OBJECTIVES OF IPHS FOR HWC-PHC

3 SECTION

The broad objectives of the Indian Public Health Standards (IPHS) for PHC in rural and urban areas include the following:

1. To define uniform benchmark to ensure high quality services that are accountable, responsive, and sensitive to the needs of the community.
2. To specify the minimum assured (essential) and achievable (desirable) services that are expected to be provided at different levels of public health facilities.
3. To provide guidance on health systems strengthening components which includes architectural design of facilities, human resources for health, drugs, diagnostics, equipment, administrative and logistical support services to improve the overall health related outcomes
4. To achieve and maintain an acceptable standard of the quality of care at public facilities
5. To facilitate monitoring and supervision of the facilities
6. To provide guidance and tools for governance, leadership and evaluation.

POPULATION NORMS FOR HWC-PHC

5 SECTION

Normally, a PHC in rural areas is to be established for a population of 20,000 (in hilly and tribal areas) and 30,000 (in plains). It should be established co-terminus with Panchayats (depending upon the population) to establish effective convergence and linkages with citizen centric services. A Primary Health Centre (PHC) that is linked to a cluster of Sub Health Centre - HWCs would be strengthened as HWC to deliver the expanded range of primary care services with complete 12 package of services. In addition, it would also serve as the first point of referral for all the SHC-HWCs in its jurisdiction.

In urban areas, usually the population density is high and there are various types of health care facilities which provide inpatient care. So, the approach in urban areas for establishing PHCs shall be different from that in rural areas. UPHCs are established for every 50,000 population, and in close proximity to urban slums. Multispecialty Polyclinics provide specialist healthcare services to a population of 2.5 to 3 lakhs, encompassing the catchment population of 5-6 UPHCs, depending upon geographic location, population density, available infrastructure, etc.

Population norm for HWC-PHC			
S. No.	**Type of PHC facility**	**Plain (population)**	**Hilly and Tribal areas (population)**
1	**Rural PHC**	30,000	20,000
2	**Urban PHC**	50,000	–
3	**Polyclinic**	2.5 lakh - 3 lakh	–

6 SECTION

GENERAL PRINCIPLES OF IPHS

- IPHS defines the standards in the local context of the country and its implementation is the state's/UTs responsibility with technical support from MoHFW. IPHS does not define the implementation process. However in the interest of rendering quality patient services, it suggests that in-house hiring of clinical and critical staff should be prioritized rather than those services which can efficiently be run even through outsourcing model like security, cleaning, laundry, etc.
- While planning and designing services at public health facilities, health needs of the entire district should be considered as a whole rather than focusing on individual facilities within that district. This holistic assessment should include a systematic review of the burden of disease in that district, the local epidemiology and the specific needs and requirements of communities in different parts of the district. While placing services at various levels, "continuum of care" approach needs to be ensured for the population.
- For each district/city, the final number of health facilities will be influenced by its population, time to care, geographical need, local epidemiology and burden of disease, community requirements and the health seeking behaviour of the population. Every district should have a district health action plan, with all health facilities identified and mapped, and indicating the type and level of services they provide.
- Depending on the services provided at a particular facility, it may be deemed as a primary or secondary care service provider facility:
  - Health and Wellness Centres (Sub-Centres and PHCs), in both rural and urban areas will provide primary care services.
  - Multispecialty polyclinics, nearer to the community, will provide ambulatory specialist services in urban areas.
  - Community Health Centres, in rural areas can be either non-FRU or FRU depending on the range of services provided. In urban areas, CHCs will provide services at par with FRU.
  - District and Sub-District Hospitals will provide secondary care services.
- Implementation of all national programmes at individual facilities must be in line with the latest GoI/state guidelines developed for that programme.
- Requirements of individual national health programmes (in terms of service delivery, infrastructure, human resources, drugs, and diagnostics) have been reviewed and included in IPHS. Therefore, achieving IPHS compliance would go a long way in fulfilling the requirements of various health programmes.
- The specific set of services to be provided at a particular facility is clearly defined in the list of services. Requirements of individual national health programs have already been considered in this list. This will help to identify requirements for infrastructure, HRH, drugs, diagnostics, and equipment.
- IPHS prescribes norms for allopathic services. However, AYUSH services have been retained in IPHS 2022 as desirable. The HRH, medicines, and other inputs required for AYUSH services shall be given by Ministry of AYUSH.

