Guidance on Cafeteria Approach for Operationalizing Urban HWCs
Background

- Evolution of Primary Health Care in Urban Areas
- Concept of Urban Health and Wellness Center
- Purpose of the document

Proposed model-based solutions and implementation strategy

- Model 1: Prefabricated HWCs
- Model 2: Mobile UHWCs
- Model 3: Public-private partnership
- Model 4: Digital U-HWC
According to the World Health Organization (WHO), primary health care is the most inclusive, equitable, cost-effective, and efficient approach towards achieving universal health coverage. The Government of India, under the National Health Mission, has established a strong network of primary health care in rural areas with dedicated resources linked for efficient functioning. However, the urban population’s special needs require a different approach. In 2013, the Ministry of Health and Family Welfare launched the National Urban Health Mission to establish a network of public health facilities in urban areas catering to the health care needs of the urban population with a special focus on the urban poor and vulnerable sections.

According to Census 2011, the total urban population in India was approximately Rs 38 crore, constituting 31% of the total population. According to the UN Habitat Report, 2017, India is expected to be almost 50% urban by 2050. To address the growing needs of the urban population, the Government of India has launched a few flagship initiatives such as Pradhan Mantri–Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) and Fifteen Finance Commission grants (XV-FC) to build a resilient health system in the country. This initiative will reinforce India’s vision and commitment towards inclusive growth by establishing (i) a responsive and adaptive urban primary health care delivery system, (ii) the provision of quality urban health services closer to the community, and (iii) enhanced capacity for planning, management, innovation, and knowledge sharing for improved health outcomes.

Under these initiatives, a new concept of urban health and wellness center (UHWC) has been introduced to bring urban health care services closer to the community, similar to the National Rural Health Mission initiative.

**Concept of Urban Health and Wellness Center**

As per the Indian Public Health Standards 2022, the UHWC (Figure 1) is envisaged as the first point of contact for urban communities seeking a public health care delivery system. The UHWC is intended to cater to a population of 15,000-20,000 and will be led by a medical officer supporting the community health workforce. The community health workforce will provide community health services in the catchment areas. The UHWC will essentially operate on the principles of comprehensive primary health care, focusing on preventive and promotive aspects. It will also link the population to higher referral centers for specialized care.

**Urban Health & Wellness Center (UHWC)**

*Team*

- Medical Officer, Staff Nurse & MPW (Male)

- **Expanded Package of Services**

- **Essential Drug List (EDL)**

- **Essential Diagnostic : 14**

- **Treatment, Follow Up and support care**

- **Tele-Consultation**

*Figure 1. Urban health and wellness center*
Under the PM-ABHIM and XV-FC grants, each state has been given a fixed target of UHWCs that need to be operationalized every year. Based on the proposed plan and financial resources, the necessary approvals are provided annually to all the states. However, progress in the context of UHWC has been limited primarily due to land unavailability in urban areas, the continuous expansion of city limits, limited coordination with urban local bodies, and the scarcity of human resources in urban areas.

**Purpose of the document**

The aim of this document is to suggest possible options for operationalizing UHWCs allowing flexibility to the state governments to choose from the basket of models based on their local context and analyze the benefits and limitations of using the cafeteria approach in its truest sense. These models can be adopted as a whole or in parts and can be combined based on the local needs, context, and available resources.

**Proposed model-based solutions and implementation strategy**

In urban areas, several different models of UHWCs can be implemented based on the different challenges being faced in operationalization. Some of the operational challenges incurred while setting up UHWCs are as follows:

- Limited availability of land and infrastructure
- Continuously growing city limits
- Paucity of human resources

The different indicative models are described in detail in the following sections.

**Model 1: Prefabricated HWCs**

Prefabricated HWCs can be an effective solution for operationalizing UHWCs and significantly reducing construction time for newer facilities and costs while still providing a functional and safe environment for the clients and service providers. The prefab structures primarily have three components:

1. Civil work foundation/substructure
2. Superstructure/structural component
3. Walls/roofing made of infills or various panels, either prefab or as per new and innovative technology

The standards of all three components need to be maintained and ensured, which will vary with the width, length, and expected height of the prefab infrastructure to be created. So, the proper layout and design component is of paramount importance.

