 50, or 100 beds), is mandatory. States must ensure recruitment and placement to meet these minimum essential requirements detailed in Annexure 9. Key cadres include:

- **Specialists:** The core specialist team essential for FRU functioning includes a Physician, Surgeon, Obstetrician & Gynaecologist, Paediatrician, Anaesthetist and Dentist. Their 24/7availability (in-house or on-call) is critical. Depending on bed strength and scope (particularly for 50/100 bedded UCHCs or 50-bed rural FRUs), additional specialists like Ophthalmologist, Orthopaedic Surgeon, ENT Surgeon, Radiologist, and Psychiatrist are desirable.
- **Medical Officers (MBBS):** Adequate number of General Duty Medical Officers (GDMOs) are required to ensure 24/7coverage for emergency services, OPD, IPD, and managing national health programs. While IPHS provides overall numbers, specific ratios like 1 MO per 10 critical care beds and 1 per 20 non-critical beds, as suggested for Critical Care Blocks (CCB), could be deployed at the FRU, especially if HDU/Step-down beds are operationalized.
- **Nursing Staff:** This includes Staff Nurses, Nursing assistants and a Matron/Assistant Nursing Superintendent, depending on facility size. Adherence to specified nurse-to-bed ratios is crucial for quality care. Specialized roles like Nurse Practitioner in Critical Care or Nurse Practitioner Midwife represent potential future enhancements.
- **Allied Health Professionals:** Essential cadres include pharmacists, laboratory technicians, radiology technicians, OT technicians, ECG technicians and clinical psychologist. Depending on services offered and IPHS norms for bed strength, others like Ophthalmic Assistants, Dental Assistants/Hygienists, Physiotherapists, and Counsellors (for RMNCAH + N, NCDs, HIV/AIDS, Mental Health, and Family Planning) are required.
- **Support Staff:** Includes administrative staff (Hospital Manager for larger facilities, Clerical staff, Data Entry Operators), cleaning staff (Safai Karamcharis/Housekeeping), security personnel, laundry and kitchen staff etc.

Rational Deployment and Retention Strategy

Given the difficulty in posting full-time specialists in remote blocks, states may implement:

- Cluster-based pooling of specialists within 2–3 nearby blocks.
- Roving specialist teams (OBG, surgeon, anaesthetist etc) with pre-defined schedules.
- Rural posting allowances and promotion-linked incentives for specialists posted in FRUs.
- Tie-ups with medical colleges for mentoring, pooling of specialists from medical colleges for fixed day consultations, DNB postings, DRP postings or faculty deputation.
- Capacity Building for Multiskilling with performance linked incentives.
- Optimal Utilization of Tele Medicine/Tele Radiology Services.

5.2 Strategies for Ensuring Specialist and Skilled MO Availability

The shortage of specialists, particularly Anaesthetists and Obstetricians/Gynaecologists, in public health facilities, especially in rural and remote areas, remains a major bottleneck for FRU operationalization. Addressing this requires a multi-pronged strategy:

- **Recruitment and Retention:** States must prioritize transparent and timely recruitment processes. Attractive innovative retention strategies are needed, potentially including attractive financial incentives (core or performance-linked), provision of good quality residential accommodation, ensuring a safe and supportive work environment, and establishing clear pathways for career advancement.
- **Task-Shifting/Sharing through Training:** Recognizing the specialist gap, a key strategy initiated over a decade ago is to train MBBS MOs in specific life-saving skills. This approach is not merely supplementary but a core requirement for achieving universal FRU functionality. Mandatory participation in and deployment after completion of these competency-based trainings is crucial:
- **Comprehensive Emergency Obstetric and Newborn Care (CEmONC) Training:** This revised 24-week (6-month) residential program equips MOs with the skills to manage obstetric emergencies, perform C-sections, and provide essential newborn care. Successful completion and certification are essential for MOs expected to provide CEmONC services without an OBGY specialist.
- **Life-Saving Anaesthetic Skills (LSAS) Training:** This revised 24-week (6-month) residential program trains MOs to administer safe anaesthesia for emergency obstetric surgeries and other life-saving procedures. Given the critical shortage of Anaesthetists, LSAS-trained MOs are indispensable for making C-section services available 24x7 at FRUs.
- **Other Essential Skill Training:** Shorter training like Basic Emergency Obstetric and Newborn Care (BEmOC) for newly recruited MOs (10 days), training package on Newborn Stabilization for MOs and Staff Nurses (3 days) placed at Newborn Care Unit, Skilled Birth Attendant (SBA) training for ANMs/Staff Nurses (21 days), revised Navajat Shishu Suraksha Karyakram (NSSK) for Staff Nurses/ ANMs appointed at labour room, basic trauma life support (based on ATLS principles or courses like EMTC), management of NCD emergencies, and basic critical care skills for MOs and nurses are also vital for the FRU team

Expanding the Scope of Task Shifting

In addition to LSAS and CEmONC training, the following training should be institutionalised:

- **EmCrit (Emergency and Critical Care):** For MOs to manage trauma, shock, poisoning, and acute emergencies.
- **Certificate in Mental Health (DMHP/NIMHANS-approved modules):** This certificate is for GDMOs who handle outpatient mental health cases.
- **Geriatric and Palliative Care modules:** For in-charge medical officers to lead home-based palliative interventions and elderly-friendly services.
- **Medico-Legal Documentation and Injury Assessment:** Especially for MOs handling emergency and assault cases.
- **Rational Deployment:** Posting trained personnel strategically is the key. Pairing CEmONC and LSAS-trained MOs, piloted in models like the "Buddy Buddy" system, can enhance confidence and service delivery. Ensuring that specialists and trained MOs are posted to designated FRUs and retained there is crucial to avoiding mismatches between infrastructure and workforce.
- **Hub-and-Spoke Models & Telemedicine:** Leveraging technology can help bridge gaps. Establishing formal hub-and-spoke linkages between CHC-FRUs and District Hospitals/ Medical Colleges can facilitate specialist support, including tele-mentoring and consultations via platforms like e-Sanjeevani. This allows specialists at the 'hub' to guide MOs at the 'spoke' (CHC-FRU) in managing complex cases.

5.3 Comprehensive Capacity Building Plan

Continuous need assessment based on supportive supervision should translate into capacity building for all staff categories at the CHC-FRU to ensure quality service delivery and adaptation to evolving needs:

- **Induction and Orientation**: All newly recruited staff must undergo a structured induction program covering their roles and responsibilities, facility protocols (including emergency codes referral pathways), patient rights, medico-legal aspects, and relevant national health programs.
- **Clinical Skills Enhancement:**
  - » Regular, competency-based refresher training on CEmONC, essential newborn care, integrated management of childhood illnesses (IMNCI), trauma stabilization (ATLS principles), management of emergencies, basic critical care skills, and management of common medical/surgical conditions relevant to FRU level.
  - » Hands-on skills training using simulation and skills labs (e.g., Daksh and Dakshta programs for RMNCAH + N skills).
- **Quality and Patient Safety:** Training on NQAS standards and assessment methodology, Infection Prevention and Control (IPC) protocols (including hand hygiene, standard precautions, biomedical waste management), patient safety practices (medication safety, surgical safety checklist use), and medico-legal documentation requirements.
- **Digital Health Literacy:** Training on the effective use of HMIS, RCH portal, PMSMA portal, MPCDSR portal, e-Sanjeevani, ABDM platform components (ABHA, HFR, HPR), CPHC-NCD application etc, and basic computer/IT skills for data entry, reporting, and accessing online resources.
- **Soft Skills Development:** Training on attitude, behavior and effective communication skills (doctor-patient, inter-professional), patient counselling, delivering respectful and dignified

care (especially maternal care), teamwork, ethical conduct, and stress management techniques should be conducted regularly.

- **Programmatic Updates:** Periodic training on updates and guidelines related to National Health Programmes being implemented through the CHC-FRU
- **Leadership and Management:** Specific training for facility in-charges, RKS members, and senior staff on leadership, team management, financial management, supply chain management, supervision skills, and quality improvement methodologies.
- **Emerging Health Issues:**
  - » **Climate Change and Health:** Sensitization and training modules for health workers on the local health impacts of climate change, early warning systems, management of climate-sensitive diseases (e.g., heat stroke), and facility-level adaptation measures.
  - » **Antimicrobial Resistance (AMR):** Training on principles of AMR, interpretation of antibiograms, antimicrobial stewardship practices (rational prescription, de-escalation), IPC measures for AMR prevention, and AMR surveillance protocols.

5.4 Roles, Responsibilities, and Performance Expectations

- **Clarity of Roles:** Job descriptions for all positions should be clearly defined, outlining specific roles, responsibilities, and reporting relationships, as provided in Annexure 10.
- **Accountability and Performance:** Implement a transparent performance appraisal system linked to defined responsibilities, adherence to protocols, and contribution to quality indicators. Team-based incentives linked to performance, and career progression opportunities could be explored, where feasible .
- **Team-Based Approach:** Foster a culture of collaboration, trust, mutual respect, and effective communication among all cadres of staff (doctors, nurses, paramedics, support staff) to ensure coordinated patient care. CHC-FRUs should adopt a team-based approach led by the medical officer in charge, supported by specialists (or trained GDMOs), nurse practitioners, staff nurses, paramedics, lab staff, and community workers. All team members should have clear job descriptions, undergo regular refresher training, and participate in monthly team reviews to track service quality and gaps.
- **Professional Conduct and Safety:** All staff must adhere to professional codes of conduct, maintain patient confidentiality, and provide care with dignity and respect, ensuring gender sensitivity. The facility management must ensure necessary safety measures for HRH, including providing appropriate Personal Protective Equipment (PPE), promoting standard precautions and hand hygiene, displaying relevant SOPs, regular safety training, and ensuring necessary immunizations for healthcare workers.

SECTION 6: QUALITY ASSURANCE, GOVERNANCE, AND PATIENT RIGHTS

Institutionalizing Governance and Accountability Systems

Every CHC-FRU must be governed through robust, transparent institutional mechanisms. The Rogi Kalyan Samiti (RKS) must be functional, meet quarterly, and include community representatives, Panchayati Raj Institute (PRI) members, and local NGOs where possible. Facility-level governance should include the following:

- Clear **Standard Operating Procedures (SOPs)** for service delivery, infection control, biomedical waste management, fund utilization and referral handling.
- Monthly **facility quality review meetings** to assess patient outcomes, complaints, grievance redressal, and performance against IPHS indicators.
- **Digital dashboards** for monitoring OPD/IPD numbers, births, emergency cases, and stock status of drugs and diagnostics.

Ensuring high-quality care, robust governance, and the protection of patient rights are fundamental to the successful functioning of CHC-FRUs. This requires adherence to national quality standards, effective oversight mechanisms, and a patient-centric approach.

6.1 Mandatory Adherence to NQAS and Pathway to Certification

The National Quality Assurance Standards (NQAS) are the primary framework for defining, measuring, and improving the quality of care at all levels of care including CHC-FRUs.

- **NQAS Framework:** NQAS provides a comprehensive set of standards broadly arranged under eight "Areas of Concern": Service Provision, Patient Rights, Inputs, Support Services, Clinical Care, Infection Control, Quality Management, and Outcome. These standards and their measurable elements and assessment tools guide facilities in improving processes and achieving better patient outcomes.
- **Mandatory Certification:** All CHC-FRUs are mandated to implement NQAS and actively work towards achieving certification, first at the State level and subsequently at the National level. States should establish a clear timeframe for achieving certification as part of their implementation plans. NQAS certification should be linked to performance monitoring and potential incentives.
- **Assessment Process:** Facilities should utilize the official NQAS assessment tools (checklists and assessor guidebooks specifically designed for CHCs/FRUs) for regular self-assessment to identify gaps and guide improvement efforts. Periodic internal and external assessments should complement this as part of the certification pathway.
- **Integration of Quality Initiatives:** Achieving NQAS certification requires a holistic approach. Facilities should integrate and leverage other national quality initiatives:
  - » **Kayakalp:** Focuses on improving hygiene, sanitation, and cleanliness within the facility,

contributing to infection control and patient experience.

- **LaQshya:** Specifically targets quality improvement in labour rooms and maternity OTs, directly impacting the quality of CEmONC services.
- **SUMAN:** Ensures assured, dignified, and quality maternal and newborn care with zero denial of services; SUMAN-notified facilities must meet high-quality standards, aligning with NQAS.
- **MusQan:** ensures quality child health services through well-equipped Newborn Stabilization Units (NBSUs), dedicated paediatric wards, and functional Nutritional Rehabilitation Centres (NRCs) in alignment with NQAS.
- **Mera Aspataal:** A platform for capturing patient feedback, providing valuable insights into patient satisfaction and areas needing improvement.

6.2 Strengthening Clinical Governance, Patient Safety, and IPC

Robust clinical governance structures and practices are essential for ensuring safe and effective care:

- **Clinical Governance Framework:** CHC-FRUs must establish and implement a strong clinical governance framework. This includes:
  - **Clinical Audits:** Regularly conducting clinical audits (e.g., audit of C-sections, antibiotic use, AEFIs, specific procedures) and mortality reviews (confidential review of maternal, neonatal, and child deaths) to identify systemic issues and improve practices.
  - **Adherence to STGs:** Ensuring clinical care follows nationally approved Standard Treatment Guidelines (STGs) and protocols.
  - **Evidence-Based Practice:** Promoting the use of current evidence-based practices in clinical decision-making.
  - **Continuous Professional Development:** Facilitating ongoing learning and skill development for clinical staff (linked to Section 5.3).
- **Patient Safety Culture:** Actively promoting a culture of patient safety is paramount. This involves implementing specific safety protocols, such as:
  - Safe medication storage and administration practices (e.g., checking drug allergies, correct dosage, proper labelling).
  - Safe surgical practices, including mandatory use of the WHO Surgical Safety Checklist.
  - Accurate patient identification procedures.
  - Structured and effective communication during patient handovers (e.g., using SBAR - Situation, Background, Assessment, Recommendation).
  - Measures to prevent patient falls.
  - Implementing risk management strategies, potentially guided by frameworks like the MoHFW's Risk Management Framework Manual for District Hospitals, adapted for the CHC-FRU context.
- **Infection Prevention and Control (IPC):** Implementing comprehensive IPC measures is critical not only for patient safety (preventing Healthcare-Associated Infections - HAIs) but also for combating Antimicrobial Resistance (AMR). IPC measures are fundamental for pandemic preparedness as well. Key IPC practices include:
  - Strict adherence to hand hygiene protocols.
  - Appropriate use of Personal Protective Equipment (PPE).

- » Rational Use of Drugs
- » Safe injection practices.
- » Proper sterilization and disinfection of instruments and equipment.
- » Maintaining environmental cleanliness.
- » Effective biomedical waste management (as detailed in Section 4.3).
- » Strengthening of mortality audits and reviews to identify gaps in IPC practices and improve patient safety.

6.3 Empowering Rogi Kalyan Samitis (RKS) for Oversight and Community Engagement

Rogi Kalyan Samitis (Patient Welfare Committees) or Hospital Management Societies play a vital role in governance at the facility level. For CHC-FRUs, their role should be strengthened:

- **Mandate and Functions:** RKS should actively function as oversight bodies, monitoring and ensuring the quality and availability of services, ensuring patient rights are upheld, promoting community participation in hospital management, and facilitating the mobilization and appropriate utilization of resources (including untied funds, user fees where applicable, donations) primarily for patient welfare activities. They should ensure the facility environment is clean, safe, and patient-friendly.
- **Constitution and Functioning:** RKS must be constituted per the latest MoHFW guidelines, ensuring representation from local elected officials, health officials, community members (including women), NGOs, and potential donors. Regular meetings (Governing Body quarterly, Executive Committee more frequently) with proper documentation are essential. Robust financial management practices must be followed, including maintaining separate bank accounts mapped to PFMS, proper accounting, and annual audits.
- **Empowerment for Local Action:** Appropriate financial and administrative powers should be delegated to the RKS Executive Committee and the Facility-in-charge to enable timely decision-making for addressing local needs, undertaking minor repairs, procuring emergency supplies, or contracting essential support services (like cleaning security).
- **Community Accountability Link:** The RKS serves as a crucial platform for making the CHC-FRU accountable to the community it serves, facilitating dialogue, feedback, and collaborative problem-solving.

6.4 Upholding Patient Rights and Grievance Redressal

A patient-centric approach requires safeguarding patient rights and providing avenues for feedback and redressal:

- **Display and Adherence to Patient Charter:** The Citizens' Charter or a clearly defined Patient Rights Charter must be prominently displayed in local languages throughout the facility, and all staff must be oriented to adhere to its principles.
- **Informed Consent:** Robust processes must be in place to obtain and document valid informed consent before any examination, procedure, or treatment, ensuring the patient (or legal guardian) understands the risks, benefits, and alternatives.
- **Confidentiality and Privacy:** Patient information must be kept confidential, and privacy must be respected during consultations, examinations, and procedures.

- **Respectful and Non-discriminatory Care:** All patients must be treated with dignity, respect, and courtesy, regardless of gender, caste, religion, socio-economic status, or health condition. Ensure respectful maternity care practices.
- **Grievance Redressal Mechanism:** A clearly defined, accessible, and responsive grievance redressal mechanism must be established at the CHC-FRU. Information on how to complain should be displayed. The RKS can play a role in overseeing this mechanism. Complaints should be acknowledged, investigated, and addressed on time.
- **Patient Feedback:** Actively solicit and utilize patient feedback through mechanisms like suggestion boxes and the Mera Aspataal platform to identify areas for service improvement.

Clinical and Administrative Audits

FRUs must institutionalise:

- **Clinical audits:** Review of maternal deaths, neonatal deaths, stillbirths, child deaths, trauma case outcomes, referrals, Exit Interviews, Patient satisfaction surveys and medico-legal documentation.
- **Administrative audits:** Functionality of OTs, equipment uptime, adherence to maintenance schedules, and inventory control.
- **Community scorecards or citizen feedback systems:** to gather real-time patient satisfaction reports through platforms like Mera Aspataal.

SECTION 7: FUTURE-READY CHC-FRUS: INTEGRATION AND ADAPTATION

To remain effective and relevant in a rapidly changing health landscape, CHC-FRUs must proactively integrate emerging technologies and adapt to evolving challenges like climate change, antimicrobial resistance, and future pandemics.

7.1 Leveraging Digital Health for Enhanced Care and Efficiency

Strengthening digital health systems is a core requirement for modernizing CHC-FRU operations and ensuring seamless care delivery, real-time reporting, and interoperability across levels of the health system.

Digital Health Infrastructure:

- **Connectivity:** Reliable, high-speed broadband internet is essential for all digital health functions, including reporting, telemedicine, and EHR use.
- **Hardware:** Adequate functional computers, printers, scanners, webcams, and—where relevant—tablets or smartphones for clinical and data management staff (e.g., MOs, nurses, DEOs, pharmacists).
- **Software and Platforms:** CHC-FRUs must ensure the use of and integration with key national digital health systems:
  - **Health Management Information System (HMIS):** For routine performance reporting with emphasis on data quality and timeliness.
  - **RCH Portal:** For registration and tracking of maternal and child health services (ANC, PNC, delivery, immunization).
  - **National Programme Portals:** Including NIKSHAY for TB and CPHC-NCD for screening and management of NCDs.
  - **eSanjeevani:** Infrastructure and trained staff for HUB and SWASTHYA platforms to support teleconsultations, referrals, and remote specialist advice.

