

The Urban Primary Health Center (UPHC) under NUHM

Roles, Responsibilities and Management

This document is targeted towards the Medical Officers in-charge and Staff of the UPHC in order to understand the functions of the UPHC and the roles and responsibilities of the UPHC staff.

The concept of primary health centers is foundational to the Indian health system. The PHC was introduced by the Bhore Committee in 1946 as the basic unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. While so far, the PHC has been limited to the rural domain, urban areas have had many versions of the PHC, varying from state to state under various projects, providing a range of services such as urban health posts, urban health and family welfare centers, urban health centers etc. However, such services have been sporadic unsystematic in their population coverage, service package and locations.

With the introduction of the NUHM, the health needs of the urban population are being systematically and nationally addressed for the first time. The Urban Primary Health Center, on the lines of a rural PHC is envisaged as the nodal point for delivery of health care services under the NUHM. While the basic concept remains the same, the services and services delivery mechanism of UPHCs is modified to address the unique health and livelihood challenges faced by the urban population. The urban areas today are increasingly becoming congested, especially slum and slum-like habitations, and with poor or no proper sanitation, water supply, garbage disposal mechanism, resurgence in urban infectious diseases. The specific details regarding UPHCs have been detailed in this document.

1. Population coverage

Depending on the spatial distribution of the slum population, the population covered by a U-PHC may vary from 50,000 for cities with sparse slum population to 75,000 for highly concentrated slums. The U-PHC may cater to a slum population between 25,000-30,000.

2. Timings

The hours of operation of the UPHC must enable the urban working population to conveniently access the UPHC. With this objective, states may opt for any suitable timings, provided the UPHC provides 8 hours of service, which are convenient to the community it caters to. Thus it is recommended that the U-PHC operates preferably from 12 noon to 8 pm. If states opt for dual shifts, this shall entail employing additional staff. High caseloads may be a criterion for allocating additional staff to UPHCs.

3. **Location:** The UPHC must be located either within or at a distance or not more than ½ a kilometer from a slum or slum-like habitation, to ensure easy access by the most vulnerable of the urban population.

4. Staff

The suggested staff pattern of the U-PHC is as follows:

Cadre	Number at UPHC
MO I/C	1
2nd MO (part time)	1
LHV	1
Nurse	1
Lab Technician	1
Pharmacist	1
ANMs	3-5
Public Health Manager/ Mobilization Officer	1
Support Staff	3
M & E Unit	1

5. Functions of the UPHC

The UPHC is to work as the nodal institution of providing health services to its designated population, although it can be accessed by anyone outside its designated catchment area. Towards this end, the following are the key functions of the UPHC:

- i. **Health Needs/Vulnerability Assessment:** The UPHC must customize its services based on the identified needs of its population. In order to identify the needs of the population, a vulnerability assessment/health service needs assessment is to be conducted by the ASHAs for each household covered by them. Members of the MAS are expected to support ASHA during the Assessment. The ASHA will be supervised by her ANM/Facilitator in this work. The ANM/Facilitator will also compile the data collected by all the ASHAs under her. Each ASHA will be provided an incentive on completion of the assessment in her allotted households. It must be ensured that all slum and slum like areas, including pockets inhabited by the homeless such as railway tracks, under-flyover areas, footpaths, temple premises etc are covered in the assessment.

This data forms the baseline information which captures the status of health and vulnerability of the catchment population. The data so collected will indicate the prevalence of specific conditions and diseases in the population, based on which the UPHC is expected to plan for the services to be delivered by them through the facility as well as special outreach sessions. This will also help in the establishment of a patient-provider relationship and a sense of responsibility towards the population

linked to the UPHC. This would also call for coordination with the MAS established in the area as well as orienting and guiding the ASHAs in their work. The UPHC would therefore be the hub of all activity as regards community mobilisation. The Assessment is to be an annual exercise, based on which the UPHC will plan for its activities for the year.

ii. Facility based service provision

The UPHC's key responsibility is to provide comprehensive preventive, promotive and non-domiciliary curative care. Thus services provided by U-PHC would include OPD (consultation), basic lab diagnosis, drug /contraceptive dispensing and delivery of Reproductive & Child Health (RCH) services, as well as preventive and promotive aspects of all communicable and non-communicable diseases. The UPHC shall also provide free and easy access to drugs and diagnostics. This includes drugs prescribed by specialists elsewhere especially with regard to non-communicable diseases like diabetes and hypertension. Provision will have to be made for services like Anti-Rabies Vaccination, which are important in the urban scenario.

