Ministry of Health and Family Welfare
Government of India

Operational Guidelines for

Pradhan Mantri Ayushman Bharat Health Infrastructure Mission

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Introduction to PM Ayushman Bharat Health Infrastructure Mission

1.1 BACKGROUND AND RATIONALE

1.1.1. The COVID 19 pandemic has highlighted the fact that essential public health functions necessary to respond to such an outbreak were weak. Limited laboratory capacity at all levels meant that functions of testing, case detection, surveillance and outbreak management were challenging and facilities for critical care provision lacked adequate Intensive Care Units, Isolation Beds, Oxygen supply, and Ventilators. COVID 19 also illustrated that despite using the health systems approach to horizontal integration between programmes, much more needs to be done to strengthen convergence between institutions created for vertical disease control programmes and the district and sub district service delivery systems.

1.1.2. In the early months of the pandemic, particularly in states with weak health systems there was a significant decline in the delivery of non-COVID essential services, on account of marshalling of all resources for COVID related activities. Health systems across the country were hard put to manage the delivery of both sets of services, viz. the COVID and non-COVID essential health services.

1.1.3. Public health has significant externalities (food and drug regulation/, public health action, including health promotion and prevention and surveillance for infectious disease) which require government intervention. Persistent inequities in access and coverage are a barrier to India's progress in health indicators and markets do not address inequities in health care.

1.1.4. The on-going COVID 19 pandemic has demonstrated that India's health systems need to be better equipped to address public health needs across primary, secondary, and tertiary care levels. India's current epidemiological and demographic status, with the rapid rise in non- communicable diseases, a double burden of chronic and infectious diseases, and unfinished agenda of reproductive, maternal new-born and child health services has created an increasing demand on health care and public health services.

1.1.5. At the same time, high costs of care, persistent health inequalities, and reduced access to essential public health services particularly for those living in remote areas and in slum and slum like areas, challenge our health system. COVID 19 and predecessor Infectious diseases such as SARS, H1N1, NIPAH and Zika outbreaks have highlighted that the health systems needs to fully prepare and gear up to respond to public health emergencies.

1.1.6. 27.5% of all deaths in India in 2016 were due to communicable diseases, maternal, neonatal and nutritional disorders while non-communicable diseases and injuries accounted for 61.8% and 10.7% deaths respectively. Communicable diseases also contribute to 32.7% of DALYs in India (Source: India: Health of the Nation's States, ICMR) whereas injuries contribute to 11.9% of DALYs in India, and 10.7% of deaths in India. It is anticipated that about 3-5% of emergencies would require ICU facilities and oxygen supported beds for critical care. There is an urgent need to strengthen these facilities and create additional amenities (infrastructure, equipment etc.) including for dialysis, in existing district hospitals to meet such unforeseen epidemics, disasters etc.

1.1.7 The present architecture of the public hospitals is not equipped fully to handle the critical requirement of clinical management of affected patients while maintaining essential services during periods of public health challenges posed by pandemics such as the current COVID-19 pandemic. Many of the hospital buildings currently available do not have the provision for segregating a part of the building as an infectious diseases treatment block\ wing. As a result, in order to avoid mixing of COVID and non-COVID patients, at many places full hospitals were required to be designated as COVID Dedicated Facilities. Apart from that, at many district headquarters, especially in districts with largely rural settings, district hospital is the only hospital available where critical care services can be provided to people. As a result, either large amounts of expenses are necessitated on account of transportation of patients to other districts or in case the only available hospital is designated as the COVID (pandemic) dedicated hospitals, there is a severe adverse impact on the other essential services such as institutional deliveries, blood transfusion services, dialysis and chemotherapy etc. Strengthening all the districts with Critical Care Hospital Blocks of 50-100 beds as per the population size, will enable the public healthcare system at the district level to respond adequately during the public health challenges posed by future pandemics and in periods of epidemic outbreaks and enable the health systems to also maintain the essential health services in such times. In other times when there is no epidemic, these blocks will continue to provide health services, especially for critical care.

1.1.8. The disease burden in the country also demonstrates the need for provision of high quality laboratory services at district and block levels. Delays in diagnosis compromise early detection and initiation of appropriate treatment. In the case of infectious disease outbreaks, such delays can lead to widespread community transmission.

1.1.9. Both general and out of hours laboratory services (e.g. emergency services, critical care services) are being provided through laboratories that are largely fragmented. Also, public health surveillance for abnormal morbidity/mortality, reporting of human or animal disease patterns and testing of samples etc. for public health needs remains a weak area in most districts.

1.1.10. The present public healthcare system structure at the Block level is not equipped to handle public health emergencies and also to respond and monitor the healthcare services. Every Block in the Country is envisaged to have a Community Health Centre (CHC) at the Block headquarter and serve as a hub for referral from the Sub-Health Centres (SHCs) and Primary Health Centres (PHCs) within the block. However, the status of availability of CHCs across

states is highly variable, with the block level CHC in some states in effect being just another PHC. In some other states, the block CHC, on the other hand, is also a First Referral Unit. The functions of a Block CHC are mostly focused on clinical services that too largely RMNCH+A and selected infectious diseases. The outbreak of COVID-19 has highlighted a constrained public health response as a result of a suboptimal public health focus at the block level.

1.1.11. The COVID-19 pandemic has also highlighted the various challenges faced in provisioning of trained human resources. Experience suggests that as the pandemic evolves and as the experts gain a better understanding of the epidemiology and virulence of the disease, the training needs also evolve. With a pandemic like COVID-19 which is a new infection, experimentation in arriving at the best treatment protocol also leads to changing training needs. The Ministry has set up the iGOT training platform for online training of healthcare professionals. More importantly over a period of last 5 months, the Central Institutions of Excellence such as the AIIMS Delhi, PGI Chandigarh etc. have assumed the much needed mentorship role for building confidence of the healthcare professional providing treatment services to the patients, be it about personal protection, infection prevention, plasma therapy, patient monitoring or about the best possible line to treatment. These institutions have also acted as training sites (albeit the trainings being largely offsite!!) for the healthcare professional and for undertaking clinical studies to inform further policy direction. This Ministry has set up INIs like AIIMS Delhi and several other large hospitals cum teaching institutes such as Safdarjung and RML Hospital. Also, 22 new AIIMS are being established under the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). These are tertiary healthcare, medical education and research institutes. In addition, the Ministry of HRD also operates 2 advanced medical education and tertiary healthcare institutes/ hospitals. However, these hospitals have not been designed to deal with infectious disease patients. Infectious disease hospitals are specially designed, with negative pressure systems and other special features to control spread of the infectious disease.

1.1.12. The complexity of COVID-19 pandemic, which has spread to over 150 Countries in the World, has highlighted the need of having competent core capacities for surveillance and response, diagnostic labs, logistics (including PPEs, Masks, Sanitizers and Disinfectants) and appropriate quarantine and isolation facilities at various levels. During the course of past 3-4 months, the Country has faced numerous challenges like quarantine of evacuees (for China, Iran, Italy), widespread migration, containment of complex clusters and development of diagnostic capacities across the Country.

1.1.13. The 40 metro cities (including Tier I and Tier II cities) presently do not have any infrastructure for regular surveillance for community based health measures and health facilities. Similarly, implementation of the Integrated Health Information Platform (IHIP), an IT enabled comprehensive surveillance platform has also only been implemented in 7 states. Capacities for timely data collection, collation and analytics also need strengthening. The Epidemiological Intelligence Service, housed in the NCDC has been instrumental in containing recent out breaks of Nipah in Kerala and Zika in Rajasthan and Madhya Pradesh. However, the EIS too needs to be strengthened to have the capacity to effectively lead the technical response to pandemics of the magnitude of COVID-19.

1.1.14. There is a need for an integrated surveillance program at all levels (Zonal and State levels) and also its expansion to various metro cities. It is also envisaged that the IT level surveillance network is developed, so that that there is uninterrupted data flow particularly sites of screening to tracking in the community and further linking it up with diagnostic laboratories and isolation hospitals. The proposal encompasses strengthening of all Divisions of NCDC focused on applied public health and epidemiological intelligence, building capacity for emerging and re-emerging infections, surveillance and its evaluation, National program for anti-microbial resistance (AMR) containment under the One health approach, biosafety-biosecurity, occupational safety & climate change, and building of competencies among front line health care workers for strengthening community surveillance at National, Regional and District levels.

1.1.15. A major impediment for quick response mechanism is non-availability of dedicated secondary/ tertiary level medical facilities near the disaster site due to damage to the health facilities. In major public health emergencies such as COVID-19, the health system gets overwhelmed and there is need to deploy field hospitals. With increasing frequency of natural and man-made disasters, incl. complex emergencies, a pressing need has been felt for development of quick response medical clinical teams. Keeping this in mind, WHO under its "Global EMT (Emergency Medical Team) Initiative" calls for quality assured, accredited, self-sufficient in every aspect wherein, member countries deploy medical teams in another member country during times of disasters, natural calamities as per the need of the host country. This also gives an opportunity for countries providing EMTs not only to strengthen its system to global standards but also deploy these teams for internal requirements. It is envisaged to develop these capacities through the Health Emergency Operation Centres (HEOCs) and the self-contained container based mobile hospitals.

1.1.16. Emerging infections continue to disrupt the health care system and are becoming increasingly complicated to detect and treat successfully. The public health system is continually reminded of the challenges posed by the unexpected, whether it is the pandemic or a bioterrorist act. Thus, there is increasing need to strengthen the infrastructure for creating favourable environment for epidemiological studies on virus outbreak and other pathogens related to public health importance.

1.1.17. There is need for setting up institutions which can serve to advance an evolving science of disease elimination to design and develop theoretical, quantitative, qualitative, behavioural and applied research practice in order to better translate evidences to policy in partnership with other research institutes, national programs and international organizations towards making time bound promise of communicable disease elimination a reality.

1.1.18. Emergence of highly infectious and pathogenic viral infections cause significant burden on public health system. It becomes difficult controlling such diseases, which are highly infectious and pathogenic in nature and have zoonotic origin or spread by aerosols or vectors. Recently, our country has witnessed recent emergence of infections like Ebola, H5N1, CCHF, KFD, Nipah, H7N9, and MARS CoV, SARS CoV 1 & 2. This has shown countrywide need of enhancing laboratory capacity, networking of institutions dealing with emerging

viral diseases of zoonotic importance for by sharing the expertise, reagents and various trainings including biosafety and biosecurity to laboratory management to deal with these.

1.1.19. COVID 19 has shown that significant investments are needed to strengthen public health systems. Without additional funding, the health system will not only fail to respond to outbreaks/disasters and other emergencies but also be ineffective in delivering other essential services, delaying and disrupting the country's progress towards the achievements of the goals and targets of the National Health Policy 2017 (NHP, 2017) and the Sustainable Development Goals. (SDGs).

1.2 FEATURES OF THE SCHEME

1.2.1 OBJECTIVES OF PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION

1.2.1.1 To strengthen grass root public health institutions to deliver universal Comprehensive Primary Health Care, including surveillance, active community engagement and improved risk communication, health education and prevention; and to strengthen public health institutions and public health governance capacities, to meet challenges posed by the current and future pandemics/epidemics with capacities for comprehensive diagnostic and treatment including for critical care services.

1.2.1.2 To expand and build an IT enabled disease surveillance system by developing a network of surveillance laboratories at block, district, regional and national levels, Points of Entry and in Metropolitan areas, for effectively detecting, investigating, preventing and combating Public Health Emergencies and Disease Outbreaks.

1.2.1.3 To support research on COVID-19 and other infectious diseases, including biomedical research to generate evidence to inform short-term and medium-term response to COVID-19 like pandemics and to develop core capacity to deliver the One Health Approach to prevent, detect, and respond to infectious disease outbreaks in animals and humans.

1.2.2 COMPONENTS OF PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION

The Scheme is a Centrally Sponsored Scheme with some Central Sector components. The Scheme has following components:

A. Centrally Sponsored Scheme (CSS) Components:

1. **Ayushman Bharat - Health & Wellness Centres (AB-HWCs) in rural areas**: Support for infrastructure development for 17788 Sub-Health Centres is proposed in 7 High Focus States (Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal) and 3 North Eastern States (Assam, Manipur and Meghalaya).
    - For the remaining States, the infrastructure support for building-less SHCs is already being provided under FC-XV Health Grants through Local Governments and through NHM as well. For the UTs, the support is provided through NHM. This arrangement will continue.

2. **Ayushman Bharat - Health & Wellness Centres (AB-HWCs) in Urban areas**: Support for 11044 Urban Health & Wellness Centres across the country is proposed under this component.

3. **Block Public Health Units (BPHUs):** Support for 3382 BPHUs in 11 High Focus States/ UTs (Assam, Bihar, Chhattisgarh, Himachal Pradesh, UT - Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand), is proposed under this component.
   - For the remaining States, the support for establishing BPHUs is being provided under FC-XV Health Grants through Local Governments.
   - For the UTs, the proposed District Integrated Public Health Labs under the PM Ayushman Bharat Health Infrastructure Mission at the Districts will be catering the needs of the Blocks in the UTs.

4. **Integrated District Public Health Laboratories** in all districts.

5. **Critical Care Hospital Blocks** in all districts with a population more than 5 lakhs, in state government medical colleges / District Hospitals.

Out of the five CSS Components, the components of Ayushman Bharat – Health and Wellness Centres (AB-HWCs) in rural areas, Ayushman Bharat – Health and Wellness Centres (AB-HWCs) in urban areas and Block Public Health Units are partially financed through the '*FC-XV Health Grants through Local Governments*'.

B. Central Sector (CS) Components

The PM Ayushman Bharat Health Infrastructure Mission has the following CS components:

1. **Critical Care Hospital Blocks in 12 Central Institutions.**
2. Strengthening surveillance of infectious diseases and outbreak response. Support for **20 Metropolitan Surveillance Units, 5 Regional NCDCs and implementation of IHIP in all states.**
3. Strengthening surveillance capacities at **Points of Entry. Support for 17 new Points of Entry Health Units and Strengthening of 33 existing Units.**
4. Strengthening Disaster and Epidemic Preparedness. **Support for 15 Health Emergency Operation Centres & 2 Container based mobile hospitals.**
5. **Bio-security preparedness and strengthening Pandemic Research and Multi-Sector, National Institutions and Platforms for One Health**. Support for setting up of a National Institution for One Health, a Regional Research Platform for WHO South East Asia Region, 9 Bio-Safety Level III Laboratories and 4 new Regional National Institutes of Virology (NIVs).

The Central Sector components of the proposed Scheme will be implemented by the central agencies/ subordinate offices/ autonomous bodies under the Department of Health & Family Welfare and the Department of Health Research, by following the existing procedure.

1.2.3 RESOURCE ENVELOPE OF THE CSS COMPONENTS OF PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION IS GIVEN IN TABLE 1.

