Menu of options for operationalization of
Polyclinics under XV-FC
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Rapid urbanization along with demographic and epidemiological transitioning have led to wider health disparities between people from high and low socioeconomic backgrounds. Despite an improvement in the Sustainable Development Goals (SDG) indicator 3.8.1 for Universal Health Coverage (UHC), which rose from 45 in 2000 to 67 in 2019, 30 percent of the world’s population still lacks access to health care services. Moreover, India has witnessed a significant rise in urban health challenges over the last decade, primarily due to the country’s growing urbanization.

Estimates suggest that the percentage of people living in urban areas in India will increase to about 40 percent by 2030. Numerous social and financial hurdles prevent an increasing number of urban poor and vulnerable people from receiving health care, and their health indices are poorer than those of their rural counterparts. Reports state that 40 percent of urban residents lack access to basic necessities and that 90 percent or more of those living in cities breathe polluted air. Further, the lack of green spaces, poor water and sanitation facilities, and poor air quality are associated with non-communicable diseases, and their risk factors are all problems that urbanization is linked to in terms of its effects on health.

The COVID-19 pandemic has highlighted that public health action—such as surveillance, contact tracing, community mobilization, and other containment measures—in urban areas need substantial strengthening. It has also shown that such public health action is ineffective if focused only on slum and slum-like areas. Action for outbreaks needs to address the entire urban population across all sections. Decentralizing primary health care, particularly in urban areas, would enhance disease surveillance for epidemic and outbreaks and facilitate risk-factor mitigation through focused health promotion and wellness initiatives.

The launch of various initiatives like the National Urban Health Mission (NUHM), Ayushman Bharat–Health and Wellness Centres (AB-HWCs), Pradhan Mantri–Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), and Fifteenth Finance Commission (XV-FC) reinforces India’s vision and commitment towards inclusive growth through establishing the following:

- a responsive and adaptive urban primary health care delivery system;
- provision of quality of urban health services closer to the community; and
- enhanced capacity for planning, management, innovation, and knowledge sharing for improved health outcomes.

Through the XV-FC initiative, the Government of India seeks to establish Urban Health and Wellness Centres (uHWC) within populations of 15,000–20,000, bring essential services closer to underserved urban communities. This endeavor is expected to improve access to an extended array of services, reduce out-of-pocket expenditure (OOPE), improve disease surveillance, and strengthen referral linkages. It also provides the states with an opportunity to establish polyclinics in selected urban primary health centers (UPHCs) and enables the reach of specialist services to poor communities, thus building trust in the public health system.

In line with the Government of India’s efforts to revamp urban primary health care, additional resources under PM-ABHIM and XV-FC were allocated to the states.

This document developed, under Samagra, a USAID funded, PSI led project, implemented by PATH, aims to outline the menu of options, the key features of each option, and the operational and monitoring mechanism of polyclinics. It will also highlight the delineation of a menu of options, presenting the most fitting polyclinic model that aligns with the specific local context of the state. Further, it will enable all stakeholders to understand the key steps involved in the establishment and operationalization of polyclinics and provide insights toward scaling up and replicating similar models in the long run.
Bringing specialist health care closer to the community

Of the existing five to six UPHCs in urban areas, one UPHC is planned to evolve into a polyclinic that will provide outpatient specialist services to the population in its catchment area, which consists of about 2.5–3 lakh of urban residents. As per the XV-FC guidelines, separate polyclinics will not be required for areas with functional urban community health center (UCHCs) providing specialist services. Similarly, in cases where there are state-specific dispensaries that render specialist services to the community, the state may take a call on whether they want to establish new polyclinics in that area or simply connect the existing UPHCs to these dispensaries for specialist services.

Where established, polyclinics serve as outpatient clinics providing specialist services at designated UPHCs and referral services to secondary and tertiary health care facilities. They offer a range of medical services, such as consultations, diagnostics, preventive care, and treatment for common illnesses.

