

ASSESSING FIELD LEVEL IMPLEMENTATION OF CPHC (Comprehensive Primary Health Care) THROUGH AYUSHMAN BHARAT HWCs (Health and Wellness Centres) in Tamil Nadu

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Executive Summary

This study, taken up to assess the progress of Health and Wellness Centres, an important part of the Ayushman Bharat scheme, indicates that, in Tamil Nadu, though the piloting of Universal Health Coverage has indicated the benefits the scaling up is in a slow phase. Infrastructure improvement at the Health Sub-Centre level is the main reason. Though there are no shortage of medicines, there is shortage of essential human resources, the pan of training a team at the sub-district level for CPHC is lacking, implementation of IT support like telemedicine is also lacking. Since the scheme of ASHA is not adopted every where and the support groups have not been created community participation is not existing. The VHNDs are used for immunization and other related services and cannot be considered as community mechanism. The well experienced and having good rapport with the community, the first Village Health Nurses can do more in propagating the CPHC. The State has achieved the agreed number of facilities to upgrade as HWCs but still there is a huge number of first port of call, HSCs, need to be upgraded in a time bound manner.

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Introduction:

Health can be defined as, "physical, mental, and social well-being, and not merely the absence of disease and infirmity"(WHO: 2006). Ill health/sickness can not be predicted. In many poor countries, the patients spend from their own pockets to get cured/seek health care. Many a times this leads to pushing their families below the poverty line.

Studies on out of pocket expenditure (OOPE) for health indicate that OOPE among the BRICS countries is the largest in India. Patients in India are the sixth largest self-spenders for health care in the world. This medical expenditure is a major cause of poverty. . Catastrophic health expenditure is spending that is so high that the family is forced to borrow money or reduce other essential expenditure, pushing the family below poverty line.

The Government of India, with a view to address the high levels of out of pocket expenditure for health care, set up a High Level Expert Group (HLEG) in 2010 to develop a plan for operationalizing the Universal Health Coverage that suits Indian conditions. The HLEG, keeping the principles of equity and universality in healthcare, developed a process through which the Universal Health Coverage can be achieved in India. The suggested model envisaged that a primary health care team for about 1000 households that provides comprehensive primary health care services and facilitating networked secondary care centers for referrals is the cost effective way for achieving Universal Health Care.

The National Health Policy 2017 kept in view the HLEG suggestions and announced the Ayushman Bharat scheme, a national health care program to ensure Universal Health Coverage that has two main components. The first one is the National Health Protection Scheme, an insurance coverage of Rs.5 lakh each for 50 crore beneficiaries for secondary and tertiary care hospitalizations. The second component is the establishment of health and wellness centres to strengthen the grassroots primary health care facilities.

The Government of Tamil Nadu, one of the first states to experiment with the Universal Health Coverage (UHC), piloted the plan in three Community Development Blocks in February 2017. This pilot project covered 67 health sub centres in the selected three blocks. A year later, an independent evaluation of the project has indicated that simple interventions like improving basic infrastructure, medicines and manpower at the sub-Health Centre (SHC) level improves patients' accessibility and reduce the expenditure on health care. It was decided by the Government that in the following years one or two blocks in each Health Unit Districts will be taken up for implementing the UHC on the National model of Health and Wellness Centres and all the 385 blocks will be covered in a phased manner. It is planned to cover 985 health sub-centres.

In Feb 2017 the Government of Tamil Nadu launched a pilot project to see if it could strengthen health sub - centres in the state to gauge what impact it would make on the delivery of primary health services. This project and its outcome are more significant at this time when the central government is planning the Ayushman Bharat a national health care program health insurance and health wellness centre to upgrade grassroots primary Health Care.