Table 1: Resource Envelope of the CSS components of PM Ayushman Bharat Health Infrastructure Mission

S. No.	Component	Central Share	State Share	15th FC Share	Grand Total
Centrally Sponsored Scheme components					
1	AB-HWCs in rural areas in seven High Focus States and three NE States - Infrastructure of 17788 rural AB-HWCs*	2608.89	1479.8	5783.97	**9872.66**
2	AB-HWCs in urban areas (11,024 urban HWCs)	4863.41	2945.55	12146.25	**19955.2**
3	Block Public Health Units (BPHUs) in 11 High Focus States/UTs – 3382 BPHUs**	1712.27	775.04	1342.21	**3829.52**
4	Integrated Public Health Labs (IPHLs) in all the Districts	990.4	492.2	0	**1482.6**
5	Critical Care Hospital Blocks in the districts	11952.4	7112.37	0	**19064.8**
Sub-total of CSS components		**22127.4**	**12805**	**19272.43**	**54204.8**

** Ten States covered under **Infrastructure support to Building-less SHCs** are Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal and three NE States viz. Assam, Manipur and Meghalaya*

*** 11 High Focus States/UTs covered **under BPHUs** are Assam, Bihar, Chhattisgarh, Himachal Pradesh, UT-Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand.*

1.2.4 PHYSICAL DELIVERABLES ENVISAGED UNDER CSS COMPONENTS UNDER PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION IS GIVEN IN TABLE 2.

Table 2: The Component-wise physical deliverables of CSS components under PM Ayushman Bharat Health Infrastructure Mission for five years is given below:

Component	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	Total
Infrastructure support to Building-less SHCs in rural areas	3683	3684	2066	2113	2220	17788
Urban - Health & Wellness Centres (Urban -HWCs) in Urban areas	1038	2604	4674	7267	11024	11024
Block Public Health Units in 11 High Focus States/UTs.	339	677	677	677	1012	3382
Integrated District Public Health Laboratory (No of districts)	70	147	147	147	219	730
Critical Care Hospital Blocks in the districts	58	117	117	117	193	602

1.2.5: FINANCIAL YEAR WISE BREAK-UP OF ALLOCATION OF RESOURCES UNDER PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION AS GIVEN IN TABLE 3.

Table 3: Financial Year wise break-up of allocation of resources under PM Ayushman Bharat Health Infrastructure Mission (Rs. In Crore)

Component type	2021-22	2022-23	2023-24	2024-25	2025-26	Total
Centrally Sponsored Scheme (CSS)						
Central Share	2412.91	3942.80	3361.67	4495.12	7914.89	22127.39
State Share	1388.16	2276.34	1962.40	2655.64	4522.42	12804.95
15th FC share	2026.98	2965.34	4000.04	4743.88	5536.19	19272.43
Sub-total of CSS Components	5828.04	9184.48	9324.11	11894.64	17973.50	54204.78
CS components	3327.92	1280.61	1691.69	1656.65	1382.89	9339.78
Grand Total	**9155.97**	**10465.09**	**11015.80**	**13551.30**	**19356.40**	**63544.56**
Grand Total with M&E and PMC @1% of scheme						**64180**

1.3 SCOPE OF THE GUIDELINES

a. These Operational guidelines, will provide detailed guidance on Centrally Sponsored Components of the scheme and are intended to lay down the processes for preparation of plans by the States.

- Chapter-1: Provides the brief Introduction and rationale for the scheme, Objective of the scheme, Resource Envelop of CSS components and Physical deliverables under the scheme.
- Chapter-2 lays out Implementation Framework, guiding principles, planning, appraisal and approval process, fund flow mechanism, reporting and monitoring and evaluation.
- Chapter-3 provides a detailed description for the Construction of Building less Sub Health Centres (SHCs).
- Chapter-4 lays out the guidance for establishing Urban Health and Wellness Centres (Urban-HWCs) and access to specialist services/polyclinics.
- Chapter-5 focusses on the setting up of Block Public health Units (BPHUs) in the 11 EAT States.
- Chapter-6 provides the detailed guidance on establishing District Integrated Public Health labs, and
- Chapter-7 provides details for establishment of Critical Care Blocks.

b. Each chapter provides the background and the rationale for the intervention proposed, objectives, physical deliverables planned under the component with the indicative unit cost particulars, factors to be considered while planning and the negative list for which the funds should not be utilized. States/UTs are required to conduct comprehensive gap analysis before submitting the proposals for approval.

2

Implementation Framework

2.1 GUIDING PRINCIPLES

2.1.1 All components of the proposed Scheme are designed in a manner so asto lead to fulfilment of objectives set out in the National Health Policy, 2017. Convergence with the existing schemes and programmes of the Ministry shall be ensured. It will also be ensured that there is no overlap in deployment of resources.

2.1.2 Synergies and convergence of efforts of various implementation agencies will be ensured so that the health ecosystem created through the interventions under the PM Ayushman Bharat Health Infrastructure Mission leads to convergence of efforts with citizen centric health care service delivery.

2.1.3 Continued focus shall be maintained on the health sector reform agenda to create enabling environment and conditions for delivery of intended outcomes.

2.1.4 Options for outcome based financing will be adopted for the Centrally Sponsored Components, wherever feasible. Suitable benchmarks for the intended outcomes will be developed. Under this mechanism, support will be provided to the States/UTs amounting to the unit cost of the relevant Component on demonstration of achievement of the pre-fixed benchmarks for the same. This will incentivize states to economise and take up faster roll out and implementation of the scheme.

2.1.5 All interventions pertaining to establishing infrastructure would assessexisting structures so as to leverage earlier investments. Creation of infrastructure at district and sub district levels, would ensure that every district has the basic minimum capacity to provide critical care for infectious diseases/other emergencies, strengthen the block as a public health unit, ensure universal access to high quality primary health care through HWCs in rural and urban areas, build surveillance and outbreak management capacity through integrated laboratory services and thus ensure that citizens are able to access primary and secondary care within the district itself.

2.1.6 Given the high need in Aspirational Districts, these would be prioritized for early rollout.

2.1.7 While all health services from the public health institutions are universal, appropriate measures will be taken to ensure that *equitable* access is provided especially to women, children and those belonging to weaker section.

2.1.8 Gap analysis will be done for preparing the project plans with adequate justification and realistic timelines.

2.1.9 The implementation of the proposed components at district and sub district levels, and especially at HWCs would focus on citizen centric services to enable better and easier access to entitlements, establish referral linkages to AB-PMJAY for those who are covered by the scheme to provide services across the full continuum of care.

2.1.10 Private sector capacities would be leveraged through suitable PPP and contracting (outsourcing, insourcing etc.) arrangements. Investments from private sector would be explored through mechanisms such as: Viability gap funding from the existing government schemes. Partnerships with Civil Society Organisations will also be explored.

2.1.11 A multi-sectorial approach would be followed to address social determinants of health specially for preventive and promotive care through the HWCs. Special focus will be given to the wellness component to promote healthy lifestyles through Poshan Abhiyan, Fit India, Eat Right and Eat Safe.

2.1.12 Recognizing that effective health care and particularly public health action relies on action on social and environmental determinants, community engagement, participation and ownership mechanisms shall be strengthened with increased involvement and role for the Panchayati Raj Institutions, Urban Local Bodies, women Self Help Groups and Resident Welfare Associations. 3 of the 5 CSS components are partially financed through the XV FC Grants for Health Sector through the Local Bodies. In particular PRIs and ULBs would be actively involved to leverage on their community connect, through capacity building and a renewed focus on active participation in existing institutions such as Village Health, Sanitation & Nutrition Committees (VHSNC) in rural areas, Sthaniya Swasthya Sabhas (SSS) envisaged to be set up in urban areas, the Jan Arogya Samitis (JAS) being set up at the HWCs and Rogi Kalyan Samitis at health facility level. Such capacity building would also include management of outbreaks, pandemics/other emergencies and disasters, to better equip such Local Self Government Institutions to lead the response.

2.1.13 Augmented infrastructure and HR are critical to achieve health outcomes but commensurate investments need to be made in enabling quality improvements and patient centred care in facilities and enable training and capacity building of all cadres of personnel, particularly for in-service training. In addition to strengthening district hospitals as training hubs, the use of digital technology platforms will be leveraged to provide refresher training, on the job mentoring and support for all health workers, service providers and programme managers, and multiskilling of HR wherever necessary. Medical Colleges will also be engaged to provide specific skill based training and also mentor and support Health and Wellness Centres in rural and urban areas. Learning from the COVID 19 experience, capacity building for all cadres will include content to enable activities related to outbreak management so that they can be repurposed for contacttracing/surveillance, etc in future pandemics.

2.1.14 Initiatives such as the Integrated Health Information Platform (IHIP) and the National Digital Health ecosystem will enable the development of expertise and knowledge sharing across

multiple institutions, improve capacity for epidemiological analysis, enhance ability for forecasting and effective monitoring, strengthen real time surveillance in public health emergencies, generate data for public health action, ensure portability of health information at a national level, thus expanding and facilitating rapid and timely responses to future pandemics. Wherever Information Technology is used, due care will be taken of the data security and privacy of individual data

2.1.15 The indicative unit costs have been estimated based on detailed deliberation with stakeholders, domain experts and implementing agencies i.e. NHM, NHSRC, Central Hospitals division, ICMR, NCDC, eHealth Division, International Health Division and Emergency Medical Relief (EMR) Division in the Ministry. The costs may vary depending upon prevailing rates of construction, increase in prices of equipment and increases in Dearness Allowance for employees, etc.

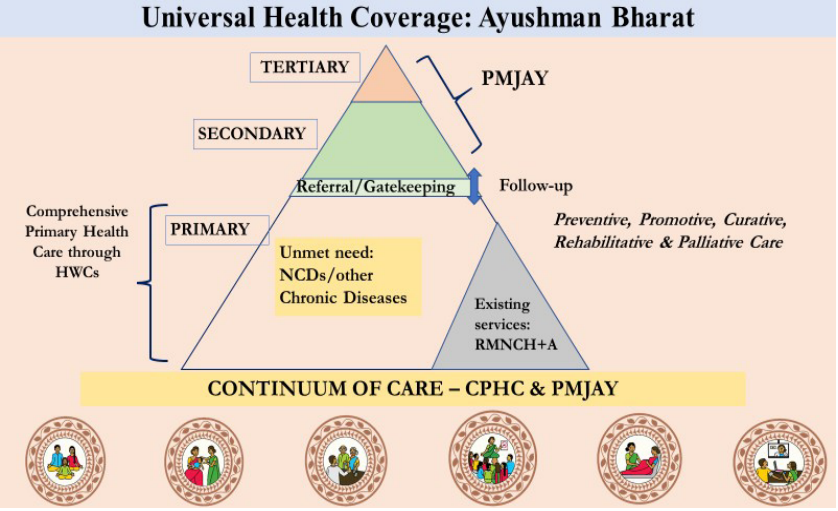
2.1.16 Indicative unit costs will be used for the purpose of preparation of proposals, budgeting and for according approvals. However, given that variations in costs will be there especially among the states, the capital and recurring costs of goods and services, shall be supported at the prices discovered through a transparent procurement processes and by following due process as per extant rules in this regard.

2.1.17 **The continuum of care approach:**

2.1.17.1 It is important to strengthen the public health system to not only enable public health actions in case of future outbreaks, and pandemics, (such as early detection, management and mitigation) but ensure that essential non pandemic related health services are not compromised. Integrating these functions into primary health care is the starting point.

2.1.17.2 Sustained and accelerated efforts to operationalize the Ayushman Bharat – Health and Wellness Centres (AB-HWCs) will enable attention to community and system level primary health care interventions for preventive, promotive, curative, rehabilitative and palliative care. Services cover those related to RMNCHA+N communicable diseases, common non-communicable diseases, including mental health, care for the elderly, and basic emergency and trauma care. The provision of free medicines, diagnostics and access to telemedicine services close to community is expected to expand coverage and quality of primary health care and reduce patient hardship and improve quality of care. Effective primary health care delivery also includes undertaking public health functions throughcommunity and facility level action for surveillance, screening and early detection, vector control, etc.

2.1.17.3 To provide seamless continuum of care between primary, secondary, and tertiary levels, HWC would be linked with the AB-PMJAY for thosecovered under the scheme, in rural and urban areas. Strengthening of secondary care facilities to provide high quality care, initiated under NHM and continued under this proposal would be universally available to those who seek care in public health facilities.



2.1.17.4 In both rural and urban areas, HWC offer the opportunity to ensure that girls and women would have access to care not just for reproductive health services, but also for the newer elements of the Comprehensive Primary Health care package including screening, diagnosis, and treatment for hypertension, diabetes and mental health. Since services are provided close to community, access to essential services would be sustained for such sub population groups. Teleconsultation services are of particular importance in reducing access barriers for women and will ensure gender equity.

2.1.17.5 The annual health calendar for HWC in rural and urban areas which is an important avenue for health promotion and prevention would include campaigns for disaster preparedness, risk communication & health education. It is also envisaged that greater community ownership and participation in service delivery would be ensuredthrough institutions such as the Jan Arogya Samitis (JAS) in the rural HWCs and the Sthaniya Swasthya Sabhas in urban areas.

2.1.17.6 States could also explore partnerships with the not for profit/private sector, particularly in urban areas across a range of areas including service delivery, community outreach, and capacity building. To compensate for the lack of service delivery infrastructure, options such as Mobile Medical Units, Evening OPDs, use of NGO clinics, religious spaces, etc could be considered.

2.2 IMPLEMENTATION MECHANISM

2.2.1 PM Ayushman Bharat Health Infrastructure Mission is a Centrally Sponsored Scheme, with few Central Sector Components. The CSS components of the PM Ayushman Bharat Health Infrastructure Mission will be implemented by following the existing Framework, institutions and mechanisms of the National Health Mission. For the CSS components, the PM Ayushman Bharat Health Infrastructure Mission would leverage the existing National Health Mission (NHM) structure available at central and State levels for appraisal, approval, implementation and monitoring. This will ensure to avoid duplication especially, w.r.t FC-XV Health Grants support and NHM Support for the similar activities.

2.2.2 State Health Society, established under National Health Mission (NHM), will be the implementing agency at the State level and shall play a pivotal role in planning for the PM Ayushman Bharat Health Infrastructure Mission. Similarly, at the district level, the District Health Society, headed by the District Collector, will play a crucial role in not only planning as per the guidelines and also, for effective implementation and robust monitoring of the units of various components under PM Ayushman Bharat Health Infrastructure Mission, under the overall supervision of the District Collector.

2.2.3 The National Health Systems Resource Centre (NHSRC) would provide technical support including for capacity building, on CSS components of the scheme.

2.3 PLANNING, APPRAISAL AND APPROVAL PROCESS

2.3.1 PLANNING

(a) The Ministry shall, for each financial year, communicate the Resource Envelope to the States/ UTs well in advance, so that the States can factor-in the requirement of commensurate State Share in the budget proposals of the States.

(b) The Ministry will also share the guidance document for preparation of the Annual Programme Implementation Plan (PIP) of the State / UT under PM Ayushman Bharat Health Infrastructure Mission.

(c) Depending on the Resource Envelope under PM Ayushman Bharat Health Infrastructure Mission and resources under FC-XV Health Grants through Local Governments (applicable for three components as given in Para 1.3.2 (A) of the Chapter-1 of the document), State shall prepare an Annual Programme Implementation Plan.

(d) For the units under FC-XV Health Grants, the institutional mechanism, preparation of proposals, submission of proposals, appraisal and approvals, as explained in *Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments* (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf)) shall be followed.

