

RAPID ASSESSMENT OF AYUSHMAN AROGYA MANDIR IN THE STATES OF MEGHALAYA AND KARNATAKA

Dissertation Submitted to



The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

Pragya Verma

Under the Supervision and Guidance of

Dr Goutam Sadhu

2024



Maj Gen (Prof) Atul Kotwal, SM, VSM

MBBS, MD (PSM), PDF (Epidemiology),

FRCP Edin, FAMS, FIPHA, FIAPSM

Executive Director



National Health Systems Resource Centre

राष्ट्रीय स्वास्थ्य प्रणाली संसाधन केंद्र

Ministry of Health and Family Welfare

Government of India

Internship Completion Certificate

This is to certify that **Pragya Verma** in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her internship at **National Health Systems Resource Centre (NHSRC)** during March 15 - June 14, 2024.

She has been an eager learner and her conduct during the internship has been satisfactory.

Place: Delhi

Date: 18/6/2024

Preceptor/Head of the Organization

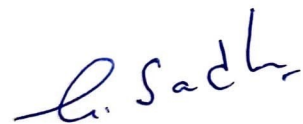
Name of the organization: NHSRC

Maj Gen (Prof.) Atul Kotwal, SM, VSM
Executive Director

National Health Systems Resource Centre
NIHFW Campus, Munirka, New Delhi-110067

CERTIFICATE

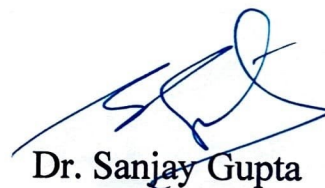
This is to certify that dissertation titled “**Rapid Assessment of Ayushman Arogya Mandir in the states of Meghalaya and Karnataka**” is a record of the research work undertaken by **Ms. Pragya Verma** in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

A handwritten signature in blue ink, appearing to read 'G. Sadhu'.

Dr. Goutam Sadhu

Faculty Guide
IIHMR University, Jaipur

Date: 1/07/2024

A handwritten signature in blue ink, appearing to read 'S. Gupta'.

Dr. Sanjay Gupta

School Dean
IIHMR University, Jaipur

Date: 1/07/2024

DECLARATION BY STUDENT

I hereby declare that this dissertation titled *Rapid Assessment of Ayushman Arogya Mandir in the States of Meghalaya and Karnataka* is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



Name of Student: PRAGYA VERMA

Date 1/7/24.

Abstract

Introduction: India's healthcare system is undergoing significant transformation to enhance primary healthcare services, ensuring equitable access to quality care for all. In 2018, the Government of India announced the creation of 1,50,000 HWCs, now named Ayushman Arogya Mandir (AAM), as part of its flagship program- Ayushman Bharat. AAM aim to provide a broad spectrum of CPHC services, including preventive, promotive, curative, rehabilitative, and palliative care, expanding services to cover non-communicable diseases, mental health, and many more services in addition to providing maternal and childcare services. However, post-implementation there is a need to assess the performance of these AAM/HWC to identify gaps, challenges, and opportunities for improvement including infrastructure, service delivery, availability of drugs and diagnostics and to understand stakeholder's perspective towards AAM.

Methodology: A rapid assessment of AAM was done in a cross-sectional study to assess AAM in Karnataka and Meghalaya over a period of two months. These 2 states are fundamentally different from each other one representing southern India while one is from north-eastern states of India, both having their own distinct geography. Twelve health facilities (including Sub Health Centre (SHC), Primary Health Centre (PHC) and Urban Primary Health Centre (UPHC)) were purposively chosen from both the states. Quantitative and qualitative data was collected using a facility-based assessment tool and interviews with stakeholders to understand their perspectives about AAM respectively.

Results: The transformation of primary health facilities into AAM/HWCs has led to significant improvements in infrastructure. Among the visited facilities, all SHCs have Community Health Officers (CHOs), and 8 out of 11 PHCs/UPHCs have Medical Officers (MOs). Training for the Expanded Package of Services (EPS) was partially completed for MOs, CHOs, ANMs, and ASHAs. There was a notable increase in outpatient services following the launch of AAM/HWC. They primarily focused on RMNCAH+N (Reproductive, Maternal, Neonatal, Child, Adolescent Health plus Nutrition), non-communicable diseases (especially hypertension and diabetes), and communicable diseases. However, services for oral health, ENT, emergency and trauma care, geriatric and palliative care, and

mental health are only partially available. The wellness sessions are regularly conducted in both states. Drug and diagnostic availability is below the national Essential Drugs List (EDL). National portals and apps are used in both states, with additional state-specific initiatives. However, network issues and the unavailability of specialists hinders effective teleconsultations and data management. Staff is burdened with maintaining multiple registers and extensive data management processes. Community participation platforms are more functional in Meghalaya compared to Karnataka.

Conclusion: The transformation of SHCs, PHCs, and UPHCs into AAM marks a significant step towards achieving universal health coverage in India. While most AAM adhere to guidelines, challenges remain, particularly in service delivery beyond maternal and child health, family planning, and NCD services. Teleconsultation services need enhancement to address network issues, specialist shortages, and equipment quality for continuous care. IT integration is overall good in Karnataka and staff is well adapted with the digital platforms while Meghalaya still relies more on manual system. Wellness sessions are conducted regularly in both states. However, the number of wellness sessions and community reach is better in Meghalaya than Karnataka where physically patients are more accessible than virtually through digital platforms pertaining to lack of IT integration in Meghalaya. Routine assessments of primary health facilities are essential for providing field-based evidence to guide policy decisions and enhance the quality of care in AAM.

ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to all those who have supported and guided me throughout the completion of this thesis. This work would not have been possible without the invaluable assistance, encouragement, and contributions of numerous individuals and organizations.

First and foremost, I am deeply grateful to the National Health Systems Resource Centre (NHSRC) for providing me with the opportunity to undertake this internship. The experience and knowledge gained during my internship at NHSRC have been instrumental in shaping the direction and substance of this research. I am particularly thankful to Maj. General (Dr, Prof.) Atul Kotwal, my mentor at NHSRC, for his unwavering support, insightful guidance, and constructive feedback throughout this period. I would also like to mention Dr. Surabhi Sethi for her constant guidance and words of motivation given to me throughout the completion of this project. I am immensely grateful to work under their mentorship. I would also like to thank Dr. Neha Dumka for always encouraging me and motivating me to push my limits and take learnings from my mistakes and move forward.

I'm also thankful to the entire team of ED-Secretariat for their assistance and for creating a conducive environment for research and learning. The collaborative spirit and dedication of the team have inspired me to strive for excellence in my work.

I am deeply appreciative of the healthcare professionals and administrative staff at the Ayushman Arogya Mandir and Health and Wellness Centres in Karnataka and Meghalaya. Their cooperation and willingness to share their experiences and insights have been invaluable to this study.

I am thankful to Dr. Goutam Sadhu, Professor and my guide for his insights, perspective and for hands-on support to complete my study. His expertise and guidance have been crucial in the development and completion of this thesis. I'm grateful to Dr. Piyusha Majumdar for providing her constant support and words of encouragement throughout my journey.

A special note of gratitude to our President, Dr. P.R. Sodani and IIHMR University for providing me the opportunity to complete my dissertation in NHSRC.

I am also grateful to my friends Dr. Sucharita Mahajan and Dr. Shivani Shelke for their love, support, and for making my college journey a memorable experience. Our discussions and collaborative efforts have greatly enriched my understanding of the field.

Last but not least, I would like to mention my source of forever motivation, my family and I thank them for their unwavering support, patience, and encouragement throughout this journey, without them I would not have been able to achieve so much in my life. Your belief in me has been a constant source of motivation.

This thesis is a result of the collective efforts of all these wonderful individuals and organizations. I am deeply thankful to each one of you for your contribution to this work.

Pragya Verma

MBA-HM 27TH BATCH

IIHMR UNIVERSITY

Table of Contents

DECLARATION BY STUDENT	i
CERTIFICATE	ii
Certificate from Faculty Guide and School Dean	iii
Abstract	iv
ACKNOWLEDGEMENTS	vi
LIST OF FIGURES.....	ix
LIST OF TABLES.....	ix
ABBREVIATIONS	x
CHAPTER 1: INTRODUCTION	1
CHAPTER 2: REVIEW OF LITERATURE.....	5
CHAPTER 3: METHODOLOGY	15
CHAPTER 4: RESULTS.....	18
A. INFRASTRUCTURE	23
B. HUMAN RESOURCE AND TRAINING	27
C. SERVICE DELIVERY.....	31
E. DRUGS & DIAGNOSTICS	37
F. IT / DIGITAL INTEGRATION	41
G. COMMUNITY ENGAGEMENT/ PARTICIPATION	44
STRENGTHS & GOOD PRACTICES.....	46
CHALLENGES.....	48
CHAPTER 5: DISCUSSION	50
CHAPTER 6: CONCLUSION AND RECOMMENDATIONS	53
REFERENCES.....	56
ANNEXURES.....	58
ANNEXURE 1: AAM Field visit tool	58
ANNEXURE 2A: DRUGS AT AAM-SHC.....	74
ANNEXURE 2B: DRUGS AT AAM PHC/UPHC	81
ANNEXURE 3A: DIAGNOSTIC TESTS AT AAM-SHC.....	94
ANNEXURE 3B: DIAGNOSTIC TESTS AT AAM-PHC/UPHC	95

LIST OF FIGURES

Figure 1 Organization of service delivery	2
Figure 2 Key components of the Programme.....	4
Figure 3 Overview of facilities visited.....	18
Figure 4 Population distribution % of Karnataka.....	20
Figure 5 Population distribution % of North-eastern states	20
Figure 6 OPD footfall at AAM/HWC.	32
Figure 7 Teleconsultations at AAM/HWC	35
Figure 8 Wellness sessions at AAM/HWC.....	36
Figure 9 Drug availability at AAM/HWC.....	38
Figure 10 Diagnostics availability at AAM/HWC	39
Figure 11 Lab tests conducted in a month at AAM/HWC.	40
Figure 12 Number of registers maintained at the AAM/HWC	42
Figure 13 Percentage (%) of JAS functional.....	45

LIST OF TABLES

Table 1 : Profile of states visited for rapid assessment of AAM	18
Table 2: Key indicators.....	21
Table 3 Status of Infrastructure present in Karnataka and Meghalaya during field assessment.	23
Table 4: Human resource present at AAM during field visit	27
Table 5: Training given on Expanded Package of Services	29
Table 6 Teleconsultations at AAM/HWC in a month.....	35
Table 7 Availability of Drugs and Diagnostics at AAM.....	37

ABBREVIATIONS

AAM Ayushman Arogya Mandir

ANM Auxiliary Nurse Midwife

AWCs Anganwadi Centres

AYUSH Ayurveda, Yoga and Naturopathy, Unani, Siddha And Homeopathy

BCC Behaviour Change Communication

BCM Block Community Manager

BMO Block Medical Officer

BPM Block Programme Manager

CHC Community Health Centre

CHO Community Health Officer

CPHC Comprehensive Primary Health Care

DH District Hospital

EML Essential Medicines List

FRU First Referral Unit

HWC Health and Wellness Centre

SHC Sub Health Centres

IEC Information Education Communication

IT Information Technology

MAS Mahila Arogya Samiti

MLHP Mid-Level Health Provider

MO Medical Officer

MOIC Medical Officer In charge

MPW Multi Purpose Worker

OOPE Out of Pocket Expenditure

OPD Outpatient Department

PHC Primary Health Centre

RCH Reproductive and Child Health

SHGs Self Help Groups

UHC Universal Health Coverage

UPHC Urban Primary Health Centre

VHSNC Village Health Sanitation and Nutrition Committee

CHAPTER 1: INTRODUCTION

India's healthcare system is undergoing a transformative shift towards strengthening primary healthcare services to ensure equitable access to quality care for all citizens. The National Health Policy of 2017 highlighted the requirement of “Health and Wellness Centres” in order to strengthen primary health care, dedicating two thirds of the health budget to primary health care. In February 2018, the Government of India announced the establishment of 1.5 lakhs Health & Wellness Centres (HWCs) by transforming existing Sub Health Centres and Primary Health Centres to deliver Comprehensive Primary Health Care.

HWCs, now renamed as *Ayushman Arogya Mandir (AAM)* represent one of the pillars of Ayushman Bharat, aiming to provide an expanded range of CPHC services including preventive, promotive, curative, rehabilitative and palliative care. These centres enhance and broaden existing Reproductive & Child Health (RCH) and Communicable Disease services, incorporating care for Non-Communicable Diseases such as hypertension, diabetes, and cancers (oral, breast, and cervical). They also provide services for mental health, ENT, eye care, dental health, geriatric and palliative care, trauma care, and health promotion activities like yoga.

According to IPHS 2022 guidelines(1),AAM is classified into:

1. Primary Health Centre (PHC):
 - a. AAM-PHC in rural areas
 - b. AAM- UPHC in urban areas
2. Sub Health Centre (SHC):
 - a. AAM-SHC in rural areas
 - b. Urban AAM (UAAM) in urban areas

AAM are designed to facilitate early identification, ensure treatment adherence, provide follow-up care, and maintain continuity of care through appropriate referrals. They also focus on optimal home and community follow-up, disease

surveillance, and health promotion and wellness sessions for an expanded range of CPHC services. The twelve CPHC service packages are(2) :

1. Pregnancy and Childbirth care
2. Neonatal and Infant Health Services
3. Child and Adolescent Health Services
4. Family Planning, Contraception and Reproductive Health Services
5. Communicable Disease management: National Health Programme
6. Treatment of Common Infectious Diseases and Minor Illnesses
7. Screening, Prevention, Control and Management of Non-communicable Diseases
8. Ophthalmic and ENT care for common problems
9. Basic Oral Health Care
10. Geriatric and Palliative Health Care Services
11. Emergency care including Burns and Trauma
12. Screening and Basic Management of Mental Health Ailments

In addition to clinical services, AAM serve as a platform for teleconsultation and expanding diagnostics.

Appropriate Care must be given at all the levels from the level of family/household/community upto higher facility level.

Organisation of service delivery (2):

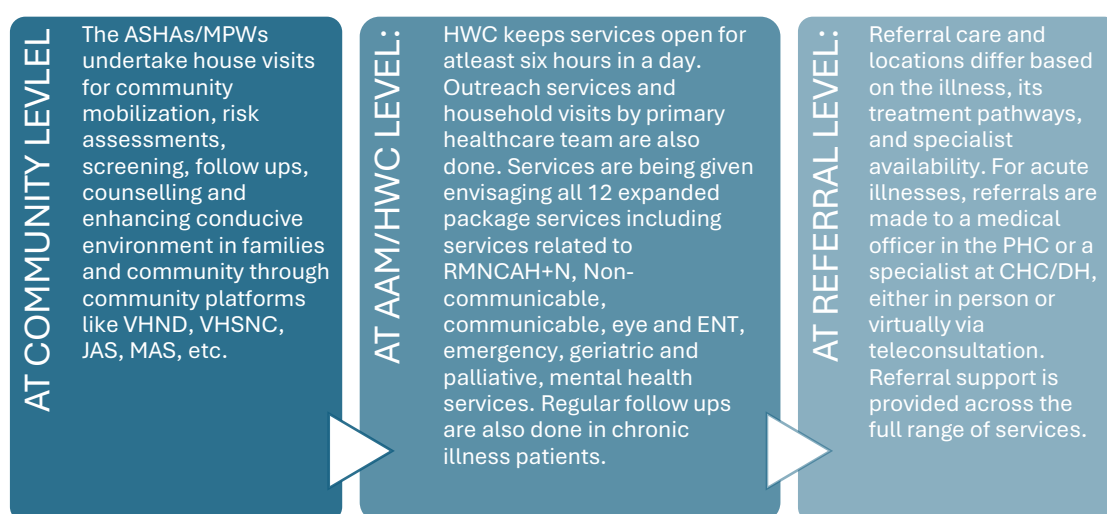


Figure 1 Organization of service delivery

Key Components of Ayushman Arogya Mandir (AAM)

Delivering comprehensive primary health care through AAM involves substantial changes at all levels of the health system, including (2):

- **Expanded Service delivery:** AAM broadens services beyond maternal and child health including non-communicable diseases, palliative and rehabilitative care, oral, eye, and ENT care, mental health services, and initial emergency and trauma care.
- **Continuum of Care- Tele-health and referral:** AAMs act as gatekeepers, connecting secondary and tertiary care with follow-up care, and using teleconsultation for referral advice, online training, and case management support.
- **Expanding HR – CHO and multiskilling:** Community Health Officer (CHO), trained in public health and primary health care are newly posted at AAM-SHC to enhance clinical management, continuity of care, drugs dispensing and follow up care. All service providers at AAM receive training to deliver the expanded range of services.
- **Medicines and Expanding diagnostics:** – AAMs ensure the availability of essential medicines and diagnostics within the community, offering 106 free medicines at AAM-SHCs and 172 at AAM-PHCs, and 14 diagnostic tests at AAM-SHCs and 63 at AAM-PHCs.
- **Community Mobilization and Health Promotion** – community engagement through – VHSNCs, MAS and SHGs promotes health action and ensures universal health coverage in an equitable manner.
- **Robust IT System-** AAM teams are well equipped to create electronic health record, track patients for treatment adherence and follow up using various IT tools.
- **Infrastructure** – AAM are upgraded to provide space for expanded service delivery, medicine dispensation, diagnostics, wellness activities and display of communication materials.

- **Partnerships for knowledge and implementation-** Collaborations with development partners and technical support agencies enhance AAM integration and provide implementation support, research, and advocacy.
- **Financing- provider payment reforms-** Performance linked payments encourage health care demand and ensure timely, quality care close to the community.



Figure 2 Key components of the Programme.

Currently, total of 1,73,283 AAM (1,27,428 SHCs, 23,885 PHCs, 5,094 UPHCs) are operational in India as on 22 June 2024 (according to AB-HWC portal).

However, there is a need to assess the performance of these AAM/HWC to identify gaps, challenges, and opportunities for improvement.

