WEST BENGAL MEDICAL SERVICES CORPORATION LTD.
(Wholly owned by the Government of West Bengal)
Swasthya Sathi, GN-29, Sector-V, Salt Lake, Kolkata-700 091.

NOTICE INVITING TENDER FOR

Preparation of Model Architectural Plan, Elevation,3D perspective view, working drawing; Architectural, Structural & Electrical along with submission of detailed estimate & B.O.Q ; Civil & Electrical for construction of Community Health Centre(CHC) in different districts at West Bengal

NIT Reference No. :- WBMSCL/NIT- 221/2022 Dated – 28/05/2022

WEST BENGAL MEDICAL SERVICES CORPORATION LIMITED
(Wholly Owned by the Government of West Bengal)
Registered Office: SwasthyaSathi, GN-29, Sector-V, Salt Lake, Kolkata-700091
Phone: 033-4034-0300 ◊ Email: info@wbmsc.gov.in ◊ website: www.wbmsc.gov.in

NIT Reference No. :- WBMSCL/NIT- 221/2022 Dated – 28/05/2022

Managing Director, West Bengal Medical Services Corporation Limited, Swasthya Sathi, GN-29, Sector-V, Kolkata - 700 091, invites e-tender for the works detailed in the table below

(Submission of Bid through online)

Sl. No.	Name of the work	Earnest Money (Rs.)	Time of Completion	Eligibility of Contractor
1.	**Preparation of Model Architectural Plan, Elevation,3D perspective view, working drawing; Architectural, Structural & Electrical along with submission of detailed estimate & B.O.Q ; Civil & Electrical for construction of Community Health Centre(CHC) in different districts at West Bengal**	32,000.00	45 Days	Intending bidders having Trade license in similar nature of job and produce credentials of a similar nature of completed work of the minimum value of Rs. 6,40,000.00 during last 5(Five) years prior to the date of issue of this tender notice or (ii) Two similar nature of completed work, each of the minimum value of Rs. 4,80,000.00 during last 5(Five) years prior to the date of issue of this tender notice or (iii) One single running work of similar nature which has been completed to the extent of 80% or more and value of which is not less than the amount Rs. 6,40,000.00.

Note:

a) For contract value exceeding 2.5 lakh deductions of TDS on GST is mandatory.

b) Quoted rate must be inclusive of GST.

c) Completion certificate should contain
i) Name of work, ii) Name of Agency, iii) Amount put to tender, iv) Tender No, v) Schedule month and year of commencement and completion as per the work order, vi) actual date of completion, vii) Gross value of the work done as per final bill.

d) Payment will be made after getting the work done certificate & recommendation from the respective Site Engineer.

e) **The prospective bidders must have the credential(s) of satisfactory completion as a prime agency during the last 5(five) years from the date of issue of this Notice as mentioned in Eligibility criteria under authority of State/ Central Govt., State /Central Govt. undertaking/ Statutory Bodies Constituted under the Statute of the Central / State Govt. The Credential Certificate has to be issued shall be issued by the Engineer-in-Charge of the works not below the rank of Executive Engineer or equivalent. Credential Certificate must have included Work Order, BOQ and Work completion Certificate.**

f) Payment certificates in lieu of credentials will not be accepted.

g) Valid up to date clearance of Income Tax return / GST Registration Certificate/ Professional Tax Enrolment/latest Deposit Challan / P.T. (Deposit Challan) / Pan Card / License / Voter ID Card for self-identification to be accompanied with the Technical Bid Documents, Income Tax Acknowledgement Receipt for latest assessment Year to be submitted.

h) The contractors who have been delisted of debarred by any government department shall not be eligible in anyway.

i) Joint venture will not be allowed to participate in the above NIT.

j) A prospective bidder participating in a single job either individually or as partner of a firm shall not be allowed to participate in the same job in any other form.

k) A prospective bidder shall be allowed to participate in a single job either in the capacity of individual or as a partner of a firm. If found to have applied severally in a single job, all his applications will be rejected for that job.

l) CV of proposed Architect, Civil, Electrical Engineers for the design of the proposed preparation of Model Architectural Plan, Design and Estimate to be uploaded along with bid document.

m) Where there is a discrepancy between the unit rate & the line item total resulting from multiplying the unit rate by the quantity, the unit rate quoted shall govern.

n) Prevailing safety norms has to be followed so that LTI (Loss of time due to injury) is zero.

o) No mobilization /secured advance will be allowed.

p) Agencies shall have to arrange land for erection of Plant & Machineries, storing of materials, labour shed, laboratory etc. at their own cost and responsibility.

q) Constructional Labour Welfare Cess @ 1 % (one percent) of the cost of construction will be deducted from every bill of the selected agency. GST, Royalty & all other Statutory Levy / Cess will have to be borne by the contractor. As the rates in the Schedule of rate are inclusive of GST & Cess as stated above.

r) In connection with the work, Arbitration will not be allowed. The Clause No. 25 of 2911(ii) is to be considered as deleted clause vide gazette notification no 558/SPW-13th December, 2011.

s) The work is of URGENT in nature and agency entrusted for it shall have to complete the work within stipulated time without any failure. It is a day to day maintenance of different important facilities. You have to ensure the presence of skilled personal with necessary tools and plants for 24X7.

t) Refund of EMD: The Earnest Money of all the unsuccessful bidders, deposited online, shall be refunded in accordance with the Memorandum of the Finance Department vide No. 3975-F(Y) dated 28th July, 2016.(Refer "Annexure-I" in Bidders Guideline).

u) Penalty for suppression / distortion of fact. Submission of false document by tenderer is strictly prohibited & if found action may be referred to the appropriate authority for prosecution as per relevant IT Act with forfeiture of earnest money forthwith.

v) The Earnest Money may be forfeited if ; -

i) If the Bidder withdraws the Bid during the period of Bid validity.
ii) In case of successful Bidder, if the Bidder fails to execute formal agreement within the stipulated time period.
iii) During scrutiny, if it is come to the notice of tender inviting authority that the credential or any other document which were uploaded & digitally signed by the Bidder are incorrect /manufactured / fabricated.

w) The successful Bidder shall have to execute Formal Agreement with Managing Director, West Bengal Medical Services Corporation Limited within 7(Seven) days from the issuance of Provisional Work order.

x) Bank guarantee shall be accepted for the purpose of the security.

1. In the event of e–filing, intending bidder may download the tender documents from the website: http://https://wbtenders.gov.in directly with the help of Digital Signature Certificate. Necessary Earnest Money will be deposited by the bidder electronically online through his net banking enabled bank account, maintained at any nationalized bank by generating NEFT/RTGS challan from the e-tendering portal and also to be documented through e-filing.

   As per G.O. No. 1592 – F(Y) dated. 20.03.2014 of the Finance Deptt. of Govt. of West Bengal, in case of e–tendering, EMD/Bid security will have to be submitted as soft copy (scanned copies of the originals) along with the tender for instruments and in case of deposit of money it should compulsorily be deposited on – line by the bidders. The L1 bidder will submit the hard copy of the documents to the tender inviting authority with his acceptance letter of the LOI within specified time as mentioned in the letter of acceptance. Failure to submit the hard copy with the acceptance letter within the time period prescribed for the purpose may be construed as an attempt to disturb the tendering process and dealt with accordingly legally including blacklisting of the bidder.

2. Both Technical bid and Financial Bid are to be submitted concurrently duly signed digitally in the website https://wbtenders.gov.in

3. Dully filled in copies of Section – II (Forms I to V) in prescribed proforma with proper dated signature in the relevant spaces to be uploaded electronically.

   Documents in support of the information furnished in Forms I to V, must be attached/uploaded for evaluation and the file number & page number has to be indicated in the respective column of the Form.

4. i) On selection of RTGS/NEFT as the payment mode, the e-Procurement portal will show a pre-filled challan having the details to process RTGS/NEFT transaction.
   ii) The bidder will print the challan and use the pre-filled information to make RTGS/NEFT payment using his Bank account.
   iii) The EMD of the bidders disqualified at the technical evaluation will be refunded through an automated process to the respective biddres' bank accounts from which they made the payment transaction.

5. 4. The Financial Offer of the prospective Tenderer will be considered only if the Tenderer qualifies in the Technical Bid. The decision of the Managing Director, WEST BENGAL MEDICAL SERVICES CORPORATION LIMITED will be final and binding on all concerned and no challenge against such decision will be entertained.

6. In case of inadvertent typographical mistake found in the Specific Price Schedule of Rates i.e. Bill of Quantity (BOQ), the same will be treated as to be so corrected as to conform with the prevailing relevant Schedule of Rates and/or Technically Sanctioned Estimate.

7. Running payment for work may be made to the executing agency as per availability of fund. The executing agency may not get a running payment unless the gross amount of Running Bill stands at least 20% (Twenty Percent) of the tendered amount. Provisions in Clause(s) 7, 8& 9 contained in W.B. Form No. 2911(ii) so far as they relate to quantum and frequency of payment is to be treated as superseded.

8. Bids shall remain valid for a period not less than 120 (one hundred twenty) days after the dead line date for Financial Bid submission.

9. Important Information:

DATE AND TIME SCHEDULE:

Sl. No.	Particulars	Date & Time
1	Date of uploading of NIeT Documents (online)(Publishing Date)	01.06.2022, 9.00 A.M
2	Tender documents download start date (online)	02.06.2022, 9.00 A.M
3	Bid proposal submission start date (online)	06.06.2022,10.00 A.M
4	Technical & Financial Bid proposal Submission end date(online)	17.06.2022 4.00P.M
5	Bid opening date of Technical evaluation (online)	20.06.2022 ,3.00P.M
6	Bid opening date of Financial proposal	To be notified later

10. Cost of Tender Documents: **NIL** (As per Notification of the Secretary, Public Works Department, CRC Branch, Government of West Bengal vide No. 199-CRC/2M-10/2012 dated: 21/12/2012 communicated by the Technical Secretary, Public Works Department, Government of West Bengal that the intending tenderers shall not have to pay the cost of tender documents for the purpose of participating in e-tendering.)

11. Earnest Money: The amount of Earnest Money is to be submitted Online through his net banking enabled bank account, maintained at any nationalized bank by generating NEFT/RTGS challan from the e-tendering portal and also to be documented through e-filing. The process of deposit of earnest money through offline instruments like Bank Draft, Pay Order etc. will be stopped for e–tender procurement of this office w.e.f. 01.09.2016.

    Once the financial bid evaluation is electronically processed in the e-Procurement portal, EMD of the technically qualified bidders other than that of L1 and L2 bidders will be refunded through an automated process to the respective bidders' bank accounts from which they made the payment transaction. If the L1 bidder accepts the LOI and the same is processed electronically in the e-Procurement portal, EMD of the L2 bidder will be refunded through an automated process to his bank account from which he made the payment transaction.

    The earnest money of the successful bidder (being converted to security deposit) deposited, will remain under the custody of the department till satisfactory completion of the work in full including extended quantity if ordered for. Besides this, necessary percentages shall be deducted from the progressive bids so as to make it 3% (Three percent) of the value of work billed for as per memorandum no. 201-F(Y) dated 18th January 2021.

12. The Bidder, at his own responsibility and risk is encouraged to visit and examine the site of works and its surroundings and obtain all information that may be necessary for preparing the Bid and entering into a contract for the work as mentioned in the Notice Inviting Tender, before submitting the offer with full satisfaction. The cost of visiting the site shall be at his own expense.

13. The intending Bidders should clearly understand that whatever may be the outcome of the present invitation of Bids, no cost of Bidding shall be reimbursable by the Department. The Managing Director, WEST BENGAL MEDICAL SERVICES CORPORATION LIMITED reserves the right to reject any or all the application(s) for purchasing Bid Documents and/or to accept or reject any or all the offer(s) without assigning any reason whatsoever and is not liable for any cost that might have been incurred by any Tenderer at the stage of Bidding.

14. The intending bidders are required to quote the rate online only. No offline tender will be entertained.

15. If more than one Bidder quoted same rate and which are found lowest at the time of opening, such similar multiple rates will not be entertained / accepted. Lowest offer will be ascertained by sealed bid amongst the lowest bidders.

16. Contractor shall have to comply with the provisions of (a) the contract labour (Regulation Abolition) Act. 1970 (b) Apprentice Act. 1961 and (c) minimum wages Act. 1948 and any other notification thereof or any other laws relating thereto and the rules made and order issued there under from time to time.

17. During the scrutiny, if it comes to the notice of the tender inviting authority that the credential(s) and/or any other paper(s) of any bidder is / are incorrect/ manufactured/fabricated, that bidder(s) will not be allowed to participate in the tender and that application will be rejected outright.

18. The Managing Director, WBSMCL reserves the right to cancel the N.I.T. or issue corrigendum notices to the NIT due to unavoidable circumstances and no claim in this respect will be entertained.

19. List of "Technically Qualified Bidders" will be published in the web portal only. Financial Bid will be opened within a short period after such publication. Therefore, Bidders are requested to view the tender status on a regular basis.

20. In case of any objection regarding prequalifying an Agency, that should be lodged to the ManagingDirector, WEST BENGAL MEDICAL SERVICES CORPORATION LIMITED within 1(one) day from the date of publication of the list of qualified agencies and beyond that time schedule no objection will be entertained.

21. Before issuance of the work order, the tender inviting authority may verify the credential(s) and/or other document(s) of the lowest tenderer, if found necessary. After verification, if it is found that the document(s) submitted by the lowest tenderer is/are either manufactured or false, the work order will not be issued in favour of the said Tenderer.

22. If any discrepancy arises between two similar clauses on different notifications, the clause as stated in later notification will supersede former one in following sequence;-
    a) Notice Inviting Tender
    b) Special Terms and Conditions
    c) Financial Bid
    d) Schedule of Works

    All works covered in the clause appearing hereinafter shall be deemed to form a part of the appropriate item or items of works appearing in the work schedule whether specifically

mentioned in any clause or not and the rates quoted shall include all such works unless it is otherwise mentioned that extra payment will be made for particular works.

23. Schedule of Rates applicable for execution of the work **: The submitted rate as per BOQ of online tender**.

24. As per memorandum no. 4608-F(Y) dated.18.07.2018 of Finance Department Govt. of West Bengal, the successful bidder will have to submit Additional Performance Security @10% of the tendered amount, if the accepted bid value is 80% or less of the estimated amount put to tender. The Additional Performance Security shall be submitted in the form of Bank Guarantee from any Scheduled Bank before issuance of the Work Order. If the bidder fails to submit the Additional Performance Security within seven working days from the date of issuance of Letter of Acceptance, his Earnest Money will be forfeited and other necessary actions as per NIT like blacklisting of the contractor, etc, may be taken. The Bank Guarantee shall have to be valid upto end of the Contract Period and shall be renewed accordingly, if required. The Bank Guarantee shall be returned immediately on successful completion of the Contract. If the bidder fails to complete the work successfully, the Additional Performance Security shall be forfeited at any time during the pendency of the contract period after serving proper notice to the contractor. Necessary provisions regarding deduction of security deposit from the progressive bills of the contractor as per relevant clauses of the contract shall in no way be altered/affected by provision of this Additional Performance Security.

Intending tenderers are required to submit online attested/self-attested photocopies of valid enlistment renewal certificate, valid partnership deed (in case of partnership firm), current Professional Tax Deposit Challan / Professional Tax Clearance Certificate, PAN Card, Trade License from the respective Municipality, Panchayet etc. (in case of S & P Contractors only), [Non statutory documents]

In case of Registered Unemployed Engineers' Co-operative Societies and Registered Labour Cooperative Societies, attested photocopies of documents of credentials showing satisfactory completion of a single work in any Government Department commencing on or after 01.04.2009 of value not less than 40% of the Estimated Cost of the work applied for, 'Certificate of Registration' from the respective Assistant Registrar of Co-operative Societies, Professional Tax Deposit Challan / Professional Tax Clearance Certificate, PAN Card, must be submitted online. Payment certificates in lieu of credentials will not be accepted. [Non statutory documents]

The intending tenderer is required to quote the rate in figures as well as in words inclusive of all incidental fees , charges , taxes etc.

Conditional / incomplete quotation will not be entertained.
Issuance of work order as well as payment will depend on availability of fund and no claim whatsoever will be entertained for delay of Issuance of work order as well as payment, if any. Intending tenderers may consider this criterion while quoting their rates.

If any tenderer withdraws his offer before acceptance or refuse within a reasonable time without giving any satisfactory explanation for such withdrawals, he shall be disqualified from submitting tender to WEST BENGAL MEDICAL SERVICES CORPORATION LIMITED for a minimum period of 1(one) year.

Tax and other deductions shall be made as below:

i) GST will be deducted as applicable.
ii) Cess @ 1% (One Percent) of the cost of construction works will be deducted from the bills of the contractors on all contracts awarded on or after 01.11.2006 in pursuance with G.O. No. 599A/4M- 28/06 dated 27.09.2006.
iii) 2% (Two percent) Income Tax of the cost of construction work will be deducted from the bill.

iv) Security Money deposit @ 1% (One Percent) will be deducted from the progressive bills in addition to the earnest money to make a total deposit of 3%(Three Percent) of the value of work executed.

- Modification in the West Bengal Form No.: 2911/2911(i)/2911(ii)Clause 17 of CONDITIONS OF CONTRACT of the Printed Tender Form shall be substituted by the following vide Govt. Notification No 5784-PW/PW/L&A/2M-175/2017 dated 12.09.2017:

'Clause 17 - If the contractor or his workmen or servants or authorized representatives shall break, deface, injure, or destroy any part of building, in which they may be working, or any building, road, road-curbs, fence, enclosure, water pipes, cables, drains, electric or telephone posts or wires, trees, grass or grassland or cultivated ground contiguous to the premises, on which the work or any part of it is being executed, or if any damage shall happen to the work from any cause whatsoever or any imperfection become apparent in it at any time whether during its execution or within a period of three months or one year or three years or five years, as the case may be (depending upon the nature of the work as described in the explanation appended hereto) hereinafter referred to as the Defect Liability Period, from the actual date of completion of work as per completion certificate issued by the Engineer-in-Charge, the contractor shall make the same good at his own expense, or in default, the Engineer-in-Charge may cause the same to be made good by other workmen and deduct the expense (of which the certificate of the Engineer-in-Charge shall be final and binding on all concerned) from any sums, whether under this contract or otherwise, that may be then, or at any time thereafter become due to the contractor from the Government or from his security deposit, either full, or of a sufficient portion thereof and if the cost, in the opinion of the Engineer-in-Charge (which opinion shall be final and conclusive against the contractor), of making such damage or imperfection good shall exceed the amount of such security deposit and/or such sums, it shall be lawful for the Government to recover the excess cost from the contractor in accordance with the procedure prescribed by any law for the time being in force.-
Provided further that the Engineer-in-Charge shall pass the "Final Bill" and certify thereon, within a period of thirty days with effect from the date of submission of the final bill in acceptable form by the contractor, the amount payable to the contractor under this contract and shall also issue a separate completion certificate mentioning the actual date of completion of the work to the contractor within the said period of thirty days. The certificate of the Engineer-in-Charge whether in respect of the amount payable to the contractor against the "Final Bill" or in respect of completion of work shall be final and conclusive against the contractor . However, the security deposit of the work held with the Government under the provision of clause 1 hereof shall be refundable to the contractor in the manner provided here under:-

(a) For work with three months Defect Liability Period:
   i) Full security deposit shall be refunded to the contractor on expiry of three months from the actual date of completion of the work.

(b) For work with one year Defect Liability Period:
   i) Full security deposit shall be refunded to the contractor on expiry of one year from the actual date of completion of the work.

(c) For work with three years Defect Liability Period:
   i) 30% of the security deposit shall be refunded to the contractor on expiry of two years from the actual date of completion of the work;
   ii) The balance 70% of the security deposit shall be refunded to the contractor on expiry of three years from the actual date of completion of the work;

(d) For work with five years Defect Liability Period:
   i) No security deposit shall be refunded to the contractor
   ii) for 1s t 3 years from the actual date of completion of the work;
   iii) 30% of the security deposit shall be refunded to the contractor on expiry of four years from the actual date of completion of the work;

iv) The balance 70% of the security deposit shall be refunded to the contractor on expiry of five years from the actual date of completion of the work;

Explanation :

The word 'work' means and includes building work, road work, drain work, sanitary and plumbing work and/or any other work contemplated within the scope and ambit of this contract. For

i) The work of patch repair or patch maintenance in nature or a combination thereof, the Defect Liability Period ofthe work shall be three months from the actual date of completion of the work.

ii) Thorough Bituminous Surfacing work with bituminous thickness less than 40 mm, Repair & Rehabilitation of any road / bridge / culvert / building / Sanitary & Plumbing work, the Defect Liability Period of the work shall be one year from the actual date of completion of the work;

iii) Extension of building / bridge / culvert, Construction of new flexible pavement up to bituminous level which has been designed for a period of 3 years or more, Widening and strengthening of flexible pavement designed for a period of 3 years or more, Improvement of riding quality / Strengthening of flexible pavement designed for a period of 3 years or more; Providing only mastic asphalt layer over existing bituminous surface without providing bituminous profile corrective course / bituminous base course, the Defect Liability Period of the work shall be three years from the actual date of completion of the work;

iv) Construction of new building / new bridge / new culvert, Reconstruction of building / bridge / culvert including construction of approach roads for bridge / culvert, Construction of rigid pavement, Reconstruction of rigid pavement, Construction of new flexible pavement covered by mastic work which has been designed for a period of 5 years or more, Widening and strengthening of flexible pavement covered by mastic work which has been designed for a period of 5 years or more, Improvement of riding quality / Strengthening of flexible pavement covered by mastic work which has been designed for a period of 5 years or more, the Defect Liability Period of the work shall be five years from the actual date of completion of the work;

Successful Tenderers will be required to obtain valid Registration Certificate & Labour License from respective Regional Labour Offices where construction work by them are proposed to be carried outas per Clauses u/s 7 of West Bengal Building & other Construction Works' Act, 1996 and u/s 12 of Contract Labour Act.

Power of Attorney holders are not allowed to sign Tender Documents unless otherwise approved by the Government.

Clause-25 of the conditions of contract of the West Bengal Form No. 2911/2911(ii) may be treated to be omitted and there is no provision for arbitration for resolution of disputes that may arise out of the contracts to be entered into by the Department with the contractors for the purpose of carrying out execution of public works as per G.O No. 558/SPW dated 13-12-2011 of P.W.D.

Successful tenderers will be required to observe the following conditions strictly:

a. Employees' Provident Fund and Miscellaneous Provisions Act, 1952 and Employees StateInsuranceAct,1948 should be strictly adhered to wherever such Acts become applicable.
b. Minimum wages to the workers shall be paid according to the rates notified and/or revised by the State Government from time to time under the Minimum Wages Act, 1948 in respect of scheduled employments, within the specified time as per law. Payment of bonus, wherever applicable, has to be made.

c. Adequate safety and welfare measures must be provided as per the provisions of the Building and other Construction Workers' (Regulation of Employment & Conditions of Service) Act, 1996 read with West Bengal Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Rules, 2004.
d. All liabilities arising out of engagement of workers are duly met before submission of bills for payment.

If there is any violation of any or all the relevant above criterion during execution of the job, it will render the concerned agencies ineligible for the work then and there or at any subsequent stage as may be found convenient.

Special Terms & Conditions

i)The plan of the proposed Community Health Centre(CHC) must comply with the Guidelines of Indian Public Health Standards (IPHS) -2012 read with Guiding Principle of Infrastructure Planning & Design Requirements for building new health facilities as per Technical & Operational Guidelines of XV Finance Corporation – Health Grants.(Copies of relevant pages are enclosed herewith . The selected Architectural Firm however should go through the whole documents)
ii) The Plan of the proposed Community Health Centre (CHC) must comply with the Building Bye Laws of Local Bodies./Panchayat .(Copy of site plan is enclosed). The selected Architect may inspect the proposed site of construction before finalization of the plan .Necessary approval of the said plan from the respective local body /Panchayat (as applicable) shall have to be obtained by the selected Architect before submission of the same to H&FW Department. Necessary fees/charges in the regard shall have to be borne by the selected Architect. (If Applicable).
iii) The structural drawing must conform latest I.S.Code and to be vetted by reputed Engineering & Technical University approved by AICTE. Detail structural analysis shall also have to be submitted along with the drawing. Long section of each beam with detailing at the junction shall have to be shown in the drawing.
iv)The Foundation Design shall have to be made on the basis of Soil Exploration Report of the particular site of construction which will be made available to the selected Architect by the concerned DMPU Engineers.
v)The Architectural drawing will consist of Plan , four sides elevation , at least two sectional views with proper dimension.
vi)The Electrical Drawing will consist Single Line Diagram (SLD) and Conduit Layout.
vii)The selected Architect must follow time line of each component of work as detailed below failing which the matter will be treated as a case of breach of contract and necessary penal measure will be taken as per relevant clause of contract.

Stage	Scope of Work	Time Line
1.	Preparation of model plan as per satisfaction of the authority of Health & Family Welfare Department.	7 (seven) days from the date of issue of W/O
2.	Preparation of 3D Perspective View after finalization of model plan (Three options are to be submitted)	12(Twelve) days from the date of issue of W/O
3.	Preparation of working Drawing consisting of Architectural , Structural & Electrical Detailing.	25(Twenty five) days from the date of issue of W/O
4.	Preparation of detailed estimate for both Civil & Electrical components following latest P.W.W. Schedule of Rates and guidelines. Detailed estimate will consist detailed measurement with analysis of rates & Electrical Load Flow Studies.	35(Thirty five) days from the date of issue of W/O
5.	Preparation of Bill of quantities (BOQ) for Civil & Electrical component as per vetted estimate along with DPR.	38(Thirty eight) days from the date of issue of W/O

vii) On successful completion of the aforesaid stages of work payment will be made as per following schedule

Sl. No.	Description	% age of payment
1.	After satisfactory completion up to & including stage 2	20%
2.	After satisfactory completion up to & including stage 4	40%
3.	After satisfactory completion up to & including stage 5	40%

INSTRUCTION TO BIDDERS

SECTION – I

1. General guidance for e-Tendering

Instructions/Guidelines for tenders for electronic submission of the tenders online have been annexed for assisting the contractors to participate in e-Tendering.

1. Registration of Contractor

   Any contractor willing to take part in the process of e-Tendering will have to be enrolled &registered with the Government e-Procurement system, through logging on to https://wbtenders.gov.in the contractor is to click on the link for e-Tendering site as given on the web portal.