The UPHC will not admit patients for in-patient care. The UPHC will also provide services of counseling and have a help desk for assisting patients with special needs. Indian Public Health Standards will be developed for U-PHC. To further strengthen the delivery of specialized OPD care, the UPHCs, if need arises, can utilize the services of specialist on weekly basis. These services can be remunerated at norms in accordance with those of Special outreach camps.

iii. Outreach

While primary health care through Urban PHCs will be universally available to all citizens residing in urban areas, Outreach services will be provided on a targeted basis for the slum and other vulnerable population. By their demonstrated focus on the poor and vulnerable, outreach services thus embody the essence of the NUHM, more than any other program component. Unlike rural areas, Sub-centres will not be set up in the urban areas as distances and mode of transportation are much better here. In the absence of sub-centers in urban areas, outreach services become critical and very important to enabling access to basic health services for the marginalized population.

Outreach services will be provided through the Female Health Workers (FHWs), essentially ANMs with an induction training of three to six months, who will be headquartered at the Urban PHCs. These ANMs will report at the U-PHC and then move to their respective areas for outreach services (including school health) on designated days. They will be provided mobility support for providing outreach services.

UPHCs will provide regular outreach (once a month) through the organization of Urban Health and Nutrition Day (UHND), as well as Special Outreach Services (for need based specific services). Please refer to detailed guidelines on planning and conducting Outreach sessions released by the

MoHFW. The MO/IC of the Urban PHC is responsible for ensuring the development of an annual calendar for the UHND in her/his catchment area, and reviewing the coverage and quality of UHND services and ensure timely submission of monthly and quarterly reports by ANM.

iv. Referral

As the first point of care for the urban vulnerable population, the UPHC's role in referring patients to appropriate institutions is critical. The UPHC must identify nearest and most conveniently accessible higher level facilities for referrals. The UPHC must also identify institutions for specialized services such as de-addiction centers, rehabilitation facilities, mental health care facilities, specialized counseling centers besides other medical specialties, and motivate the patients to comply with the referral. The UPHC must also leverage on NGOs in the city or community groups active in the area who would be able to extend support to patients requiring their specific services, whether medical, financial, rehabilitative or psycho-social support. The UPHC must also follow up with patients through the ASHA to ensure whether the referral has been followed by the patient, and whether the issue has been adequately addressed. Facilitation of patients referred from UPHCs at secondary and tertiary levels of care would help develop a two way referral loop.

v. Disease Surveillance and Epidemic Control: The UPHC shall have the additional task of performing disease surveillance and notification in its catchment area. Notification may also be ensured from private and non-profit organizations working in health. The UPHC Program Manager shall have a key role to play in this respect. This will involve liaising with the community and health workers on the one hand and IDSP and specific disease control programs on the other. As the nodal health service institution in the area, the UPHC can provide valuable feedback and evidence based advocacy for provision of clean water, sanitation services and garbage disposal on behalf of the community to the agencies responsible for these services. In the case of an outbreak, the UPHC must identify the cause and initiate remedial measures and necessary public health action. In case such a unit is functional within the ULB, the UPHC must provide all necessary support.

vi. Convergence with Disease Control programs: Convergence with disease control programs is essential for effective and complete service delivery at the UPHC. The UPHC must focus on the following programs:

- a. Revised National TB Control Program (RNTCP): The UPHC can have a co-located RNTCP clinic which can be manned by a trained person, and shall have provision of medicines to patients. Arrangements for nutritional support can be made by liaising with NGOs. Facilities of microscopy and X-Ray may be provided at selected centres. Partnerships may be formed with private hospitals for the purpose of notification and treatment. Special provisions may be made for migrant workers and vulnerable groups who are not able to report to the same DOTS centre so that continuity of care can be maintained. Provision will have to be made under the program for those who do not have proof of residence. Special care will have to

be taken to map vulnerable patients and map them to community providers. In high risk areas, provision may be made for a Senior Treatment Supervisor at UPHC level.