**Available materials:**

According to the guidelines provided by the MoHFW, there are multiple options available for prefab structures. These options are certified by the Building Materials and Technology Promotion Council (BMTPC). States can choose based on the local context and geographical conditions. However, technical experts recommend using PUF (Poly Urethane Foam) and EPS (Ethyl Poly Esterene) panels for constructing health care facilities. (Please refer to the GoI Letter attached for more information) There are different techniques for constructing prefabricated structures. A few popular techniques are shown in Figure 2 below:
The advantages of prefabricated construction are as follows (Figure 3):

- Ready to deploy and quick setup time
- Sustainable, durable, and low impact on the environment due to construction
- Value for money and leads to lower site outlays due to less time on-site

**Anticipated challenges**

Prefabricated structures are usually associated with an increased risk of early depreciation, leading to damages and leakages that are difficult to recover and refill. Additionally, installing prefabricated units requires a high level of precision, from handling to position on site precision for the right delivery.
Suggestive geography
To determine the location for setting up a prefab structure, it is important to assess the availability of land in collaboration with the urban local body. The success of this model will largely depend on the guidance and expertise of the health department in establishing prefab structures in emergency COVID-19 response plans.

Example: The Government of NCT of Delhi has established mohalla clinics to provide free curative services, diagnostics, and drugs to vulnerable groups. These clinics are built in the community using a prefabricated box-like structure consisting of two to three rooms and a primary health care team comprising one medical officer, one pharmacist, one mohalla clinic assistant, and one Multi Purpose Health Worker. The Delhi Health Society procures medicines and consumables, while laboratory tests are outsourced on a public-private partnership (PPP) model. These clinics aid in alleviating the out-of-program experience incurred on health and increase the accessibility to health care. As per the online resources available, more than 300 Mohalla clinics are being functional in Delhi providing primary health care services to the population.

Model 2: Mobile UHWCs
Mobile health care delivery is an innovative model that provides a wide range of services to vulnerable populations, particularly those living in resource-limited areas. Mobile clinics can improve access by serving as a vital link between the community and clinical facilities in non-recognized slums, migrant settlements, growing city limits, and similar geographies.

Advantages
Mobile clinics can help overcome barriers to health care, including transportation, time, system complexity, and trust. Under the National Health Mission, the Government of India already runs a scheme of mobile medical units to provide health care services to hard-to-reach/inaccessible areas where vulnerable communities exist.

It is important to develop a network of mobile UHWCs (M-UHWCs) that are equivalent to physical UHWCs and provide a comprehensive package of service delivery at the doorstep of the community. This will help build trust in the communities and ensure that the urban population has enhanced access to quality health care services. However, it is important to note that M-UHWCs should be seen as a temporary alternative to the physical facility-based model of UHWCs.

Operational models
The three models similar to the lines of the mobile medical unit are described below:

Modality 1: Government-operated model
An in-house model means having all resources deployed and managed by the government, including both non-recurring (capital costs including mobile vans, instruments, etc.) and recurring expenditures (human resources, drugs, and consumables).

Modality 2: OPEX model
In this model, the non-recurring particulars, such as van, instruments, etc., will be provided by the state and the operations and management (including human resource, and service delivery) of running the center, i.e., OPEX, will be outsourced to an agency. However, drugs and consumables supplies may be provided by the government.
Modality 3: OPEX-CAPEX model

In this model, both non-recurring particulars and operations and management will be given to the outsourcing agency. However, drugs and consumable supplies may be provided by the government.

Modality 4: Refurbishing retro wheels into rolling HWCs

This model is conceptualized to repurpose scraped and not usable transport buses/larger vans and turn them to usable health clinics. These clinics can either be used as mobile health centers or as fixed cabin-like centers that operate out of refurbished old buses. The aim of this model is to make use of the existing resources with minimal financial investment. The government may cover the refurbishment cost and engage service providers to offer services according to the rosters. Existing frontline staff may be engaged in the mobilization of the community for the utilization of services from the M-HWCs.

Note: For all the modalities; The funding will be borne by the government utilizing the National Urban Health Mission, PM, ABHIM and 15th financial resources, and the unit cost criteria will be the same as decided by GOI under these schemes for each activity as per the usual UHWC operational costs.