Integration with ABDM

CHC-FRUs must ensure full alignment with the Ayushman Bharat Digital Mission to enhance service accessibility and data exchange. Each facility must:

- Register on the Health Facility Registry (HFR) and ensure that all service providers are enrolled on the Healthcare Professionals Registry (HPR).
- Facilitate ABHA ID creation for all patients and promote linkage of digital health records.
- Prepare for integration with the Unified Health Interface (UHI) to support interoperability and digital health service delivery.

Electronic Health Records (EHR) and Digital Documentation

- Adopt progressive EHR/EMR systems with basic modules for OPD/IPD documentation, laboratory services, pharmacy management, and discharge summaries.
- Move towards phasing out paper-based records to improve accuracy, accessibility, and continuity of care.
- Telemedicine and Remote Support
- Enable telemedicine readiness for including specialist outreach, remote monitoring (where applicable), and continuing medical education for staff.
- Use e-Sanjeevani-HUB and SWASTHYA platforms for real-time teleconsultation and referral tracking.

Digital Dashboards and Real-Time Monitoring

- Use digital dashboards to monitor service availability—such as blood stock levels, bed occupancy, and emergency preparedness.
- Ensure visibility of dashboards to call centres, district authorities, and higher facilities to support real-time triaging, routing, and emergency management.

7.2 Building Climate-Resilient Services and Infrastructure

Climate change poses significant threat to health and health systems. CHC-FRUs must be designed and operated with resilience, environmental safety, and sustainability as core principles. Facility planning and operations must align with national guidelines on climate-resilient health systems, NDMA norms, SAPCCHH frameworks, and global climate action commitments.

Climate-Resilient Infrastructure

- **Context-Responsive Design:** Incorporate structural features suited to local climate risks—elevated plinths and efficient drainage in flood-prone areas; earthquake-resistant construction in seismic zones; wind-resistant design in cyclone zones; passive cooling, improved ventilation, and heat-resistant materials in high-temperature regions.
- **Water Security:** Install rainwater harvesting, groundwater recharge systems, and mechanisms to protect water storage tanks from contamination during floods or other extreme events.
- **Energy Security:** Ensure uninterrupted power supply for essential services through reliable backup systems, including solar or hybrid renewable power—especially for lighting, blood storage, vaccine refrigeration, and water heating—contributing to low-carbon, climate-friendly operations.
- **Infectious Disease Preparedness:** Include designated isolation spaces and ensure alignment with national pandemic preparedness protocols.

Integrated Planning and Systems Strengthening

- **Comprehensive Climate Adaptation Planning:** Integrate climate considerations into infrastructure design/retrofitting, service delivery protocols, water and energy management, and supply chain logistics. Actions must be guided by State/District Action Plans for Climate Change and Human Health (SAPCCHH).
- **Surge and Disaster Readiness:** CHC-FRUs in coastal, tribal, or disaster-prone areas must include surge capacity, waterproofing, safe storage of supplies, and emergency evacuation provisions per NDMA health sector guidelines.

Surveillance for Climate-Sensitive Health Risks

Strengthen surveillance for climate-linked illnesses—heat-related conditions, vector-borne diseases (e.g., malaria, dengue), and water-borne diseases (e.g., cholera, typhoid). Ensure strong linkages with BPHUs, IPHLs, and IDSP/IHIP units at district, state, regional, and national levels for early warning, coordinated response, and timely public health action.

Climate-Specific Preparedness and Response

- Develop and operationalize local hazard-specific plans—such as Heat Action Plans, flood response and continuity plans, and protocols for service restoration after extreme events.
- Ensure that emergency workflows maintain uninterrupted essential services during climate shocks.

Workforce Capacity for Climate-Resilient Health Services

Incorporate training modules on the health impacts of climate change, management of climate-sensitive diseases, disaster preparedness, and facility-level climate resilience measures into routine capacity-building programs for all staff.

Green and Sustainable Operations

Adopt green infrastructure and sustainable practices, including:

- LED lighting, energy-efficient appliances, solar heating, and rooftop solar panels where feasible.
- Rainwater harvesting, greywater recycling for toilets or landscaping, and water-efficient fixtures.
- Green landscaping to reduce heat load and improve air quality.
- Bio-digester toilets or eco-friendly sewage systems in rural or water-scarce areas.
- Implement measures to minimize environmental footprint through efficient energy use, renewable energy adoption, water conservation, and effective waste management.

7.3 Role in AMR Surveillance, Stewardship, and Pandemic Preparedness

CHC-FRUs are critical nodes in the national response to Antimicrobial Resistance (AMR) and future pandemics:

- **AMR Surveillance:** CHC-FRUs should participate in the National AMR Surveillance Network (NARS-Net) as guided by the National Centre for Disease Control (NCDC). This involves collecting relevant clinical samples (e.g., blood cultures), performing standardized bacterial identification and Antimicrobial Susceptibility Testing (AST), and reporting quality data using designated platforms like WHO Network (WHONET). This data informs national and global surveillance (GLASS) and guides treatment protocols.
- **Antimicrobial Stewardship (AMS):** Implement robust AMS programs within the CHC-FRU. Key components include:
  - » Promoting rational antimicrobial prescribing based on National Treatment Guidelines and local antibiogram data (developed using surveillance results).
  - » Educating prescribers and patients on appropriate antibiotic use.
  - » Implementing measures to optimize antibiotic use (e.g., formulary restrictions, prospective

audit and feedback where feasible).

  - » Reducing unnecessary antibiotic use, particularly for viral infections or where bacterial co-infection is unlikely (a lesson reinforced during COVID-19).

- **Infection Prevention and Control (IPC):** Recognize that strong IPC practices (Section 6.2) are fundamental to both preventing the spread of resistant organisms (AMR containment) and limiting transmission during infectious disease outbreaks (pandemic preparedness). Consistent adherence to IPC is non-negotiable.
- **Pandemic Preparedness and Response:** CHC-FRUs must be prepared to play a crucial role during future pandemics or major outbreaks, leveraging lessons learned from COVID-19. This includes:
  - » **Surveillance:** Participating in enhanced surveillance activities, including syndromic surveillance reported by frontline workers and reporting unusual clusters of illness.
  - » **Testing:** Facilitating sample collection for diagnostic testing and coordinating with designated laboratories.
  - » **Case Management:** Providing initial assessment, stabilization, and management of cases as per national guidelines, potentially in designated isolation areas if required.
  - » **Maintaining Essential Services:** Develop business continuity plans to ensure that essential FRU services (especially CEmONC trauma care) remain available even during a public health emergency.
  - » **Coordination:** Strengthening linkages with the broader public health system (IDSP, NCDC) and participating in One Health initiatives that recognize the interconnectedness of human, animal, and environmental health in driving zoonotic diseases and AMR.

Digital integration, climate resilience, AMR control, and pandemic preparedness are interconnected priorities. Strengthening core systems IPC, laboratory capacity, supply chains, and digital platforms supports early detection, effective response, and continuity of care during health emergencies. CHC-FRUs must adopt an integrated approach across these areas and participate in the ICMR AMR surveillance network, reporting antimicrobial use and resistance patterns as per national protocols.

In addition to linking with IDSP, the CHC-FRU must function as a node in the District Public Health Response Unit under PM-ABHIM. It should:

- Conduct syndromic surveillance using HMIS, IDSP, and eSanjeevani follow-ups.
- Participate in block-level mock drills for disease outbreak response, fire safety, and disaster scenarios.
- Have clear protocols for stockpiling essential supplies and evacuation plans, updated annually.

7.4 NQAS Certification

All CHC-FRUs must progressively achieve National Quality Assurance Standards (NQAS) certification. This must be treated as a quality improvement process through internal assessments, mentoring, peer learning, and third-party evaluation. Facilities must designate quality teams, conduct monthly internal audits, and enter data on Kayakalp and NQAS dashboards. Certification ensures patient-centric care and institutional accountability. Training of FRU staff on quality indicators and documentation formats must be part of the routine induction plan.

SECTION 8: IMPLEMENTATION FRAMEWORK AND STRATEGIC RECOMMENDATIONS

The implementation of FRU guidelines and successfully upgrading all CHCs to functional FRU must follow a structured, phased approach aligned with the state's capacity, infrastructure readiness, and human resources availability, robust monitoring, and strong national, state, and district leadership.This will ensure that functional First Referral Units (FRUs) are progressively made available across all blocks, delivering the 12 assured services and effectively managing emergency and referral care.

8.1 Phased Rollout Strategy for Universal Upgradation

States must prepare a **block-wise prioritisation list** of CHCs to be converted into FRUs, a phased approach is recommended:

Comprehensive Facility Assessment: States/UTs must conduct a rapid, standardised assessment of all existing CHCs against these revised FRU guidelines, utilising IPHS 2022 assessment tools and NQAS checklists. This assessment should quantify gaps in infrastructure, specific equipment, human resource availability (by cadre), essential drug/supply availability, and current service delivery capacity (especially for 24/7 emergency services, C-sections, and blood storage).

- **Prioritisation and Phasing: Based on the gap analysis, states should develop a prioritised** phasing plan for upgradation. Prioritisation criteria could include:
  - » CHCs in High Focus Districts/States or Aspirational Districts/Blocks.
  - » CHCs located in remote or underserved areas with poor access to higher facilities
  - » Facilities serving populations with poor health indicators (high MMR/NMR/IMR/U5MR).
  - » Facilities with existing potential (e.g., better infrastructure, some specialist availability) that require less investment for full functionality.
  - » Clear, realistic timelines should be set for achieving functional FRU status for CHCs in each phase.
- **State and District Action Plans:** States/UTs must translate this policy into actionable plans. This requires developing detailed District Health Action Plans and incorporating these into the annual State Programme Implementation Plans (PIPs) submitted under NHM. These plans must clearly outline the following:
  - » Facility-specific gap analysis results.
  - » Specific activities are planned for infrastructure upgradation, equipment procurement, and HR recruitment/training/deployment.
  - » Detailed timelines for each facility/phase.
  - » Quantified resource requirements (financial, human, material).
  - » Monitoring indicators and mechanisms.
  - » These prioritised facilities must be integrated into District Health Action Plans (DHAPs) and reflected in annual PIPs under NHM and PM-ABHIM.

PHASE	DURATION	FOCUS	EXPECTED OUTCOMES
Phase I – Planning	0–6 months	Gap assessment, prioritisation, budgeting	FRU list finalised, IPHS gaps documented
Phase II – Upgradation	6–24 months	Infrastructure strengthening, HR deployment, and procurement	50% priority FRUs upgraded
Phase III – Integration	24–36 months	Digital systems, referral linkages, and M&E setup	Facility dashboards live, e-Sanjeevani operational
Phase IV – Certification	36–48 months	NQAS assessment, quality teams, external audit	Certified FRUs with sustained performance

8.2 Resource Planning and Financial Considerations

Significant investment is required for universal CHC-FRU upgradation:

- **Funding Sources:** States should strategically leverage multiple funding streams:
  - **National Health Mission (NHM):** Utilize funds available under various NHM components, including Infrastructure Maintenance, RCH Flexipool, NUHM Flexipool, and potentially specific allocations for FRU strengthening. NHM allows significant portions of funds for infrastructure.
  - **PM Ayushman Bharat Health Infrastructure Mission (PM-ABHIM):** Where applicable (districts meeting criteria), funds under PM-ABHIM for establishing Critical Care Hospital Blocks can potentially complement FRU strengthening, particularly for ICU/HDU development.
  - **State Budgets:** State governments must allocate substantial funds to supplement central funding.
  - **Rogi Kalyan Samitis (RKS):** Utilize funds generated locally by RKS (user fees where appropriate, donations) for patient welfare activities, minor repairs, and potentially bridging critical gaps in consumables or emergency drug procurement.
  - **Public-Private Partnerships (PPP):** Explore potential PPP models for specific non-clinical services (e.g., diagnostics, ambulance, sanitation) or for specialist service provision, ensuring alignment with public health goals and affordability.
  - **Leveraging CSR and other funds:** CSR funds can also be strategically leveraged to support infrastructure development, procurement of essential equipment, and capacity-building initiatives at FRUs. In addition, funding may also be mobilised from ministries such as the Ministry of Development of North- Eastern Region (DoNER), Ministry of Minority Affairs (MoMA), Ministry of Tribal Affairs (MoTA), Ministry of Mines, Ministry of Coal, as well as from international and national donor agencies.
- **Financial Management:** Strict adherence to NHM financial management guidelines is essential. This includes ensuring the timely release of funds from state to district to facility level, robust tracking of expenditure (utilizing PFMS mapping for all accounts, including RKS), prevention of fund parking, timely submission of utilization certificates, and regular audits (statutory and concurrent) covering all NUHM/NRHM funds, including those managed by RKS.

8.3 Interdepartmental Convergence

Coordination between **engineering wings, human resource cells, procurement divisions, and**

state quality assurance units is essential. Each state should designate a **nodal officer for FRUs** to anchor activities across departments and ensure timely implementation.

8.4 Strengthening Supply Chains and Logistics

Consistent availability of essential supplies is critical for 24x7 functionality:

- **Drugs and Consumables:** Implement robust supply chain management systems, potentially leveraging platforms like the Drug & Vaccine Distribution Management System (DVDMS), to ensure uninterrupted availability of all essential drugs (including emergency medicines for CEmONC, trauma, NCDs, anaesthesia, palliative care (opioids etc), diagnostic reagents, and medical consumables including vaccines at the CHC-FRU level. Buffer stocks for critical items should be maintained. This must address the supply availability gaps previously identified in facilities. Linkages with the Free Drug and Diagnostic Service Initiative must ensure essential medicines and diagnostics are provided free of cost.
- **Equipment Procurement and Maintenance:** Streamline procurement processes to ensure the timely availability of standardised, quality equipment meeting IPHS specifications. Establish clear protocols, dedicated budgets, and accountability for regular preventive maintenance, calibration, and timely repair/replacement of equipment, potentially through centralised or regional biomedical engineering support services.
- **Blood Logistics:** Ensure efficient and reliable logistics for sourcing blood units from licensed blood banks, safe storage within the BSU (maintaining cold chain), and inventory management to prevent expiry and ensure emergency availability.

8.5 Monitoring, Supervision, and Supportive Guidance

FRU implementation must be monitored using monthly progress reports from Block PMUs, supported by real-time dashboards (HFR, IPHS tracker). States must:

- Conduct quarterly review meetings chaired by the Mission Director.
- Include FRU performance as a standing agenda item in State Health Society meetings. Flag high-priority gaps requiring MoHFW support

Effective implementation requires continuous monitoring and support:

- **Supportive Supervision:** Shift from traditional inspection-based supervision to a model of regular supportive supervision. State and district teams should visit CHC-FRUs to provide mentoring, facilitate problem-solving, reinforce protocols, and support quality improvement efforts rather than merely identifying faults.
- **Technical Support:** Ensure that CHC-FRUs have ongoing technical support from district and state program officers, specialists from higher centres, and designated technical support institutions like Regional Resource Centres or academic partners.
- **Performance Monitoring and Review:** Conduct regular performance reviews at district and state levels, utilising the M&E framework and KPIs outlined in Section 9.2. Data from HMIS, IPHS dashboard, NQAS portal, and other relevant sources should be triangulated and used actively for data-driven decision-making, identifying underperforming facilities or districts, and allocating resources or support accordingly.
- **Accountability Mechanisms:** Strengthen accountability at all levels – facility in-charge, district health officials, state program managers – for achieving and sustaining FRU functionality targets.

8.6 State/UT Level Adaptation and Action Planning

While these guidelines provide a national framework, successful implementation hinges on state-level ownership and adaptation:

- **Contextual Adaptation:** States/UTs are encouraged to adapt these national guidelines to their specific geographical, epidemiological, and resource contexts while ensuring adherence to the core principles, essential criteria, and minimum standards outlined herein.
- **Inter-departmental Coordination:** Establish strong coordination mechanisms at the state and district levels between the Department of Health and Family Welfare and other relevant departments/agencies responsible for infrastructure (Public Works Department), electricity supply, water and sanitation, IT infrastructure, and human resource management/ recruitment, to ensure timely support for CHC-FRU upgradation.
- **Capacity Building Execution:** States must take ownership of planning and executing the comprehensive capacity-building plan (Section 5.3). This includes identifying and accrediting suitable training sites (Medical Colleges, DHs) for specialised training like CEmONC and LSAS, ensuring adequate trainers, and facilitating staff release for training.
- **Communication and Advocacy:** Develop and implement a clear communication strategy to disseminate these revised guidelines to all stakeholders, including healthcare providers at all levels, facility managers, RKS members, Panchayati Raj Institutions, and the community. Advocate for the importance of functional CHC-FRUs and promote community engagement in supporting their local facilities.

Each state should nominate a **State FRU Nodal Officer** and form an **FRU Coordination Cell** at the state level. NHSRC will provide technical support in training, gap assessments, monitoring toolkits, and quality certification readiness.

Monthly progress reviews must be conducted at the district level and quarterly at the state level to track progress using dashboards and corrective actions.

8.7 Role of Technical Partners and NHSRC

NHSRC, along with development partners and public health institutions, will support the states in:

- Orientation and training of state/district teams.
- Developing and validating FRU operational checklists.
- Handholding states in achieving NQAS certification.

Building a national knowledge portal for FRU best practices and innovations.

SECTION 9: MONITORING AND EVALUATION FRAMEWORK

9.1 Purpose of Monitoring

Monitoring and evaluation (M&E) ensure that FRUs operate efficiently, deliver quality services, and continuously improve based on data and field evidence. It is essential to track progress, ensure accountability, and drive continuous improvement in CHC-FRU functionality. A structured M&E system enables early identification of service gaps, ensuring corrective actions, and evidence-based planning. It also builds transparency and accountability across all levels-facility, block, district, and state.Given the historical challenges in ensuring designated FRUs were functional, this framework must move beyond tracking inputs (like infrastructure completion) to focus rigorously on processes and outcomes indicative of sustained 24/7quality service delivery.

9.2 Key Performance Indicators (KPIs)

- **Key Performance Indicators (KPIs)**: Specific, measurable, achievable, relevant, and time-bound (SMART) KPIs must be defined aligned to national targets and tracked. These should cover:
  - **Service Availability:** % of days/shifts specialists/trained MOs are available, % of days OT is functional, % of days BSU is functional with adequate stock.
  - **Service Utilization:** Number and rate of C-sections, number of complicated deliveries managed, number of newborns resuscitated/managed, number of trauma/NCD emergencies stabilized, blood transfusion utilization.
  - **Quality Indicators:** NQAS assessment scores, compliance rates with key protocols (e.g., surgical safety checklist), infection rates (HAIs).
  - **Outcome Indicators:** Facility-based maternal deaths and maternal near miss cases, neonatal mortality rate, case fatality rates for key conditions (e.g., PPH, eclampsia, severe trauma), patient satisfaction scores (Mera Aspataal).
  - **Input/Process Indicators:** Availability of essential drugs and equipment (stock-out rates), adherence to referral protocols, and staff training completion rates.
- **Data Collection and Reporting Systems:** Leverage existing digital platforms:
  - **Sign and share single login if available**
  - **HMIS:** For routine delivery and input data.
  - **IPHS Dashboard:** This is used to track compliance with IPHS standards.
  - **NQAS Portal:** This is for tracking progress towards NQAS certification.
  - **NCD Portal:** For NCD data
  - **RCH Portal:** For detailed RMNCAH + N indicators.
  - **PMSMA Portal**: For ANC screening, high-risk pregnancy detection and follow-up
  - **FBNC portal:** For tracking sick and small newborns admitted in NBSUs and further management (including referral)

- » **MPCDSR Portal:** To report, review, and monitor maternal, perinatal, and child deaths.
- » **NHM MIS Reports:** For state and national aggregation of FRU functionality status.
- » Ensure mechanisms for timely, accurate, and complete data entry at the facility level.