CHAPTER 2: REVIEW OF LITERATURE

S.no.	Title	Author	Year	Findings
1.	India's health and wellness centres: realizing universal health coverage through comprehensive primary health care.	Rajani R Ved, Garima Gupta, et al.	2019	India's health care system is shifting focus towards NCDs, necessitating a re-evaluation of primary health care quality and capacity. The Ayushman Bharat initiative aims to transform public health centres into health and wellness centres, offering free comprehensive primary health care, requiring paradigm shifts in human resources and service delivery.(3)
2.	Health and wellness centers: a paradigm shift in health care system of India?	Hariom K. Solanki, Rama Shankar Rath, et al.	2020	The research paper discusses the changing disease epidemiology in India, focusing on NCDs, mental health issues, accidents, and injuries as emerging health threats. It highlights the weakness of the existing three-tiered public health system in India, leading to non-uniform coverage, overburdened health facilities, and high OOPe for individuals, potentially pushing many into poverty. The proposed HWCs in India are designed to provide comprehensive primary

				healthcare services under 12 domains, including promotive, preventive, and curative aspects, with a focus on health promotion and disease prevention activities like yoga.(4)
3.	Health &Wellness Centers to Strengthen Primary Health Care in India: Concept, Progress and Ways Forward	Chandrakant Lahariya	2020	The AB-HWC initiative focus on team-based service delivery with mid-level healthcare providers like CHOs included in the centers. The paper analyzes the key design aspects of HWCs in relation to primary health care services and operations. The paper also highlights the need for dedicated focus on population-based and public health services within the AB-HWCs to ensure comprehensive primary healthcare delivery.(5)
4.	Health and Wellness Centres as a strategic choice to manage noncommunicable diseases and universal health coverage	Aravind Gandhi P, Ria Nangia, et al.	2022	Study highlights the significance of primary healthcare in managing NCDs and the role of HWCs in expanding NCD services at the community and facility levels. Challenges in NCD management at the primary care level are identified, including lack of awareness, erratic supply of NCD drugs

				and diagnostics, capacity building for health manpower in NCD management, information flow for continuity of care, and less community participation in NCD screening and management. The study emphasizes the importance of addressing these challenges to progress towards UHC, meet NCD-related targets, and effectively implement the envisioned package in HWCs.(6)
5.	Health And Wellness Centres: Expanding Access to Comprehensive Primary Health Care in India	Nirupam Bajpai, Manisha Wadhwa	2019	The research paper refers to Operational Guidelines for Comprehensive Primary Health Care through HWCs, emphasizing the importance of providing a package of essential services within a short timeframe to reduce morbidity and mortality burdens. It draws on the Rural Health Statistics Report 2017 to highlight the gaps in rural health facilities, indicating the need for creating new centres to function as HWCs instead of just upgrading existing ones. The paper also mentions the role of ICT in healthcare delivery, showcasing how

				digitization can enhance the efficiency of service delivery and improve health outcomes.(7)
6.	An Assessment of Implementation of CPHC through Ayushman Bharat Health and Wellness Centres in Karnataka and Goa	Jyoti S. Hallad, H. R. Channakki, et al.	2020	The assessment in Karnataka and Goa underscores the importance of addressing challenges related to human resources, infrastructure, service delivery, and community engagement to strengthen the primary healthcare system through the Ayushman Bharat scheme. Community feedback in both states has been positive, with ASHAs, MPWs, and patients acknowledging the benefits of having MLHPs, essential medicines, and healthcare services available locally, reducing the need for travel to higher-level healthcare facilities. (8)
7.	Assessment of Functioning of Health and Wellness Centers of Western Odisha: A Cross-Sectional Study of this article	Smita K. Panda, Devasish Panda, et al.	2023	Studies indicate sub optimal utilization of public health systems for common illnesses in rural and urban areas, emphasizing the importance of accessible primary care facilities like HWCs. The study highlighted staffing issues at HWCs, with shortages of MOs and staff

				nurses, impacting services like emergency care, mental health, and oral health, while services like family planning and NCD management were more consistently available. The HWCs establishment under the Ayushman Bharat program is a significant national initiative, with a goal to operationalize many HWCs to enhance primary healthcare services across India.(9)
8.	Assessment of functioning of Health and Wellness Centers in a district of Western Gujarat.	Hetal Rathod, Pradeep Pithadia, et al.	2020	The research paper focuses on assessing the functioning of HWCs in Jamnagar district, Gujarat. The study showed Satisfactory performance of most HWCs, with the presence of CHOs and MPWs in the majority of centers. Prevalence rates of NCDs like hypertension, diabetes mellitus, cancer (oral, breast, cervical) were reported. Identified areas for improvement included the need for staff training in areas like Technology and refresher training. It also highlighted that while most HWCs were functioning well, some services like laughing club, music therapy, and meditation

				(wellness sessions) were lacking.(10)
9.	Enablers and barriers to work performance: A mixed methods assessment of Ayushman Bharat-Health and Wellness Centres in Punjab state of India	Shankar Prinja, Neha Purohit, et al.	2023	This study shows performance variations among HWCs and the reasons behind these by understanding the perspective of CHOs and ANMs. The research utilizes a mixed methods approach, combining quantitative facility assessments with qualitative in-depth interviews to understand perceptions about service delivery. Findings suggest that infrastructure differences exist between high and low-performing HWCs, with capacity influenced by factors like training, work experience, self-belief, and role clarity. The study emphasizes the importance of improved communication, supportive supervision, incentives, role clarity, and management capacities to enhance work efficiency in HWCs.(11)
10.	Assessment of health and wellness centres in hilly district of Himachal Pradesh	Abhilash Sood, Devender Kumar, et al.	2021	A cross-sectional study was done to evaluate the HWCs in Hamirpur district, Himachal Pradesh. The study utilized a validated checklist provided by the NHM, Himachal

				Pradesh to assess various domains of the HWCs. The study identified deficiencies in human resources, inadequate skill competencies among newly appointed healthcare workers, and limited tele-consultations despite the availability of telemedicine equipment at the health centres. The results indicated gaps in service delivery and information technology at PHCs. The assessment of sub-centres revealed high gaps in training for health workers and skill competencies.(12)
11.	Health system readiness for roll out of the Ayushman Bharat Health and Wellness Centres – Early experiences from Punjab State	Sehr Brar, Neha Purohit, et al.	2022	The study assessed the health system readiness for establishing HWCs through facility assessment and knowledge evaluation of community health officers (CHOs) and auxiliary nurse midwives (ANMs) in Punjab state. The study underscores the necessity for state and local interventions to strengthen physical infrastructure, ensure a consistent supply of medicines, establish patient referral mechanisms, and enhance community

				engagement for successful HWC operationalization.(13)
12.	Rapid assessment of NCD services rollout in Health and Wellness Centres in North-Eastern Indian state: A cross-sectional study	Erin Hannah, Neha Dumka, et al.	2023	The research paper focuses on the rollout of NCD services in HWCs in Manipur, India. It acknowledges the unique challenges faced by North-Eastern states in providing routine healthcare services, highlighting the need for tailored approaches to healthcare delivery. Findings revealed increased demand and community awareness for expanded primary healthcare services. Challenges included infrastructural gaps, logistical delays, training deficiencies, funding issues, weak community-level coordination, and disruptions due to the COVID-19 pandemic.(14)
13.	How useful do communities find the health and wellness centres? A qualitative assessment of India's new policy for primary health care	Shriyuta Abhishek, Samir Garg, et al.	2024	The study aims to understand the usefulness of HWC services from the perspective of community through FGDs conducted in various districts of Chhattisgarh, India. Beneficiaries appreciated the proximity of HWCs to their communities, making healthcare services easily accessible. They also

				highlighted the convenience of having essential medicines, blood pressure measurement apparatus, and point-of-care tests available at HWCs for conditions like hypertension, diabetes, minor injuries, and ante-natal care. (15)
14.	Factors Influencing Utilization of Health and Wellness Centers (HWCs) in Odisha: A Mixed Method Study from Beneficiaries' Perspective	Amitosh Dandsena, Paramjot Panda, et al.	2024	The study aimed to evaluate the perception of people in managing hypertension, identify challenges, demographic and clinical factors, barriers associated with healthcare utilization, and assess the knowledge, attitude, awareness, and perception levels among the population towards HWCs and services for hypertension management. Factors including education, proximity to health facility, income status, illness, etc. affect utilization of HWCs Study revealed positive influences on utilization, due to factors of distance proximity to HWCs, free drugs and diagnostics, and barriers to utilization included transportation difficulties, unawareness, and poor perceptions of HWCs.(16)

Research Gap:

In India's healthcare landscape, Ayushman Arogya Mandir (AAM) under Ayushman Bharat initiative have become crucial for improving primary healthcare. Existing studies show they have made significant progress in enhancing services, especially for non-communicable diseases (NCDs) and maternal and child health. However, despite these advances, there are important gaps that need more investigation.

One key issue is the lack of thorough assessments, especially in states like Karnataka and Meghalaya, which have unique demographic, geographic, and health challenges. These states include both urban and rural areas, each needing healthcare solutions that fit their specific needs. Meghalaya's rugged terrain, for example, creates particular challenges that require focused evaluations of how AAM perform there.

Research also indicates that AAM operate differently across various states, highlighting disparities in service access and effectiveness among different groups. There is also insufficient data on the infrastructure and staffing issues at AAM, which are critical for understanding how well these centres can deliver care. Addressing these nuances is essential for developing targeted interventions that can improve healthcare services effectively.

Moreover, while technology such as IT and telemedicine holds promise for enhancing healthcare delivery, there is a lack of detailed analysis on how well these tools are being used and their impact.

Similarly, there is a need for more research into community engagement and its role in influencing how AAM are perceived and utilized by the public. Understanding these factors better can help refine strategies to increase community trust and improve healthcare outcomes.

Overall, the absence of comprehensive assessments across key areas—like infrastructure, staffing, service delivery, technology integration, and community involvement—underscores the need for focused research efforts. Such studies not only provide crucial data for adjusting policies and allocating resources but also support informed decision-making among healthcare providers and policymakers. By addressing these research gaps in states like Karnataka and Meghalaya, we can significantly advance healthcare under the Ayushman Bharat initiative and enhance health outcomes across these regions.

CHAPTER 3: METHODOLOGY

Research Question

How are AAM/HWC performing in terms of infrastructure, service delivery, availability of drugs and diagnostics and use of IT systems?

Objective

The primary objective of this rapid assessment is to assess the overall performance of Ayushman Arogya Mandir (AAM).

Specific objectives of the assessment are:

- To assess the infrastructure and facilities available at AAM/HWC.
- To evaluate the quality and accessibility of expanded package of services offered at AAM/HWC.
- To document best practices and challenges in operationalization of AAM/HWC.
- To understand the stakeholder's perspective towards the functional AAM for service delivery including wellness component.

Scope of assessment

The scope of this assessment encompasses various dimensions of healthcare delivery, including infrastructure, services offered, staffing, patient satisfaction, accessibility, health outcomes, financial sustainability, and policy compliance. The assessment involved analysis of facility-based records, official reports and databases, qualitative assessments through interviews and observations, and stakeholder engagement to gather diverse perspectives and insights.

Research Methodology

Study design: Cross-sectional study with a mixed methodology approach.

Study Setting: Two states, namely Karnataka and Meghalaya are chosen for the study which are fundamentally different from each other one representing southern India while one is from north-eastern states of India, both having their own distinct geography. Primary healthcare settings of two states (Meghalaya and

Karnataka) were assessed in both urban and rural areas including AAM-UPHC, AAM-PHC, and AAM-SHC.

Inclusion criteria

- Facilities that have been converted into AAM/HWC.
- AAM/HWC operational for more than 1 year.

Study tools

The study tool used in the study was pre-formed for a national assessment to be done across multiple states of India. The tool was developed after extensive expert consultations with multiple stakeholders and national team. The study tool consisted of a facility-based tool and a checklist which were used to assess the health facility and a checklist for drugs and diagnostics respectively. The facility tool included key domains like infrastructure, human resource and their training, service delivery, expanded package of services, drugs, diagnostics, IT systems, teleconsultations, etc.

Interview guide was used to conduct stakeholder interviews and collect qualitative data in order to understand stakeholder's perceptive of AAM/ HWC and quality of care provided to beneficiaries. Interviews were taken from healthcare staff of all the 24 facilities including interviews of multiple stakeholders (MOs, CHOs, ANMs, ASHAs and Beneficiaries).

Duration of the study: The study was conducted in the span of two months during which field visits were conducted in the month of April, 2024.

Sample: A sample of total 24 facilities was taken including 13 SHCs, 6PHCs, 5UPHCs.

Sampling: Purposive sampling was done to select total of twelve health facilities from each state consisting of AAM-SHC, AAM-PHC and AAM-UPHC. As Karnataka is a larger state, health facilities were chosen across 4 districts and Meghalaya being a smaller state included 2 districts in the study area.

Data collection

Both primary and secondary data was collected for the rapid assessment of the AAM. A facility-based tool and checklist was used for all the target groups for the primary data

collection. Interview guide was used to collect qualitative data from stakeholder's interviews of the healthcare staff and beneficiaries. Data was manually captured and then converted into excel sheets and stored digitally. Secondary data was taken from the AAM registers, AAM portal, facility reports, AAM assessment reports and available literature.

Data entry and storage

Data recorded under various key domains was entered into the Microsoft excel spreadsheet for further processing and analysis.

Data analysis

Quantitative Data: The quantitative data collected in this study was compiled, entered, and analyzed using MS-Excel. Descriptive statistics were employed to summarize the data. Measures of central tendency (median) was computed for continuous variables. The results were visualized using appropriate charts.

Qualitative Data: The qualitative data derived from interviews was analyzed using thematic analysis. Themes were refined through an iterative process of reviewing and grouping based on similarity. The final themes were supported by direct quotes from participants, providing rich, contextual insights into the study's findings. This thematic analysis enabled a deep understanding of the stakeholders' perspectives and the overall functioning of the AAM facilities.

Ethical considerations

Assessment was carried out only after prior permission from all the health authorities. Written approval was taken from the states. As it was a part of national field assessment, Informed verbal consent of the participants was taken before asking any questions.

CHAPTER 4: RESULTS

Overview of the field visit:

A rapid assessment of AAM was done in Karnataka and Meghalaya to assess the overall performance with respect to availability of infrastructure, human resource, service delivery, medicines, diagnostics, IT systems and community platforms. 12 facilities from both states were visited including AAM-SHC, AAM-PHC and AAM-UPHC. During the field visit, interactions with stakeholders was also done to understand their perspective about AAM.

Interviews were taken from healthcare staff of all the 24 facilities including interviews of 13 CHOs, 8 MOs, 24 ANMs, 24 ASHAs and 10 beneficiaries who attended the OPD on the day of the visit for availing any health service.

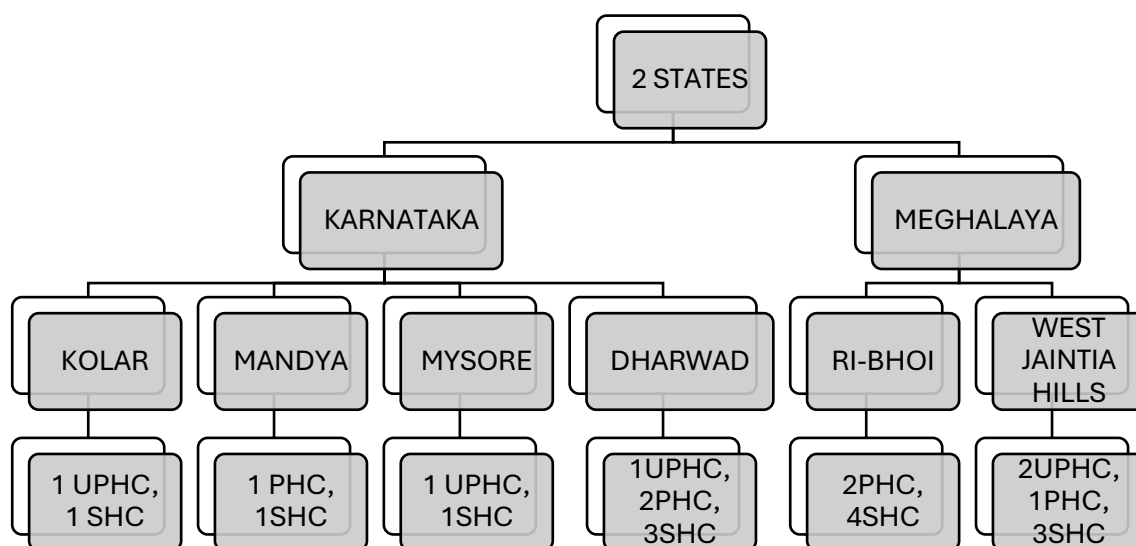


Figure 3 Overview of facilities visited

Table 1 : Profile of states visited for rapid assessment of AAM

STATE PROFILE	KARNATAKA	MEGHALAYA
Geography	Positioned at 7th in India for a geographical spread of 1,91,791.00 km ²	Positioned at 23rd in India for a geographical spread of 22,429 km ²
Population (Census 2011)	6.1 crore	29.66 lakhs
Rural population (%)	61.33	79.9

Urban population (%)	38.67	20.1
Population distribution	It is estimated that 30.1% of the total population are below the age of 19 years, 17.3% within 20 to 29 years, while 52.6% are 30 years and above in Karnataka (<i>Figure 2</i>).	It is estimated that 33.4% of the total population are below the age of 19 years, 19.4% within 20 to 29 years, while 47.2% are 30 years and above in North-Eastern states (<i>Figure 3</i>).
Health infrastructure (as per RHS 2021-22)		
Number of Districts	30	11
Number of Villages	30715	7003
Number of DH	16	11
Number of SDH	147	2
Number of CHC	212	28
Number of PHC	2138	122
Number of UPHC	383	459
AAM Operational status	Total of 9,905 (6,501 SHCs, 2,161 PHCs & 368 UPHCs) primary care facilities have been upgraded and are currently operational as AAM in the state as on 22 June 2024 (according to AB-HWC portal).	Total of 592 (412 SHCs, 116 PHCs & 19 UPHCs) primary care facilities have been upgraded and are currently operational as AAM in the state as on 22 June 2024 (according to AB-HWC portal).