(e) For the units under PM Ayushman Bharat Health Infrastructure Mission fund support, the existing institutional mechanism, preparation of proposals, submission of proposals, appraisal and approvals, as per the NHM PIP's proposal shall be followed. This is imperative to have a distinction between the units supported under FC-XV Health Grants and PM Ayushman Bharat Health Infrastructure Mission budgetary support, to ensure clarity in approval process, fund releases and submission of timely UCs and reporting of expenditure.

(f) As the physical deliverables of the various components for a State/UT, for a particular year, are known in advance to the State/UT, including the units to be supported under FC-XV Health Grants for the year, the State may prepare and intimate to the districts, the district-wise distribution of the number of units to be taken up.

(g) Prioritization: Preferential allocations are to be made to the Aspirational / Tribal / Left Wing Extremism (LWE) / Remote / Hill districts. In other districts, such units may be prioritized where critical inputs such as land, etc are readily available.

(h) Based on the information provided by the State Government (through the State Health Society), the District Health Action Plans (DHAPs) will be prepared by the District Health Society under NHM, duly factoring in the resources under FC-XV Health Grants (as applicable to them) and the PM Ayushman Bharat Health Infrastructure Mission resources, duly ensuring that there is no duplication. The DHAPs shall also clearly indicate the lists of units to be financed through the XV FC Grants and the PM Ayushman Bharat Health Infrastructure Mission.

(i) Detailed gap analysis must be carried out and the costs must be carefully estimated. Wherever the estimated costs are more than the indicative unit costs as given in para 2.33 of these Guidelines, detailed justification must be provided.

(j) All such DHAPs will be scrutinized at the State level by the State Health Society and, the State level proposals shall be recommended by the General Body (GB) of the State Health Society (SHS) for the consideration of the Ministry.

(k) For preparing the specific Action plan for various CSS components under the scheme, details are given in the subsequent respective chapters (Chapters 3 to 7) of the document.

(l) Critical parameters, to be factored, while preparing the plans, for each of the components are given in Annexure II**.**

(m) The States/UTs have to prepare the proposals in the format given in the Appendix 2.1, along with the required annexures.

2.3.2 APPRAISAL AND APPROVAL

(a) At the National level, existing National Programme Coordination Committee under NHM, will examine and appraise the proposals.

(b) Approvals will be accorded by the Ministry based on the recommendations of the NPCC.

(c) For the units under FC-XV Health Grants for the three components as explained at Para 1.3.2 (A) of the Chapter-1, institutional mechanism, preparation of proposals, submission of proposals, appraisal and approvals, as explained in *Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments* dated 31st August 2021 shall be followed. (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf)).

2.4 MEMORANDUM OF UNDERSTANDING

All the such participating States where state share is applicable, shall have to enter into an MoU with the Ministry of Health and Family Welfare, Government of India, for implementing the CSS components of the scheme. The term of the MoU will be for the full period of the scheme, i.e., from 2021-22 to

2025-26. Approvals shall be accorded to a State/UT only after the respective State/UT has formally entered in to the MoU. The MoU outlines the responsibilities and commitments of both the Ministry and the respective State/UT, inter alia including the following aspects -

- Timely release of central share by the Ministry and its subsequent timely transfer by the State/UT government to the State Health Society.
- Timely release of corresponding State share to the State Health society
- Adherence to the technical and operational guidelines, issued by the Ministry, from time to time.
- Commitments for taking required actions to achieve the mutually agreed physical deliverables, within the specified timelines.
- Submission of required progress reports by the States, from time to time.
- Compliance with the principles of financial propriety and ensuring due diligence in implementation of the Scheme.

Copy of the MoU is attached at Annexure I.

2.5 UNIT COSTS

The unit costs for each component have been derived based on the norms devised for various components of the scheme. These costs are indicative, and may vary based on the local context and conditions. Indicative Unit costs for the various components are given in table 4:

Table 4: Unit Costs of various CSS components of PM Ayushman Bharat Health Infrastructure Mission:

(Amount in lakhs)

S. No.	Component	Capital Cost	Recurring Cost	Remarks
1	Infrastructure support to 17788 Building-less SHCs in rural areas	55.5	0	in seven High Focus States and three NE States *
2	Setting up of 11,024 Urban HWCs in urban areas	0	75.00	
3	Setting up of 3382 Block Public Health Units (BPHUs)	80.96	20.145	in 11 High Focus States/UTs**
4	Integrated Public Health Labs (IPHLs) in all the districts	1.25 Cr	49.05	
5	Critical Care Hospital Blocks in the districts			
	i. 100 bedded CCBS at DHs	44.50 Cr	7.912 Cr	
	ii. 50 bedded CCBs at DHs	23.75 Cr	4.592 Cr	
	iii. 50 bedded CCBs at Govt Medical College Hospitals	23.75 Cr	-	

The unit rates indicated for different CSS components of PM Ayushman Bharat Health Infrastructure Mission above are utilized for the purpose of arriving the requirement of financial outlay under the scheme and actual requirements will vary from State to State. Hence, while planning and sending the proposals to the Ministry, the States/UTs may plan and propose their own unit cost, based on their local context, with full justification. Decisions will be taken by the Ministry, after appraisal of the proposals of States/UTs by the NPCC. States/UTs must exercise due diligence for discovering the actual costs and must follow an open, transparent and competitive tendering process. The important aspects to be considered are detailed as under:

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

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

iii. **IT platform for approval and monitoring**: The State have to prepare the proposals as per the format given in the Appendix 2.1 and send along with the required annexures. Further, NHM-PMS system will be utilized to enable the State to send the proposals in online-mode, to ensure the easier appraisal and issuance of approvals. This will ensure, non-duplication with the units, being funded under FC-XV Health Grants and also, enable easier monitoring of the progress. The NHM-PMS system will also be used for the regular up-dation of the progress, which would be essential for release of subsequent instalments of grants.

iv. **Infrastructure works:**

a) All the five components, barring Urban HWCs, have different proportions of the Infrastructure, with the Building-less SHCs, PHCs, being purely infrastructure work.

b) In the component of BPHUs, the infrastructure support is provided for and the BPHU should ideally be located in the Block Medical Offices or Block CHC premises and have a linked laboratory also preferably located in the same premises for better synergy between clinical, programmatic and public health functions.

c) Similarly, in the urban HWCs component, the refurbishing of existing space for running the Urban HWCs is provisioned.

d) The components of Critical Care Blocks and District Integrated Public Health Labs have infrastructure works, to be planned for timely completion of the units.

v. **HR support under PM Ayushman Bharat Health Infrastructure Mission:**

a) All the components except Rural HWCs, are being provided with the HR support under recurring expenses. The States may carry out the recruitment/ engagement of HR for various components under PM Ayushman Bharat Health Infrastructure Mission, in a timely manner, so that the units may be made functional, as soon as the constructions are complete.

b) For the component of Urban HWCs, as the minor infrastructure refurbishing of the existing space of the ULBs or government buildings is likely to take very less time, simultaneous action for engagement of HR is critical to make the Urban HWCs functional at the earliest, providing services.

c) **HR support is envisaged under PM Ayushman Bharat Health Infrastructure Mission only till the scheme period** only. States have to plan and take necessary action to support the HR, including approval of additional positions and for filling up such additional posts, from their own resources, after the scheme period.

2.6 FUND RELEASE, EXPENDITURE AND SUBMISSION OF UCs

As the PM Ayushman Bharat Health Infrastructure Mission is a CSS scheme, the central share will be released will be based on fulfilment of necessary conditions such as submission of UCs and expenditure reports as per extant Rules and instructions of the Central Government in this regard. The conditions for release of funds will be the same as under the National Health Mission.

2.7 REPORTING

States/UTs shall submit Monthly progress on the implementation of various CSS components of the Scheme to the Ministry, as prescribed, from time to time and the same have to be updated in the Progress Monitoring System, developed for PM Ayushman Bharat Health Infrastructure Mission. States/UTs have to collect the progress from all the Districts and Institutions and same have to be submitted and updated on regular basis. States/UTs have to establish a mechanism for collecting and compiling the reports and will ensure entry of the progress on a regular basis.

2.8 MONITORING MECHANISM

2.8.1 District Health Society in the District will be monitoring the implementation of all the components sanctioned in the District under PM Ayushman Bharat Health Infrastructure Mission, against the approvals on a periodic basis.

2.8.2 Additional Chief Secretary/Principle Secretary/Secretary (Health) in the States/UTs as the chairperson of EC of the State Health Society, will be responsible for monitoring the progress and implementation status of various components of PM Ayushman Bharat Health Infrastructure Mission under the scheme.

2.8.3 At the national Level, the Ministry, under the NHM Framework, will monitor the progress of implementation of various components across the country. Overall, oversight will be provided by the Mission Steering Group (MSG).

APPENDIX 2.1

Format for submission of State Proposals for FY 2021-22.

Code	Activities	Proposal by States/UTs			State Remarks
		Number of Units	Unit Cost (In Rs)	Amount Proposed (In Lakhs)	
	Grand Total PM Ayushman Bharat Health Infrastructure Mission				
ANB.1	**Infrastructure Support for Building-less Sub Health Centres in 7 high Focus States and 3 NE States*** -No. of SHCs sanctioned for Capital expenditure				
ANB.2	**Urban health and wellness centres (HWCs)**				
ANB.2.1	No. of Urban HWCs, being established in the ULB or other government or rented premises				
ANB.2.2	No. of urban health facilities (UPHCs / Urban CHCs) where specialist services are to be provided / Poly Clinics				
ANB.3	**Block Public Health Units in in 11 High Focus States/UTs ****				
ANB.3.1	No of BPH units sanctioned for capital works				
ANB.3.2	No of BPH units supported for recurring expenditure				
ANB.4	**Integrated Public Health Labs (IPHLs) in all the Districts**				
ANB.4.1	No. of District IPHLs established newly– Support for non-recurring expenditure				
ANB.4.2	No. of District IPHLs established newly - Support for recurring expenditure				
ANB.4.3	No. of Existing District IPHLs Strengthened - Support for non-recurring expenditure				
ANB.4.4	No. of Existing District IPHLs Strengthened - Support for recurring expenditure				

Code	Activities	Proposal by States/UTs			State Remarks
		Number of Units	Unit Cost (In Rs)	Amount Proposed (In Lakhs)	
ANB.5	**Critical Care Hospital Blocks**				
ANB.5.1	**Critical Care Hospital Block/Wing (100 Bedded at District Hospitals)**				
ANB. 5.1.1	No. of CCBs (100 bedded) established at District Hospitals- support for capital works				
ANB. 5.2.1	No. of CCBs (100 bedded) established at District Hospitals- support for recurring expenditure				
ANB.5.2	**Critical Care Hospital Block/Wing (50 Bedded at District Hospitals)**				
ANB.5.2.1	No. of CCBs (50 bedded) established at District Hospitals- support for capital works				
ANB.5.2.2	No. of CCBs (50 bedded) established at District Hospitals- support for recurring expenditure				
ANB.5.3	**Critical Care Hospital Block/Wing (50 Bedded at Government Medical Colleges)**				
ANB.5.3.1	No. of CCBs (50 bedded) established at GMCs- support for capital works				
	Grand Total PM Ayushman Bharat Health Infrastructure Mission				

** Ten High Focus States covered under the component of **Building-less Sub Health Centres** are Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal and three NE States viz. Assam, Manipur and Meghalaya*

*** 11 High Focus States/UTs covered under the Component of **BPHUs** are Assam, Bihar, Chhattisgarh, Himachal Pradesh, UT-Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand*

3

Infrastructure Support to 'Building-less' Sub Health Centre–Health & Wellness Centres (SHC-HWCs) in Rural Areas

3.1 BACKGROUND

3.1.1 It is important to strengthen the Public Health System, not only, to enable public health actions in case of future outbreaks and pandemics (such as early detection, management and mitigation), but ensure that essential non-pandemic related health services are not compromised. The Ayushman Bharat – Health and Wellness Centres (AB-HWCs), the flagship programme of the Government, will enable attention to community and system level primary health care interventions for preventive, promotive, curative, rehabilitative and palliative care. The provision of free medicines, diagnostics and access to telemedicine services closer to community is expected to expand coverage and quality of primary health care and reduce patient hardship and improve quality of care. Effective primary health care delivery also includes undertaking public health functions through community and facility level action for surveillance, screening and early detection, vector control, etc.

3.1.2 AB-HWCs offer the opportunity to ensure that girls and women would have access to care not just for reproductive health services, but also for the newer elements of the Comprehensive Primary Health Care package including screening, diagnosis, and treatment for hypertension, diabetes and mental health. Since services are provided close to community, access to essential services would be sustained for such sub population groups. Teleconsultation services are of particular importance in reducing access barriers for women and will ensure gender equity. These centres will not only provide primary level clinical care services for an expanded range of services as per *Operational guidelines of Comprehensive Primary Health Care* and subsequent *Operational Guidelines on the expanded range of services* at the centre but also ensure outreach services are provided to their catchment population.

3.1.3 Under the AB-HWCs programme, it is envisaged that 1,50,000 AB-HWCs shall be set up in the country by December 2022. Out of these, 12,500 HWCs are being setup by the Ministry of AYUSH as AYUSH-HWCs. As per Rural Health Statistics, 2020, as on 31st March 2020, there are 47,518 Sub Health Centres, which are functioning in rented buildings / panchayat or voluntary society buildings and these SHCs require building to be constructed. These infrastructure gaps of SHCs are significant especially in 7 High Focus States and

3 North-eastern states (*seven High Focus States (Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal) and three NE States (Assam, Manipur and Meghalaya))* such as in Uttar Pradesh (3654), Bihar (5356), Rajasthan (2859), etc. These gaps may not be completed within a specific timeline with the support available under NHM. Therefore, under PM Ayushman Bharat Health Infrastructure Mission, it is proposed that support will be provided for necessary infrastructure for 17,788 SHC level AB-HWCs in rural areas in 7 High Focus States and 3 North-eastern states, at a total cost of ₹. 9,872.66 crore. Wherever feasible, option for rental or renovation and repurposing of existing vacant buildings of other departments will also be explored. Operational costs for managing AB-HWCs, would be met through the existing scheme and mechanisms, i.e., through the National Health Mission. Support for Infrastructure of 10,421 SHC level AB-HWCs will flow from the resources from *15th Finance Commission (FC-XV) Health Grants through Local Governments* in these 10 states and remaining support will be through PM Ayushman Bharat Health Infrastructure Mission Assistance.

3.2 PHYSICAL DELIVERABLES FOR THIS COMPONENT UNDER PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION

PM Ayushman Bharat Health Infrastructure Mission has provided grants of Rs. **9872.66** crores for construction of 17,788 Sub Health Centres cumulatively over a **five-year duration from FY 21-22 to FY 25-26** for providing Buildings to the Sub Health Centres, that are presently functional in rented or rent-free panchayat/ vol. society building. Details of the funds allocated for each financial year are given at para 1.3.5 under Chapter 1**.**

Unit cost for the Building-less SHC under this component is Rs 55.5 lakhs per SHC.