Health and wellness centres, which represents the base pillar of Ayushman Bharat, are envisaged to deliver an expanded range of services to address the basic primary health care needs of the entire population in their area, rather than focus selectively on population sub-groups, thus expanding access, universality and equity close to community. The emphasis on health prevention and promotion is designed to bring focus on keeping people healthy by engaging and empowering individuals and communities to choose healthy behaviours and make changes that reduce the risk of developing chronic diseases and other morbidities. In order to ensure delivery of Comprehensive Primary Health Care (CPHC) services, existing Sub Health Centres covering a population of 3000-5000 would be converted to Health and Wellness Centres (HWC), with the principle being "time to care" to be not more than 30 minutes. Primary Health Centres in rural and urban areas would also be converted to HWCs. The HWC at the sub health centre level would be equipped and staffed by an appropriately trained Primary Health Care team, comprising of Multi-Purpose Workers (male and female) & ASHAs and led by a Mid-Level Health Provider (MLHP). Together they will deliver an expanded range of services. In some states, sub health centres have earlier been upgraded to Additional PHCs. Such Additional PHCs will also be transformed to HWCs. A Primary Health Centre (PHC) that is linked to a cluster of HWCs

would serve as the first point of referral for many disease conditions for the HWCs in its jurisdiction. In addition, it would also be strengthened as a HWC to deliver the expanded range of primary care services.

A key addition to the primary health team at the SHC-HWC, would be the Mid-level Health Provider (MLHP) who would be a Community Health Officer (CHO) - a BSc. in Community Health or a Nurse (GNM or B.SC) or an Ayurveda practitioner, trained and certified through IGNOU/other State Public Health/Medical Universities for a set of competencies in delivering public health and primary healthcare services. It is important to ensure the following processes for selection of the MLHPs are followed so that candidates with the right attitude, competencies and motivation to work in rural and remote settlements are recruited. States should especially undertake local selection to maximize retention. The Tamil Nadu Government's model focused on recruiting a GNM or ANM as the MLHP. No studies are available to assess the progress of implementation of the HWCs in Tamil Nadu. This study aims to assess the progress of HWC in Tamil Nadu.

Objectives:

The main objective of this study is to assess the preparedness of the State of Tamil Nadu and the health facilities to implement the Ayushman Bharat Scheme through Health and Wellness Centres in the state.

Methodology

It is a descriptive cross sectional study. 5 HUDs in 3 districts namely Ramanathapuram, Dindigul and Namakkal were selected for the study. The public health facilities SHC/PHC/UPHC were selected, In each HUD selected two PHCs, two HSCs and one UPHC was selected. At each health facility Key Informant interview was done with the facility incharge using the interview schedule suggested by the program division of the Ministry. Observation and verification of records were carried out. PRC staffs have collected information from the selected facilities directive interview. Data collected from Medical Officers, Staff Nurses, VHNs. Two to three clients were interviewed at their exit. In each HUD 25 exit interviews were conducted and five FGDs, one in each HUD, were also conducted at a village away from the HSC village. The data collected are analyzed and presented in the following sections:

Facilities visited for the study:

S.No	District	HUDs	PHCs
1	Dindigul	Dindigul	Dindigul (UPHC)
			Kanapadi
			Anaipatti
		Palani	Oddanchadram (UPHC)
			Ayyalur
			K. Keeranur
2	Ramanathapuram	Rameshwaram	Rameshwaram (UPHC)
			Kamuthakudi
			Thankatchi Madam
		Paramakudi	Paramakudi (UPHC)
			Naripaiur
			Pampur
3	Namakkal	Namakkal	Solaikadu
			Thenurpatti
			Namakkal (UPHC)

A. State/District Preparedness

A.1 Planning of Health and Wellness Centres (HWCs) -Infrastructure

The Government of Tamil Nadu plans to implement the HWCs in a planned and phased manner. Under Universal Health Coverage (UHC), three development blocks were selected and the UHC was piloted in May 2017. On the lessons learnt, the UHC was expanded to 39 blocks, one each in each Health Unit District. On the guidelines of the Union Health Ministry, by June, 2018, 716 PHCs, 214 Urban PHCs and 985 Health Sub-Centres were converted into Health and Wellness Centres. By April 2019 all the Rural and Urban Primary Health Centres were made as Health and Wellness Centres. While transforming the existing facilities into HWCs, the State was conscious to keep the existing State policies in delivering Public Health services. The expanded health services with focus on Non-Communicable Diseases control was to be delivered without compromising the existing MCH services. There are 8713 Health Sub-Centres, 1422 Additional PHCs and 478 Urban PHCs in Tamil Nadu.