- All statutory and regulatory standards relevant to a particular facility should be followed and adhered to in accordance with the latest national/state guidelines, rules, and regulations.
- A Citizens' Charter should be prominently displayed near the entrance of the facility. This should provide information about the various services being offered, timings, responsibilities of patients and providers, details of referral vehicles and facilities, the number of free drugs and diagnostics being provided and other citizen friendly information. Patients' rights should be ensured, and they should also be made aware of their responsibilities (e.g., to keep the facility clean and avoid spitting in corners, avoiding over-crowding by attendants, respecting visiting hours, not causing any harm to public property or indulging in violence against healthcare professionals etc.). A sample Citizens' Charter is placed at **Annexure *1*.**
- All HWC-PHCs, should have façade branding as per the GoI guidelines. IT infrastructure should be set up to enable teleconsultation services and reporting on the respective databases.

the National Health Programs in their catchment area.

Different training programs for Induction, skill building and leadership, new programs and if required, refresher training should be planned systematically. Diligent records of all trainings attended by the HRH should be maintained by the facility in-charge. Cross-learning should be promoted where the HRH upon successful completion of the training program briefs the other staff about their key learnings.

8.2.2. Conduct and Behavioural Standards

The HRH placed in the public health facilities should adhere to the highest ethical and behavioural standards and provide patient care with utmost respect for the dignity of life. It is important that states orient health professionals to discharge their duties in a professional and courteous manner, facilitating greater acceptability of HRH in the community as well. They should also be oriented on gender sensitivity and efforts should be made to ensure that this concept is inculcated in their conduct and actions.

Soft skills including an empathetic attitude, manners and courteousness at bedside should be a core value, especially towards the marginalized and vulnerable. The privacy and dignity of patients should be maintained, and the principles of patient confidentiality strictly adhered to. Dress codes (with a name badge) and adherence to punctuality should be emphasized.

8.2.3. Safety Measures for HRH

It is crucial that the safety of the HRH providing services at all levels be ensured. For this purpose, the following must be adhered to:

- Sufficient provision of Protective gear like gloves, masks, gowns, caps, personal protective equipment, lead aprons, dosimeters etc. and their use by Health Care workers must be as per the standard protocols in place.
- Promotion of Hand Hygiene and practice of standard precautions by Health care workers should be standard practice.
- Display of standard operating procedures at strategic locations in the hospital.
- Regular training of Health care workers in standard precautions, Patient safety, infection control and Bio-medical waste management should be part of their training requirements.
- Immunization of Health care workers against Tetanus, Typhoid and Hepatitis B should be ensured.
- Provision of round the clock Post Exposure Prophylaxis (PEP) against HIV in case of needle stick injuries should be initiated in the emergency department.

8.3. MEDICINES

Access to essential medicines is a major determinant of health outcomes and an integral, and often crucial component of health care. An approach to ensuring access to medicines closer to community has been promoted through "Essential drug policy". It is necessary for the states to prioritize the medicines that should be made available based on the disease prevalence data and update the state EDL.

All essential medicines should be available free of cost in all PHCs/UPHCs under 'Free Drug Service Initiative' of GoI.

The list of medicines mentioned under IPHS is as per the List of Essential Medicines for HWC-PHC ***(Annexure 6)*** *(http://nhm.gov.in/New_Updates_2018/Om_and_orders/CPHC/Others/H_WC_SHC_and_PHC_updated_EML_as_on_March_2020_-.pdf)*. From the list**,** the state should identify types of medicines that are critical for

service delivery and ensure that these are always available in all health facilities. Additional medicines for the management of locally prevalent diseases should also be included. These norms do not preclude the inclusion of other medicines which are on the state list of essential medicines but not mentioned in the IPHS guidelines. With the launch of universal NCD screening and comprehensive primary care, long term dispensing (one to three months) of drugs for the management of chronic illnesses such as diabetes and hypertension has been initiated. Systematic inventory management for smooth procurement, adequate storage space and systematic NCD registers, and records will need to be maintained for these. Temperature sensitive medicines should be stored in proper cold chain/refrigerator as deemed by the manufacturer's instructions. Relevant AYUSH drugs and a pharmacist to dispense should be available at facilities where AYUSH services are being provided.