- **Monitoring Levels and Frequency**
  - » **Facility Level:** Internal monitoring by a dedicated quality team and regular review by the facility in charge and RKS.
  - » **District Level:** Monthly/Quarterly reviews by the District Quality Assurance Committee (DQAC) and District Health Society, analysing data from all CHC-FRUs.
  - » **State Level:** Periodic reviews by State Quality Assurance Committee (SQAC) and State Health Society, monitoring district performance and providing support.
  - » **External Assessment:** Periodic external assessments for NQAS certification and potentially supportive supervision visits by state/regional teams.

Performance Monitoring Framework for FRUs

DOMAIN	INDICATOR	TARGET
IPHS Compliance	The facility meets ≥80% essential criteria	All FRUs within 3 years
Service Coverage	>100 deliveries/month and >75% bed occupancy. For Hilly and tribal areas: >65 deliveries/month and >50% bed occupancy	Progressive increase
Emergency Response	% of trauma/emergency cases stabilized before referral (out of total emergency cases registered)	≥90%
Maternal Health	% of C-sections conducted (out of total indicated* deliveries) at FRU vs. referred **Cases with indication for c-section*	≥80% managed locally
Newborn Health	% of newborns treated/ managed (successful discharge) at NBSU (out of total newborn admission)	>80%
Child Health	% of children treated/ managed (successful discharge) at Paediatric Ward (IPD)	>80%
CAC Services (MMA)	% MTP against total abortion	Progressive monitoring
Maternal Deaths	% maternal deaths against total registered cases **(should include death of a woman from direct or indirect obstetric causes, during pregnancy + childbirth / within 42 days of its termination)*	Progressive reduction
Neonatal Deaths	% newborn deaths against live births	Progressive reduction
Referral Linkage	% referred cases with documentation and tracking (out of total referred cases)	100%
Digital Integration	Real-time reporting on HMIS dashboard	Monthly
HR Deployment	Availability(%) of sanctioned specialists in place/ trained Medical Officers	≥80%

DOMAIN	INDICATOR	TARGET
Patient Feedback	A monthly scorecard from Mera Aspataal or similar	≥80% Satisfaction
NQAS Progress	Number of FRUs internally assessed or certified	Progressive by year 3

Data Use for Improvement: Establish clear feedback loops where monitoring data is regularly analyzed and discussed at review meetings (facility,block, district, state). These loops are used to identify bottlenecks, prioritize interventions, implement and track the impact of corrective actions.

9.3 Tools and Platforms for Monitoring

Facilities and states must use the following tools and digital platforms:

- Health Management Information System (HMIS) for service indicators.
- IPHS Tracker Dashboard for facility readiness scores.
- Public Financial Management System (PFMS) for fund tracking.
- eSanjeevani and Referral Portals are used for monitoring patient movement.
- Mera Aspataal is responsible for patient feedback and grievance redressal.
- NQAS Assessment App for quality scoring and documentation.
- NCD Portal for NCD screening, treatment, and follow-up.
- RCH Portal for monitoring RMNCAH + N services.
- PMSMA portal for ANC screening and follow-up
- FBNC portal for monitoring of sick and small newborns and further referral
- MDSR Portal for maternal death surveillance and response.
- CDSR Portal for neonatal death surveillance and response

9.4 Reporting Responsibilities

LEVEL	RESPONSIBILITY
CHC-FRU	Daily data entry, reporting through HMIS; monthly review of KPIs
BPMU	On-site verification, uploading service delivery reports
DPMU	Consolidation, supportive supervision, and dashboard reporting
State Health Society	Quarterly performance review and flagging low-performing FRUs
MoHFW/NHSRC	Provide national oversight, support third-party verification, and publish a national FRU dashboard.

9.5 Feedback and Course Correction

Monthly review meetings at the block level and quarterly reviews at the district and state levels must include FRU-specific indicators. Underperforming facilities must be identified and prioritised for mentoring and support. Action taken reports must be documented and reviewed.

SECTION 10: CONCLUSION AND THE WAY FORWARD

The policy decision to upgrade every Community Health Centre in India to a fully functional First Referral Unit represents a paradigm shift towards ensuring universal access to essential emergency and referral care. This ambitious goal holds immense potential for significantly reducing preventable deaths and disabilities arising from obstetric complications, trauma, acute NCD events, and other emergencies, thereby contributing substantially to achieving national health goals and the Sustainable Development Goals.

These revised guidelines provide a comprehensive, evidence-informed framework to steer this transformation. Built upon the foundation of IPHS 2022 and NQAS, they define clear standards for services, infrastructure, human resources, and quality while expanding the scope of the traditional FRU to encompass critical areas like trauma stabilization and emergency management. Furthermore, they integrate forward-looking perspectives on digital health, climate resilience, AMR containment, and pandemic preparedness, ensuring that CHC-FRUs are equipped for current needs and future challenges.

Successfully implementing these guidelines requires a concerted, coordinated, and sustained effort from all stakeholders. It demands significant investment in infrastructure, equipment, and human resources, particularly in ensuring the availability of skilled personnel through strategic recruitment, retention, and targeted training programs like CEmONC and LSAS. Robust monitoring systems that track functionality and quality outcomes, along with strengthened governance mechanisms such as empowered Rogi Kalyan Samitis and efficient supply chain management are critical for ensuring effective FRU performance.

While the path to universal CHC-FRU functionality presents considerable challenges, it is an essential investment in building a resilient, equitable, and high-quality public health system capable of meeting the diverse health needs of India's population. States and Union Territories are urged to adopt, adapt, and rigorously implement these guidelines, translating the national vision into tangible improvements in healthcare delivery at the grassroots level. Through collective commitment and effective action, the goal of ensuring timely, life-saving care for all citizens at the first referral level can be realized.

SECTION 11: ANNEXURES AND OPERATIONAL CHECKLISTS

Annexure 1: FRU Facility Readiness Checklist (Aligned with IPHS 2022)

DOMAIN	CRITERIA	STATUS (YES/NO)
Infrastructure	Functional Operation Theatre OT has power backup	
	Labour Delivery Recovery (LDR) Room Number of beds in LDR room LDR has Newborn Care Corner (NBCC)	
	Newborn Stabilisation Unit (NBSU) Number of beds in NBSU	
	Emergency services available 24*7 Number of beds in Emergency care Emergency care area has triage demarcation Emergency care area has triage protocol	
	Blood Storage Unit (BSU) operational BSU linked to blood bank	
	Total Number of functional beds available	
Human Resources	Physician posted or available Surgeon posted or availableOBG specialist posted or available Anaesthetist, posted or available Paediatrician posted or available	
	CEmONC trained Medical Officers posted LSAS-trained Medical Officers posted Are NBSU staff trained in NSSK	
	Nursing staff available and providing 24*7 services Nursing staff are trained in Skilled Birth Attendant (SBA) Nursing staff have emergency care experience	
	Lab technician available 24x7 Pharmacist available 24x7	
Drugs & Diagnostics	Number of Essential Drugs available (Kindly provide list) Was there any Stockout of essential drugs (last 30 days) Number of Essential Diagnostics available (Kindly provide list) Was there any Stockout of essential diagnostics (last 30 days)	

DOMAIN	CRITERIA	STATUS (YES/NO)
Referral Readiness	GPS-tracked ambulance Ambulance has trained staff (*Specifications as per NAS guidelines)	
	The referral register is maintained and monitored	
Digital Readiness	The facility is registered on HFR Data is updated on HMIS	
	Telemedicine/eSanjeevani functional including follow-up	

Annexure 2: Monthly Monitoring Template for Block Programme Management Unit (BPMU)

INDICATOR	CURRENT MONTH
Total Number of deliveries (including normal, C-section, instrument assisted delivery)	
Number of deliveries (normal)	
Number of deliveries (C section)	
Number of Family Planning surgeries done – sterilization	
Number of Comprehensive Abortion Care services provided	
Number of Emergency cases managed locally (treated and sent home and not referred to higher facility)	
Referrals made to the higher centre (Refered in and out)	
Bed occupancy rate*	
Any training session conducted for MOs?	
Number of training sessions for MOs conducted (Specify name and number)	
Patient satisfaction score as per Mera Aspataal	

Bed Occupancy rate -Total Occupied Bed-Days/ Total available Bed-days 100

Annexure 3: FRU Implementation Milestone Tracker (State/District Level)

MILESTONE	Target Date	Achieved Date	REMARKS
The facility prioritised and notified			
Gap assessment completed			
Civil work and procurement completed.			
HR posted and trained.			
IPHS compliance achieved			
Telemedicine and referral linkage functional			
The NQAS certification process initiated			

Annexure 4: Role Matrix for FRU Implementation

LEVEL	Responsible Team	Key Roles
Facility	MO In-Charge, BPMU	Service delivery, reporting, SOPs
District	DPMU, QA Team	HR deployment, infrastructure readiness
State	SHS, Engineering, HR Cell	Budgeting, PIP approval, technical guidance
NHSRC	QA Cell	Mentoring, training, certification readiness
MoHFW	Quality and Infrastructure Divisions	Policy oversight and support

Annexure 5: List of services available at CHC-FRU/UCHC-FRU

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
CLINICAL SERVICES									
EMERGENCY SERVICES									
1	ACCIDENT AND EMERGENCY								
1.1	Triage	E	-	E	-	E	-	E	-
1.2	Resuscitation	E	-	E	-	E	-	E	-
1.3	Stabilisation	E	-	E	-	E	-	E	-
1.4	Management and referral, as appropriate	E	-	E	-	E	-	E	-
1.5	Medico Legal Reporting	E	-	E	-	E	-	E	-
2	CAPACITY TO MANAGE COMMON EMERGENCIES, INCLUDING BUT NOT LIMITED TO								
2.1	RTA (including blast injuries)	E	-	E	-	E	-	E	-
2.2	Coma/ unconsciousness	E	-	E	-	E	-	E	-
2.3	Snake/dog Bite/other animal bites	E	-	E	-	E	-	E	-
2.4	Shock	E	-	E	-	E	-	E	-
2.5	Convulsions	E	-	E	-	E	-	E	-
2.6	Poisoning	E	-	E	-	E	-	E	-
2.7	Drowning	E	-	E	-	E	-	E	-
2.8	Burns	E	-	E	-	E	-	E	-
2.9	Septicemia	E	-	E	-	E	-	E	-
2.10	Dehydration	E	-	E	-	E	-	E	-
2.11	Myocardial Infarction	E	-	E	-	E	-	E	-
2.12	Acute respiratory conditions	E	-	E	-	E	-	E	-
2.13	Stroke	E	-	E	-	E	-	E	-
2.14	Meningoencephalitis	E	-	E	-	E	-	E	-
2.15	Dengue/cerebral malaria	E	-	E	-	E	-	E	-

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
2.16	Hemorrhage	E	-	E	-	E	-	E	-
2.17	Fractures	E	-	E	-	E	-	E	-
3	**PEDIATRIC EMERGENCIES INCLUDE**								
3.1	Dehydration	E	-	E	-	E	-	E	-
3.2	Pneumonia	E	-	E	-	E	-	E	-
3.3	Fever	E	-	E	-	E	-	E	-
3.4	Convulsions	E	-	E	-	E	-	E	-
3.5	Shock	E	-	E	-	E	-	E	-
Intensive Care and Operative services									
4	Operation Theatre (with NBCC)	E	-	E	-	E	-	E	-
5	Labour room/LDR (with NBCC)	E	-	E	-	E	-	E	-
6	NBSU	E	-	E	-	E	-	E	-
7	Blood Storage	E	-	E	-	E	-	E	-
8	**COMMON SURGICAL PROCEDURES**								
8.1	Suturing of wounds	E	-	E	-	E	-	E	-
8.2	Incision and drainage of abscesses	E	-	E	-	E	-	E	-
8.3	Debridement of compound wounds	E	-	E	-	E	-	E	-
OPD services									
9	General medicine	E	-	E	-	E	-	E	-
10	General surgery	E	-	E	-	E	-	E	-
11	Obstetrics & Gynecology (including Family Planning)	E	-	E	-	E	-	E	-
12	Pediatrics	E	-	E	-	E	-	E	-
13	Ophthalmology	-	-	-	D	-	D	E	-
14	Orthopedics	-	-	-	D	-	D	E	-
15	Pathology/ Microbiology	-	D	E	-	E	-	E	-
16	ENT	-	-		D	-	D	E	-
	Psychiatrist	-	-	-	-	-	-	-	D
17	Pre-Anesthetic Check Up	E	-	E	-	E	-	E	-
18	Family Medicine	-	D	-	D	-	D	-	D
19	Physiotherapy	E	-	E	-	E	-	E	-
20	PMR Services	-	-	-	-	-	-	-	D
21	Family Welfare Clinic	E	-	E	-	E	-	E	-
22	Counselling	E	-	E	-	E	-	E	-
23	Nutrition	E	-	E	-	E	-	E	-
24	Health & Wellness Services	E	-	E	-	E	-	E	-
25	Immunization Services	E	-	E	-	E	-	E	-

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
26	Dental	E	-	E	-	E	-	E	-
27	Eye – Refraction, Screening for Glaucoma/Cataract etc on daily basis) and cataract/ glaucoma (weekly basis)	E	-	E	-	E	-	E	-
28	NCD clinic (diagnosis, management, follow- up, and referral, as appropriate)	E	-	E	-	E	-	E	-
29	Cold chain services	E	-	E	-	E	-	E	-
30	Integrated Counseling and Testing services (HIV)	E	-	E	-	E	-	E	-
31	**INTEGRATED COUNSELLING SERVICES**								
	Maternal and child health (including Family Planning)	E	-	E	-	E	-	E	-
	Adolescent health	E	-	E	-	E	-	E	-
	Tobacco cessation	E	-	E	-	E	-	E	-
	Mental health	E	-	E	-	E	-	E	-
	Drug de-addiction	E	-	E	-	E	-	E	-
	Nutritional counseling (and early childhood development)	E	-	E	-	E	-	E	-
	Domestic violence, sexual violence etc.	E	-	E	-	E	-	E	-
	Health education and BCC	E	-	E	-	E	-	E	-
	Health education for prevention of RTIs/ STIs	E	-	E	-	E	-	E	-
32	**IPD services**								
	General ward- gender based	E	-	E	-	E	-	E	-
	Post-Operative ward	E		E	-	E	-	E	-
	Isolation room	-	D	-	D	-	D	-	D
	Maternity ward	E	-	E	-	E	-	E	-
33	**Referral services**								
	Assured referral services with transportation facilities	E	-	E	-	E	-	E	-
NATIONAL HEALTH PROGRAMMES (NHP)									
NHPs should be delivered through the CHCs. Integration with other existing programmes is vital to provide comprehensive services									
34	**MATERNAL HEALTH**								
	Minimum 4 ANC check-ups that include all the undermen- tioned services:	E	-	E	-	E	-	E	-
	Registration & associated services:								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	As some antenatal cases may directly register with CHC, the suggested schedule of antenatal visits is reproduced below	E	-	E	-	E	-	E	-
	1st visit: Within 12 weeks—preferably as soon as pregnancy is suspected—for registration of pregnancy and first antenatal check-up.								
	2nd visit: Between 14 and 26 weeks								
	3rd visit: Between 28 and 34 weeks								
	4th visit: Between 36 weeks and term								
	24-hour delivery services including normal and assisted deliveries								
	All referred cases of complications in pregnancy, labour, and post-natal period								
	Ensure postnatal care for 0 & 3rd day at the health facility both for the mother & newborn and referring to the ANM of the mother's area for ensuring 7th& 42nd day postnatal home visits.								
	Identification and Management of obstetric complications including PPH, Eclampsia, Sepsis etc. during PNC.								
	Provisions of Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakarm (JSSK) as per guidelines								
	Essential and Emergency Obstetric Care including surgical interventions (Caesarean Section) and other medical interventions	E	-	E	-	E	-	E	-
35	NEWBORN CARE AND CHILD HEALTH								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	Care and Resuscitation in the Newborn Corner in the Labour Room and Operation Theatre (where Caesarean Section takes place)	E	-	E	-	E	-	E	-
	Early initiation of breastfeeding within one hour of birth and support for expressing breast milk and using katori/ spoon for LBW/ pre- terms								
	Newborn Stabilization Unit (NBSU) – 4-6 bedded for basic care and stabilization prior to referral, if needed								
	Counselling on Infant and Young Child Feeding as per IYCF guidelines. Routine and emergency care of sick children as per Facility based IMNCI strategy								
	Full Immunization of infants and children against Vaccine Preventable Diseases and Vitamin-A prophylaxis Tracking of vaccination dropouts and left outs								
	Prevention and management of routine childhood diseases, infections, and anemia etc.								
	Kangaroo mother care for LBW babies								
	Management of Malnutrition cases								
36	**FAMILY PLANNING**								
	Full range of family planning services including IEC, counselling, provision of Contraceptives, Non-Scalpel Vasectomy (NSV), Laparoscopic Sterilization Services and their follow up	E	-	E	-	E	-	E	-
	Safe Abortion Services as per MTP act and Abortion care guidelines of MoHFW								
	MTP Facility approved for 2nd trimester of pregnancy								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	Medical method of abortion	E	-	E	-	E	-	E	-
	MTP using manual vacuum aspiration (MVA) technique								
37	ADOLESCENT HEALTH CARE								
	To be provided through adolescent friendly clinics Services should be comprehensive i.e., a judicious mix of promotive, preventive, curative, and referral services.	E	-	E	-	E	-	E	-
	Package of services								
	Information, education, and counselling on issues related to nutrition, SRH, mental health, gender-based violence, non- communicable diseases and substance use and appropriate referrals								
	Commodities: IFA Tablets, Tab Albendazole, sanitary napkins, contraceptives, other medicines (paracetamol, anti- spasmodic etc.) and immunization services.								
	Management of common adolescent health problems, RTI/STI, anemia, menstrual problems, ANC for pregnant adolescents.								
	Screening for diabetes and hypertension and HIV testing and counselling								
	Referral services for ICTC, de- addiction centre, non-Communicable diseases clinics.								
	Outreach services by counsellors will be carried out at schools, colleges, youth clubs and in community at least twice a week to sensitise the adolescents, caregivers and influencers on various adolescent health issues and apprise them of various available adolescent f riendly health services								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
38	SCHOOL HEALTH								
	Screening, health care and referral:	E	-	E	-	E	-	E	-
	Screening of adolescents for 4 D's								
	Basic medicines for common ailments in young children.								
	Referral cards for priority services at District/Sub-District hospitals.								
	Immunization (Fixed day activity; coupled with education about the issues of Micronutrient (Vitamin A & IFA) management:								
	Weekly supervised distribution of Iron- Folate tablets coupled with awareness raising								
	Administration of Vitamin-A								
	De-worming during National Deworming Day								
	Provision of sanitary napkins								
	Peer education interventions								
	Monitoring & Evaluation								
	Health Promoting Schools								
	Counselling services								
	Regular practice of yoga, Physical education, health education								
	Peer leaders as health educators.								
	Adolescent health education-existing in few places								
	Linkages with the out of school children								
	Health clubs, Health cabinets								
	First Aid room/ corners or clinics								
39	COMMUNICABLE DISEASES PROGRAMMES								
	NTEP: Diagnostic services through the microscopy Centre at the CHCs and treatment services in line with NTEP guidelines	E	-	E	-	E	-	E	-