2. Digital Signature certificate (DSC)

Each contractor is required to obtain a class-I, class-II or Class-III Digital Signature Certificate(DSC) for submission of tenders, from the approved service provider of the National Information's Centre(NIC) on payment of requisite amount details are available at the Website stated in Clause-2 of Guideline to Bidder DSC is given as a USB e- Token.

3. The contractor can search & download NIT & Tender Documents electronically from computer once he logs on to the website mentioned in Clause 2 using the Digital Signature Certificate. This is the only mode of collection of Tender Documents.

4. Participation in more than one work

A prospective bidder shall be allowed to participate in the job either in the capacity of individual or as a partner of a firm. If found to have applied severally in a single job all his applications will be rejected for that job.

5. Submission of Tenders

General process of submission:- Tenders are to be submitted through online to the website stated in Cl. 2 in two folders at a time for each work, one in Technical Proposal & the other is Financial Proposal before the prescribed date & time using the Digital Signature Certificate(DSC). The documents are to be uploaded virus scanned copy duly Digitally Signed. The documents will get encrypted (transformed into non readable formats).

6. Eligibility to Participate

i. Bidders must have valid trade license without which no bidder will be allowed to participate.
ii) Bidder must have valid PAN, ESI, EPF registration without which no bidder will be allowed to participate.
iii) Bidders not fulfilling the eligibility criteria need not to participate and in the event of their participation without being fulfilling the eligibility criteria, their bids will summarily be rejected.

A. Technical proposal

The Technical proposal should contain scanned copies of the following in two covers (folders)

A-1.Statutory Cover file Containing

i) Earnest money (EMD) as prescribed in the NIT against each of the serial of work in favour of the Managing Director, West Bengal Medical Services Corporation Limited.
ii) Tender form No. 2911(ii) &NIT(Properly upload the same Digitally Signed).The rate will be quoted in the BOQ. Quoted rate will be encrypted in the B.O.Q. under Financial Bid. In case of Quoting any rate in 2911(ii) the tender is liable to summarily rejected).

A-2. Non statutory / Technical Documents

i) Professional Tax (PT) deposit receipt challan for the financial year 2017-18,ProfessionalTax clearance certificate, Pan Card, Income Tax Return, Certificate of provisional registration of GSTIN and valid Trade License.
ii) Registered Deed of partnership Firm/ Article of Association & Memorandum
iii) Registration Certificate and Clearance Certificate issued by the Assistant Register of Cooperative Society (ARCS) bye laws are to be submitted by the Registered labour Co-Operative Society/ Engineer's Co operative Society.
iv) Requisite Credential Certificate for completion of at least one similar nature of work under the authority of State/ Central Govt. having a magnitude of at least 40(forty)percent of the

Estimated amount put to tender during the last 5(Five) years prior to the date of issue of this NIT is to be furnished in applicable cases.

v) Valid Service Tax Registration should possess by the tenderer.

Note:- Failure of submission of any of the above mentioned documents will render the tender liable to be rejected for both statutory & non statutory cover.

THE ABOVE STATED NON-STATUTORY/TECHNICAL DOCUMENTS SHOULD BE ARRANGE IN THEFOLLOWING MANNER

Click the check boxes beside the necessary documents in the My Document list and then click the tab "Submit Non Statutory Documents" to send the selected documents to Non-Statutory folder. Next Click the tab "Click to Encrypt and upload" and then click the "Technical" Folder to upload the Technical Documents.

Sl. No.	Category Name	Sub Category Description	Details
A.	CERTIFICATES	CERTIFICATES	1. Certificate registration of GSTIN. 2. PAN 3. P. Tax (Challan) (2018-19 to 2020-21) 4. Latest IT Receipt 5. IT-Return for last three years 6. Trade License
B.	Company Details	Company Details -I	1. Proprietorship Firm (Trade License in civil works) 2. Partnership Firm (Partnership Deed, Trade License in civil works) 3. Society (Society Registration copy, Trade License in Architectural works) 4. Registered and Empanelled at Council of Architecture (COA)
C.	Credential(in applicable cases)	Credential 1 Credential 2	Documents of Credentials as per Notification No. 03-A/PW/O/10C-02/14Dated :12.03.2015 Intending bidders having Trade license in similar nature of job and produce credentials of a similar nature of completed work of the minimum value of Rs. 6,40,000.00 during last 5(Five) years prior to the date of issue of this tender notice or (ii) Two similar nature of completed work, each of the minimum value of Rs. 4,80,000.00 during last 5(Five) years prior to the date of issue of this tender notice or (iii) One single running work of similar nature which has been completed to the extent of 80% or more and value of which is not less than the amount Rs. 6,40,000.00.
D.	Financial (If necessary)	Work in hand	1. Authenticated
		Payment certificate – 1 Payment certificate - 2	Only payment certificates not the TDS certificate.

Opening of Technical proposal: -

i) Technical proposals will be opened by the Managing Director, West Bengal Medical Services Corporation Limited and his authorized representative electronically from the web site stated using their Digital Signature Certificate.

ii) Intending tenderers may remain present if they so desire.

Opening of Financial proposal: -

i) The financial proposal should contain the following documents in one cover(folder) i.e. Bill of quantities (BOQ) the contractor is to quote the rate in the manner (Above/ Below/ At per) online through computer in the space marked for quoting rate in the BOQ.

ii) Only downloaded copies of the above documents are to be uploaded virus scanned & Digitally Signed by the contractor.

The eligibility of the Bidder will be ascertained on the basis of document submitted / uploaded &digitally signed in support of the minimum criterion as mentioned above. If any document submitted / uploaded by the Bidder is either manufactured or false the eligibility of Bidder will be out rightly rejected at any stage without prejudice and action will be taken as per stipulation of IT Rules in force.

Sd/-
Managing Director
West Bengal Medical Services Corporation Limited

INSTRUCTION TO BIDDERS

SECTION–II

FORM–I

B.1. PRE-QUALIFICATION APPLICATION.

To

Managing Director,

West Bengal Medical Services Corporation Limited

Ref:-Tender for

N.I.T. No: WBMSCL/NIT-221/2022, Dated –28/04/2021 of West Bengal Medical Services Corporation Limited

Dear Sir,

Having examined the Statutory, Non statutory, Instruction to Bidders & NIT documents along with its Agenda & corrigendum, I/we hereby submit all the necessary information and relevant documents for evaluation

The application is made by me / us on behalf of

In the Capacity

The necessary evidence admissible by law in respect of authority assigned to us on behalf of the group of firms for Application and for completion of the contract documents is attached herewith. We are interested in bidding for the work(s)given in Enclosure to this letter. **We understand that:**

(a) Tender Inviting & Accepting Authority/Engineer-in-Charge can amend the scope & value of the contract bid under this project.

(b) Tender Inviting & Accepting Authority/Engineer-in-Charge reserve the right to reject any application without assigning any reason.

(c) **Enclo:- e-Filling:-**

(d) 1. Statutory Documents.

(e) 2. Non Statutory Documents.

Date:-Signature of applicant

Including title and capacity in which application is made.

SECTION–II
FORM–II

B.3. STRUCTURE AND ORGANISATION.

B.3.1. Name of applicant:

_____

B.3.2. Office Address: _____

_____

_____

Telephone No.:

_____

Fax No. : _____

E-mail ID : _____

B.3.3. Name & address of Bankers: _____

_____

_____

B.3.4. Attach an organization chart showing the structure of the company with names of Key personnel and technical staff with Bio-data.

Note: Application covers Proprietary Firm, Partnership, Limited Company or Corporation,

Date:

Signature of applicant.
Including title and capacity in which application is made.

SECTION–II

FORM –III

B.4. EXPERIENCE PROFILE.

B.4.1. Name of the Firm:

_____

_____

B.4.2. LIST OF PROJECTS COMPLETED THAT ARE SIMILAR IN NATURE TO THE WORKS HAVING MORE THAN 40% OF THE PROJECT COST EXECUTED DURING THE LAST FIVE YEARS.

Name, Location & nature of work	Deptt. Concern	Engineer in-Charge	Contract price in Indian Rs.	% of Participation of company	Original Time Schedule		Actual Time Schedule		Reasons for delay in completion (if any)
					Start Date	Completion Date	Start Date	Completion Date	

Note: a) Certificate from the Employers to be attached

b) Non-disclosure of any information in the Schedule will result in disqualification of the firm

Date: Signature of applicant

Including title and capacity in which application is made.

[Print out in Agency's Letter head & upload the filled proforma with digitally signed as stated below]

SECTION–II

FORM –IV

DECLARATION BY THE TENDERER

I/We have inspected the site of work and have made myself/ourselves fully acquainted with local conditions in and around the site of work. I /We have carefully gone through the Notice Inviting Tender and other tender documents mentioned therein along with the drawing attached. I/We have also carefully gone through the 'Priced schedule of Probable Items and Quantities'.

My/Our tender is offered taking due consideration of all factors regarding the local site conditions stated in this Detailed Notice Inviting Tender to complete the proposed work referred to above in all respects.

I/We promise to abide by all the stipulations of the contract documents and carry out and complete the work to the satisfaction of the department.

I/We declare that I/We in the capacity of individual/ as a partner of a firm not debarred in the last financial year.

I/We also agree to procure tools, plants and others as per requirement, at my/our cost required for the work.

Signature of Tenderer

Date :

Postal address of the Tenderer

Name of the Firm with Seal

SECTION–II

FORM –V

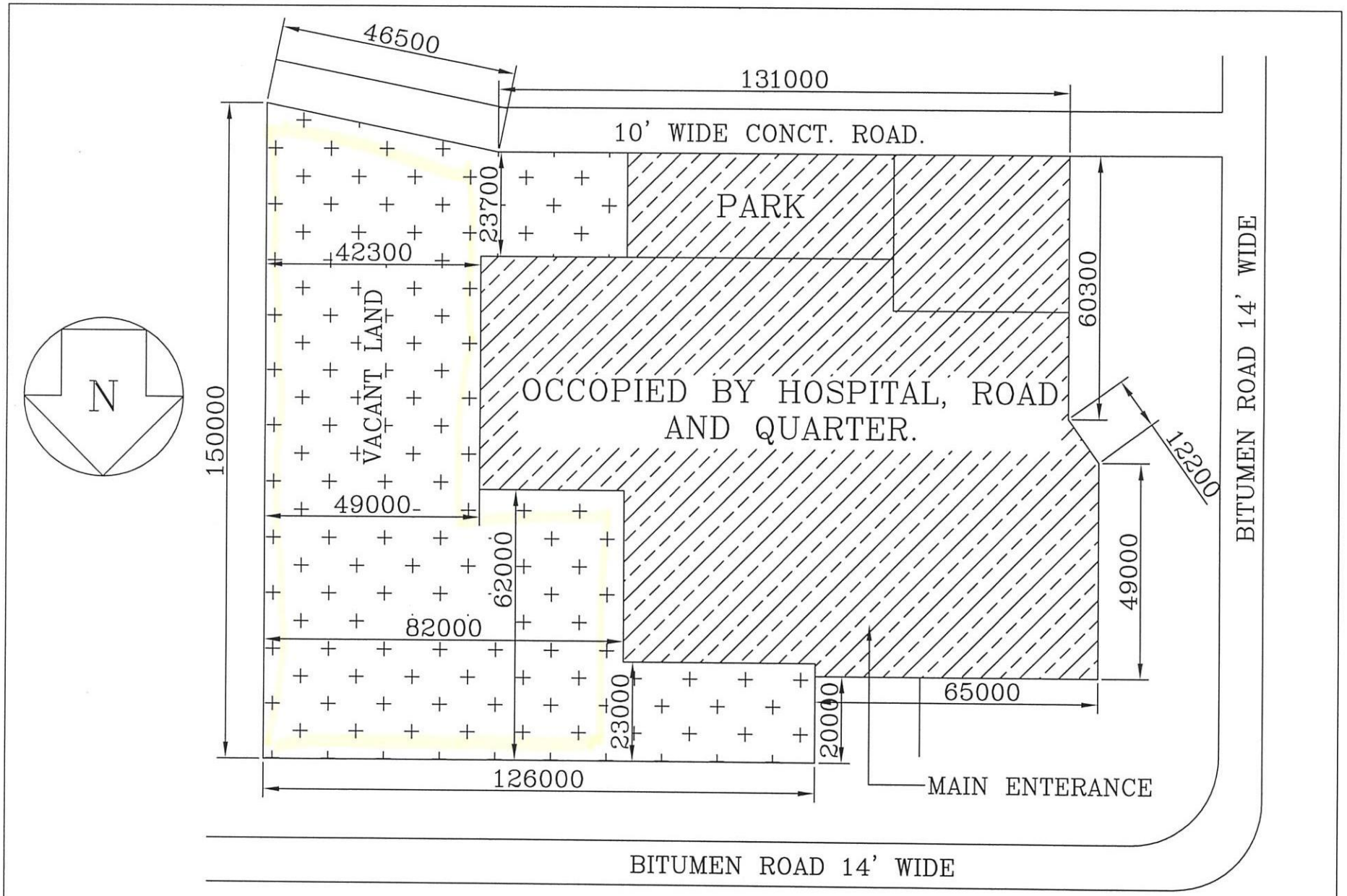
Bill Of Quantity(BOQ)

Name of Work: Preparation of Model Architectural Plan, Elevation,3D perspective view, working drawing; Architectural, Structural & Electrical along with submission of detailed estimate & B.O.Q ; Civil & Electrical for construction of Community Health Centre(CHC) in different districts at West Bengal

Sl. No.	Description of items	Area	Unit	Rate (@ Rs.)	Amount (Rs.)
1	Preparation of Model Architectural Plan, Elevation,3D perspective view, working drawing; Architectural, Structural & Electrical along with submission of detailed estimate & B.O.Q ; Civil & Electrical for construction of Community Health Centre(CHC) in different districts at West Bengal	1900	SQ.M		
			Total Amount		

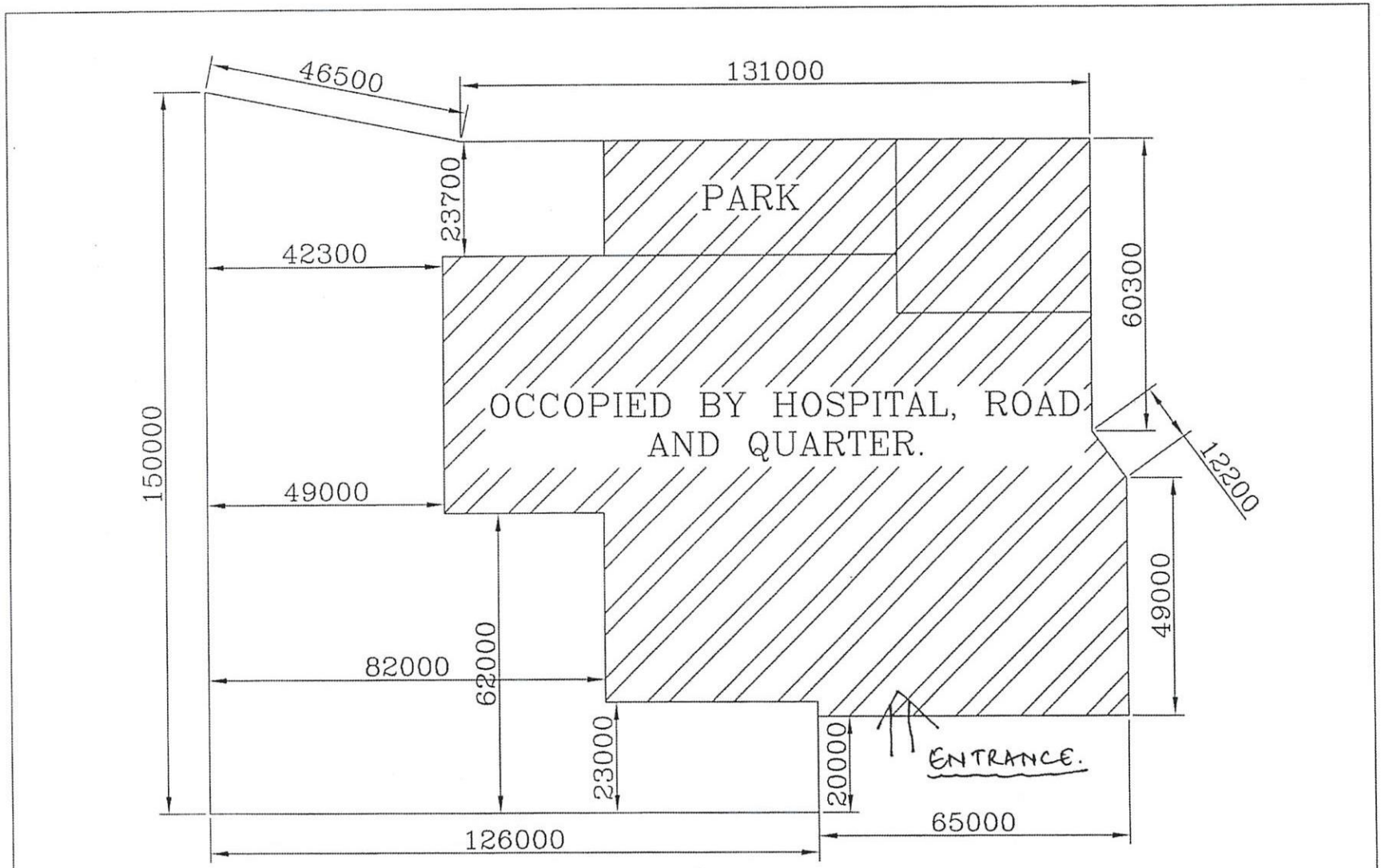
Total amount in words :

Note: All Rates are Inclusive All Taxes and Duties. The actual area in each floor covered by the outer faces of the columns will be considered for payment without considering architectural projections , chajjas , ramp etc. No extra payment for roof area , staircase room, septic tank , u.g. reservoir etc. will be entertained.



ROUGH LAYOUT OF MAHESBATI BPHC RAINA–I

ALL DIMENTION ARE IN MM.



ROUGH LAYOUT OF MAHESBATI BPHC RAINA–I

ALL DIMENTION ARE IN MM.

S. Adj 20/05/22
Sub-Assistant Engineer (Civil)
National Health Mission
District Health & Family Welfare Samity
Purba Bardhaman
Government of West Bengal

Assistant Engineer (Civil)
National Health Mission
District Health & Family Welfare Samity
Purba Bardhaman
Government of West Bengal

CMOH & Secretary
DH & FWS, Purba Bardhaman

Ministry of Health and Family Welfare
Government of India

TECHNICAL & OPERATIONAL GUIDELINES

IMPLEMENTATION OF 15TH FINANCE COMMISSION (FC-XV) - HEALTH GRANTS THROUGH LOCAL GOVERNMENTS

31.08.2021

MINISTRY OF HEALTH AND FAMILY WELFARE

Contents

List of Appendices:

Chapter 1: Overarching Principles for Planning and Implementation

1.1 Introduction

The Fifteenth Finance Commission (FC-XV) has recommended grants through local governments for specific components of health sector to the tune of Rs 70,051 crores and the same have been accepted by the Union Government. These grants for health through Local Governments will be spread over the five-year period from FY 2021-22 to FY 2025-26 and will facilitate strengthening of health system at the grass-root level.

The state wise annual resource envelope for each component over the next five years is already specified by the FC-XV report and is included as Appendix in the respective chapters.

Since the utilization of these FC-XV grants are to be completed on-time, to claim the subsequent instalments, the 28 States will be required to ensure completion of these activities in a time bound manner so that the FC-XV funds are efficiently utilized. **The funds released under the FC-XV grants for each Financial Year have to be utilized in the respective financial year.** States are required to ensure that optimal and effective utilization of funds are ensured at the District and Rural Local Bodies (RLB) / Urban Local Bodies (ULB) level.

1.2 Objective of the document

These technical and operational guidelines are intended for state and district programme managers, and the representatives of state and district rural and urban local bodies so that district specific plans may be drawn up specific to the need and context and consolidated into an actionable State Plan. The guidelines are structured as follows:

Chapter-1: lays out overarching principles for the use of the FC-XV grants for planning and gap analysis as per the needs identified by the Health Department in consultation with the Urban and Rural Local bodies; Chapter-2 lays out the guidance for establishing Urban Health and Wellness Centres (Urban-HWCs) and access to specialist services/polyclinics; Chapter-3 provides a detailed description for the Construction of Building less Sub Health Centres (SHCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs); Chapter-4 addresses the component related to the conversion of rural SHCs and PHCs to Health and Wellness Centres (HWCs); Chapter-5 focusses on the creation of Block Public health Units (BPHUs) and Chapter-6 provides direction on Support for Diagnostic Infrastructure to Primary Health Care facilities- SHCs, PHCs and urban PHCs (UPHCs).

Each chapter provides the description of each of the specific components, objectives of the component, the unit cost applicable for the component, factors to be considered while planning and the negative list for which the funds should not be utilized. As per the components, State, especially the Districts and Local Bodies are required to conduct comprehensive gap analysis as critical planning exercise before submitting the proposals for approval.

1.3 Components of XV-FC

Out of the total grants for health through Local Governments of Rs 70,051 crore, Rs 43,928 Crore has been allocated as tied grants for the 28 states through Rural Local Bodies (RLBs) and Rs. 26,123 Cr has been allocated as tied grants for Urban local bodies (ULBs). These grants are for strengthening primary care through the following specified components:

1.3.1 Rural Components

A. Building-less Sub-Centres, Primary Health Centres (PHCs), Community Health Centres (CHCs)
B. Conversion of rural PHCs and Sub-Centres to Health and Wellness Centres (HWCs)
C. Support for diagnostic infrastructure to the primary healthcare facilities
D. Block Level Public Health Units

Table 1: Year wise break up for the four components:

(Rs. In Crore)

Sr. No	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Building-less Sub Centres, PHCs, CHCs	1350	1350	1417	1488	1562	7167
2	Block level Public Health Units	994	994	1044	1096	1151	5279
3	Support for diagnostic infrastructure to the primary healthcare facilities	3084	3084	3238	3400	3571	16377
3.a	Sub-Centres	1457	1457	1530	1607	1687	7738
3.b	PHCs	1627	1627	1708	1793	1884	8639
4	Conversion of rural PHCs and Sub Centres into health and wellness centre	2845	2845	2986	3136	3293	15105
	Total Grants for primary health sector in rural areas	**8273**	**8273**	**8685**	**9120**	**9577**	**43928**

1.3.2 Urban Components

A. Support for diagnostic infrastructure to the primary healthcare facilities.

B. Urban Health and wellness centres (HWCs)

Table 2: Year wise break up for the two components:

(Rs. In Crore)

Sr. No	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Support for diagnostic infrastructure to the primary healthcare facilities – Urban PHCs	394	394	415	435	457	2095
2	Urban health and wellness centres (HWCs)	4525	4525	4751	4989	5238	24028
	Total Grants for primary health sector in urban areas	**4919**	**4919**	**5166**	**5424**	**5695**	**26,123**

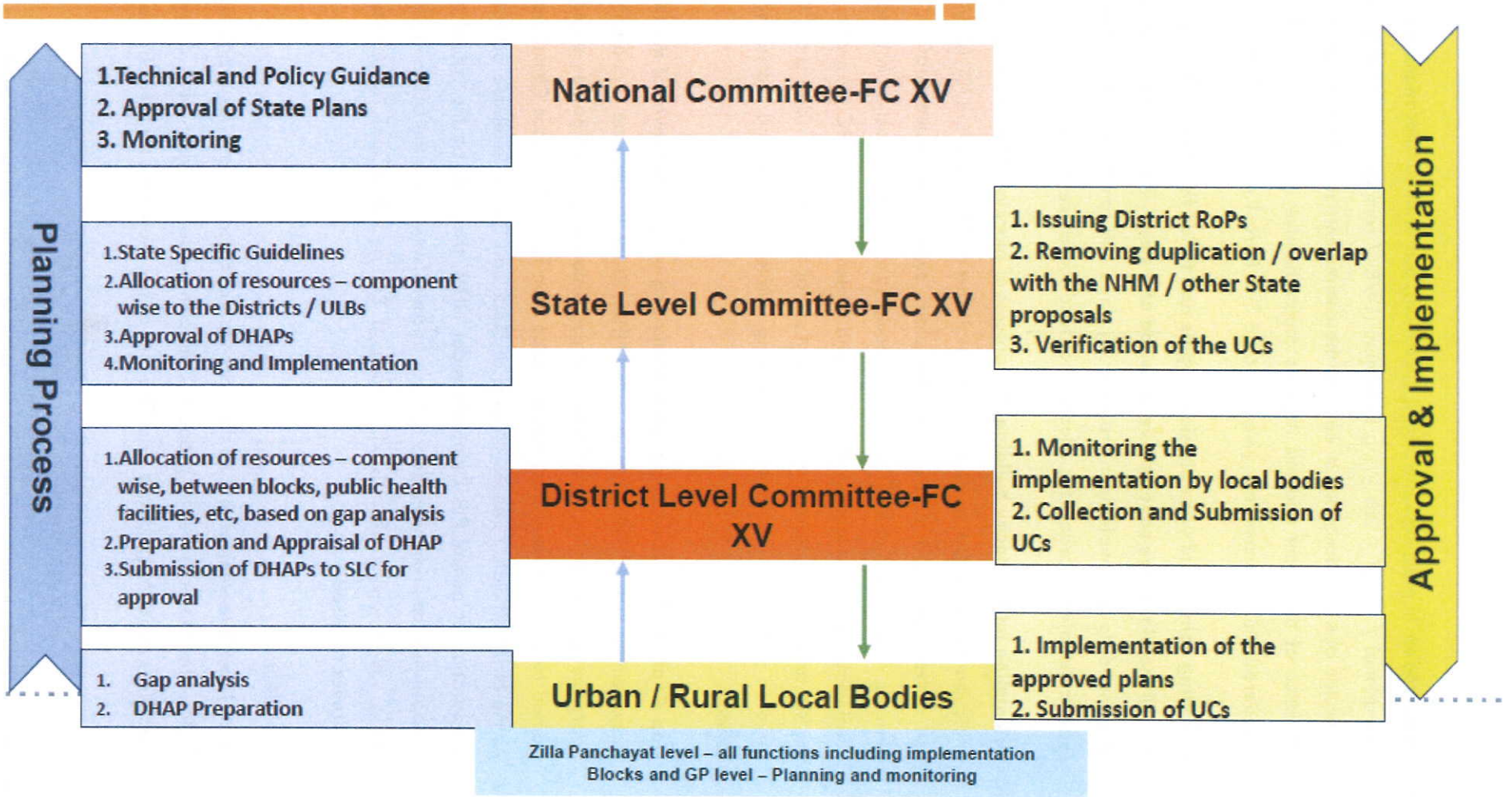
1.4 Planning and Budgeting

1.4.1 Pre-Planning

The key activities to be performed prior to preparation of the plan under XV-FC at State level will include:

i. **Developing the State specific guidance** for deciding the criteria for resource envelope and component wise target distribution among the districts / RLBs and ULBs. As per the DoE's guidance note (Annexure : Para 7 at page-7), at the district level, the Zilla Panchayats or Autonomous District Councils shall handle / implement the rural components of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector (not at Block Panchayat or Gram Panchayat level), because the components require technical experience as well as exposure in relevant subjects. However, rural local bodies below the district level (as the case may be), such as Block /Taluk level Panchayats, and Gram Panchayats / Village Councils must be involved in planning and monitoring of these components for the health facilities located in their jurisdiction. Similarly, at the district level, the urban local bodies shall handle / implement the urban components of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector.