The PHC/UPHC should have Standard Operating Procedures (SOPs) for indenting, stocking of medicines, logistics for their stocking up and transportation. Indenting based on consumption, stock rotation and the distribution network should be robust and ideally through a centralized drug purchasing and distribution system to ensure that there is no stock-out of essential medicines at public facilities. This will ensure quality check and provision for recall, if required. Additionally, monitoring the rational use of higher generation antibiotics, slow- and fast-moving drugs, timely replacement of rapidly prescribed drugs, maintaining a buffer stock of critical drugs and quality control are other essential parameters.

Provisions for the local purchase of drugs during emergency situations and stock-outs of critical medicines, including during outbreaks, epidemics and pandemics, should be in place. Every effort should be made to procure generic medicines that include a mechanism for robust quality control. There should be a computerized system for receiving, inspecting, handing over, and retrieval of drugs.

All prescriptions should be clear, legible, in capital letters and contain the generic/non-proprietary name. Ideally, all electric physician order entries should be ensured. Standard treatment guidelines should be followed for drug prescriptions and patient management. Prescription audits should include a review of drugs being prescribed from outside (indicative of the not availability at the facility) and those that are not being prescribed under their generic names. Internal audit of stores should also be done on a regular basis to assess procurement of items as per laid down procedure by respective state governments.

Storage of medicines should be such that spoilage is minimized. Drug stores should avoid dampness (for example, no leaking roofs) and basic principles like 'first expiry, first out' for drugs and vaccines should be followed. Buffer stocks should be kept in separate spaces or cupboards for different programmes in the drug store; storage of drugs in clinical areas should be avoided beyond 5-7 days. The store should have refrigerators/ice- lined refrigerator (ILR) for drugs and vaccines that require maintenance of the cold chain.

8.4. DIAGNOSTICS

Diagnostics are an integral part of the health care system and provide information needed by service providers to make informed decisions about care provision related to prevention, screening, detection, treatment, and management of illness. Limited availability and access to quality laboratory and radiology services are among the major challenges contributing to delayed or inappropriate responses to disease control and patient management. The availability of necessary reagents and equipment, laboratory personnel and their capacity building, mechanisms for internal and external quality assurance and follow-up with clinicians should be strengthened.

The essential tests being offered at different levels of facilities as per free diagnostics list are placed at ***Annexure 7***. Additional diagnostic tests for the management of locally prevalent diseases should also be

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included (e.g., screening tests for Kala Azar in locally endemic areas). These norms do not preclude the inclusion of other diagnostic tests that the state decides to provide at public health facilities.

The complete list of all tests being provided should be clearly displayed. For specialized, advanced, and specific diagnostic tests, linkages with multispecialty polyclinics, CHC/UCHC, SDH, District Hospitals, Medical Colleges and National Reference Laboratories should be established. In all cases, transport must be managed carefully in order to maintain integrity of the sample, giving attention to temperature, preservation needs, special transport containers and time limitations. It is also important to ensure the safety of those handling the material before, during and after transport.

The important and essential lab imaging and other diagnostic and support services have clearly been defined either as essential or desirable. Wherever applicable such services need to be established and delivered as per the centre, state and local applicable guidelines.

The sample collection and test results should be provided to patients during OPD hours when doctors are available, so that repeat visits by the patient, or their family members is avoided. The turnaround time for test results should also be standardized, adhered to, and monitored.

The availability of necessary reagents and equipment, laboratory personnel and their capacity building, mechanisms for internal and external quality assurance and follow-up with clinicians should be strengthened. Internal Quality Control (IQC) to detect, evaluate and correct errors due to test system failure, environmental conditions, or operator performance, before patient results are reported is also an essential measure.

Validation of procedures and equipment should be carried out by running samples in parallel using both old and new equipment and methods for a period of time to determine that the expected results can be obtained. These validation procedures should be completely recorded. The staff posted in diagnostic services can be trained under EQAS programme run by government institutes.