These clinics are typically staffed by a team of specialists, general doctors, nurses, and other health care professionals. However, there is a need to develop roosters or micro plans for specialist services at the polyclinics. An indicative structure of human resources at polyclinics is shown in Figure 1.

In addition to the human resources available at UPHCs, an indicative list of specialists and other support staff have been enlisted in the XV-FC guidelines, and states have been given the option to engage additional specialists based on local needs and context. These specialists can be in-sourced on a per hour/per patient basis from the local private sector.

Apart from this, polyclinics will serve as a referral facility for the catchment UPHC facilities. They may also serve as a hub to connect with spokes—uHWCs and UPHCs—for conducting specialist telemedicine services. A continuum-of-care approach for strengthening primary health care across all facilities in urban centers is provided in Figure 2.
States have received approvals under the XV-FC grants for the establishment and operationalization of polyclinics, but the progress has been primarily limited due to limited availability of specialists in tier-2 and tier-3 cities. This document will also propose methods to operationalize polyclinics, taking into factors such as population density, health care needs, available resources, and the specific local context to adopt the best-suited model.

Additionally, a state may have different models of polyclinics based on the city-specific context and availability of specialist doctors. Moreover, a model that is applicable to one city or area may not necessarily serve the purpose or meet the needs of the population in another area. For example, in Tier-1 cities where specialists are already available in abundance, the city can adopt an in-house model, whereas Tier 2/3 cities, with limited or unavailability of specialists, will need to adopt or develop a hybrid model.

In urban areas of India, several different models of government polyclinics can be implemented to provide health care services to the population. The right polyclinic model may be adopted based on one of these two factors:

• The availability of specialists in public and private sector in the cities
• Local needs and the disease prevalence or conditions like trauma and accidents prevalence within the community to roll out specific specialist services.

Therefore, there is a need for more than one kind of polyclinic model to provide services to the people in different areas within a city or state. A combination of these models may also be adopted in a single city or state.

MODELS OF POLYCLINICS

Steps to operationalize the in-house polyclinic model

To operationalize the in-house model of polyclinics, the following steps may be undertaken:

Needs assessment: Conduct a needs assessment to identify the specific specialist areas required within the polyclinic. Determine the demand for specialized services and the gaps in the existing health care provision. The existing vulnerability assessment done under NUHM may be utilized for identifying the local needs of the catchment population of the polyclinics.

Recruitment and selection: Advertise positions and conduct a rigorous selection process to identify qualified specialists. Evaluate their expertise, experience, and compatibility with the polyclinic’s goals and values.

Microplanning: Microplanning for rotating specialists among various health facilities and for special outreach camps can be undertaken. Initially, a fixed-day specialist provision can be made to optimize the utilization of specialist resources and ensure equitable access to specialized care across multiple facilities.

Facility and infrastructure setup: Ensure that the polyclinic has the necessary infrastructure, equipment, and support systems in place to accommodate the recruited specialists. This may include setting up specialized clinics, procuring medical equipment, and implementing electronic health record systems. An indicative list of equipment based on specialty is provided in Annexure 1.

Plan for requisite drugs and diagnostics: To deliver effective and efficient specialist services, there is a need to ensure availability of requisite drugs and diagnostics in line with the specialized services.

Demand-generation activities: To boost the use of health care facilities, demand-generation activities should be conducted. This includes mobilizing frontline health care workers, including local ANMs and ASHAs, to create awareness and encourage the community to utilize the expanded range of services offered at the polyclinics.

Performance monitoring mechanisms: Regularly assess the performance and outcomes of the in-house model, considering patient satisfaction, healthcare outcomes, and operational efficiency. Use this feedback to identify areas for improvement and make necessary adjustments to enhance the effectiveness of the model.

Referral mechanisms: Develop efficient systems for patient referral and coordination of care between urban HWCs, UPHCs, polyclinics, and secondary and tertiary health care facilities. Digital mechanisms may also be explored for tracking the beneficiaries and building a robust referral mechanism for forward and backward linkages.