Figure 4. Pictures depicting the old buses being refurbished into clinics/health centers

The medical officer will be responsible for planning the route map of the M-UHWCs. It will require a detailed area mapping with the catchment population and subgrouping of areas for deciding outpatient days (OPDs) as a part of the microplanning of the center. The site selection for daily OPDs should be fixed and done in coordination with the ward leadership. If possible, the site should be selected adjacent to a nearby government building with one to two rooms and toilets for the effective delivery of services. Schools can also be included on the route map for monthly visits to cover and engage the adolescent population. Figure 5 gives an example of route mapping of M-UHWC that can be referenced for local contextualizing and designing.
The success of M-HWC will depend on the crucial role of community structures such as Jan Arogya Samitis and Mahila Arogya Samitis of the catchment area. These structures will play a crucial role in creating awareness on a day-to-day basis about the schedule, location, service delivery schedule, and the type of services being provided by the mobile vans.

**Branding:** The branding of M-UHWC will be the same in line with the Government of India facility branding package for AB-HWCs.

**Suggestive geography:** The deployment of M-HWCs should be given priority in areas where the urban primary health centers are non-functional or brick-and-mortar models are not viable. It is also essential to prioritize areas that require focused community-based outreach interventions to establish a connection with the health centers initially. The micro plans of the M-HWC for route mapping, frequency, etc., can be developed as per the local context. The frequency of mobile medical unit visits must be at least once a month and additional visits will depend upon local conditions such as all-weather roads, access conditions, terrain, and accessibility to health facilities.

**Model 3: Public-private partnership**

Considering the extensive involvement of the private sector in urban areas, they may be leveraged in a mixed-model approach, wherein UHWCs can be operated by leveraging their human resources, infrastructure, etc. PPP is one of the most effective ways to increase private sector participation in public services delivery. This can bring accountability to the private sector and improve the efficiency of overall public health service delivery.

**Possible operational models**

**Modality 1: Management of HWC**

The UHWC is managed by a private agency or a non-governmental organization (NGO), while the government provides the infrastructure. The private agency/NGO is responsible for all the services envisaged for the HWC, including supporting and administrative services.
Example: Karuna Trust has been managing primary health centers across many states in India. States may adopt similar mechanisms by engaging reputable organizations to manage UHWCs. The link of a Memorandum of Understanding between the trust and the Meghalaya government is given in the link http://nhmmeghalaya.nic.in/programmes/ppp/mou-karuna-trust.pdf and can be used as an example of the public-private partnership model that can be used as a reference for establishing similar interventions.

Modality 2: Service-based outsourcing

According to this model, a public entity contracts its OPD-based clinical/diagnostic services to a private operator. This means that the private operator will be responsible for the delivery of OPD-based clinical consultation or diagnostic services (like laboratory services in-house or in the hub and spoke model). However, the infrastructure and relevant diagnostic equipment and consumables can be provided by the government.

Example: The NTR Vaidya Pariksha scheme in Andhra Pradesh is a hybrid model of laboratory and radiology services. The state government has collaborated with private partners to provide free of cost laboratory and radiology services at public health facilities. While the public sector provides the basic (High volume low cost) tests, wide range of other advanced (High cost, low volume) tests, are outsourced under the NTR Vaidya Pariksha scheme provides a including some advanced tests not provided by the public sector.

http://hmfw.ap.gov.in/ntr-vaidya-initiative.aspx

In Madhya Pradesh, a similar approach is being adopted. In addition to the mandatory rapid diagnostic tests at the primary health care facilities, more than 30 more diagnostic tests are being implemented in partnership with a private agency as an effort to extend the service package of the primary-level diagnostic services.

Modality 3: Integrated PPP model

In this model, both infrastructure and services are provided by the outsourced agency. This approach works best for the not-for-profit organizations that have been running their clinics in a particular area for a long time and have established better connections with the community. These clinics with few interventions can be upgraded to provide all services envisaged for the HWCs and branded as UHWCs.