The plan of transforming the existing health facilities and the status is as given in the table:

	HSC	Addl PHC	Urban PHC	Total
Existing facilities	8713	1384	460	10557
2017-18	67	12		81
2018-19	918	702	214	1834
2019-20	796	668	246	1710
Total proposed	985	1421	460	2866

% to prposed	77%	77%	47%	56%
2020-21 Proposed	667	-	-	667
Total -2020-HWC	2448	1384	460	4292
% to all facilities	18%	100%	100%	47%
Target by Gol (2022-23)	7291	1421	420	9132

In 2020 all the Rural and Urban PHCs have been transformed into Health and Wellness Centres.

Health and Wellness centres in the visited districts

District	HUD	HSC	HWC	Addl.PHC	HWC	Urban PHC	HWC	Total		HWCs- Prop20- 21
								Instns	HWC	
Dindigul	Dindigul	167	79	27	27	4	4	198	134	26
	Palani	144		20	20	4	4	168	37%	
Ramnad	Ramnad	112	91	20	20	3	3	135	137	200
	Paramakkudi	132		21	21	2	2	155	47%	
Namakkal	Namakkal	240	16	37	37	8	8	285	61 21%	25

It may be observed from the above tables that while the Rural and Urban Primary Health Centres have been transformed into Health and Wellness Centres, the progress of transformation of Health Sub-Centres is lacking. The decision regarding transformation of the facilities is done at the State level and the districts are to do the gap analysis and demand funds for the renovation/ upgradation of the facilities, select suitable candidates to be trained and posted as Middle Level Service Provider.

A.2 Human Resources

The Government of Tamil Nadu decided to train and post one additional Village Health Nurse (ANM/GNM) as the Mid Level Service provider (MLHP) in HWC-HSC, under the UHC. Currently there are 700 ANMs and 58 GNMs posted as MLHP-758 in the Transformed HWC-HSCs. In addition to the VHN one Women Health Volunteer is engaged in collaboration with the Women and Child Development Department. At the HWC-PHCs three Staff Nurses have been posted to NCD screening. Laboratory Technicians are posted at the Block PHCs/CHCs for diagnostic services.

Capacity building of the human resource is done through: for ANM/GNM, certificate course in CPHC by the Dr.MGR Medical University, a two day training on IT platform and proposed mentoring by the Medical Officers at the hub-tele mentoring. The staff nurses at the PHC will undergo a one month certificate course on CPHC and the two day IT training to manage IT platforms. The lab technicians at the CHCs will be trained on UHC operationalization and IT training.

The Government of India suggested a qualified AYUSH person or Staff Nurse to be trained and posted as Middle Level Health Provider (MLHP), the Tamil Nadu Government has taken a policy to post either ANM or GNM to be trained and posted as MLSP at the SC-HWCs.

The district nodal officer for CPHC has been identified in all the three districts visited and the orientation on CPHC has been done. The block level and PHC level training are to be taken up. Monthly meetings of the district officials is conducted at state level. Fortnightly meetings are held for the block level team members. Monitoring is done by field visits and review meetings.

ASHAs, MPWs and Staff Nurses are trained in NCD and are available in all the three districts.

A.3 Expanded service delivery

In the service delivery, apart from the existing MCH services, the twelve services suggested under the CPHC are included and are part of the Certificate program curriculum. Standard Treatment Guidelines to Village Health Nurse/MLSP have been developed.

In all the HSCs population enumeration has been initiated. The Women Health Volunteers visit households and collect CBAC forms. In all the Sub-Centre area universal screening of NCDs has been initiated.

A.4 Medicines

The State has revised the Essential Drug List to include the medicines for the expanded services at the Health and Wellness centres. The drugs are Indented by the Primary Health Centres on Quarterly basis. Separate indenting is done by PHCs for the HSC-HWCs. Medicines for Hypertension and Diabetes is supplied to the HSCs. There are no stock out rates in any of the district visited. For meeting the drug demand under expanded services the following drug kits are provided to the HSC-HWCs: Kit A , Kit B drugs, UHC Kit, NCD drugs, Family Welfare Kit. The PHCs are provided with Insulin injection and antibiotic injections in addition to the Essential Drugs under EDL.