Figure 1: Flow Diagram for Planning, Preparation, Implementation and Monitoring



ii. **Prioritization**: In planning district fund allocations, preferential allocations are to be made to the Aspirational / Tribal / Left Wing Extremism (LWE) / remote / Hill districts. However, within a particular district, allocations in each of the components should cover more units for effective utilization of the grant and this requires comprehensive gap analysis and the factors to be considered while planning are given at Table 3 of Para 1.4.2 of this chapter.

iii. **Indicating component wise physical targets and funds for each of the district/ULB to ensure that all the blocks are covered over a period of 5 years.** This is a crucial task at the State level which needs to be completed in pre-planning stage and communicated to all the districts with the specific directives / orders for allocation of funds component-wise.

iv. **Orientation and Capacity building:** The process of planning should be preceded by orientation and capacity building of the RLB and ULB at district and Block/Ward/Division levels so that they are actively engaged in preparing the plans, supporting implementation, and undertaking periodic reviews and monitoring. States should take necessary action in building capacities of Rural Local Bodies in planning, utilization and implementation of FC-XV grants. The ownership of the RLB and ULB is critical to ensure optimal use of the funds provided under FC-XV. It will also serve to strengthen decentralized planning, implementation and monitoring for the overall district.

v. **Gap Analysis:** District planning teams comprising of representatives of the District Programme Management Unit (DPMU) set up under NHM, Block Programme Management Unit (BPMU), Representatives of District and Block/Ward/Division level Local Bodies would be created and trained to prepare the District Health Action Plan for 15th Finance Commission (DHAP-FC-XV). As the NHM officials / representatives at Block and District level are actively involved in the preparation of annual PIP Proposals under NHM, they will be the critical team members to prepare the comprehensive gap analysis in coordination with the ULB and RLB representatives along with involving officials of Panchayat Raj and Municipal Administration Department, wherever required.

1.4.2 Key Principles

i. **State level five-year plan:** As the year-wise and component-wise grants are known to the States, the States have to prepare component-wise five-year plan as per the technical guidelines MoHFW, guidance from DoE and as per their local context. This will ensure proper

allocation of resources to the Districts in-advance – component wise, which will facilitate proper planning by the Districts for the current financial year and for the remaining four years. The factors that could be considered in allocation of resources to the Districts are explained in the Table 3 given below.

Table 3: Factors (component-wise) to be considered for inter-se allocation of resources to the Districts:

S.NO.	FC-XV Component	Factors to be considered for inter-se allocation of FC-XV grants to the Districts
1.	Block Public Health Unit	Number of Blocks in the State / District. States may prioritize the blocks in the Aspirational districts, including Tribal districts (as notified by MoTA) and Left Wing Extremism (LWE) affected districts (30 districts as informed by MHA), while doing inter-se allocation of resources among districts. Similarly, depending on the resources available, efforts may be made to saturate the blocks in the Hill districts of the Hill states/UTs (NE States, Himachal Pradesh, Uttarakhand, Jammu & Kashmir and Ladakh).
2.	Building-less SHCs, PHCs and CHCs	Number of Building-less SHCs / PHCs / CHCs in the District The States may prioritize the new constructions of healthcare facilities, **especially those Sub Health Centres, that have been converted into Ayushman Bharat Health and Wellness Centres (AB-HWCs)**, based on the grants of FC-XV available and few factors to be considered in this regard are: • Run-down / dilapidated building structures which are required to be re-built. • Construct new buildings, where services are being provided from rented buildings especially in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers. • New buildings in lieu of existing rented buildings that may not have adequate infrastructure/ space for carrying out the required activities. • New buildings, if required as per shortfall of population norms as per details given in RHS 2020. **States are informed that if the existing rented buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**

S.NO.	FC-XV Component	Factors to be considered for inter-se allocation of FC-XV grants to the Districts
3.	Conversion of Rural PHCs and Sub Centres into Health and Wellness Centre	Number of functional SHC-HWCs and PHC-HWCs in the District. District may apportion resources to the block panchayats in proportion to the number of functional SHC-HWCs as on date. Preferably, SHC-HWCs that are functional for more than one year can be selected for allocation of FC-XV resources.
4.	Diagnostic Infrastructure (Rural and Urban)	Number of SHCs, PHCs and UPHCs in the District. Actual allocation of resources is to be done after comprehensive gap analysis, for strengthening the Diagnostic Infrastructure at the SHCs, PHCs and UPHCs and building the diagnostic capacity in a Hub and Spoke model.
5.	Urban Health and Wellness Centres	Based on the vulnerability assessment and mapping of the urban areas, the slum / vulnerable areas will be prioritized where presently no primary health care facility exists The priority is to ensure that there is one Urban-HWC per 15,000-20,000 population catering predominantly to poor and vulnerable populations, resident in slum and slum-like areas. Decisions regarding the required number of Urban-HWCs, would depend on population density, presence of slums & similar habitations, vulnerable population, peri-urban areas and newly Notified Urban Areas and would be decided by the State Level Committee (SLC) based on justification provided by the ULB.

ii. **Five-year Plan:** Districts should also similarly, develop a comprehensive plan for 5 years, to utilize FC-XV grants in the given time frame. The template for the same will be enabled on the IT platform.

iii. **First-year Plan:** The state is required to plan for fund utilization for the 1st year keeping in view the limited timeline for its utilization and the necessity to complete the implementation of first year units / components before the end of financial year for effective utilization of FC-XV grants.

iv. **District Health Action Plan (DHAP):** As per the resource allocation indicated to the district component wise and year wise, each District would prepare a District Health Action Plan for the FC-XV grants (DHAP-FC-XV) – year wise and component wise, covering all the rural and urban components, based on the financial allocation and specific physical targets communicated by the state. **For current financial year (FY 21-22), the districts have to prepare the plan duly keeping in mind the limited time-line and the necessity to complete the execution of works within the available time of the financial year.** The DHAP-FC-XV for each district, thus prepared, would

provide granular details on number of block/ward/division wise facilities that would receive the FC-XV funds on annual basis.

v. While preparing the **District Health Action Plan (DHAP)**, the districts should not only give emphasis on the technical guidance of FC-XV, but also a holistic assessment of the components should be undertaken including the systematic review of the burden of disease in that district, local epidemiology, rural demographic profile and the specific needs and requirements of communities in different parts of the district.

vi. **Unit Costs and Number of Units**: The unit costs for each component have been derived based on the upper limit and are also included in the respective chapters for each of the components. The States could plan for more number of functional units under each component, within the available resources, on the basis of comprehensive gap analysis.

vii. **Negative List**: State is required to strictly comply to the negative lists, which is specified for each of the components. States should not utilize the grants for the activities in the negative list.

viii. **Non-duplication:** States should ensure that there is no duplication or overlap of proposals, tasks, procurements, constructions, hiring of HR etc. for which funds have already been provided under NHM, State budgets, any other funds.

ix. **The fund under the FC-XV health grants should not be used by the State as the State's contribution for any CSS component or for any other mandate, apart from the components listed for the utilization of the health grants under FC-XV.**

x. **Centralized Procurement of medicines, Medical equipment, diagnostics and other consumables, etc**: As stated in the DoE's Guidance Note (Para 8 at Page 8), on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other consumables, etc, through a mechanism which include Central purchase at State level through established mechanisms like State Medical Services Corporations / Societies or State Health Society. For the centrally procured items, the State level Committee may also work out a mechanism for the payment of such centrally procurement items.

xi. **Collaboration with the other departments:** The RLBs / ULBs would ensure convergence with various schemes relating to the wider determinants of health and wellness such as urban development, drinking water, sanitation, education, nutrition being implemented by other ministries and departments.

xii. **Grievance Redressal:** The PRIs / ULBs will be required to monitor the implementation of the components for which the procurements / recruitments have been done centrally and any concern / issue should be raised in writing to the DLC.

xiii. **State level monitoring mechanism**: As the expenditure of FC-XV grants is to be completed within the same financial year, the States should fast track the preparation of the District plans and

subsequently, the State plan based on the gap analysis, appraise them in the SLC and send it to NLC for appraisal and approval.

xiv. **IT platform for approval and monitoring**: The State/SLC will send the progress reports on both physical and financial progress against the approved plan on quarterly basis to the Ministry of Health and Family Welfare, Govt. of India. A dashboard with the progress monitoring system (PMS) of 15th Finance Commission components is being prepared and would be made available to the States, to enable to send the proposals from the District level committee to State level committee for consideration and examination and further from State level committee to National level committee for appraisal and approval. This PMS would also be utilized to monitor the progress of all the components of FC-XV, both to track the physical as well as financial progress. The dashboard has to be updated by States regularly and the regular up-dation of the progress would be essential for release of subsequent instalments of FC-XV grants to the States.

xv. **Learning from NHM for implementation of some of the components of FC-XV grants:**

a. **Advantages of implementation of 3 components of FC-XV grants by the States:** As the States are already implementing three of the five components, namely, Building-less Sub Centres, PHC and CHC in rural areas, Conversion (provision of recurrent costs) of SHC/PHC to HWC, and support for diagnostic infrastructure in rural and urban areas, the Guidelines for these components including financial norms for various interventions, including Human Resource, recurrent costs if applicable, layouts in terms of specifications, operational details, etc., are already being used by states in planning for NHM and would serve as the basis for district planning.

b. **New Components for the States:** The components viz, Urban – HWCs, and Block Public Health Units (BPHU), are new interventions and States should orient all the stakeholders including health department, panchayat raj and municipal administration department officials and ULBs and RLBs to assist the planning process at the State and District level.

xvi. **Factors to be considered while planning component wise action plan:** Factors that are to be considered while planning have been given in detail in the respective chapters.

a. As the States / districts are already aware about the shortfalls / building-less SHCs, PHCs, in rural areas, number of the blocks and functional SHC and PHC level HWCs, the district level planning would be easier, based on the resource allocation to the districts, as allocated by the State.

b. Prioritizing blocks that are remote or cover larger proportion of marginalized populations, including tribal areas and similarly, prioritizing the facilities located in these backward areas of the district, has to be kept in mind to ensure the equitable access of intended services through FC-XV grants.

c. Similarly, the effective implementation of the component of the urban HWCs, depends on mapping the vulnerable areas within the territorial jurisdiction of the urban local bodies to finalize the location of such facilities in close collaboration with ULB.

xvii. Infrastructure works:

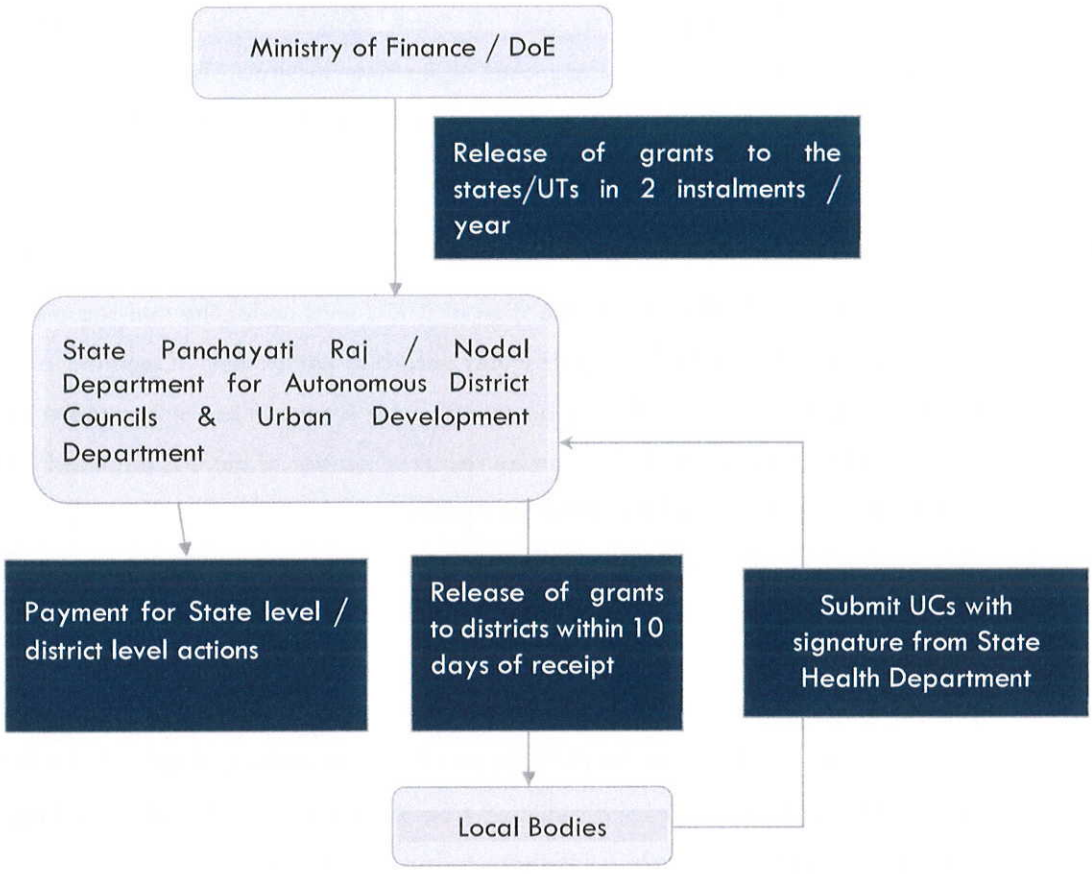
a. Out of the various components, the Building-less SHCs, PHCs, is the only component, where it is purely infrastructure work.
b. The component of conversion of SHCs and PHCs into HWCs does not include infrastructure related works.
c. In the component of BPHUs, the infrastructure support is provided for and the BPHU should ideally be located in the Block Medical Offices or Block CHC premises and have a linked laboratory also preferably located in the same premises for better synergy between clinical, programmatic and public health functions.
d. Similarly, in the urban HWCs component, the refurbishing of existing space for running the Urban HWCs is provisioned.
e. The component involving diagnostic infrastructure for SHCs, PHCs and UPHCs does not involve any civil or associated infrastructure work. This component covers the recurring expenditure for providing the diagnostic services at these facilities and non-recurring expenditure component for procurement of diagnostic equipment required. This activity can be taken up based on the principle of a Hub and Spoke Model and also on a PPP (Outsourcing) basis, wherever feasible.

xvii Recurring expenditure:

a. The component of BPHU involves creation of BHPU units under the non-recurring component and support of HR and other inputs under recurring component. Once the constructions of BPHUs are completed, the HR may be recruited for running these units and the FC-XV grants may be utilized accordingly. HR can be recruited earlier, if there is existing infrastructure / space available that can be utilized for BHPUs.
b. The component of Urban HWCs involves only recurring activities, except for minor infrastructure refurbishing of the existing space of the ULBs or government buildings for running the Centres. As soon as the premises are ready, the urban HWCs should start providing services from these premises and FC-XV grants may be utilized accordingly.
c. As the component of conversion of SHCs and PHCs are to be utilized only for the functional HWCs, the FC-XV grants may be utilized from the date of approval of the proposal of this component, as the grants are only meant for operational expenses of the functional HWCs.
d. For the component of diagnostic infrastructure at SHCs, PHCs and UPHCs, the FC-XV grants

may be utilized for recurring expenses for provision of diagnostic services at the functional SHCs, PHCs and UPHCs from the date of approval of these components. As there are substantial resources factored under this component, capital expenditure activities such as procurement of essential equipment, based on the gap analysis, will also be covered under this component of FC-XV grants. For the diagnostic component in rural and urban areas, a detailed gap analysis will need to be undertaken at each level of facility. After **ensuring that** the recurring expenses related to diagnostic services at SHCs, PHCs and UPHCs are provided for, the first charge of the remaining funds of this component should be to ensure provision of essential diagnostic tests at the Block and sub Block facilities (PHC-HWC and SHC-HWC in rural areas and U-PHCs). Once the needs of these facilities have been met, procurement of essential in-house diagnostic equipment for CHC/SDH and DH to address complex primary health care needs that cannot be undertaken at HWC- PHC/SHC or the Block level would also be permitted and taken up in a hub and spoke model.

1.4.3 **Fund flow:** The Figure 2 below represents the flow of funds for FC XV allocation:



1.5 Components and basis for allocation of resources to the districts

While detailed technical guidelines on each of the components is available separately, to help the State planning team, a brief on each component is provided below:

1.5.1 Rural Components

A. Building-less Sub Health Centres (SHCs), and Primary Health Centres (PHCs), Community Health Centres (CHCs)

The XV-FC has provisioned for supporting infrastructure to achieve the targets of the National Health Policy, 2017. The fund allocated under XV-FC may be utilised for construct buildings for the building less primary healthcare facilities and States / Districts may give priority to SHCs and PHCs depending on their local context. It is suggested to the Districts and States that SHCs may be given priority under this component, especially for those Sub Health Centres which are building less, operating in rented or rent-free panchayat/ Voluntary Society Buildings. The PHCs may be taken up after meeting the requirement of the SHCs. The facilities to be upgraded may be selected based on the following criteria:

a. Prioritization based on infrastructure availability:

i. Run-down / dilapidated building structures which are required to be re-built.

ii. Construct new buildings, where services are being provided from rented buildings especially in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers.

iii. New buildings in lieu of existing rented buildings that may not have adequate infrastructure/ space for carrying out the required activities.

iv. New buildings, if required as per shortfall of population norms as per details given in RHS 2020[3].

v. **States are informed that if the existing rented buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**

vi. Prioritising based on land availability: even among the above prioritized facilities, those SHCs for which site/land has already been acquired[1] are to be prioritised.

[1] Minimum estimated land required for SC-HWCs is 3000 sq. ft. and for PHC-HWCs is 15000 sq. ft.

b. Prioritising based on location: The new site (in case land has been acquired for multiple sites) located in Aspirational districts/ Tribal areas/ Left Wing Extremism (LWE) affected areas/ Hill areas are to be prioritised.

c. The prioritization should also take into consideration the local capacities available, so that the new buildings get completed in the stipulated time. In cases where two or more facilities are proposed for construction, the RLBs needs to indicate their priority.

d. **The maximum unit cost of construction of a new building is set at ₹ 55.5 lakhs for an SHC, ₹ 1.43 crore for a PHC. The district-wise allocation for this component may be done based on the proportion of building less SHCs and PHCs.**

B. Conversion of rural PHCs and Sub-Centres to Health and Wellness Centres (HWCs)

a. The XV-FC has provided grant in aid support to all 28 States for meeting the running cost of functional SHC and PHC level HWCs in the district. On examination of the funds available, it is suggested that **except in a few States (Odisha, Bihar, Rajasthan, Haryana)**, funds available may not be sufficient for all the functional SHC and PHC level HWCs in the Districts as on date.

b. Accordingly, detailed guidelines on selection of HWCs for support under this component is given in the respective chapter. The district and State must ensure that there is no duplication of activity.

c. The proportion of rural PHCs and SHCs to be converted into HWCs may be made the basis for district-wise allocation.

C. Support for diagnostic infrastructure to the primary healthcare facilities

a. The XV-FC health grants are to strengthen the diagnostic infrastructure at Sub-Health centres (SHCs), and Primary Health Centre (PHCs) to achieve the IPHS and CPHC norms so that the intended comprehensive primary healthcare could be delivered.

b. The DHAP and the State plan should ensure that all the required clinical and public health diagnostic services are provided to the community either by strengthening in-house service delivery capacities or by expanding the same under the PPP mechanism, as deemed appropriate and suitable at the Block, District and State level keeping in view the capacity and inclination of the private providers in hard-to-reach areas and difficult terrains.

c. Presently 14 tests at Sub Health Centre/ Health & Wellness Centre level and 63 tests at PHC level are to be conducted as per guidelines on free diagnostics initiative. The team responsible for gap analysis and planning should look in to following components:

   i. Availability of Health Services, lab services and caseload
   ii. Gap in terms of infrastructure for providing diagnostic services as per CPHC guideline
   iii. Availability of Human Resources for providing services as per IPHS

iv. Availability and functionality of the diagnostics and lab equipment including storage
v. Availability of IT infrastructure
vi. Availability of rapid/point of care test kits, reagents, and other consumables and their optimal storage conditions
vii. Gap in the existing Logistic Management System
viii. Equipment maintenance mechanism
ix. Distance / Travel time from Hub/ availability of transport services
x. Need for capacity building of existing HR

d. **For equipping a new / greenfield SHC or PHC with the required diagnostic infrastructure, a maximum of ₹ 3.91 lakhs for each SHC and a maximum of ₹ 25.86 lakhs for each PHC could be proposed.** For the existing / brownfield SHCs and PHCs in rural areas, the grant could be used depending on the gap analysis and comprehensive diagnostic plan of the district. So, the unit rate for each SHC / PHC may vary as per the identified gaps in the facility but should not exceed the maximum limits specified under FC-XV grants.
e. After saturating all the diagnostics related requirements of SHCs and PHCs, States and the districts may plan to utilise the balance amount for strengthening the diagnostics infrastructure at the CHC/ SDH/ district hospital level in a Hub and Spoke model to support the SHCs and PHCs and with the approval from National Level Committee.
f. The initial district-wise allocation may be done based on proportion of SHCs and PHCs in the district.

D. <u>Block Level Public Health Units:</u>

a. Support is being provided under XV-FC to establish Block Public Health Units (BPHUs) across all the blocks of 28 states. The BPHUs will have three major components:
   i. Public Health Unit for providing public health functions such as surveillance and detection of outbreaks.
   ii. Block Public Health Lab for providing advanced diagnostics services for clinical and public health functions.
   iii. Hub for data compilation, analysis, and feedback, through a Health Management Information System and IHIP.
b. The BPHU will serve as the referral unit for the Health and Wellness Centres (Sub Health Centre/Primary Health Centre) in the block.
c. A comprehensive plan is to be prepared for the following activities under this component of XV-FC:
   i. Infrastructure requirement

ii. Requirement for IT Support
iii. Requirement for equipment for Block Public Health Lab
iv. HRH for BPHU

d. A maximum of ₹ 80.96 lakhs of Capital expenditure per BPHU and a maximum of ₹ 20.14 lakhs of recurring/operational expenditure per BPHU (applicable once the constructions / non-recurring activities are completed either in the same financial year or in the subsequent year) is prescribed. Details are given in the respective chapter.
e. The proportion of blocks in the district would be the basis of district wise allocation of budget and targets.

1.5.2 Urban Components

A. Support for diagnostic infrastructure to the primary healthcare facilities: The XV-FC grant will provide support for strengthening the diagnostic services in the urban PHCs. The range of diagnostic tests has been expanded in alignment with the guidelines of comprehensive primary healthcare services under Ayushman Bharat.

a. For each urban PHC, support will be provided for the following components:

i. Procurement of diagnostic equipment
ii. Setting up IT support
iii. Procurement of kits
iv. Sample transportation
v. Equipment Maintenance
vi. Monitoring
vii. Capacity Building
viii. Miscellaneous cost

b. For equipping a new / greenfield UPHC with the required diagnostic infrastructure, a maximum of ₹ 25.86 lakhs for each UPHC could be proposed. For the existing / brownfield UPHCs in urban areas, the grant could be used depending on the gap analysis and comprehensive diagnostic plan of the district. So, the unit rate for each UPHC may vary as per the identified gaps in the facility but should not exceed the maximum limits specified under FC-XV grants.
c. The proportion of existing and new Urban PHCs may be made the basis of district-wise/ULB wise allocation of budget and targets.

B. Urban Health and Wellness Centres (Urban HWCs): To strengthen the health systems to deliver comprehensive primary healthcare through Ayushman Bharat-Health and Wellness Centres (AB-HWCs) in urban areas, health grant has been recommended for:

a. **Urban Health and Wellness Centres:** The urban HWCs are expected to increase its reach in the urban areas and cover the vulnerable and the marginalized by acting as satellite centres

to be established under the UPHCs. Each UPHC that caters to a population of approximately 50,000, is expected to have 2-3 UHWCs under it, depending on the vulnerable population of the urban local body and as per the detailed guidance given in the Chapter 2.

b. **Provision of specialist services at Urban health facilities / Polyclinics**: The Polyclinics are envisioned to ensure continuum of care by providing specialty services closer to the community. In urban areas, currently 5-6 UPHCs are catering to a population of 2.5-3 lakhs; one of the UPHCs, among these 5-6 UPHCs would be identified to be upgraded as a Polyclinic with availability of specialist services on a rotation basis. For areas with functional Urban CHCs (UCHCs) providing specialist services, separate polyclinics may not be required.

As the 15th FC grants are to plug the critical gaps in the Primary Health care, SLC may proportionately allocate the budget and targets between Metros, million plus cities, Other cities, towns, etc., (except those having a population of less than 50,000 population) giving priority to unserved and underserved slum or slum like populations.