The conditions for smooth implementation include the following:

- **High political and administrative commitment and leadership:** Official letters expressing political and bureaucratic commitment are essential for the success of this model.
- **Adequate budgetary allocations:** Budget provisions must be planned and approved in due consultation and negotiation with the outsourcing agency/party on time for a smooth rollout.
- **Phased rollout:** The implementation plan should be in a phased manner to build on the experience and improve implementation.
- **Timely payments to service providers and penalties when required:** Transparent fund flow mechanisms with defined timelines are crucial to reduce delayed payments that may hamper the service delivery and trust between parties.
- **A robust monitoring framework:** It is important to have well-defined review and monitoring criteria for continuous quality improvement. These criteria should be built into the model conditions.
Steps for operationalizing the PPP model

Step 1: Developing Memorandum of Understandings/contracts:
In order to ensure an effective and seamless partnership, it is important for both parties, namely the government and the agency, to establish clear terms and conditions. This should include the type of services to be provided, the type of resources, details about the funding provisions, payment mode and frequency, accountability criteria, and monitoring indicators for review and analysis. Majorly, all PPPs can vary across contracting in and out models with a degree of variation and plurality in modes.

Step 2: Selection of the private partner
Selecting a right partner is very important for the effective delivery of quality services to the population. Based on the right selection, this model can help augment the constrained capacities and efforts of the states in terms of resources such as infrastructure. If a for-profit partner is chosen, it is important to implement a strict monitoring mechanism with penalties to keep a check on the quality of services being provided and to prevent any wrongdoings. On the other hand, not-for-profit partners are more focused on improving service accessibility and affordability with the aim of universal health coverage. They are not driven by the profit garnered during the process. Most not-for-profit partners aim to build and support the public health care system from the lens of sustainability. To achieve this goal, it is important to collaborate with the government and document clear implementation criteria in the Memorandum of Understanding.

Step 3: Clear review, monitoring, and financing mechanism
A monitoring framework with predefined review indicators is essential for mid-course corrections and improvement. The frequency of review, improvement plan implementation, and penalty terms and conditions should be part of the consultative process. All of these details should be laid out in a clear written agreement before finalizing the partnership. It is the most important step for making this model effective and bringing accountability to the private sector.

Model 4: Digital UHWC

Digital UHWC (Digi-UHWC) is a tech-enabled model best suited for geographies where there is very limited physical infrastructure set up for optimum functionality of UHWCs and a dearth of human resources, particularly medical officers. Digi-UHWC serves as a single window for primary health care, providing doctor consultations, diagnosis, referral care to specialists, and pharmacy services to all under one roof. This model is primarily conceptualized by harnessing teleconsultation, teleradiology, and lab services. Digi-UHWC is an effective solution for the urban population that face poor referral issues, which can lead to loss of follow-up of patients.

The Digi UHWC represents an inventive approach that harnesses digital technology solutions while integrating established digital-based services within the NHM framework, including Telemedicine, Teleradiology, and the Health Management Information System.

Operational Aspects: Digi UHWC will have its unique NIN member and separate database of its catchment population for all portals available within the purview of National Health Mission. It will have its own community health workforce which will be the driving force for linking the services in population to the digi UHWC. The operational management of a Digi UHWC can be delegated to the nearest functional UWHC, which will oversee overall operations. Utilizing common web-based platforms such as Zoom or Google Meet, teleconsultation methods can facilitate daily OPD-based services, with a dedicated time slot reserved each day for the digital UHWC.
The disadvantages of Digi-UHWCs are as follows:

- Digi-UHWC led by a facilitator to link the community with the service provider is more prone to poor management and requires stringent monitoring.
- The digital services rendered through Digi-UHWC should never be treated as an end-to-end permanent solution and as a replacement for the physical facility-based model of UHWCs led by a medical doctor.

The advantages of Digi-UHWCs are as follows:

- Digi-UHWCs reduce the barriers to health care due to the non-availability of a medical officer at UHWCs. A staff nurse or an Ayush medical officer facilitates the correct diagnosis and treatment via teleconsultation with a trained MBBS doctor or a specialized doctor.
- It also enables need-based linkages with specialized teleconsultation services.
- Digi-UHWC can effectively help in reducing loss to follow-up of patients maintaining the trust of the community and providing services in a time-bound manner.

The prerequisites for the implementation of Digi-UHWCs are as follows:

- Digital IT set-up
- Linking of facilities under teleconsultation and other digital-based services
- ABHA ID integration of patients
Disclaimer: This document is made possible by the support of the American People through the United States Agency for International Development (USAID.) The contents of this document are the sole responsibility of PSI/PATH, and do not necessarily reflect the views of USAID or the United States Government.