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	HIV/AIDS Control Programme services to be provided at the CHC level include:								
	Integrated Counselling and Testing Centre (ICTC)								
	Blood Storage Centre								
	Sexually Transmitted Infection clinic								
40	NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME								
	Provide diagnostic/ linkages to diagnosis and treatment facilities for routine and complicated cases of Malaria, Filaria, Dengue, Japanese Encephalitis, and kala-azar in endemic zones	E	-	E	-	E	-	E	-
41	NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)								
	Diagnosis and treatment of cases and complications including reactions of leprosy along with counselling of patients on prevention of deformity and cases of uncomplicated ulcers	E	-	E	-	E	-	E	-
42	NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT (NPCB&VI)								
	The eye care services that should be made available at the CHC include:	E	-	E	-	E	-	E	-
	Vision Testing with Vision drum/Vision Charts.								
	Refraction								
	The early detection of visual impairment and their referral.								
	Awareness generation through appropriate IEC strategies and involving community for primary prevention and early detection of impaired vision and other eye conditions.								
43	INTEGRATED DISEASE SURVEILLANCE PROJECT (IDSP)								
	Under Integrated Disease Surveillance Project, CHC will function as peripheral surveillance unit and collate, analyse, and report	E	-	E	-	E	-	E	-

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	information to District Surveillance Unit on selected epidemic prone diseases. In outbreak situations, appropriate action will be initiated through Rapid Response Teams (RRT)								
44	**NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS (NPPCD)**								
	The early detection of cases of hearing impairment, deafness, and referral.	E	-	E	-	E	-	E	-
	Provision of Basic Diagnosis and treatment services for common ear diseases.								
	Awareness generation through appropriate IEC strategies and greater participation/ role of community in primary prevention and early detection of hearing impairment/ deafness								
45	**NATIONAL MENTAL HEALTH PROGRAMME (NMHP)**								
	Early identification, diagnosis, and treatment of common mental disorders (anxiety, depression, psychosis, schizophrenia, Manic Depressive Psychosis).	E	-	E	-	E	-	E	-
	IEC activities for prevention, removal of stigma and early detection of mental disorders.								
	Follow-up care for cases on treatment.								
	With short-term training, medical officers can deliver basic mental health care using limited number of drugs and provide appropriate referral service	-	D	-	D	-	D	-	D
46	**NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE (NPCDCS)**								
	Cancer Control	E	-	E	-	E	-	E	-
	Facilities for early detection and referral of suspected cancer cases.								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	Screening/diagnosis for Cervical, Breast & Oral Cancers								
	Education about Breast Self-Examination and Oral Self Examination.								
	PAP smear for Cancer Cervix								
47	**Diabetes, CVD and Stroke**								
	Promotion & Prevention:	E	-	E	-	E	-	E	-
	Promotion of healthy dietary habits								
	Promotion of physical activity								
	Avoidance of tobacco and alcohol								
	Stress Management								
	Diagnosis, management, and follow-up of uncomplicated cases of Diabetes, CVD, and strokes								
	Treatment & Timely Referral of complicated cases of Diabetes Mellitus, Hypertension, IHD, CHF etc.								
48	**NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME (NIDDCP)**								
	IEC activities in the form of posters, pamphlets, and Interpersonal communication to promote consumption of iodized salt, monitoring of iodized salt through salt testing kits.	E	-	E	-	E	-	E	-
49	**NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF FLUOROSIS (NPPCF)**								
	(*Essential in Fluorosis affected villages)	E	-	E	-	E	-	E	-
	Clinical examination and preliminary diagnostic assessment for cases of fluorosis if facilities are available								
	Monitoring of village/ community level								
	Fluorosis surveillance and IEC activities.								
	Referral Services								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	IEC activities in the form of posters, pamphlets, Interpersonal communication to prevent Fluorosis.								
50	NATIONAL TOBACCO CONTROL PROGRAMME (NTCP)								
	Health education and IEC activities regarding harmful effects of tobacco use and secondhand smoke.	E	-	E	-	E	-	E	-
	Promote quitting of tobacco in the community and offering brief advice to all smokers and tobacco users.								
	Making the premises of CHC tobacco free; display of mandatory signages								
	Setting up a Tobacco cessation Clinic, by training the counselor in tobacco cessation								
51	NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY								
	Medical rehabilitation services.	E	-	E	-	E	-	E	-
	Home visits to disabled/ bed ridden clients by rehabilitation workers (on referral from PHC/ Sub-centre. Geriatric Clinic: twice a week)								
52	PHYSICAL MEDICINE AND REHABILITATION (PMR)								
	Primary prevention of Disabilities:	E	-	E	-	E	-	E	-
	Screening, early identification and detection Counseling.								
	Issue of Disability Certificate by CHC doctors.								
	Community based Rehabilitation Services								
	Referral to higher centres and follow-up								
	Basic treatments like Exercise and Heat therapy, ROM exercises, cervical and Lumbar Traction								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
53	NATIONAL ORAL HEALTH PROGRAMME								
	Dental care and Dental Health education services as well as root canal treatment and filling/ extraction of routine and emergency cases.	E	-	E	-	E	-	E	-
	Oral Health education in collaboration with other activities e.g., Nutritional education, school health and adolescent health								
54	NATIONAL PROGRAMME FOR PALLIATIVE CARE (NPPC)								
	Health education/ awareness raising	E	-	E	-	E	-	E	-
	OPD services through trained manpower/ Consultation for all patients requiring pain management due to any cause								
	Rehabilitation Services								
	Referral for Higher centre								
	Home based care								
SUPPORT SERVICES									
55	Central Sterilization Supply Department (CSSD)/ equipment sterilization services	E	-	E	-	E	-	E	-
56	Laundry services	E	-	E	-	E	-	E	-
57	Engineering Services: Electricity/water (Civil Engineering may be outsourced)	E	-	E	-	E	-	E	-
58	Generator: 5 kVA with POL for	E	-	E	-	E	-	E	-
59	Telephony: minimum two direct lines with intercom facility	E	-	E	-	E	-	E	-
60	Use of power through solar panels	-	D	-	D	-	D	-	D
OTHER SERVICES									
61	Disabled friendly services	E	-	E	-	E	-	E	-
62	Hospital Management Information System	E	-	E	-	E	-	E	-
	IT Section								
	Reporting								
	Feedback								
	Surveillance								

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
63	Server Room	E	-	E	-	E	-	E	-
64	Internal Communication system	E	-	E	-	E	-	E	-
	Intercom								
	Biometrics								
	Public addressal system								
65	Token Display system	E	-	E	-	E	-	E	-
66	Disability Certificates as defined in the PWD Act	E	-	E	-	E	-	E	-
67	Ambulance Services (referral)	E	-	E	-	E	-	E	-
68	Housekeeping Services	E	-	E	-	E	-	E	-
69	Dietary Services	E	-	E	-	E	-	E	
70	Security Services	E	-	E	-	E	-	E	-
71	Telemedicine and tele-radiology	E	-	E	-	E	-	E	-
72	Skype, ZOOM etc. for consultation for a higher identified centre	-	D	-	D	-	D	-	D
73	Birth & Death registration/ certificate	E	-	E	-	E	-	E	-
TRAINING									
74	**Training and Orientation**								
	Orientation training of male and female health workers in various National Health Programmes including RCH, Adolescent health services and immunization	E	-	E	-	E	-	E	-
	Skill based training to ASHAs.	E	-	E	-	E	-	E	-
	Initial and periodic Training of allied health professionals in treatment of minor ailments.	E	-	E	-	E	-	E	-
	Periodic training of doctors and allied health professionals through Continuing Medical Education, conferences, skill development trainings.	E	-	E	-	E	-	E	-
	All health staff of CHC to be trained in IMEP.	E	-	E	-	E	-	E	-
	There should be provision of induction training for doctors, nursing, and allied health professionals	E	-	E	-	E	-	E	-

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
	Mechanism for ensuring quality assurance in trainings by Training feedback and Training effectiveness evaluation	E	-	E	-	E	-	E	-
	Trainings in minor repairs and maintenance of available equipment should be provided to the user.	E	-	E	-	E	-	E	-
	Training of para medics in indenting, forecasting, inventory, and store management	E	-	E	-	E	-	E	-
	Development of protocols for equipment (operation, preventive, and breakdown maintenance)	E	-	E	-	E	-	E	-
ADMINISTRATIVE & MAINTENANCE SERVICES									
75	**ADMINISTRATIVE AND OTHER SERVICES**								
76	System of assured grievance redressal	E	-	E	-	E	-	E	-
77	Store	E	-	E	-	E	-	E	-
	General								
	Medicine								
	Storage for temperature sensitive Medicines								
	Condemnation Multi purposes services maintenance Room								
78	Electric Supply (power generation and stabilization)	E	-	E	-	E	-	E	-
79	Standby power back up facility	E	-	E	-	E	-	E	-
80	Water supply (plumbing)	E	-	E	-	E	-	E	-
81	Pest control services	E	-	E	-	E	-	E	-
82	Ambience	E	-	E	-	E	-	E	-
83	Horticulture	E	-	E	-	E	-	E	-
84	Designated space for IEC	E	-	E	-	E	-	E	-
85	Signages	E	-	E	-	E	-	E	-
86	Bio waste material management with linkage with common biomedical waste treatment facility	E	-	E	-	E	-	E	-
87	Rainwater harvesting in facilities more than 500 square meter	-	D	-	D	-	D	-	D
88	Finance	E	-	E	-	E	-	E	-

S NO.	SERVICES	FRU – CH 30 beds		FRU – CH 50 beds		FRU – UCHC 50 beds		FRU – UCHC 100 beds	
		E	D	E	D	E	D	E	D
89	Monitoring and Supervision	E	-	E	-	E	-	E	-
	Monitoring and supervision of activities of Sub Centre through regular meetings/ periodic visits, by LHV, Health Assistant Male and Medical Officer etc.								
	Monitoring of all National Health Programmes by Medical Officer with support of LHV, Health Assistant Male and Health educator.								
	Monitoring activities of ASHAs by LHV and ANM (in her Sub Centre area).								
	Health educator will monitor all IEC and BCC activities								
	Health Assistants Male and LHV should visit Sub Centres once a week. Vi. Checking for tracking of missed out and left out ANC/ PNC, Vaccinations etc. during monitoring visits and quality parameters (including using Partograph, AMTSL, ENBC etc.) during delivery and post-delivery. Timely payment of JSY beneficiaries.								
	Timely payment of TA/DA to ASHAs.								
90	Medical records Room	E	-	E	-	E	-	E	-
91	Inventory Management	E	-	E	-	E	-	E	-
92	Epidemic Control and Disaster Preparedness	E	-	E	-	E	-	E	-
93	Nosocomial Disease reporting	E	-	E	-	E	-	E	-
94	Immunization of Health care workers against Tetanus, Typhoid and Hepatitis B.	E	-	E	-	E	-	E	-
95	Provision of round the clock Post exposure prophylaxis against HIV in	E	-	E	-	E	-	E	-
96	Record of Vital Events and Reporting	E	-	E	-	E	-	E	-
	Recording and reporting of Vital statistics including births and deaths.								

S NO.	SERVICES	FRU – CH		FRU – CH		FRU – UCHC		FRU – UCHC	
		30 beds		50 beds		50 beds		100 beds	
		E	D	E	D	E	D	E	D
	Maintenance of all the relevant records concerning services provided in PHC								
97	Clinical Governance	E	-	E	-	E	-	E	-
	Incident reporting (including Maternal Death Surveillance and Response (MDSR); Child Death Review (CDR); Near miss reporting								
	Audits (including prescription audit)								

Note: The services mentioned under desirable are over and above the services mentioned as essential.

Annexure 6: List of Service Areas at CHC-FRU/UCHC-FRU

SERVICE AREA	FRU – CHC		FRU – UCHC	
	30 beds	50 beds	50 beds	100 beds
EMERGENCY				
24*7 Emergency Care*	4 beds	6 beds	6 beds	11 beds
Labour Room Complex				
NBSU	4 beds	4 beds	4 beds	4 beds
Labour Delivery Recovery (LDR) Units	2	3	3	3
NBCC	1	1	1	1
IPD	30 Beds	50 Beds	50 Beds	100 Beds
NRC (10 Beds)	D	D	D	D
Operative Services				
Pre- Anaesthetic Check Up	E	E	E	E
OBGYN Surgery	E	E	E	E
Emergency Surgery				
General Surgery	E	E	E	E
Eye Surgery	-	-	-	E
Outpatient Services				
Medicine/Family Medicine	E	E	E	E
Surgery	E	E	E	E
Paediatrics	E	E	E	E
Obstetrics and Gynaecology	E	E	E	E

SERVICE AREA	FRU – CHC		FRU – UCHC	
	30 beds	50 beds	50 beds	100 beds
Family Medicine	D	D	D	D
Oral/Dental	E	E	E	E
Ophthalmology	-	D	D	E
Orthopedics	-	D	D	E
ENT	-	D	D	D
Public Health Specialist/Epidemiologist	-	-	-	D
Psychiatrist	-	-	-	D
Radiologist	-	-	D	E
Pathology/Microbiology/Biochemistry	D	E	E	E
NCD	E	E	E	E
Counselling	E	E	E	E
Family Welfare Clinic	E	E	E	E
Nutrition	E	E	E	E
Health and Wellness services	E	E	E	E
Community Based Rehabilitation Services	E	E	E	E
Dressing Room	E	E	E	E
Immunization	E	E	E	E
Physiotherapy	E	E	E	E
ART Services	E	E	E	E
PMR Services	-	-	-	D
In-patient Services				
Wards	3	3	3	3
Laboratory Services				
Number of Lab tests	97	97	97	97
Diagnostic Services				
USG with colour doppler (including for new borns)	E	E	E	E
Digital X-Ray	E	E	E	E
Radio-Visio-Graphy (RVG) – digital dental X-Ray	E	E	E	E
Support Services				
Blood Storage Unit	E	E	E	E
Medical Record room (MRD)	E	E	E	E
Registration Counter	E	E	E	E

SERVICE AREA	FRU – CHC		FRU – UCHC	
	30 beds	50 beds	50 beds	100 beds
Pharmacy	E	E	E	E
Store	E	E	E	E
Dietary	E	E	E	E
Effluent Treatment Plant (ETP)	E	E	E	E
Power Sub-Station/Transformer	E	E	E	E
Overhead water tank – two independent water sources. Separate tank for critical care areas (450 L per bed per day)	16200 L	16200 L	16200 L	45000 L
Telemedicine	E	E	E	E
Administrative Area				
Administrative offices/areas	E	E	E	E
Birth and Death Registrations	E	E	E	E
Server Room	E	E	E	E
Housekeeping Room	E	E	E	E
Staff Room	E	E	E	E
Ambience				
Digital Token System and Computerized Registration	E	E	E	E
Cafeteria	D	D	D	D
ATM	D	D	D	D
Parking	E	E	E	E
Garden	E	E	E	E
GR Help Desk	-	-	-	D
Suggestion & feedback System	E	E	E	E
Water harvesting	E	E	E	E
Residential Area				
Staff Residences	E	E	E	E
Guest house linkages for patients and attendants	D	D	D	D
Other Area				
Ambulance (Linked Services)	E	E	E	E

Note: The services mentioned under desirable are over and above the services mentioned as essential.