1.6. Roles and Responsibilities:

The summary of the National, State and District Level Committee roles and responsibilities are listed below:

Table 4: Roles and responsibilities for planning, implementation and monitoring:

Level	Planning	Implementation	Monitoring
National level Committee	• Guidance to States for flow and utilization of grants, with a timeline of deliverables and outcomes • Appraisal and approval of state proposals	• Provide technical guidance related the XV-FC grants	• Review progress
State Level Committee	• District wise resource allocations as worked out by the State Health Department • Set target and physical deliverables for the districts	• Identify of local bodies based on State specific structure • Delegation of powers to RLBs/ ULBs • Provide all the assistance for implementation of FC XV – Health Grants to the districts.	• Review progress • Facilitate Collection and sending of the UCs of FC-XV grants to GoI • Ensuring timely submission of progress reports
District Level Committee	• Validate district specific gap assessment report prepared by the district planning team • Prioritising within district • Ensuring there is no duplication of activity within FC grants or any other source of fund	• Provide overall guidance to RLB/ULBs on implementation • Mobilize the District Health team to support RLB/ULB in planning and provide technical support	• Mobilize the District Health team to support RLB/ULB in planning and provide technical support • Review progress • Coordinate with Local Bodies for collection of

Level	Planning	Implementation	Monitoring
	• Finalise the Costing of plan of the district as per the guidelines	• Appraise the proposals received from RLB/ULB and recommend to SLC	**UCs** and submitting to the State • Check and prevent any duplication • Ensuring timely submission of progress reports

1.7. Financial Approvals and fund transfer

1.7.1 Fund Releases and submission of UCs and releases of subsequent instalments: The details are already communicated to the States by the DoE vide letter dated 16th July 2021. Copy is attached with this document at Annexure. It is reiterated that timely completion of the activities and submission of UCs and providing the physical and financial progress in the Progress Monitoring System are crucial to get the subsequent instalments of the FC-XV grants. The allocation of the funds state-wise and component wise have been provided in the respective chapters of the components for ease of reference for the States and Districts.

1.7.2 Pooling of funds: Functions such as engaging competent human resources for health, procurement of medicines, equipment, diagnostics & consumables, contracting agencies to provide diagnostic services (as in the Hub and Spokes model), etc are critical for implementation of above components. Efficient use of funds for these activities, are dependent on economies of scale, standardized processes, including quality assurance, and require complex technical expertise. **(DoE's Guidance Note at Annexure (Para 8 at Page 8) and reiterated again at sub-point 10 under para 1.4.2 of this Chapter)**

1.7.3 State level / District level HRH services: Most of the State Health Departments have developed effective modalities for recruitment of Human Resources for Health such as Medical Officers, Nurses, Lab Technicians, Pharmacists and other para-medical staff, through mechanisms such as a State / District level agency of government or through empanelled agencies. Under National Health Mission, States/UTs are supported to deploy such agencies. States have been undertaking these human resource recruitments through these empanelled agencies, which have established transparent and systematic procedures.

1.7.4 Procurement Cell: The RLBs / ULBs would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement. Such a strategy would eventually create capacities within the ULBs to handle these responsibilities independently.

1.7.5 Utilization of savings: In case of savings under the head of both non-recurring and recurring expenditure under any component, states could propose utilization of these savings, for the same component in the next year.

1.8 Monitoring and Reporting

The State/SLC will send the progress reports on both physical and financial progress against the approved plan on quarterly basis to the Ministry of Health and Family Welfare, Govt. of India. A dashboard will be prepared to monitor the activities of 15th FC grants, which would track the physical as well as financial progress. The dashboard would be updated by States regularly.

1.9 Timelines

The targeted time frames for the preparation and appraisal of the plans under 15th FC are as follows:

Table 5: Targeted time-lines for activities:

Activity	Time frame
Issuance of technical guidelines to the States on planning of 15th FC grants by MoHFW	31st August 2021
Orientation of the State Health Departments by MoHFW	By 3rd September 2021
Orientation to the District teams including health, Panchayat raj and municipal administration department by the State Health Department	By 10th September 2021
Orientation of the RLBs and ULBs of the States by the State Health Departments in coordination with State Panchayat Raj and Municipal Administration Departments	By 10th September 2021
Conduct of first SLC and arrival of the district wise allocation of all the components of FC-XV grants and Communicating to the Districts	By 10th September 2021
Gap Analysis and preparation of DHAPs for FY 21-22 and sending to the State level committee for approval	By 15th September 2021
Consideration of the District Health Action Plans by the State level committee and forwarding to the National level committee	By 20th September 2021
Appraisal and approval by NLC	By 30th September 2021

Appendix 1.1: Total XV FC Health Grants – State wise

S. No.	State	Year wise Allocation (In Cr.)					Total
		2021-22	2022-23	2023-24	2024-25	2025-26	
1	Andhra Pradesh	490	490	514	540	567	2601
2	Arunachal Pradesh	49	49	51	54	56	259
3	Assam	280	280	293	308	323	1484
4	Bihar	1133	1133	1190	1249	1312	6017
5	Chhattisgarh	339	339	356	373	392	1799
6	Goa	31	31	33	35	37	167
7	Gujarat	629	629	661	694	728	3341
8	Haryana	305	305	320	335	352	1617
9	Himachal Pradesh	98	98	103	108	114	521
10	Jharkhand	446	446	469	492	517	2370
11	Karnataka	552	552	579	608	638	2929
12	Kerala	559	559	587	616	647	2968
13	Madhya Pradesh	923	923	969	1018	1069	4902
14	Maharashtra	1331	1331	1397	1467	1541	7067
15	Manipur	44	44	46	49	51	234
16	Meghalaya	59	59	61	64	68	311
17	Mizoram	31	31	33	35	36	166
18	Nagaland	57	57	60	63	66	303
19	Odisha	462	462	485	510	535	2454
20	Punjab	401	401	421	443	465	2131
21	Rajasthan	833	833	875	918	964	4423
22	Sikkim	21	21	22	23	24	111

		Year wise Allocation (In Cr.)					
S. No.	**State**	2021-22	2022-23	2023-24	2024-25	2025-26	**Total**
23	Tamil Nadu	806	806	846	889	933	4280
24	Telangana	419	419	441	463	486	2228
25	Tripura	85	85	90	94	99	453
26	Uttar Pradesh	1830	1830	1921	2017	2118	9716
27	Uttarakhand	150	150	158	165	174	797
28	West Bengal	829	829	870	914	960	4402
	Total	13,192	13,192	13,851	14,544	15,272	**70,051**

Appendix 1.2: District wise allocation of resources of all the components of FC-XV grants by the States for FY 21-22

Code	Activities	Amount in Crores		
		District 1	Districts 2,3,4, ...	District 'last'
	Total FC-XV grants for FY 21-22			
FR	**Rural components**			
FR.1	**Building-less Sub Health Centres, PHCs, CHCs**			
FR.2	**Block Public Health Units**			
FR.3	**Support for diagnostic infrastructure to the primary healthcare facilities**			
FR.3.1	No. of SHC			
FR.3.2	No. of PHC			
FR.4	**Conversion of rural Sub Health Centres and PHCs to HWCs**			
FU	**Urban Components**			
FU.1	**Support for diagnostic infrastructure to the primary healthcare facilities**			
FU.2	**Urban health and wellness centres (HWCs)**			

Appendix 1.3: Summary Budget Sheet Template for Districts /States for FY 21-22

Code	Activities	No. of Units			Unit Cost	Budget Proposed (In Lakhs)			State Remarks
		In Aspirational Districts	In Non-Aspirational Districts	Total		In Aspirational Districts	In Non-Aspirational Districts	Total	
	Total FC-XV grants								
FR	**Rural components**								
FR.1	**Building-less Sub Health Centres, PHCs, CHCs**								
FR.1.1	No. of SHCs taken up for this financial year								
FR.1.2	No. of PHCs taken up for this financial year								
FR.1.3	No. of CHCs taken up (not applicable in most of the States)								
FR.2	**Block Public Health Units**								
FR.2.1	No of BPH units sanctioned for capital works								
FR 2.2	No of BPH units supported for recurring expenditure								
FR.3	**Support for diagnostic infrastructure to the primary healthcare facilities**								
FR.3.1	No. of SHCs supported for recurring expenditure for provision of diagnostic services								Individual SHC will have its own unit cost

Code	Activities	No. of Units			Unit Cost	Budget Proposed (In Lakhs)			State Remarks
		In Aspirational Districts	In Non-Aspirational Districts	Total		In Aspirational Districts	In Non-Aspirational Districts	Total	
FR 3.2	No. of SHCs supported for capital expenditure for procurement of diagnostic equipment based on the gap-analysis								Individual SHC will have its own unit cost depending on the gap analysis
FR.3.3	No. of PHCs supported for recurring expenditure for provision of diagnostic services								Individual PHC will have its own unit cost
F.R.3.4	No. of PHCs supported for capital expenditure for procurement of diagnostic equipment based on the gap-analysis								Individual PHC will have its own unit cost depending on the gap analysis
FR.4	**Conversion of rural Sub Health Centres and PHCs to HWCs**								
FR.4.1	No. of functional SHC-HWCs, whose operational expenses being met from this support								
FR.4.2	No. of functional PHC-HWCs, whose operational expenses being met from the support								
FU	**Total Urban**								
FU.1	**Support for diagnostic infrastructure to the primary healthcare facilities**								
FU.1.1	No. of Urban PHCs supported for recurring								Individual UPHC will have its own unit cost

Code	Activities	No. of Units			Unit Cost	Budget Proposed (In Lakhs)			State Remarks
		In Aspirational Districts	In Non-Aspirational Districts	Total		In Aspirational Districts	In Non-Aspirational Districts	Total	
	expenditure for provision of diagnostic services								
	No. of Urban PHCs supported for capital expenditure for procurement of diagnostic equipment based on the gap-analysis								Individual UPHC will have its own unit cost depending on the gap analysis
FU.2	**Urban health and wellness centres (HWCs)**								
FU.2.1	No. of Urban HWCs, being established in the ULB or other government or rented premises								
FU.2.2	No. of urban health facilities (UPHCs / Urban CHCs) where specialist services are to be provided / Poly Clinics								Unit cost depends on the no of Urban HWCs under this selected urban health facility

Chapter-2: Urban Health and Wellness Centres (Urban-HWCs) and Access to specialist services / Polyclinics

2.1 Introduction

- The National Urban Health Mission (NUHM) was set up in 2013, as a sub mission of the National Health Mission, to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections through facilitating equitable access to available health facilities by rationalizing and strengthening the existing capacity of health delivery.
- Under Ayushman Bharat, Urban Primary Health Centres (UPHCs) are being strengthened as Health and Wellness Centres (UPHC-HWCs) to deliver Comprehensive Primary Health Care (CPHC). Currently, this is done through enabling Urban PHCs, covering a population of 50,000. Outreach functions in this population, are undertaken by five ANMs and 20-25 ASHAs, with a normative coverage of **a population of 10,000 served** by a team of one ANM and five ASHA.
- Healthcare needs and aspirations of urban residents are different from those in rural areas. The current strategy of relying on outreach teams of ANM and ASHA alone to provide selective services is not sufficient. State experiences demonstrate that provision of health care services by trained service providers from facilities closer to poorer, and vulnerable urban communities is likely to improve access to an expanded range of services, reduce OOPE, improve disease surveillance, and strengthen referral linkages. At the same time, state experiences also show that the establishment of "poly clinics" in selected Urban Primary Health Centres, enables reach of specialist services to poor communities, thus building trust in the public health system.
- 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 and improve reporting for epidemic/outbreaks and risk factor mitigation through focused health promotion and wellness activities.
- A paradigm shift in urban primary health care is envisaged, based on the learning from the management of the COVID-19 pandemic, which has affected urban areas disproportionately. As part of this shift, Universal Comprehensive Primary Health Care would be provided through setting up ***Urban Health and Wellness Centres (Urban-HWCs)*** and

strengthening selected Urban Primary Health Centre - Health and Wellness Centres (UPHC-HWCs) for provision of specialist services/polyclinics. Such Urban-HWCs would enable decentralised delivery of primary health care to smaller populations, closer to their homes, thereby increasing access to care especially for the vulnerable and marginalised.

2.2 Urban Health and Wellness Centres (Urban HWCs):

The Urban-HWCs are envisaged to deliver comprehensive primary health care to the community, and public health related actions and would also enable strengthening the care continuum for upward and downward linkages, improve access to high quality care, minimize the out of pocket expenditure incurred on health care services, and decongestion of secondary and tertiary health care facilities. Decentralizing primary health care in urban areas would enable improved disease surveillance and reporting for epidemic/outbreaks and Risk factor mitigation through health promotion and wellness activities. The three components of Urban HWCs are detailed as below;

2.2.1 Establishing urban-HWCs to provide comprehensive primary health care and undertake public health action.

i. Support under this component of FC-XV is to establish Urban HWCs to decentralize primary health care below the existing UPHC level HWCs.

ii. The unit of planning for establishment of Urban HWCs would be the city / major urban local body. In the million plus cities, subdivisions into two or more segments could facilitate such planning.

iii. The location and population coverage of the Urban HWCs could be flexible depending on population densities and presence of vulnerable and marginalized population sub-groups. The principle of Urban HWC location would be such that it becomes the first port of call for individuals and families in urban areas and is linked to the nearest UPHC level HWCs for administrative, reporting, and supervisory purposes and where there is no existing UPHC level HWCs, new Urban -HWC can be planned as per gap.

iv. Given the challenges of acquiring land for construction of new facilities, utilization of infrastructure already created through other government initiatives and Urban Local Bodies, as well as rented commercial spaces/residential facilities would be explored. The use of Mobile Medical Units, and evening OPDs will be considered as alternate service delivery modes. In addition, states may plan for use of community infrastructure such as community and charitable institutions. NGO run clinics may also be explored.

v. Urban HWCs would provide outpatient care for a range of expanded services. Public health functions related to surveillance and early outbreak management as well as interventions for screening and prevention of chronic communicable and non-communicable diseases, would also be undertaken by the team at the UHWC.

vi. These Urban HWCs would be staffed with a Medical Officer, a Staff Nurse and two support staff, and will provide both facility based and outreach services, largely for ambulatory care. Outreach services would be undertaken by the ANM (MPW-F), and ASHA. The outreach team will be expanded by the addition of a Male-MPW, with specific responsibilities for disease surveillance, addressing public health actions, and health promotion and prevention efforts, including WASH, wellness promotion, attention to lifestyle changes, through convergence with ULBs/Residents associations, etc.

vii. States could explore outsourcing/contracting out of Urban HWCs through well designed and monitored Public Private Partnerships (PPP) with NGOs and not for profit private sector in urban areas but ensure that there is no fragmentation between curative care, public health activities and health promotion and prevention for the target population. The Private/NGO partner must ensure delivery of preventive, promotive, and curative care as well as all public health functions related to surveillance, management of outbreaks, etc.

viii. With the creation of Urban Health and Wellness Centres to cover smaller population cohorts, the existing Urban Primary Health Centre level Ayushman Bharat Health and Wellness Centres (UPHC level HWCs) would, in addition to providing clinical services and provide administrative control, serve as a hub for teleconsultation, surveillance, reporting, capacity building, monitoring and supervision, of the Urban HWCs in its coverage area. UPHC level HWCs will also be linked to the component of strengthening public health surveillance in Metropolitan areas.

2.2.2 Ensuring continuum of care by linking with secondary and tertiary care through appropriate mechanisms.

a. Services for specialist consultation (Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology, Psychiatry/Psycho-social care), would be provided on a rotational basis at UPHC-HWCs or at Urban CHCs. Such poly clinic services would be limited to outpatient care to minimize the need for specialised equipment at every UPHC level AB-HWCs. Access to specialist services / Polyclinics is envisaged for every 2.5-3 lakh population depending on the local context. The select UPHCs-HWCs or urban CHCs for specialist / Polyclinic services would be strengthened with equipment, laboratory services for diagnosis, disease surveillance, public health etc.

b. These Poly clinics could also serve as a referral point and link with a telemedicine hub at a medical college, thereby reducing the congestion at secondary and tertiary level hospitals.

c. Linkages for secondary and tertiary care for all, would be through the Urban HWCs and District Hospitals. Given that most states have insurance schemes including AB-PMJAY, referrals for those eligible would be to government facilities/empanelled private health facilities.

2.2.3 Promoting community engagement through various platforms and ensure universal reach of public health interventions, including action on wellness promotion and social and environmental determinants.

a. COVID-19 has demonstrated that mechanisms of community engagement that span all sections of society and economic classes are essential. A good public health system should be equipped for universal reach. Currently the mechanism for community engagement- the ASHA and Mahila Arogya Samities (MAS) are in place only in slum and slum like areas, and do not reach the homes of middle- and upper-income classes.

b. Urban areas are characterized by heterogeneous population that often live in close juxtaposition. Thus, it is common to find slums coexisting near the homes of the wealthy. A uniform mechanism of community engagement across all these sections is not possible, no matter how active and well intentioned, by ASHA and MAS

c. ASHA and MAS however are a key mechanism to reach the vulnerable and marginalized. They will continue to be strengthened including their linkages with Urban Local Bodies (ULB) which have positive potential to impact the social and environmental determinants of health. Where Self Help Groups are established through programmes such as the National Urban Livelihood Missions/State level or NGO led SHGs, they would also be actively involved.

d. For other sections, location based *Resident Health Associations (Sthanniya Swasthya Sabhas)* would be formed, preferably with the locus being a public health facility. Such associations would be a platform or federation comprised of representatives of MAS, (from poorer areas), Resident Welfare Association (RWA) such as Gully/Mohalla committees. This would ensure that information about public health activities, and awareness about lifestyle changes, healthy diets, smoking/alcohol cessation, are disseminated across all residents in an area, irrespective of socio-economic status.

e. Urban HWCs would be monitored and supported by the UPHC-HWCs. Support is also provided for engaging the services of specialists on a periodic basis, at the selected UPHC-HWCs, based on local need and demand. It is envisaged that the Urban-HWCs

would create a mechanism for representatives of Service Providers and Resident Welfare Associations (RWAs) to converge into a Sthaniya Swasthya Sabha to discuss and disseminate public health related issues on a monthly / quarterly basis.

f. Health promotion and wellness activities are an important component of UHWC services. Such associations would also lead the process of wellness promotion in coordination with the local public health facility and ULB so that safe spaces are created/earmarked for urban residents to undertake regular physical activity such as walking, cycling, exercise, yoga, etc.

g. The Sthaniya Swasthya Sabhas would also be the fulcrum for managing public health actions for "well to do" sections of society in towns/cities including taking up drives for vector control awareness and Public Health actions for containing disease outbreaks, (like COVID related containment measures, home isolation, support to home isolated cases, etc.).

2.3 Objectives:

i. Establish Urban-HWCs to provide decentralized comprehensive primary health care and improve public health action especially focussing on the slums & similar habitations, vulnerable population and areas with limited access to public health interventions.

ii. Strengthen Public Health Surveillance, timely reporting, and analysis.

iii. Promote community engagement to ensure universal reach of public health interventions, including action on social and environmental determinants of health.

iv. Increase access to specialist services polyclinics, which are close to the community to minimize patient hardship, reduce time to care and improve continuum of care.

2.4 Factors to be considered

a. Administrative and institutional related activities towards utilization of funds by ULB would be governed by the Key Principles detailed in Chapter 1.

b. The priority is to ensure that there is one Urban-HWC per 15,000-20,000 population catering predominantly to poor and vulnerable populations, residents of slum and slum-like areas. This will be linked to the UPHC-HWCs at the population of 50,000. All the HWC-UPHCs and the Urban-HWCs are required to have a National Identification Number (NIN-ID) and register on the AB-HWC portal.

c. Since the aim is to strengthen the ownership and accountability of the ULBs for delivery of primary health care and essential public health functions, the state would work closely with the ULBs through the State Department of MA&UA to map the areas under each ULB to prioritize the location of the UPHC-HWCs.

d. All ULBs would be allocated a number of Urban-HWCs, based on the FC-XV allocation for the State. State /Municipal Corporation may need to leverage other funding sources if additional number of Urban-HWC are needed.

e. Decisions regarding the required number of Urban-HWCs, would depend on population density, presence of slums & similar habitations, vulnerable population, peri-urban areas and newly Notified Urban Areas would be decided by the State Level Committee (SLC) based on justification provided by the ULB. It will be essential that these areas are classified and placed under the Rural or Urban designations and provide services as mandated.

f. The Urban-HWC would be the first port of call for individuals and families in urban areas and would be linked to the nearest UPHC –HWCs for administrative, financial, reporting, and supervisory purposes.

g. The timings of Urban-HWC would be as per the schedule fixed by States considering the local needs of urban population.

h. **Urban-HWC should not be located in areas which are within 3- 5 kms distance of an UPHC-HWCs, Urban-CHC, SDH or a DH or any State level Dispensaries / Public Health Facilities.** This would ensure that this new initiative of Urban-HWC is focused on hitherto uncovered areas.

i. The ceiling of the unit cost for the Urban-HWC is fixed. State could decide to increase the number of units which can be made operational within the given funds, if the cost of setting up the unit is lower than the unit cost support provided or through the supplementation of resources by ULBs. ULBs should actively contribute through the provision of space in existing ULB owned buildings, community buildings owned by ULBs/RWAs, space available with NGOs/Charitable organizations, space in markets, shopping complexes, etc to ensure that these Urban-HWCs are enabled to provide primary health care services to the community.

j. State may explore engagement with private and not for profit sector for critical gap filling activities such as capacity building, Urban-HWCs management, provision of outreach services, diagnostic services, as appropriate to the local context, need and availability of the organizations to provide services etc. The contracting in/ contracting out / outsourcing of services should be complementary to Public sector services and should be well designed with monitor able indicators.

2.5 Support for this component under FC-XV

The XV-FC Health Grants to Local Governments - Urban Local Bodies provides Rs. 24, 028 crores to ULBs for setting up ***Urban HWCs***, across the country over five years. State-wise and year-wise

allocation is given at Appendix-1. Detailed unit cost particulars (Rs. 75 lakhs per urban HWC including the provision of specialist services at select higher level Urban primary health care facilities/U-CHCs, are given at Appendix-2. Detailed Guidance note on Urban HWCs is given at Appendix-3 and on provision of polyclinic /specialist services is given at Appendix-4.

2.6 Guidance for identification of facility, approvals and operationalization

2.6.1 Allocation by the State to Districts: Based on the resource available and number of functional UPHCs in the State / ULBs, the State will allocate resources to the Districts / ULBs. States must ensure that that the grant under this component is released to all the Districts / ULBs of the State. As the resources available under this component are substantial, the efforts should be made to saturate the ULBs in the Aspirational, Tribal and backward areas / blocks / districts of the State and accordingly, allocation is to be made. If any ULB has not been allocated support under this Urban-HWC component of FC-XV, the State Level Committee must provide a strong justification for such exclusion.

2.6.2 Apportioning by the Districts: Depending on the grants available to the District / ULBs, district /ULB will plan for the number of Urban HWCs that can be supported under this component of FC-XV. The District Level Committee, as elaborated in the Guidance Note to the States dated 9th July 2021 and as explained in Chapter-1, will take necessary actions. As the resources available under this component are substantial, Districts /ULBs may give preference to the areas where poor and vulnerable populations reside and slum and slum-like areas of the ULBs and accordingly, identification of locations for Urban- HWCs are to be finalized.

2.6.3 DLC will finalize the number of Urban-HWCs that can be covered with the financial allocation made by the State for this component of FC-XV.

2.6.4 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-I (or may be given in this chapter as well) to the State.

2.6.5 A Software is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and effective monitoring

2.6.6 After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV. **As per DOE guidance Note dated 16th July, 2021, (DoE's Guidance Note at Annexure (Para 8 at Page 8) and reiterated again at sub-point 10 under para 1.4.2 of Chapter 1), on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other**

consumables, etc., through a mechanism which may include centralized purchase at State level to ensure purchase of quality products at reasonable/competitive prices in an efficient manner after following the due processes/procedures and practices with the prior approval by the National Level Committee".

i. As the component involves multiple activities such as Infrastructure upgradation /provision of essential drugs and diagnostics / team based incentives and remuneration to HR and other HR related components, besides the operational diagnostic expenditure of PoC tests and independent monitoring, as per the decision of the State, DLC should ensure that the funds under this component are to be sent by the Urban Local Bodies **in-time** or **in-advance** to the State level agency (either State Health Society) or to the District level agency (District Health Society), as per the local context. This will ensure timely payment of remuneration and incentives to the primary healthcare team working at these SHC level HWCs. State level decision on the mobilization of funds from the ULBs to District or State level agency should be fully followed by the concerned Urban Local Bodies and DLC should monitor the compliance.

ii. Some States may opt for releasing the money to the Urban Local Bodies excluding the funds required for State level / District level agency activities for this component, as per their context as decided at the State level.

   a. Concerned Urban Local Bodies should be actively involved in the planning and monitoring of all the functional urban-HWCs. To the extent possible, the city level institutional arrangements should be utilized for this purpose.

   b. Capacity of the urban local bodies for all components of the FC-XV will need to be improved, by the state by undertaking the requisite trainings through state level institutions as per the plan in this regard (Detailed plan will be communicated separately). Since the aim is to strengthen the ownership and accountability of the ULBs for delivery of primary health care and essential public health functions, the state/District would work closely with the ULBs through the Department of Municipal Administration Institute.

2.6.7 The ULBs and DLC are required to focus on optimal utilisation of the grant for recurring expense incurred in the AB-HWC especially for Human Resources, their

training skills, salary and incentives, range of health care package of services to be offered, drugs, equipment, IT infrastructure, community structures and independent monitoring, all as defined in the CPHC guidelines.

2.6.8 **Negative List for this component of FC-XV:** The funds under this component cannot be utilized Repair and Renovation works already undertaken under the NHM Funds.