These are five indicative models that urban program managers may adopt based on their local context.
In-house polyclinic model by recruiting specialists from the public sector

Polyclinics can be made operational by cultivating in-house expertise through the recruitment of specialized doctors, tailored to address local vulnerabilities. By harnessing the expertise of specialists in various medical disciplines, polyclinics can offer comprehensive and specialized care under one roof. The recruitment of these specialists not only strengthens the capabilities of the polyclinics but also ensures that patients have access to a diverse range of medical expertise. Additionally, it allows for the efficient utilization of resources and improves health care outcomes by minimizing the need for referrals to secondary- and tertiary-level health care facilities. Overall, the in-house model of polyclinics, reinforced by the recruitment of specialists from the public sector, plays a pivotal role in advancing health care accessibility and quality for the communities they serve.
Ideal Geography
Cities that have adequate availability of specialists.

Key features of the model
By attracting specialists to join the polyclinics, especially in underserved areas, this initiative helps bridge the gap and bring quality comprehensive primary healthcare closer to the urban poor population. Patients who previously had to travel long distances or face lengthy waiting time to see a specialist can now receive timely and comprehensive care closer to home. This model not only improves health care equity but also contributes to the overall development of the local health care system by retaining and utilizing the expertise of specialists within the public sector. Ultimately, the in-house model of polyclinics, through the recruitment of specialists, is a transformative approach that empowers communities with better access to specialized health care services, thereby enhancing the overall well-being and health outcomes of the population (see Figure 3).

Some key features of the in-house specialist model are as follows:

**Strengthened local health care system:** This model plays an important role in developing and strengthening of the local health care system. By retaining and utilizing the expertise of specialists within the public sector, it facilitates the establishment of a resilient and sustainable health care capacity and expertise within the local community. This, in turn, results in better health care outcomes and the resilience of the health care system in the long run.

**Patient-centered care:** With a multidisciplinary team of specialists working together, the in-house model promotes patient-centered care. Specialists can collaborate, consult, and develop personalized treatment plans, ensuring that patients receive comprehensive and coordinated care tailored to their specific needs.

**Comprehensive health care services:** The model offers a wide range of medical services under one roof, with specialists from various disciplines available within the polyclinic. This allows for holistic and integrated care, ensuring that patients have access to a diverse array of medical expertise.

**Efficient utilization of resources:** The recruitment of specialists within the public sector helps optimize the utilization of health care resources. A set of specialists can be utilized to operationalize more than one polyclinic by making micro plans and rosters for a network of UPHC polyclinics.

**Enhanced accessibility and convenience:** By recruiting specialists to work within the polyclinics, the model improves access to specialized health care services, particularly in underserved areas.

**Improved health care equity:** By bringing specialists to regions that typically face shortages of specialized health care professionals, the model promotes equity by ensuring that all patients have equal opportunities to receive high-quality care, regardless of their geographic location.

Monitoring mechanism
- Performance monitoring based on KPIs and financial monitoring.
- Platforms such as Ayushman Bharat-Health and Wellness Centers (AB-HWCs), NCD Portal, NIKSHAY, and Integrated Health Information Platform (IHIP).

Strengths of the model
- State-owned systems if implemented efficiently can deliver better outcomes
- More administrative control and easy to monitor
- Resources are allocated based on local needs

Anticipated challenges
- Recruitment and retention of specialists
- Competitive salary/remuneration in urban areas
- Focused IEC, demand generation, and community mobilization
Fixed-day specialist polyclinics by engaging specialists from secondary and tertiary government facilities

Many urban areas face a dearth of specialist doctors who could potentially work full-time in public health facilities. In such cities, polyclinics can be made operational by leveraging the available specialist doctors from secondary and tertiary government health care facilities. These facilities may include local district hospitals, sub-district hospitals, and medical colleges. As per the DO letter Z-28016/9/2019-NRHM dated July 20, 2019, it was suggested that every medical college should adopt ten rural and urban HWCs; states could adopt a similar approach too. Some polyclinics could be linked to these centers to provide specialized services on a fixed-day basis. Moreover, specialists working in the army, railways, PSUs, and other government institution like Employees State Insurance Corporation (ESIC) can also be roped in to operationalize the polyclinics.