***Number of beds for 24x7 emergency care:**

Non-FRU CHC (30 Beds): 4 beds (2 Red +2 Yellow)
FRU CHC (30 beds): 4 beds (2 Red +2 Yellow)
FRU CHC (50 beds): 6 beds (2 Red +2 Yellow +1 Isolation +1 Paediatrics)
FRU UCHC (50 beds): 6 beds (2 Red +2 Yellow +1 Isolation +1 Paediatrics)
FRU UCHC (50 beds): 11 beds (3 Red +5 Yellow +1 Isolation +2 Paediatrics)

Annexure 7: Suggested Layout for a Model CHC-FRU/UCHC- FRU

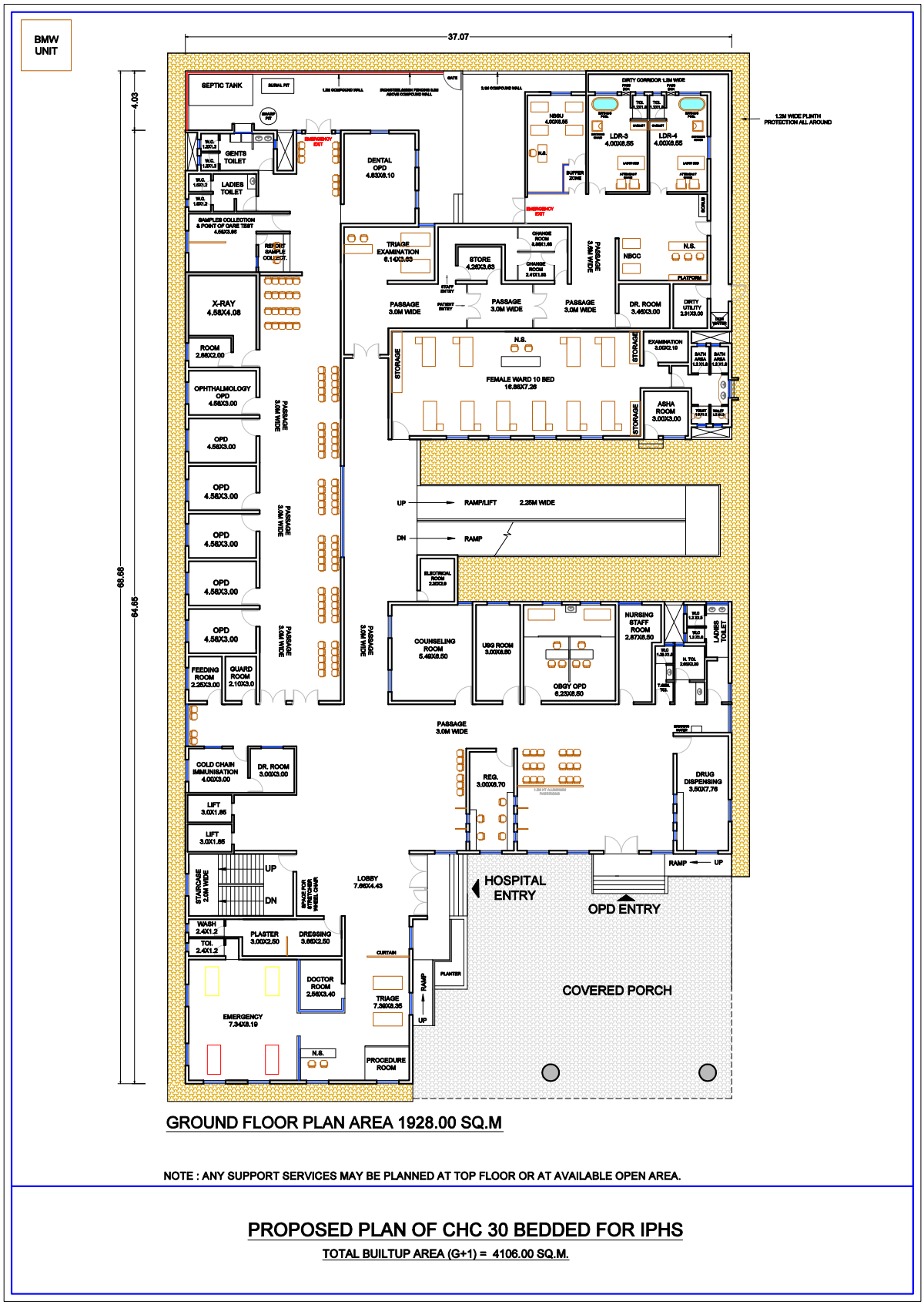
A standard FRU should have:

- Entry and waiting area with triage
- Separate OPD, emergency, labour room, OTs
- Adjacent postnatal ward and NBSU
- Wards (female, male, paediatric)
- Diagnostic block (lab, X-ray, ultrasound)
- Drug store, pharmacy, administrative room
- Medico-legal services room (confidential space)

Layout given for:

- FRU CHC 30 Bed GROUND FLOOR
- FRU CHC 30 Bed FIRST FLOOR
- CHC 50 Bed GROUND FLOOR
- CHC 50 Bed FIRST FLOOR
- CHC 50 Bed SECOND FLOOR
- 100 Bedded UCHC FIRST FLOOR
- 100 Bedded UCHC GROUND FLOOR
- Block Public Health Unit

Layout of 30 Bedded FRU CHC

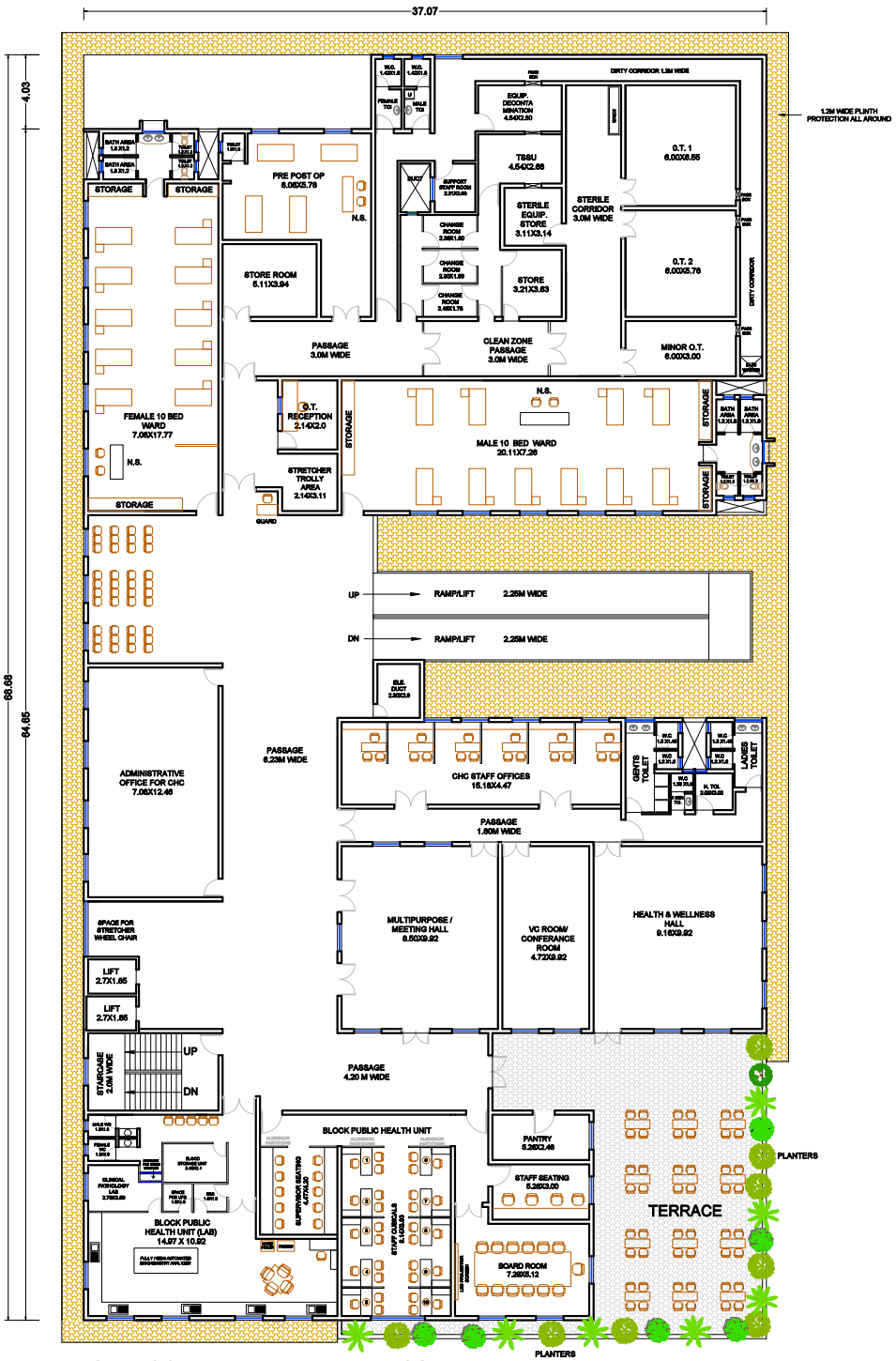


GROUND FLOOR PLAN AREA 1928.00 SQ.M

NOTE : ANY SUPPORT SERVICES MAY BE PLANNED AT TOP FLOOR OR AT AVAILABLE OPEN AREA.

PROPOSED PLAN OF CHC 30 BEDDED FOR IPHS

TOTAL BUILTUP AREA (G+1) = 4106.00 SQ.M.



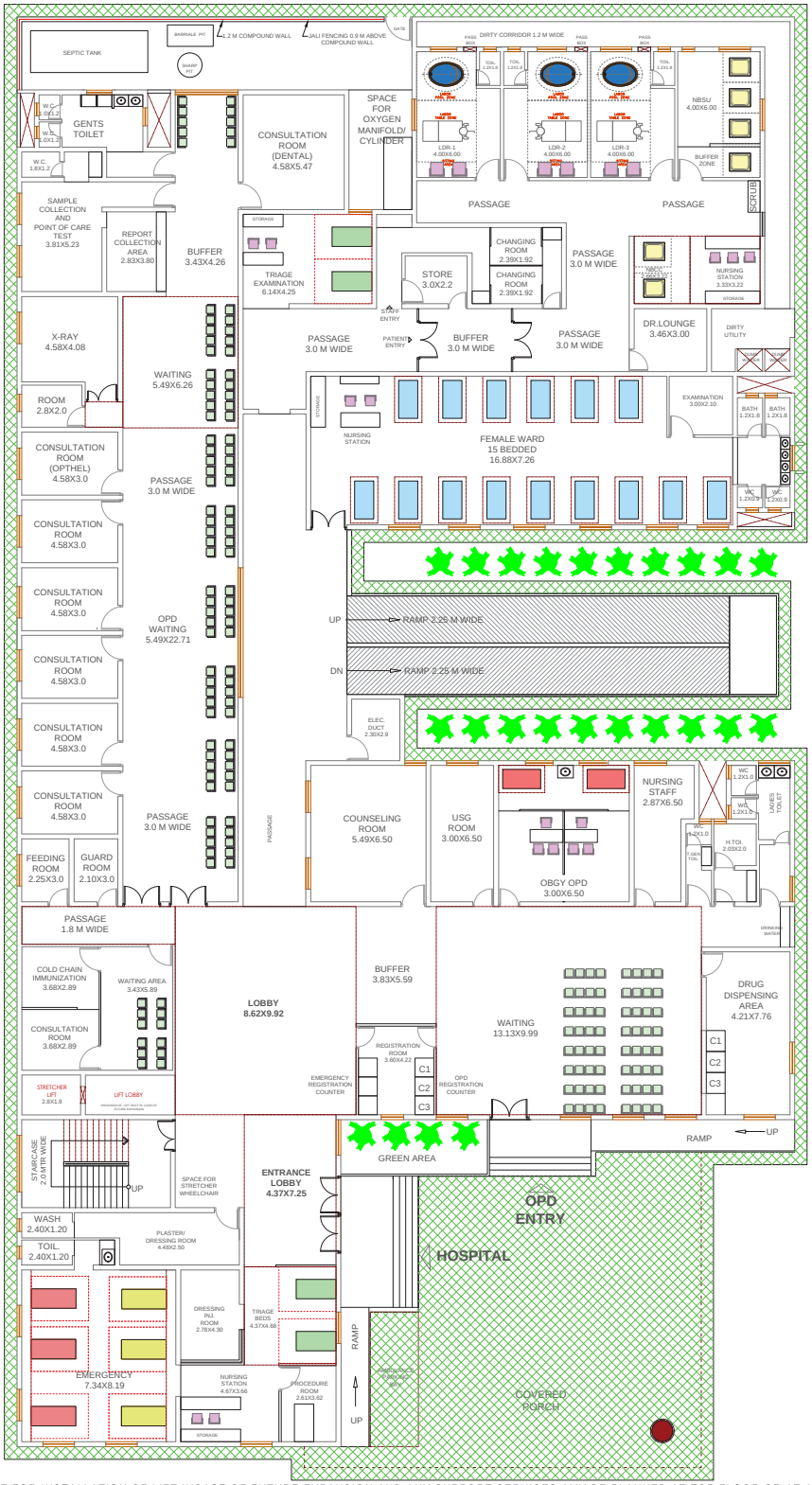
FIRST FLOOR PLAN AREA 2178.00 SQ.M

NOTE : ANY SUPPORT SERVICES MAY BE PLANNED AT TOP FLOOR OR AT AVAILABLE OPEN AREA.

PROPOSED PLAN OF CHC 30 BEDDED FOR IPHS

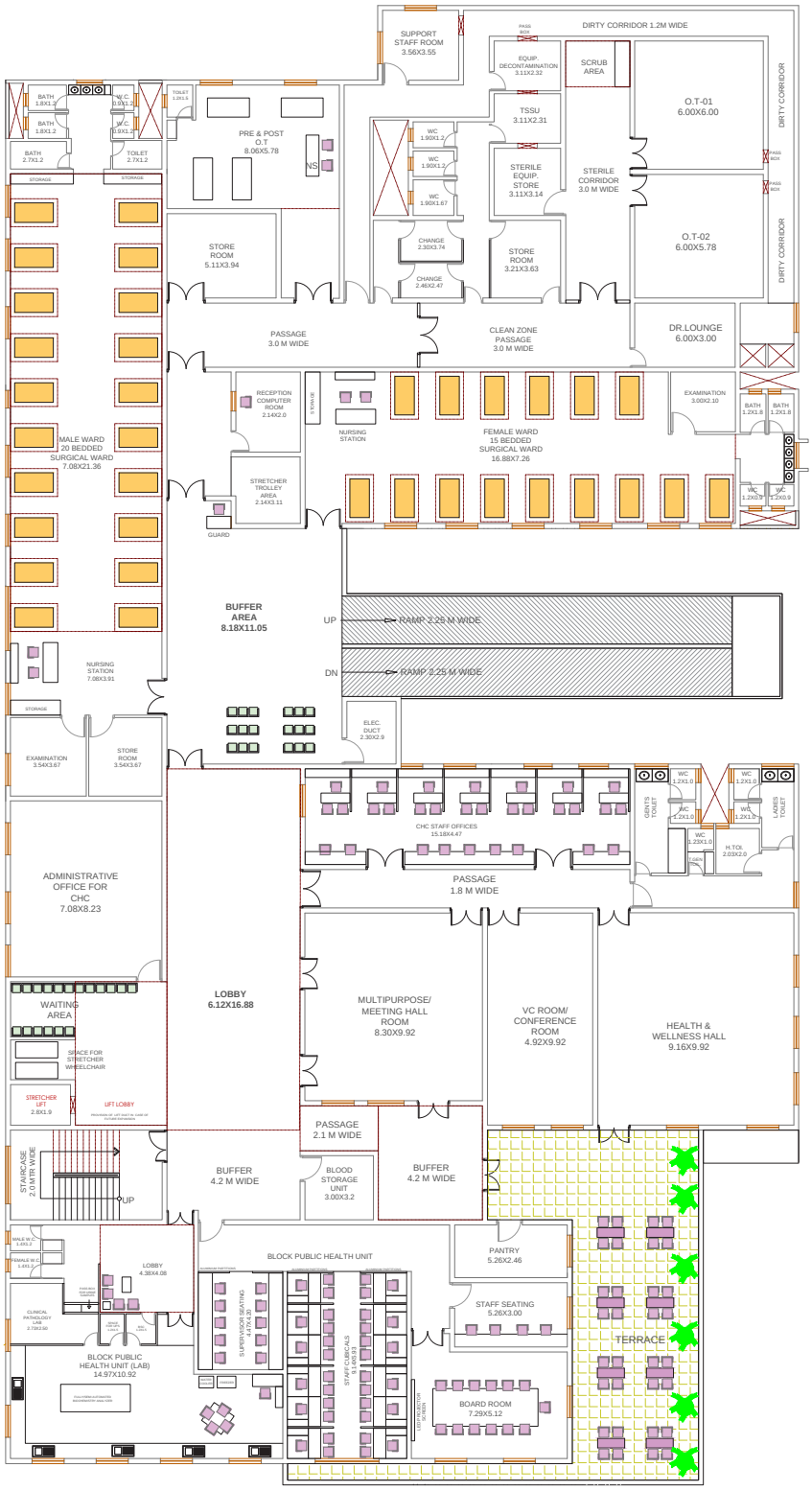
TOTAL BUILTUP AREA (G+1) = 4106.00 SQ.M.

Layout of 50 Bedded FRU CHC/UCHC



NOTE:
PROVISION OF LIFT DUCT FOR INSTALLATION OF LIFT INCASE OF FUTURE EXPANSION AND ANY SUPPORT SERVICES AMY BE PLANNED AT TOP FLOOR OR AT AVILABLE OPEN AREA.

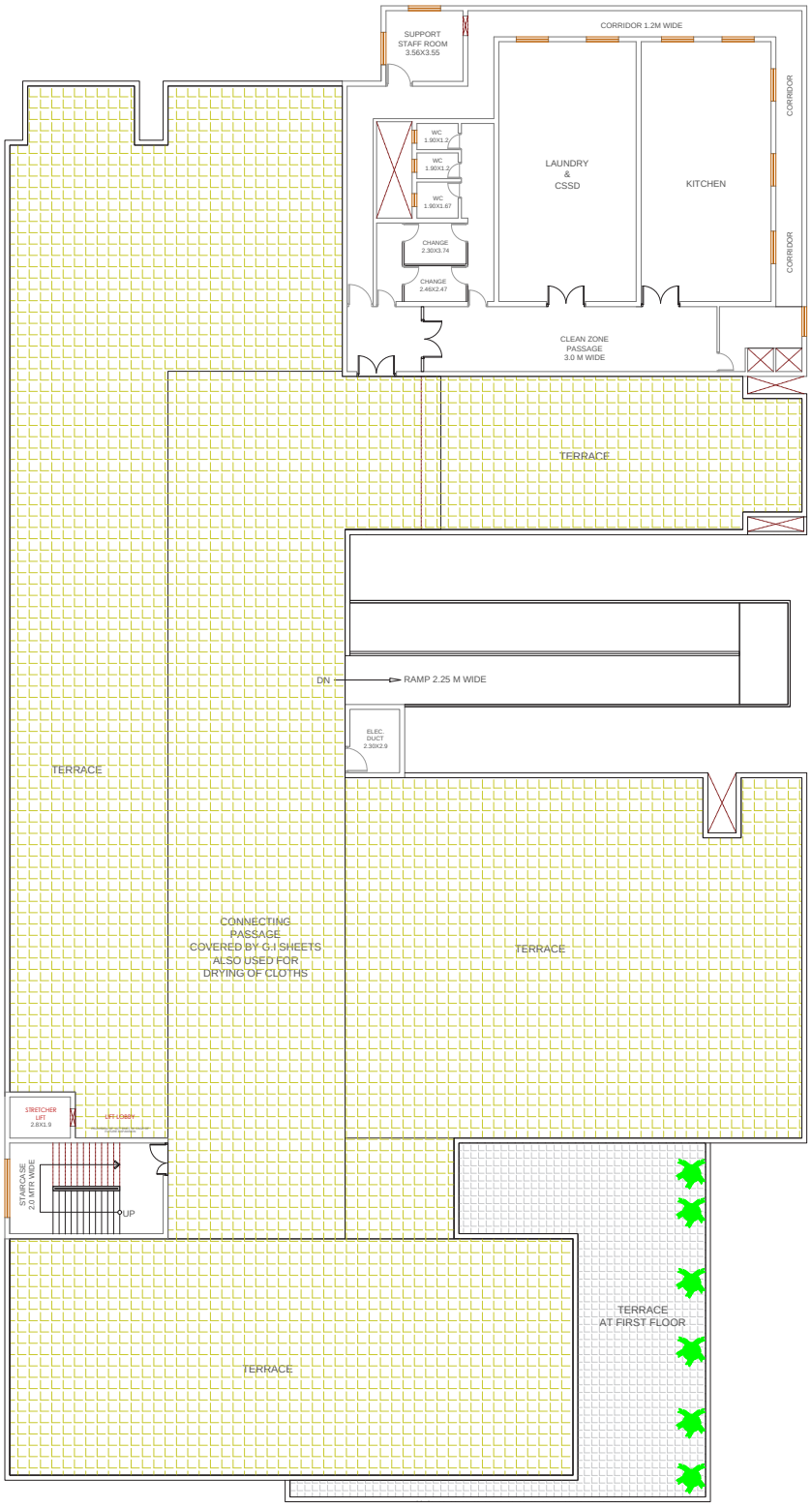
GROUND FLOOR PLAN	**COVERED AREA-2250 SQM**
PROPOSED PLAN OF CHC 50 BEDDED FOR IPHS	**TOTAL BUILTUP AREA (G+2)=4750.00 SQMT**



NOTE:
PROVISION OF LIFT DUCT FOR INSTALLATION OF LIFT INCASE OF FUTURE EXPANSION AND ANY SUPPORT SERVICES AMY BE PLANNED AT TOP FLOOR OR AT AVILABLE OPEN AREA.