Appendix 2.1: Grants for Urban Health and Wellness Centres as indicated in XV Finance Commission

S. No.	State / UTs	2021-22 Grants in 15th FC	2022-23 Grants in 15th FC	2023-24 Grants in 15th FC	2024-25 Grants in 15th FC	2025-26 Grants in 15th FC	Total Grants in 15th FC
1	Andhra Pradesh	102.88	102.88	108.02	113.48	119.17	546.43
2	Arunachal Pradesh	5.24	5.24	5.50	5.78	6.07	27.83
3	Assam	69.93	69.93	73.43	77.10	80.95	371.34
4	Bihar	185.43	185.43	194.71	204.44	214.66	984.67
5	Chhattisgarh	133.88	133.88	140.58	147.60	154.99	710.93
6	Goa	20.48	20.48	21.50	22.58	23.71	108.75
7	Gujarat	260.73	260.73	273.76	287.45	301.83	1384.50
8	Haryana	139.33	139.33	146.30	153.62	161.30	739.88
9	Himachal Pradesh	1.41	1.41	1.48	1.56	1.64	7.50
10	Jharkhand	119.21	119.21	125.17	131.42	138.00	633.01
11	Karnataka	122.93	122.93	129.08	135.54	142.31	652.79
12	Kerala	322.22	322.22	338.34	355.25	373.01	1711.04
13	Madhya Pradesh	427.83	427.83	449.22	471.68	495.27	2271.83
14	Maharashtra	774.13	774.13	812.84	853.48	896.16	4110.74
15	Manipur	9.83	9.83	10.32	10.84	11.38	52.20
16	Meghalaya	23.30	23.30	24.47	25.69	26.98	123.74
17	Mizoram	12.01	12.01	12.61	13.24	13.90	63.77
18	Nagaland	22.61	22.61	23.74	24.93	26.18	120.07
19	Odisha	89.19	89.19	93.65	98.34	103.25	473.62
20	Punjab	241.75	241.75	253.83	266.52	279.85	1283.70
21	Rajasthan	106.49	106.49	111.82	117.41	123.28	565.49
22	Sikkim	8.19	8.19	8.60	9.03	9.48	43.49
23	Tamil Nadu	356.48	356.48	374.30	393.01	412.67	1892.94
24	Telangana	133.60	133.60	140.28	147.29	154.66	709.43
25	Tripura	41.68	41.68	43.76	45.95	48.25	221.32
26	Uttar Pradesh	424.55	424.55	445.83	468.07	491.47	2254.47
27	Uttarakhand	81.57	81.57	85.65	89.93	94.42	433.14
28	West Bengal	287.92	287.92	302.31	317.43	333.30	1528.88
	Total	**4,524.80**	**4,524.80**	**4,751.10**	**4,988.66**	**5,238.14**	**24,027.50**

Appendix 2.2: Indicative Unit cost particulars of Urban Health and Wellness Centres (Urban HWCs)

a. Components of Urban HWCs

Non-Recurring components	Recurring Components
Arrangements of premises / Rental / upgradation of Infrastructure	Drugs
Tele-consultation	Human Resource *(GDMO-1, Staff Nurse-1, MPW (M)-1, Support staff-2)*
Basic equipment's and furniture (excluding diagnostics support for UPHCs)	Capacity building for HR
	Team Based Incentives
	Drugs
	Quality Assurance activities for Infection Prevention control
	Operational expenses for running UHWC (other than rent, untied grants, consumables etc.)
	IEC/Branding
	Wellness Activities
	Untied fund
	Tele-consultation
	Monitoring
	Other items (convergence, Provision of specialist services, consumables, etc.)
@ 70 lakhs per Urban-HWC per annum for both recurring and non-recurring component	
@ Rs. 5 lakh/Urban-HWC for Polyclinic services	

b. Indicative Unit cost particulars

	Items	Budget outlay (in Rs.)	Remarks
One-time cost	Arrangements of premises / Rental / up-gradation of Infrastructure	25,00,000	Wherever ULB provides the building on free of cost, this component may be utilized for other activities to create more urban HWCs. • If the rented premises are arranged, max ceiling of Rs.1 lakh per premises per month may be adopted.
	Tele-consultation	1,00,000	
	Basic equipment and furniture (excluding diagnostics support for UPHCs)	2,00,000	

	Items	Budget outlay (in Rs.)	Remarks
Recurring cost	Human Resource *(GDMO, Staff Nurse, MPW (M), Support staff)*	20,00,000	
	Capacity building of Human Resource	1,00,000	
	Team Based Incentives	2,00,000	
	Drugs	12,00,000	
	Quality Assurance activities for Infection Prevention control	1,00,000	
	Operational expenses for running UHWC (other than rent, untied grants, consumables etc.)	1,20,000	This activity may be added for operational expenses for UHWCs @ Rs. 10,000/mon
	IEC/Branding	75,000	
	Wellness Activities	1,00,000	This activity may be added for wellness activities
	Untied fund	1,00,000	This activity may be added for untied fund @ Rs. 1 lakh/UHWC
	Teleconsultation	5,000	
	Monitoring	1,00,000	
	Other items (convergence, Provision of specialist services, consumables, etc.)	1,00,000	This activity may be added for undertaking other activities such as provision of specialist services, convergence etc.
Total of urban HWC components		70,00,000	
	For Polyclinic services @ Rs. 5 lakh/UHWC*	5,00,000	
	Grand Total	**₹75,00,000**	

*-To be pooled at the level of Urban PHC or Urban CHC where the specialist services are being provided

Appendix 2.3: Guidance on establishing Urban Health and Wellness Centre (Urban-HWCs)

2.3.1 Infrastructure:

a. For establishment of Urban-HWCs, infrastructure already existing with other government initiatives or Urban Local Bodies (ULB) or rented commercial spaces, residential flats, community halls, govt. housing etc. may be utilized, as support for new construction of urban-HWCs is not envisaged under the scheme e.g. buildings provided by ULBs for "Basti Dawakhana" in Greater Hyderabad Municipal Corporation of Telangana, space and basic infrastructure/ furniture provided by ULBs for "Atal clinics" in Jharkhand.

b. The service areas/space are to be earmarked and signs posted for the following: registration, waiting area, OPD, pharmacy, treatment/injection, counselling, wellness, separate toilets etc. The choice of the building should ensure that the quality of services is not compromised. The premises are required to be disabled friendly and necessary infrastructure should be in place.

2.3.2 Functions: The Urban-HWC would perform the following functions:

a. Facility based services: Urban-HWC will deliver comprehensive range of primary health care services i.e. preventive, promotive and curative as described in the Operational Guidelines for Comprehensive Primary Health Care through Health and Wellness Centres issued in 2018[2].

b. Community based services:

i. The Urban-HWC team in collaboration with ULB would enable household survey/ population enumeration for slums & similar habitation, low-income groups, homeless and other categories of vulnerable population through MPW, Urban ASHA, MAS or through mobilizing other volunteers.

ii. Allocation of areas/demarcation of population for enumeration between frontline workers Urban ASHA and MPW should be undertaken for universal population coverage.

iii. The Urban-HWC will provide outreach services (UHND) through MPW (F)/MPW (M), ASHA & supported by MAS on a targeted basis for slums & similar habitations and vulnerable population in a defined geographic area of the Urban-HWC.

iv. The ULB would facilitate the Residential Welfare Associations (RWAs) to undertake public health activities including health promotion activities about clean environments,

[2]http://nhsrcindia.org/sites/default/files/Operational%20Guidelines%20For%20Comprehensive%20Primary%20Health%20Care%20through%20Health%20and%20Wellness%20Centers.pdf

lifestyle changes, healthy diets, etc. and also spread awareness on the diseases prevalent in the community viz seasonal, infectious etc. Community linkages with existing SHGs and Galli/Mohalla committees may also be utilized for the purpose.

v. The ULBs would ensure convergence with various schemes relating to the wider determinants of health and wellness such as urban development, drinking water, sanitation, education, nutrition being implemented by other ministries and departments.

c. Public Health Functions, including preventive and promotive care

i. ASHA and MAS are a key mechanism to reach the vulnerable and marginalized population. They will continue to be strengthened including their linkages with Urban Local Bodies (ULB) and strengthen the outreach and preventive and promotive functions including public health actions.

ii. For other sections, ULBs would enable the formation of *Resident Health Associations* preferably with the locus being a public health facility. Such associations would be a platform or federation comprised of representatives of MAS, (from poorer areas), Resident Welfare Association (RWA) such as Gully/Mohalla committees. This would ensure that information about public health activities, as well as awareness about lifestyle changes, healthy diets, weather events like heat strokes, etc. are disseminated across all residents in an area, irrespective of socio-economic status and area of residence or work.

iii. Engagement of the Primary Health Care team at the Urban-HWC with schools for screening of early childhood diseases, through an active School Health Programme may also be promoted. These linkages are essential under the Ayushman Bharat – School Health and Wellness Ambassador Initiative and the same can be leveraged for engaging with the teachers and students.

iv. Public health functions related to regular surveillance, timely IDSP reporting and early outbreak management with contact tracing, referrals and follow-up as well as interventions for screening and prevention of chronic communicable and non-communicable diseases will be undertaken by Urban-HWCs supported by the ULBs, under the overall supervision of the linked HWC-UPHC.

v. Preventive and Promotive healthcare services such as awareness on healthy lifestyles, wellness activities like yoga, meditation, physical exercise and other activities would be provided at the Urban-HWC. These centres will also provide guidance on "Eat Right" and engaging with the community on their eating practices.

vi. Health promotion activities would be organized every month at Urban-HWCs as per Annual health calendar issued by MoHFW with a list of health-related days. Other activities may also be included based on the local health needs, to ensure that

communities are empowered on social issues like gender-based violence, harmful effects of alcohol and tobacco and substance abuse.

d. Access to specialist services/Polyclinics:

Tele-consultation services would be made available in all Urban-HWCs for availing specialist consultations. The state in collaboration with ULB would decide on the level of facility to serve as a hub (UPHC/UCHC/District Hospital/Medical Colleges/Existing hubs which have been developed as hubs can be linked or expanded to provide these services). Some States are experimenting with Specialist Clinics like AMA Clinic in Odisha and evening specialist services in Karnataka at the HWC-UPHC level.

e. Human Resources: The Urban-HWC is to be staffed with a Medical Officer, a Staff Nurse/Pharmacist, Male-MPW and two support staff. Ideally, the ANM and ASHA are responsible for the catchment area of an Urban-PHC wherever available will be drawn from HWC-UPHC / U-CHC for respective Urban-HWC while deriving their salary from their linked HWC-UPHC. In case where ANM, ASHA are not available, the State may engage new ASHA, ANM for Urban-HWCs depending on the local needs and resources available. Savings are more likely in urban HWCs, as diagnostic services to these Urban HWCs may be provisioned under the component of Diagnostic Infrastructure at Urban PHCs.

Table 6: Human Resources:

Type of staff	No. required
Medical Officer (new recruitment)	1
Staff Nurse (new recruitment)	1
One MPW (Male) (new recruitment)	1
Guard (Outsourced)	1
Cleaning Staff (Outsourced)	1
Total	5

f. Training and Capacity Building: The staff posted at Urban-HWC would be oriented/trained in the competencies to deliver primary health care and public health functions, as well in the use of Digital and IT systems to access online training and real time reporting of data. They would also be trained in undertaking vulnerability assessment and community-based processes to enhance reach to marginalized communities.

g. Medicines, Diagnostics and Equipment: The provisioning of medicines and diagnostics is to be made as per CPHC guidelines for Urban-PHCs. The EDL for each facility to be made as per govt. guidelines and the existing e-aushadi mechanism, shall be used for drug management. The hub and spoke model shall be adopted for diagnostics at Urban-HWCs.

The budget available under FC-XV for diagnostic services could be utilized. The details of the services which are being provided at these centres (diagnostics and medicines as well) are to be displayed at the centre.

h. Monitoring and Supportive Supervision: The Urban-HWC Medical officer would report to the Medical Officer of the linked Urban-PHC, who would undertake periodic review meetings to ascertain effective implementation and ensure early collective action. The ULBs would also be involved in such review meetings.

i. Citizen charter: A Citizens Charter should be prominently displayed near the entrance of the facility. This should provide information about the various services being offered, timings, responsibilities of patients and providers, details of referral vehicles and facilities, the number of free drugs and diagnostics and other citizen friendly information. Patients' rights should be ensured, and they should also be made aware of their responsibilities (e.g. to keep the facility clean and avoid spitting in corners, avoiding over-crowding by attendants, respecting visiting hours etc.). Important contact numbers (such as fire, police, ambulance, blood banks and referral centres) must be clearly visible.

Appendix 2.4: Establishing specialist services / polyclinic at higher urban primary healthcare facilities to ensure access to specialist services/Polyclinics

In selected Urban-PHCs based upon the context of the local area, state would make arrangements to provide selected specialist services on a periodic basis, so as to bring these services closer to the people. The timings are required to be displayed along with the days of the visit. It will be important to provide the same as per the needs of the community and the requirements which they list. The funds for these activities will be pooled from the urban HWCs @5 lakhs per urban HWCs for the provision of specialist services at the selected UPHC or UCHC.

2.4.1 Operationalization:

a. The XV-FC provides for provision of specialist healthcare services by strengthening all HWC-UPHCs or a selected UCHC, depending upon geographic location, density, available infrastructure, disease burden, community needs etc.

b. In addition to the existing Urban-PHC functions, these would provide specialist care on rotational basis (day care/ambulatory) to the urban population residing in catchment area of all associated UPHCs and Urban-HWCs

c. A separate Urban-PHCs with specialist services may not be required wherever U-CHC is functional and providing Specialist services. The same U-CHC may be strengthened to ensure specialist services are being provided in the area.

2.4.2 Referral linkages can be established between the Urban CHC, UPHCs and Urban-HWCs to ensure continuum of care and assured care. This can be supplemented through teleconsultations for services which can be provided without the patient having to visit the higher centre physically

2.4.3 Infrastructure:

- Strengthening of existing infrastructure of UPHCs for provision of specialist services should be based on services planned (not under this component of FC-XV but through regular NUHM support or through Urban Local Bodies support). Improvements of the premises should preferably be ensured with support from the ULBs. New construction for specialist services at the select UPHCs is not envisaged under this component of FC-XV.
- Separate earmarked space to be made available for specialists OPD, registration, Dental, refraction, physiotherapy, laboratory, treatment/Injection, examination, pharmacy, imaging services etc.

2.4.4 Service Provision: The HWC-UPHCs with specialist services would provide the following services:

i. Outpatient specialist care, with provision for 2 day-care observation beds.

ii. Fixed day rotational specialist OPD services for Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology and Psychiatry. Dental, physiotherapy and optometrist services etc. may be planned as per local needs and requirement.

iii. Laboratory tests for the specialties concerned along with point of care testing would be provided.

iv. For improvement of diagnostic infrastructure to provide specialist services at the select UCHC or UPHC (where human resource is available for performing the tests), the resources under the component of Diagnostic Infrastructure for UPHCs of FC-XV may be utilized, both, by equipping these facilities with the required infrastructure / equipment and support for sample transport under a hub and spoke model.

v. The select UCHC / UPHC for providing specialist services can be a hub for UPHCs/ Urban HWCs for providing Tele-consultation services.

vi. The medicines required to provide the specialist services at these UPHCs / urban CHCs would be supported under Free Drugs Services Initiative or ULB support.

   a) Timings: The timings of U-PHCs with specialist services would be decided by the States as per the need of the community and availability of staff to be positioned at these centres. Evening OPDs should be encouraged.

   b) Human Resource: In addition to HR available at UPHCs, the following is the indicative list of specialists and other support staff required for provision of specialist services at the select Urban-PHCs / urban CHCs.

Table 7: Human Resources:

Type of staff	No. required
Specialist each for Medicine, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Dermatology and Psychiatry*	6
Dentist (May be on fixed days)	1
Staff Nurse	2
Optometrist	1
Physiotherapist,	1
Integrated counsellor	1
Multipurpose Worker/Guard (Outsourced)	1
Cleaning staff (Outsourced)	1
Total	**14**

*- The State can be given the option to engage additional specialists based on local needs and context. **These specialists can also be in-sourced on a per hour / per patient basis.**

2.4.5 Training and Capacity Building:

The staff posted at these select UPHCs / urban CHCs for providing specialist services should be given orientation/training on various program activities, public health surveillance, etc. Besides this, they would also be trained on various IT applications. U-PHCs with specialist services would function and report on e-hospital/e-shushrut application of NIC and C-DAC and other portals such as AB-HWC, HMIS, RCH, NCD, IHIP, etc.

2.4.6 Referral Services:

i. Clear referral pathways with mapping of the Speciality Services (type of services and timings for which they are available) need to be established between Urban-HWCs, UPHCs and UPHCs / urban CHCs providing specialist services.

ii. The select UPHCs / urban CHCs providing specialist services shall provide assured referral linkages with higher centres like Maternity Homes, SDH, DH and Medical College Hospital in the City/District. Besides this, specific institutions like de-addiction centre, rehabilitation facilities, old age homes and specialized counselling Centres should be identified to enable ease of access to services. It will be required to provide the details of the nodal persons from each of these centres to the UPHCs with specialist services staff.

2.4.7 Citizen charter: A Citizens Charter should be prominently displayed near the entrance of the facility. This should provide information about the various services being offered, timings, responsibilities of patients and providers, details of referral vehicles and facilities, the number of free drugs and diagnostics and other citizen friendly information. Patients' rights should be ensured, and they should also be made aware of their responsibilities (e.g. to keep the facility clean and avoid spitting in corners, avoiding over-crowding by attendants, respecting visiting hours etc.). Important contact numbers (such as fire, police, ambulance, blood banks and referral centres) must be clearly visible.

Chapter-3: Construction of Building-less Sub centres, PHCs and CHCs

3.1 Introduction

The Sub Centres and Primary Health Centres provide the first level of healthcare close to the community. The National Health Mission has supported not only construction of these peripheral facilities but also encouraged the states to operate such facilities in rented buildings where government buildings or land for construction was not available. In addition, a few States are also providing services from Rent Free Panchayat / Voluntary Society Buildings to ensure care closer to the community and as per the given population norm.

The FC-XV[3] report (Para 7.145, page 215) states that *"an assessment of infrastructure gaps in rural PHCs/Sub centres based on Rural Health Statistics, 2019, shows that 885 PHCs and 33,886 Sub centres do not have the necessary infrastructure to meet the targets of the National Health Policy, 2017. The Commission proposes to provide support for necessary infrastructure for 27,581 HWCs at the Sub Health Centre level and 681 HWCs at the Primary Health Centre level in rural areas in close collaboration with rural local bodies (Annex 7.10 D)."*

3.2 Factors to be considered

Despite the best efforts by the States, there are still gaps in terms of functional public health facilities in existing government owned building. Some of the civil infrastructure is in a dilapidated status. So, taking cognizance of this fact, FC-XV has provisioned certain amount for each state to meet this gap to the extent possible within the resources allotted. Therefore, the States may utilize these funds for **new constructions of the building-less facilities** as per the allocations made under the FC-XV grants. The States may prioritize the **new constructions of Sub Health Centres** based on the funds available under the FC-XV:

i. **Run-down / dilapidated building structures** which are required to be re-built.
ii. Construct new buildings, where services are being provided from **rented buildings** which lack required space and infrastructure to provide the comprehensive package of services, lab infrastructure and space to conduct wellness activities; Priority may be given to Sub Health Centres, especially in Aspirational districts, Tribal and remote areas, to reduce time to care and geographical barriers.
iii. New buildings in lieu of Rent-Free Panchayat / Voluntary Society Building, especially where space and infrastructure is inadequate to provide the entire range of 12 CPHC

[3] https://fincomindia.nic.in/ShowContentOne.aspx?id=9&Section=1

services, lab infrastructure, for wellness activities.

iv. New buildings, if required as per shortfall of population norms (details given in RHS 2020[3])

v. **States are informed that if the existing rented buildings are located well within the reach of the community, have sufficient space for carrying out all the intended services and have sufficiently robust construction, then the State need not plan for re-locating from these buildings.**

The SLC /DLC shall mandate the quality check of the constructed facilities as per the norms set by the State in accordance with the other construction works undertaken. The SLC should ensure third party monitoring and quality checks to ensure that the works undertaken meet the required quality parameters and are constructed as per the terms and conditions decided by the State.

3.3 Support for this component under FC-XV

The Fifteenth Finance Commission (FC-XV) has provided grants of **Rs.7,167 crores** cumulatively for all **28 states for a five-year duration from FY 21-22 to FY 25-26** for supporting infrastructure of Sub Health Centres, Primary Health Centres and Community Health Centres which are functional in building-less - rented or rent-free panchayat/ vol. society building.[4] Details of the funds allocated for each financial year are given in **Appendix-1**

3.3.1 Unit cost for the Building-less SHC / PHC / CHCs under this component of FC-XV is given below:

- Unit cost per SHC is 55.5 lakhs
- Unit cost per PHC is 1.43 Cr
- Unit cost per CHC is 5.75 cr

A Guidance note to the States to effectively plan for construction of buildings for the Building-less SHCs / PHCs / CHCs are given in Appendix-2.

3.4 Guidance for identification of facility, approvals and operationalization

3.4.1 Allocation by the State to Districts: Depending on the resources available under this component of FC-XV and the building less facilities in the State, it is suggested to the States that priority shall preferably be given to building-less SHCs / SHC-HWCs in the first instance and if more resources are available after saturation of all the SHCs level building-less institutions, then building-less PHCs / PHC-HWCs may be taken up. Accordingly, the State can allocate resources to the Districts based on the number of

[4] https://fincomindia.nic.in/ShowContentOne.aspx?id=9&Section=1

such building-less SHCs in a district. As the resources available under this component are limited, the efforts should be made to saturate the provision of infrastructure to the building-less SHCs / PHCs of Aspirational, Tribal and backward areas / blocks / districts of the State and accordingly, **allocation of resources amongst the districts** is to be made. Depending on the resources available, State has to finalize a five-year plan for the total number of building-less facilities that can be covered under this component of FC-XV and then work out its year-wise phasing.

3.4.2 Apportioning by the Districts: Depending on the grants available to the District, district will identify the building-less SHCs / PHCs. The District Level Committee, as elaborated in the DoE's Guidance Note to the States dated 16th July 2021 and as further explained in Chapter-1, will take necessary actions. As the resources available under this component are limited, Districts may saturate the provision of infrastructure to the building-less SHCs / PHCs of Aspirational, Tribal and backward areas / blocks of the District and accordingly, identification of building-less facilities may be taken up. The choice of prioritizing a 'building-less' SHC or PHC and their location, would rest with the **District Level Committee. As per the DoE's guidance note (Para 7 at page-7), at the district level, the Zilla Panchayats or Autonomous District Councils shall handle / implement all rural components including this component in close coordination with the District Health Department under the overall supervision of the District Collector (not at Block Panchayat or Gram Panchayat level), because the components require technical experience as well as exposure in relevant subjects. However, rural local bodies below the district level (as the case may be), such as Block /Taluk level Panchayats, and Gram Panchayats / Village Councils must be involved in planning and monitoring of these components for the health facilities located in their jurisdiction.**

3.4.3 Selection of sites for construction should be such that its benefits reach larger segments of vulnerable populations such as SC / ST population dominated blocks/areas, and remote areas. Land should be available for the selected facilities and land purchase cost should not be covered with this component. To the extent possible, lands available with the local bodies / government land revenue department should be utilized. The land allocated should be ideally with-in the community to improve access to care.

3.4.4 The States /District may pool in additional funds from other sources like District Mineral Fund (DMF), CSR funds, etc. as supplementary financial resources for addition of extra-facilities in the select public healthcare facilities or to cover more number of building-less facilities in the district / State, duly conforming to the requirements and

mandates under each fund.

3.4.5 Also, timely completion of construction is important for effective utilization of **funds under this component of FC-XV,** the process of land transfer and other revenue records up-dation should be completed by the district at the earliest, much before the arrival of approval from the State.

3.4.6 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-I to the State.

3.4.7 A software package is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

3.4.8 After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV

i. As the component is only for infrastructure work, as per the decision of the State, the activity may be done through the engineering wing of the State level department or through Zilla Parishad engineering wing. **As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

3.4.9 Local Bodies (District and Block) should be actively involved in the monitoring of the progress of the construction work. To the extent possible, the institutional arrangements such as JAS / VHSNCs should be utilized for this purpose.

3.4.10 The DLC will also ensure that monitoring of the construction is under-taken, and UCs are submitted on time.

3.4.11 **Negative List for this component of FC-XV:** The funds under this component cannot be utilized for the following:

i. Repair and Renovation works already undertaken under the NHM Funds.
ii. This amount should not be used for the construction of a single room /wellness area or any other single project like boundary wall, toilets, water tanks etc.
iii. Construction of boundary walls, entrance, pavements, footpaths etc.

Appendix 3.1: Grants for Building-less Sub-centres, PHCs, CHCs as indicated in XV Finance Commission

State	2021-22	2022-23	2023-24	2024-25	2025-26	Total (Rs. In crore)
Andhra Pradesh	1.17	1.17	1.23	1.29	1.36	6.22
Arunachal Pradesh	1.06	1.06	1.10	1.16	1.22	5.60
Assam	13.32	13.32	3.98	14.69	15.41	70.72
Bihar	329.29	329.29	345.6	363.00	381.10	1748.27
Chhattisgarh	10.75	10.75	11.28	11.85	12.45	57.08
Goa	1.54	1.54	1.61	1.70	1.78	8.18
Gujarat	1.17	1.17	1.24	1.29	1.36	6.23
Haryana	29.51	29.51	30.97	32.53	34.15	156.67
Himachal Pradesh	2.68	2.68	2.81	2.96	3.11	14.24
Jharkhand	118.54	118.54	124.41	130.67	137.19	629.35
Karnataka	10.06	10.06	10.56	11.09	11.64	53.41
Kerala	0.50	0.50	0.52	0.55	0.58	2.64
Madhya Pradesh	30.03	30.03	31.52	33.10	34.75	159.44
Maharashtra	50.07	50.07	52.55	55.21	57.96	265.87
Manipur	2.03	2.03	2.12	2.24	2.35	10.78
Meghalaya	3.21	3.21	3.37	3.54	3.72	17.06
Mizoram	0.56	0.56	0.58	0.61	0.64	2.95
Nagaland	1.03	1.03	1.08	1.13	1.19	5.46
Odisha	72.83	72.83	76.43	80.28	84.29	386.66
Punjab	20.26	20.26	21.26	22.33	23.45	107.57
Rajasthan	191.39	191.39	200.87	210.98	221.51	1016.14
Sikkim	0.53	0.53	0.55	0.58	0.60	2.79
Tamil Nadu	71.21	71.21	74.73	78.50	82.41	378.05
Telangana	2.81	2.81	2.96	3.11	3.26	14.95
Tripura	0.25	0.25	0.26	0.27	0.29	1.32
Uttar Pradesh	333.68	333.68	350.22	367.84	386.18	1771.59
Uttarakhand	1.43	1.43	1.49	1.57	1.65	7.57
West Bengal	49.04	49.04	51.46	54.05	56.75	260.33
All States	**1,349.95**	**1,349.95**	**1,416.76**	**1,488.12**	**1,562.35**	**7,167.14**

Appendix 3.2: Note on Infrastructure Planning and Design requirements:

This document lists the **guiding principles for building new health infrastructure** with the **model layout plans** and **suggestive area** required for building new health facilities. The states may modify the layout for these facilities and plan for their construction and operationalization as per the FC XV allocation of grants to the State, based on the local context.