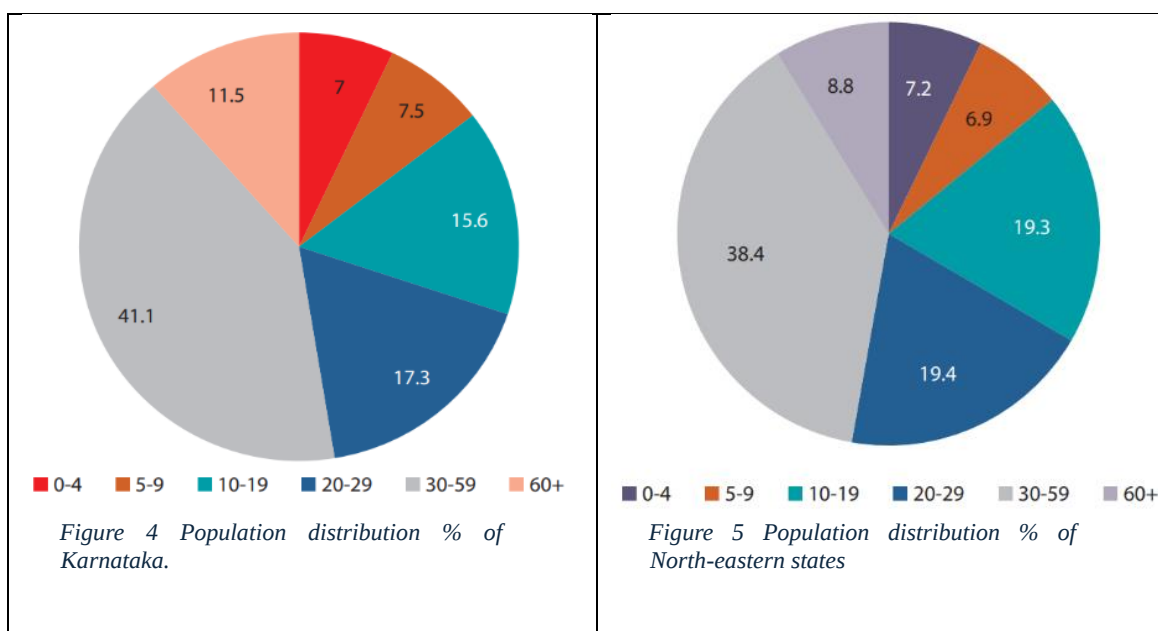


Table 1 provides a comparative profile of Karnataka and Meghalaya based on various parameters relevant to the rapid assessment of Ayushman Bharat Health and Wellness Centres (AAM). Karnataka, with a geographical spread of 1,91,791.00 km², is positioned as the 7th largest state in India, significantly larger than Meghalaya, which covers 22,429 km² and ranks 23rd in geographical size. Karnataka has a much larger population of approximately 6.1 crore compared to Meghalaya's 29.66 lakhs. In terms of demographic distribution, Karnataka has a more balanced urban-rural population with 38.67% urban and 61.33% rural, whereas Meghalaya is predominantly rural with 79.9% of its population living in rural areas.

Regarding health infrastructure, Karnataka has a higher number of districts (30), villages (30,715), and healthcare facilities such as District Hospitals (16), Sub-Divisional Hospitals (147), Community Health Centres (CHCs) (212), Primary Health Centres (PHCs) (2,138), and Urban Primary Health Centres (UPHCs) (383). In contrast, Meghalaya, with fewer districts (11) and villages (7,003), has a more limited healthcare infrastructure, including fewer CHCs (28), PHCs (122), and UPHCs (25).

Both states have upgraded a significant number of primary care facilities to AAM status under Ayushman Bharat, with Karnataka operating 9,905 facilities and Meghalaya operating 592 facilities as of June 2024.

Table 2: Key indicators

Indicators	Karnataka	Meghalaya	India
Total population (in crores) (Census 2011)	6.1	0.30	121.08
Rural %	61.33	79.93	68.85
Urban%	38.67	20.07	31.14
Sex ratio (SRS 2020)	916	NA	907
Total literacy rate % (Census 2011)	75.4	72.9	72.99
Male literacy rate %	82.5	76	80.89
Female literacy rate %	68.1	74.4	64.64
Infant mortality rate (IMR)(SRS 2020)	19	29	28
Maternal mortality ratio (MMR) (SRS 2018-20)	69	NA	97
Total fertility rate (TFR) (SRS 2020)	1.6	NA	2.0

Table 2 highlights key indicators comparing Karnataka, Meghalaya, and the national averages for various socio-demographic and health metrics. Karnataka generally performs better than Meghalaya in literacy rates, with total literacy rates at 75.4%

versus 72.9%. Meghalaya, however, has a higher rural population percentage (79.93%) compared to Karnataka (61.33%). Karnataka also reports lower infant mortality rates (19 per 1000 live births) and maternal mortality ratios (69 per 100,000 live births) than Meghalaya (IMR 29, MMR not available). These indicators highlight significant demographic and health disparities between the two states, influencing their healthcare needs and the implementation of healthcare programs like Ayushman Bharat.

KEY FINDINGS OF THE ASSESSMENT:

A. INFRASTRUCTURE

Table 3 Status of Infrastructure present in Karnataka and Meghalaya during field assessment.

S.NO.	Status of Infrastructure	Karnataka	Meghalaya
1	Status of building ownership (Government Owned/ Rented)	Govt (12)	Govt (11/12), Rented (1/12)
2	Presence of boundary wall	Y	Y (10/12), Partial (1/12), N (1/12)
3	External branding undertaken as per guidelines	Y	Partial (branding for HWC is done)
4	Accessibility provisions for elderly/ people with disabilities (ramps at entry, wheelchairs etc.)	Y (8/12), N (4/12)	Y (7/12), N (5/12)
5	Continuous electricity supply including power backup of 8 hours	Y (10/12), N (2/12)	Y (12/12) (Solar)
6	Availability of potable water supply 24X7	Y (12/12)	Y (10/12), N (2/12)
7	Adequate space for patient examination with privacy	Y (11/12), N (1/12)	Y (10/12), N (2/12)
8	Adequate waiting space with seating arrangement for 20 users	Y (11/12), N (1/12)	Y (8/12), N (4/12)

9	Adequate dedicated space for laboratory/ diagnostics services	Y (11/12), N (1/12)	Y (9/12), N (3/12)
10	Adequate dedicated space for pharmacy/ medicine dispensation	Y (10/12), N (2/12)	Y (8/12), N (4/12)
11	Adequate dedicated space/ room identified for Wellness activities	Y (7/12), N (5/12)	Y (6/12), N (6/12)
12	Functional toilet facilities- separate for male and female	Y (7/12), N (5/12)	Y (6/12), N (6/12)
13	Display of citizen charter at the facility	Y (9/12), N (3/12)	Y (10/12), N (2/12)
14	Display of health promotion / IEC material at the facility	Y (12/12)	Y (9/12), N (3/12)
15	Deep burial/ sharps pit for BMW Management	None (Managed by external hired agency)	Y (10/12), N (2/12)
16	Are residential facilities for staff available within premises	Y (3/12), N (9/12)	Y (12/12)

The infrastructure of primary health facilities has improved significantly, especially with the upgrade of SHCs, PHCs, and UPHCs to HWCs, now renamed as Ayushman Arogya Mandir (AAM). Despite rebranding efforts, the renaming of these facilities to ‘Ayushman Arogya Mandir’ remains a challenge, particularly in Meghalaya, where none of the facilities have done rebranding as state has not yet adopted the name change to AAM.

The ownership of the buildings housing these facilities is predominantly government-owned in both Karnataka and Meghalaya (except one UPHC in Meghalaya, which operates from rented premises). Most of the Health Facilities (HFs) are well-equipped with essential utilities such as piped water supply and power backup, either through inverters or solar power, ensuring good infrastructure for smooth service delivery. Nonetheless, a few facilities in Karnataka (2SHCs), suffer from electricity supply issues despite having power backups, and one SHC in Meghalaya lacks an independent water supply, necessitating water purchases twice a week.

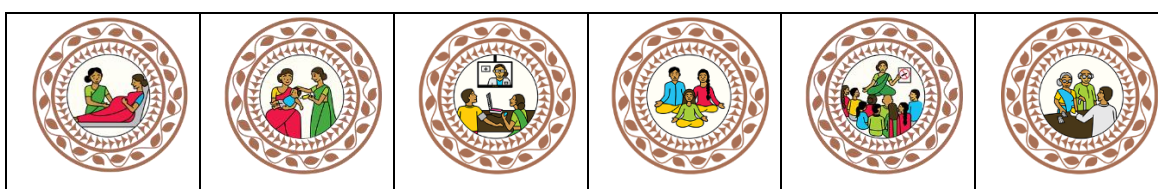
All the visited facilities have complete boundary walls in all the visited facilities of both the states.

Functional toilets are present across all facilities, although separate toilets for males and females are often missing, particularly at the SHC level. Accessibility to health facilities varies significantly; in Karnataka, these facilities are conveniently located closer to communities, whereas in Meghalaya, residents often endure long walks to reach their nearest health centres, preferring the closest facility regardless of its type.

The display of the Citizens' Charter is evident in most facilities, along with Information, Education, and Communication (IEC) materials in local languages, ensuring that essential health information is accessible to all. IEC related to expanded range of services is limited. There is overcrowding of IEC in some of the visited facilities.

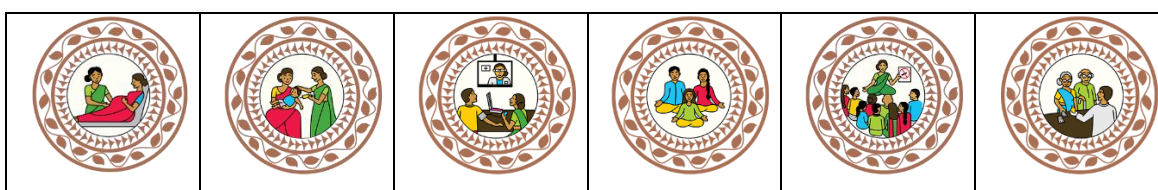
Residential facilities for staff are more commonly functional in Meghalaya, likely due to the region's rugged terrain and hilly environment. In contrast, in Karnataka, only three out of the twelve visited facilities offer residential accommodations for staff.

Wellness activities, despite the lack of dedicated spaces, are regularly conducted in all health facilities, promoting overall well-being within the community.



For biomedical waste management, Karnataka relies on external agencies to regularly collect waste as needed, while Meghalaya has effective in-house systems like sharp pits or deep burial methods. Notably, one of the PHC in West Jaintia Hills of Meghalaya has implemented ‘BIOWAT,’ a cost-effective solution for liquid waste management, exemplifying innovative approaches to sustainable healthcare practices.

In Karnataka, many of the health facilities have achieved quality certifications such as the National Quality Assurance Standards (NQAS) or the Kayakalp award, symbolizing their commitment to quality healthcare. However, in Meghalaya, none of the visited facilities have received these certifications, highlighting a disparity in the recognition of significance of healthcare quality between the two states.



B. HUMAN RESOURCE AND TRAINING

A critical requirement for transforming a Sub Health Centre (SHC) or Primary Health Centre (PHC) into an Ayushman Arogya Mandir (AAM) is to ensure that the primary healthcare team is fully staffed and equipped with the necessary skills to deliver comprehensive primary healthcare services. The primary healthcare teams needed to provide the expanded package of services include (17):

1. SHC: Each SHC should have a team comprising at least three service providers, including a Community Health Officer (CHO), two Multi-Purpose Workers (Male/Female) and a team of ASHAs with norms requiring one ASHA per 1000 population or adjusted for hilly and tribal regions.
2. PHC: According to the Indian Public Health Standards (IPHS), a PHC team should be led by a Medical Officer (MO) and supported by a staff nurse, pharmacist, and laboratory technician.

Table 4: Human resource present at AAM during field visit

HUMAN RESOURCE	KARNATAKA	MEGHALAYA
Percentage of AAM -SHC with dedicated full time CHO	100% (6/6)	100% (7/7)
Percentage of AAM -PHC with dedicated full time MBBS MO as facility in charge	33.33% (1/3)	100% (3/3)
Percentage of AAM -UPHC with dedicated full time MBBS MO as facility in charge	100% (3/3)	50% (1/2)
Percentage of AAM-SHC with two ANM/MPWs	0% (None, all had one ANM/MPW) (0/6)	71.43% (5/7)

Percentage of AAM-PHC/UPHC with full complement* of HR.	66.66% (4/6)	80% (4/5)
---	--------------	-----------

* Full complement includes 1 Medical Officer (MBBS); 2 Nurse; 1 Lab Technician; 1 Pharmacist

During the assessment of health facilities in Karnataka and Meghalaya, it was found that all SHCs in both states have CHOs in place, along with Auxiliary Nurse Midwives (ANMs). In Karnataka, each SHC has only one ANM, whereas in Meghalaya, most SHCs have an adequate number of ANMs, except for one SHC. At the PHC/UPHC level, Medical Officers are present in four out of six facilities visited in Karnataka, while in Meghalaya, one UPHC lacked a Medical Officer among the five facilities assessed.

Regarding the full complement of human resources at the PHC/UPHC level, Meghalaya has the required staffing (one Medical Officer (MBBS), two Nurses, one Lab Technician, and one Pharmacist) in 80% of the visited facilities, whereas Karnataka meets this criterion in 66.66% of its facilities.

Stakeholder's perspective:

ASHA are only available for urban slums, but we also require ASHAs in urban areas as available in rural areas to support healthcare staff of the facility to have a better reach in the community. -MO from Karnataka

More trainings should be provided especially for emergency and trauma care using skill labs and refresher courses should also be done to enhance our skills and knowledge. - CHO from Karnataka

There has been no increment in our salaries since last 2 years which was promised to us previously. -CHO from Karnataka

Table 5: Training given on Expanded Package of Services

Training on expanded service package (Yes/ No)	KARNATAKA	MEGHALAYA
CHO	Y	Y
MO	Y=3, Partial=1, N=2 (MO vacant=2)	Y=2, Partial=1, N=2 (MO vacant=1)
SN	Y (3/6)	Y (2/5)
ANM	Y (7/12), Partial (3/12), N (2/12)	Y (11/12), N (1/12)
ASHA	Y (12/12)	Y (11/12), N (1/12)

Training for Expanded Package of Services (EPS) is partially done for MOs, CHOs, ANMs and ASHAs in the visited health facilities with few packages lacking on training. Healthcare staff is aware about all the expanded package of services. However, training for Staff nurses at PHC level of facility is absent in many of them related to EPS in both states. Training of health care staff is supported through a training monitoring portal called SASHAKT- Systematic Assessment of Health care providers Knowledge and Training. It is supposed to be providing real time update on the success and progression of trainings, but it is unheard of in many facilities and remains underutilized.

Stakeholder's perspective:

Trainings given for 6-7 days on expanded range of services were very helpful to enhance service delivery and provide quality treatment to patients. -MO from Karnataka.

More trainings should be provided especially for emergency and trauma care using skill labs and refresher courses should also be done to enhance our skills and knowledge. - CHO from Karnataka

We have given training on ASHA First app, after which we can submit our own claims and track our incentives from our mobile phones. It is easier now to track and manage our claims. -ASHA from Meghalaya

C. SERVICE DELIVERY

AAM provide expanded package of services beyond the traditional RCH and communicable diseases and common ailments as advertised previously. Services has changed and revamped for a better turnout which is evident through increase in number of patients in OPD, services increased through expanded packages, continuity of care given through referrals and teleconsultations, changing perception towards AAM, increased awareness and promotion of health seeking behaviour through wellness sessions at AAM.

Stakeholder's perspective about AAM:

People's perception has changed towards HWCs, previously they used to think that quality services are not provided here, and they preferred private practitioners over us, but now patients have started coming to us. -MO from Meghalaya

Services are within the reach of community, Out of Pocket Expenditure (OOPE) is reduced because of availability of free medicines, quality of treatment has improved, and now comprehensive care can be given to patients. -CHO from Karnataka

More elderly patients and patients with chronic conditions like hypertension are now coming to us due to increased availability of free medicines and services for comprehensive care. -ANM from Meghalaya

I live near UPHC (1km away), and I frequently come to the centre for minor injuries or illness. This health facility is easily accessible to me and my family, so we don't have to go to any other place to get treatment of common illness. -Beneficiary from Karnataka

Previously we used to think it is a centre for pregnant women, mothers, and children only, but now we know that we can also come here to get treatment and take medicines. -Beneficiary from Meghalaya

There's a notable increase in turnout for OPD services post launch of Comprehensive Primary Health Care services, with approximately 892 patients per month in Meghalaya PHCs/UPHCs and 365 per month in Meghalaya SHCs; 1955 patients per month in Karnataka PHCs/UPHCs and 431 in Karnataka SHCs.

Previously people were unaware about services provided at the health facility, OPD footfall was low, medicines were not available, but now people are happy with the transformation after which more services are present and free medicines are available for patients. -MO from Meghalaya

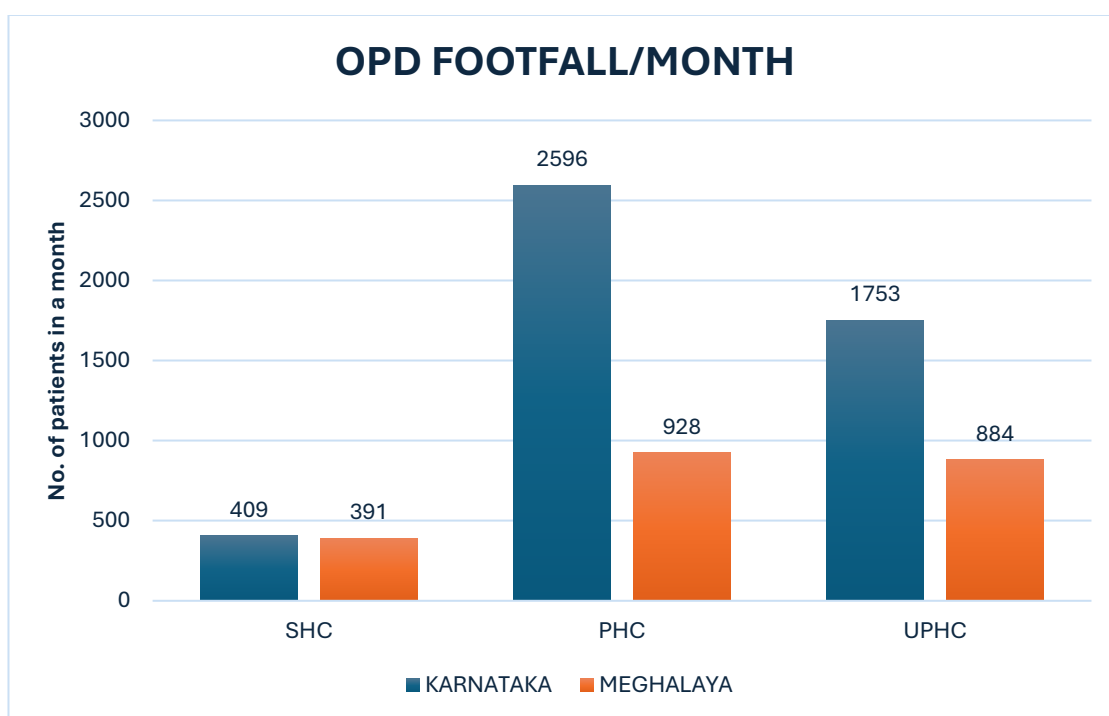


Figure 6 OPD footfall at AAM/HWC.