FIRST FLOOR PLAN | **COVERED AREA-2145 SQM**

PROPOSED PLAN OF CHC 50 BEDDED FOR IPHS

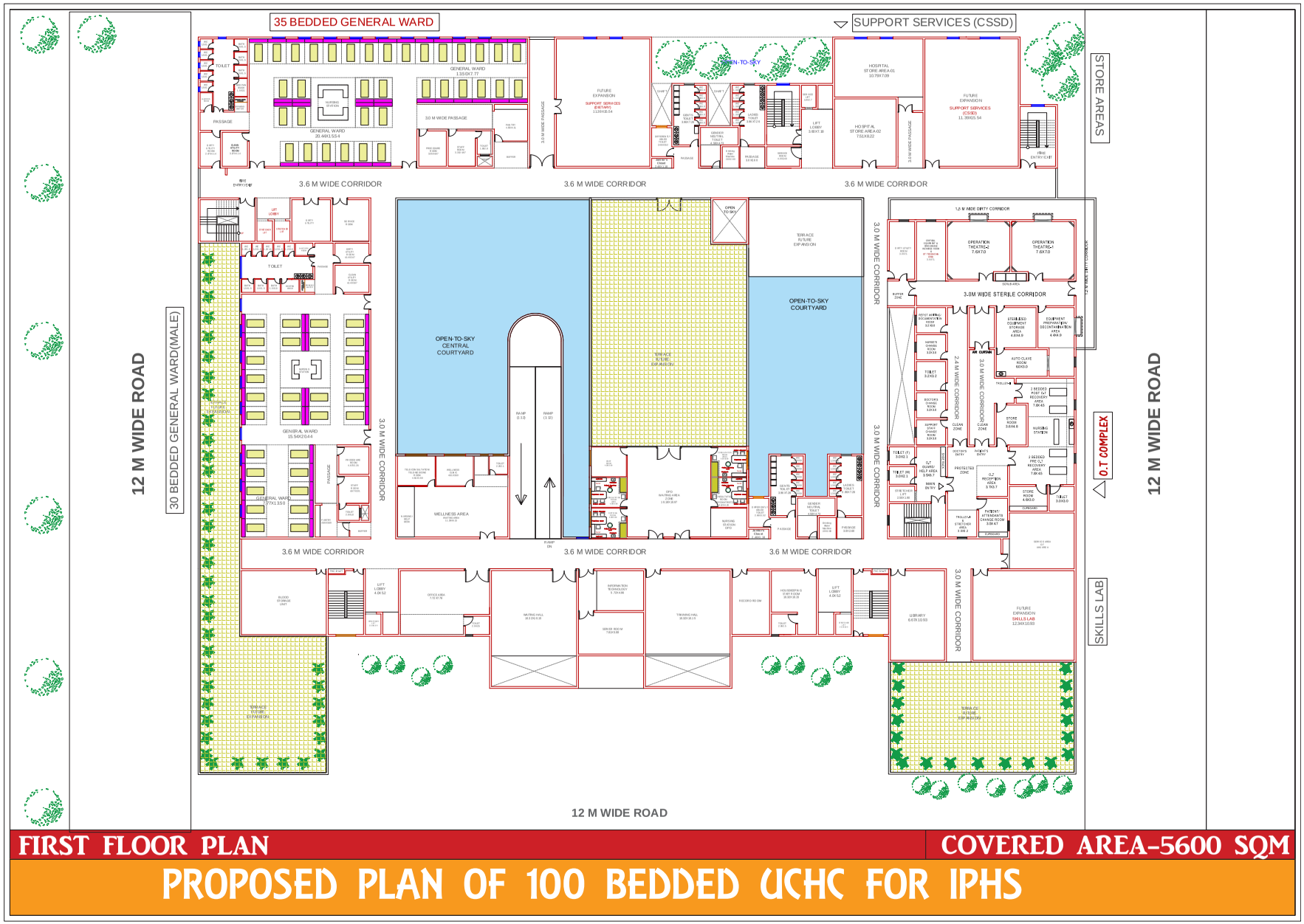


NOTE:
PROVISION OF LIFT DUCT FOR INSTALLATION OF LIFT INCASE OF FUTURE EXPANSION AND ANY SUPPORT SERVICES AMY BE PLANNED AT TOP FLOOR OR AT AVILABLE OPEN AREA.

SECOND FLOOR PLAN | **COVERED AREA-355 SQM**

PROPOSED PLAN OF CHC 50 BEDDED FOR IPHS

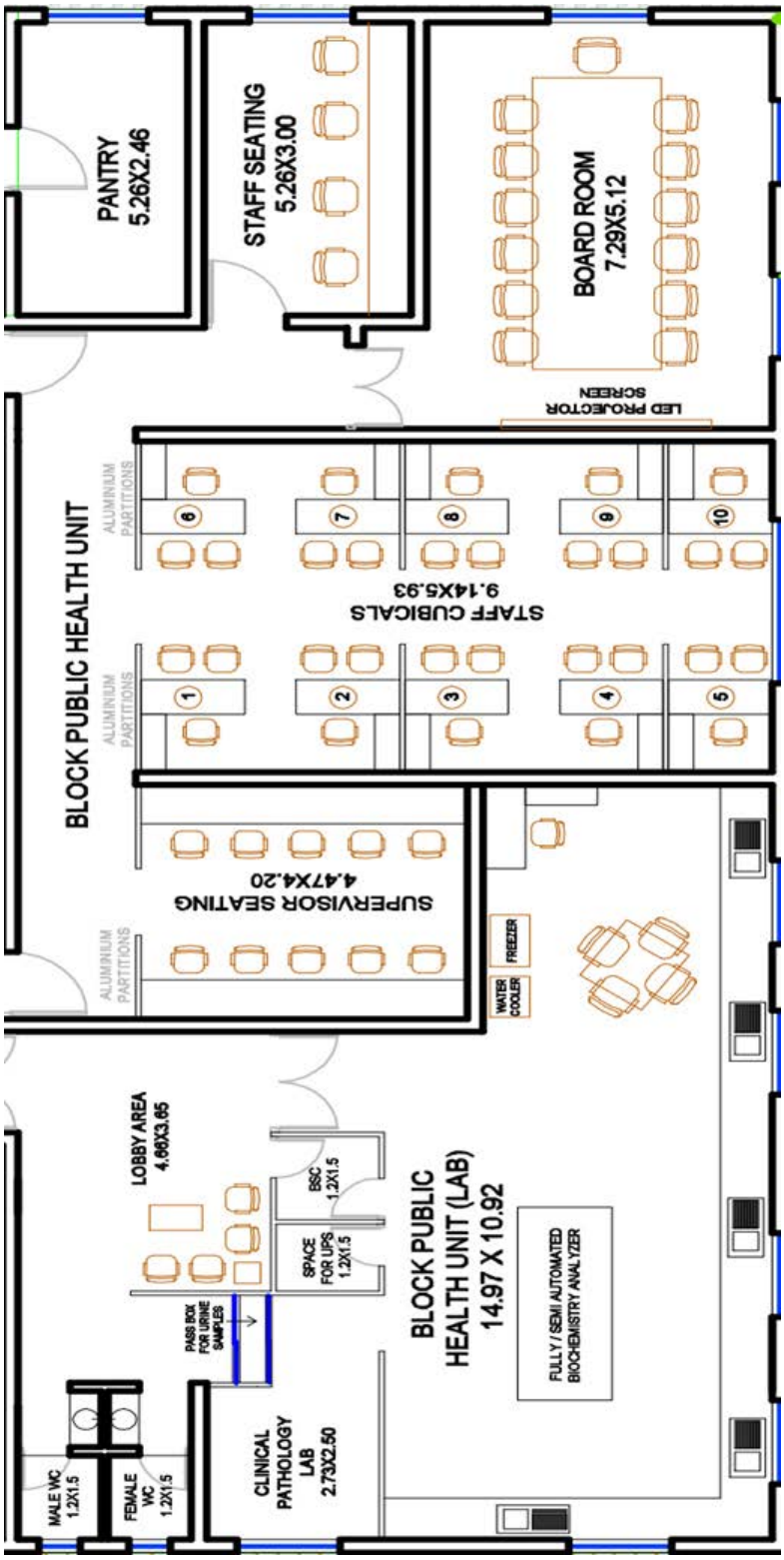
Layout of 100 Bedded FRU UCHC



FIRST FLOOR PLAN | COVERED AREA-5600 SQM

PROPOSED PLAN OF 100 BEDDED UCHC FOR IPHS

Layout of Block Public Health Unit



Annexure 8: Disaster Management & Preparedness

Fire safety Norms

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

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

Expected Levels of Fire Safety in Hospitals

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

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

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

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

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

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

Open space

1. Hospitals shall make provisions for sufficient open space in and around the hospital building to facilitate the free movement of patients and emergency/fire vehicles.
2. These open spaces shall be kept free of obstructions and shall be motorable.
3. Adequate passageway& clearance for fire fighting vehicles to enter the hospital premises shall be provided.

4. The width of such entrances shall not be less than 4.5 meters with clear head room not less than 5 meters.
5. The width of the access road shall be a minimum of 6 meters.
6. A turning radius of 9 meters shall be provided for fire tender movement.
7. The covering slab of storage/static water tank shall be able to withstand the total vehicular load of 45 tone equally divided as a four-point load (if the slab forms a part of path/driveway).
8. The open space around the building shall not be used for parking and/or any other purpose.
9. The Setback area shall be a minimum 4.5 meters.
10. The width of the main street on which the hospital building abuts shall not be less than 12 mtrs & when one end of that street shall join another street, the street shall not be less than 12 meter wide.
11. The roads shall not be terminated in dead ends.

Instructions for Fire Safety for Hospital Staff Instructions for Personal Safety

All Hospital Staff should know:

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

Matters to be reported to the Fire officer

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

Instructions for Fire Incidents

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

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

Clean electricity

1. Two nos. of earthling should be there at each electrical installation. Copper plate earthing should be preferred.
2. Provision of surge protection/suppressor should be there. Surge suppressors are rated according to size of voltage spike they can handle, so only units of high enough joules rating to protect the equipment should be used.
3. Load calculation should be proper, accordingly the distribution, electrical switchgear rating,

circuitry, cabling, and electrical installation should be there.

4. The size of cabling and wiring should be about 1.5 times or more to the actual electrical load calculated.
5. Adequate powers back up with another source such as DG, Photovoltaic etc. should be there in synchronization with the first source.
6. Some places which are very important, provision of uninterrupted power supply should be there.
7. Phase sequence should be proper as for motorized load.
8. Load monitoring should be there. to avoid any overloading
9. A lot of motorized as well as semiconductor material devices are there hence provision of power factor improvement should be there.
10. All the Connection and joint should be tight with proper size of thimbling.
11. Balancing of electrical load should be proper and monitored via measuring devices.
12. Suitable place should be selected for electrical installation.
13. Sensitive equipment should be provided with proper rating UPS for extra safety against disturbances as voltage spike and noise.
14. The Electrical Switch Room shall be housed in a dedicated room/cupboard located on the ground floor and in association with an external wall and shall have internal access. The room shall be located so that it does not present difficulties for services distribution from adjoining spaces or rooms, and it shall be located to provide for economic distribution of services. The main switchboard shall be of metal clad cubicle design to approved standards and regulations. Each switchgear assembly shall have sufficient spare capacity. Electronic surge protection shall be provided on the incoming mains.

Earthquake Safety Provisions

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

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

Post-Earthquake Assessment of Hospital Structures

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

Annexure 9: List of Human Resources for Health at CHC-FRU/UCHC-FRU

STAFF	FRU – CHC				FRU – UCHC			
	30 beds		50 beds		50 beds		100 beds	
	E	D	E	D	E	D	E	D
Administrative staff								
Nursing In charge (Administrative cum clinical staff)	1	-	1	-	1	-	1	-
Hospital Manager	1	-	1	-	1	-	1	-
Health Information Management Professional/Medical Record Analyst/ Medical Record Assistant	1	-	1	-	1	-	1	1
Accountant	1	-	1	-	1	-	1	-
Data Entry Operator/ statistical assistant**	4	1	4	1	4	1	4	2
Sanitary Inspector	1	-	1	-	1	-	1	-
Registration Clerk	1	-	1	1	1	1	2	1
Specialists and Medical Officers								
Physician/Family Medicine Specialist	1	1	1	1	1	1	1	1
Surgeon	1		1	-	1	-	2	-
Obstetrician & Gynecologist	1		1	-	1	-	2	-
Pediatrician	1		1	-	1	-	2	-
Anesthesiologist	1		1	-	1	-	2	-
Ophthalmologist	-	-	-	1	-	1	1	-
Orthopaedician	-	-	-	1	-	1	1	-
ENT	-	-	-	1	-	1	1	-
Public Health Specialist/ Epidemiologist	-	-	1	-	-	-	1	-
Psychiatrist	-	-	-	-	-	-	-	1
Radiologist	-	-	-	-	-	1	1	-
Microbiologist/ Pathologist/ Biochemist	-	1	1	-	1	-	1	-
PMR Specialist	-	-	-	-	-	-	-	1
GDMO*	6	2	6	2	6	2	9	3
MO Dental	1	-	1	-	1	-	2	-
Allied Health Professionals								
Clinical Psychologist or Psychiatrist Social worker	1	-	1	-	1	-	1	-
Dietitian	-	1	-	1	-	1	1	-
Social Worker/ Community Based Rehabilitation Worker	1	-	1	-	1	-	1	-
Counselor***	3	-	3	-	3	-	3	-
Physiotherapist	1	-	1	-	1	-	1	-
Other Allied Health Professionals								
Medical Laboratory Technologist/Lab technician****	5	2	5	2	5	2	6	2
OT technologist/ OT technician	1	1	2	-	2	-	2	1
Radiology and Imaging Technologist/ Radiology technician	1	1	1	1	1	1	2	1

STAFF	FRU – CHC				FRU – UCHC			
	30 beds		50 beds		50 beds		100 beds	
	E	D	E	D	E	D	E	D
ECG Technologist/ ECG Technician	1	-	1	-	1	-	1	1
TSSU Assistant	2	-	2	-	2	-	2	1
Dental Assistant	1	-	1	-	1	-	1	-
Optometrist/ Ophthalmic assistant/ Vision technician	1	-	1	-	1	-	1	-
Cold chain/Vaccine logistic Assistant	1	-	1	-	1	-	1	-
Pharmacists								
Pharmacist (Allopathic)	2	-	2	-	2	-	2	-
Pharmacist (AYUSH)	-	1	-	1	-	1	-	1
Storekeeper/Store In charge	-	1	-	1	-	1	1	1
Sanitation staff								
OT #	3	-	3	-	3	-	3	-
LDR							3	-
Floor including, blood storage unit, OPD, wards, kitchen utensils/premises and other areas	2	-	3	-	3	-	6	-
Outer Premises	2	-	2	-	2	-	2	-
Other Staff								
Dresser	1	1	2	1	2	1	3	-

Staff Nurses

STAFF NURSES	NURSE: BED RATIO	FRU – CHC		FRU – UCHC	
		30 beds	50 beds	50 beds	100 beds
IPD	1:6	15	24	24	48
NBSU	1:3	3	3	3	3
NRC@ (Desirable)	1 per shift	3	3	3	3
Emergency	1 per shift	3	6	6	9
OT	2 nurses in each OT for each shift + 2 Nurse in elective OT for one shift +1 Nursing I/C + 2 nurses for pre & post Operative areas	11	11	11	13
LDR	1 Nurse/Midwife for 2 LDRs ; +1 Neonatal Nurse for 4 LDRs	6	9	9	9
OPD	-	5	5	5	10

**GDMOs:*

FRU CHC (30 Bedded): 6 (1 in Emergency & OPD and 1 in IPD in every shift for three shifts) FRU CHC (50 Bedded): 6 (1 in Emergency & OPD and 1 in IPD in every shift for three shifts) FRU UCHC (50 Bedded): 6 (1 in Emergency & OPD and 1 in IPD in every shift for three shifts) FRU UCHC (100 Bedded): 9 (1 in Emergency & OPD and 2 in IPD in every shift for three shifts)

*** Data Entry Operator: Data Entry and other IT related activities*

**** Counsellor: RMNCHA–1, NTEP- 1 and NCD- 1 (at least two should be female)*

***** Lab Technician:*

FRU CHC (30 Bedded): 5 (1 in each shift and one additional in morning & evening shift) FRU CHC (50 Bedded): 5 (1 in each shift and one additional in morning & evening shift) FRU UCHC (50 Bedded): 5 (1 in each shift and one additional in morning & evening shift) FRU UCHC (100 Bedded: 6 (2 in in each shift for three shifts)

@NRC is a desirable service for CHC FRU and onwards, so the total Staff Nurse required does not include the staff nurse in NRC, However the desired number are indicated in the table.

Note:

1. The number of HR indicated as desirable is over and above the HR indicated as essential.

2. All the HR indicated under the support staff is to be only hired in-house, if the related services are not outsourced.

3. Meaning thereby, for outsourced services, the HR is to be provided by the outsourcing agent

**Staff Nurses: Nurse: Bed ratio*

1. IPD- 1:6

2. NBSU- 1:3

3. NRC @ (Desirable)- 1 per shift

4. Emergency- 1 per shift

5. OT- 2 nurses in each OT for each shift + 2 Nurse in elective OT for one shift+1 Nursing I/C + 2 nurses for pre & post Operative areas.

6. LDR- 1 Nurse/Midwife for 2 LDRs +1 Neonatal Nurse for 4 LDRs

**Staffing for AYUSH is separate as per AYUSH IPHS guidelines.*

Annexure 10: Roles & Responsibilities of HRH at CHC-FRU/UCHC-FRU

General Physician

- Provide quality OPD and IPD services.
- Prescribe and administer medication, therapy, and other specialized medical care to treat or prevent illness, disease, or injury.
- Management of all emergencies.
- Management of lifestyle diseases including Hypertension, Diabetes, Bronchial asthma, Obesity etc. and treat chronic ailments of immune disorders like Arthritis and other multisystem diseases, metabolic diseases, hematological or blood-related aberrations.
- Follow standard operating procedures/clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- The management of special cases referred to her/him; providing curative prescription/ procedures/ surgeries; based on need, emergency and availability of resources.
- Refer the patient to other specialist/practitioners when necessary.
- Attend and treat all medico-legal cases.
- Keeping himself/herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.
- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Following the Acts, Rules, Regulations made by the Central/State Governments or local administrative bodies or any other relevant act relating to the protection and promotion of public health.
- Provide Teaching/Training/Capacity building to doctors and other healthcare staff, as and when required.
- Participate in community outreach programmes and in National Health Programmes.
- Ensure his/her attendance and availability at the Hospital/Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- He/she must also ensure availability to the hospital over the residential landline/mobile, whenever necessary.
- Monitor the patient progress or response to treatments and ensure records of the same are maintained by the Superintendent/Officer-in-charge of the Hospital/Health Centre.
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- She/he must resolve observed deficiency (if any) in the patient care immediately or report it in writing, to the officers-in-charge.
- Ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.
- Provide supportive supervision to nursing staff and delegates tasks appropriately.
- Comply to the orders of the Superintendent/Officer-in-charge, on all matters connected with the patient and management of the Hospital/Health Centre..