3.2 Guiding principles for infrastructure planning

While planning the new construction of the health facility, it is imperative to consider following points which would enable the state and districts to place the required design elements thereby delivering quality services that are integrated with essential primary and secondary care service:

a. The new facility should ideally be located centrally to allow for access to a large proportion of the catchment area. It can also be built near the Panchayat Office, Primary Health School / Anganwadi Centre etc.

b. Every health facility should ensure availability of essential infrastructure as per Operational Guidelines for Comprehensive Primary Health Care: Health and Wellness room (for HWCs), emergency room & wards (for PHCs and CHCs), examination room, laboratory services, storage and dispensing facilities for drugs as the core areas.

c. The infrastructure for SC-HWCs, PHC-HWCs and CHCs should follow the rules and regulations as laid down in the state by-laws and the associated National Building Code and are friendly for differently abled, patient friendly with appropriate culture and gender sensitive amenities.

d. There should be availability of drinking water, hand-washing area, separate female and male toilets, parking area, waiting area, laundry facilities and waste disposal as per BMWM Rules, 2018.

    i. All new infrastructure should be environment friendly with scope for enough natural light, water harvesting, solar energy, etc.

    ii. Availability of an open area for management of any disasters or emergency cases.

    iii. The facilities should be in line with the national and state disaster management plan / National Disaster Management Plan for hospital safety, 2016 issued by NDMA, GoI.

    iv. Regular piped water supply and reliable electricity for service delivery should be made available at the site of new construction. This should be ensured in collaboration with the concerned departments and if required, facilitation should be done at the district level. The water storage along with the required equipment also needs to be provided.

v. New electrical appliances should have a minimum 3-star rating from Bureau of Energy Efficiency or equivalent recognized organization to minimize the energy input. When choosing the technology, guidelines and standards issued by the Ministry of New and Renewable Energy must be adhered to (Gazette of India April 16, 2018, No 1456).

vi. To ensure compliance with safety norms, all new hospital buildings should comply with provisions prescribed for seismic zone IV and V and mitigation measures to be undertaken as per National Building Code if such buildings are situated in these zones.

vii. The infrastructure should be planned, designed and built to take account of future expansion – both with regards to the quantity and range of services to be provided, either through expanding it vertically or horizontally.

viii. Citizen Charter should be displayed near the entrance of the building indicating various services, their timings, responsibilities of patients and providers, details of referral vehicles and facilities, number of diagnostics and drugs being provided free and other citizen friendly information should be displayed prominently.

ix. The process and flow of services should be properly organized, in order to minimize patient discomfort and ensuring safety. The IPHS 2012 and CPHC guidelines would be followed for SHC, PHC and CHC or updated as per the latest available guidelines of GoI.

x. HWCs should offer space for health education, conducting yoga sessions, community meetings on health awareness, and a display of key health messages related to public health.

xi. The infrastructure should be planned, designed and built to take account of future expansion – both with regards to the quantity and range of services to be provided, either through expanding it vertically or horizontally.

3.3. Layout Plan: The flow of services should be in alignment with the IPHS 2012 guidelines or the most recent ones released by GoI and as given in the Appendix 3).

The essential areas to be planned for all health care facilities:

i. Waiting area - For patient registered at registration counter, there should be seating arrangement for them while they wait for their consultation. Adequate seating arrangement/ chair should be available.

ii. Consultation room – Room of Community Health Officer / Medical Officer and Specialists, should have enough space to accommodate desks and chairs, where

interaction with patients can be undertaken with confidentiality and dignity. It should be well lit and ventilated.

iii. Examination room (This can be combined with the Consultation room if there is a space constraint). It should be co-located with consultation room or Can be clubbed with the consultation room with due privacy features for the patient. It should have adequate space for accommodating an examination table (wheeled, wall mounted, single piece), space for free movement around examination table, curtains for privacy and wall mounted cupboard where essential equipment, etc. can be kept.

iv. Record keeping: Every HWC must plan to ensure safe upkeep of the necessary records preferably utilizing IT systems.

v. Day care beds: The facility may sometimes require the patient to be under medical supervision for a period of a few hours at Sub-Centre and PHC-HWCs.

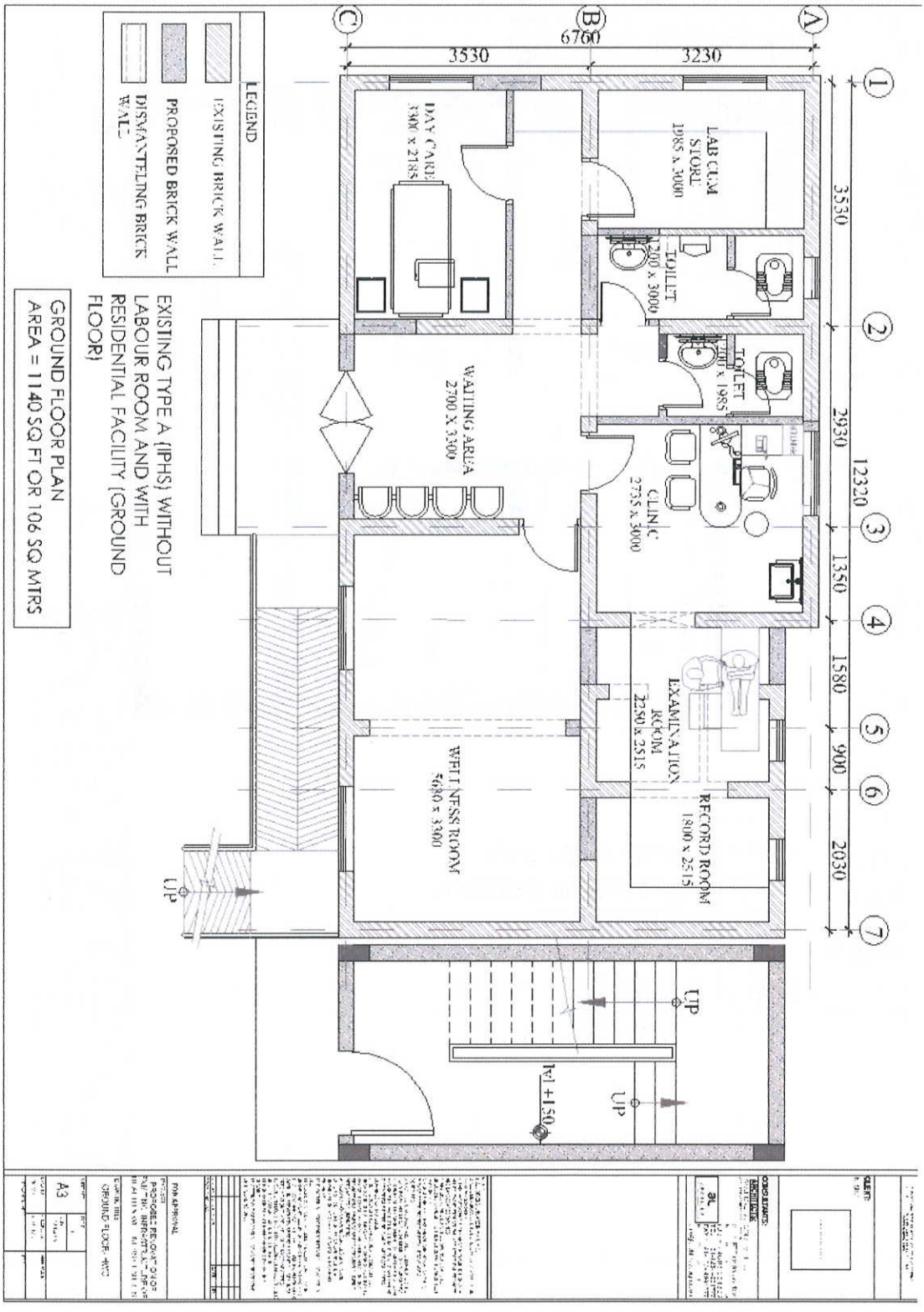
vi. Store: Adequate and spacious stores located away from patient traffic with facility for storing drugs, consumables, records, linen, furniture, equipment and sundry articles. GoI Guidelines for safe disposal of expired drugs and vaccines should be adhered to.

vii. Support services – Drinking water / Handwashing facilities: Washroom facility, laundry facilities and waste disposal as per BMWM Rules, 2018 should be part of planning.

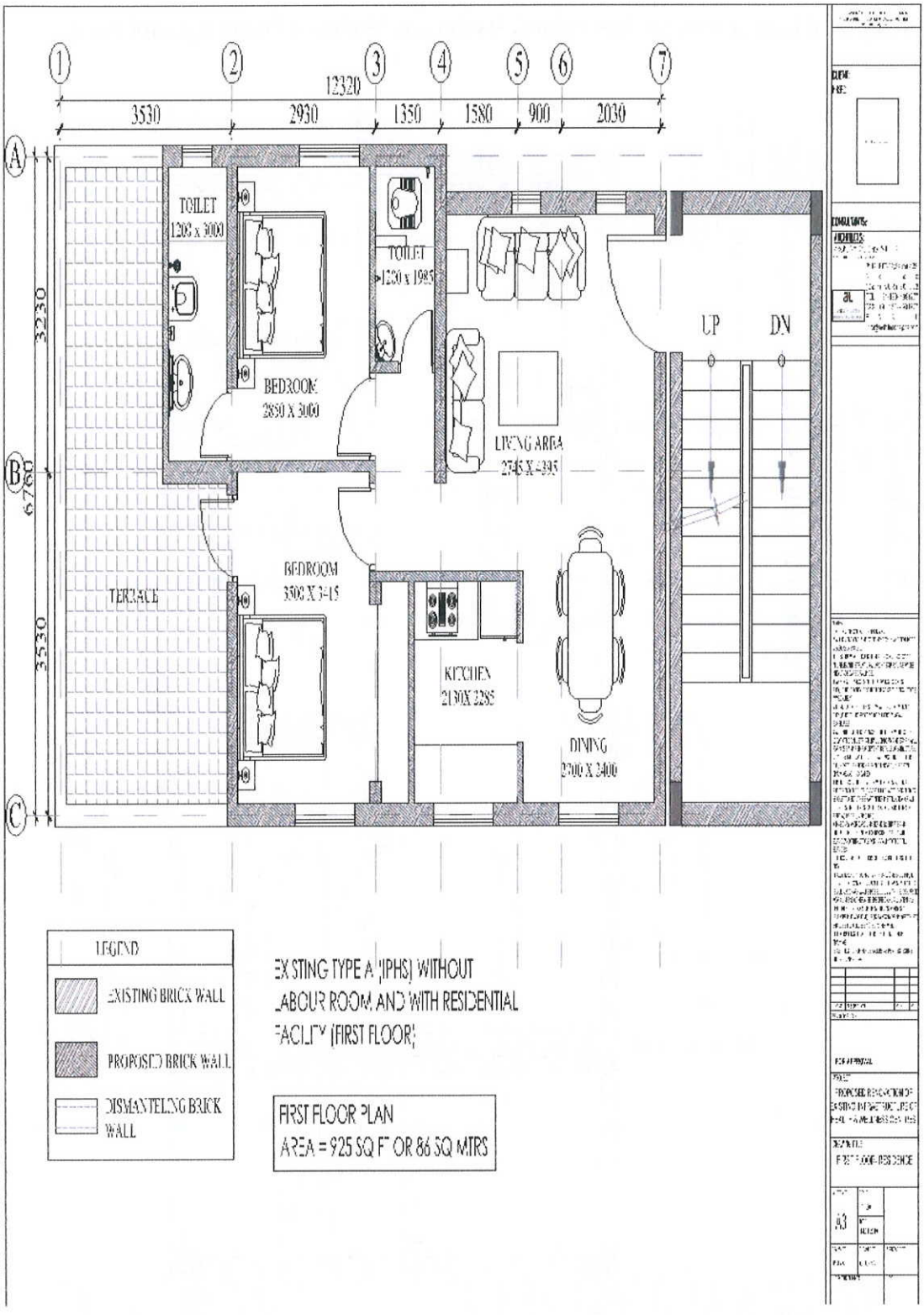
Table 8: Suggestive area for facility:

S.No.	Type	Suggestive Area in sq. ft
1.	Primary Health Centre	
	PHCs / PHC level HWCs	**8,369.8**
2.	SHC – HWC with residential facilities	**3,766.0**
	SHC - HWC building without Residence	**2,098.0**
3.	Community Health Centre (30 bedded)	**22,596.0**

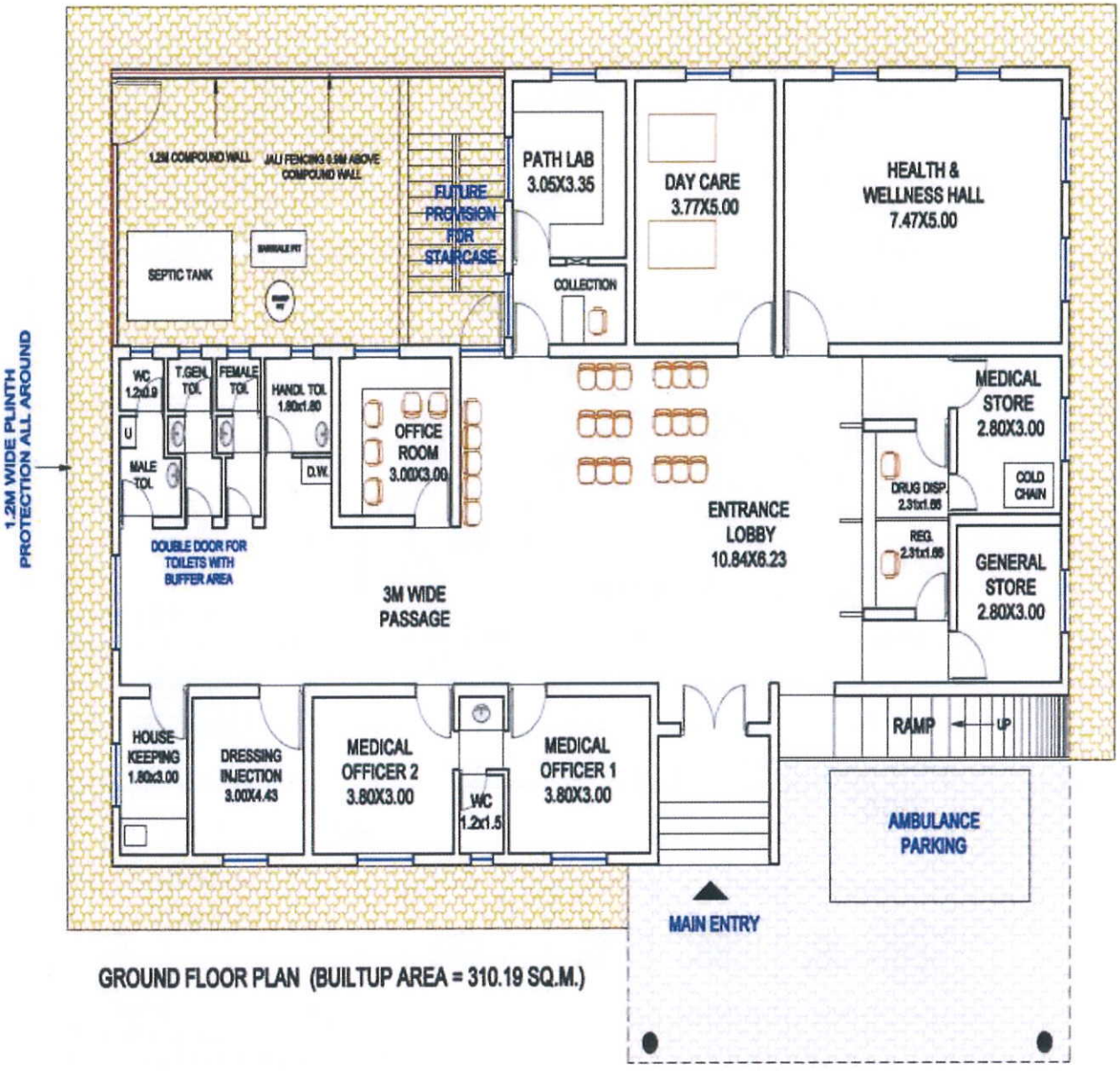
a. Suggested Layout plan for Sub Centre- Health and Wellness Centre (ground floor)



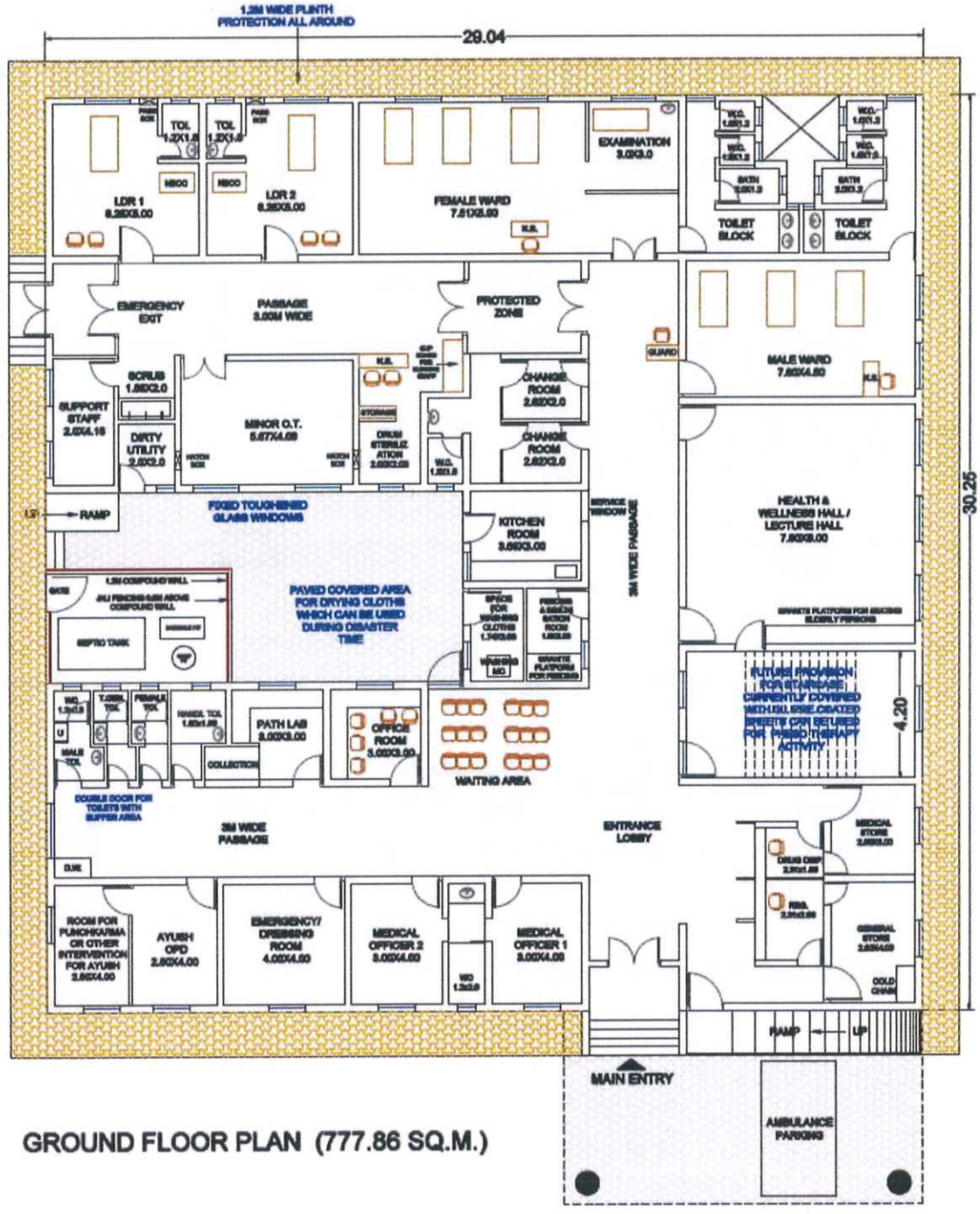
b. Suggested Layout plan for Sub Centre- Health and Wellness Centre (first floor)



c. Suggested Layout plan for Primary Centre- Health and Wellness Centre

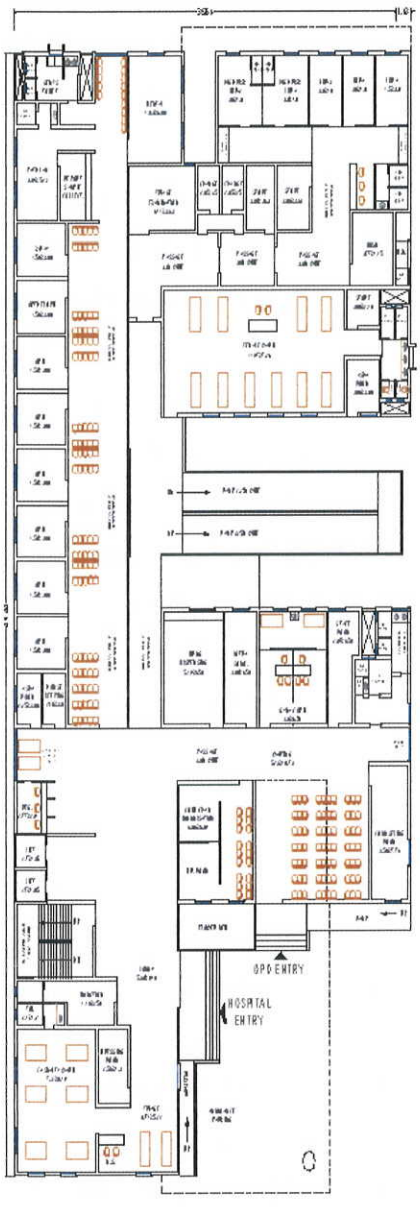


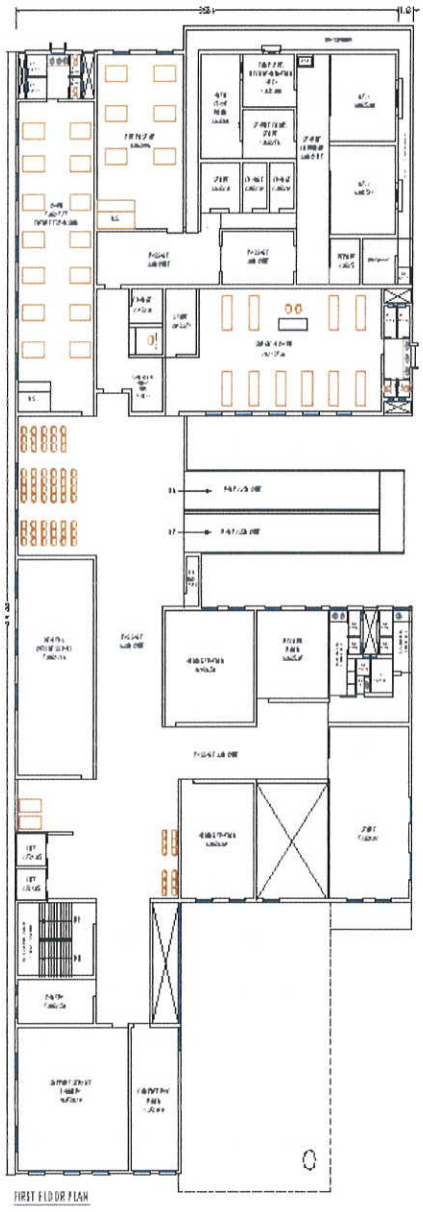
d. Suggested Layout plan for Primary Centre- Health and Wellness Centre



GROUND FLOOR PLAN (777.86 SQ.M.)

e. Suggested Layout plan for 30/50/100 bedded Community Health Centre





Chapter-4: Conversion of Rural Sub Health Centres and Primary Health Centres to AB-HWCs

4.1 Background

- Ayushman Bharat- Health and Wellness Centres (AB-HWCs) are intended to deliver Comprehensive Primary Health Care (CPHC) which is universal and free. It is envisaged that 1,50,000 SHCs and PHCs in rural and urban areas will be transformed as AB-HWCs by December 2022.
- The COVID19 pandemic has further highlighted the need to strengthen primary health care system and build local capacities in rural areas to integrate public health actions into Primary Health Care and ensure uninterrupted delivery of essential services particularly during the pandemic.
- Operational Guidelines on *Ayushman Bharat Comprehensive Primary Health Care through Health and Wellness Centres (2018)* provide detailed guidance on the conversion of SHCs and PHCs into HWCs. Further, AB-HWCs are being implemented by the States since 2018 and hence, these existing operational guidelines with the necessary time-to-time updates provided by the Ministry are to be followed by the States while implementing this component of the FC-XV. Link to the guidelines is : https://abhwc.nhp.gov.in/download/document/45a4ab64b74ab124cfd853ec9a0127e4.pdf

4.2 Factors to be considered

4.2.1 To enable the States to achieve the target of 1.5 lakhs of functional HWCs by December 2022, so far, under the National Health Mission (NHM), sanctions have been given to convert more than 1.5 lakhs SHCs and PHCs into HWCs, including the approvals in the RoP 21-22. Hence, States have been sanctioned financial support for meeting the non-recurring expenditure to convert the SHCs and PHCs into HWCs. Further, under RoP-21-22, financial approval was provided for a few months to meet the recurring expenditure of functional HWCs, keeping in view that the grants under the FC-XV are to be available to the states for this component and have to be fully utilized by the States within this fiscal year.

4.2.2 Hence, the grant-in-aid under this component of Fifteenth Finance Commission (FC-XV) shall preferably be utilized by all 28 States **ONLY** for ***recurring*** expenditure for the Sub Health Centres and rural PHCs that have been transformed into AB-HWCs. This grant may also be utilized for one-time cost for building additional facilities to undertake wellness activities depending on the Resource Envelope available. This will ensure optimal utilization of the FC grants under this component.

4.2.3 It is also to highlight that FC-XV allocations to a State / District will not cover the requirement of recurring expenditures of **all the functional SHC and PHC level HWCs** in a State / District and hence, the State especially, the Districts have to plan in such a way that the selected SHC and PHC-HWCs continue to be supported under FC-XV for five years from FY 21-22 onwards to ensure continued support to these selected functional AB-HWCs. **For the remaining SHC and PHC level HWCs, State/District may continue to obtain the support from NHM funds as well other sources. One HWC should not be funded from both FC-XV funds and NHM. All components of a particular HWC should be funded entirely and exclusively from one source- viz: either FC-XV or NHM.**

4.2.4 Based on the data uploaded by the States in HWC portal on the functional SHC and PHC level HWCs as on 14th August 2021, and the unit costs for operationalizing HWCs, it is estimated that the grant available under FC-XV for this component for present FY 21-22 will be sufficient **ONLY** to cover the recurring expenditure of significant proportion of functional SHC-HWCs in 25 States. **In the remaining 3 States, (Orissa, Bihar, Rajasthan)**, the grant available under FC-XV for this component is sufficient to cover the recurrent expenditure of **ALL** the functional SHC-HWCs as on date, besides covering the recurring expenditure of some proportion of PHC level HWCs functional as on date.