3.3 FACTORS TO BE CONSIDERED, WHILE PLANNING

3.3.1. Despite the best efforts by the States, there are still gaps in terms of functional public health facilities in government-owned building. Some of the civil infrastructure is in a dilapidated status. So, taking cognizance of this fact, under PM Ayushman Bharat Health Infrastructure Mission, efforts are being made to saturate the provision of infrastructure to the SHCs in the 10 States (*seven High Focus States (Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal) and three NE States (Assam, Manipur and Meghalaya)*, duly factoring-in the provision of FC-XV Health Grants through Local Governments to the extent of resources available.

3.3.2. The States may plan the **constructions of buildings for Sub Health Centres** based on the funds available, duly ensuring that there is no duplication and suggestive factors to be considered while deciding the facilities are:

- Run-down / dilapidated SHC building structures which are required to be re-built.
- Construct new SHC buildings, where services are being provided from rented buildings which lack required space and infrastructure to provide the comprehensive package

of services, lab infrastructure and space to conduct wellness activities; Priority may be given to Sub Health Centres in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers.

- New SHC buildings in lieu of Rent-Free Panchayat / Voluntary Society Building, especially where space and infrastructure is inadequate to provide the entire range of 12 CPHC services, lab infrastructure, for wellness activities.
- New buildings, if required as per shortfall of population norms (details given in RHS 2020).
- **States are informed that if the existing rented SHC buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**

3.3.3 The State shall mandate the quality check of the constructed facilities as per the norms set by the State in accordance with the other construction works undertaken. The State should ensure third party monitoring and quality checks (as pertinent to the GLs under FC-XV Health Grants) to ensure that the works undertaken meet the required quality parameters and are constructed as per the terms and conditions decided by the State. Pages No.51-55 of Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf) may be referred for detailed Guidance on Infrastructure planning and design requirements.

3.4 IDENTIFICATION OF FACILITY, APPROVALS AND OPERATIONALIZATION

3.4.1 These 10 States may plan duly factoring the resources available under PM Ayushman Bharat Health Infrastructure Mission and FC-XV Health Grants for this component, as resources of *FC-XV Health Grants* for this component have been factored-in / included under PM Ayushman Bharat Health Infrastructure Mission. Hence, depending on the total resources (exclusive under PM Ayushman Bharat Health Infrastructure Mission + FC-XV Health Grants) available for this component and the building less SHCs in the State, State should make efforts to complete the infrastructure to the Building-less SHCs in the first two years of implementation. Land should be available for the selected facilities and land purchase cost should not be covered with this component.

3.4.2 Selection of SHCs for construction should be such that its benefits reach larger segments of vulnerable populations such as SC / ST population dominated blocks/areas, and remote areas. To the extent possible, lands available with the local bodies / government land revenue department should be utilized. The land allocated should be ideally with-in the community to improve access to care. As stated supra at Para 3.4.1, the facilities where land allocation is awaited can be prioritized in the subsequent years.

3.4.3 The States /District may pool in additional funds from other sources like District Mineral Fund (DMF), CSR funds, etc. as supplementary financial resources for addition of extra-facilities in the select SHCs or to cover more number of building-less SHCs in the district / State, so that by 2025-26, the entire district is saturated to have own government buildings for all the SHC-HWCs in the districts.

3.4.4 The existing mechanism of State for construction of Building-less SHCs may be taken up, involving the identified agencies for such works that are financed exclusively through the FC-XV Health Grants through Local Governments. However, for the works financed through the PM Ayushman Bharat Health Infrastructure Mission grants, as per the decision of State Level Committee, the State/Districts have to involve the respective engineering wing as identified by the SLC.

3.4.5 The Districts will also ensure that monitoring of the construction is under-taken, and UCs are submitted on time as per the mandate under NHM, as elaborated in Chapter-1.

3.4.6 **Negative List for this component of PM Ayushman Bharat Health Infrastructure Mission:** The funds under this component cannot be utilized for the following:

- Land should be available for the selected facilities and land purchase cost should not be covered with this component.
- Repair and Renovation works already undertaken under the NHM Funds.
- Facilities or any of its components should not over-lap with the funds provided under FC-XV grants.
- This amount should not be used for the construction of a single room /wellness area or any other single project like boundary wall, toilets, water tanks etc.
- Construction of boundary walls, entrance, pavements, footpaths etc.

3.4.7 State is requested to send their proposals to the MoHFW, duly proposing under the respective FMR Code of ANB -1 as given in Appendix 2.1.

APPENDIX 3.1

The Component-wise State wise breakup of Physical targets after factoring-in the FC-XV Grants from 2021-22 to 2025-26- AB-HWCs

S. No.	State	2021-22			2022-23			2023-24			2024-25			2025-26			Total		
		Units			Units			Units			Units			Units			Units		
		Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission
1	Assam	**384**	24	360	**384**	24	360	**25**	25	0	**26**	26	0	**28**	28	0	**847**	127	720
2	Bihar	**1866**	593	1273	**1866**	593	1273	**623**	623	0	**654**	654	0	**687**	687	0	**5696**	3150	2546
3	Jharkhand	**661**	214	447	**660**	214	446	**224**	224	0	**235**	235	0	**247**	247	0	**2027**	1134	893
4	Manipur	**35**	3	32	**36**	4	32	**4**	4	0	**4**	4	0	**4**	4	0	**83**	19	64
5	Meghalaya	**81**	6	75	**82**	6	76	**6**	6	0	**6**	6	0	**7**	7	0	**182**	31	151
6	Odisha	**382**	131	251	**382**	131	251	**138**	138	0	**145**	145	0	**152**	152	0	**1199**	697	502
7	Punjab	**11**	11	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**11**	11	0
8	Rajasthan	**755**	345	410	**756**	345	411	**362**	362	0	**380**	380	0	**399**	399	0	**2652**	1831	821
9	Uttar Pradesh	**1436**	601	835	**1436**	601	835	**631**	631	0	**663**	663	0	**696**	696	0	**4862**	3192	1670
10	West Bengal	**88**	88	0	**88**	88	0	**53**	53	0	**0**	0	0	**0**	0	0	**229**	229	0
	Total	**5699**	**2016**	**3683**	**5690**	**2006**	**3684**	**2066**	**2066**	**0**	**2113**	**2113**	**0**	**2220**	**2220**	**0**	**17788**	**10421**	**7367**

4

Ayushman Bharat–Health & Wellness Centres (AB-HWCs) in Urban Areas

4.1 BACKGROUND

4.1.1 The National Urban Health Mission (NUHM) was set up in 2013, as a sub mission of the National Health Mission, to improve the health status of the urban population in general. Support is provided to the States to have Urban PHCs @50,000 per population. Outreach functions in this population, are undertaken by five ANMs and 20-25 ASHAs, with a normative coverage of a population of 10,000 served by a team of one ANM and five ASHAs. Under Ayushman Bharat, Urban PHCs are being strengthened as Health and Wellness Centres (UPHC-HWCs) to deliver Comprehensive Primary Health Care (CPHC).

4.1.2 Healthcare needs and aspirations of urban residents are different from those in rural areas. The current strategy of relying on outreach teams of ANM and ASHA alone to provide selective services is not sufficient. State experiences demonstrate that provision of health care services by trained service providers from facilities closer to poorer, and vulnerable urban communities is likely to improve access to an expanded range of services, reduce OOPE, improve disease surveillance, and strengthen referral linkages. At the same time, state experiences also show that the establishment of "poly clinics / provision of specialist services" in selected Urban PHCs, enables reach of specialist services to poor communities, thus building trust in the public health system.

4.1.3 Lack of a frontline health workforce in our cities has emerged as one of the biggest limiting factors in our response to the COVID-19 pandemic. Therefore, a paradigm shift is envisaged in delivery of urban primary healthcare based on the learnings from the management of COVID-19 pandemic which has affected urban areas disproportionately, especially in metropolitan areas such as Delhi, Mumbai, Pune, Chennai, Bengaluru, Hyderabad, Ahmedabad, Surat etc. A significant proportion of the urban population also constitutes of the migrants from other states. Also, a large proportion of these are usually settled in congested urban settings. Expansion and strengthening of the grass-root primary healthcare delivery institutions has thus emerged as a pressing need in the changed context. Limited capacities of health systems in urban areas and the disruption in non-COVID essential health services also underlines the need for provision of Universal and CPHC capacities in urban areas.

4.1.4 Accordingly, Universal CPHC is planned to be provided through Urban Health and Wellness Centres (Urban HWCs) and Polyclinics, by providing support for setting up of 11,024 Urban HWCs (UHWCs) in close collaboration with Urban Local Bodies. Such Urban HWCs would enable decentralized delivery of primary health care services closer to people, thereby increasing reach of the public health systems to the vulnerable and marginalized. The availability of space to set up new infrastructure in urban areas could pose a challenge. Therefore, the use of Mobile Medical Units and evening OPDs will be considered as alternate service delivery modes. In addition, use of community infrastructure such as religious places, NGO clinics and provision of space by the municipal bodies etc., would also be explored.

4.1.5 Support for 6,984 urban AB-HWCs (against a total of 11,024 urban AB-HWCs) will flow from the resources from the *FC-XV Health Grants through Local Governments*, in 28 states under the PM Ayushman Bharat Health Infrastructure Mission

4.1.6 Pages No.28-31 of Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf) may be referred for detailed Guidance on components of Urban HWCs and objectives intended under this component.

4.2 PHYSICAL DELIVERABLES FOR THIS COMPONENT UNDER PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION

4.2.1 Under PM Ayushman Bharat Health Infrastructure Mission, 11,024 Ayushman Bharat – Health and Wellness Centres are envisioned to be set up in urban areas across the country over five years. Support for 6,984 urban AB-HWCs (against a total of 11,024 urban AB-HWCs) will flow from the resources from FC-XV Health Grants, in 28 states. State-wise and year-wise allocation is given at para 1.3.5 under Chapter 1.

4.2.2 Pages No.37-45 of Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf) may be referred for indicative unit cost particulars (Rs. 75 lakhs per urban HWC including the provision of specialist services at select higher level Urban primary health care facilities/U-CHCs), instructions in establishing Urban HWCs and on provision of polyclinic /specialist services.

4.3 FACTORS TO BE CONSIDERED, WHILE PLANNING

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

required number of Urban-HWCs, would depend on population density, presence of slums & similar habitations, vulnerable population and newly Notified Urban Areas.

4.3.2 The State may work closely with the ULBs through the State Department of MA&UA, as PM Ayushman Bharat Health Infrastructure Mission encompasses the Urban HWCs created through FC-XV Health Grants through ULBs.

4.3.3 States may also plan for managing these Centres through NGOs and other competent organizations for effective delivery of intended services to the vulnerable population of the urban areas. Here also, close consultation and collaboration with ULBs would be required.

4.3.4 State /Municipal Corporation may need to leverage other funding sources if additional number of Urban-HWCs are needed, over and above through the combined sources of PM Ayushman Bharat Health Infrastructure Mission and FC-XV Health Grants in a State / District / ULB.

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

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

4.3.7 Locations for Urban-HWC (either under PM Ayushman Bharat Health Infrastructure Mission or under FC-XV) should be so chosen as to ensure that this new initiative of Urban-HWC is focused on hitherto uncovered areas. **Final decision on the population norms and the location of these units may be decided by the States as per their local context. The proposals so prepared shall be appraised by the NPCC before approval is accorded.**

4.3.8 States may also plan, providing few Urban HWCs under each UPHC, based on the requirement and vulnerable population to be provided with outreach and healthcare services.

4.3.9 ULBs should be actively involved for contribution (in addition to the FC-XV facilities) through the provision of space in existing ULB owned buildings, community buildings owned by ULBs/RWAs, space available with NGOs/Charitable organizations, space in markets, shopping complexes, etc to ensure that these Urban-HWCs are enabled to provide primary health care services to the community.

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

4.4 IDENTIFICATION OF FACILITY, APPROVALS AND OPERATIONALIZATION

4.4.1 The States/UTs should plan for Urban-HWCs duly factoring-in the resources available under PM Ayushman Bharat Health Infrastructure Mission and FC-XV Health Grants for this

component, as resources of *FC-XV Health Grants* for this component have been factored-in / included under PM Ayushman Bharat Health Infrastructure Mission. Hence, depending on the total resources (exclusive under PM Ayushman Bharat Health Infrastructure Mission + FC-XV Health Grants) available for this component and the requirement for Urban HWCs in the State, the State will determine the number of Urban HWCs that can be supported under the PM Ayushman Bharat Health Infrastructure Mission.

4.4.2 State may give preference to the areas where the ULBs are able to arrange the physical infrastructure and where poor and vulnerable populations reside and slum and slum-like areas.

4.4.3 The process of transfer of buildings from ULBs or other government buildings or lease agreements with the identified premises and completion of refurbishing works at these premises, etc should be completed at the earliest once the locations are decided by the States.

4.4.4 States have the flexibility to follow the norms of execution of Urban HWCs under FC-XV Health Grants for the implementation of units under PM Ayushman Bharat Health Infrastructure Mission funds as well. In such cases, the PM Ayushman Bharat Health Infrastructure Mission portion of funds may also be sent to the respective Urban Local Bodies in-time or in-advance. This will ensure uniformity in the execution of this component and will also ensure ownership of the ULBs for the Urban HWCs within their jurisdiction. State may execute the units under PM Ayushman Bharat Health Infrastructure Mission budgetary support for this component, through State Health Department as well. In both the cases, it is more important that Concerned Urban Local Bodies should be actively involved in the planning and monitoring of all the functional urban-HWCs. To the extent possible, the city level institutional arrangements should be utilized for this purpose.

4.4.5 Capacity of the urban local bodies need to be improved, by the state by undertaking the requisite trainings through state level institutions as per the plan in this regard. The ULBs are to be oriented on optimal utilisation of the grant and also on the aspects such as Human Resources for Health, their training skills, salary and incentives, range of health care package of services to be offered, drugs, equipment, IT infrastructure, community structures and independent monitoring, all as defined in the *Operational Guidelines on Ayushman Bharat - Comprehensive Primary Health Care through Health and Wellness Centres* issued by Ministry of Health and Family Welfare and available at https://ab-hwc.nhp.gov.in/download/document/45a4ab64b74ab124cfd853ec9a0127e4.pdf

4.4.6 **Negative List for this component of PM Ayushman Bharat Health Infrastructure Mission:**

- The funds under this component cannot be utilized Repair and Renovation works already undertaken under the NHM Funds.
- Construction of new buildings is not allowed.
- Procurement of land should not be undertaken under this component.

4.4.7 State is requested to send their proposals to the MoHFW, duly proposing under the respective FMR Code of ANB -2.1 and 2.2 as given in Appendix 2.1.