Obstetrics & Gynaecology Specialist

- Provide quality OPD, IPD and OT services related to Obstetrics & Gynaecology.
- Management of normal and complicated deliveries.
- Provision of ultrasonography services, in case of the specialist, is trained in ultrasound.
- Counselling and provision of family planning services and performing family planning operations (conventional and laparoscopic).
- Management of common neonatal problems.
- Provision of services regarding RTI/STI and infertility.
- Perform duties regarding MTP/MVA services and provision of safe abortion services.
- Conducting Maternal Death Review in the institution as FB-MDSR.
- Management of Medico-Legal Cases (Rape, Sexual Assault).
- Follow standard operating procedures/clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- Collect, record, and maintain patient's information, such as medical history, reports, and examination results, from patients, family members, or other medical professionals.
- He/she shall be responsible for all the special cases referred to her/him; providing curative prescription/procedures/surgeries; based on need, emergency and availability of resources.
- Refer the patient to other specialist/practitioners when necessary.
- Keeping himself/herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.
- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Following the Acts, Rules, Regulations made by the Central/State Governments or local administrative bodies or any other relevant act relating to the protection and promotion of public health.
- Participate in community outreach programmes (e.g. anaemia prevention, pulse polio, save the girl child, adolescent and school health, etc.) throughout the year.
- Ensure his/her attendance and availability at the Hospital/Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- He/she must also ensure availability to the hospital over the residential landline/mobile, whenever necessary.
- Monitor the patient progress or response to treatments and to ensure records of the same as maintained by the Superintendent/Officer-in-charge of the Hospital/Health Centre.
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- Ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.
- Provide supportive supervision to nurses and GDMOs tasks appropriately.
- Implement orders of the Superintendent/Officer-in-charge, on all matters connected with the patient and management of the Hospital/Health Centre.
- Any additional responsibility, as assigned by the authority.

Paediatrician

- Provide quality OPD and IPD services.
- Prescribe and administer medication, therapy, and other specialized medical care to treat or prevent illness, disease, or injury.
- Management of all emergencies.
- Management of lifestyle diseases including Hypertension, Diabetes, Bronchial asthma, Obesity etc. and treat chronic ailments of immune disorders like Arthritis and other multisystem diseases, metabolic diseases, hematological or blood-related aberrations.
- Follow standard operating procedures/clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- The management of special cases referred to her/him; providing curative prescription/ procedures/ surgeries; based on need, emergency and availability of resources.
- Refer the patient to other specialist/practitioners when necessary.
- Attend and treat all medico-legal cases.
- Keeping himself/herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.
- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Following the Acts, Rules, Regulations made by the Central/State Governments or local administrative bodies or any other relevant act relating to the protection and promotion of public health.
- Provide Teaching/Training/Capacity building to doctors and other healthcare staff, as and when required.
- Participate in community outreach programmes and in National Health Programmes.
- Ensure his/her attendance and availability at the Hospital/Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- He/she must also ensure availability to the hospital over the residential landline/mobile, whenever necessary.
- Monitor the patient progress or response to treatments and ensure records of the same are maintained by the Superintendent/Officer-in-charge of the Hospital/Health Centre.
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- She/he must resolve observed deficiency (if any) in the patient care immediately or report it in writing, to the officers-in-charge.
- Ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.
- Provide supportive supervision to nursing staff and delegates tasks appropriately.
- Comply to the orders of the Superintendent/Officer-in-charge, on all matters connected with the patient and management of the Hospital/Health Centre..

General Surgeon

- Provision of quality OPD and IPD services and also management of all kinds of surgical emergencies.
- Management of cases of poisoning, burns.
- Performing surgery (elective and emergency) on patients to treat injuries, diseases, or deformities.
- Work with other physicians and surgeons to decide on treatments and procedures before, during, and after surgery.
- Management of patients in the intensive care unit, particularly when there is non-availability of 'General Medicine specialist'.
- Follow standard operating procedures/clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Collect, record, and maintain patient's information, such as medical history, reports, and examination results, from patients, family members, or other medical professionals.
- He/she shall be responsible for all the special cases referred to her/him; providing curative prescription/procedures/surgeries; based on need, emergency and availability of resources.
- Refer the patient to other specialist/practitioners when necessary.
- Attend and treat all medico-legal cases
- Keeping himself/herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.
- Following the Acts, Rules, Regulations made by the Central/State Governments or local administrative bodies or any other relevant act relating to the protection and promotion of public health
- Provide Teaching/Training/Capacity building to doctors and other healthcare staff, as and when required.
- Ensure his/her attendance and availability at the Hospital/Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- Monitor the patient progress or response to treatments and to ensure maintenance of records of the same
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- Ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.
- Supportive supervision for GDMOs and Staff nurses.
- Implant orders of the Superintendent/Officer-in-charge, on all matters connected with the patient and management of the Hospital/Health Centre.
- Any additional responsibility, as assigned by the authority.

Anaesthetist

- Provide quality OPD (Pre Anaesthetic Check-up Clinic and Pain Clinic), OT sessions and IPD services.
- Perform bedside Pre-Anaesthetic Check-up for the patients who cannot move or be shifted from their beds.
- Provide services as an intensivist, in management of critical cases.
- Clinical management of acute pain services and participation in pain medicine units where applicable.
- Provision of acute resuscitation services for all emergencies.
- Management of patients in the intensive care unit.
- Follow standard operating procedures/clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- He/she shall be responsible for all the special cases referred to her/him; providing curative prescription/procedures/surgeries; based on need, emergency and availability of resources.
- Refer the patient to other specialists/practitioners when necessary.
- Attend and treat all medico-legal cases
- Keeping himself/herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.
- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Following the Acts, Rules, Regulations made by the Central/State Governments or local administrative bodies or any other relevant acts relating to the protection and promotion of public health.
- Provide Teaching/Training/Capacity building to GDMOs and other healthcare staff, as and when required.
- Ensure his/her attendance and availability at the Hospital/Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- Monitor the patient progress or response to treatments and ensure maintenance of records of the same as directed by the Superintendent/Officer-in-charge of the Hospital/Health Centre.
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- Ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.
- Supportive supervision for GDMOs and Staff nurses.
- Managing nursing staff and delegates tasks appropriately.
- Implant orders of the Superintendent/Officer-in-charge, on all matters connected with the patient and management of the Hospital/Health Centre.

Medical Officer (GDMO)

- Provision of quality OPD and IPD services and also management of all kinds of surgical The Medical Officer will be organizing and performing duties necessary for the routine Outpatient services and make suitable arrangements for the treatment of emergency cases which come outside the normal OPD hours.
- He/she will screen cases needing specialized medical attention, and scale attention of a specialist in the hospital.
- He/she will support specialists in OPD, IPD, emergency, OT etc.
- The Medical Officer will ensure that all the members of his/her Health Team are fully conversant with the various National Health & Family Welfare Programs including NHM to be implemented in the area allotted to each Health functionary.
- He/she will prepare operational plans and ensure effective implementation of the same to achieve the laid down targets under different National Health and Family Welfare Programmes.
- The MO will ensure the effective implementation of National Health Programmes – Reproductive and Child Health Programme, Universal Immunization Programme, National Vector Borne Disease Control Programme, National Programme for control of Blindness, Non-Communicable Diseases Programmes, National Mental Health Programme, Control of Communicable Diseases, Leprosy, Tuberculosis, Sexually Transmitted Diseases and Ayushman Bharat
- He/she will take timely actions for RTI, court cases and expeditious implementation of orders of the courts as applicable.
- He/she will discharge all the financial duties entrusted to him/her.
- He/she will ensure appropriate utilization of funds as per the guidelines and GFR (General Financial Rules) provisions.
- He/she will monitor and guide the activities of Hospitals/PHC/CHC committees, patient welfares societies of hospitals, village health & sanitation committees.
- He/she will attend all calls from the in-patients, while He/she is 'on-call duty'.
- He/she will ensure inter-sectoral/inter-departmental coordination, involvement of community leaders, various social welfare agencies and people for effective provision of patient centric healthcare
- He/she will be involved in 'performance audit' of staff as per the guidelines of 'Performance Audit'.
- He/she will facilitate, coordinate, supervise, monitor, and implement the provisions of all the health sector Acts and the Rules
- As a member of the health care team, he/she will exemplify an example in attitude toward patients and staff, thereby, performing duties with respect, dignity, privacy, and modesty to the patients.
- He/she will perform any other duties which a Medical Officer is expected to perform in view of his position and any other duties which will be assigned as and when required.
- Ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.

Staff Nurse

- She/he will assess the needs of the patients in the ward, make a nursing care plan for all patients consulting with ward sister.
- She/he will give direct patient care and allotted responsibility to her/him by the ward sister.
- She/he will take steps to ensure the patient are comfortable and maintain the safety of the patient (universal safety precaution).
- She/he will carry out procedures of admission, discharge and transfer of patient of the ward.
- She/he will be responsible for taking a history of the patient.
- She/he will prepare and assist in the diagnostic procedure in the ward.
- She/he will provide minor dressing in an emergency.
- She/he will ensure sterilization of all articles, maintain all equipment, gadgets, electrical connections, light, fan etc.
- She/he will administer drugs by injection upon written order of the Doctor.
- She/he will keep abreast of the handling of special gadgets & equipment including in patient care in the place of posting.
- She/he will ensure the distribution of the diet, milk, etc.
- She/he will be responsible for observation of the patient's condition, take prompt action and report to the concerned medical officer.
- She/he will give health education to the patients and their family members under care.
- She/he will make records of all procedures of her/his patients and keep them up to date.
- She/he will take care that case papers are not allowed to be handled by anyone except the doctor-in- charge of the patient. This is specifically for medico-legal cases.
- She/he will ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.
- She/he will respect the cultural and religious differences of the patients.
- Any other assignments given from time to time.

She/he will be responsible

- To maintain the aseptic environment of the Operation Theatre
- To carry out the instruction of O.T. staff nurse when necessary and to act as the O.T. staff nurse in her/ his absence.
- To assist the Surgeon and Anaesthetist in operation theatre.
- To count all instruments and mops before closing the wounds.
- To monitor the condition and take care of the patient during the operation and postoperatively in the recovery room.
- To ensure fumigation in the O.T. room as and when indicated.

She/he will be responsible -To provide antenatal, intra-natal, postnatal care as taught in the practice protocols as per LAQSHYA standards.

Medical Laboratory Technologist/Lab technician

- He/she will receive and process samples.
- He/she will draw blood samples for testing (primarily by performing vein punctures).
- He/she will label specimens/vials accurately and distribute them to the appropriate departments/ processing centres at the recommended transportation condition.
- He/she will prepare samples/slides for testing using various types of laboratory equipment.
- He/she will conduct all the necessary laboratory investigations including routine microscopy.
- He/she will give instructions to the patient regarding sample collection.
- He/she will be friendly, courteous and sympathetic while working with patients.
- He/she will write/print and issue the laboratory reports to the patients.
- He/she will ensure that patient confidentiality is always maintained.
- He/she will be responsible for the upkeep and routine maintenance of the instruments in the laboratory and update of instrument maintenance records.
- He/she will ensure cleanliness clean/sterilize and maintain work area and all lab equipment, accessories and supplies.
- He/she will make timely indents for chemical, reagents & equipment repairs.
- He/she will prepare chemical reagents, stains, solutions and biological media according to formulae, accurately label all reagents and other stock in the laboratory.
- He/she will take care of all quality assurance and quality control norms in the laboratory, including EQAS, IQAS.
- He/she will follow all safety protocols and standard operating procedures to maintain hygiene and for prevention of the infection.
- He/she will maintain the data about all lab procedures and will maintain records of supplies, stock and investigations that are done.
- He/she will submit weekly/monthly reports of the laboratory work.
- He/she will keep himself/herself informed about new laboratory techniques.
- He/she will participate in the development of new medical laboratory procedures and techniques.
- He/she will participate in training, workshops and continuing education programmes.
- He/she will keep himself/herself updated regarding various guidelines on hospital infection control and management of spills (e.g. Mercury, Chemicals, Body fluids).
- He/she shall maintain the containers and specimens that may be involved in court cases, in as applicable.
- He/she will act as auditee during an internal audit of the lab.
- S/he will ensure the privacy and confidentiality of the patients.
- Will give adequate time to each patient and provide care with respect and dignity.
- S/he will respect the cultural and religious differences of the patients.
- Any other assignments given from time to time.

Annexure 11: List of Diagnostic Tests and Equipment at CHC-FRU/UCHC-FRU

List of diagnostic tests at FRU Community Health Centres (Rural & Urban)

S No.	Diagnostic test	Product/Equipment Required
1.	Essential Hemoglobin, Total leucocyte count, Differential leucocyte count, Platelet count, Complete blood count, Erythrocyte sedimentation rate, Blood group and Rh typing, Blood cross matching, Peripheral blood film, Reticulocyte count, Absolute eosinophil count, Bleeding time and clotting time, Sickling Test for screening of Sickle cell anemia, Sickle cell test rapid for screening of Sickle cell anemia (Strip test), NESTROFT Test for screening of Thalassemia, DCIP test for screening HbE hemoglobinopathy, Screening test for G6PD enzyme deficiency, MP slide method, Malaria rapid test, Prothrombin Time (PT) and INR, Activated partial thromboplastin time, Human chorionic gonadotropin (HCG) (Urine test for pregnancy), Urine test for pH, specific gravity, leucocyte esterase, glucose, bilirubin, urobilinogen, ketone, protein, nitrite, Urine Microscopy, 24-hours, urinary protein, Urine for microalbumin, Urine for creatinine and Albumin to creatinine ratio (ACR), Stool for ova and cyst, Stool for Occult Blood, Semen analysis, Test for Dengue, RPR/VDRL test for syphilis, HIV test (Antibodies 1/2 and HIV 1/2), Hepatitis B surface antigen test, HCV Antibody Test (Anti HCV), Sputum, pus etc. for AFB, Typhoid test (IgM), Blood sugar, Glucose Tolerance test (GTT), S. Bilirubin (T), S. Bilirubin direct and indirect, Serum creatinine, Blood Urea, SGPT, SGOT, S. Alkaline Phosphatase, S. Total Protein, S. Albumin & AG ratio, S. Globulin, S. Total Cholesterol, S. Triglycerides, S. VLDL, S.HDL, S. LDL, S. GGT, S. Uric acid, S. Amylase, S. Iron, Total Iron binding capacity, Glycosylated hemoglobin (HbA1C), S. Sodium, S. Potassium, Serum Calcium, S. Magnesium, Wet mount and Gram stain for RTI/STD, Gram staining for clinical specimen, Throat swab (Albert stain) for Diphtheria, Stool for hanging drop for Vibrio Cholera,	Essential Hemoglobinometer, Hematology analyzer (5 Part), Hematology analyzer (5 Part), Manual with reading using ESR analyzer., Blood group kit (manual), Microscopy, Rapid card tests for combined P. Falciparum and P. vivax, Automated coagulation analyzer, Multiparameter urine strip (dipstick), Manual method/Fully automated biochemistry analyzer, Turbidometer, Microscopy (with Neubauer chamber and slide), Rapid card test for combined NS1 antigen, IgM, and IgG antibodies b) ELISA, Glucometer only for screening, Filaria Strip test, Electrolyte Analyzer (Indirect ion selective electrode)

S No.	Diagnostic test	Product/Equipment Required
	Visual Inspection Acetic Acid (VIA), rK39 for Kala Azar, Test for Filariasis, TB – Mantoux, Troponin - I, CRP (including newborn) (Quantitative), Pap smear Chip based Real time micro-PCR test, S.TSH (including for new-born screening), S. Free T3, S. Free T4, S. Sodium, S. Potassium, S. Magnesium.	
2.	**Desirable** D-dimer, Throat swab (Albert stain) for Diphtheria, Stool for hanging drop for Vibrio Cholera, S. Ferritin, Cytology, Histopathology,Hemoglobin electrophoresis, Blood culture, Urine Culture, Other cultures (pus, throat swab etc.), Organism identification and antimicrobial sensitivity for cultures	**Desirable** Electrophoresis Machine, Chemoluminescence Immunoassay, Automated Blood Culture System

** For Hub Lab Note: The Diagnostic tests and equipment mentioned under desirable are over and above the essential tests and equipment*

Annexure 12: List of Equipment at CHC-FRU/UCHC-FRU

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
1	Medicine/ Family Medicine OPD	**Equipment*:**	
		Thermometer, Examination Light, Wall mounted Hight Measuring Scale,	
		Stethoscope, Weighing Machine, (Both adults and pediatrics), LED torch, Measuring tape, Sphygmomanometer, stethoscope+ Otoscope, tuning fork (156), percussion hammer, wooden tongue depressor	
		Accessories/Consumables:** roof/wall mounted single piece curtain to ensure privacy, LED Torch, Gloves, Shoe covers. Head Caps, masks, Gowns.	
		Furniture*:** Examination table with in built IV stand, with, Footstool, Colour coded bins, Stool, slim model doctor's table and chair, and slim model two	
		armless chairs for patients and attendants. X-Ray's view box	
2	Surgery OPD	**Equipment:** Same as under * in Medicine OPD	
		Instruments: Removal of Stitches Tray	
		Accessories/Consumables: Same as under ** in Medicine OPD	
		Furniture: Same as under *** in Medicine OPD	
3	Obs & Gynecology OPD	**Equipment:** Same as under * in Medicine OPD + Foetal Doppler, CTG Machine, Obstetric/ Gynaecologic Ultrasound, Foetoscope	
		Instruments: Removal of Stitches Tray, Gynaecological Examination Tray, Vaginal speculums, and spatula Tray.	
		Accessories/Consumables: Same as under ** in Medicine OPD	
		Furniture: Same as under *** in Medicine OPD	
4	Pediatrics OPD	**Equipment:** Same as under * in Medicine OPD + Otoscope, tuning fork (156), percussion hammer, weighing scale (Digital and standing Weighing scale), infantometer, stadiometer, wooden tongue depressor, non-stretchable measuring tape.	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		Accessories/Consumables:	
		Same as under ** in Medicine OPD	
		Furniture: Same as under *** in Medicine OPD	
5	NCD Clinic	**Equipment:** Same as under * in Medicine OPD+ glucometer, Otoscope, tuning fork (156), percussion hammer, wooden tongue depressor	
		Instruments:	
		Mouth Mirror, Cusco's Speculum	
		Accessories/Consumables: Same as under ** in Medicine OPD	
		Furniture: Same as under *** in Medicine OPD+ glucometer strips	
7	Dental OPD	**Equipment:** Dental chair with all the probes (Air Rotor, Ultrasonic Scalar with four tips, Compressor oil free medical grade (noise-free), Suction fitted in the dental chair medium and high vacuum., Air rotor hand piece contra angle two and one straight hand piece (4 lakhs RPM), LED light cure unit, Diathermy Bipolar, Latest foot operated light of 20,000 and 25,000/- Lux, Dental X-ray IOP/OPG X-ray viewer with LED light), Horizontal Autoclave with UV light	
		Instruments: Mouth mirror and Examination Instruments	
		Accessories & Consumables: Same as under ** in Medicine OPD	
		Furniture: Same as under *** in Medicine OPD	
7	Pre-Anesthetic Check Up Room	**Equipment**	
		* Same as under Medicine OPD + Spirometer	
		Accessories & Consumables: Same as under ** in Medicine OPD	
		Furniture: Same as under *** in Medicine OPD	
8	Family Medicine		**Equipment**
			* Same as under Medicine OPD
			Accessories/ Consumables