A.5 Diagnostics

At the HSC level six tests have been prescribed in addition to sputum collection, at the PHC level 20 tests are to be done in addition to 20 tests via LIMS portal, ECG is done and sample are collected to be tested at the Block level Public Health Laboratory. Essential list of diagnostics for facilities has been prepared. The consumables are indented through the District Drug Warehouse. Free diagnostic tests are done at the inhouse laboratories at PHCs/CHCs and Block Public Health Laboratories.

A.6 Infrastructure

The HSC-HWCs will have government owned building, safe water supply, uninterrupted power supply and clean toilets. These centres will be branded as per the State policy. Similarly, the PHC-HWCs will have renovated building with branding as per the state policy and dedicated space for laboratory. At the block level, Block Public Health Laboratory building will be provided. Gap analysis at the facilities of the selected blocks have been completed. Infrastructure upgradation has been planned.

A.7 IT system and Tele Health

A comprehensive UHC-IT platform has been developed to ensure continuum of care from community to referral units. A tablet has been provided to the HSC-HWC alongwith data cards. All the services provided are entered in the UHC portal. At PHC level apart from Tablet, a desk top has been provided, the NCD portal is available and the details of the patients and treatment provided are entered in this platform. Data cards and internet connection is made available at the PHC level.

A.8 IEC, Community outreach and Health Promotion

Community outreach is planned. The regular VHN carries out house to house visit regularly. The Mobile Medical Units cover the unreached geographical areas. IEC sessions are conducted regularly at the village level, Anganwadi Centres, on the VHN Days. Yoga sessions are planned and conducted for three days in a week on the AN Clinic days. VHN Days are used for health education/promotion.

A.9 Partnerships

The NCD screening, identifying the target group is done through Women Health Volunteers selected and trained through the Women and Child Welfare department. ICDS centres are partnered with for addressing malnutrition.

Part B Facility Readiness HWC-SHC/PHC/UPHC

B.I. Primary Health Centres – Health and Wellness Centre

B.I.1. Infrastructure

Seventy percent of the PHCs visited have upgraded government buildings and the remaining are to have the repair/construction work is to be completed. The functional facilities are branded as per the

design suggested by the State department. The required physical spaces and other facilities like 24hrs water facility, electricity, space for examination etc are available in all PHCs.

B.I.2. Human Resources Available

For the Primary Health Centres to function as HWC, three Staff Nurses are required to screen for Non Communicable Diseases (NCD). The medical officer of the PHCs are to guide the MLHPs at the SHC-HWCs. Among the visited PHCs, all the PHCs were having atleast one MBBS medical Officer. In many of the PHCs either one of the MO is deputed to other place or lying vacant. In these situations, the existing MO is not able to manage the HWC activities. Except in one PHC no where the AYUSH MO was present. Among the para-medical staff, staff nurses were not available in full strength. One or two posts were lying vacant or the existing staff were deputed to other facilities. Similarly, the posts of Lab technician and Pharmacists are almost vacant in all the visited PHCs. Thus, the services of diagnostics and drug dispensing are affected. Multipurpose Worker (Female) are available in PHCs Whereas MPW (Male) are not available everywhere. ASHAs are available in villages located in hill area and in some villages of the aspirational districts.

The medical officers have undergone CEMONC training and other Program related training like IMNCI, RNTCP, etc. The Staff Nurses and MPW (F) have been trained in Skill Lab, PPIUCD, SBA, Immunization and RNTCP. Team formation and training on CPHC has not been initiated.

B.I.3. IT Support

In fifty percent of the PHCs desktop/laptop is available for medical officers. RCH portal, HMIS, CPHC-NCD, HWC, are the portals available at PHC. The major important portals not available at this level are Nikshay, ANMOL and E-Hospital.

The population enumeration and CBAC forms are being collected in PHC areas where the Women Health Volunteers have been engaged. In other places the population enumeration and CBAC data collection are not happening. Tele consultations are not being done in any of the PHCs visited.

B.I.4. Drugs/Diagnostics

All the essential drugs suggested for the PHCs are available in all the PHCs visited. There was no stock out in any of the PHCs. The drugs prescribed for NCDs are available to take care of 3 month demand. In many of the PHCs all the suggested diagnostics are not available due to absence of laboratory technicians.

Untied funds are being used for local purchase of drugs/consumables as per the state specified rate contracting.