APPENDIX 4.1

State wise physical deliverable for this component under PM Ayushman Bharat Health Infrastructure Mission for the period of 2021-22 to 2025-26 after factoring in the FC-XV Grants

State / ULTs	FY 21-22			FY 22-23			FY 23-24			FY 24-25			FY 25-26		
	Units			Units			Units			Units			Units		
	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission
Andaman and Nicobar Islands	**0**	0	0	**1**	0	1	**2**	0	2	**3**	0	3	**4**	0	4
Andhra Pradesh	**73**	73	0	**182**	137	45	**328**	144	184	**510**	151	359	**775**	159	616
Arunachal Pradesh	**1**	1	0	**2**	2	0	**4**	4	0	**6**	6	0	**8**	8	0
Assam	**11**	11	0	**28**	28	0	**50**	50	0	**77**	77	0	**117**	108	9
Bihar	**19**	19	0	**48**	48	0	**86**	86	0	**133**	133	0	**202**	202	0
Chandigarh	**9**	0	9	**23**	0	23	**41**	0	41	**64**	0	64	**92**	0	92
Chhattisgarh	**9**	9	0	**23**	23	0	**41**	41	0	**63**	63	0	**96**	96	0
D & N Haveli	**0**	0	0	**1**	0	1	**2**	0	2	**3**	0	3	**4**	0	4
Daman & Diu	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0
Delhi	**107**	0	107	**268**	0	268	**482**	0	482	**749**	0	749	**1,139**	0	1139
Goa	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0
Gujarat	**64**	64	0	**159**	159	0	**286**	286	0	**445**	383	62	**677**	402	275
Haryana	**19**	19	0	**49**	49	0	**87**	87	0	**136**	136	0	**194**	194	0
Himachal Pradesh	**4**	2	2	**10**	2	8	**18**	2	16	**28**	2	26	**40**	2	38
Jammu & Kashmir	**10**	0	10	**25**	0	25	**44**	0	44	**69**	0	69	**104**	0	104
Jharkhand	**11**	11	0	**29**	29	0	**51**	51	0	**80**	80	0	**121**	121	0
Karnataka	**87**	87	0	**218**	164	54	**392**	172	220	**609**	181	428	**926**	190	736

State / ULTs	FY 21-22			FY 22-23			FY 23-24			FY 24-25			FY 25-26		
	Units			Units			Units			Units			Units		
	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission	Total	15th FC	PM Ayushman Bharat Health Infra-structure Mission
Kerala	**17**	17	0	**42**	42	0	**75**	75	0	**116**	116	0	**177**	177	0
Ladakh	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0
Lakshadweep	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0
Madhya Pradesh	**27**	27	0	**68**	68	0	**122**	122	0	**190**	190	0	**290**	290	0
Maharashtra	**108**	108	0	**269**	269	0	**484**	484	0	**753**	753	0	**1,145**	1145	0
Manipur	**2**	2	0	**5**	5	0	**8**	8	0	**13**	13	0	**18**	15	3
Meghalaya	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0
Mizoram	**2**	2	0	**5**	5	0	**9**	9	0	**14**	14	0	**20**	19	1
Nagaland	**1**	1	0	**3**	3	0	**5**	5	0	**7**	7	0	**10**	10	0
Odisha	**17**	17	0	**44**	44	0	**78**	78	0	**122**	122	0	**185**	138	47
Puducherry	**3**	0	3	**8**	0	8	**14**	0	14	**21**	0	21	**32**	0	32
Punjab	**3**	3	0	**8**	8	0	**14**	14	0	**22**	22	0	**34**	34	0
Rajasthan	**75**	75	0	**189**	142	47	**339**	149	190	**528**	157	371	**803**	164	639
Sikkim	**0**	0	0	**1**	1	0	**1**	1	0	**1**	1	0	**2**	2	0
Tamil Nadu	**93**	93	0	**232**	232	0	**417**	417	0	**648**	524	124	**986**	550	436
Telangana	**50**	50	0	**125**	125	0	**224**	187	37	**349**	196	153	**530**	206	324
Tripura	**1**	1	0	**3**	3	0	**5**	5	0	**7**	7	0	**10**	10	0
Uttar Pradesh	**125**	125	0	**312**	312	0	**562**	562	0	**874**	624	250	**1,329**	655	674
Uttarakhand	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0
West Bengal	**90**	90	0	**224**	224	0	**403**	403	0	**627**	423	204	**954**	444	510
Total	**1038**	**907**	**131**	**2,604**	**2124**	**480**	**4,674**	**3442**	**1232**	**7,267**	**4381**	**2886**	**11,024**	**5341**	**5683**

5

Block Public Health Units (BPHUs)

5.1 BACKGROUND

5.1.1 Every block in the country is envisaged as having a CHC/ Block PHC/ SDH at the Block Headquarter (HQ) which serves as a hub for referral from the SHCs and PHCs of the block. However, the situation across states is variable, with the Block CHC functioning as just another PHC in some states. In some other states, on the other hand, the Block CHC also serves as a First Referral Unit (FRU).

5.1.2 The present public healthcare system structure at the Block level is not equipped to handle public health emergencies and also to respond and monitor the healthcare services. Currently, the functions of a Block CHC are mostly focused on clinical services that too largely RMNCH+A and selected infectious diseases. The outbreak of COVID-19 has highlighted a constrained public health response as a result of a suboptimal public health focus at the block level.

5.1.3 Block Public Health Units are proposed in all the 3382 blocks in 8 High Focus States and 3 Hill states (Assam, Bihar, Chhattisgarh, Himachal Pradesh, UT-Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand). Support for 1,048 Block Public Health Units in these 11 states covered under the PM Ayushman Bharat Health Infrastructure Mission, will flow from the resources from the FC-XV Health Grants through Local Governments.

5.1.4 The BPHU would encompass the service delivery facility (CHC/PHC/SDH), a Block Public Health Laboratory, and a Block HMIS Cell. The goal of the Block Public Health Unit is to protect and improve the health of the population in the block. Decentralization at this level would enable a focus on reaching remote areas and unreached populations. It is envisaged that the Block Headquarter level facility (variously referred to as Community Health Centres (CHCs)/ Sub- Divisional Hospitals (SDHs)/Block Primary Health Centres (PHCs), (the nomenclature may vary across states) *would be strengthened* to become a Block Public Health Unit. Further details on Block PH Unit, Laboratory and HMIS Unit and the objectives of BPHU may be referred from the Pages No.67-70 of Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf)

5.2 PHYSICAL DELIVERABLES FOR THIS COMPONENT UNDER PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION

5.2.1 The scheme envisages that all the Blocks in the *11 EAG States/UTs (Assam, Bihar, Chhattisgarh, Himachal Pradesh, UT - Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand) should be having a functional BPHU system by 2025-26 with a financial outlay* of Rs.3829.52 crore. The physical deliverables of number of blocks to be covered over the five years period is given at Appendix 5.1. The Composite Unit Cost per BPHUs is:

1. Total capital cost (infrastructure for Block Public Health Unit, equipment for Block Public Health Lab and health facility, IT infrastructure for Lab and HMIS Unit)- 80.96 Lakhs
2. Total recurring cost (human resource, consumables, monitoring, etc) of Block Public Health Unit with Labs- 20.145 Lakhs

5.2.2 Detailed Unit cost particulars are given at Pages No.76-79 of Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf).

5.3 FACTORS TO BE CONSIDERED

The details such as Monitoring, Accountability, Decentralized Planning, Infrastructure & Equipment, Human Resources and Capacity Building may be accessed at Pages No.70-71 of Operational and Technical Guidelines of Implementation of FC-XV Health Grants through Local Governments (https://nhsrcindia.org/sites/default/files/2021-09/FCXV%20Technical%20and%20Operational%20GLs%20to%20States%20dated%2031082021.pdf))

5.4 IDENTIFICATION OF FACILITY, APPROVALS AND OPERATIONALIZATION

5.4.1 **As the scheme envisages that all the Blocks in the *11 EAG States/UTs should be having a functional BPHU system by 2025-26,*** it is suggested that as the process to complete the non-recurring / capital portion of the BPHU will take nine to twelve months, the State may utilize this time-period to complete the process of engagement of required Human Resource under three components of BPHU. Accordingly, in the first year (FY 21-22), **recurring expenditure is not to be factored-in** and while planning for subsequent years, the recurring expenditure is to be charged first, before proceeding to plan to establish new BPHU units in the districts. This is arrived with the presumption that all the Blocks require full set of activities under non-recurring components to establish BPHUs and applying the principles stated above.

5.4.2 These 11 States may plan duly factoring the resources available under PM Ayushman Bharat Health Infrastructure Mission and FC-XV Health Grants for this component, as resources of *FC-XV Health Grants* for this component have been factored-in / included under PM Ayushman Bharat Health Infrastructure Mission. Hence, depending on the total resources (exclusive

under PM Ayushman Bharat Health Infrastructure Mission + FC-XV Health Grants) available for this component and the number of Blocks in the State, State may first prepare a five-year Action Plan for the State and subsequently, District wise year wise Action plans may be prepared accordingly. State should make efforts to initiate the capital works in majority of the Blocks, where sufficient lands are available, in the first two years of implementation and efforts should be made to identify the lands for other Blocks within this leeway time.

5.4.3 The States /District may pool in additional funds from other sources like District Mineral Fund (DMF), CSR funds, etc. as supplementary financial resources required to cover the additional / newly formed blocks in the State (as the support under PM Ayushman Bharat Health Infrastructure Mission is planned based on the Number of Blocks in the States in June-July 2020, based on the data available in LG Code database). These 11 States may utilize the savings under PM Ayushman Bharat Health Infrastructure Mission + FC-XV Grants, for covering additional Blocks, based on the Gap analysis.

5.4.4 The units/Blocks supported under two different funding sources i.e. FC-XV Health Grants and PM Ayushman Bharat Health Infrastructure Mission are required to be kept distinct and separate for all the years of support being provided under each scheme. Planning teams at the State and Districts should have clear mapping of the Blocks / BPHUs supported under these two different sources of funding.

5.4.5 As all the blocks located in these 11 States are covered, plan to be chalked out by the State/ District team, duly prioritizing the Blocks, where there are full contingent of HRH is already available. Preferably, blocks with good infrastructure set-up and complete / near-complete HR availability should be given preference in the first few years for this component.

5.4.6 The State/ UT may plan to initiate the infrastructure work for subsequent years BPHU units, keeping in view the time taken to complete the infrastructure and other related works. Procurement of the equipment and other accessories should be aligned with the infrastructure completion along with efforts for ensuring availability of the required Human Resources.

5.4.7 States may follow the same mode of execution of BPHUs as under the FC-XV Health Grants for the implementation of BPHUs under PM Ayushman Bharat Health Infrastructure Mission funds as well. This will ensure uniformity in the execution of this component and will also lead to synergies in engagement of economies of scale, standard processes, quality assurance and Human Resources for Health to manage these BPHUs.

5.4.8 **Negative List:** The funds under this component cannot be utilized for the following:

i. Repair and Renovation works of Block level facilities already undertaken under the NHM Funds, FC-XV Health Grants, State Funds, any other grants for health e.g. MOTA, MOMA, CSR etc.

ii. Construction of boundary walls, entrance, pavements, footpaths etc.

iii. Purchase of Solar panels, electronic items like TVs, cameras etc., unless otherwise provided under the norms by the Ministry.

5.4.9 State is requested to send their proposals to the MoHFW, duly proposing under the respective FMR Code of ANB -3.1 and 3.2 as given in Appendix 2.1.

APPENDIX 5.1

State-wise physical deliverables for establishing BPHUs for the period of FY 2021-22 to 2025-26 under PM Ayushman Bharat Health Infrastructure Mission after factoring in the 15th FC grant

S. No.	State	2021-22			2022-23			2023-24			2024-25			2025-26			Total		
		Units			Units			Units			Units			Units			Units		
		Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission	Total	15th FC	PM Ayushman Bharat Health Infrastructure Mission
1	Assam	**23**	7	16	**46**	5	41	**46**	4	42	**46**	3	43	**68**	3	65	**229**	22	207
2	Bihar	**53**	53	0	**107**	48	59	**107**	39	68	**107**	33	74	**160**	28	132	**534**	201	333
3	Chhattis-garh	**15**	15	0	**29**	13	16	**29**	11	18	**29**	9	20	**44**	7	37	**146**	55	91
4	Himachal Pradesh	**8**	2	6	**16**	2	14	**16**	1	15	**16**	1	15	**24**	1	23	**80**	7	73
5	Jammu & Kashmir	**29**	0	29	**57**	0	57	**57**	0	57	**57**	0	57	**87**	0	87	**287**	0	287
6	Jharkhand	**26**	26	0	**53**	24	29	**53**	19	34	**53**	16	37	**79**	14	65	**264**	99	165
7	Madhya Pradesh	**31**	31	0	**63**	28	35	**63**	23	40	**63**	19	44	**93**	16	77	**313**	117	196
8	Odisha	**31**	31	0	**63**	28	35	**63**	23	40	**63**	19	44	**94**	16	78	**314**	117	197
9	Rajasthan	**30**	30	0	**59**	26	33	**59**	22	37	**59**	18	41	**88**	15	73	**295**	111	184
10	Uttar Pradesh	**83**	83	0	**165**	74	91	**165**	60	105	**165**	50	115	**247**	43	204	**825**	310	515
11	Uttara-khand	**10**	3	7	**19**	2	17	**19**	2	17	**19**	1	18	**28**	1	27	**95**	9	86
	Total	**339**	**281**	**58**	**677**	**250**	**427**	**677**	**204**	**473**	**677**	**169**	**508**	**1012**	**144**	**868**	**3382**	**1048**	**2334**

6

District Integrated Public Health Laboratories

6.1 BACKGROUND

6.1.1 The disease burden in the country demonstrates the need for provision of high-quality laboratory services at district and block levels. COVID-19 highlighted that limited laboratory capacity at all levels meant that functions of testing, case detection, surveillance and outbreak management were challenging. Delays in diagnosis and reporting compromise early detection and delay initiation of appropriate treatment and the necessary public health action for controlling the spread of disease. Although, both general and out of hours laboratory services (e.g. emergency services, critical care services) are currently being provided through laboratories, the capacities for public health surveillance for abnormal morbidity/mortality, reporting of human or animal disease patterns and testing of samples etc. for public health needs remain limited in most districts.

6.1.2 Improving the efficiency and effectiveness of the laboratory services to support programmatic scale-up, requires Integrated District Laboratory systems. This will optimise access to laboratory services, quality assurance efforts, cost-effectiveness, and efficient use of human resources. To address these gaps, an Integrated Public Health Laboratories in all 730 districts will be set-up under the scheme. An integrated model for the laboratory is crucial to increase efficiency, avoid duplication of laboratory resources, improve patient services, channelize resources for development of capacity for multi-disease testing and to equip the laboratory in terms of better preparedness and response to emerging disease threats.

6.1.3 The District Integrated Public Health Laboratory unit would also serve as the apex of a network to link labs with block, state and regional public health and veterinary labs to support multi-sectoral collaboration for clinical management and public health surveillance. Integrated Public Health laboratories will establish multi-level linkages from blocks to districts, to state and finally to zonal/regional and National level laboratories for providing a comprehensive set of laboratory services which can also aid in timely prediction of outbreak and supporting policy decisions. IPHLs at the District level will mentor and handhold BPH Labs of the BPHUs and ensure regular training and capacity building of the staff. To allow IPHL seamlessly blend into the existing laboratory services network, interconnected and functional linkages both upwards and downwards are envisaged. *The upward and downward linkages with block and zonal/state/regional labs would be clearly defined and documented*

6.2 OBJECTIVES FOR ESTABLISHMENT OF DISTRICT INTEGRATED PUBLIC HEALTH LABORATORIES

i. To strengthen the capacity of health system to respond to all public health needs and threats comprehensively through an integrated system of laboratories.

ii. To strengthen the infectious and non-infectious disease surveillance system at national and sub-national levels and to provide accurate and timely data for analysis, information and policy decisions to detect, prevent and respond to public health threats in a timely manner.

iii. To provide training and mentorship to block Public Health Lab in terms of capacity building and serve as diagnostic hub for block CHC labs (spokes).

iv. To work closely with district and block Public Health units/IDSP units and support laboratory investigation of outbreaks.

v. To reduce mortality, morbidity and OOPE by effectively preventing and controlling the diseases and improving nation's health through rapid and reliable screening, early detection and diagnosis.