The concept of fixed-day specialist polyclinics involves engaging specialists from secondary and tertiary government facilities to provide services on designated days at UPHCs, which are targeted to be upgraded as polyclinics. By leveraging the expertise of specialists, fixed-day polyclinics can expand their scope to provide a broader array of specialized or super-specialized services to patients. This approach improves access to specialized care by bringing specialists closer to the patients’ communities.
Ideal geography
• Cities with availability of specialists in secondary and tertiary government facilities
• Tier-1 and tier-2 cities
• Cities with district hospitals and medical colleges

Key features of the model
The fixed-day model encourages continuity of care, as the same specialists visit the polyclinic on regular intervals, allowing them to build relationships with patients and provide ongoing treatment and follow-up care. The model also promotes collaboration among health care professionals, enabling the sharing of knowledge and expertise, leading to better patient outcomes. The fixed-day model also allows the provision of supplementary services such as super-specialist consultations in line with local vulnerabilities. Bringing specialized health care contributes to a holistic care approach and simultaneously also reduces the case load at secondary and tertiary facilities, benefitting those who require primary consultations and follow up care (see Figure 4).

Some key features of the fixed-day specialist model are as follows:
Enhanced accessibility: Patients can receive specialized care in their local communities, thereby reducing the need for long-distance travel to larger hospitals. This improves convenience, especially for those with limited mobility or those living in rural areas.
Reduced waiting time: By bringing specialists to the polyclinics on specific days, patients can avoid long waiting time, typically associated with busy tertiary hospitals. This helps expedite diagnosis, treatment, and follow-up care.
Efficient resource utilization: Fixed-day polyclinics optimize the use of resources by leveraging the existing infrastructure and facilities of the polyclinic. The specialists’ visits are scheduled in advance, ensuring that the appropriate equipment, staff, and support services are available on those specific days.

Collaborative care: Fixed-day specialist polyclinics encourage collaboration and knowledge sharing between specialists and primary care physicians. This interdisciplinary approach improves the overall quality of care and facilitates a seamless continuum of treatment for patients.
Cost-effectiveness: By providing specialized care at the polyclinic level, the health care system can potentially reduce the costs associated with hospital admissions and outpatient visits to larger facilities. This benefits both patients and the health care system as a whole.

Monitoring mechanism
• Platforms such as AB-HWCs, NCD, NIKSHAY, and IHIP
• Performance monitoring based on KPIs

Strengths of the model
• Regular service delivery to the community
• Reduced time needed for initiating a polyclinic
• Easier to add more specialist services compared to the recruitment model

Anticipated challenges
• Adherence to micro plans and duty rosters
• Follow-up care and quality may be compromised as specialist doctors are available only on specific days
A polyclinic may also be operationalized by engaging a local not-for-profit, charitable, or faith-based institution, or community-based organization, or nongovernmental organization (NGO) wherein UPHC is run by a non-profit entity but falls under the regulatory oversight and governance of the state NHM.