- b. Vector Borne Disease Control Programs- Malaria, Dengue and Chikungunya are major public health problems in urban areas while Kala Azar and Leptospirosis exist in some states. The UPHC must provide diagnosis and treatment of these according to requirement. The UPHC can be made the hub for these along with notification and targeted action. SMS system of alerts can be used for the purpose as in some places(Kolkata Municipal Corporation). ASHA would be a useful link with the community, and the UPHC may use hired workers for targeted action like source reduction in the vicinity of cases detected. Thus the UPHC would become the hub of all vector control measures with involvement of Medical Officer and field staff. Program should make provision for notification from private sector so that appropriate action can be initiated. Attention needs to be paid to skill upgradation of workers, IEC and IPC. Involvement of MAS and RWAs may be necessary for the purpose.
- c. Non-Communicable Diseases- As these are emerging conditions in urban areas provision needs to be made for diagnosis, treatment, monitoring and follow-up of patients. Screening for cancers, basic diagnostic procedures like Blood Pressure monitoring and Blood Glucose measurement, medicines prescribed at the PHC or by a specialist at a higher centre, are some of the services which should be available at the UPHC. ASHAs and ANMs along with MAS and RWAs shall actively engage in health promotion activities. Screening for cervical cancer shall be made available at UPHC. National leprosy Elimination Program- Provision of MDT should be made at UPHC. ASHA shall have a role in spreading awareness, encouraging early detection, and referring complicated cases to the UPHC. The UPHC shall maintain referral linkages for management of cases. Rehabilitative care shall have to involve the community.
- d. Other programs- Staff of UPHCs to be sensitized and trained on first-aid for burns patients. Accident cases, primary eye care, basic care for mentally ill patients and others.

vii. *Data collection, recording and management*

Every facility must properly record the data collected through vulnerability/health assessment surveys. These must be compiled and analyzed through appropriate software (as decided by the state) or manually and be effectively used for planning of health services. Facility based uploading of HMIS data must be done at the UPHC level. Appropriate equipment and technology requirements should be provided by the state. Being the point of baseline data generation, the quality of data collected and entered must be supervised by the public health manager or the MO/IC. All staff must be trained to collect, handle and use data skillfully.

viii. *Converging and Innovating for better health outcomes*

States are encouraged to involve private practitioners for special drives on immunization, diabetes, etc, and to involving schools for public health action like “slum cleaning (safaiAbhiyan)”, health promotion, etc in order to develop a community based approach towards addressing social determinants of health.

UPHCs converging with other service providers and stakeholders can be instrumental in igniting a social movement for health in their catchment area. The objective of convergence would be optimal utilization of resources and ensuring availability of all services at one point (U-PHC) thereby, enhancing their utilization by the urban population. NGOs will be utilized for community mobilization, capacity building, and other preventive and promotive activities for health and health determinants.

ix. *Weekly clinics for specialized care*

States may decide to conduct weekly clinics for specialized services, depending on needs of their target population such as geriatric care clinic, adolescent health clinic, diabetes clinic, etc at the UPHCs. The UPHCs may involve other private or charitable health providers to provide services during these clinics. Community health workers, volunteers, MAS members and ASHAs can be leveraged upon for publicizing these clinics. Building a network of stakeholders for successful conduct of such clinics is essential.

- x. **Sharing of Information and Entitlements:** The UPHC must share information on services being provided, Citizens’ Charter, entitlements of beneficiaries and benefits provisioned to them. These should be in the public domain with easy access.

6. Management of the UPHC

The overall management and functioning is the responsibility of the MO/IC. The MO/IC must ensure proper supervision of staff under him. Although under the domain of other UPHC staff, outreach activities must also be effectively supervised by the MO. The MO must prepare a monthly and annual calendar of activities including all weekly clinics, special and routine outreach services and any other innovations, and clearly specify the roles and responsibilities of each staff member in these activities. The MO must also ensure proper functioning of laboratory, all equipment, furniture and infrastructure of the UPHC. In case of any breakdowns, the MO must immediately make efforts to get the equipment fixed or replaced. The MO must also ensure continuous supply of drugs, diagnostics and reagents.

The Hospital management committees shall be established on the lines of NHM. Grievance redressal mechanism must also be put in place at the UPHC. The grievances once collected must be adequately addressed and responded to by the center in a timely manner.

7. Infrastructure, Financing and Governance Mechanism:

Building for new UPHCs and other additional infrastructure shall be provided by the State Government as per specified parameters. The cost within these parameters can be counted as part of 25% State share. Assured package of services for the primary level care at the U-PHCs would be defined as part of the IPHS.

Each U-PHC will get Rs. 2.5 lakh as untied grant every year for local public health action and for its maintenance and upkeep. (The District Health Society may re-appropriate the overall amount amongst various health institutions by +25%, depending on need and utilization levels.)

Each UPHC will be managed by a Rogi Kalyan Samiti (RKS) as per NHM guidelines. The UPHC will report to the City PMU/District PMU as the case may be. It shall maintain linkages with secondary and tertiary care centres in the city/town.