8.5. EQUIPMENT

Medical equipment plays a significant role in patient care. It is a crucial component of health systems, as it enables the service providers to diagnose, monitor and treat various kinds of diseases. Having appropriate quality of medical equipment, helps to prevent patients from being denied any health services. All the necessary equipment to provide clinical, support and other services should be meeting essential quality parameters through the state procurement policies and procedures. The equipment mentioned under IPHS should be included in the list of essential equipment at different levels of facilities. However, the list is not exhaustive and additional equipment, if required, can be procured to provide the full range of services being offered at the facility.

A systematic and robust programme for bio-medical equipment maintenance and monitoring should be in place at all public health facilities. To improve the functionality and life of equipment, simultaneously improving healthcare services in PHCs/UPHCs along with reducing cost of care and improving the quality of care, provisions have been made in the IPHS for bio-medical engineers and technicians to oversee equipment maintenance at public health facilities. The maintenance of medical equipment requires a wide range of technical abilities, and the costs and time required to train a technician increases with the level of skill that has to be attained. Training of technicians to do front-line maintenance for medical equipment in public health facilities is essential.

An effective equipment audit assesses the present equipment status and ensures better equipment procurement in the future. The audit should be done on a periodic basis and contain details like name, cost

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of equipment, date of purchase, manufacture and installation, name and address of supplier, department where installed, environmental control, spare parts inventory, technical manual, after sales service agreement, guarantee, warranty period, life of equipment, depreciation per year, up/down time, date of condemnation and replacement. Number of services delivered by each major equipment needs to be noted down, to analyze the value for the money invested in purchasing high-cost equipment.

Along with maintenance and monitoring programme, it is also essential that a condemnation policy is in place at all facilities so that the practice of out-of-use equipment and furniture being scattered around the facility is mitigated. Condemnation should be done periodically by condemnation committee after careful examination of items. The list of items with code number, the date of purchase, repair, correct value and other relevant details should be thoroughly prepared by the committee.

Biomedical Equipment Management & Maintenance Program (BMMP) is an initiative by Ministry of Health and Family Welfare to provide support to state governments to outsource medical equipment maintenance comprehensively for all facilities so as to improve the functionality and life of equipment, simultaneously improving healthcare services in public health facilities- reducing cost of care and improving the quality of care. Detailed list of equipment is placed **at *Annexure 8.***

8.6. QUALITY ASSURANCE

Well maintained Infrastructure, adequate & skilled human resource, functional equipment & instruments, and sufficient drugs & consumables ensure the fulfilment of the 'Structural' requirements for establishing a well-functional health facility. However, for attaining enhanced satisfaction with improved clinical outcomes, it becomes equally pertinent to ensure 'Quality' in the 'Processes' of the care within a health facility.

As a healthcare provider, while it is important to ensure provision of safe and evidence based clinical care, it is equally fundamental to provide the care that makes patients' and visitors' experiences rewarding. Ensuring 'Quality of Care' as a key component would require undertaking conscious and concerted efforts to identify the 'Gaps' by measuring the Quality of Care (QoC) in all its three dimensions, namely structure, process and outcome (Donabedian Model of QoC).

Subsequently, available resources are channelized, and focussed efforts undertaken for closing the gaps and bringing about the 'Improvement' in the services.

For ensuring provision of 'Quality of Care', IsQua (International Society for Quality in Healthcare) accredited *National Quality Assurance Standards (NQAS)* for District Hospitals, CHCs, PHCs, UPHCs and Health and Wellness Centre- Sub centres have been formulated by the Ministry of Health & Family Welfare, GOI. Setting standards is a dynamic process, and the standards provide roadmap for the health facilities to improve the care.