The functional coordination among the primary care team is very weak. The ASHAs refer cases to the SHC and the referred cases are being attended by the VHNs at SHC. The cases referred to the PHCs are attended by the medical officer. However, complication management and initiation of treatment plan and follow up care are not being discussed.

The PHC HWC are functioning as 24x7 for delivery and emergency cases.

In each facility on an average 1500 old cases and 1200 new cases are attended in a month. In each facility fixed day weekly special clinics for ANC, Immunization are conducted. Screening camps for NCD/out reach camps are conducted on pre-announced day and VHNDays are also conducted on these out reach camp days. There are no patient support groups formed in the villages of any of the facility area.

Monthly meetings and weekly review meetings are the mechanisms followed for monitoring the service delivery.

B.II. Urban Primary Health Centres – Health and Wellness Centre

B.II.1 Infrastructure

Out of the 5 UPHCs visited in 2 upgradation/repairs have been completed and in 2 facilities it was underway in one work has not been initiated. All the facilities were having 24 hrs. electricity, water connection, Room for OP consultation and patient waiting area to accommodate 8-10 patients, space for laboratory, medicine distribution, provision for cold chain maintenance was available in 3 facilities, separate toilets for male and female, drainage and waste disposal, approach road. Citizen charter and IEC on services were available in 4 facilities, examination room with adequate privacy and labour room were available in 3 facilities visited. Wellness room or place for yoga services were available in 2 facilities. Space for sterilization was available only in 3 facilities.

B.II.2. Human Resources

Five UPHCs were visited in all the facilities one MO was available. None of the centres had AYUSH MO. In all the centres one or two Staff Nurses were available and in all centres vacancies were there. Laboratory technicians were available in all centres and except in one centre, Pharmacists were available. In one centre outreach workers, Urban Health Nurses were not available and in other centres they were available as per the population norm, one per 10000 population. ASHAs were not available in any of the centres.

The medical officers were trained in BeMONC, CEMoNC, Family Planning etc. The staff nurses and outreach workers were trained in MCH, Skilled Birth Attendance, Immunization, Computer skills etc. The CPHC training has not been done for any category of staff.

B.II.3. IT Support

In four UPHCs desktop/laptop is available for medical officers. RCH portal, HMIS, CPHC-NCD, HWC, are the portals available at UPHC. The major important portals not available at this level are Nikshay, ANMOL and E-Hospital.

The population enumeration and CBAC forms are not being collected in any of the UPHC areas. Tele consultations are not being done in any of the UPHCs visited.

B.II.4. Drugs/Diagnostics

All the essential drugs suggested for the UPHCs are available in all the facilities visited. There was no stock out in any of the centres. The drugs prescribed for NCDs are available to take care of 3 month demand. In two of the centres all the suggested diagnostics for CPHC are available due to absence of laboratory technicians.

Untied funds are being used for local purchase of drugs/consumables as per the state specified rate contracting.

The functional coordination among the primary care team is very weak. The UHNs refer cases to the UPHC and the referred cases are being attended by the MO. However, complication management and initiation of treatment plan and follow up care are not being discussed.

The UPHCs function in two sessions, 9 am to 1 pm in the morning session and 2 pm to 4 pm in the evening session. For delivery and attending emergency it functions as 24x7 unit. In each facility on an average 1000 old cases and 1500 new cases are attended in a month. In each facility fixed day weekly special clinics are conducted. Screening camps for NCD/out reach camps are conducted on Fridays and VHNDays are also conducted on these out reach camp days. There are no patient support groups formed in any of the facility area.

Monthly meetings and weekly review meetings are the mechanisms followed for monitoring the service delivery.

B.III. Health Sub Centres – Health and Wellness Centre

B.III.1. Infrastructure

Out of the 9 Health Sub Centres (SHC_HWC) visited in 7 upgradation /repairs have been completed and in 1 facility it was underway and in one work has not been initiated. All the facilities were having 24 hrs. electricity, 24 hrs water connection was available in 8 facilities, Room for OP consultation was available in all centres and patient waiting area was there in 8 facilities, space for laboratory, medicine distribution was not there in any of the facilities. Toilets for patients, drainage and waste disposal, approach road were available in almost all facilities. Citizen charter and IEC on services were

available in all facilities. Examination room with adequate privacy and labour room were available in 8 facilities visited. Wellness room or place for yoga services were available in 7 facilities.