Services under RMNCAH+N: Reproductive, Maternal, Newborn, Child, and Adolescent Health plus Nutrition (RMNCAH+N) services are universally provided. 3SHCs in Meghalaya are also conducting deliveries whereas none of the SHCs in Karnataka are delivery points. ANC check-ups are done routinely with regular follow up including identification of high-risk pregnancies and referral to higher centres. Immunization is also occurring regularly in both the states. Regular school health talks are also conducted by the healthcare team. Family planning preferred in Meghalaya are oral contraceptive pills (OCP) and modern contraceptives like Antara while more modern contraceptives like Antara, chaya and IUCD in addition to condoms and OCPs are preferred choices in Karnataka. Few incidences of home deliveries and immunization refusal with dropouts are found in some villages of Meghalaya.

Patients prefer to use Oral Contraceptive Pills (OCP) for family planning despite of availability of modern contraceptives because of their hesitancy and unawareness.

-ANM from Meghalaya

Non-communicable disease services: All AAM centres offer services for non-communicable diseases, specifically hypertension (HTN) and diabetes mellitus (DM), including screening, management, and referrals. Revised CBAC forms are used as a community assessment tool for NCDs, helping frontline workers engage the community for facility-based screening. Medications for chronic conditions like HTN and DM are provided for one month, with regular follow-ups. Both states reported limited screening for breast, cervical, and oral cancers, with a stronger focus on diabetes and HTN than on cancer screening.

Services have improved significantly especially for non-communicable diseases (NCDs), people are more aware about services provided at PHC and are engaged in health seeking behaviour through wellness sessions provided here. -MO from Karnataka

Services under Communicable diseases: The disease control program services including National Tuberculosis Elimination Program is found in the health facilities. The SHC-AAM collect the sputum samples and send them to nearby

PHC-AAM for testing. The confirmed cases are being followed up for treatment compliance. Surveillance of infectious diseases at the community level to check and prevent spread of communicable diseases is conducted regularly. Multi-Purpose Workers-Male (MPW-M) is present in few facilities of Karnataka and awareness activities are conducted using IEC material at the community level.

Services under other Expanded packages: The expanded services were partially available at the visited facilities. The provision of expanded services mainly focuses on awareness generation and basic management of Eye/ENT/Oral/Emergency cases, with home-based care for the elderly as case need. Mental health package is not functional, no screening is happening for mental health ailments and lack of availability of drugs in the health facilities. Tele MANAS services have minimal presence and need to be strengthened. Services in Karnataka for other packages are better functioning as compared to Meghalaya as more specialized services are available through specialists' visits and teleconsultations happening routinely.

Continuum of Care: Referral transport and continuum of care mechanisms are established, with patients mainly opting for upward referral to Primary Health Centres (PHCs), Community Health Centres (CHCs) or the District Hospital (DH) through physical consultations and teleconsultation, while downward referrals are done partially for limited services like chronic NCD patients, and they are managed by ASHA/ANM/CHO ensuring continuum of care. In Meghalaya, referrals are done to PHC/ CHC/ DH depending upon the proximity to the facility and urgency of the case because transportation is a challenge for patients of Meghalaya with ambulance services present in limited facilities. In Karnataka, majority cases are handled at the level of facility where the patient has arrived, but for complicated cases patients are appropriately referred to specialists present at the higher facility.

Teleconsultation services:

Teleconsultations are happening to improve availability of higher-level care and maintaining the care continuum, by addressing physical and geographical access. Teleconsultation services are available but are primarily limited to consultations with MO at PHC from SHCs, with specialist teleconsultation being negligible in

Meghalaya. Teleconsultations are not much used by MO at PHC/UPHC level due to unavailability of specialists at the HUBs. Overall utilization of teleconsultation remains suboptimal because of network connectivity problems, lack of specialist availability, and a general preference for in person consultations.

There is always a waiting period of half an hour or more to connect the call due to which patients become reluctant to use these teleconsultations. -CHO from Meghalaya

Teleconsultations are happening effectively in Karnataka as opposed to Meghalaya with much higher number on regular basis. Hubs are manned with specialists that are available and accessible. Online consultations are done to PHC from SHC and to specialists present at Hubs.

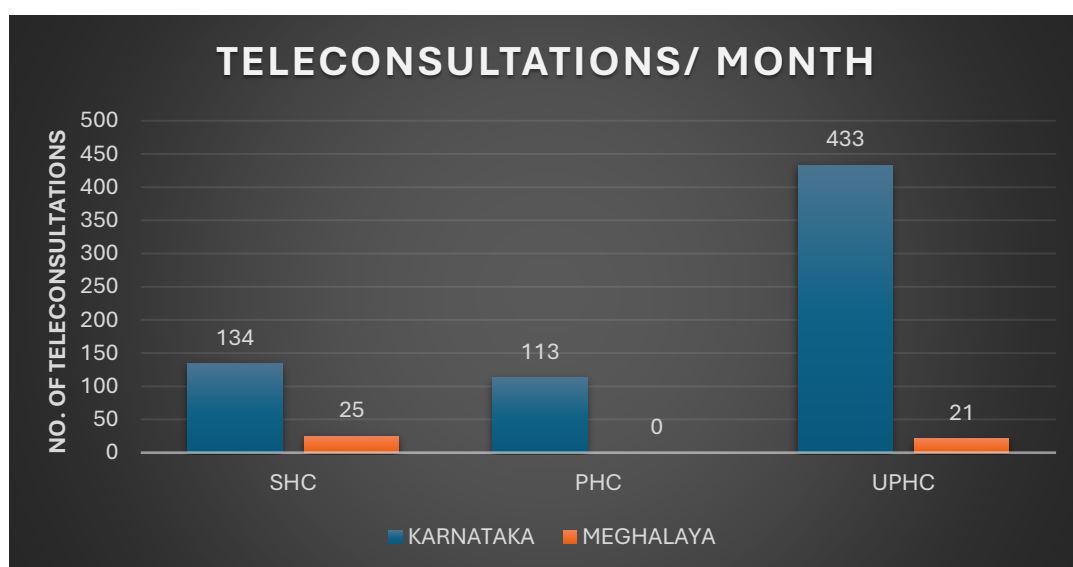


Figure 7 Teleconsultations at AAM/HWC

Table 6 Teleconsultations at AAM/HWC in a month

TYPE OF FACILITY	KARNATAKA	MEGHALAYA
SHC	134 (n=6)	25 (n=6)
PHC	113 (n=1)	0 (n=3)
UPHC	433 (n=1)	21 (n=2)

Wellness services: Wellness sessions like Yoga, exercises are being conducted regularly with increasing awareness about wellness component through AAM. Wellness sessions are conducted more in Meghalaya in comparison to wellness sessions in Karnataka. Few equipment like shoulder wheel is installed at all centres but the utilization is minimal.

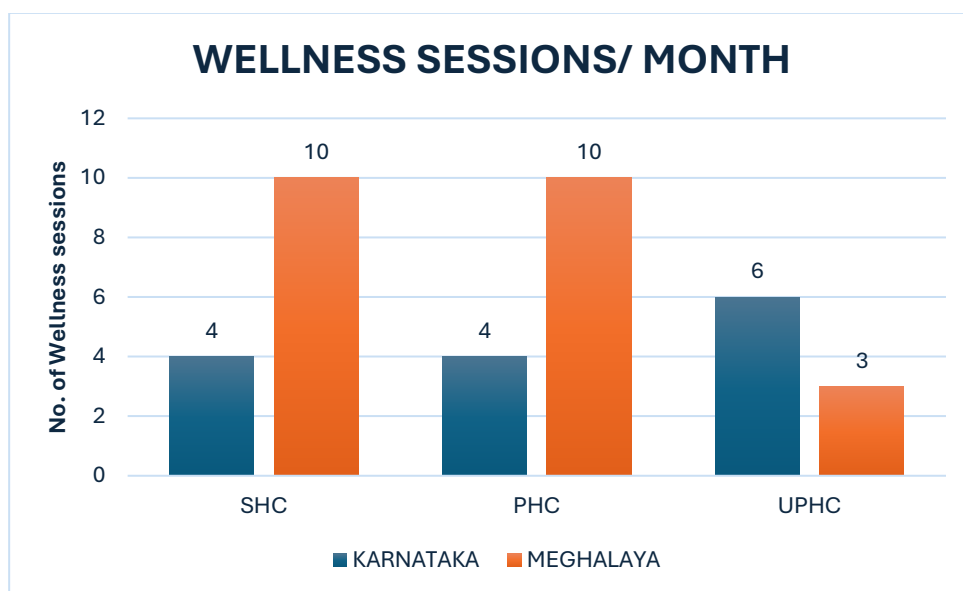


Figure 8 Wellness sessions at AAM/HWC

This is my fourth visit in this month, I live 500m away from here. I come here every Saturday morning for yoga session. -Beneficiary from Karnataka

E. DRUGS & DIAGNOSTICS

The functionality of AAM/HWC depends on the drugs and diagnostics availability covering varied range of community healthcare needs for people getting services at AAM.

Table 7 Availability of Drugs and Diagnostics at AAM.

STATE	TYPE OF FACILITY	DRUGS	DIAGNOSTICS
KARNATAKA	UPHC	108	25
	PHC	109	19
	SHC	57	11
MEGHALAYA	UPHC	61	13
	PHC	74	17
	SHC	56	8

Availability of essential medicines:

Under National Health Mission (NHM) financial aid is given to States for free essential medicines in public health facilities as per their needs under 'Free Drugs Service Initiative' (FDSI) programme. Essential Medicines Lists (EMLs) are critical to the success of the initiative. In April 2022, revised IPHS 2022(1) guidelines for Health and Wellness Centre – SHC/PHC/UPHC were released, containing facility-specific Essential Medicines Lists (EMLs). EML of SHC has 106 essential medicines and PHC/UPHC has 172 medicines.

At subcentre level the number of medicines available in visited AAM-SHCs are in the range of 51-106 in state of Karnataka as compared to 27-93 medicines in Meghalaya. At PHC/UPHC level, available medicines are in the range of 73-153 in Karnataka while in Meghalaya it is lower in the range of 51-150 medicines. Only 16.66% of total 12 facilities are found to be having 80% of EML list in both Karnataka and Meghalaya.

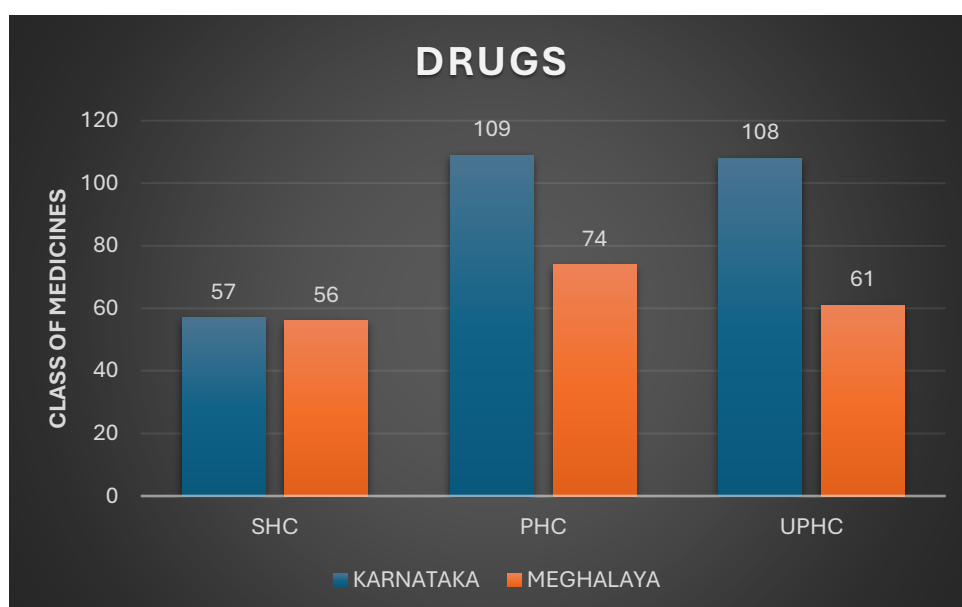


Figure 9 Drug availability at AAM/HWC

In Karnataka, the medication supply chain management at the AAM-PHC and UPHC levels is facilitated through the Karnataka State Medical Supplies Corporation Limited (KSMSCL). Both SHCs and PHCs are found to be well adapted to usage of e-Aushadhi portal for indenting and procurement of drugs but two of the visited SHCs are still doing it manually. At PHC level 100% indenting is through e-Aushadhi portal while it is 66.66% at SHC level. In Meghalaya, indenting of drugs primarily occurs through offline modes (manually) for SHCs, while in PHC/UPHC, indenting is facilitated through Meghalaya Medical Drugs and Services Limited (MMDSL), in lieu of DVDMS system in Meghalaya. While MMDSL is 100% functional at PHC/UPHC level whereas at SHC level none of the facilities are using MMDSL for indenting. Inventory management in both the states is done as per significance and usability of drugs following the rule of FEFO (First Expiry First Out). Both states adhere to the principle of FEFO, ensuring that drugs are utilized based on their expiry dates.

Public transport is not available in our area due to which it becomes difficult to regularly visit the health facility, but sometimes we do come to take medicines. - Beneficiary at PHC (Meghalaya)

Availability of diagnostics:

The AAM/HWC should be equipped to offer essential diagnostic and screening services required for conditions mandated at their level. The Ministry of Health and Family Welfare (MOHFW) endorses the 'Free Diagnostics Service Initiative' (FDSI) program under NHM. This initiative aims to deliver accessible and cost-effective pathological and radiological diagnostic services nearer to communities, thereby reducing Out-of-Pocket Expenditure (OOPE). Currently, health & wellness centres provide 14 diagnostic services at Sub Health Centres (SHCs) and 63 at Primary Health Centres (PHCs)/Urban Primary Health Centres (UPHCs).

Out of total 14 tests, the number of tests available in visited AAM-SHCs are in the range of 10-13 tests in state of Karnataka as compared to 7-11 tests available in Meghalaya. At PHC/UPHC level, available diagnostics are in the range of 17-30 in Karnataka while in Meghalaya it is much lower in the range of 10-24. Only 25% of total 12 facilities are found to be having 80% diagnostic tests of total list in Karnataka and 16.66% in Meghalaya.

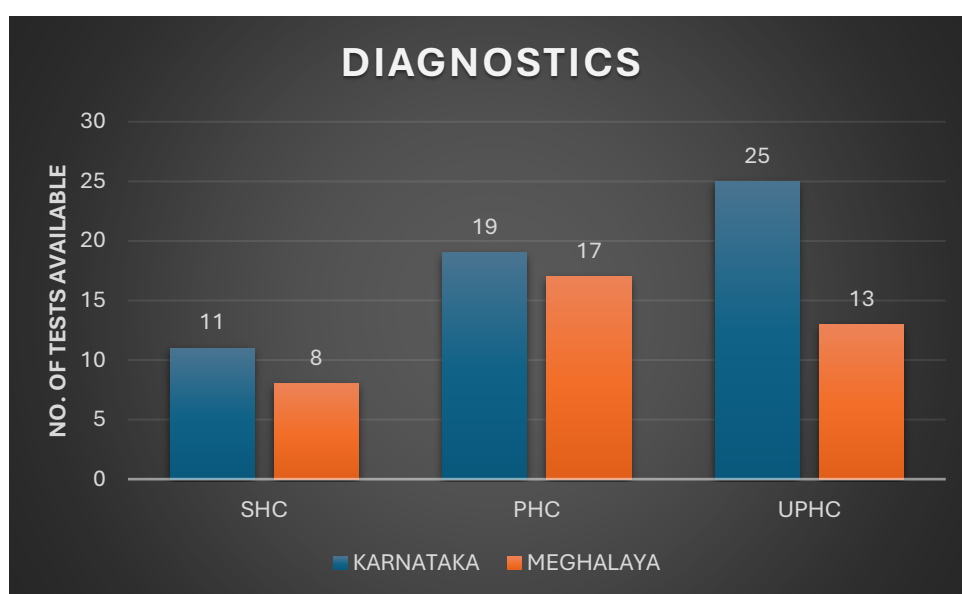


Figure 10 Diagnostics availability at AAM/HWC

Sample transportation facility is present in 33.33% of SHCs in Karnataka and 28.6% in Meghalaya. At PHC/UPHC level, 66.66% of facilities has this provision in Karnataka while this number is lower in Meghalaya with 20% of facilities having transportation facility.

Although services at AAM have improved, but transportation is still a major challenge at our facility because there is no sample transportation available, we ourselves have to take test sample to higher facility on our own vehicle. -CHO from Karnataka

The available diagnostics are used more efficiently in the state of Karnataka as compared to Meghalaya primarily because of a higher footfall in the facilities of Karnataka. This is evident from the higher number of tests done monthly in the facilities of Karnataka than in Meghalaya.

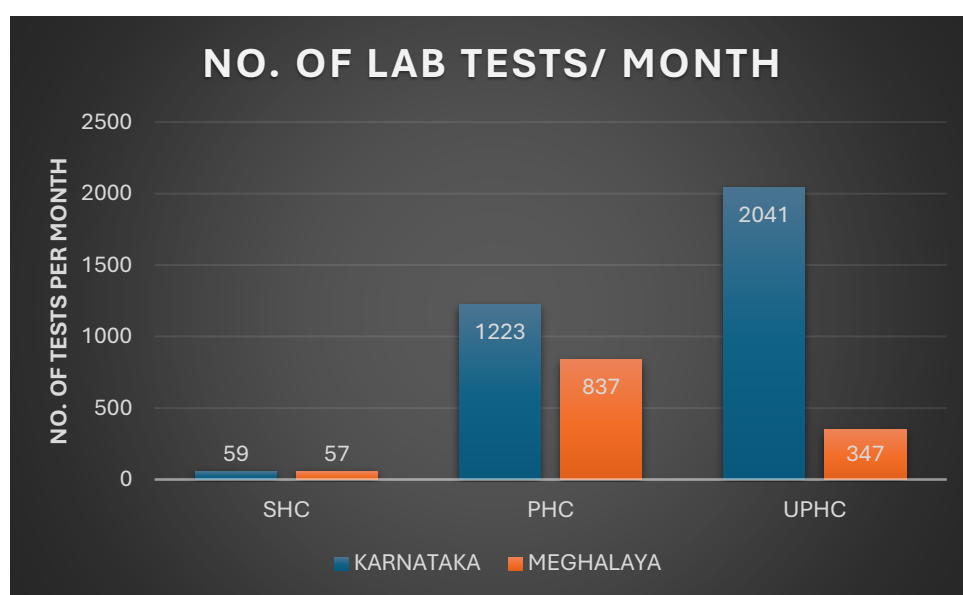


Figure 11 Lab tests conducted in a month at AAM/HWC.