6.3 PHYSICAL DELIVERABLES FOR THIS COMPONENT UNDER PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION

6.3.1 PM Ayushman Bharat Health Infrastructure Mission envisages the establishment of District Integrated Public Health Labs in all the districts (730) of the country for a five-year duration from FY 21-22 to FY 25-26 with a financial outlay of Rs. 1482.40 crores. The physical deliverables of number of districts to be covered over the five years period is given at Appendix 6.1. The Unit cost particulars per IPHL is:

1. **Capital Cost:** Strengthening /establishing District IPHLs in 730 districts @ **Rs. 1.25 Crore** per unit
2. **Recurring Cost:** Strengthening /establishing District IPHLs in 730 districts @ **49.05 lakhs** per annum from the second year of the scheme for the functional units till the end of the scheme period

6.3.2 State shall ensure no duplication of fund for setting-up of District IPHL from NHM, State funds, etc

6.4 FACTORS TO BE CONSIDERED

6.4.1 The term '**Integrated Public Health Laboratories (IPHL)**' extends to a laboratory system providing comprehensive services including infectious disease diagnostics and other diagnostic services such as Haematology, Clinical Chemistry, Microbiology and Pathology, all combined under one laboratory service. The IPHLs are envisaged to play a key role in early detection of disease, surveillance, monitoring of therapy as well as supportive

laboratory parameters including haematology, clinical biochemistry and clinical pathology. It will function as a *district laboratory under various public health programs including NACP, NTEP, NVBDCP, NVHCP, IDSP, etc converging/integrating all these vertical programs at district level*. Also, would provide accurate and timely data for analysis, research, information and policy decisions to detect, prevent and respond to public health threats in real time. It will support block and district surveillance units and act as a hub to provide technical support to block public health labs and other peripheral laboratories for sample collection, testing and referral as per GoI guidelines.

6.4.2 The IPHLs will be a key platform *to establish close integration and coordination between health and other concerned departments like veterinary, water, food and environment, forest, and climate change, etc.* Such close integration and coordination at the district level to be established with existing laboratories under various departments like Central Pollution Control Board (CPCB), FSSAI, PHED, veterinary, forensic department, etc. This will help in sharing of data, time-bound reporting of identified investigations of public health importance between the departments

6.4.3 There are the District hospitals which have been either merged or upgraded into Medical Colleges, but their labs are only providing clinical services. All such District Hospitals Laboratory need to continue providing public health functions including outbreak investigations.

6.4.4 For making the lab functional there is a need to assess the existing type of diagnostic services being provided at the facility, existing human resource, capacity of existing HR, available equipment, available space in and around existing laboratories. In case, there is no scope within the constructed area of lab, preferably in the adjoining space/ area in the existing DH needs to be identified for IPHL.

6.4.5 The existing clinical laboratories, public health laboratories or any other program laboratory need to be mapped and restructured to provide comprehensive services as envisaged under District IPHL.

6.4.6 An ideal IPHL design should have two components- a central sample collection facility and an integrated diagnostic testing facility. Both these components can be established as a combined unit on the same floor or in parts at different floors.

6.4.7 Development of IPHL will involve physical, functional and data integration of different sections of the district hospital laboratories.

i. The physical integration will include establishment of a central sample collection facility in a patient-friendly location.

ii. The functional integration will require various vertical program sections to operate as the coordinated limbs of a single body i.e. the district public health laboratory, in the process, sharing space, manpower and the equipment thus avoiding duplication and disconnect.

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

6.5 IDENTIFICATION OF FACILITY, APPROVALS AND OPERATIONALIZATION

6.5.1 **Setting-up of District IPHL:** District IPHL needs to be set up in an existing DH by reorganizing the existing district clinical lab. Wherever, District Public Health Laboratory (DPHL) is existing, needs to be integrated with IPHL as per the protocols defined in the guidelines. For making the labs functional, there is a need to assess the existing type of diagnostic services being provided at the facility, existing human resource, capacity of existing HR, available equipment, available space in and around existing laboratories. In case, there is no scope within the constructed area of lab, some adjoining space/ area in the existing DH needs to be identified for IPHL.

6.5.2 **Services:** Integrated District Public Laboratory (IPHL) will conduct clinical and public health diagnostic tests as per Indian Public Health Standards (IPHS) under one roof. Provide support to routine surveillance and outbreak investigation of Infectious diseases, may perform environmental investigations (such as water culture for coliforms) and rapid diagnostic tests to support outbreak investigations, as and when needed.

6.5.3 Most of the lab tests indicated at the IPHLs are part of IPHS. In case of any additional lab tests (like Microbiological analysis of water, etc.), the capacity needs to be enhanced as per the vision of IPHS. Similarly, under free diagnostics, through hub and spoke models many district labs have already been augmented and in order to improve the testing capability many new equipment have also been added with support of funding from NHM. Since commitment of IPHL is beyond clinical lab services, the requirements for public health surveillance, infectious disease etc. also needs to be part of the system.

6.5.4 In many states the diagnostic services are outsourced, and this commitment could be for different time periods and vary in terms of the number of tests covered. While planning and establishing IPHLs, focus may be laid to ensure that the population is able to benefit from the extended range of services as envisaged under these guidelines.

6.5.5 The flow of services in IPHL is critical for ensuring functional integration which requires the various vertical program sections to operate as the coordinated limbs of a single body – the district public health lab, in the process sharing the space, manpower and the equipment avoid duplication and disconnect.

6.5.6 **Infrastructure:** The existing facility may be re-structured/re-organised, or a new facility can be established (in-case enough space not available). However, while demolishing any old building, it should be ensured that alternate arrangements are made for effectively running the existing services. For the proper functioning of IPHLs, there is a need to assess

the available space in and around the existing lab and in case there is no scope within the constructed area of the lab, some adjoining space/ area in the existing DH needs to be identified for IPHL. The new space can be utilised ideally vertically but can be developed horizontally if ample space is available.

6.5.7 *The layout of the lab is based on the range of services to be provided*. However, planning should be prospective and taking into account expected burden of disease and epidemiological transition. Thus, new structures should be planned, designed and constructed taking into account the scope for future expansion. Broadly, the structure will include following units:

- **Central sample collection facility** and
- **Integrated Laboratory (clinical and public health testing facility)**.
- **Auxiliary Area**

6.5.8 **Human Resource:**

i. The existing HR functional in various labs and norms suggested under IPHS shall be the basis for calculating the existing lab staff and what is required for implementing IPHL. Under District IPHL, the duplication of the staff will be eliminated, and HR will be utilized comprehensive and inclusive of all programs. IPHS defines the minimum performance standard for lab technicians as 200 tests per day. The HR requirement / support will be based on this.

ii. There should be a system for regular induction and refresher training and each laboratory staff should undergo at least trainings on documentation (specimen handling manual, specimen request form, specimen logbook, acceptance/rejection criteria, critical alerts, inventory management, result reporting format, IQC records etc.), SOP development, sample collection, packaging and transport, laboratory safety, infection prevention and biosafety cabinet certification and practical training on syndrome based-diagnostic testing, including internal quality control.

iii. IPHL staff should be responsible for training and mentorship of Block Public Health Laboratory staff. The laboratory in-charge will be responsible for training and competency assessment of laboratory staff. A system for regular induction and refresher training (yearly) shall be developed for different levels of laboratory staff.

6.5.9 A new addition in the PH lab is ***Lab Information Management system (LIMS)***. This needs to be linked with existing data reporting system of the hospital which will ultimately feed into the electronic health information system i.e. Integrated Health Information Platform (IHIP). The lab data reporting system will include all the surveillance data being reported from the integrated block PH unit. This will help in improving analyzing capacity of the local units so that early response for mitigation can be taken.

6.5.10 **Equipment:** A list and specifications of important equipment is given in the revised free diagnostic initiative guidelines. Support for diagnostics is available from various sources like NHM, State resources and also under PM Ayushman Bharat Health Infrastructure Mission. While projecting the needs of the facility, all the available equipment either under various programs or from different sources must be taken into account.

6.5.11 No vertical or standalone purchase of equipment should be encouraged without following the open, competitive and transparent process and efforts should be made for avoiding duplication and utilizing the flexibilities built in the system. Before purchasing any new equipment, a comprehensive gap analysis is a mandatory exercise to be undertaken at all the facilities.

6.5.12 The requirement for human resource, equipment and budget for infrastructure needs to be based on each DH-wise gap analysis. Once the requirement is assessed, a comprehensive proposal for the district integrated PH lab and its linkage with all block PH lab needs to be established.

6.5.13 The process of quality assurance of IPHL should be in accordance with the QA programme and with other specific requirements of the GOI. The upward and downward linkages with block and zonal/state/regional labs to be clearly defined and documented. Under the overall ambit of the Quality Assurance Programme of Government of India, the quality initiatives and accreditations shall be undertaken to define the mechanism of NQAS and EQAS.

6.5.14 **Negative List for this component of PM Ayushman Bharat Health Infrastructure Mission:** The funds under this component cannot be utilized for the following:

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

6.5.15 Further detailed technical guidelines for IPHL will be shared by the Ministry separately in due course.

6.5.16 State is requested to send their proposals to the MoHFW, duly proposing under the respective FMR Code of ANB -4.1 to 4.4 as given in Appendix-2.1.

APPENDIX 6.1

The State wise breakup of physical deliverable for District IPHL under PM Ayushman Bharat Health Infrastructure Mission from FY 2021-22 to 2025-26

S. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total Units*
1	Andaman and Nicobar Islands	0	1	1	1	0	**3**
2	Andhra Pradesh	1	3	3	3	3	**13**
3	Arunachal Pradesh	2	4	4	4	8	**22**
4	Assam	3	7	7	7	9	**33**
5	Bihar	4	8	8	8	10	**38**
6	Chandigarh	0	0	0	0	1	**1**
7	Chhattisgarh	3	6	6	6	7	**28**
8	D & N Haveli	0	0	0	0	1	**1**
9	Daman & Diu	0	0	0	0	2	**2**
10	Delhi	1	2	2	2	4	**11**
11	Goa	0	0	0	0	2	**2**
12	Gujarat	3	7	7	7	9	**33**
13	Haryana	2	4	4	4	8	**22**
14	Himachal Pradesh	1	2	2	2	5	**12**
15	Jammu & Kashmir	2	4	4	4	6	**20**
16	Jharkhand	2	5	5	5	7	**24**
17	Karnataka	3	6	6	6	9	**30**
18	Kerala	1	3	3	3	4	**14**
19	Ladakh	0	0	0	0	2	**2**
20	Lakshadweep	0	0	0	0	1	**1**

S. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total Units*
21	Madhya Pradesh	6	11	11	11	16	**55**
22	Maharashtra	4	7	7	7	11	**36**
23	Manipur	2	3	3	3	4	**15**
24	Meghalaya	1	2	2	2	3	**10**
25	Mizoram	1	2	2	2	3	**10**
26	Nagaland	1	2	2	2	4	**11**
27	Odisha	3	6	6	6	9	**30**
28	Puducherry	0	1	1	1	1	**4**
29	Punjab	2	4	4	4	8	**22**
30	Rajasthan	3	7	7	7	9	**33**
31	Sikkim	0	1	1	1	0	**3**
32	Tamil Nadu	4	8	8	8	10	**38**
33	Telangana	3	7	7	7	9	**33**
34	Tripura	1	1	1	1	3	**7**
35	Uttar Pradesh	8	15	15	15	22	**75**
36	Uttarakhand	1	3	3	3	3	**13**
37	West Bengal	2	5	5	5	6	**23**
	Total	**70**	**147**	**147**	**147**	**219**	**730**

**Units means number of District IPHL to be set-up by the respective State/UT in each FY from 2021-22 to 2025-26*

7

Critical Care Hospital Blocks

7.1 BACKGROUND

7.1.1 The COVID pandemic has highlighted the need for critical care facilities, especially at the level of the districts. The country's increasing disease burden particularly related to the sequelae of chronic communicable and non-communicable diseases and injury also requires access to critical care. Non-communicable diseases and injuries account for 61.8% and 10.7% deaths respectively. (Source: India: Health of the Nation's States, ICMR).

7.1.2 Average medical expenditure per hospitalization (both rural and urban, private and public combined) is Rs. 20135/- (as per NSSO 2017-18). It is anticipated that about 3-5% of emergencies would require ICU facilities and oxygen supported beds for critical care. There is an urgent need to strengthen these facilities and create additional amenities (infrastructure, equipment etc.), in existing district hospitals to meet such unforeseen epidemics, disasters etc.

7.1.3 The current architecture of the public hospitals is not equipped fully to handle the dual burden of meeting critical care needs and maintaining essential services as was seen during the two waves of the COVID-19 pandemic. Many hospital buildings especially in districts, do not have provision for segregating a part of the building as an infectious disease treatment block/wing. As a result, in order to avoid mixing of COVID and non-COVID patients, entire hospitals were required to be designated as COVID Dedicated Facilities, thereby resulting in inability to provide non COVID essential services such as institutional deliveries, blood transfusion services, dialysis and chemotherapy etc.

7.1.4 Under PM Ayushman Bharat Health Infrastructure Mission , Government of India would support 100 and 50-bedded Hospital Blocks/ Wings to augment the capacity of public health facilities to provide assured critical care. These block/wings will enhance capacity to manage patients requiring critical care from the sequelae of infectious diseases, during pandemics, or are in need of critical care for any other condition, including during emergencies.

7.1.5 The 100 and 50-bedded Critical Care Hospital Block/Wings would be self-contained, and be equipped with critical, supportive and ancillary services such as Emergency area, Intensive Care Units (ICU), Isolation Wards/Oxygen supported beds, Surgical unit, two labour, delivery, recovery rooms (LDRs) with one New-born care corner. The capacity of support services like Imaging facility, Dietary services, CSSD with Mechanized Laundry, etc. needs to be linked

with existing DH or to be created if not available. These blocks/wings would be also be supported with Medical Gas Pipeline Systems, Oxygen generation plants/ Oxygen supply, Air Handling Units (AHUs) etc. and mechanism for Infection Prevention Control.

7.2 OBJECTIVE OF THE CRITICAL CARE BLOCKS

7.2.1 To augment the capacity of the district for assured treatment and management of patients with infectious diseases or critical illnesses by creating Critical Care Hospital Blocks /Wings at District Hospitals/ Medical Colleges.