The main pillars of Quality Measurement Systems are Quality Standards. These standards have been defined for various level of facilities under NQAS. The standards have been grouped within the eight Areas of Concern. Each standard further has specific Measurable Elements. These standards and Measurable elements are checked in each department of a health facility through department specific checkpoints. These defined standards are available in following link:

http://qi.nhsrcindia.org/cms-detail/revised-national-quality-assurance-standards/MjM3

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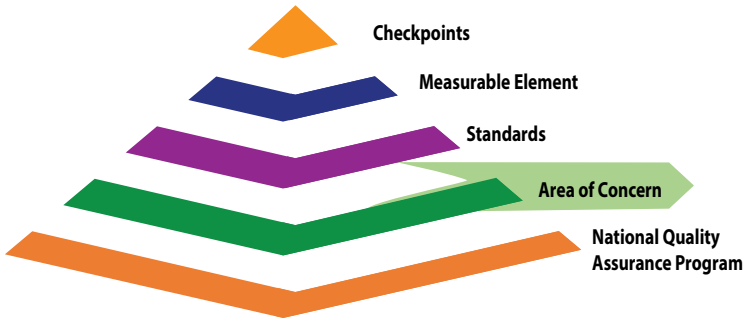
Figure: Measurement system under NQAS



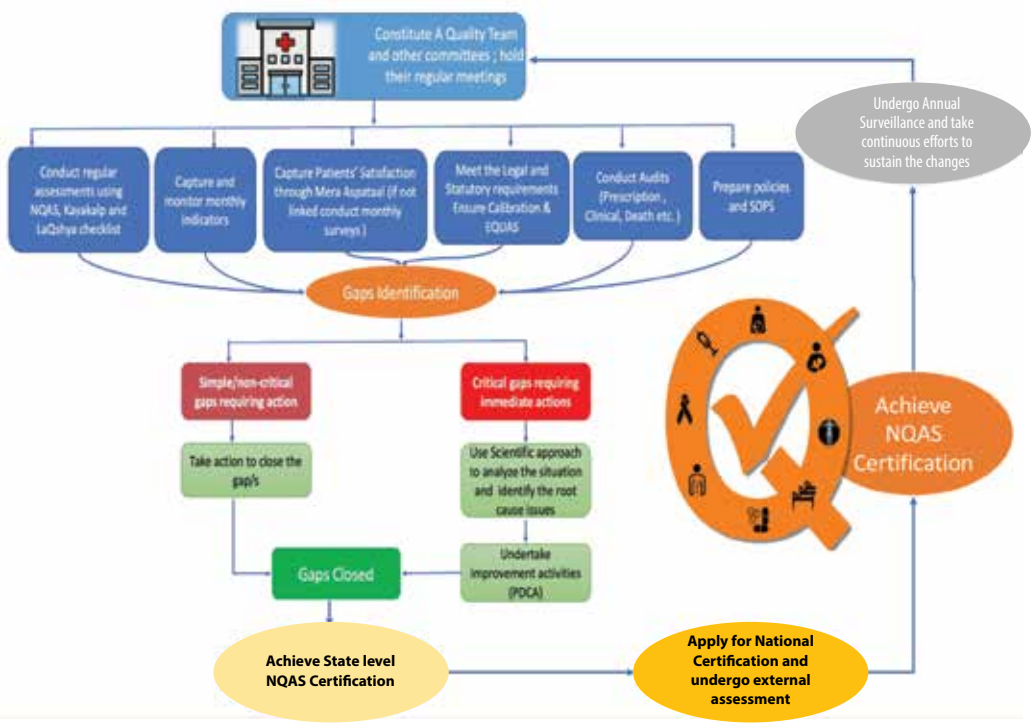
A well-built institutional framework from facility (Quality team) to the National level (Central Quality Supervisory Committee) supports the seamless implementation of the standards (Figure - Institutional Framework under NQAS). Facilities which are able to meet the defined standards and criteria are certified and incentivized (subject to annual surveillance and ensure sustaining the changes). With this, National Quality Assurance Program (NQAP) envisages to instil the culture of Quality and Safety in our health systems.

Figure: Institutional Framework under NQAS

It is expected that all public health facilities would implement these standards by undertaking following steps:

1. Formation of Quality team
2. Plan for quarterly Internal Assessment
3. Monthly Patient Satisfaction Survey
4. Collation and Analysis of Key Performance Indicators
5. Define Quality Policy and Objectives
6. Plan for Medical and Death Audits
7. Preparation of SOPs and Work instructions
8. External Quality Assurance of Lab-EQAS and Calibration of measuring Equipment
9. Traversing the Assessed Gaps
10. Quality Certification- State and National
11. Sustenance and incentives

Figure: Road map for healthcare facilities to achieve NQAS certification



Summary of the activities is given below:

Under the ambit of National Quality Assurance Programme various other initiatives like *Kayakalp, LaQshya and Mera Aspataal* (My Hospital) have also been initiated to work on specific domains of quality improvement. These domains together support the implementation of National Quality Assurance Programme.