F. IT / DIGITAL INTEGRATION

A robust IT system is one of the nine key reforms brought about with the introduction of Ayushman Bharat to deliver comprehensive primary healthcare through Ayushman Arogya Mandir (AAM)(2). A fully functional IT system can support the AAM team in planning, recording, monitoring, and management of delivery of all essential services. IT systems setup from the level of ASHA upwards can support service delivery, improve administrative functions including monitoring and supervision, assist in the provision of performance and team linked financial incentives and support logistics and supply chain management of drugs, diagnostics, and other consumables.

Both Karnataka and Meghalaya have adopted GoI's IT systems, portals, and applications to streamline health-related activities and improve data management including AAM portal, Health Management Information System (HMIS), Non-Communicable Disease (NCD) portal and app, Reproductive and Child Health (RCH) portal, Auxiliary Nurse Midwife On-Line (ANMOL) app, Integrated Health Information Platform (IHIP) portal, Nikshay portal, e-Sanjeevani, e-Aushadhi, Family Planning Logistics Management Information System (FPLMIS) etc. This move towards digitalization includes strides taken to improve IT infrastructure, providing essential equipment such as laptop/desktop to MO, tablets to ANM and CHO, and smartphones to frontline workers.

Both states are also taking initiatives and have developed their own specific portals and apps. In Karnataka, there are applications and portals such as ASHA Soft, designed to capture detailed service information provided by ASHA workers, facilitate online payments to their bank accounts, and generate various reports to monitor program progress, a pilot project known as CHO Soft is also underway in selected districts to facilitate Performance Based Incentives (PBI) for CHOs. In Meghalaya, state has introduced its own app, the MOTHER App, in lieu of the RCH portal and ANMOL App for tracking pregnant women. Healthcare staff prefers MOTHER App than RCH portal and ANMOL app. Efforts are underway to synchronize data with the RCH portal for consistency.

We are able to enter data on apps using our mobile phones, but it would be easier to use if these apps and portals are made in local language to have a better understanding and we can fill data more accurately. -ASHA from Karnataka

However, despite the push towards digitalization, many health facilities still rely heavily on maintaining numerous physical registers. At the level of PHCs this number is much higher in Meghalaya ranging from 25-177 registers while in Karnataka this range is from 30-60 registers. At SHCs level, 20-35 registers are maintained in both the states. These large numbers of registers lead to duplication of data entries across multiple portals and physical registers, increasing the workload and potential for errors.

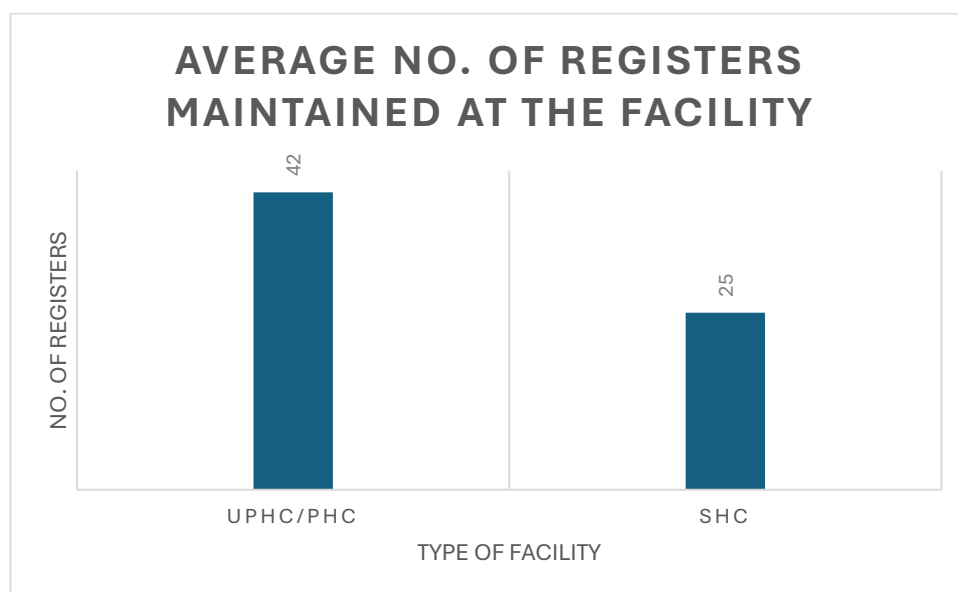


Figure 12 Number of registers maintained at the AAM/HWC

**An anomaly was found at one UPHC of Meghalaya which was maintaining 177 registers at the facility.*

Although there is a lot of progress in digitalization at primary health facilities but still there are many challenges that persists in IT systems on the ground level. The dual maintenance of manual and digital records is time consuming and burdensome for healthcare staff. There are inconsistencies between manual and digital entries resulting in inaccurate data. Healthcare workers struggle with managing multiple logins and data entries for various portals. Network connectivity is a major concern that hinders the data entry, teleconsultations and processing of claims and incentives for healthcare workers. Furthermore, Meghalaya has more persistent challenges in adapting digital system pushing them back to manual documentation as their preferred choice of data recording. Karnataka is found to be more digitally adaptive upto the level of ASHAs and is openly accepting digital record maintenance using portals and apps and requests elimination of physical documentation in paper format.

Stakeholder's perspective:

There are too many portals and apps in addition to registers and paper records due to which data management and record maintenance becomes difficult and staff gets overburdened due to duplication of work. -MO from Karnataka

We do use apps and portals, but we prefer register and paper-based records as it is easier to access them whenever we need it, which is not the case for digital data because of bad network connectivity we are unable to access them timely. - CHO from Meghalaya

We are capable to use all the apps and portals efficiently without facing any problem, but we still have to enter same data on various portals as well as maintain registers too which becomes difficult along with our regular duties. - ANM from Karnataka

It is easier to fill data manually in our registers and keep it with us during household visits, we don't know how to operate apps and portals to fill patients' data. -ASHA from Meghalaya

G.COMMUNITY ENGAGEMENT/ PARTICIPATION

Community platforms play a crucial role in supporting and overseeing the healthcare system, enhancing both service delivery and utilization of public health facilities. These include Village Health Sanitation Nutrition Committees (VHSNCs) at the village level, Jan Arogya Samitis at Ayushman Arogya Mandir, Mahila Arogya Samiti (MAS) in urban areas, and Rogi Kalyan Samiti (RKS) at higher-level health facilities. These institutional platforms are designed to foster community participation. At the SHC/PHC level, Jan Arogya Samitis facilitate community engagement, governance, and accountability in healthcare services. They collaborate with VHSNCs to promote health and address social determinants through community interventions. Mahila Arogya Samiti (MAS) plays a similar role in urban areas, focusing on planning, implementing, and monitoring health-related activities, particularly in slums. They raise awareness about health issues and advocate for best practices in health, nutrition, water, sanitation, and other social determinants, encouraging active community involvement.

In Meghalaya, JAS is 100% functional at the level of both SHCs and PHCs. Community participation is effectively done using community platforms like JAS, MAS, and VHSNC. VHND sessions are also happening regularly with more than 8 sessions conducted monthly in the health facilities in Meghalaya.

In comparison, community platforms are found to be weak in Karnataka where only 50% SHCs and 66.66% PHCs JAS is found to be functional. While VHND sessions are happening regularly in health facilities of Karnataka, but community platforms like VHSNC, JAS and MAS are found to be lacking in many of them. RKS is present in few facilities. Untied fund is received under the Arogya Raksha Kosh (ARK)/RKS fund where JAS and MAS are absent in health facilities.

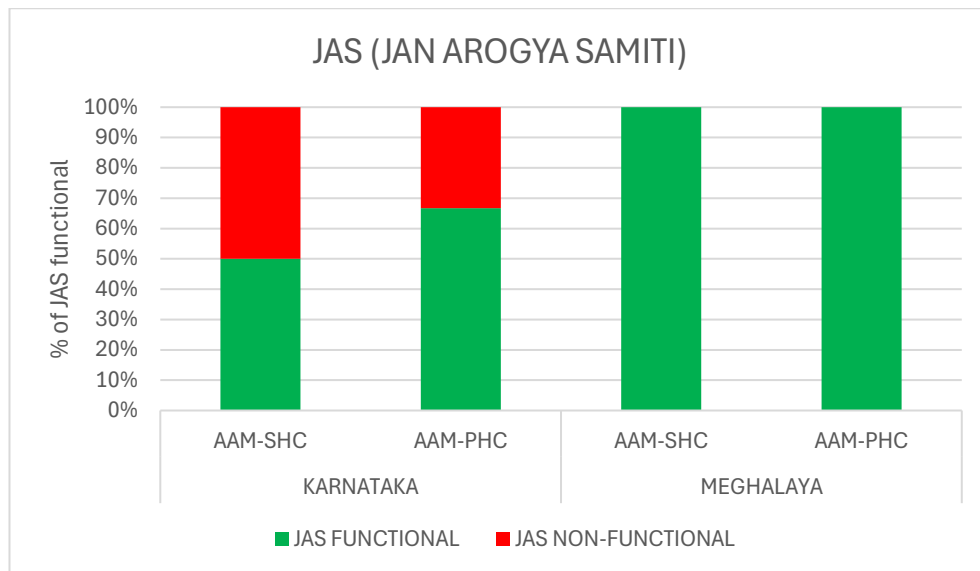


Figure 13 Percentage (%) of JAS functional

STRENGTHS & GOOD PRACTICES

1. Meghalaya

- **ASHA First App:** The state has successfully implemented the ASHA First App, facilitating Direct Benefit Transfer (DBT) payments to Accredited Social Health Activists (ASHAs). This end-to-end application not only expedites payments to ASHAs but also serves as a valuable monitoring and tracking tool for program officers at all levels. ASHAs can submit their claims directly through smartphones or laptops, ensuring timely payments and efficient financial management. ASHAs first put their claims in the app, in chain manner approvals are given in the app starting from the ANM of the area and at last final approval is given by the Mission Director NHM, after which the state accounts manager releases the money through PFMS directly to the account of the ASHAs.
- **BIOWAT:** The introduction of the BIOWAT (Biodegradable Waste Treatment) facility at Nartiang PHC exemplifies innovative liquid waste management practices. This facility employs a four-stage treatment process, significantly enhancing waste management capabilities. With an approximate expenditure of Rs. 2,00,000, the BIOWAT facility demonstrates a commitment to sustainable and environmentally friendly healthcare infrastructure.
- **Chief Minister's Safe Motherhood Scheme (CM-SMS):** It has 4 components. i. Mobility support for pregnant women and families to access institutional delivery services. ii. Provision of transit homes for temporary accommodation near healthcare facilities. iii. Mobility support for Auxiliary Nurse Midwives (ANMs) to conduct home visits and Village Health and Nutrition Days (VHNDs). iv. Financial incentives for attendants, including Traditional Birth Attendants (TBAs) up to Rupees 1000, to encourage their participation and support for institutional delivery.
- **Hospital Management Information System (HMIS):** The implementation of the Hospital Management Information System facilitates the digitalization of healthcare records, enhancing data management and accessibility across Primary Health Centers (PHCs) and higher-level health facilities.

- **Meghalaya Medical Drugs and Services Limited (MMDSL):** The initiative streamlines drug and medical equipment procurement, supply, and maintenance for state health facilities. By ensuring continuous access to essential medical supplies and enhancing service providers' skills in drug management, the initiative contributes to improved healthcare delivery and efficiency.

2. Karnataka

- **ASHA SOFT:** Implemented software system for managing incentive remuneration for ASHAs, streamlining administrative tasks and ensuring timely payments. Additionally, CHO SOFT is also started in some districts on a pilot basis to facilitate Performance Based Incentives (PBI) for CHOs.
- **Ayushmati Clinic:** Established specialized care clinics to cater to specific healthcare needs, offering tailored services to patients.
- **Mobile Dental Unit:** Implemented mobile dental units to deliver specialized dental care to underserved populations, enhancing access to dental services.
- **NAMMA Clinic** are present to provide healthcare services to uncovered populations, addressing disparities in healthcare access.
- **Regular follow-ups:** The AAM team conducted regular follow-ups for high-risk cases such as TB and diabetes using patient monitoring report booklets, emphasizing proactive management and patient care.
- **BIN cards:** Maintained BIN cards to track drug consumption and monitor shortages of medicines, facilitating effective management of pharmaceutical supplies.

CHALLENGES

- Challenge persists to make all the expanded package of services fully functional especially mental health package which is not functioning properly in any of the visited facilities in both states.
- The duplication of data entry across multiple portals compounded operational challenges, exacerbated by the maintenance of multiple registers for the same data across various levels of healthcare delivery.
- With the operationalization of multitude of portals simultaneously, there was a lack of a centralized data entry point (absence of a single interface for data entry) means various portals and apps are not synchronized, further complicating data management processes.
- Network connectivity is a major concern which interrupts the data entry, teleconsultations and processing of claims and incentives for healthcare workers, especially in rural areas.
- Teleconsultation remains suboptimal because of network connectivity problems, lack of specialist availability, and bad quality equipment used for consultations.
- Limited Drugs and Diagnostic Services: drugs and diagnostics present are much lower than advised in the EDL list. The availability of drugs and diagnostic services are limited to more commonly used drugs and point-of-care tests, which may not always meet the comprehensive needs of patients.
- The visited facilities do not have a dedicated covered area for conducting yoga and wellness sessions.
- Deep burial/sharp pits are not available as per Bio Medical Waste (BMW) guidelines in Karnataka. Disposal of BMW is done by collection by BMW team regularly or as per requirement of the health facilities.

- The facilities visited are found to be lacking in quality certification especially in the state of Meghalaya where none of the visited facilities are certified.

CHAPTER 5: DISCUSSION

The rapid assessment of AAM in Karnataka and Meghalaya reveals a satisfactory overall performance with certain areas needing improvement. Similar studies in other states like Madhya Pradesh, Odisha, Gujarat, Himachal Pradesh, Punjab, Jammu and Kashmir have also done similar assessments of AAM(9,10,12,18–20). Positive influence of transformation of health facilities into AAM is found from stakeholders in terms of increased awareness about services, availability of medicines and diagnostics, increased number of patient footfall, similarly shown in assessment done in Madhya Pradesh(20). Positive feedback is also reported from the community for upgradation to AAM and posting a trained health provider in the community(8,19).

A key finding is that adequate infrastructure is available in all the visited facilities, which aligns with the operational guidelines of Ayushman Bharat that emphasize the importance of robust infrastructure for effective service delivery(2). Primary health care teams exhibit good team dynamics and coordination, performing their designated roles effectively. However, there is a notable gap in training for the expanded range of services. Similar findings were also present in the study done in Himachal Pradesh where high gaps were found in skill competency and training for health workers (12) . The SASHAKT portal, which is intended for entering regular training updates for staff, is underutilized. According to the operational guidelines of Ayushman Bharat, continuous training and skill enhancement are crucial for the effective functioning of HWCs. Ensuring that all health personnel, including Community Health Officers (CHOs), Auxiliary Nurse Midwives (ANMs), and Accredited Social Health Activists (ASHAs), receive comprehensive training on the expanded range of services is essential. The guidelines emphasize the importance of skill-building initiatives to enhance the competency of healthcare providers (2).

Services provided by AAM focus mainly on RMNCAH+N, NCDs (especially hypertension and diabetes), and communicable diseases. However, services related to oral health, ENT, emergency and trauma care, geriatric and palliative care are only partially available. The study done in Odisha also identified that maternal and childhood services, family planning, NCD services are given

regularly, but basic oral health, ENT, emergency and palliative care services are inadequate(9). Mental health services also require strengthening, including the expansion of Tele MANAS services and the creation of awareness about them. The operational guidelines stress the need to offer a comprehensive range of services, including care for common communicable diseases, basic oral health care, elderly and palliative care services, emergency medical services, and mental health care(2). The partial availability of these services indicates a gap in achieving the envisioned comprehensive care. The guidelines recommend regular monitoring and assessment to ensure that HWCs provide the full spectrum of services and address any gaps in service delivery(2). The wellness component, introduced as an additional package, is successfully implemented, with wellness sessions being conducted regularly in both states. However, the number of wellness sessions and community reach is better in Meghalaya than Karnataka where physically patients are more accessible than virtually through digital platforms pertaining to lack of IT integration in Meghalaya. IT integration is overall good in Karnataka and staff is well adapted with the digital platforms maybe because of overall better development in the state of Karnataka fostering the IT industry of the country.

The availability of drugs and diagnostics is below the national Essential Drugs List (EDL). Indenting is done through the eAushadhi portal in Karnataka and the MMDSL portal in Meghalaya up to the PHC level, but integration is needed down to the SHC level. HWCs should ensure the availability of essential drugs and diagnostics to meet the healthcare needs of the community as per operational guidelines. It also highlights the importance of maintaining an adequate supply of medicines and diagnostics to provide timely and effective care(2).

National portals and apps are used in both states, and additional state specific initiatives like ASHA Soft in Karnataka and the MOTHER app in Meghalaya are noteworthy. However, network issues and the unavailability of specialists hinder effective teleconsultations and data management. Staff are also burdened with maintaining multiple registers and extensive data management processes. The operational guidelines advocate for robust IT systems to support teleconsultation and efficient data management, highlighting the need for improved IT infrastructure and training(2). Addressing network issues and ensuring the

availability of specialists for teleconsultations are crucial for effective healthcare delivery.

Community participation platforms function better in Meghalaya compared to Karnataka. Meghalaya's strong community platforms, including JAS, VHSNC, and VHND, contrast with many facilities in Karnataka where JAS is yet to be formed. Community engagement is important in achieving goals of Ayushman Bharat through strengthening of community platforms and ensuring active participation and accountability in healthcare delivery(2).