7.2.2 To ensure health system preparedness for future outbreaks.

7.3 PHYSICAL DELIVERABLES FOR THIS COMPONENT UNDER PM AYUSHMAN BHARAT HEALTH INFRASTRUCTURE MISSION

7.3.1 PM Ayushman Bharat Health Infrastructure Mission envisages the establishment of Critical Care Blocks in all Districts with population more than 5 lakhs with a financial outlay of Rs. 19064.80 crores. The physical deliverables of number of Critical Care Blocks to be covered over the five years period is given at Appendix-7.1 and 7.2. The unit cost for critical care units is given in Table 7:

Table 7: Unit cost for Critical Care Hospital Blocks (Capital and Recurring)

Type of critical care units	Capital Cost (in Rs.)	Recurring Cost (in Rs.)
100 bedded	44.50 Cr	7.912 Cr
50 bedded	23.75 Cr	4.592 Cr
50 bedded in Medical Colleges	23.75 Cr	-

7.4 FACTORS TO BE CONSIDERED, WHILE PLANNING

7.4.1 <u>If the critical care wing/block is created at a new site, following factors should be considered:</u>

- Accessibility for the public (with good road connectivity) and to the district hospital/ medical college.
- Compliance as per state and centre government guidelines for disasters including fire regulations should be ensured.
- Ensuring the structure is not in a low-lying flood prone area
- Ensuring it is adequately serviced by public utilities such as water, electricity and telephone connectivity, sewage and storm-water disposal.
- Ensuring elderly and disabled friendly access.
- Minimizing exposure to air, noise, water and land pollution and that the building is vector-breeding proof

7.4.2 For critical care wings located within the district hospital, following factors should be considered:

- The block should preferably have a distinct entry independent of the main entry for outpatients, so that minimum time is lost in attending to cases which need resuscitation and also to others requiring emergency management.
- There should be easy approach and access for ambulances with adequate space for the free passage of vehicles and a covered area for alighting patients.
- Stretchers, wheelchairs and trolleys should be available at the entrance of the block at a designated area.
- Lay out should be such that it follows the functional flow for clinical management of the patient.
- Signage should be displayed at the entry of the hospital with additional signage at key points.
- The Emergency area of the critical care block should have a dedicated triage and four clinical management zones (red, yellow, green, black).
- The triage area should have dedicated space with wall mounted multipara monitors and medical gas outlets.

7.5 IDENTIFICATION OF FACILITY, APPROVALS AND OPERATIONALIZATION

7.5.1 Under PM Ayushman Bharat Health Infrastructure Mission support will be provided to 602 districts across all States/ UTs. For the 102 Districts having more than 20 lakh population, the Size of the Critical Care Block are to be limited to 25% of the existing District Hospitals Beds capacity subject to a minimum of 50 and a maximum of 100 beds. For 274 districts with 5-20 lakhs population, it is envisaged to set- up 50 bedded Critical Care Hospital Block/ Wing. Besides the above, 226 districts, with Government Medical Colleges, would also be supported to establish a 50 bedded Critical Care Hospital Block / wing.

7.5.2 Critical Care Wing or block is expected to be part of the existing district hospital or Medical College Hospital. While planning infrastructure of the critical care block, overall infrastructure of the existing hospital should be taken into account. Planning should also not be limited to only existing infrastructure but also take account of future expansion. If the space is not available, then linkages and access to the district hospital within 30 minutes should be ensured.

7.5.3 The infrastructure for all facilities should follow the rules and regulations as per National Building Code and the state by-laws. At some places, old and dilapidated facilities may need to be demolished to build new infrastructure at the same site. However, while demolishing any old building, it should be ensured that alternate arrangements are made for effectively running the existing services.

7.5.4 **Human resource:**

A critical care block requires specialists, GDMOs, nurses, paramedical and support staff as per the norms indicated below:

HR Norms	**Specialists** - round the clock for OT, ICU, Emergency, delivery unit and other areas as per IPHS.
	GDMO - 1 for 10 beds - critical care area and 1 for 20 beds non critical area
	Nurses - 1:1 ICU; 1:2 Step Down Unit; 1:6 wards and other areas; OT - 2 per OT per shift; 1 nurse round the clock for delivery unit
	Support staff - as per IPHS/GoI guidelines

Depending upon the performance and case load, specialists, doctors and other staff can be added further if required.

7.5.5 All the staff of the critical care block will undergo induction training and also specific trainings for the area they will be posted in. The states will be advised to implement non-rotational posting so that proficiency and capacity of the trained staff is properly utilized and not diluted by their posting in such areas where specific skills cannot be utilized.

7.5.6 Drugs will be as per Essential medicine/drug list including drugs for critical care (HDU and ICU) and Diagnostics as per essential and free diagnostic list. The Equipment will be ensured as per the Technical Guidelines for Critical Care Blocks after gap analysis.

7.5.7 **Negative List for this component of PM Ayushman Bharat Health Infrastructure Mission:** The funds under this component cannot be utilized for the following:

- Repair and Renovation works already undertaken under the NHM Funds.
- Facilities or any of its components should not over-lap with the funds provided under FC-XV grants.
- This amount should not be used for the construction of a single room /wellness area or any other single project like boundary wall, toilets, water tanks etc.
- Construction of boundary walls, entrance, pavements, footpaths etc.

7.5.8 Detailed Technical Guidelines on setting up of Critical Care Blocks, with the details of infrastructure, HR , Equipment, Lab Information System and Layout plans shall be shared by Ministry separately in due course.

7.5.9 State is requested to send their proposals to the MoHFW, duly proposing under the respective FMR Code of ANB -5.1 to 5.3 as given in Appendix 2.1.

APPENDIX 7.1

The State wise breakup of Physical deliverables for Critical Care Hospital Blocks under PM Ayushman Bharat Health Infrastructure Mission for FY 2021-22 to 2025-26

S. No.	State/ UT	Grand Total for 5 years			
		Total Critical Care Blocks	100 bedded	50 bedded	50 bedded in Medical Colleges
1	Andaman and Nicobar Islands	1	0	0	1
2	Andhra Pradesh	13	2	0	11
3	Arunachal Pradesh	1	0	0	1
4	Assam	27	1	22	4
5	Bihar	38	18	13	7
6	Chandigarh	0	0	0	0
7	Chhattisgarh	23	1	16	6
8	D & N Haveli	0	0	0	0
9	Daman & Diu	1	0	0	1
10	Delhi	9	4	0	5
11	Goa	2	0	1	1
12	Gujarat	32	6	15	11
13	Haryana	22	0	17	5
14	Himachal Pradesh	8	0	2	6
15	Jammu & Kashmir	9	2	1	6
16	Jharkhand	22	2	14	6
17	Karnataka	30	3	10	17
18	Kerala	14	1	4	9
19	Ladakh	0	0	0	0
20	Lakshadweep	0	0	0	0
21	Madhya Pradesh	50	2	35	13
22	Maharashtra	36	7	11	18
23	Manipur	2	0	1	1
24	Meghalaya	2	0	0	2
25	Mizoram	1	0	0	1
26	Nagaland	1	0	0	1
27	Odisha	28	1	19	8
28	Puducherry	3	1	1	1
29	Punjab	21	4	14	3
30	Rajasthan	33	4	15	14
31	Sikkim	1	0	0	1
32	Tamil Nadu	37	5	13	19
33	Telangana	31	2	21	8
34	Tripura	1	0	0	1
35	Uttar Pradesh	74	30	22	22
36	Uttarakhand	7	0	4	3
37	West Bengal	22	6	3	13
	Total	**602**	**102**	**274**	**226**

APPENDIX 7.2

The State wise breakup of Physical deliverables for Critical Care Hospital Blocks–Category wise - under PM Ayushman Bharat Health Infrastructure Mission for FY 2021-22 to 2025-26 (Year-wise distribution)

S. No	State/ UT	2021-22				2022-23				2023-24			
		Critical Care Blocks for this year	100 bedded	50 bedded	50 bedded in Medical colleges	Critical Care Blocks for this year	100 bedded	50 bedded	50 bedded in Medical colleges	Critical Care Blocks for this year	100 bedded	50 bedded	50 bedded in Medical colleges
1	Andaman and Nicobar Islands	0	0	0	0	0	0	0	0	0	0	0	0
2	Andhra Pradesh	1	0	0	1	2	0	0	2	2	0	0	2
3	Arunachal Pradesh	0	0	0	0	0	0	0	0	0	0	0	0
4	Assam	2	0	2	0	5	0	4	1	5	0	4	1
5	Bihar	4	2	1	1	8	4	3	1	8	4	3	1
6	Chandigarh	0	0	0	0	0	0	0	0	0	0	0	0
7	Chhattisgarh	3	0	2	1	4	0	3	1	4	0	3	1
8	D & N Haveli	0	0	0	0	0	0	0	0	0	0	0	0
9	Daman & Diu	0	0	0	0	0	0	0	0	0	0	0	0
10	Delhi	1	0	0	1	2	1	0	1	2	1	0	1
11	Goa	0	0	0	0	0	0	0	0	0	0	0	0
12	Gujarat	4	1	2	1	6	1	3	2	6	1	3	2
13	Haryana	3	0	2	1	4	0	3	1	4	0	3	1
14	Himachal Pradesh	1	0	0	1	1	0	0	1	1	0	0	1
15	Jammu & Kashmir	1	0	0	1	1	0	0	1	1	0	0	1
16	Jharkhand	2	0	1	1	4	0	3	1	4	0	3	1
17	Karnataka	3	0	1	2	6	1	2	3	6	1	2	3
18	Kerala	1	0	0	1	3	0	1	2	3	0	1	2
19	Ladakh	0	0	0	0	0	0	0	0	0	0	0	0
20	Lakshadweep	0	0	0	0	0	0	0	0	0	0	0	0
21	Madhya Pradesh	5	0	4	1	10	0	7	3	10	0	7	3
22	Maharashtra	4	1	1	2	7	1	2	4	7	1	2	4
23	Manipur	0	0	0	0	0	0	0	0	0	0	0	0
24	Meghalaya	0	0	0	0	0	0	0	0	0	0	0	0
25	Mizoram	0	0	0	0	0	0	0	0	0	0	0	0

S. No	State/ UT	2021-22				2022-23				2023-24			
		Critical Care Blocks for this year	100 bedded	50 bedded	50 bedded in Medical colleges	Critical Care Blocks for this year	100 bedded	50 bedded	50 bedded in Medical colleges	Critical Care Blocks for this year	100 bedded	50 bedded	50 bedded in Medical colleges
26	Nagaland	0	0	0	0	0	0	0	0	0	0	0	0
27	Odisha	3	0	2	1	6	0	4	2	6	0	4	2
28	Puducherry	0	0	0	0	0	0	0	0	0	0	0	0
29	Punjab	1	0	1	0	5	1	3	1	5	1	3	1
30	Rajasthan	3	0	2	1	7	1	3	3	7	1	3	3
31	Sikkim	0	0	0	0	0	0	0	0	0	0	0	0
32	Tamil Nadu	4	1	1	2	8	1	3	4	8	1	3	4
33	Telangana	3	0	2	1	6	0	4	2	6	0	4	2
34	Tripura	0	0	0	0	0	0	0	0	0	0	0	0
35	Uttar Pradesh	7	3	2	2	14	6	4	4	14	6	4	4
36	Uttarakhand	0	0	0	0	2	0	1	1	2	0	1	1
37	West Bengal	2	1	0	1	5	1	1	3	5	1	1	3
	Total	**58**	**9**	**26**	**23**	**116**	**18**	**54**	**44**		**18**	**54**	**44**

APPENDIX 7.2 Contd.

S. No.	State/UT	2024-25				2025-26			
		Critical Care Blocks for this year	100 bedded	50 bedded	50 bedded in Medical colleges	Total Critical Care Blocks	100 bedded	50 bedded	50 bedded in Medical colleges
1	Andaman and Nicobar Islands	0	0	0	0	1	0	0	1
2	Andhra Pradesh	2	0	0	2	6	2	0	4
3	Arunachal Pradesh	0	0	0	0	1	0	0	1
4	Assam	5	0	4	1	10	1	8	1
5	Bihar	8	4	3	1	10	4	3	3
6	Chandigarh	0	0	0	0	0	0	0	0
7	Chhattisgarh	4	0	3	1	8	1	5	2
8	D & N Haveli	0	0	0	0	0	0	0	0
9	Daman & Diu	0	0	0	0	1	0	0	1
10	Delhi	2	1	0	1	2	1	0	1
11	Goa	0	0	0	0	2	0	1	1
12	Gujarat	6	1	3	2	10	2	4	4
13	Haryana	4	0	3	1	7	0	6	1
14	Himachal Pradesh	1	0	0	1	4	0	2	2
15	Jammu & Kashmir	1	0	0	1	5	2	1	2
16	Jharkhand	4	0	3	1	8	2	4	2
17	Karnataka	6	1	2	3	9	0	3	6
18	Kerala	3	0	1	2	4	1	1	2
19	Ladakh	0	0	0	0	0	0	0	0
20	Lakshadweep	0	0	0	0	0	0	0	0
21	Madhya Pradesh	10	0	7	3	15	2	10	3
22	Maharashtra	7	1	2	4	11	3	4	4
23	Manipur	0	0	0	0	2	0	1	1
24	Meghalaya	0	0	0	0	2	0	0	2
25	Mizoram	0	0	0	0	1	0	0	1
26	Nagaland	0	0	0	0	1	0	0	1
27	Odisha	6	0	4	2	7	1	5	1
28	Puducherry	0	0	0	0	3	1	1	1
29	Punjab	5	1	3	1	5	1	4	0
30	Rajasthan	7	1	3	3	9	1	4	4
31	Sikkim	0	0	0	0	1	0	0	1

S. No.	State/UT	2024-25				2025-26			
		Critical Care Blocks for this year	100 bedded	50 bedded	50 bed-ded in Medical colleges	Total Critical Care Blocks	100 bedded	50 bedded	50 bedded in Medical colleges
32	Tamil Nadu	8	1	3	4	9	1	3	5
33	Telangana	6	0	4	2	10	2	7	1
34	Tripura	0	0	0	0	1	0	0	1
35	Uttar Pradesh	14	6	4	4	25	9	8	8
36	Uttarakhand	2	0	1	1	1	0	1	0
37	West Bengal	5	1	1	3	5	2	0	3
	Total	**116**	**18**	**54**	**44**	**196**	**39**	**86**	**71**

PRADHAN MANTRI–AATMANIRBHAR SWASTH BHARAT YOJANA (PM-ASBY)

Memorandum of Understanding (MoU)

Between

Ministry of Health & Family Welfare,

Government of India

and

Government of _____[Name of State / UT]

Annexure-I

DRAFT Memorandum of Understanding (MoU) FOR IMPLEMENTATION OF the Pradhan Mantri – Aatmanirbhar Swasth Bharat Yojana (PM-ASBY)

BETWEEN

the Ministry of Health & Family Welfare (MoHFW)

&

THE STATEs/ UTs

1. PREAMBLE

1.1 WHEREAS the Pradhan Mantri – Aatmanirbhar Swasth Bharat Yojana, (hereinafter to be referred as PM-ASBY), has been approved by the Union Cabinet in September 2021 **and launched in October 2021**, to be implemented over a period of five until FY 2025- 2026 from FY 21-22, is a Centrally Sponsored Scheme with some Central Sector Components, and aims at supporting the States and UTs to develop a robust health system to respond to future pandemics, consistent with the outcomes envisioned in the Sustainable Development Goals (SDG)-3 indicators falling within the health domain and general principles laid down in the National and State policies, including the National Health Policy, 2017.