- *Kayakalp* aims to promote Cleanliness, Hygiene, and Infection Prevention. It is an award scheme in which facilities are assessed at three-level (Internal, Peer, External) using objective checklist covering eight thematic areas (a) Hospital Upkeep, (b) Sanitation & Hygiene, (c) Waste Management, (d) Infection control, (e) Support Services (f) Hygiene Promotion, and (g) Beyond the hospital boundary. Facilities scoring 70% and above after external assessment are recognized and incentivized.
- *LaQshya* is quality improvement initiative, which aims to improve facility-based quality of care around birth, which normally takes place in the Labour Room and Maternity OT of a high case-load facility.
- *Mera Aspataal* (My Hospital) an ICT based platform which captures 'Voice of Patients' visiting and receiving care from the healthcare facilities. Inputs received on *Mera Aspataal* support facilities to identify the "Dissatisfiers" and to take up further actions to mitigate them.

Patient Safety and Infection Control

Some of the patient safety and infection control measures are given below:

- Hand washing facilities in all areas should be installed. Compliance with the correct method of hand hygiene by health care workers should be ensured.
- Safe clinical practices as per standard protocols to prevent health care associated infections should be instituted. ***(Annexure 9).***
- There should be proper written hand over system between health care staff.
- Safe Injection practices as per the prescribed protocol should be followed.
- Ensuring Safe disposal of Bio-Medical Waste as per rules should be adhered to.

- For reducing environmental pollution including those relating to Mercury, GoI Guidelines should be adhered to.
- Guidelines for Airborne Infection Control should be followed.
- Regular Training of Health care workers in patient safety, infection control and Bio-medical waste management should be scheduled and held.

8.7. IMPLEMENTATION OF IPHS

8.7.1. Governance

Effective governance of the public health system includes the establishment of institutional arrangements and policies along with their continuous monitoring to ensure proper implementation. Apart from promoting good leadership, it also includes specific interventions such as the establishment of facility based Jan Arogya Samiti (JAS); building accountability in to the system (e.g. performance appraisal, target setting and monitoring, social audit, citizens' charter); patient centric services (patient feedback, reducing out-of-pocket expenditure, improving the patient experience, grievance redressal); compliance with statutory norms (Acts and regulations) and ensuring robust clinical governance (adherence with SOPs and standard treatment guidelines, and MDSR/CDR).

Some aspects of governance relevant to public health facilities are described below:

8.7.2. Monitoring

Continuous monitoring, mentoring, ownership by the staff along with continuous support and encouragement by supervisors and higher levels of management as part of quality improvement initiatives will help achieving IPHS.

Internal mechanisms like systematic and proper record keeping and ensuring timely reporting mechanism for Robust internal and external monitoring is vital to maintain standards, identify gaps and address deficiencies in service delivery at public health facilities.

Internal monitoring mechanisms will include proper record keeping and maintenance, supportive supervision, and a regular system of audits (clinical audit, prescription audit, death audit, disaster preparedness audit) as part of clinical governance.

Health intelligence in terms of standard formats to capture data on key performance indicators will facilitate a system for robust internal monitoring. This should be regularly reviewed by senior administrative and clinical personnel to enable gap analysis. An action plan with corrective measures, the person/department responsible and timelines should be prepared and reviewed regularly.

A variety of measures should be used for external monitoring; these include patient satisfaction surveys, social accountability through Jan Aarogya Samitis/Rogi Kalyan Samitis and/or Panchayati Raj Institutions, community surveys and *Jan Sunawais* and *Jan Samvads*.

Institutional structures operational for community-based monitoring such as Village Health Sanitation and Nutrition Committees (VHSNC) and Community Action for Health - monitor delivery of preventive, promotive and curative services as part of CPHC. They are important to provide relevant inputs for decentralized health planning.

Along with monitoring of services at the facility level, a primary health centre is also responsible for monitoring and supervision of activities of:

- HWC-SC/UHWC,
- VHNDs/UHNDs, special outreach,