B.III.2. Human Resources

In eight facilities two Village Health Nurse (VHN) were available. The first VHN, already existing one, was doing outreach services and the newly added VHN as MLHP was stationed at the HSC and doing Out Patient services. In one HSC MPW (Male) was also available. In three HSC area ASHAs were available. In Tamil Nadu ASHAs were engaged in villages in hilly areas and villages in coastal area/aspirational district villages only.

The second VHNs are posted after six month training on Universal Health Coverage. All the available ASHAs have been trained upto Module 7. The First VHNs have attended all in-service trainings. However, none of the staff have been trained in team CPHC service delivery, in one HSC only it was reported that CPHC training was given. The VHNs at the HSCs are trained in NCD (Diabetes and Hypertension) screening. In some facilities Women Health Volunteers have been engaged in coordination with the Department of Women and Child Development to do community screening of NCDs.

B.III.3. IT Support

In seven SHCs laptop is available for MLHPs/MPWs. The first VHNs were provided with Laptops under an earlier scheme. ASHA are not provided with smart phones. The staff are not fully trained in computer operations/portal management. RCH portal, HMIS, CPHC-NCD, HWC, are the portals available in the tablets provided. The major important portals not available at this level are Nikshay, ANMOL and E-Hospital.

The population enumeration and CBAC forms are not being collected in any of the UPHC areas. Tele consultations are not being done in any of the UPHCs visited.

B.III.4. Drugs/Diagnostics

All the essential drugs suggested for the SHCs are available in all the facilities visited (about 22). There was no stock out in any of the centres. Stocks are available for 2 months. The drugs prescribed for NCDs are available to take care of 2 month demand.

The functional coordination among the primary care team is very weak. The VHNs refer cases to the PHC and the referred cases are being attended by the MO. However, complication management and initiation of treatment plan and follow up care are not being discussed.

The SHC-HWCs function between , 8 am and 5 pm. Wherever accommodation is provided, one of the VHNs is staying and practically, 24 hrs services are available. In each facility on an average 150 old

cases and 200 new cases are attended in a month. The first VHN visits households and on Wednesdays immunization sessions are held. Screening camps for NCD/out reach camps are conducted on Fridays and VHNDays are also conducted on these out reach camp days. There are no patient support groups formed in any of the facility area.

Weekly review meetings (on tuesdays) are the mechanisms followed for monitoring the service delivery.

B.1. Human Resources, Drugs/Diagnostics, IT support at HWCs in Tamil Nadu

Details	Facility		
	PHC (N=9)	UPHC (N=5)	HSC (N=9)
Human Resources Available			
MBBS Medical Officers			Not Applicable
1	3	5	
2	6	0	
3	0	0	
AYUSH MO	1	0	Not Applicable
Other Paramedic Staff			
Staff Nurse			
0	1	0	
1	1	0	
2	1	2	
3	5	2	
4	1	1	
Lab Technician			
0	7	1	
1	2	3	
2	0	1	
Pharmacist			
0	5	1	
1	4	4	
2	0	0	
MPW Females (VHN)	1		1
2			8
MPW Male			1
ASHAs			3

	Facility		
Details	PHC (N=9)	UPHC (N=5)	HSC (N=9)
Infrastrure			
Repairs and upgradation for HWCs completed			
Completed	6	2	7
Underway	3	2	1
Planned but not started yet	0	1	1
Has the facility been upgraded with the following inputs			
24 hours electricity	9	5	9
24 hours water supply	9	5	8
Room for OP Consultation	9	5	9
Examination Area with adequate Privacy	8	5	8
Patient Waiting Area (for at 8-10 patients)	9	4	7
Designated space for Lab and Dispensation of Medicines	9	5	2
Space for Sterilization	4	3	0
Adequate provision for Cold chain maintenance	9	3	0
If the facility is a Delivery Point-Labour room/NBCC available as per IPHS	8	4	0
Facilities for safe Drinking Water	8	5	3
Suitable Approach Road	9	5	8
Separate Male/Female Toilets for staff/Patients/both	9	4	6
Appropriate Drainage and Arrangement for Waste Disposal	9	4	6
Wellness room or provision of Yoga services	6	2	6
Furnitures/Fixtures and Equipment as per MoHFW CPHC Guidelines (Refer Annexure 1)	6	3	5
Citizen's Charter and Display of IEC to enable Community Awareness on services available at HWCs	8	4	8