Strengths of the Study:

This study is one of the few that assess the overall performance of AAM facilities, including infrastructure, human resources, service delivery, medicines and diagnostics, IT systems, and community platforms. It also facilitates comparison between functioning of AAM in two states- one representing southern, and one representing the northeastern parts of the country.

Limitations of the Study:

The cross-sectional nature of this study and purposive sampling to include only, 12 facilities from each state, limits its ability to generalize findings. More extensive, multicentric studies across various districts would provide a clearer picture and aid policymakers in decision making.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

The rapid assessment of Ayushman Arogya Mandir (AAM) highlights a significant stride towards achieving universal health coverage in India, though certain areas require improvement. The assessment's objectives were to evaluate the infrastructure, service delivery, understand strengths and challenges, and to know stakeholder perspectives of AAM. The findings reveal a mixed performance across these areas, pointing to specific recommendations for enhancement.

The infrastructure at most AAM facilities aligns with the established guidelines, particularly in the areas of maternal and child health, family planning, and non-communicable diseases (NCD) services. However, other service packages are inconsistently available. Teleconsultation services face challenges such as poor network connectivity, specialist shortages, and inadequate equipment. To address these issues, it is recommended to strengthen teleconsultation infrastructure, improve network connectivity, and ensure quality teleconsultation equipment. Additionally, enhancing the supply chain management of medicines through eAushadhi/DVDMS and updating the essential drugs lists (EDL) based on local health needs will further bolster the infrastructure.

In Karnataka, IT integration facilitates effective data management, yet community engagement remains weak. Conversely, Meghalaya shows robust community platforms but struggles with cumbersome IT systems. This highlights the need for balanced improvements across regions. Recommendations include promoting the digitalization of record maintenance and strengthening of community engagement platforms. Additionally, ensuring the availability of essential diagnostic services and establishing a reliable sample transportation system are crucial steps to improve service quality and accessibility.

The assessment identified strengths such as effective digital platform usage in Karnataka and strong community engagement in Meghalaya. However, challenges persist, including the uneven availability of service packages and the need for better teleconsultation services.

Stakeholders appreciate the wellness components and improved service delivery of AAM but have little awareness about complete package of services and express concerns about infrastructure gaps and inconsistent service implementation. These perspectives underscore the necessity of routine assessments to provide field-based evidence for policy-making and continuous improvement. Addressing these challenges involves capacity building and training for healthcare to improve care quality and fostering collaboration between healthcare providers and community members to effectively address local healthcare needs.

To address the identified challenges and enhance the effectiveness of AAM:

- ✓ **Capacity Building and Training:** Advocate for increased training opportunities focused on an expanded range of healthcare packages, with regular refresher sessions to ensure healthcare workers' proficiency.
- ✓ **Digitalization of Record Maintenance:** Transition to digital platforms for register maintenance at every data entry point, promoting appbased data entry to streamline administrative processes and improve accuracy.
- ✓ **Unified Portal System:** Implement a single data entry point for all portals to simplify administrative processes and enhance efficiency in data management.
- ✓ **Strengthening Teleconsultation Services:** Improve network connectivity, upgrade teleconsultation equipment, and promote specialist teleconsultation services. Strengthen Tele MANAS services with grassroots level awareness campaigns.
- ✓ **Strengthening eAushadhi/DVDMS:** Ensure continuous supply chain management of medicines at the AAM-SHC level.
- ✓ **Revision of Essential Drugs Lists (EDL):** Revise national and state EDLs based on local needs, with demand-based drug indenting tailored to local disease prevalence for efficient inventory management.

- ✓ **Diagnostic Services:** Ensure that minimum essential diagnostic tests are available at all facility levels per IPHS guidelines. Equip healthcare facilities with essential equipment and ensure regular maintenance. Ensure availability of diagnostics as per FDSI, either through strengthening in-house, or adopting PPP.
- ✓ **Sample Transportation System:** Establish a robust system for sample transportation to enhance service delivery.
- ✓ **Enhanced IEC Visibility:** Increase the visibility of Information, Education, and Communication (IEC) materials for expanded services, making them more pictorial for better understanding and avoiding overcrowding of IEC material.
- ✓ **NQAS Certification:** Address gaps for NQAS certification and improve the quality of care provided to patients.
- ✓ **Community Engagement:** Promote community engagement by accelerating the formation of Jan Arogya Samiti (JAS) and Mahila Arogya Samiti (MAS) associated with all the health facilities, fostering collaboration between healthcare providers and community members to address local healthcare needs effectively.

These targeted interventions aim to enhance the effectiveness and reach of AAM across India, ensuring comprehensive service delivery and improved health outcomes.

In conclusion, the transformation of SHCs/PHCs/UPHCs through AAM is a commendable step towards universal health coverage in India. By implementing the recommended measures, such as enhancing teleconsultation services, digitalizing record maintenance, ensuring robust supply chain management, and promoting community engagement, the effectiveness and reach of AAM can be significantly enhanced, ultimately leading to improved healthcare outcomes across the nation.

REFERENCES

1. Ministry of Health & Family Welfare. INDIAN PUBLIC HEALTH STANDARDS Health and wellness centre Sub health centre, Volume IV, 2022.
2. AYUSHMAN BHARAT Operational Guidelines for Comprehensive Primary Health Care through Health and Wellness Centers, NHSRC, Govt. of India, 2018.
3. Ved RR, Gupta G, Singh S. India's health and wellness centres: realizing universal health coverage through comprehensive primary health care. WHO South East Asia J Public Health. 2019 Apr 1;8(1):18–20.
4. Solanki HK, Rath RS, Silan V, Singh S V. Health and wellness centers: a paradigm shift in health care system of India? Int J Community Med Public Health. 2020 Jan 28;7(2):799.
5. Lahariya C. Health & Wellness Centers to Strengthen Primary Health Care in India: Concept, Progress and Ways Forward. Vol. 87, Indian Journal of Pediatrics. Springer; 2020. p. 916–29.
6. Gandhi Pa, Nangia R, Thakur J. Health and Wellness Centres as a strategic choice to manage noncommunicable diseases and universal health coverage. Int J Noncommun Dis. 2022;7(3):104.
7. Bajpai N, Wadhwa M. Health and Wellness Centres: Expanding Access to Comprehensive Primary Health Care in India. 2019.
8. Hallad JS, Channakki HR, Vatahati SR. An Assessment of Implementation of CPHC through Ayushman Bharat Health and Wellness Centres in Karnataka and Goa. 2020.
9. Panda SK, Panda D, Behera RR, Panda SC, Munda A, Sahu PR. Assessment of Functioning of Health and Wellness Centers of Western Odisha: A Cross-Sectional Study. Cureus. 2023 Apr 17;
10. Rathod H, Pithadia P, Patel D, Goswami M, Parmar D, Kotecha I. Assessment of functioning of Health and Wellness Centers in a district of Western Gujarat. Healthline. 2020
11. Prinja S, Kotwal A. Enablers and barriers to work performance: A mixed methods assessment of Ayushman Bharat-Health and Wellness

Centres in Punjab state of India Swarupa N Kshirsagar. Available from: <https://doi.org/10.22541/au.167960344.41737110/v1>

12. Sood A, Kumar D, Kumar A, . S, Sood A, . N. Assessment of health and wellness centres in hilly district of Himachal Pradesh. *Int J Community Med Public Health*. 2021 Nov 24;8(12):5852.
13. Brar S, Purohit N, Singh G, Prinja S, Kaur M, Lakshmi PM. Health system readiness for roll out of the Ayushman Bharat health and wellness centres – Early experiences from Punjab State. *J Family Med Prim Care*. 2022;11(4):1354.
14. Hannah E, Dumka N, Bora D, Roy A, Kotwal A. Rapid assessment of NCD services rollout in Health and Wellness Centres in North-Eastern Indian state: A cross- sectional study. *J Family Med Prim Care*. 2023;12(3):466.
15. Abhishek S, Garg S, Keshri VR. How useful do communities find the health and wellness centres? A qualitative assessment of India's new policy for primary health care. *BMC Primary Care*. 2024 Dec 1;25(1).
16. Dandsena A, Panda P, Rath J, Panigrahi AK. Factors Influencing Utilization of Health and Wellness Centers (HWCs) in Odisha: A Mixed Method Study from Beneficiaries' Perspective. *CHRISMED Journal of Health and Research*. 2023 Oct;10(4):297–306.
17. Ministry of Health & Family Welfare. Ayushman Bharat Health and Wellness Centres Assessment In 18 States Consolidated Report, March 2022.
18. Assessment of Comprehensive Primary Healthcare Services through Health and Wellness Centres in Odisha [Internet]. 2020. Available from: www.phfi.org
19. Jammu I, Khursheed Ahmad Muneer Ahmad S. Srinagar (J&K) Concurrent Evaluation of HWCs in Jammu & Kashmir. Population Research Centre. 2020.
20. Atal Bihari Vajpayee Institute of Good Governance and Policy Analysis. Arogyam Kendra, Health and Wellness centres in Madhya Pradesh: An Assessment [Internet]. State Health Resource Centre, June 2021.
21. AB-HWC. Official Website Ayushman Bharat | HWC. Available from: <http://ab-hwc.nhp.gov.in/>.

ANNEXURES

ANNEXURE 1: AAM Field visit tool

Ayushman Arogya Mandir Field Visit Tool

A. General Information		B. Facility Details	
1. Date of visit:		1. Facility Name:	
2. State:		2. Type of Facility (SHC/ PHC/ UPHC):	
3. District:		3. Linked PHC-AAM (for SC-AAM):	
4. Block:		4. Is facility NQAS / Kayakalp certified:	
5. Respondent designation: MO /CHO		5. Details of co-location (if applicable):	
6. Name/ Designation of the facility in-charge:		6. NIN ID:	
7. Data collected by:		7. Days of functioning	
8. Month & Year of operationalization as AAM:		8. Timing of functioning	

C. Community and Demographic details	
1. No of villages/ ward in the facility catchment:	
2. No. of households:	
3. Population covered:	
4. No. of eligible couples:	
5. Population above 30+ years	
6. Number of Pregnant women registered at time of visit	
7. Number of children 0-5 years	
8. Number of adolescents	
9. Number of elderly	
10. Number of ASHAs linked to the facility	
11. Number of ASHA Facilitators	

1	Status of Infrastructure	Yes/No/ Partially
1.1	Status of building ownership (Government Owned/ Rented/ Panchayat Building/ Others (Specify)	

1	Status of Infrastructure	Yes/No/ Partially
1.2	Presence of boundary wall	
1.3	External branding undertaken as per guidelines	
1.4	Accessibility provisions for elderly/ people with disabilities (ramps at entry, wheel chairs etc.)	
1.5	Continuous electricity supply including power backup of 8 hours	
1.6	Availability of potable water supply 24X7	
1.7	Adequate space for patient examination with privacy	
1.8	Adequate waiting space with seating arrangement for 20 users	
1.9	Adequate dedicated space for laboratory/ diagnostics services	
1.10	Adequate dedicated space for pharmacy/ medicine dispensation	
1.11	Adequate dedicated space/ room identified for Wellness activities including Yoga sessions (list all the places utilized for wellness activities)	
1.12	Functional toilet facilities-separate for male and female	
1.13	Display of Patient charter at the facility	
1.14	Display of health promotion / IEC material at the facility	
1.15	Deep burial/ sharps pit for BMW Management	
1.16	Are residential facilities for staff available within premises	

2	Human resource at AAMs	Posted	Vacant
2.1	Community Health Officer (CHO)/ MLHP		

2.2	Medical Officer - MBBS		
2.3	Medical Officer - AYUSH (mention specialization)		
2.4	Staff Nurse		
2.5	Lab Technician (Mention if LT is giving all lab services / program specific)		
2.6	Pharmacist		
2.7	MPW- F/ ANM		
2.8	MPW-M		
2.9	Any other, please specify		

3	Training on expanded service package (Yes/ No)	M O		S N		CH O	A N M / M P W - F			M P W - M			ASH A/C HW		
		PHC	U-PHC	PHC	U-PHC	SHC	SHC	PHC	U-PHC	SHC	PHC	U-PHC	SHC	PHC	U-PHC
3 . 1	CHO Induction Training														
3 . 2	Reproductive, Maternal, Newborn, Child and Adolescent Health Service														

	es														
3 . 3	Com munic able Disea ses														
3 . 4	NCD														
3 . 5	Eye Care														
3 . 6	Oral Care														
3 . 7	ENT Care														
3 . 8	Elderl y Care														
3 . 9	Palliat ive Care														
3 . 1 0	MNS Care														
3 . 1 1	Emer gency Care														
3 . 1 2	Any other, specif y														

4	Availability of Essential Medicines <i>Ask State/ District to share State-specific EML – compare with National EML</i>	Response
4.1	Number of essential medicines available at the facility at the time of visit	
4.2	Display of updated Essential Medicines at the facility (Yes/No)	
4.3	Specify the essential medicine(s) out of stock at the facility at the time of	

	visit Reasons to be noted in the ‘Remarks’ column.	
4.4	Specify the medicine(s) with frequent stockout episodes in the last financial year (2023-24). Reasons to be noted in the ‘Remarks’ column.	
4.5	Duration for which medicines are dispensed to patients with chronic conditions like DM/ HTN/ etc.?	
4.6	Is DVDMS or any other State system being used for indenting drugs? (Yes/No)	
4.7	How much time does it take to receive drugs at the facility after indenting?	
4.8	Are AYUSH medicines available? (Yes/ No)	

5	Availability of Essential Diagnostics <i>Ask State/ District to share State-specific list of Diagnostics, if any</i>	Response
5.1	Are the diagnostic services delivered through ‘In-house’ mode / ‘PPP’ mode / Hybrid mode? -- Specify	
5.2	Is there an updated list of diagnostic tests displayed at the facility (Yes/No)	
5.3	Number of essential tests available/performed at the facility	
5.4	Number of tests done through a public hub-and-spoke model	
5.5	Number of diagnostic tests outsourced to PPP	
5.6	Does the facility have the minimum number of equipment as per IPHS (SHC-12/ PHC-46)	
5.7	Does the facility have regular preventive maintenance/ calibration either through PPP or In-house service engineer	
5.8	Are the healthcare staff aware of Toll Free Number for	

	lodging complaints for equipment failure.	
5.9	Is sample transport system available (Yes/No). Elaborate in remarks	

6	Provision of essential services related to 12 packages under CPHC (Yes/No) and details of services being provided.	Response
1.	Care in Pregnancy and Childbirth	
a.	Is the facility a delivery point? (Yes/No)	
b.	List of high-risk pregnancies maintained and followed up	
c.	Common ailments / complaints by ANCs/ patients	
d.	Adequate IEC/ Health Promotion Material at the facility	
2.	Neo-natal and Infant Health Care Services	
a.	Common ailments / complaints for which infants are brought	
b.	Immunization services (ANM register)	
c.	Any children with congenital anomalies, disabilities and developmental delays identified or followed up	
d.	Adequate IEC/ Health Promotion Material at the facility	
3.	Childhood and Adolescent Health Care Services	
a.	Any SAM cases identified or referred and followed up	
b.	Whether CHO/ MO undertakes health talks in schools (Yes/No), details of recent one can be added in remarks	
c.	Common concerns / complaints for which adolescents come to AAM	

6	Provision of essential services related to 12 packages under CPHC (Yes/No) and details of services being provided.	Response
d.	Adequate IEC/ Health Promotion Material at the facility	
4.	Family Planning, Contraceptive Services and other Reproductive Health Care Services	
a.	Common concerns / complaints regarding FP services in community	
b.	Preferred methods of FP (may be added in remark)	
c.	Adequate IEC/ Health Promotion Material at the facility	
5.	Management of Communicable Diseases	
a.	Common communicable diseases/ ailments in the community	
b.	Any presumptive TB case referred for testing (check TB register)	
c.	Any notified TB cases in the catchment area (if yes check the register or Nikshay portal), and cases followed post treatment Adequate IEC/ Health Promotion Material at the facility	
6.	Out-patient Care for Acute Simple Illnesses and Minor Ailments	
a.	Common diseases/ minor ailments/ acute simple illnesses reported	
b.	Adequate IEC/ Health Promotion Material at the facility	
7.	Screening, Prevention, Control and Management of Non-Communicable Diseases	
a.	Common NCDs prevalent in the community	
b.	Use of revised CBAC form by ASHAs for risk assessment (Yes/No)	
c.	Have CBAC forms been	

6	Provision of essential services related to 12 packages under CPHC (Yes/No) and details of services being provided.	Response
	digitized (Yes/ No/ Partly)	
d.	Provision of services related to NCD conditions- at the facility (Yes/No/ Partly): Screening, Diagnosis, Follow-up care, Medicine dispensation	
e.	Adequate IEC/ Health Promotion Material at the facility	
8.	Basic Oral Health Care	
a.	Common oral health issues patients come with.	
b.	Which oral healthcare services are provided here	
c.	Adequate IEC/ Health Promotion Material at the facility	
9.	Eye and ENT Care	
a.	Common eye concerns/ ailments patients come with.	
b.	Which eye healthcare services are provided here	
c.	Common ENT concerns/ ailments issues patients come with.	
d.	Which ENT healthcare services are provided here	
e.	Adequate IEC/ Health Promotion Material at the facility	
10.		
a.	Common mental health/ neurological and substance use related concerns/ ailments patients come with.	
b.	Patients diagnosed with mental health concerns being followed up	
c.	Are patients with mental health issues linked to TeleMANAS? (Y/N)	
d.	Adequate IEC/ Health	

6	Provision of essential services related to 12 packages under CPHC (Yes/No) and details of services being provided.	Response
	Promotion Material at the facility	
11.	Elderly and Palliative Care Services	
a.	Common concerns / complaints/ needs shared by geriatric patients	
b.	Common conditions/ needs shared by patients on palliative care	
c.	List of bed ridden patients in the area maintained and followed up	
d.	Adequate IEC/ Health Promotion Material at the facility	
12.	Emergency Medical Services including Burns and Trauma	
a.	Common emergencies / trauma-related concerns patients come with	
b.	Availability of burn/ injuries / first aid services (Yes/No)	
c.	Availability of animal bites treatment services (Yes/No)	
d.	Adequate IEC/ Health Promotion Material at the facility	