In such a model, the not-for-profit organization (NPO) assumes the day-to-day operations and management of the polyclinic, including staffing, provision of health care services, and financial management. However, the NHM maintains a supervisory role and holds the polyclinic accountable for meeting certain standards, regulations, and guidelines. The specific nature of the state’s involvement can vary depending on the jurisdiction and health care system structure.
**Ideal Geography**
- Cities with presence of not-for-profit, charitable, or faith-based institutions, or community-based organizations, or NGOs working in field of health care
- Tier-1 and tier-2 cities

**Key features of the model**
NPO-run polyclinics can play a crucial role in addressing the health care needs of underserved populations and improving access to health care services. These facilities are typically operated by NPOs driven by a mission to provide quality health care to those in need. Key features of NGO-run primary health care facilities include a focus on underserved areas where health care infrastructure is lacking or inadequate. These facilities often prioritize preventive care, health education, and community outreach to promote wellness and empower individuals to take control of their health. These polyclinics also emphasize a patient-centered approach, providing personalized care that considers the social, economic, and cultural contexts of the communities they serve.

Some of the key features of the NPO-run polyclinic model are as follows:

**Develop a clear contracting mechanism:** There will be need for a clear contracting mechanism with NPOs willing to run a polyclinic. These contracts outline the terms and conditions of service provision, including the scope of services, quality standards, reporting requirements, and financial arrangements. This will also define the roles and responsibilities of both the parties, i.e. NHM and NPOs. Basis this, a fund flow mechanism and an annual contracting fee may be finalized based on the local context and as per the specialist services rendered by the NPO-run polyclinic. The government may provide funding or reimburse the polyclinic for the health care services delivered to specific populations or under government health care programs.

**Mission-driven approach:** An NPO-run polyclinic operates with a mission to provide health care services to the community, prioritizing the well-being of patients over generating profits.

**Multidisciplinary care:** NPO-run polyclinics typically offer a range of health care services under one roof, providing primary care, preventive care, and specialized treatments. They may have a team of health care professionals, including doctors, nurses, specialists, and allied health staff to cater to diverse health care needs.

**Community engagement:** These polyclinics actively engage with the local community through health education programs, outreach initiatives, and partnerships with community organizations. They aim to raise health awareness, promote preventive care, and address the specific health care needs of the community.

**Transparent and accountable:** NPO-run polyclinics operate with transparency and accountability, ensuring that financial records, governance processes, and outcomes are reported and accessible to stakeholders.

**Monitoring mechanism**
- Performance monitoring based on key performance indicators

**Strengths of the model**
- No issue of recruitment and retention of human resource
- Better community connections
- No risk of commercial interests
- Limited availability of specialist doctors can be catered to by this model
- Complete set of medical and paramedical staff from one NPO may lead to better cohesion among the team members and coordinated service delivery

**Anticipated challenges**
- Capacity building of the staff on regular basis and on expanded package of services
- Adherence to Government of India protocols may be an issue
Polyclinic model based on public-private partnership

The public-private partnership (PPP) polyclinic model is an innovative approach that brings together resources, expertise, and strengths of both the public and private sectors to deliver health care services. In this model, the government collaborates with private entities, such as private health care providers, corporations, or multispecialty hospitals to establish and operate polyclinics. The key features of the PPP polyclinic model include sharing responsibilities, risks, and resources between public and private partners. The government provides the infrastructure, regulatory oversight, and funding support, while the private partner contributes their management expertise, health care services, and occasionally financial investments. This partnership allows for the efficient utilization of resources, improved service delivery, and enhanced access to health care for the community. The PPP polyclinic model often emphasizes quality care, cost-effectiveness, innovation, and sustainability. It can lead to increased health care capacity, reduced waiting times, enhanced technology integration, and better patient experiences. Additionally, the partnership may extend beyond the provision of primary care services to include diagnostics and ancillary services, depending on the scope of the collaboration.
### Ideal geography
- Cities with presence of private health care providers, corporations, or multispecialty hospitals
- Tier-1 and tier-2 cities

### Key features of the model
The private sector may be leveraged in a mix-model approach, wherein polyclinics can be operated by leveraging their human resources and infrastructure. The PPP polyclinic may be operated on the following types of partnerships with the private sector:

**Contracting specialist doctors from the private sector:**
The government employs specialist doctors according to the community’s specific requirements or to address gaps in the available specialist workforce following the guidelines of the Government of India. These specialists offer their services at public health care facilities on designated days for specific hours. They may be engaged on per day, per hour, or per patient basis.