	Facility		
Details	PHC (N=9)	UPHC (N=5)	HSC (N=9)
IT Support and Teleconsultation Services			
IT Support for HWC			
Desktops/Laptops for Medical Officer-Available-Yes/No	6	4	0
Tablets for MLHP, MPWs	9	1	9
Smart Phones for ASHA	3	0	3
Training in use of IT systems complete for Staff -PHC and SHC			
Type of IT Applications in use			
· RCH Portal	9	5	9
· HMIS	9	5	9
· CPHC-NCD application	9	4	6
· HWC Portal	9	4	9
· Nikshay	3	0	0
· ANMOL by MPWs	0	0	0
· E-Hospital	0	0	0
· Any other application to support the delivery of National Health Programmes	0	0	0
Have ASHAs started filling population enumeration and CBAC data in CPHC application in smartphones? (applicable if ASHAs having smartphones)	0	0	1
If not, is the CBAC data filled manually by ASHAs digitized and entered in tablets with MPWs/MLHP?	0	0	1
Connectivity of PHC with Tele-consultation Hub established (Yes/No)	0	0	0
· Pre-Fixed Schedule of Teleconsultation services displayed for the service users	0	0	0
· Average number of Teleconsultations undertaken in day/week	0	0	0

Mention most common cases for which Teleconsultation services have been availed	0	0	0
Comment on usefulness/ challenges reported by PHC Medical Officer	0	0	0
Teleconsultation with PHC-MO established by MLHP and in use	0	0	0

	Facility		
Details	PHC (N=9)	UPHC (N=5)	HSC (N=9)
Medicines and Diagnostics			
Whether Medicines Available in the Facility as per State/National List of Essential Medicines Yes	9	5	9
Whether Medicines Available for management of NCDs	9	5	9
Medicines that are not in adequate stock for minimum three months usage	9	5	3
Reasons for Stock Out-			
short supply from PHC			3
Number of Diagnostics Tests/Lab Investigations being conducted as per MoHFW CPHC Guidelines YES	7	1	0
Reasons for Non- Availability of Lab Investigations			
- Lack of Equipment			
- Lack of Training			9
- Lack of Lab Technician*	2	4	
- Any other (specify)			

C Clients perceptions about Health and Wellness Centres in Tamil Nadu

Exit interviews were conducted with 2-3 out patients at the facilities visited. A total of Patients were interviewed. The patients have visited the facility for the following illness BP (15.9 %), diabetic (12.8%), head ache(11.7%), knee pain(14.9%), diarrhoea(5.3%) and ANC complications(10.6%). The patient informed that they were examined at the health centre and their height and weight were measured. Most of the patients were treated at the centre itself and there was no need for referral to a higher facility. No patient was charged for diagnosis, drugs or any other thing. The average distance travelled by the patient was within 2 kms for reaching Health Sub-centre/UPHC and within 4 kms for reaching a PHC. Comparing earlier visits, the patients noted that there is improvement in number of tests done has increased and the new building has good facilities. Strength of staff improved slightly when compared with earlier time. Some of the services improved when compared with early times. It has been informed IEC, citizen charter, information provided by frontline workers to patients are satisfactory. The general behaviour of the staff is also noted as improved and satisfactory. The patients felt that the treatment provided by the UPHC, PHC and HWC is good and they are satisfied with it.

FGD WITH COMMUNITY:

Focus Group Discussions were conducted in the villages that are away from the HSC village and are the service village of the health and wellness centre. There were 5 FGDs conducted in as many villages.