7.	Tele-consultation Services	Response
7.1	Availability of Teleconsultation services (Yes/ No)	
7.2	Functionality of IT infrastructure- Tablet/ laptop/ desktop for reporting and tele-consultation (<i>Specify which</i>)	
7.3	Availability of network/ data connection for teleconsultation	
7.4	Specify mode of implementation (Hub & spoke/ online platform) (<i>e-sanjeevani or any other</i>)	

	<i>state specific platform)</i>	
7.5	Specify hub facility for teleconsultation services	
7.6	Common conditions for which teleconsultation is initiated/ patients demand teleconsultation	

8	Referral Linkages	Response
8.1	Is the referral mechanism defined and displayed in the health centre? (Yes/No)	
8.2	Specify referral facility / facilities and transport for:	
a.	High risk pregnancies	
b.	Neonates and infants	
c.	Suspected TB patients	
d.	NCD patients needing higher management	
e.	Emergency and trauma care	
f.	Mental health and neurological diseases	
g.	Any others	

9.	Specify the HR using the IT Apps for data reporting	Response
9.1	AAM Portal	
9.2	HMIS portal	
9.3	National NCD portal / National NCD App	
9.4	RCH Portal	
9.5	ANMOL App	
9.6	IHIP/IDSP portal	
9.7	Nikshay Portal	
9.8	Sickle Cell App	
9.9	State Specific Portal, specify	
9.10	Any other, specify	
9.11	Any other, specify	
9.12	Any other, specify	

10	Financial (FY 2023-24)	Response
10.1	Is JAS constituted for the centres and when was it constituted? <i>If yes members list to be checked</i>	
10.2	Untied funds received for FY	

	2023-24 (Yes/No) – Amount to be specified	
10.3	Untied funds utilized in FY 2023-24– Amount to be specified	
10.4	Activities for which untied funds were utilised in the previous month	
10.5	State specific untied funds, if any (Yes/No)	

11	Support and Monitoring <i>Record the feedback from SHC-AAM staff on the following</i>	Response
11.1	Monitoring visits by MO at SHC-AAM	
11.2	Monthly meetings by MO at PHC/ UPHC- AAM	
11.3	Support by the district (specify)	

12.	List of registers to be reviewed at the facility (Nos. 1-11 are required as per NQAS)	Registered Maintained? (Yes/ No)
1.	OPD Register	
2.	Lab Register	
3.	Stock and Expenditure register (Drugs & consumables)	
4.	Referral register	
5.	Follow up Register	
6.	Quality Team Minutes of Meeting register	
7.	Training register	
8.	All meeting Register (JAS, VHSND, ASHA)	
9.	Daily Attendance register	
10.	Duty Roster/Duty plan for outreach activities	
11.	Outcome Indicator	
12.	NCD Register	
13.	Filled CBAC forms	
14.	Filled Family folders	
15.	TB register	
16.	Any other, specify	
17.	Any other, specify	
18.	Any other, specify	
	Total Number of	

	Registers Maintained:	
--	------------------------------	--

1 1	Indicator / Parameter	Ja n 20 24	Fe b 20 24	Ma rch 202 4	Data Source
1.	OPD attendance/ footfall at the AAM: Allopathic				OPD register
2.	OPD attendance/ footfall at the AAM: AYUSH				OPD register
3.	No. of ANC patients (new and old)				ANC register
4.	Number of deliveries conducted (if delivery point)				NCD Register
5.	No. of suspected TB patients on treatment				NCD Register
6.	No. of patients diagnosed by MO with DM at AAM				NCD Register
7.	No. of patients given medicines for DM at AAM				NCD Register
8.	No. of patients diagnosed by MO with HTN at AAM				NCD Register
9.	No. of patients given medicines for HTN at AAM				NCD Register
10.	No. of patients screened for Oral cancer at				NCD Register

1 1	Indicator / Parameter	Ja n 20 24	Fe b 20 24	Ma rch 202 4	Data Source
	AAM				
11.	No. of patients referred for Oral cancer diagnosis				NCD Register, Referral Register
12.	No. of patients screened for Breast cancer at AAM				NCD Register
13.	No. of patients referred for Breast cancer diagnosis				NCD Register, Referral Register
14.	No. of patients screened for Cervical cancer at AAM				NCD Register
15.	No. of patients referred for Cervical cancer diagnosis				NCD Register, Referral Register
16.	No. of patients with eye related complaints				OPD register
17.	No. of patients with ENT related complaints				OPD register
18.	No. of patients with MNS related complaints				OPD register
19.	No. of patients with Emergency/ Trauma				OPD register
20.	No. of patients with oral health				OPD register

1 1	Indicator / Parameter	Ja n 20 24	Fe b 20 24	Ma rch 202 4	Data Source
	related complaints				
21.	No. of elderly patients with any complaints				OPD register
22.	No. of palliative care patients home visited				Home visit records
23.	No. of teleconsultations done				Tele consultation/ e-Sanjeevani records
24.	No. of lab tests done				Lab register
25.	No. of wellness sessions conducted				Facility records
26.	No. of health promotion activities conducted				Facility records
27.	Number of Home visits done by CHO at AAM-SHC				Home visit records
28.	Number of Home visits done by ANM at AAM-SHC				ASHA/ ANM records
29.	No. of patients referred to a higher centre				Referral Register
30.	No. of meetings conducted by JAS				JAS Meeting Records
31.	No. of				VHND

1 1	Indicator / Parameter	Ja n 20 24	Fe b 20 24	Ma rch 202 4	Data Source
	VHND organized				records
32.	No. of VHSNC meetings conducted				Meeting records
33.	No. of MAS meetings conducted				Meeting records

E. SUMMARY

E.	Overall adherence to the functionality criteria of AAM	Response (Yes/ No/ Partial)
1.	Availability of HR (CHO + 2 ANM / 1 ANM and 1 MPW-M at SHC-AAM and MBBS MO + SN at PHC/ UPHC AAM)	
2.	Completion of training of Primary Healthcare team on all packages	
3.	Availability of essential medicines	
4.	Availability of essential diagnostics	
5.	Infrastructure strengthening including branding	
6.	Facilities for basic care in Pregnancy and Childbirth	
7.	Facilities for basic Neo-natal and Infant Health Care Services	
8.	Facilities for basic Childhood and Adolescent Health Care Services	
9.	Facilities for basic Family Planning, Contraceptive Services and other Reproductive Health Care Services	
10.	Facilities for basic management of Communicable Diseases	
11.	Facilities for basic Out-patient Care for Acute Simple Illnesses and Minor Ailments	
12.	Facilities for Screening, Prevention, Control and basic Management of Non-	

E.	Overall adherence to the functionality criteria of AAM	Response (Yes/ No/ Partial)
	Communicable Diseases	
13.	Facilities for Basic Oral Health Care	
14.	Facilities for basic Eye and ENT Care	
15.	Facilities for Screening and Basic Management of Mental Health Ailments, Neurological diseases and Substance Use	
16.	Facilities for basic Elderly and Palliative Care Services	
17.	Facilities for basic / first aid Emergency Medical Services including Burns and Trauma	
18.	Provision of teleconsultation services	
19.	Use of IT applications for CPHC	
20.	Wellness activities (including Yoga)	
21.	Maintenance of registers	
22.	Payment of incentives to ASHAs	

ANNEXURE 2A: DRUGS AT AAM-SHC

AYUSHMAN AROGYA MANDIR FIELD VISIT

ANNEXURE: DRUGS AT SUB-CENTRE (AAM-SHC)

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
Anesthetic Agent			
1	Oxygen Gas for Inhalation		
2	Lignocaine Topical form 5%		
Non opioid Analgesic, Anti-Pyretic and Non steroidal Anti Inflammatory Medicines			
3	Aspirin (Acetylsalicylic acid) Tablet 75 mg		
4	Diclofenac Tablet 50 mg Diclofenac Injection 25 mg/ml		
5	Ibuprofen Tablet 200 mg		
6	Paracetamol tablet 250 mg Paracetamol Syrup 125 mg/5 ml Paracetamol Syrup 250 mg/5 ml		
Anti allergics and medicines used in Anaphylaxis			
7	Levocetirizine 5 mg Tablet Levocetirizine Oral Liquid		
8	Hydrocortisone Succinate Injection 100 mg		
9	Pheniramine Maleate Injection 22.75 mg/ml		
10	Adrenaline Injection 1 mg/ml (1:1000)		
Antidote and other Substances used in Poisoning			
11	Atropine Injection 1 mg/ml		
12	Activated Charcoal		
Anti Convulsant/Anti Epileptic Medicines			
13	Magnesium Sulfate Injection (50% solution), 2 ml ampoule		
14	Diazepam Tablet 5 mg Diazepam Tablet 10 mg Diazepam rectal suppository (Controlled Medicine)		
15	Midazolam Nasal Spray		
16	Phenobarbitone Tablet 30 mg Phenobarbitone Tablet 60 mg Phenobarbitone Oral Liquid 20		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
	mg/5 ml		
1 7	Phenytoin Tablet 50 mg Phenytoin Tablet 300 mg		
1 8	Sodium valproate Tablet 200 mg Sodium valproate Tablet 500 mg Sodium valproate Syrup each 5 ml contains 200 mg		
Intestinal Anthelmintics			
1 9	Albendazole Tablet 400 mg Albendazole Oral Liquid 200 mg/5 ml		
Anti - Filarial			
2 0	Diethylcarbamazine Tablet 100 mg Diethylcarbamazine Oral Liquid 120 mg/5 ml		
Anti - Bacterial			
2 1	Amoxicillin Capsule 250 mg, Amoxicillin Capsule 500 mg Amoxicillin Oral liquid 250 mg/5 ml Amoxicillin Dispersible Tablet 250 mg		
2 2	Gentamicin Injection 10 mg/ml Gentamicin Injection 80 mg/ml		
2 3	Tab Co-trimoxazole [Sulphamethoxazol 80 mg +Trimethoprim 400 mg] Tab.20 mg trimethoprim + 100 mg sulphamethoxazole Co- trimoxazole Oral Liquid [Sulphamethoxazole 200 mg + Trimethoprim 40 mg/5 ml]		
2 4	Doxycycline Capsule 100 mg		
2 5	Metronidazole Tablet 200 mg Metronidazole Tablet 400 mg		
2 6	Norfloxacin tab/oral liquid		
Anti-Leprosy Medicines			

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
27	Anti-leprosy medicines, As per current program guidelines (Adults and Pediatrics)		
Anti- Tuberculosis Medicines			
28	Anti-tuberculosis medicines, As per current program guidelines (Adults and Pediatrics)		
Anti Fungal Medicines			
29	Clotrimazole Pessary 100 mg Clotrimazole Vaginal Tablet Clotrimazole Drops 1% Clotrimazole Cream 1%		
30	Miconazole Ointment		
31	Fluconazole Tablet 150 mg		
Anti-Malarial Medicines			
32	Anti-malarial medicines, As per program guidelines (Adults and Pediatrics)		
Medicines used in Palliative Care			
33	Lactulose Oral Liquid 10g/15 ml		
34	Povidone Iodine Lotion and Ointment		
Anti - Anaemic Medicines			
35	Ferrous salt 100 mg + Folic acid 500 mcg Tablet Ferrous salt 20 mg + Folic acid 100 mcg Tablet Ferrous salt 60 mg + Folic acid 500 mcg Tablet Ferrous salt 45 mg + Folic acid 100 mcg Tablet Ferrous sulphate + Folic acid Syrup		
36	Folic acid Tablet 5 mg Folic acid Tablet 400 mcg		
37	Vitamin K Injection 1 mg/ml		
38	Hydroxyurea capsule 100mg, 300mg, 500mg		
Cardiovascular Medicines			
39	Isosorbide-5- mononitrate Tablet 5 mg		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
40	Atenolol Tablet 50 mg		
41	Metoprolol Tablet 25 mg Metoprolol SR Tablet 25 mg		
42	Isosorbide dinitrate Tablet 5 mg (sublingual)		
Anti - Hypertensive Medicines			
43	Amlodipine Tablet 2.5 mg Amlodipine Tablet 5 mg		
44	Enalapril Tablet 5 mg		
45	Telmisartan Tablet 40 mg		
46	Hydrochlorothiazide Tablet 12.5 mg Hydrochlorothiazide Tablet 25mg		
Hypolipidemic Medicines			
47	Atorvastatin Tablet 10 mg		
Medicines used in Dementia			
48	Alprazolam Tablet 0.25 mg Alprazolam Tablet 0.5 mg		
Dermatological Medicines (Topical)			
49	Silver sulphadiazine Cream 1%		
50	Betamethasone Cream 0.05%		
51	Calamine Lotion		
52	Benzyl Benzoate ointment/lotion		
53	Mupirocin Ointment		
54	Potassium Permanganate 0.1%		
55	Zinc Oxide cream 10%		
Disinfectants and Antiseptics			
56	Ethyl Alcohol (denatured)) Solution 70%		
57	Hydrogen Peroxide Solution 6%		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
58	Methylrosanilinium chloride (Gentian Violet)		
59	Bleaching Powder containing not less than 30% w/w of available chlorine (as per I.P)		
60	Gamma Benzene Hexachloride Lotion 100 ml		
61	Framycetin cream 0.5%		
Ear, Nose and Throat (ENT) Medicines			
62	Ciprofloxacin Drops 0.3 % Ciprofloxacin Tablet 250 mg Ciprofloxacin Tablet 500 mg		
63	Boro spirit ear drop		
64	Wax Solvent Ear Drops: Benzocaine, Chlorobutol, Paradichlorobenzene, and Turpentine Oil		
Gastrointestinal Medicines			
65	Ranitidine Tablet 150 mg Ranitidine Injection		
66	Omeprazole Capsule 20 mg		
67	Ondansetron Tablet 4 mg Ondansetron Oral Liquid 2 mg/5 ml Ondansetron Injection 2 mg/ml		
68	Ispaghula- Granules, Husk, Powder		
69	Oral Rehydration Salts Oral Rehydration Powder 27.5 gm WHO Formula		
70	Zinc sulphate Dispersible Tablet 20 mg Zinc sulphate syrup		
71	Dicyclomine Tablet 10 mg Dicyclomine Injection		
72	Diocetyl sulfosuccinate sodium		
73	Magnesium Hydroxide Liquid		
7	Senna Tablet, Granules, Powder		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
4			
7 5	Domperidone Tablet Domperidone Syrup		
Contraceptives			
7 6	Ethinylestradiol (A) + Levonorgestrel Tablet 0.03 mg (A) + 0.15 mg (B)		
7 7	IUCD 380A IUCD 375		
7 8	Male Condom		
7 9	Ormeloxifene Tablet 30 mg		
8 0	Levonorgestrel 1.5 mg		
8 1	Medroxyprogesterone acetate Injection 150 mg		
8 2	Family Planning medicines and commodities		
Medicines used in Diabetes Mellitus			
8 3	Glimepiride Tablet 2 mg		
8 4	Metformin Tablet 500 mg Metformin SR Tablet 500 mg		
8 5	Glibenclamide Tablet 2.5 mg Glibenclamide Tablet 5 mg		
Thyroid and Anti -Thyroid Medicine			
8 6	Levothyroxine Tablet 25 mcg Levothyroxine Tablet 50 mcg Levothyroxine Tablet 100 mcg		
Vaccines			
8 7	Immunological/Vaccines, As per Current Immunization Programme Guidelines		
8 8	Rabies Vaccine		
Oxytocic and Abortifacient Medicines			
8 9	Misoprostol Tablet 200 mcg		
Medicines Acting on Respiratory Tract			

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
90	Budesonide Respirator solution for use in nebulizer 0.5 mg/ml		
91	Salbutamol Tablet 2 mg Salbutamol Oral liquid 2 mg/5 ml Salbutamol Respirator solution for use in nebulizer 5 mg/ml		
92	Normal Saline nasal drop: sodium chloride drops 0.05% w/v		
93	Syrup Dextromethorphan		
94	Hyoscinebutylbromide Tablet 10 mg		
Solutions Correcting Water, Electrolyte Distribution and Acid-Base Distribution			
95	Ringer Lactate Injection (as per IP)		
96	Sodium Chloride Injection 0.9%		
97	Dextrose 5% Dextrose 25%		
Vitamins and Minerals			
98	Ascorbic acid (Vitamin C) Tablet 100 mg		
99	Calcium carbonate Tablet 500 mg		
100	Cholecalciferol Tablet 60000 IU		
101	Pyridoxine Tablet 25 mg Pyridoxine Tablet 50 mg Pyridoxine tablet 100 mg		
102	Vitamin A Oral liquid 100000 IU/ml		
103	B Complex Tablet		
Ophthalmological Medicines			
104	Sodium cromoglycate 2% eye drop		
1	Methylcellulose Eye Drops		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
05			
Diuretics Medicines			
106	Furosemide Injection Furosemide Tablet 40 mg		

ANNEXURE 2B: DRUGS AT AAM PHC/UPHC

AYUSHMAN AROGYA MANDIR FIELD VISIT

ANNEXURE: DRUGS AT PRIMARY HEALTH CENTRE (AAM-PHC/ UPHC)

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
Anesthetic Agent			
1	Oxygen Gas for Inhalation		
2	Lignocaine Injection 2% Lignocaine Topical form 2%		
3	Lignocaine Injection 2% + Adrenaline Injection 1:200000 (5 mcg/ml)		
4	Atropine Injection 0.6 mg/ml, 1 mg/ml		
5	Midazolam Injection 1 mg/ml		
6	Ketamine Injection 10 mg/ml		
7	Injection Thiopentane 500 mg		
8	Bupivacaine Injection 0.5 mg/ml (sensorcain)		
9	Neostigmine Injection 0.5 mg/ml		
10	Vecuronium Powder for Injection 4 mg		
11	Pentazocine Injection 30mg/ml		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
1			
Non opioid Analgesic, Anti-Pyretic and Non steroidal Anti Inflammatory Medicines			
1	Aspirin (Acetylsalicylic acid) Tablet 150 mg		
2	Aspirin (Acetylsalicylic acid) Tablet 75 mg		
1	Diclofenac Tablet 50 mg Diclofenac Injection 25 mg/ml		
3			
1	Ibuprofen Tablet 200 mg		
4			
1	Ibuprofen Oral Liquid 100 mg/5 ml, 50 ml bottle		
5			
1	Paracetamol Tablet 500 mg,		
6	Paracetamol Tablet 100 mg Paracetamol Syrup 125 mg/5 ml Paracetamol Suppository 100 mg		
Anti allergics and medicines used in Anaphylaxis			
1	Levocetirizine Tablet 5mg		
7	Levocetirizine Oral liquid 2.5 mg/5 ml (Paediatric Use)		
1	Chlorpheniramine Tablet 4 mg		
8			
1	Dexamethasone Tablet 0.5 mg		
9	Dexamethasone Injection 4 mg/ml		
2	Hydrocortisone Succinate Injection 100 mg		
0			
2	Pheniramine Maleate Injection 22.75 mg/ml		
1			
2	Prednisolone Tablet 5 mg		
2	Prednisolone Oral liquid 5 mg/5 ml		
2			
3	Hydroxyzine oral syrup		
2			
4	Betamethasone Injection 4 mg/ml		
Antidote and other Substances used in Poisoning			
2	Activated Charcoal		
5			
2	Calcium gluconate Injection 100 mg/ml		
6			