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
			** Same as under Medicine OPD
			Furniture
			*** Same as under Medicine OPD
9	Eye OPD	**Equipment**	
		Same as under * in Medicine OPD + Ophthalmoscope- Direct,	
		Ophthalmoscope- Indirect with 20 D Lens, slit lamp refraction units,	
		Streak retinoscope, A- Scan Biometer, B- Scan Biometer, Keratometer, Auto-refractometer, Punctum Dilator,	
		Applanation Tonometer, Fundus Camera,	
		OCT.	
		Accessories:	
		Trial lens set with trial frame Adult/ Children, Torch	
		Accessories & Consumables	
		**Same as under Medicine OPD	
		Furniture:	
		Same as under *** in Medicine OPD	
10	Orthopedics OPD#	**Equipment:**	
		Same as under * in Medicine OPD+ Reflex hammer, Goniometer	
		Instruments: Removal of Stitches Tray	
		Accessories/Consumables: Same as under ** in Medicine OPD	
		Furniture: Same as under *** in Medicine OPD	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
11	ENT OPD		**Equipment:** Same as under * in Medicine OPD+ Ear & nasal Suction machine, Otoscope, Jobson Horne probe, Head lamp
			Instruments: Nasal Speculum, Laryngeal mirror, Nasopharyngeal mirrors Aural speculum Siegles speculum, Tuning fork (512 Hz), Bayonet forces
			Accessories/ Consumables: Same as under
			** in Medicine OPD
			Furniture: Same as under *** in Medicine OPD+ ENT examination chair
12	24x7Emergency	**Equipment:** Resuscitation Bed, Multi-Para monitors, Sphygmomanometer, Laryngoscopes with Blades (both straight and curved for adult and paediatric), Oxygen cylinder Type D, Suction Machine (Electrical), Defibrillators, Mechanical ventilators (only for red Beds), Infusion pump, Ultrasonic nebulizer, ECG Machine, Transport monitor, Transport Ventilator, Thermometers, Glucometer, stethoscope, ophthalmoscope, otoscope Examination light.	
		Instruments:	
		Magill's forceps, Artery forceps, Surgical Blade, Mayo scissors, sponge forceps etc.	
		Accessories/Consumables:	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		Ambu Bag (Adults and Paediatrics), Dressing material, syringes and needles of different sizes, wall/roof mounted single piece curtains to ensure privacy, ET & TT tube in each size, Tracheostomy set, Urinary Catheters, IV cannulas, IV and BT sets, NG tubes with each size, Gloves,	
		splints of various sizes, Goodle's airway etc.	
		Furniture: Colour coded BMW Bins, Intravenous stand, Stool, Cardiac Tables,	
		Crash Cart, Emergency Medicine Trolly.	
13	Minor OT	**Equipment:**	
		OT Table, OT light, Electrical Suction, Laryngoscope with 5 Blades (LED), Flash Autoclave - (Chamber capacity of app. 20 litres/cycle,	
		Instruments: Surgical instruments and sets as required for each surgery/ procedure.	
		Accessories/Consumables:	
		Ambu Bag (Adults and Paediatrics), Dressing material, syringes and needles of different sizes, ET & TT tube in each size, Tracheostomy set, Urinary Catheters, IV cannulas, IV and BT sets, NG tubes with each size, Gloves, Goodle's airway, Shoe covers, Head Caps, masks, Gowns etc.	
		Furniture: Colour coded BMW Bins, Intravenous stand, Stool, Cardiac Tables, Crash Cart, Emergency Medicine trolly.	
14	OT General	**Equipment:** OT Table, OT light - Ceiling Double Dome, Anaesthesia workstation, Electrical Suction, Laryngoscope with	
		5 Blades (LED), Defibrillator (AED plus Manual with ECG, Flash Autoclave - (Chamber capacity of app. 20 litres/ cycle, Surgical Diathermy – Bipolar, ECG Machine	
		- 6 Channel, Bowl Sterilizers - Different Sizes, Oxygen Cylinder D type, Washer Disinfector - 30- 45 Litres, Blood Warmer,	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		Glucometer, Thermometer, Infusion Pump	
		Instruments: Surgical instruments as required for each surgery.	
		Accessories/Consumables:	
		Ambu Bag (Adults and Paediatrics), Dressing material, syringes and needles of different sizes, ET & TT tube in each size, Tracheostomy set, Urinary Catheters, IV cannulas, IV and BT sets, NG tubes with each size, Gloves, Goodle's airway, Shoe covers, Head Caps, masks, Gowns etc.	
		Furniture: Mayo Stand, Surgical Trolley, Equipment Trolley, Emergency & Drugs Trolley, Anaesthesia Trolley (Complete with Ambu bags and other items), Difficult Airway Trolley- Bronchoscope and intubating, Crash Cart, Patient Trolley, IV Stand,	
15	**Obstetrics & Gynecology OT**	**Equipment:** OT Table, OT light - Ceiling Double Dome, Anaesthesia workstation, Electrical Suction, Laryngoscope with	
		5 Blades (LED), Defibrillator (AED plus Manual with ECG, Flash Autoclave - (Chamber capacity of app. 20 litres/ cycle, Surgical Diathermy – Bipolar, ECG Machine - 6 Channel, Bowl Sterilizers - Different Sizes, Oxygen Cylinder D type, Washer Disinfector - 30- 45 Litres, Blood Warmer, Glucometer, Open care Radiant	
		warmer, Hysteroscopy, Foetal Doppler, CTG	
		Monitor, Vacuum extractor, Pulse Oximeter baby & adult	
		Instruments:	
		Surgical instruments as required for each surgery.	
		Accessories/Consumables: Ambu Bag (Adults and Paediatrics), Dressing material, syringes and needles of different sizes, ET & TT tube in each size, Tracheostomy set, Urinary Catheters, IV cannulas, IV and	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		BT sets, NG tubes with each size, Gloves, Goodle's airway, Shoe covers, Head Caps, masks, Gowns etc.	
		Furniture: Mayo Stand, Surgical Trolley, Equipment Trolley, Emergency & Drugs Trolley, Anaesthesia Trolley (Complete with Ambu bags and other items), Difficult Airway Trolley- Bronchoscope and intubating, Crash Cart, Patient Trolley, IV Stand.	
16	**Anaesthesia Equipment list for each OT**	**Equipment:** Anesthesia Machine, O2 cylinder for Boyles- D type, N2O Cylinder for Boyles-D type, CO2 cylinder for laparoscope* (to be provided as per need), Spiro meter, Multi Para Monitor - Desirable if Anaesthesia workstation available in OT, Defibrillator (AED plus Manual with ECG), Infusion Pump, Oxygen concentrator	
		Instruments: Anaesthetic - laryngoscope Magill's with four blades, Magill's forceps (two sizes), Tongue depressors* (to be provided as per need), Adult Resuscitation Kit (to be provided as per need), Neonate Resuscitation Kit (to be provided as per need), Emergency First Aid Kit (to be provided as per need),	
		Accessories/Consumables: Ambu Bag (Adults and Paediatrics), Dressing material, syringes and needles of different sizes,	
		ET & TT tube in each size, Tracheostomy set, Urinary Catheters, IV cannulas, IV and BT sets, NG tubes with each size, Gloves, Goodle's airway, Shoe covers, Head Caps, masks, Gowns etc.	
		Furniture: Patient Trolley	
17	**Emergency OT**	**Equipment:** Basic operating theatre table, consisting of # head section, # Foot	
		section, # Body section, # Lithotomy poles, #	
		Mattress, # shoulder rest, OT light,	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		Oxygen Therapy apparatus, W/masks, flow meter, cylinder trolley, Suction Apparatus, BP Machine, Portable Autoclave, Operating lamp, mobile, 12 V including Battery, Spare bulbs and supplied with charger, Water Bath (Electric), Medium size, Tourniquet	
		– Adult, Tourniquet – Child, Proctoscope – Adult, Proctoscope – Child, Stethoscope, Thermometer, Nebulizer machine, Torch,	
		ECG 3 Channel	
		Instruments: Ambu- bag, BP handle, No. 4, artery forceps – straight, artery forceps – curved, mosquito forceps – straight, mosquito forceps – curved,	
		plain dissecting forceps, tooth dissecting forceps, right angle detector, needle holder – large, needle holder – small, BP blade, instrument trolley, stomach tube, resuscitation kit, manual, infant, dissecting scissor 8", allis tissue forceps, Mayo's scissors, dissecting scissors 8" curved, ttitch cutting scissors, gauge cutting/bandage cutting scissors 12, kidney tray – small, kidney tray – big, sponge holding forceps, Kocher's artery forceps – straight, Kocher's artery torceps – curved, cat's paw retractor, ear speculum, nasal speculum – adult, nasal speculum – child, tracheostomy set, female metallic catheter, tongue depressor, catheter introducer, vaginal Speculum –	
		large, vaginal speculum – small.	
		Accessories/Consumables: Ambu bag (adults and paediatrics), dressing material, syringes and needles of different sizes,	
		ET & TT tube in each size, tracheostomy set, urinary catheters, IV cannulas, IV and BT sets, NG tubes with each size, gloves, goodle's airway, shoe covers, head caps,masks, gowns etc.	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		Furniture: Patient trolley, surgeon's stool, fixed height with stump feet and anti - static cushion, surgical drum inch, surgical down eight inches	
18	Eye OT	**Equipment:** OT Table, OT light - Ceiling Double Dome, Anaesthesia workstation, Electrical Suction, Laryngoscope with	
		5 Blades (LED), Defibrillator (AED plus Manual with ECG, Flash Autoclave - (Chamber capacity of app. 20 litres/ cycle, Surgical Diathermy – Bipolar, ECG Machine	
		- 6 Channel, Bowl Sterilizers - Different Sizes, Oxygen Cylinder D type, Washer Disinfector - 30- 45 Litres, Blood Warmer, Glucometer, Thermometer, Infusion Pump, Cryo surgery unit, Operating Microscope,	
		Phaco Machine, Nd Yag Laser	
		Instruments: Surgical instruments as required for each surgery.	
		Accessories/Consumables: Ambu Bag (Adults and Paediatrics), Dressing material, syringes and needles of different sizes,	
		ET & TT tube in each size, Tracheostomy set, Urinary Catheters, IV cannulas, IV and BT sets, NG tubes with each size, Gloves, Goodle's airway, Shoe covers, Head Caps, masks, Gowns etc	
		Furniture: Mayo Stand, Surgical Trolley, Equipment Trolley, Emergency & Drugs Trolley, Anaesthesia Trolley (Complete with Ambu bags and other items), Difficult Airway Trolley- Bronchoscope and intubating, Crash Cart, Patient Trolley, IV Stand	
19	LDR Complex	**Equipment:** Labour bed, multipara monitor, sphygmomanometer, glucometer, foetal doppler, CTG machine, thermometer, laryngoscope with 5 blades (LED, curved & straight for adult and paediatric each size), suction machine, examination light, open care radiant warmer, vacuum extractors, pulse oximeter	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		Instruments: Magill's forceps, Mayo scissors, artery forceps, sponge holders, normal delivery kit, episiotomy kit, forceps delivery kit, craniotomy kit	
		Accessories/Consumables: Ambu bag (adults and paediatrics), dressing material, syringes and needles of different sizes,	
		ET & TT tube in each size, tracheostomy set, urinary catheters, IV cannulas, IV and BT sets, NG tubes with each size, gloves, goodle's airway, shoe covers, head caps, masks, gowns etc.	
		Furniture: Colour coded BMW bins, intravenous stand, stool, cardiac tables, crash cart with emergency medicine trolley	
20	IPD (Wards)	**Equipment:** Beds, bed side locker/ trolley, thermometer, SpO2 monitor, sphygmomanometer digital), crash cart with multipara monitor, nebulizer, laryngoscopes (LED) both straight and	
		curved for adults and pediatrics (for each size), torch	
		Instruments: Magill's forceps	
		Accessories/Consumables: Ambu bags (adult & paediatrics), dressing material, syringes and needles of different sizes, ET & TT tube in each size, tracheostomy set, urinary catheters, IV cannulas, IV and	
		BT sets, NG tubes with each size, gloves, goodle's airway, shoe covers, head caps, masks, gowns etc.	
		Furniture: Colour coded BMW bins, intravenous, stool, bed side chairs, chair for nurses and doctors, medicine trolley	
21	NBSU	**Equipment:** Radiant warmer, multipara monitor, sphygmomanometer, glucometer, laryngoscope with 5 blades (LED, curved & straight for neonates and paediatric each size), suction machine	
		Instruments: Magill's forceps	
		Accessories/Consumables: Ambu bags (neonatal & paediatrics), dressing material, syringes and needles of different sizes,	

S No.		FRU CHC (Rural)/(Urban)	
	Department	E	D
		ET & TT tube in each size, tracheostomy set, urinary catheters, IV cannulas, IV and BT sets, NG tubes with each size, gloves, goodle's airway, shoe covers, head caps, masks, gowns etc.	
		Furniture: Colour coded BMW bins, intravenous, stool, bed side chairs, chair for nurses and doctors, medicine trolley	
22	NRC* (Desirable)		**Equipment:** Bed, glucometer, height and weight measurement scale (digital), thermometer, infantometer, stadiometer,
			crash cart with multipara monitor, nebulizer, laryngoscopes (LED) both straight and curved for adults and pediatrics (for each
			size), torch.
			Instruments: Magill's forceps
			Accessories/ Consumables: Ambu bags (adult & paediatrics), dressing material, syringes and needles of different sizes, ET & TT tube in each size, tracheostomy set,
			urinary catheters, IV cannulas, IV and BT sets,
			NG tubes with each size, gloves, goodle's airway, shoe covers, head caps, masks, gowns etc.

S No.		FRU CHC (Rural)/(Urban)	
	Department	**E**	**D**
			Furniture: Colour coded BMW bins, intravenous, stool, bed side chairs, chair for nurses and doctors, medicine trolley
23	**Radiology services**	**Equipment:** X-Ray 300 mA, USG with all the probes, ECG machine	
24	**Basic Rehabilitation Equipment**	Shoulder wheel, wall ladder finger exerciser, finger exerciser web, shoulder pulley, walking aid for training – adjustable walker, reciprocal walker, exercise couch, pillow, towel, floor patterns may be designed having alternate patterns different colour tiles (1 feet X 1 feet) to help in teaching gait pattern/visual feedback for neurological impaired geriatric patients, one wheelchair, exercise charts for teaching basic exercise for neck, back, shoulder, knee joint etc, chart for showing positioning, lifting, and carrying technique for elderly, spirometer with disposable mouthpiece for those patients who need to perform breathing exercise multiple times in a day (diagnosed cases of chronic bronchitis, emphysema, cystic fibrosis), lower & upper extremity cycle/ basic ergo meter, ultrasound therapy, TENS, interferential therapy/electrotherapy unit	
25	**PMR**		NCV machine*, EMG machine**, VEP machine***, Auditory Brainstem Response machine****

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

OPD Services: -

PMR Equipment: -

NCV machine: Desirable at 100 bedded UCHC*

*EMG machine**: Desirable at 100 bedded UCHC*

*VEP machine***: Desirable at 100 bedded UCHC*

*Auditory Brainstem Response machine****: Desirable at 100 bedded UCHC*

SECTION 12: REFERENCES

1. Ministry of Health and Family Welfare (MoHFW), Government of India.
   Indian Public Health Standards (IPHS) Guidelines for Community Health Centres – 2022.
   https://nhm.gov.in
2. MoHFW.
   Operational Guidelines for First Referral Units (FRUs) – 2004.
   Available from: https://nhsrcindia.org
3. MoHFW.
   Ayushman Bharat – Comprehensive Primary Health Care through Health and Wellness Centres: Operational Guidelines – 2018.
   https://ab-hwc.nhp.gov.in
4. National Health Systems Resource Centre (NHSRC).
   Gap Assessment Reports and Dashboards under IPHS Tracking – 2023–2024.
   Internal technical reports, NHSRC.
5. MoHFW.
   Pradhan Mantri – Ayushman Bharat Health Infrastructure Mission (PM-ABHIM): Operational Guidelines – 2021.
   https://pmabhim.gov.in
6. Health Dynamics of India – 2022–2023.
   Annual Facility Data Report on CHCs, Human Resources, and IPHS compliance.
   MoHFW Statistics Division.
   https://hmis.nhp.gov.in
7. National Centre for Disease Control (NCDC), MoHFW.
   Integrated Disease Surveillance Programme (IDSP) Guidelines – 2022.
   https://idsp.nic.in
8. National Health Authority.
   Ayushman Bharat Digital Mission: Strategy Overview and Implementation Toolkit – 2021.
   https://abdm.gov.in
9. MoHFW and NHSRC.
   National Quality Assurance Standards (NQAS) for Public Health Facilities – 2022.
   https://qps.nhsrcindia.org
10. MoHFW.
    Standard Treatment Workflows for Common Conditions at FRUs and District Hospitals – 2023.
    https://clinicalestablishments.gov.in

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NHSRC/PHA/24-25/StrengtheningCHCs/0682
Government of India
Ministry of Health and Family Welfare

Nirman Bhavan, New Delhi
Date: 12th March, 2025

OFFICE MEMORANDUM

Subject: Constitution of expert committee for Revision of First Referral Units (FRUs) Operational Guidelines, 2004

The Government of India is cognizant of the growing importance of the CHCs as First Referral Units (FRUs). By strengthening FRUs, the quality and reach of healthcare services across India can be enhanced. The FRU guidelines have not been updated since 2004. It is crucial to revise the standards to make FRUs adaptable and resilient.

2. It has thus been decided to constitute a committee of experts under the Chairmanship of JS(P) on the above-mentioned subject. The constitution of the group is as follows:

Sl. No.	Name	Designation	Role
1.	Mr. Saurabh jain	JS (P)	Chair
2.	Ms. Meera Srivastava	JS (RCH)	Co-Chair
3.	Maj. Gen Dr Atul Kotawal	Executive Director, NHSRC, MoHFW, Govt of India	Co-Chair
4.	Dr. Suneela Garg	Chairperson of programme advisory committee, NIHFW	Member
5.	Mr. Harsh Mangla	Director NHM -I	Member
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9.	Dr Govind Bansal	Director RCH	Member
10.	Dr Pawan Kumar	AC, MH Division MoHFW	Member
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14.	Prof. Manish Chaturvedi	Sub-Dean Teaching NIHFW	Member
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16.	Subject Expert : Nominee from MD NHM UP		Member
17.	Subject Expert : Nominee from MD NHM Tamil Nadu		Member
18.	Subject Expert : Nominee from MD NHM Maharashtra		Member

3. The committee will review the 2004 FRU guidelines to identify and address existing gaps and addressing the recent developments as per the given TOR and submit its recommendations.

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To,

1. All the members of the committee

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