**Outsourcing polyclinic services:** The government can involve select multispecialty private agencies to manage polyclinics within their premises. However, it is crucial to establish well-defined governance structures, transparent agreements, and robust monitoring mechanisms to ensure the alignment of interests, accountability, and the safeguarding of public health goals (see Figure 5).

**Monitoring mechanism**
- State-specific provisions in the contract related to outsourcing of services to a private partner
- Performance monitoring based on key performance indicators

**Strengths of the model**
- Resource efficiency by optimal utilization of resources by leveraging the expertise and capabilities of private sector
- Provision of specialized medical services that may otherwise be limited or unavailable in public health care facilities
- Enhancement of health care capacity, enabling the treatment of a larger number of patients
- Robust governance structures, clear performance indicators, and monitoring mechanisms to ensure accountability and transparency

**Anticipated challenges**
- Negotiating and managing contractual agreements between the public and private partners can be intricate and time-consuming
- Conflicts of interest may arise due to the private partner’s profit-driven motives conflicting with public health objectives
Telemedicine-enabled polyclinic model

The telemedicine model involves setting up a network of health facilities, where polyclinics serve as spokes connected to a larger hospital (hub) that provides specialized care. Patients can access specialized care without having to travel long distances to the main hospital. Telemedicine model has been successfully implemented in several states in India, including Tripura, Tamil Nadu, and Rajasthan. Moreover, UPHCs with available space can incorporate telemedicine to expand its reach of services, including specialist consultation.

In regions facing shortages in fields such as medicine, obstetrics, and gynecology, pediatrics, ophthalmology, dermatology, and psychiatry, a teleconsultation model can be adopted. The polyclinic, which may have been established at a UCHC/UPHC, will be linked to a larger hospital or premier medical institute of excellence, such as a district-level hospital, medical college, or national-level institutes of excellence like AIIMs and PGIMER. This linkage enables the use of specialists’ expertise via teleconsultations.
**Ideal geography**

Tier-2 and tier-3 cities with limited access to specialized health care facilities and availability of internet network facilities and IT infrastructure

**Key features of the model**

A telemedicine-run polyclinic is a health care facility that primarily delivers medical services through telecommunication technologies, allowing patients to access health care remotely. This model harnesses the power of digital platforms and telecommunication tools to provide consultations, diagnoses, treatment, and monitoring of patients’ health conditions.

The model includes a large hospital that provides specialized care and various specialists have dedicated time for teleconsultation as per a predetermined schedule. Polyclinics are set up in different areas to provide primary and basic health care services and the health facility is equipped with telemedicine units. Telemedicine is used to connect polyclinics to larger hospitals for consultation and specialist care. The polyclinics also need to have basic diagnostic and pharmacy facilities.

**Monitoring mechanism**

- Performance monitoring based on key performance indicators

**Strengths of the model**

- Improved access to specialists and health care professionals who may not be available locally, ensuring equitable health care provision
- Enhanced flexibility through scheduled consultations, saving time for both patients and health care providers
- Reduced health care expenses for patients by eliminating travel costs, minimizing the need for follow-up visits to specialist doctors or facilities, and enabling early intervention via remote monitoring

**Anticipated challenges**

- Technical problems such as lack of interoperability standards for the telemedicine software, limited availability of IT infrastructure, and low-bandwidth connectivity in slums
- Coordination between the polyclinics and the larger hospital for scheduling or microplanning for specialist doctors can be a challenge
- Patients may be apprehensive about e-medicine and acceptance of a new technology
In conclusion, when considering the establishment or enhancement of an existing UPHC into a polyclinic, it is essential to explore a menu of options to best meet the needs of the community. The menu should encompass a range of considerations, such as the target population, available resources, the local health care landscape, and prevailing health care challenges. This array of options may include considerations such as the integration of specialized services, collaborations with public and private entities, adoption of telemedicine, implementation of preventive and health promotion programs, and the exploration of innovative funding models. By carefully evaluating and selecting from the menu, health care stakeholders can design and implement a polyclinic that is tailored to address local health care needs, improve access to quality care, and promote the overall well-being of the community.
### Annexure I: List of equipment for operationalization of specialist services at polyclinics