4.2.5 Further, though the FC recommends an upper limit of unit cost of 9.7 lakhs for SHC level HWCs and 5.6 lakhs for PHC level HWCs, to retain the uniformity of support under NHM and FC-XV for meeting the recurring expenditure of HWCs, the unit cost for meeting the recurring expenditure of SHC level HWCs is fixed at Rs.7.81 lakhs per HWC per annum and unit cost for meeting the recurring expenditure of PHC level HWCs is Rs.4.29 lakhs as per Operational Guidelines on *Ayushman Bharat Comprehensive Primary Health Care through Health and Wellness Centres (2018)*. The difference in the amounts can be used to fund more numbers of HWC.

4.2.6 If for any reasons specific to their local context, States need to utilize the grant under this component of FC-XV for non-recurring / one-time expenses such as infrastructure strengthening, Lab and IT infrastructure, cost for 6 months certificate course of CHOs, etc, then the unit cost mentioned in the Operational Guidelines (Rs.9.7 lakhs and Rs.5.6 lakhs for SHC-HWC and PHC-HWC respectively) is to be utilized by the States. At the same time, care should be taken that there is no duplication w.r.t to the sanctions already given under NHM support.

4.2.7 Further, present Operational Guidelines, do not allow the co-located Sub Health Centres, to be converted into HWCs and hence, the FC-XV grant should not be utilized for such purposes either.

4.2.8 Finally, it is re-iterated that optimal utilization of the funds under this component of FC-XV is to be ensured. **As stated earlier, costs for recurring expenditure of SHC-HWC or PHC-HWC should NOT be supported with multiple funding sources- (FC-XV, NHM or any other State funds).**

4.3 Support for this component under FC-XV

- As reiterated above, all the AB-HWCs (both SHC and PHC levels) in a State whether supported through NHM, FC-XV or other funding sources would follow the same processes, standards, monitoring indicators, performance benchmarks and quality parameters as laid out in the Operational Guidelines on Ayushman Bharat Comprehensive Primary Health Care through Health and Wellness Centres (2018) and other updates provided by the GOI.
- A financial allocation of Rs 15,105 crore has been made for this purpose by FC-XV as detailed in Appendix-1 of this chapter. Unit cost particulars (a maximum of Rs. 7.81 lakhs per year for a SHC-HWC and Rs. 4.59 lakhs for a PHC-HWC per year) are given at Appendix-2 of this chapter.

4.4 Guidance for identification of facility, approvals and operationalization

i. Allocation by the State to Districts: Based on the resource available and number of functional SHC / PHC HWCs, the State will allocate resources to the Districts. Criterion for prioritizing the districts as given in Chapter-I need to be followed. States must ensure that the grants under this component are allocated to all the Districts of the State.

ii. Apportioning by the Districts: Depending on the grants available to the District, district will identify the functional AB-HWCs for providing support under this component (for meeting the recurring expenditure of functional HWCs). The District Level Committee, as elaborated in the DoE's Guidance Note to the States dated 16th July 2021 and as explained in Chapter-1, will take necessary actions to plan and execute the required activities and identify the blocks in which HWC would be located.

iii. District will finalize the number of SHC-HWCs that can be covered with the financial allocation made by the State for this component of FC-XV (since for this FY 21-22, some support has already been provided by NHM for two to four months).

iv. The SHC-HWCs that are functional since 2018 onwards will be eligible and accordingly, SHC-HWCs in all the block panchayats will be selected by the DLC.

v. To ensure easier processing, District can apportion the number of the facilities (SHC-HWCs) under this component of FC-XV to the block panchayats of the Districts based on the operational SHC-HWCs as on date. Preferably, SHC-HWCs that are functional for more than one year can be selected for allocation of FC-XV resources.

vi. Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-1 to the State.

vii. Software is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

viii. After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV. **As the allocation under this component incudes substantive funding for HR related components, the operational diagnostic costs of PoC tests and independent monitoring, DoE's Guidance Note (Para 8 at Page 8) which has been reiterated again at sub-point 10 under para 1.4.2 of Chapter 1) may be referred for further action to ensure timely payment of remuneration and incentives of the primary healthcare team working at these SHC level HWCs.**

ix. **State level / District level HRH services:** Most of the State Health Departments have developed effective modalities for recruitment of Human Resources for Health such as Medical Officers, Nurses, Lab Technicians, Pharmacists and other para-medical staff, through mechanisms such as a State / District level agency of government or through empanelled agencies. Under National Health Mission, States/UTs are supported to deploy such agencies. States have been undertaking these human resource recruitments through these empanelled agencies, which have established transparent and systematic procedures.

x. **Procurement Cell:** The RLBs / Zilla Panchayats would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement. Such a strategy would eventually create capacities within the ULBs to handle these responsibilities independently.

xi. **As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

xii. Local Bodies (District and Block) should be actively involved in the monitoring of all the functional SHC and PHC level HWCs, without restricting such monitoring to those HWCs, which are supported under this component of FC-XV. To the extent possible,

the institutional arrangements such as JAS / VHSNCs should be utilized for this purpose.

xiii. Capacity building of the local bodies for all components of the FC-XV will be improved as per the plan in this regard (Detailed plan will be communicated separately). Since the aim is to strengthen the ownership and accountability of the RLBs for delivery of primary health care and essential public health functions, the state/District would work closely with the RLBs through the Department of Panchayati Raj.

xiv. The PRIs and DLC are required to focus optimal utilisation of the grant for recurring expense incurred in the AB-HWC especially for Human Resources, their training skills, salary and incentives, range of health care package of services to be offered, drugs, equipment, IT infrastructure, community structures and independent monitoring, all as per CPHC guidelines defined norms. (Costing Norms attached in Appendix 3).

xv. **Negative List for this component of FC-XV:** The funds under this component cannot be utilized for the following:

i. Repair and Renovation works already undertaken under the NHM Funds.
ii. Construction of boundary walls, entrance, pavements, footpaths etc.
iii. Purchase of Solar panels etc.
iv. Purchase of electronic items like TVs, cameras etc. which are not listed as part of the guidelines.
v. Purchase of IT hardware: (these are covered under the non-recurring costing of the HWCs as per CPHC guidelines).
vi. Cost of Diagnostic Infrastructure including purchase of refrigerators, etc (except for 30,000/- which is provided for Point of Care Diagnostics as recurring expenditure).

Appendix 4.1: Financial requirement for conversion of Rural PHCs and SCs into Health and Wellness Centres

		2021-22	2022-23	2023-24	2024-25	2025-26	Total
Sr. No.	State	Amount available under 15th FC	Amount available under 15th FC	Amount available under 15th FC	Amount available under 15th FC	Amount available under 15th FC	Amount available under 15th FC
1	Andhra Pradesh	124.67	124.67	130.55	137.45	144.32	661.66
2	Arunachal Pradesh	6.67	6.67	7.01	7.36	7.72	35.43
3	Assam	80.70	80.70	84.74	88.98	93.42	428.54
4	Bihar	195.81	195.81	205.60	215.88	226.68	1039.78
5	Chhattisgarh	90.13	90.13	94.64	99.37	104.34	478.61
6	Goa	4.00	4.00	4.20	4.41	4.63	21.24
7	Gujarat	160.01	160.01	168.01	176.41	185.23	849.67
8	Haryana	46.61	46.61	48.94	51.38	53.95	247.49
9	Himachal Pradesh	44.13	44.13	46.34	48.65	51.08	234.33
10	Jharkhand	68.71	68.71	72.14	75.75	79.54	364.85
11	Karnataka	188.86	188.86	198.30	208.22	218.63	1002.87
12	Kerala	105.43	105.43	110.70	116.23	122.04	559.83
13	Madhya Pradesh	197.76	197.76	207.64	218.03	228.93	1050.12
14	Maharashtra	191.95	191.95	201.54	211.62	222.20	1019.26
15	Manipur	8.73	8.73	9.17	9.63	10.11	46.37
16	Meghalaya	9.29	9.29	9.75	10.24	10.75	49.32
17	Mizoram	7.36	7.36	7.73	8.11	8.52	39.08
18	Nagaland	8.19	8.19	8.60	9.03	9.49	43.50
19	Odisha	125.33	125.33	131.60	138.18	145.09	665.53
20	Punjab	46.70	46.70	49.04	51.49	54.06	247.99
21	Rajasthan	263.19	263.19	276.35	290.17	304.67	1397.57
22	Sikkim	2.96	2.96	3.10	3.26	3.42	15.70
23	Tamil Nadu	148.61	148.61	156.04	163.85	172.04	789.15
24	Telangana	85.09	85.09	89.34	93.81	98.50	451.83
25	Tripura	17.89	17.89	18.78	19.72	20.71	94.99
26	Uttar Pradesh	387.35	387.35	406.72	427.05	448.40	2056.87
27	Uttarakhand	35.52	35.52	37.29	39.16	41.11	188.60
28	West Bengal	192.98	192.98	202.63	212.76	223.40	1024.75
	Total	**2,844.63**	**2,844.63**	**2,986.49**	**3,136.20**	**3,292.98**	**15,104.93**

Appendix 4.2 Conversion of SHCs and PHCs into HWCs in Rural Areas: Unit Cost

A. Unit cost for SHC-HWCs (Only Recurring Cost (as per CPHC guidelines)

Recurring items	Amount per SHC per annum (lakhs)
Remuneration to CHOs	4.80
Team Based Incentives to primary healthcare team at SHCs (ANMs, ASHAs & CHOs)	1.00
ASHA Incentives for delivery of expanded range of services @1000 per month (ceiling)	0.60
Refresher Training of CHOs and Multi-skilling of MPWs and ASHAs	0.30
IEC	0.25
IT support	0.05
Recurring cost for diagnostics	0.30
Independent Monitoring costs for performance assessment	0.51
Total per SHC per annum (lakhs)	**7.81**

B. Unit cost for Rural PHC-HWCs (Only Recurring Cost (as per CPHC guidelines)

Recurring items	Amount per SHC per annum (lakhs)
Training of Medical officers (two) @10k per MO, Staff Nurses (two) @7500 per SN and Multi-skilling of MPWs and ASHAs for co-located SHC	0.55
Team Based Incentives to primary healthcare team at PHC level HWCs	2.00
ASHA Incentives for delivery of expanded range of services @1000 per month (ceiling)	0.60
IEC	0.50
IT support	0.05
Recurring cost for diagnostics	0.30
Independent Monitoring costs for performance assessment	0.29
Total per SHC per annum (lakhs)	**4.29**

(Source-Ayushman Bharat Comprehensive Primary Healthcare through Health and Wellness Centres Operational Guidelines 2018)

Chapter-5: Block Public Health Units

5.1 Background

- Every block in the country is envisaged as having a CHC/ Block PHC/ SDH at the Block Headquarter (HQ) which serves as a hub for referral from the SHCs and PHCs of the block. However, the situation across states is variable, with the Block CHC functioning as just another PHC in some states. In some other states, on the other hand, the Block CHC also serves as a First Referral Unit (FRU). Currently, the block health facility is only equipped to provide selected clinical services, a limited range of public health functions and administrative control of the health institutions within the block.
- The present reporting channel for outbreaks or disease patterns is not routed through the block facility leading to fragmentation of care, reduced effectiveness and accountability for public health activities and response to public health emergencies.
- The COVID-19 pandemic highlighted the need for strengthening and enhancing a coordinated public health response at block and sub block levels thus ensuring an optimal focus on public health actions and increased attention to social and environmental determinants which impact health.
- The pandemic also highlighted the need for the block facility to be upgraded and equipped to provide a range of comprehensive primary care services and also essential secondary care services.
- There is therefore a need to augment the existing capacity of the facility at the Block level to meet the requirements of public health surveillance and response (early identification, management and creating evidence for research/ resource allocation), and referral support for HWCs at SHC and PHC level.

5.2 Block Public Health Unit (BPHU)

The BPHU would encompass the service delivery facility (CHC/PHC/SDH), a Block Public Health Laboratory, and a Block HMIS Cell. The goal of the Block Public Health Unit is to protect and improve the health of the population in the block. Decentralization at this level would enable a focus on reaching remote areas and unreached populations. It is envisaged that the Block Headquarter level facility (variously referred to as Community Health Centres (CHCs)/ Sub- Divisional Hospitals (SDHs)/Block Primary Health Centres (PHCs), (the nomenclature may vary across states) ***would be strengthened*** to become a Block Public Health Unit.

5.2.1 **The Block Public Health Unit** shall be responsible for developing a Block Level Plan, that sets block specific targets for national health programmes, and improves population health outcomes, including focus on social and environmental determinants of health. Its key functions are to:

i. Support and supervise peripheral facilities (Health and Wellness Centres) in implementation of public health and service delivery functions to undertake population-based screening for early identification of morbidities, health promotion and health education activities, involve and orient Panchayats/ULBs for social and environmental action adopting health lifestyles including yoga and various other wellness activities.

ii. Augment capacity of the Block facility to provide an expanded range of public health services and serve as the referral point for the HWC in the block, thereby reducing patient hardship and minimizing costs of care.

iii. Enable health system preparedness and ensure early and timely response during outbreaks, other public health emergencies, including disaster and violence.

iv. Ensure early identification for prevention and control of various infectious/emerging infectious diseases.

v. Maintain provision of essential services in the event of public health emergencies and outbreaks.

vi. Public Health Functions of BPHU would focus on planning and coordinating all health functions such as public health surveillance, early identification, vector control measures, school health programmes, supporting HWC in preventive functions such as population based screening- for chronic communicable and non-communicable diseases, RBSK, community health awareness campaigns, including the Annual Health Calendar, enabling avenues for increased physical activity and support to Eat Right and Fit India related activities.

5.2.2 **The Block Public Health Laboratory** of the BPHU will provide comprehensive diagnostic facilities for infectious and non-infectious diseases to enable public health surveillance and support in generating evidence and confirmation of potential disease outbreaks (***Improve disease surveillance (both human and animal) to support in generating evidence/forecasting potential outbreaks)***. The BPHL will be established within the premises of Block Public Health Unit. BPHL would serve as a diagnostic hub for all the HWCs functional under its jurisdiction within the block. Its key functions are to:

i. Conduct all Point of Care Tests (POCT) as applicable for CHC/SDH level, support collection, storage, and transportation of samples for various public health activities as required, including serve as hub for the diagnostic functions of the HWC in the block.

ii. Undertake surveillance, reporting and analysis of crucial epidemiological information (particularly source of infection, mode of transmission, period of infectivity) and confirmation of outbreaks.

iii. Maintain data of environmental surveillance by collaborating with concerned departments.

iv. Support the identification of initial cases associated with an outbreak, and actively coordinate with the rapid response teams engaged in outbreak investigations.

v. Undertake epidemiological surveillance, risk factor identification, and assessment of severity of outbreaks to help plan an appropriate response.

vi. The Block Public Health Laboratory to provide comprehensive diagnostic facilities for both clinical (as per IPHS) and public health functions. The diagnostic facilities will enable public health surveillance (including zoonotic-related illnesses and environmental surveillance for water and food as per one-health approach), generating evidence and confirmation of potential disease outbreaks, at block level, and be aligned with the Integrated Health Information Platform (IHIP) for surveillance and public health information.

5.2.3 The Block HMIS Cell will collect, compile and analyze clinical, programme and public health data to ensure effective monitoring, enable early detection of outbreaks, and serve to hold service providers accountable (***Improved public health data reporting and follow-up action)***. It has the following functions:

i. Undertake Data recording and compilation from peripheral facilities for decentralized reporting and analysis to support planning and monitoring of disease trends.

ii. Use data to identify pockets of higher morbidity/mortality and enable focused interventions to address these.

iii. Enable strong local surveillance and enable early detection of outbreaks.

iv. Generate reports for information and timely and appropriate corrective action by service providers and public health managers.

v. The Block HMIS Cell will collect, compile and analyse clinical/service delivery, programme and public health data of the entire block, to ensure effective monitoring, and early corrective action of programmes.

vi. The Block HMIS cell will compile, analyse data from peripheral facilities and provide feedback to the peripheral facilities, thus improving service delivery, and support in planning and monitoring of disease trends. They will also conduct a disease outbreak enquiry based on the data analysis and ensure containment measures have been put in place.

vii. The BPHU will monitor and ensure coordinated implementation and outputs of all National Health Programmes.

viii. The cell will ensure data quality and maintenance of timely reporting. The cell would also link with the district HMIS unit and be integrated with the IHIP. The system will be utilised to report, record and use the data for decision making and facilitate the health planners, PRIs in developing health plans and monitoring the activities.

ix. The BPHU would also leverage Electronic Health Records (EHR) through the National Digital Health Mission (NDHM) and enable individualized tracking of beneficiaries and longitudinal records through the life cycle for the population in the catchment area.

x. Thus, the BPHU is envisaged as having following functions:

   a. Public Health Functions such as surveillance, and early detection of outbreaks, emergency preparedness and planning,

   b. Clinical service delivery through the block health facility,

   c. Advanced Diagnostics services through a Block Public Health Laboratory for clinical and public health functions, and

   d. Serve as a hub for data compilation, analysis and feedback, through a Health Management Information System and IHIP.

5.3 Objectives of the Block Public Health Unit:

i. Improve healthcare within the block by strengthening integration between clinical and public health services.

ii. Improve disease surveillance (both human and animal) to support in generating evidence/forecast of potential outbreaks.

iii. Improved public health data reporting and follow-up action for clinical and public health functions.

iv. Enable decentralized planning for service delivery and public health activities for the block, with the support from the rural local bodies.

v. Serve as the referral point for service delivery and as focal hub for the SHC-HWCs and PHC-HWCs in the block to reduce crowding at higher level facilities and provide comprehensive primary health care (delivery of clinical and public health services).

vi. Strengthen disease surveillance (both human and animal) to support evidence generation/forecast of potential outbreaks through robust data reporting using HMIS and IHIP towards strengthening the One Health approach.

vii. Undertake preparatory activities for emergencies to which the area is prone in tandem with NDMA, NDRF, Medical Relief, Local bodies etc.

viii. In the event of emergencies and disease outbreaks, the BPHU would serve as the coordinating hub for community engagement and risk communication, organizing frontline workers & volunteers as first responders, collecting relevant health information, and providing health interventions, including essential services.

ix. Create a platform for multi-sectoral convergence (with WCD, ICDS, Water and Sanitation, School Education, Department of Social Justice and Empowerment, IMD (Ministry of Earth Sciences) to address social and environmental determinants of health.

x. Assume accountability for service delivery and public health outcomes within the block, including the Rogi Kalyan Samities (RKS) and the Jan Arogya Samities (JAS).

5.4 Factors to be considered

Since the grant is channelized through PRIs, wherever the health facility in a block is co-terminus with governance structure of rural local bodies, both the planning and decision making can be better coordinated. If planned as per population norms of the IPHS, the Sub Health Centres and PHCs would be co-terminus with the wards/Panchayats. VHNSCs would work under the umbrella of PRIs, and BPHU would develop better coordination with the standing committees of health under PRIs. The team at the BPHU would coordinate with the Panchayati Raj Institutions (PRIs) / Rural Local Bodies and the SHC-HWC and PHC-HWC health teams to develop Block Health Plans based on the disease burden, health need of the community, available infrastructure, and staff. The team would also coordinate with other departments like ICDS, education, and water and sanitation, National Disaster Management Authority (NDMA) to enable action on environmental and social determinants and improved responsiveness to outbreaks and emergencies.

i. Monitoring: Integrated Public Health Labs (IPHLs) at the District level will mentor and handhold BPH Labs of the BPHUs and ensure regular training and capacity building of the staff.

ii. Accountability: BPHU would support, supervise, and monitor the existing community-based platforms such as VHSNC and JAS in planning and supporting multi-sectoral action on social and environmental determinants of health in co-ordination with the AB-HWCs PHCs and SHCs. BPHUs would also support JAS at the HWC level in facilitating and enabling quality health care services in the community by being responsive to the citizens' varied needs and requirements. The BPHU will also support resolution of any

issues arising at the AB-HWCs and escalate any issue requiring decision with the higher authorities at the District Level.

iii. Decentralized Planning: The BPHU would serve a key role in decentralised planning to achieve Health for All. The District Health Action Plan (DHAP) can be prepared using the morbidity and mortality data available with HMIS unit, through a participatory, inclusive, and transparent process. Such a plan should contribute to the integrated plan for districts, keeping in view the long-term vision as a 5-year plan at the district level.

iv. Infrastructure and Equipment: Based on gap analysis, support will be provided to states for creating additional space required in the block health facility to accommodate the expanded functions of BPHU. Equipment, including equipment for IT services, etc. required for Block Public Health Unit, after gap analysis against IPHS for the clinical services being provided at the block level facility, can be proposed by the state.

v. Human Resources: The existing HR of the facility and the BPMU, would be part of the BPHU. The BPHU will be supported by a team with clinical and public health skills which will coordinate with the Block Program Coordination Committee (BPCC). Public health professionals (with multidisciplinary qualifications), data analyst/statistician, and a laboratory technician will be added to the existing public health unit. The total recurring cost of BPHU is inclusive of this additional HR for supporting BPHUs. The HR at the designated health facility shall be as per Indian Public Health Standards (IPHS) and public health unit will have its existing HR and add-on as proposed above.

vi. Capacity Building: To cater to the training needs of the healthcare staff including frontline workers, 'Integrated Govt. Online training' (iGOT) portal on the Ministry of HRD's DIKSHA platform can be utilized for capacity building on components such as Planning, Infection Prevention and Control Practices, Data Management & Report Writing, public health surveillance, monitoring and supervision, various program components etc. Other clinical trainings will continue as per the program guidelines.

5.5 Support for this component under FC-XV

A financial allocation of **Rs.5,279 crore** has been made for this purpose by FC-XV as detailed in Appendix-1 of this chapter. The Composite Unit Cost per BPHUs is:

a. Total capital cost (infrastructure for Block Public Health Unit, equipment for Block Public Health Lab and health facility, IT infrastructure for Lab and HMIS Unit)- 80.96 Lakhs

b. Total recurring cost (human resource, consumables, monitoring, etc) of Block Public Health Unit with Labs- 20.14 Lakhs

Unit cost particulars are given at Appendix-2 of this chapter. Besides, a table of various activities of three components of BPHU is also given.

5.6 Guidance for identification of facility, approvals and operationalization

5.6.1. It is envisaged that the process to complete the non-recurring / capital portion of the BPHU will take nine to twelve months. The State will utilize this time-period to complete the process of engagement of required HR under three components of HR. Accordingly, in the first year (FY 21-22), recurring expenditure is not to be factored-in and while planning for subsequent years, the recurring expenditure is to be charged first, before proceeding to plan to establish new BPHU units in the districts. Accordingly, the indicative number of blocks that can be covered over the five years period is given at Appendix 3. This is arrived with the presumption that all the Blocks require full set of activities under non-recurring components to establish BPHUs.

5.6.2. Allocation by the State to Districts: Based on the resources available to cover the number of blocks in the State, the State will allocate resources to the Districts proportionate to the number of blocks that can be covered with the available resources in the five-year period (as per above formula). States must ensure that that the grant under this component is released to all the Districts of the State. State may plan to saturate the blocks in the tribal and backward areas / blocks / districts of the State with the BPHU units and accordingly, allocation may be made. Further, after the completion of comprehensive gap analysis of infrastructure and HR availability in all the blocks of the districts, State may plan to cover more blocks than originally envisaged in an effort to cover more blocks with the available resources, as there will be savings.

5.6.3. Apportioning by the Districts: Depending on the grants available to the District, district will identify the blocks, within the districts, for providing support under this component. The District Level Committee, as elaborated in the Guidance Note to the States dated 9th July 2021 and as explained in Chapter-1, will take necessary actions.

i. Blocks located in the tribal /backward / remote areas of the districts may be given preference.

ii. District would undertake gap analysis of the infrastructure requirement at each selected block for all the three components of the BPHU and accordingly arrive at the requirement of non-recurring and recurring component of the BPHU per block. This would be compiled to reach the district requirement.

iii. Preferably, blocks with good infrastructure set-up and complete / near-complete HR availability should be given preference in the first few years for this component for the system to stabilize and also to enable the other blocks to learn from them.

5.6.4 Accordingly, District will finalize the number of blocks with block level requirement for recurring and non-recurring components under BPHU.

5.6.5 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter-1 to the State.

5.6.6 A software package is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

5.6.7 After the State level and National level approval, the districts may start utilizing the resources under this component of FC-XV.

5.6.8 **As per DOE guidance Note dated 16th July, 2021, (DoE's Guidance Note (Para 8 at Page 8) and reiterated again at sub-point 10 under para 1.4.2 of Chapter 1)**, on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other consumables, etc, through a mechanism which include Central purchase at State level to ensure purchase of quality products at reasonable/competitive prices in an efficient manner after following the due processes/procedures and practices with the prior approval by the National Level Committee".

5.6.9 **DoE's Guidance Note (Para 8 at Page 8) and at sub-point 10 under para 1.4.2 of Chapter 1 may be referred.**

i. **State level / District level HRH services:** Most of the State Health Departments have developed effective modalities for recruitment of Human Resources for Health such as Medical Officers, Nurses, Lab Technicians, Pharmacists and other para-medical staff, through mechanisms such as a State / District level agency of government or through empanelled agencies. Under National Health Mission, States/UTs are supported to deploy such agencies. States have been undertaking these human resource recruitments through these empanelled agencies, which have established transparent and systematic procedures.

ii. **Procurement Cell: The RLBs / Zilla Panchayats** would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement. Such a strategy would eventually create capacities within the ULBs to handle these responsibilities independently.

5.6.10 **As per DoE's Guidance Note dated 16th July 2021 (Annexure: Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

5.6.11 Local Bodies (District and Block) should be actively involved in the monitoring of BPHUs including the functional SHC and PHC level HWCs under them. To the extent possible, institutional structures such as RKS should be utilized for this purpose.

5.6.12 Capacity of the local bodies for all components of the FC-XV will be improved by the state through undertaking the requisite trainings through state level institutions.

5.6.13 The PRIs and DLC are required to make optimal use of the grant for recurring expense incurred in the AB-HWC especially for Human Resources, their training skills, salary and incentives, range of health care package of services to be offered, drugs, equipment, IT infrastructure, community structures and independent monitoring, all as per CPHC guidelines defined norms.