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
2 7	Snake Venom Antiserum a) Soluble/Liquid Polyvalent b) Lyophilised Polyvalent		
Anti Convulsant/Anti Epileptic Medicines			
2 8	Magnesium Sulfate Injection (50% solution), 2 ml ampoule		
2 9	Diazepam Oral liquid 2 mg/5 ml Diazepam Injection 5 mg/ml Diazepam Tablet 5 mg		
3 0	Phenobarbitone Tablet 30 mg Phenobarbitone oral liquid 20 mg/5 ml		
3 1	Phenytoin Tablet 50 mg Phenytoin Tablet 300 mg Phenytoin ER Tablet 300 mg Phenytoin Injection 25 mg/ml		
3 2	Sodium valproate Tablet 250 mg Sodium valproate Tablet 500 mg Sodium valproate Syrup each 5 ml contains 200 mg		
3 3	Midazolam Nasal Spray		
3 4	Carbamazepine Tablet 100 mg Carbamazepine Tablet 200 mg		
3 5	Diphenylhydantoin Tablet 100 mg		
Intestinal Anthelmintics			
3 6	Albendazole Tablet 400 mg Albendazole Oral Liquid 200 mg/5 ml		
Anti - Filarial			
3 7	Diethylcarbamazine Tablet 100 mg Diethylcarbamazine Oral Liquid 120 mg/5 ml		
Anti - Bacterial			
3 8	Amoxicillin Capsule 250 mg Amoxicillin Capsule 500 mg Amoxicillin Oral liquid 250 mg/5 ml		
3 9	Amoxicillin 500 mg + Clavulanic acid 125 mg Tablet		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
4 0	Azithromycin Tablet 250 mg Azithromycin Tablet 500 mg Azithromycin Oral Liquid 200 mg/5 ml		
4 1	Ciprofloxacin Tablet 250 mg Ciprofloxacin Tablet 500 mg Ciprofloxacin Oral liquid 250 mg/5m		
4 2	Cefixime Tablet 200 mg Cefixime Oral liquid 50 mg/5 ml Cefixime Oral liquid 100 mg/5 ml		
4 3	Tab Co-trimoxazole [Sulphamethoxazol 80 mg +Trimethoprim 400 mg] Tab.20 mg trimethoprim + 100 mg sulphamethoxazole Co- trimoxazole Oral Liquid [Sulphamethoxazole 200 mg + Trimethoprim 40 mg/5 ml]		
4 4	Gentamicin Injection 10 mg/ml Gentamicin Injection 80 mg/ml		
4 5	Doxycycline Capsule 100 mg Doxycycline Dry Syrup 50 mg/5 ml		
4 6	Norfloxacin tab/oral liquid		
4 7	Tablet Penicillin V (Phenoxymethyl Penicillin) 250 mg		
4 8	Benzyl penicillin Powder for Injection 10 lac units		
4 9	Cefazolin Powder for Injection 500 mg Cefazolin Powder for Injection 1 gm		
5 0	Cefotaxime Injection 250 Cefotaxime Injection 500 mg Cefotaxime Injection 1 g		
5 1	Ceftriaxone Powder for Injection 250 mg Ceftriaxone Powder for Injection 500 mg Ceftriaxone Powder for Injection 1 g		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
Anti - Leprosy Medicines			
5 2	Anti-leprosy medicines, As per current program guidelines (Adults and Pediatrics)		
Anti- Tuberculosis Medicines			
5 3	Anti-tuberculosis medicines, As per current program guidelines (Adults and Pediatrics)		
Anti-Fungal Medicines			
5 4	Clotrimazole Pessary 100 mg Clotrimazole Vaginal Tablet Clotrimazole Drops 1% Clotrimazole Cream 1%		
5 5	Fluconazole Tablet 150 mg		
5 6	Miconazole ointment Miconazole Tablet		
Anti-Protozoal Medicines			
5 7	Metronidazole Tablet 200 mg Metronidazole Tablet 400 mg Metronidazole Oral liquid 200 mg/5 ml		
Anti-Malarial Medicines			
5 8	Anti-malarial medicines, As per program guidelines (Adults and Pediatrics)		
Medicines used in Palliative Care			
5 9	Amitriptyline Tablet 10 mg/25 mg		
6 0	Lactulose Oral Liquid 10g/15 ml		
6 1	Tramadol capsule 50 mg		
6 2	Povidone Iodine Lotion and Ointment		
6 3	Ethamsylate Tablet		
6 4	Deriphyllin Tablet SR		
Anti- Parkinsonism Medicines			
6 5	Levodopa (A) + Carbidopa (B) 100 mg (A) + 10 mg (B)		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
Anti- Anaemia Medicines			
6 6	Ferrous salt 100 mg + Folic acid 500 mcg Tablet Ferrous salt 60mg + Folic acid 500 mcg Tablet Ferrous salt 45 mg + Folic acid 100 mcg Tablet Ferrous salt 20 mg + Folic acid 100 mcg Tablet		
6 7	Folic acid Tablet 5 mg Folic acid Tablet 400 mcg		
6 8	IFA Syrup		
6 9	Phytomenadione Injection 10 mg/ml		
7 0	Clopidogrel Tablet 75 mg		
7 1	Diltiazem Tablet 60 mg Diltiazem SR Tablet 90 mg		
7 2	Isosorbide-5- mononitrate Tablet 5 mg		
7 3	Metoprolol Tablet 25 mg Metoprolol SR Tablet 25 mg Metoprolol SR Tablet 50 mg		
7 4	Isosorbide dinitrate Tablet 5 mg (sublingual)		
7 5	Dopamine Injection 40 mg/ml		
7 6	Hydroxyurea capsule 100mg, 300mg, 500mg		
Anti - Hypertensive Medicines			
7 7	Amlodipine Tablet 2.5 mg Amlodipine Tablet 5 mg		
7 8	Enalapril Tablet 5 mg		
7 9	Hydrochlorothiazide Tablet 12.5 mg Hydrochlorothiazide Tablet 25mg		
8 0	Labetalol Tablet 100 mg Labetalol Injection 5 mg/ml		
8 1	Methyldopa Tablet 250		
8 2	Telmisartan Tablet 40 mg		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
Medicines used in Shock and Heart Failure			
8 3	Adrenaline injection 1mg/ml		
Hypolipidemic Medicines			
8 4	Atorvastatin Tablet 10 mg		
Dermatological Medicines (Topical)			
8 5	Framycetin cream 0.5%		
8 6	Silver sulphadiazine Cream 1%		
8 7	Calamine Lotion		
8 8	Betamethasone Cream 0.1%		
8 9	Benzoyl peroxide Gel 2.5%		
9 0	Benzyl Benzoate ointment/lotion		
9 1	Mupirocin Ointment		
9 2	Potassium Permanganate 0.1%		
9 3	Zinc Oxide cream 10%		
9 4	Fusidic Acid Cream 5 mg/10 gm preparation 2% or 20 mg per gram Fusidic Acid Cream 2%: 5 mg/10 mg preparation		
9 5	Permethrin Cream 5%		
Disinfectants and Antiseptics			
9 6	Cetrimide Solution 20% (concentrate for dilution)		
9 7	Chlorhexidine Solution 5% (concentrate for dilution)		
9 8	Ethyl Alcohol (denatured)		
9 9	Hydrogen Peroxide Solution 6%		
1 0	Methylrosanilinium chloride (Gentian Violet)		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
0			
1 0 1	Bleaching Powder containing not less than 30% w/w of available chlorine (as per I.P)		
1 0 2	Gamma Benzene Hexachloride Lotion 100 ml		
Diuretics Medicines			
1 0 3	Furosemide Tablet 40 mg Furosemide Injection 10 mg/ml		
1 0 4	Mannitol Injection 10% Mannitol Injection 20%		
Ear, Nose and Throat (ENT) Medicines			
1 0 5	Xylometazoline Nasal drops 0.05 % Xylometazoline Nasal drops 0.1 %		
1 0 6	Wax Solvent Ear Drops: Benzocaine, Paradichlorobenzene, Turpentine Oil		
1 0 7	Combo Ear Drops- Chloramphenicol 5% w/v + Clotrimazole 1% +Lignocaine Hydrochloride 2%		
1 0 8	Normal Saline nasal drop: sodium chloride drops 0.05% w/v		
1 0 9	Boro spirit ear drop		
1 1 0	Ofloxacin Tablet 200 mg Ofloxacin Tablet 400 mg		
Gastrointestinal Medicines			
1 1 1	Omeprazole Capsule 20 mg		
1 1 2	Ranitidine injection		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
1 1 3	Metoclopramide Tablet 10 mg, Metoclopramide Oral Liquid 5 mg/5 ml Metoclopramide Injection 5 mg/ml		
1 1 4	Ondansetron Tablet 4 mg Ondansetron Oral Liquid 2 mg/5 ml Ondansetron Injection 2 mg/ml		
1 1 5	Domperidone Tablet 10 mg Domperidone Oral Suspension 1 mg/ml; 30 ml bottle or 5 ml drops containing 10 mg/ml		
1 1 6	Hyoscinebutylbromide Tablet 10 mg Hyoscinebutylbromide Injection 20 mg/ml		
1 1 7	Ispaghula- Granules, Husk, Powder		
1 1 8	Drotaverine Tablet 500 mg		
1 1 9	Bisacodyl Tablet 5 mg Bisacodyl Suppository 5 mg		
1 2 0	Oral Rehydration Salts Oral Rehydration Powder 27.5 gm WHO Formula		
1 2 1	Zinc sulphate Dispersible Tablet 20 mg Zinc sulphate syrup		
1 2 2	Dicyclomine Tablet 10 mg		
1 2 3	Senna Tablet, Granules, Powder		
1 2 4	Diocetyl sulfosuccinate sodium		
1 2 5	Magnesium Hydroxide Liquid		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
1 2 6	Sucralfate Tablet 10 mg Sucralfate Oral Liquid 1 mg/ml		
1 2 7	Hyoscinebutylbromide Tablet 500 mg		
Medicines used in Diabetes Mellitus			
1 2 8	Glimepiride Tablet 2 mg		
1 2 9	Metformin Tablet 500 mg Metformin SR Tablet 500 mg		
1 3 0	Insulin (Soluble) Injection 40 IU/ml		
1 3 1	Premix Insulin 30:70 Injection (Regular: NPH) Premix Insulin 30:70 Injection 40 IU/ml		
1 3 2	Glibenclamide Tablet 2.5 mg Glibenclamide Tablet 5 mg		
1 3 3	Glucose Packet 75 mg for OGTT Test		
Thyroid and Anti-Thyroid Medicines			
1 3 4	Levothyroxine Tablet 25 mcg Levothyroxine Tablet 50 mcg Levothyroxine Tablet 100 mcg		
Vaccines			
1 3 5	Immunological/Vaccines, As per Current Immunization Programme Guidelines		
1 3 6	Rabies Vaccine Anti Rabies serum		
Oxytocic & Abortifacients Medicines			
1 3 7	Misoprostol Tablet 200 mcg		
1	Oxytocin Injection 5 IU/ml		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
3 8			
1 3 9	Nifedipine Tablet 10 mg		
1 4 0	Methylethergometrine Injection 0.2 mg/ml		
Psychotherapeutic Medicines			
1 4 1	Alprazolam Tablet 0.25 mg		
1 4 2	Clonazepam Tablet 0.5 mg		
1 4 3	Olanzapine Tablet 5 mg		
Medicines Acting on Respiratory Tract			
1 4 4	Budesonide Inhalation (MDI/DPI) 100 mcg/dose Budesonide Respirator solution for use in nebulizer 0.5 mg/ml		
1 4 5	Salbutamol Tablet 2 mg Salbutamol Oral liquid 2 mg/5 ml Salbutamol Respirator solution for use in nebulizer 5 mg/ml		
1 4 6	Montelukast Tablet Montelukast syrup		
1 4 7	Syrup Dextromethorphan		
1 4 8	Syrup Bromhexine Hydrochloride		
1 4 9	Syrup Pheniramine Maleate		
1 5 0	Ipratropium Inhalation (MDI/DPI) 20 mcg/dose Ipratropium Respirator solution for		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
	use in nebuliszer 250 mcg/ml		
Solutions Correcting Water, Electrolyte Distribution and Acid-Base Distribution			
1 5 1	Ringer Lactate Injection (as per IP)		
1 5 2	Sodium Chloride Injection 0.9%		
1 5 3	Pediatric solution like Isolyte P, N/2 & N/5		
1 5 4	Potassium chloride Oral liquid 500 mg/5 ml		
1 5 5	Dextrose 5% Dextrose 25%		
Vitamins and Minerals			
1 5 6	Ascorbic acid (Vitamin C) Tablet 100 mg		
1 5 7	Calcium carbonate Tablet 500 mg		
1 5 8	Cholecalciferol Tablet 60000 IU		
1 5 9	Pyridoxine Tablet 25 mg Pyridoxine Tablet 50 mg Pyridoxine tablet 100 mg		
1 6 0	Vitamin A Oral liquid 100000 IU/ml		
1 6 1	B Complex Tablet, B Complex Injection		
Ophthalmological Medicines			
1 6 2	Lignocaine Eye Drops 4%		

S · N o ·	Drug Name	Is the dru g Ava ilab le? (Yes / No)	Any remark s/ specifi c reason for unavai lability ?
1 6 3	Tropicamide Eye Drops 1%		
1 6 4	Ciprofloxacin Drops 0.3% Ciprofloxacin Eye/Ear Drops		
1 6 5	Sodium cromoglycate 2% eye drop		
1 6 6	Methylcellulose Eye Drops		
Contraceptives			
1 6 7	Ethinylestradiol (A) + Levonorgestrel (B) Tablet 0.03 mg (A) + 0.15 mg (B) Tablet 0.03 mg (A) + 0.15 mg (B) with Ferrous Fumarate		
1 6 8	IUCD 380A IUCD 375		
1 6 9	Male Condom		
1 7 0	Ormeloxifene Tablet 30 mg		
1 7 1	Levonorgestrel 1.5 mg		
1 7 2	Medroxyprogesterone acetate Injection 150 mg		

ANNEXURE 3A: DIAGNOSTIC TESTS AT AAM-SHC

Ayushman Arogya Mandir Field Visit Tool

Annexure: Sub-centre AAM

Sl	Test Name	Available	Not available
1	Hemoglobin		
2	Human chorionic gonadotropin (HCG) (Urine test for pregnancy)		
3	Urine test for ph, specific gravity, Leucocyte esterase glucose, bilirubin, urobilinogen, ketone, hemoglobin, protein, nitrite		
4	Blood sugar		
5	Malaria test		
6	HIV (Antibodies to HIV 1&2)		
7	Dengue		
8	Visual Inspection – Acetic Acid		
9	HbsAg test for Hepatitis B		
10	Smear for Filaria (endemic areas only)*		
11	Rapid Test Kit for Syphilis		
12	Test for iodine in salt (used for food)		
13	Water testing for fecal		

	contaminatio n and chlorination		
14	Sputum for AFB (Sample collection only; transported to TB microscopy centre for testing)		

ANNEXURE 3B: DIAGNOSTIC TESTS AT AAM- PHC/UPHC

Ayushman Arogya Mandir Field Visit Tool

Annexure: PHC/ UPHC AAM

Sl	Test Name	Available	Not- Available
1	Haemoglobin		
2	Total leucocyte count		
3	Differential leucocyte count		
4	Platelet count		
5	Complete blood count		
6	Erythrocyte sedimentation rate		
7	Blood group and Rh typing		
8	Peripheral blood film		
9	Reticulocyte count		
10	Absolute eosinophil count		
11	Bleeding time and clotting time		

Sl	Test Name	Available	Not-Available
12	Sickling Test for Sickle cell anemia		
13	Quantitative test for G6PD enzyme deficiency		
14	a. MP slide method and b. Malaria rapid test		
15	Prothrombin Time (PT)		
16	Activated partial thromboplastin time (APTT)		
17	Urine test for pregnancy - HCG		
18	Urine test for pH, specific gravity, leucocyte esterase, glucose, bilirubin, urobilinogen, ketone, protein, nitrite		
19	Urine Microscopy		
20	24-hours urinary protein		
21	Urine for microalbumin		
22	Urine for creatinine and Albumin to creatinine ratio (ACR)		
23	Stool for ova and cyst		
24	Stool for Occult Blood		
25	Test for Dengue		

Sl	Test Name	Available	Not-Available
26	RPR/VDRL test for syphilis		
27	HIV test (Antibodies 1/2 and HIV 1/2)		
28	Hepatitis B surface antigen test		
29	HCV Antibody Test (Anti HCV)		
30	Sputum for AFB		
31	Typhoid test (IgM)		
32	Blood sugar		
33	Glucose Tolerance Test (GTT)		
34	S. Bilirubin (T)		
35	S. Bilirubin direct and indirect		
36	Serum creatinine		
37	Blood Urea		
38	Uric acid		
39	SGPT		
40	SGOT		
41	S. Alkaline Phosphatase		
42	S.Total Protein		
43	S. Albumin & AG ratio		
44	S. Total Cholesterol		
45	S. Triglycerides		
46	S.VLDL		
47	S.HDL		
48	S. LDL		
49	Serum Sodium		
50	S.Potassium		
51	Serum Calcium		
52	Smear for RTI/		

Sl	Test Name	Available	Not-Available
	STD		
53	Gram staining for clinical specimen		
54	Throat swab for Diphtheria		
55	Visual Inspection Acetic Acid (VIA)		
56	rK39 for Kala Azar*		
57	Smear for Filaria*		
58	TB – Mantoux		
59	RA factor (Quantitative)		
60	CRP(including new born) (Quantitative)		
61	TSH (including for new-born screening)		
62	Urine culture and antimicrobial sensitivity		
63	Pap smear		