1.2 AND WHEREAS the key objective of the **PM-ASBY** would be to develop a Public Health System to meet the needs of future pandemics by integrating essential public health functions and service delivery with the objective to strengthen grass roots public health institutions in rural and urban areas, to deliver universal comprehensive primary health care, including surveillance, active community engagement and improved risk communication, health education and prevention and to strengthen public health institutions and public health governance capacities to meet challenges posed by the current and future pandemics/ epidemics with capacities for comprehensive diagnostic and treatment including for critical care services.

1.3 And whereas the Operational Guidelines for implementation of the PM-ASBY provide for the MoU to be signed between the MOHFW for such a participating State/UT for which the state's share of funds, commensurate to the central share of funds, is applicable;

1.4 And whereas, the state share is applicable to the participating state of _____(name of State/UT);

NOW THEREFORE, the MOHFW and the State/UT Government/Administration of _____ (Name of State/UT), being signatory to this MoU, hereby enter into this MoU and thereby commit to work together for implementation of the PM-ASBY and have agreed as set out herein below –

2. DURATION OF THE MoU

This MoU[1] will be operative with effect from 1st November 2021 or the date of its signing by the parties concerned whichever is earlier and will remain in force till 31st March 2026 or till its renewal through mutual agreement or till extension of PM-ASBY, by the Government of India, whichever is later.

3. RESOURCE ENVELOP AND DELIVERABLES

3.1 The component-wise agreed outlay for the PM-ASBY for the Scheme period (from 2021-22 to 2025-26), with details of sources for the funding, is reflected in the Annexure 1A.

3.2 The component-wise agreed outlay for the PM-ASBY for the Scheme period (from 2021-22 to 2025-26) with details of heads of expenditure, i.e. capital and recurring, is reflected in the Annexure 1B.

3.3 The component-wise and financial year-wise agreed deliverables for the PM-ASBY, for the Scheme period (from 2021-22 to 2025-26), are reflected in the Annexure 2.

4. OVERARCHING PRINCIPLES

4.1 PM-ASBY is a Centrally Sponsored Scheme (CSS), with few Central Sector Components. The CSS components of the PM-ASBY will be implemented by following the existing Framework, institutions and mechanisms of the National Health Mission. For the CSS components, the PM-ASBY would leverage the existing National Health Mission (NHM) structure available at central and State levels for appraisal, approval, implementation and monitoring.

4.2 State Health Society, established under National Health Mission (NHM), will be the implementing agency at the State level and shall play a pivotal role in planning for the PM-ASBY. Similarly, at the district level, the District Health Society, headed by the District Collector, will play a crucial role in not only planning as per the guidelines and also, for effective implementation and robust monitoring of the units of various components under PM-ASBY, under the overall supervision of the District Collector.

4.3 Institutional arrangements and Funds releases will be as per Operational Guidelines of the implementation of the Prime Minister Aatmanirbhar Swasth Bharat Yojana (PM-ASBY) dated 25th October 2021, as revised by the MOHFW, from time to time, in consultation with stakeholders.

4.4 The Guiding Principles set out in para 2.1 of the Operational Guidelines of the implementation of the Prime Minister Aatmanirbhar Swasth Bharat Yojana (PM-ASBY) dated 25th October 2021, shall be followed.

4.5 For the three components, namely, Infrastructure support to rural Health and Wellness Centres / Building-less Sub Health Centres in Rural Areas, Block Public Health Units (BPHUs) and Urban Health and Wellness Centres (Urban HWCs), will utilize the resources of FC-XV Health Grants through Local Governments in the respective States, the mechanism for planning, implementation, and monitoring shall be synergized as per the Technical and Operational Guidelines for the implementation of FC-XV Health Grants through Local Governments dated 31st August 2021, by the State.

4.6 A common Indicator framework and Output Outcome Framework would be prepared encompassing all the components of PM-ASBY for providing a common results framework and communicated to the state. The signatories shall take all necessary measures for achievement of the Outputs and Outcomes so set out, in the prescribed timeframe.

4.7 Any necessary addition or modification in any of the clauses or Annexures of this MoU shall be made only with mutual agreement and shall be recorded in writing. Such additions of modifications shall be appended to this MoU.

5. GOVERNMENT OF INDIA COMMITMENTS

5.1 Release of funds in accordance with the approved funding pattern and budget, compliance to agreed performance indicators, within an agreed time. However, the funds committed through this MoU may be enhanced or reduced, depending on the pace of implementation of the State's plans and achievement of the milestones relating to the agreed performance Indicators.

5.2 Facilitating multilateral and bilateral development partners to co-ordinate their assistance, monitoring and evaluation arrangements, data requirements and procurement rules etc. within the framework of an integrated State Health Plan.

5.3 Assisting the States in mobilizing technical assistance inputs.

5.4 Developing and disseminating protocols, standards, training modules and other such materials for improving implementation of the programme.

5.5 Consultation with States, on a regular basis, at least once a year, on the reform agenda and review of progress.

5.6 Prompt consideration and response to requests from states for policy, procedural and programmatic changes.

5.7 Holding joint annual reviews with the State, other linked Central Government Departments and participating Development Partners;

5.8 Dissemination of and discussion on any evaluations reports etc., that have a bearing on policy and have the potential to cause a change of policy.

6. STATE GOVERNMENT COMMITMENTS

6.1 The State Government shall ensure that the funds made available to support the agreed State Plan under this MoU are used for financing the agreed State Plan approval in accordance with agreed financing schedule and not used to substitute routine expenditures that are the responsibility of the State Government.

6.2 The State share shall be 40% in all States and UTs with legislature except for Jammu & Kashmir, Himachal Pradesh, Uttarakhand, North Eastern States where the State/UT contribution will be 10%.

6.3 The State shall ensure that the implementation of the programme/activities envisaged is as per the PM-ASBY guidelines provided by Ministry and other guidance as updated from time to time.

6.4 Representative of the MoHFW and/or development partners providing financial assistance under the MoU mechanism as may be duly authorized by the MoHFW from time to time, may undertake field visits to any part of the State and will have access to such information as may be necessary to make an assessment of the progress of the health sector in general and PM-ASBY in particular.

6.5 The accounts are maintained, and audit is conducted as per the rules and utilization certificates are submitted within the period stipulated under General Financial Rules (GFR), 2017. The State Governments shall comply to the financial guidelines issued to the states by the Financial Management Group established under National Health Mission by the Ministry of Health and Family Welfare. In addition, states shall have to follow State Finance Rules related to procurement and General Finance Rules in relation to furnishing of Utilization Certificate and other related Matters

6.6 State shall follow the extant instructions of the Central Government for fund releases under the Centrally Sponsored Schemes.

6.7 The State shall organize the audit of the PM-ASBY account of the State Health Society after close of every financial year. The State Government will prepare and provide to the MoHFW, a consolidated statement of expenditure, including the interest that may have accrued.

6.8 The funds provided for the PM-ASBY, including both central share, the state share and the XV FC Grants for Health Sector, shall also be liable to statutory audit by the Comptroller and Auditor General of India.

6.9 The State shall take prompt corrective action in the event of any discrepancies or deficiencies being pointed out in the audit. Every audit report and the report of action taken thereon shall be tabled in the next ensuing meeting of the Governing Body of the State Society. The State Government shall also table the audit report of the scheme in the house of State Legislative Assembly.

6.10 State shall endeavour to implement all the activities as indicated in the plan and take such other action as is needed to achieve the plan objectives.

6.11 State shall make effort in filling up vacant posts as per the agreed institutional reforms.

6.12 State agrees and commits to achieve all the key deliverables as set out in Annexure 2, for five years from FY 2021-22 till FY 2025-2026.

6.13 **Recruitment/Appointment of HR:**

6.13.1 Support for HR requirement for these components will be provided only up to the scheme period, i.e. up to FY 25-26 and after that, states would be responsible for maintaining the facilities including Human Resources. The State has **taken into consideration that the recurring HR expenditure will not be available beyond the scheme period.**

6.13.2 **The State commits that it shall create and fill up the regular posts in the required places, to manage and and ensure that the assets created under the PM-ASBY are kept fully functional even beyond the scheme period.**

6.13.3 Under PM-ASBY, only contractual/outsourced Human Resource is permissible to be engaged. However, if the State Government appoints permanent human resources either on its own or by virtue of orders of Hon'ble Court, then the State Government shall be liable to maintain the same at its own cost, and the liability of the Central Government will strictly be only to the extent of agreed and approved PM-ASBY-Plan.

6.13.4 The State Health Society is responsible for appointment (contractual/conditional) employees, their transfers/termination of services, payment of wages, salary, remuneration, etc. There would be no privity of contract between the Central Government and the employees appointed by the State Health Society.

6.14 State agrees for an annual review of both progress of the plan and of the institutional reforms, carried out by the State. This review would be integrated into the NHM's annual Common Review Mission, undertaken by a multi-disciplinary /multi -stakeholder team comprising of Central Government officials, public health experts, civil society representatives, other partners and stakeholders.

7. SUSPENSION

Non - compliance of the commitments and obligations set in the MoU and/or upon failure to make satisfactory progress may require Ministry of Health & Family Welfare to review the assistance committed through this MoU leading to suspension, reduction or cancellation thereof. The MoHFW commits to issue sufficient alert to the State Government before contemplating any such action.

Signed this_____day of _____ (month) _____(year) 2021

For and on behalf of

Government of.....	Government of India Ministry of Health & Family Welfare
Addl. Chief Secretary / Principal Secretary/ Secretary (HFW)	Joint Secretary (Policy), Ministry of Health & Family Welfare Government of India

ANNEXURE-1

Total Allocation under CSS components of PM-ASBY for five years from FY 2021-22 for the State of _____

A. Component-wise fund allocation for five CSS components under PM-ASBY for five years from FY 21-22 to 25-26 (Central and State Share):

S.No	CSS Component	No of Units approved for the State	Amount Sanctioned under PM-ASBY (In Rs Crores)			
			Central Share	State Share	FC-XV Share	Total
1.	Rural AB-HWCs					
2.	Urban Health and Wellness Centres					
3.	Block Public Health Units					
4.	District Integrated Public Health Labs					
5.	Critical Care Blocks					
	a. 100 Bedded Blocks in District Hospitals					
	b. 50 Bedded Blocks in District Hospitals*					
	c. 50 Bedded Blocks in Govt Medical Colleges**					
Grand Total Financial outlay to Assam						

B. Component-wise fund allocation for five CSS components under PM-ASBY for five years from FY 21-22 to 25-26 (capital and recurring cost):

S.No.	CSS Component	No of Units for the scheme period	Amount Sanctioned under PM-ASBY (In Rs Crores)		
			Capital Cost	Recurring Cost	Total Cost
1.	Rural AB-HWCs				
2.	Urban Health and Wellness Centres				
3.	Block Public Health Units				
4.	District Integrated Public Health Labs				
5.	Critical Care Blocks				
	a. 100 Bedded Blocks in District Hospitals				
	b. 50 Bedded Blocks in District Hospitals				
	c. 50 Bedded Blocks in Govt Medical Colleges				
Grand Total Financial outlay					

ANNEXURE-2

Component-wise physical deliverables envisaged under PM-ASBY for five years

S. No		2021-22	2022-23	2023-24	2024-25	2025-26	Total
	Components	Units	Units	Units	Units	Units	Units
1	AB-HWCs in rural areas						
2	AB-HWCs in urban areas						
3	Block Public Health Units						
4	Integrated Public Health Labs in all Districts						
5	Critical Care Blocks						
	a. Critical Care Blocks (100 bedded)						
	b. Critical Care Blocks (50 bedded)						
	c. Critical Care Blocks (Medical Colleges 50 bedded)						

ANNEXURE - II

Parameters, to be factored, while preparing Plans under PM-ASBY scheme

S.No.	FC-XV Component	Critical Parameters, while preparing Action Plan
1.	Block Public Health Units	All the Blocks in these 11 States to be covered / saturated, including those in Tribal areas and Left Wing Extremism (LWE) affected areas. Calculations of the support under PM-ASBY, are based on the number of Blocks in the States as on July 2020 (LG Code database) Comprehensive gap analysis on the requirement, will enable, to cover also the new blocks, created by the States subsequently.
2.	Building-less SHCs	Efforts should be made to Number of Building-less SHCs in these 10 States, including those in Tribal areas and Left Wing Extremism (LWE) affected areas. Calculations of the support under PM-ASBY, are based on the number of Building-less SHCs in the States as per RHS 2019 and informal verifications with the State health teams. Comprehensive gap analysis on the requirement, will enable, to cover also the Building-less SHCs in the State as on date. The States may prioritize the constructions of Buildings for the Building-less SHCs, **especially those Sub Health Centres, that have been converted into Health and Wellness Centres (AB-HWCs)**, and few factors to be considered in this regard are: • Run-down / dilapidated building structures which are required to be re-built. • Construct new buildings, where services are being provided from rented buildings especially in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers. • New buildings in lieu of existing rented buildings that may not have adequate infrastructure/ space for carrying out the required activities. • New buildings, if required as per shortfall of population norms as per details given in RHS 2020. **States are informed that if the existing rented buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**
3.	Urban Health and Wellness Centres in all the States/UTs	Based on the vulnerability assessment and mapping of the urban areas, the slum / vulnerable areas will be prioritized where presently no primary health care facility exists. The priority is to ensure that there is one Urban-HWC per 15,000-20,000 population catering predominantly to poor and vulnerable populations, resident in slum and slum-like areas. The norms are relaxable as per the local context of the States. Decisions regarding the required number of Urban-HWCs, would depend on population density, presence of slums & similar habitations, vulnerable population, peri-urban areas and newly Notified Urban Areas.

S.No.	FC-XV Component	Critical Parameters, while preparing Action Plan
4.	District Integrated Public Health Labs in all the 730 districts	Depending on the gap analysis, some districts require establishment of new DIPH labs, and some districts requires strengthening of existing PH labs. Calculations of the support under PM-ASBY, are based on the number of districts in the States as on July 2020 (LG Code database) Comprehensive gap analysis on the requirement, will enable, to cover the requirement for new districts, created by the States subsequently.
5.	Critical Care Blocks in 602 Districts	Based on the Population of 2011, under PM-ASBY, support will be provided to 602 districts across all States/ UTs. For the 102 Districts having more than 20 lakh population, the Size of the Critical Care Block are to be limited to 25% of the existing District Hospitals Beds capacity subject to a minimum of 50 and a maximum of 100 beds. For 274 districts with 5-20 lakhs population, it is envisaged to set- up 50 bedded Critical Care Hospital Block/Wing. Besides the above, 226 districts, with Government Medical Colleges, would also be supported to establish a 50 bedded Critical Care Hospital Block / wing All other districts (with less than 5 lakhs population) to be linked with the nearest CCBs. Comprehensive gap analysis on the requirement, will enable, to cover the requirement for new districts, created by the States subsequently.

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