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<tr>
<th>S.No</th>
<th>Specialty</th>
<th>Equipment for OPD</th>
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</table>
| 1    | Medicine OPD               | Examination light  
Thermometer  
Wall-mounted height-measuring scale  
Stethoscope  
Weighing machine (Adult)  
LED torch  
Measuring tape  
Digital BP machine  
Oxygen cylinder/concentrator with humidifier and flowmeter  
Patient examination table with mattress with footsteps  
Ceiling-operated privacy curtains  
Patient stool for sitting  
Wall clock with second hand  
Equipment for adult resuscitation kit  
Pulse oximeter  
Nebulizer  
Portable suction machine |
| 2    | Obstetrics and Gynecology  | Fetal Doppler  
Fetoscope  
Wall-mounted focus lamp for perineal and PV examination portable  
Autoclave Drum Set 2  
Sim’s vaginal speculum  
Pulse oximeter  
Biomedical waste buckets (Color-coded)  
Needle hub cutter (Electric)  
IUCD/PPIUCD tray  
Emergency drug tray  
Instrument trolley  
Stand and tray for bleaching solution (One bowl)  
Digital hemoglobinometer  
Glucometer and strips glucometers with 50 strips  
Retractors and speculums (Ant. vaginal wall retractor, Post. vaginal wall retractor, Sim’s speculum double-ended, Cusco speculum, Artery forceps, Allis forceps)  
Suture removal set (Artery, Scissor)  
Kidney trays and square trays  
Infantometer  
Proctoscope |
| 3    | Pediatrics                 | Digital weighing scale  
Stadiometer  
Wooden tongue depressor  
Non-stretchable measuring tape  
Resuscitation tray (AMBU Bag 250 ml with mask size 0 & 1, Mucus extractor, Foot-operated suction machine, ET tubes, laryngoscope for newborn, infant, and child)  
Vaccine carrier  
Oxygen hood (Infants, Children)  
Measuring Tape |
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<thead>
<tr>
<th>S.No</th>
<th>Specialty</th>
<th>Equipment for OPD</th>
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</table>
| 4    | Orthopedic        | Reflex hammer  
Ortho fracture table  
Skeleton traction set  
Cramer wire splints (10)  
Thomas splint (10)  
X-ray reader box |
| 5    | ENT               | Diagnostic otoscope  
Jobson Horne probe  
Head lamp  
Nasal speculum  
Wooden tongue depressor  
Laryngoscope  
Nasopharyngeal mirrors  
Aural speculum  
Siegel's speculum  
Tuning fork (156 Hz)  
Bayonet forceps  
Bulls lamp |
| 6    | Physiotherapy     | Shoulder wheel  
Wall ladder finger exerciser  
Finger Exerciser web  
Shoulder pulley  
Walking aid for training (Adjustable walker)  
Reciprocal walker  
Exercise couch  
One wheelchair  
Spiro meter  
Lower and upper extremity cycle/basic ergo meter |
| 7    | Ophthalmology     | Ophthalmoscope  
Slit Lamp  
Retinoscope  
Trial frame (Adults and children)  
Trial lens set  
Streak retinoscope  
Punctum dilator  
Applanation tonometer  
Snellen drum with remote  
Trial lens set with trial frame for adults and children  
Color vision chart (Original Ishihara)  
Near vision chart with different languages |
| 8    | Dental            | Dental chair |
| 9    | Other general equipment/material | Autoclave with two drums  
Stretcher and wheelchair  
Goggles, plastic apron, and gloves for examination of patients with biohazard |