Common illness reported are irregular menstrual cycles of women in the age group of 30-49, hypertension, fever, diarrhoea, knee pain, body pain and blood pressure. The herbal decoction (*Nilavembu kashayam*) has been given to the patients with fever. For common minor illness medicines, tablets, tonic and ointment are disbursed. The average distance is 4 kms between UPHC, HWC, PHC and the remote hamlets area. Immunization of children and ANC check up is done at the nearest UPHC, HWC and PHC and at a pre-informed area, AWC on Wednesday. Medical facilities for the following diseases such as cough, cold, fever, skin allergies, diarrhoea are available in the nearest HWC, PHC and UPHC. Multipurpose worker / VHN visited and taken particulars of household members. But information on chronic diseases and related information were not collected. The common man in the villages are aware about NonCommunicable Diseases. But they don't have any clue about how many people are affected, but know that the number is increasing now-a-days. They are also aware

that a health facility nearby is functioning as a Health and Wellness Centre with improved facilities and services and they can avail health services within half an hour when need arises. The front line workers and through IEC / Citizen Charter they are aware of the services to be available at SHC-HWC. The people aware that they can avail free treatment for common illness at SHC-HWC for which they earlier had to travel long distances.

Community demand for health services is listed below:

1. Extension of OP timings.
2. Physician should be available at PHC level on 24 hours basis as illness occurs at anytime.
3. User charges should not be levied ever.
4. Diagnostic services should be expanded with increased manpower and modern equipments..
5. Village Health and Sanitation Committee should properly be constituted and function effectively.

Exit interviews were conducted with 2-3 out patients at the facilities visited. The patients have visited the facility for the following illness BP (15.9 %), diabetic (12.8 %), head ache (11.7%), knee pain (14.9 %), diarrhoea (5.3%) ,general illness (28.7%) and ANC complications (10.6%). The patient informed that they were examined at the health centre and their height and weight were measured. Most of the patients were treated at the centre itself and there was no need for referral to a higher facility. No patient was charged for diagnosis, drugs or any other thing. The average distance travelled by the patient was within 2 kms for reaching Health Sub-centre/UPHC and within 4 kms for reaching a PHC. Comparing earlier visits, the patients noted that there is improvement in number of tests done has increased and the new building has good facilities. Strength of staff improved slightly when compared with earlier time. Some of the services improved when compared with early times. It has been informed IEC, citizen charter, information provided by frontline workers to patients are satisfactory. The general behaviour of the staff is also noted as improved and satisfactory. The patients felt that the treatment provided by the UPHC, PHC and HWC is good and they are satisfied with it.

Summary and Conclusions:

This study was undertaken to assess the progress of implementation of one of the Ayushman Bharat components, Health and Wellness Centres in Tamil Nadu. The study was taken up in

5 health unit districts of Tamil Nadu. The study indicates that improving Primary Health Centre infrastructure to suit the requirements of Health and Wellness Centre was taken up by the State and declared all the rural as well as urban PHCs as HWCs. Upgradation of PHCs by repairing/adding required space etc has been done and the State designed branding has also been done in about 70% of the facilities. Medical officers and staff nurses are available in the PHCs still there is a gap between sanctioned post and persons in position. There exists huge vacancies in the posts of Laboratory Technicians and Pharmacists. Training on CPHC to the facility level staff is lacking and team work for CPHC does not exist. However, screening for NCDs is carried out in all facilities. Drugs, particularly for NCDs is available without any shortage. IT support has not been fully created. Telemedicine/consultation is to start yet.

The infrastructure and human resource at the Health Sub-Centre level is very poor. Though all the HSCs in selected blocks have been redesignated as HWCs, the staff position is weak. The State has developed a model in which the ANM/GNM qualified person is trained and posted as the Mid-Level Service provider against the national model of having BSC (Nursing) /AYUSH qualified person as MLHP. Many centres do not have a building completed or repair/renovation completed. Drugs in many facilities are enough for two months requirement. The household surveys (denominator) have not been completed and the data is not available in electronic record form. Since tele medicine has not been started mentoring of MLHP/2nd VHN is not carried out by the MO officer of the PHC. For diagnostics, samples are collected and transported through the bike given for this purpose and sent to the CHC for testing. The clients are satisfied with the improved services provided and feel that they get health services at a nearby place and vast improvement has taken place in the services provided.

Though the small improvements at the facilities have had its impact on the health seeking behaviour of the clients, the CPHC activities need to be implemented in letter and spirit. Introduction of telemedicine, creating electronic data base / health record of households and wellness activities in the facilities, community involvement in the form of support groups will help in achieving the Universal Health Coverage.

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ANNEXURE:



Urban PHC, Dindigul



PHC, Sirunayakanpatti



Focus Group Discussion



Ramnad District



Focus Group Discussion, Ramnad