5.6.14 **Negative List for this component of FC-XV**: The funds under this component cannot be utilized for the following:

i. Repair and Renovation works of Block level facilities already undertaken under the NHM Funds.
ii. Construction of boundary walls, entrance, pavements, footpaths etc.
iii. Purchase of Solar panels etc.
iv. Purchase of electronic items like TVs, cameras etc.

Appendix 5.1: Financial allocation for establishing BPHUs

		2021-22	2022-23	2023-24	2024-25	2025-26	Total (Rs in Cr)
S. No.	State / UTs	Funds available	Funds available	Funds available	Funds available	Funds available	Total Funds available
1	Andhra Pradesh	134.42	134.42	141.14	148.20	155.61	713.79
2	Arunachal Pradesh	22.94	22.94	24.09	25.29	26.56	121.82
3	Assam	5.31	5.31	5.58	5.86	6.15	28.21
4	Bihar	49.47	49.47	51.94	54.54	57.27	262.69
5	Chhattisgarh	13.56	13.56	14.24	14.95	15.70	72.01
6	Goa	2.41	2.41	2.53	2.66	2.79	12.80
7	Gujarat	50.31	50.31	52.82	55.46	58.24	267.14
8	Haryana	28.58	28.58	30.00	31.50	33.08	151.74
9	Himachal Pradesh	1.85	1.85	1.95	2.05	2.15	9.85
10	Jharkhand	24.44	24.44	25.66	26.95	28.29	129.78
11	Karnataka	38.23	38.23	40.15	42.15	44.26	203.02
12	Kerala	30.59	30.59	32.12	33.72	35.41	162.43
13	Madhya Pradesh	28.99	28.99	30.44	31.96	33.56	153.94
14	Maharashtra	70.83	70.83	74.37	78.09	82.00	376.12
15	Manipur	14.09	14.09	14.79	15.53	16.31	74.81
16	Meghalaya	9.25	9.25	9.72	10.20	10.71	49.13
17	Mizoram	5.23	5.23	5.49	5.77	6.06	27.78
18	Nagaland	14.89	14.89	15.63	16.42	17.24	79.07
19	Odisha	29.08	29.08	30.53	32.06	33.66	154.41
20	Punjab	30.18	30.18	31.69	33.28	34.94	160.27
21	Rajasthan	27.40	27.40	28.77	30.21	31.72	145.50
22	Sikkim	6.44	6.44	6.76	7.10	7.45	34.19
23	Tamil Nadu	77.47	77.47	81.35	85.42	89.69	411.40
24	Telangana	118.52	118.52	124.45	130.67	137.21	629.37
25	Tripura	11.67	11.67	12.26	12.87	13.51	61.98
26	Uttar Pradesh	76.53	76.53	80.36	84.37	88.59	406.38
27	Uttarakhand	2.22	2.22	2.33	2.44	2.57	11.78
28	West Bengal	69.22	69.22	72.69	76.32	80.14	367.59
	Total	**994.12**	**994.12**	**1043.85**	**1096.04**	**1150.87**	**5279.00**

Appendix 5.2: Unit cost for establishing the Block Public Health Unit Components

i. **Block Public Health Unit:**

BLOCK PUBLIC HEALTH UNIT			
S. No.	Particulars	Cost per Block Public Health Unit (in Rs.)	Total (in Rs.)
1	**Infrastructure**		
1.1	Area (sq. ft.)	1000	
1.2	Cost (2000 per sq. ft.) (one time)	20,00,000	20,00,000
2	IT Equipment		
2.1	Set up Cost (one time)	2,00,000	2,00,000
	Total non-recurring		22,00,000
2.2	**Recurring cost**	**4,000 per month**	**48,000**
3	Monitoring and Supervision	2,000 per month	24,000
4	**Human resource (all HR will be as existing IPHS & BPMU some add on HR is reflected here for one year)**		
4.1	Epidemiologist/Entomologist	42,500 per Epidemiologist (1 per Unit)	42,500
4.2	Public Health Personnel	42,500 per specialist (1 per Unit)	42,500
4.3	Veterinary Doctors (Hiring/linkages with veterinary department)	42,500 per doctor (1 per Unit)	0
4.4	Lab Technician	24000 per technician (1 per Unit)	24,000
	HR Cost per month		1,09,000
	HR Cost per Year		13,08,000
	Recurring cost per year (HR+ Others)		**13,80,000**

ii. Block Public Health Laboratory

BLOCK PUBLIC HEALTH LABORATORY			
S. No.	Particulars	Unit cost (in Rs.) * Unit	Total cost (in Rs.)
1	**Infrastructure (already available at CHC as per IPHS)**		
1.1	Area (sq. ft.)	1,000	
1.2	Cost (2000 per sq. ft.)	20,00,000	20,00,000
2	Equipment as per IPHS 2012 are presently available, additional equipment indicated below is required		
2.1	Hemoglobinometer electronic	6,500 (2 per Unit)	13,000
2.2	a) Semiautomated Biochemistry analyser OR b) Fully automated Biochemistry analyser	13,00,000	13,00,000
2.3	Hematology analyser	5,00,000	5,00,000
2.4	Spirometer	4,500 (4 per Unit)	18,000
2.5	Rotor/shaker	15,000	15,000
2.6	ESR analyser	1,50,000	1,50,000
2.7	TrueNat (Chip based Real time micro PCR)	7,00,000	7,00,000
	Total		**46,96,000**
2.8	Consumables including masks, PPE, etc. Bio medical waste		58,500
3	Human resource (all HR will be as per IPHS, some add on HR is reflected here)		
3.1	Lab Technician	24,000 per technician (2 per unit)	24,000
	HR Cost per month		24,000
	HR Cost per Year		2,88,000
	Recurring Cost per year (HR+ Others)		**3,46,500**

iii. HMIS Unit

S. No.	Particulars	Cost per Block HMIS Cell (in Rs.)	Total (in Rs.)
1.1	Infrastructure		
1.2	Area (sq. ft.)	500	
2	Cost (2000 per sq. ft.)	10,00,000	10,00,000
2.1	IT Equipment		
2.2	Set up Cost	2,00,000	2,00,000
3	**Total**		**12,00,000**
	Recurring cost	4,000	48,000
3.1	Human resource *(supported by existing staff some add on HR is reflected here)*		
	Data Manager	20,000 per manager (1 per Unit)	20,000
	HR Cost per month		20,000
	HR Cost per Year		2,40,000
	Recurring Cost per year (HR+ Others)		**2,88,000**

iv. Composite Unit cost per BPHUs

Total capital cost (in Rs) of the Block PH Unit with Labs	**80,96,000**
Total recurring cost (in Rs) of Block PH Unit with Labs	**20,14,500**

v. Table of Recurring and Non-recurring activities under three Components of the BPHUs

Components	Block PH Unit	Block HMIS Cell	Block PH labs
Non-Recurring	Support for infrastructure IT equipment Furniture and others	Support for infrastructure IT equipment Furniture and others	Support for infrastructure Equipment as per IPHS 2012 -Hemoglobinometer -Electronic Semi-automated Biochemistry analyser or Fully automated Biochemistry analyser -Hematology analyser -Spirometer

			-Rotor/shaker -ESR analyser -TrueNat (Chip based Real time micro PCR)
Recurring	HR - Human resource (all HR will be as existing IPHS & BPMU) Epidemiologist / Entomologist Public Health Personnel Veterinary Doctors (Hiring / linkages with veterinary department) / Lab Technician	Human resource *(supported by existing staff and besides, exclusive Data manager and other supporting staff are proposed*	Consumables including masks, PPE, etc. Bio medical waste. Human resource (all HR will be as per IPHS) Lab Technician and other critical cadres

Appendix 5.3: Indicative number of Block Public Health Units, based on the resources available

		2021-22		2022-23		2023-24		2024-25		2025-26		Total (Rs in Cr)		Total No of Blocks in the State (as per LG code)	Blocks, yet to be covered after FC XV Grants
S. No.	State / UTs	Funds available	Units Possible	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Total Funds available	Total Units		
1	Andhra Pradesh	134.42	166	134.42	124	141.14	102	148.2	86	155.61	73	713.79	551	668	117
2	Arunachal Pradesh	22.94	28	22.94	21	24.09	18	25.29	14	26.56	13	121.82	94	114	20
3	Assam	5.31	6	5.31	5	5.58	4	5.86	4	6.15	3	28.21	22	230	208
4	Bihar	49.47	61	49.47	46	51.94	37	54.54	32	57.27	27	262.69	203	534	331
5	Chhattisgarh	13.56	16	13.56	13	14.24	10	14.95	9	15.7	8	72.01	56	146	90
6	Goa	2.41	2	2.41	3	2.53	2	2.66	1	2.79	2	12.8	10	12	2
7	Gujarat	50.31	62	50.31	46	52.82	39	55.46	32	58.24	27	267.14	206	250	44
8	Haryana	28.58	35	28.58	26	30	22	31.5	19	33.08	15	151.74	117	142	25
9	Himachal Pradesh	1.85	2	1.85	2	1.95	1	2.05	1	2.15	1	9.85	7	81	74
10	Jharkhand	24.44	30	24.44	22	25.66	19	26.95	16	28.29	13	129.78	100	264	164
11	Karnataka	38.23	47	38.23	35	40.15	29	42.15	25	44.26	21	203.02	157	228	71
12	Kerala	30.59	37	30.59	29	32.12	23	33.72	20	35.41	16	162.43	125	152	27
13	Madhya Pradesh	28.99	35	28.99	27	30.44	23	31.96	18	33.56	16	153.94	119	313	194

S. No.	State / UTs	2021-22		2022-23		2023-24		2024-25		2025-26		Total (Rs in Cr)		Total No of Blocks in the State (as per LG code)	Blocks, yet to be covered after FC XV Grants
		Funds available	Units Possible	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Funds available	Units under Capital Cost	Total Funds available	Total Units		
14	Maharashtra	70.83	87	70.83	66	74.37	54	78.09	45	82	38	376.12	290	352	62
15	Manipur	14.09	17	14.09	13	14.79	11	15.53	9	16.31	8	74.81	58	70	12
16	Meghalaya	9.25	11	9.25	9	9.72	7	10.2	6	10.71	5	49.13	38	46	8
17	Mizoram	5.23	6	5.23	5	5.49	4	5.77	3	6.06	3	27.78	21	26	5
18	Nagaland	14.89	18	14.89	14	15.63	11	16.42	10	17.24	8	79.07	61	74	13
19	Odisha	29.08	35	29.08	28	30.53	22	32.06	18	33.66	16	154.41	119	314	195
20	Punjab	30.18	37	30.18	28	31.69	23	33.28	19	34.94	17	160.27	124	151	27
21	Rajasthan	27.4	33	27.4	26	28.77	21	30.21	17	31.72	15	145.5	112	352	240
22	Sikkim	6.44	7	6.44	7	6.76	5	7.1	4	7.45	3	34.19	26	32	6
23	Tamil Nadu	77.47	95	77.47	72	81.35	59	85.42	49	89.69	43	411.4	318	388	70
24	Telangana	118.52	146	118.52	110	124.45	90	130.67	75	137.21	65	629.37	486	589	103
25	Tripura	11.67	14	11.67	11	12.26	9	12.87	7	13.51	7	61.98	48	58	10
26	Uttar Pradesh	76.53	94	76.53	71	80.36	58	84.37	49	88.59	42	406.38	314	828	514
27	Uttarakhand	2.22	2	2.22	2	2.33	2	2.44	2	2.57	1	11.78	9	95	86
28	West Bengal	69.22	85	69.22	64	72.69	53	76.32	44	80.14	38	367.59	284	346	62
	Total	**994.12**	**1214**	**994.12**	**925**	**1,043.85**	**758**	**1,096.04**	**634**	**1,150.87**	**544**	**5,279**	**4,086**	**6,855**	**2,769**

Chapter-6: Support for Diagnostics Infrastructure to the primary healthcare facilities- Sub-centres, PHCs and Urban PHCs

6.1 Background

- The Fifteenth Finance Commission (FC-XV) recommended grants to provide support for diagnostic infrastructure in Sub-Health centres, PHCs and Urban PHCs with the vision of providing **Comprehensive Primary Health Care** near to the community. This will strengthen the comprehensive primary care services at the grass roots encompassing preventive, promotive, basic curative, rehabilitative and palliative health care.
- Availability of quality, free diagnostics at public health facilities is one of the most effective ways for achieving the goal of providing universal health coverage as recognized by National Health Policy 2017. Ministry of Health and Family Welfare, Government of India, released *Operational Guidelines for the Free Diagnostics Service Initiative under NHM in 2015* (link of the resource - https://nhm.gov.in/New_Updates_2018/NHM_Components/Health_System_Stregthening/Drugs_&_logistics/Operational_Guidelines_Free_Drugs_Service_Initiative.pdf) in to address the urgent need for accessible and quality diagnostics in public health facilities. An expanded basket of tests was recommended and a hub and spoke model was suggested to enable provision of laboratory services from district till primary care level.
- Further, a detailed Guidance Document for Implementing Laboratory Services in States under NHM-Free Diagnostics Service Initiative was shared with the States in August 2019 (Link of the resource - https://nhm.gov.in/New_Updates_2018/NHM_Components/Health_System_Stregthening/Comprehensive_primary_health_care/letter/Guidance_document_for_Free_Laboratory_Services.pdf)
- The range of diagnostics tests has been further expanded in alignment with the guidelines of comprehensive primary health care services under Ayushman Bharat. Presently, 14 tests at Sub Health Centre/ Health & Wellness Centre level and 63 tests at PHC/UPHC level need to be conducted as per guidelines on free diagnostics initiative (See Appendix 1). The tests encompass haematology, serology, biochemistry, clinical pathology, microbiology and any other test for improved public health surveillance/clinical condition.
- The States may undertake the delivery of the expanded diagnostic tests in a hub and spoke model also including the BPHUs in their ambit. This can be achieved by either strengthening the in-house service delivery capacities or by expanding the same under

the PPP mechanism, as deemed appropriate and suitable at the Block, District and State level duly keeping in view the capacity of the private providers in hard to reach areas and difficult terrains.

- The FC-XV recognised that in the efforts to achieve the ideal of universal health coverage, rural and urban local bodies can play a key role in the delivery of primary health care services especially at the "cutting-edge" level. Strengthening the local governments in terms of resources, and capacity building can enable them to play a catalytic role in health care delivery, including in the time of crisis like the current COVID-19 pandemic.

6.2 Status on Free Diagnostics Service Initiative under NHM

The Free Diagnostic Service initiative has been implemented in 33 States/UTs. States/UTs have already adopted different models (In-house/ In-house with hub and Spoke/ Hybrid model detailed below) contextual to their needs. The detail of these models are as follows:

i. In-house model of service delivery: The laboratory services are provided through in-house laboratories of the respective health laboratory services. The reagents supply, equipment repair and maintenance are required to be ensured at all times. The States can also explore the reagent rent model at the higher labs with an adequate case load to ensure that the same is cost-effective.

ii. In-house system with Hub and Spoke Model of Service delivery: In hub and spoke model, the samples are collected at peripheral facilities/collection centres and safely transported to a central laboratory which acts as the Hub. The Hub can be block level Community Health Centres/Sub District Hospital /District Hospital Lab/Medical College/or a public laboratory set up for the purpose. Sampling of patients is carried out by laboratory technicians at the spoke health facilities. Samples are transported by the laboratory technicians/courier of the spokes / hubs either to sample aggregating points located at select PHCs, and CHCs, or directly to the hub laboratory. Samples should be picked up once a day from PHCs and travelling time to receiving hub laboratory should not exceed 2 hours (starting from where pick-up was started).

iii. Hybrid model of service delivery: In this model, States/UTs undertake all high volume and low-cost tests not requiring highly skilled manpower within public health facilities and all high cost, technologically demanding and lower frequency diagnostic services through outsourced mode as a way of gap filling. Sample collection and transportation will be similar to hub and spoke model.

6.3 Objectives of the support under this component of FC-XV

i. To ensure the availability of a minimum set of diagnostics appropriate to the level of care as per **Comprehensive Primary Health Care** package for HWCs and as per IPHS norms.

ii. To strengthen/ fully equip laboratories at primary healthcare facilities in both rural and urban areas

iii. To ensure adequate availability and training of the Human Resources at HWCs in performing laboratory functions and equipment maintenance

iv. To facilitate early detection, prevention and containment of any chronic /infectious disease – towards strengthening the public health surveillance, reporting and analysis

v. To leverage the approved technology for expeditious use of Point of Care diagnostics

vi. To contribute towards achieving Universal Health Coverage

vii. Reduce high Out of Pocket Expenditure (OOPE) incurred by patients on diagnostics.

6.4 Factors to be considered

6.4.1 The core objective of this component under FC-XV is to equip all the primary healthcare facilities such as SHCs, PHCs and Urban PHCs with all the diagnostic infrastructure, for effective delivery of comprehensive primary health care near to the community. Depending on the context and requirement, additional diagnostic needs for effective delivery and management of cases at these primary healthcare facilities may be attended through referring the samples to the diagnostic facilities at the higher public healthcare facilities or referring the patients wherever warranted (such as X-ray). In the process, the diagnostic infrastructure at the higher public healthcare facilities also have to be commensurately improved to attend these tasks. Strategically, the Block Public Health Unit component of the FC-XV has the lab components, at the Block level to cater to the higher-level diagnostic needs.

6.4.2 The funds provided under this diagnostic infrastructure component of FC-XV are substantial and thus, allow the states to plan not only to ensure access to essential diagnostic tests but also expand the range of tests available so that the HWCs at Sub Health Centre & Primary Health Centres of rural and urban areas are able to provide better quality of care based on accurate diagnosis. This will also strengthen the credibility of the public in the public health system.

6.4.3 While the FC-XV funds are meant to support diagnostic infrastructure at the levels of SHC, PHC and UPHC, the needs for the range of diagnostic tests in the community vary. Further, not all tests can be made available at these primary healthcare facilities, given

the complexity of test, need for qualified HR, space to locate such equipment and requirement of maintenance of the diagnostic equipment. Thus, the Block Public Health Laboratory/Laboratory at Block facility/SDH, District Public Health Laboratory/DH Laboratory could also be strengthened based on local need and availability of qualified HR, for provision of diagnostic services to the people accessing the primary healthcare facilities (SHCs, PHCs and UPHCs) through sample transportation and referral of patients especially for the tests such as Blood and Urine cultures, etc.

6.4.4 Based on the analysis of the funds available under this component, it is arrived that the State is supported with substantially high financial assistance under this component of diagnostic support. As the financial assistance is given separately for SHC, PHC and UPHC for diagnostic infrastructure, the financials available are sufficient for catering to the requirements of both recurring expenditure of these SHCs, PHCs and UPHCs in the State for the next five years and further, the financials available will also cater to improve the diagnostic infrastructure of these SHCs, PHCs and UPHCs with all the required diagnostic equipment and upgradation (except the HR support), not only to effectively provide all the 12 packages of CPHC services at these facilities, but also, effectively equip these facilities with the diagnostic-care-continuum with the Block and District level public health care facilities.

6.4.5 As these SHCs, PHCs and UPHCs are presently having varied level of diagnostic infrastructure, one-size-fit-all unit costing method is not suitable for this component of FC-XV. A detailed gap-analysis of these facilities with the required diagnostic infrastructure, duly factoring-in the available HR and diagnostic-care-policy of the State, is a pre-requisite to effectively utilize this component of FC-XV. A comprehensive gap analysis is required for all the facilities to strengthen the hub and spokes for timely testing and reporting in a time-bound approach to plan for the necessary procurement. While undertaking the facility level gap analysis, the equipment, human resources which are in position as per the latest IPHS need to be taken into consideration **for avoiding duplication**. The facility should be reviewed comprehensively for the functions it is required to perform and the equipment which is available. The current case load of the facility can be considered for augmenting the existing equipment if needed based on a sound rationale.

6.4.6 In this regard, it is instructed that while planning and submitting proposals under this component of FC-XV, State is required to categorize support areas among the following:

i. Diagnostic and Laboratory Equipment including storage

ii. Software/ IT Infrastructure including the option to print diagnostic reports or send via e-mail / electronic media.

iii. Rapid/point of care test Kits, reagents, etc. and their optimal storage conditions

iv. State specific diagnostic kits for early detection of disease conditions like Filaria / Kala-Azar / Leprosy in specific endemic areas or blocks or districts

v. Sample Transportation (Cost and Mode of sample transportation to hub – reducing the Turn Around Time)

vi. Diagnostic Equipment Maintenance and time bound repairs

vii. Monitoring of the Equipment uptime, Cost-effective utilization and replenishment of the reagent

viii. Capacity Building of all teams (For early identification and counselling for testing to obtain the lab results and providing treatment / follow-up)

ix. Misc. (other consumables for sample collection, processing and safe disposal, disinfectants; boxes for sample transportation, internet connection).

6.4.7 The states should strive to plan and operationalize all essential diagnostic tests to cater to the needs of the population to deliver Comprehensive Health Care services along with the diagnostic needs for conducting active and passive public health surveillance.

a. The selected facilities (SHC, PHCs and U-PHCs) will ensure basic diagnostic facilities with linkages for advanced testing facilities at Block Public Health Units / Block level facilities or SDHs +/ DHs or specially, Integrated District Public Health Laboratories at the District level. It is imperative that these linkages are established and accounted for during the planning phase and communicating the same between the hub and spoke facilities.

b. Since the role of SHC-HWCs and PHC-HWCs in rural and urban areas is to ensure seamless continuum of care, if the requirement for such a test is approved by the treating Medical officer/Specialist via direct examination/teleconsultation, the HWC would issue a referral slip for doing diagnostic tests at the designated centres (higher level public health care facility or outsourced private diagnostic facilities).

i. High volume and low-cost tests not requiring highly skilled manpower should preferably be done within the public health facilities and not be outsourced.

ii. High cost, low volume tests requiring expensive equipment and technologically complicated processes, could be outsourced, with adequate checks and balances as safeguards to prevent abuse. For

higher end, low volume tests, such as the blood and urine cultures, etc, the following options are suggested:

- Where there is space in the CHCs/SDHs/DHs, the states could procure the equipment directly, engage qualified HR and offer the diagnostic service directly.
- If the facility is able to provide space, and procure/maintain equipment, but not able to hire qualified HR, they could contract-in private operators to manage these facilities within the government health facility where services are offered on a cashless basis to beneficiaries referred through the Public health facilities.
- If there is no space within the DH/SDH, state could contract out such high-end diagnostic tests to private providers/encourage private providers to set up facilities for such tests within a district to service a cluster of districts, thereby reducing patient hardship and OOPE.

iii. Sample transport: States/UT adopting 'Hub & Spoke' or Hybrid model should ensure safe transport of the sample from all spokes to associated hubs / lower to higher facility. The process of collection and transport has been described in detail in IPHL guidelines. The chain for transport collection and testing should be established keeping in view the distances and the time taken for transportation, availability of public transport, identification of available runners.

iv. Test reports should be given as printed reports to the patients for all tests done as well as sample drawn within the health facility (including rapid tests/point-of-care tests). The intimation that the reports are ready (to collect from the institution where the sample has been taken) will be sent through SMS to the patient along with the link for the soft copy of the reports wherever possible. This service will be in-addition to the right of the patients to receive the hard copy of reports where the sample was given.

v. For the effective management of samples and associated investigation data, surveillance and for timely reporting, digitalization is important. Laboratory Information Management System (LIMS) will allow the spokes to track samples, inventory management (consumables and reagents) and timely communication of the test results. Hubs will be able to collect, store and

analyze the data collected from the spokes for timely actions. This data will be fed directly into IHIP.

vi. Given the increasing availability of digital technology, radiology investigations, (X-Rays and USG) could be undertaken at the level of PHC-HWCs at rural and urban areas with establishment of systems for capturing, transmission and reporting of tests where in house expertise is not available. In this regard, Tele-radiology is already in use in number of States.

vii. Equipment Maintenance: In the in-house model, at the time of procurement, the state government should ensure that the vendor provides the following as complimentary services:

a) 3-5 years of AMC and CMC;
b) supply of reagents for 5 years / reagent rental model
c) annual / bi-annual calibration of equipment (based on the use)
d) monitoring of equipment uptime and downtime; this is required to be linked with the repair and maintenance contract which is provided to the vendor
e) initial and annual refresher training of laboratory technicians and diagnosticians on the equipment and its upkeep, software, reporting, imitating breakdown for repairs, disinfection / IPC protocols and biomedical waste management.
f) Including calibration of equipment on a regular basis
g) Improve the quality of equipment for large scale screening loads.

viii. Quality Assurance: To ensure reliable and accurate testing, it is important to adhere to quality procedures and protocols. The process of quality assurance would be in accordance to the NQAS program of GoI.

ix. Infection Prevention Control measures: The IPC maintenance should be given due importance keeping in view of the cross-infections / contamination from the samples collected.

x. Grievance Redressal System: Patients can file complaints or give feedback regarding laboratory services including sample collection, reporting etc. using integrated grievance redressal mechanism as per the guidelines of GRS and health helpline (104) through help desk/call centre/web portal.

xi. A system of regular monitoring and periodic review by the district/block units will be ensured on the following indicators to assess the performance. The District/Block Team can undertake onsite visits besides monitoring

performance using online portal. The suggested Monitoring Indicators are as given below:

a) Total number of tests being performed at the lab against the list of essential tests (HWCs-SHC-14/ PHC-63 tests)
b) Total samples rejected / not fit for testing – along with reason
c) Repeat sampling rate – and the time taken to complete the repeat sampling process
d) Test results outside biological reference interval
e) Average turnaround time of test reports and identification of any outliers
f) Number of facilities reporting in LIMS as per the protocols
g) No. of trained HR/LTs/Staff nurses
h) Tests which are being outsourced despite in-house capacity and the reasons

6.5 Guidance for identification of facility, approvals and operationalization

6.5.1 The FC-XV grant is to improve substantially the diagnostic infrastructure in Sub Health Centres (SHCs), Primary Health Centres (PHCs) and Urban Primary Health Centre (U-PHCs) in 28 States under the vision of comprehensive primary health care. A specific amount of Rs. 18,472 Crore has been committed to support diagnostic infrastructure in HWC - sub centres, PHCs and urban PHCs. State-wise budget allocated for support of diagnostic infrastructure in SHCs / SHC-HWCs, PHCs / PHC-HWCs and urban PHCs / UPHC-HWCs are given in the Appendix 2.a, 2.b and 2.c respectively. (*as per Annex 7.10 A-I, A-II & A-III of XV-FC report*).

6.5.2 The unit cost of establishing new / green field diagnostic infrastructure for SHCs and PHCs in urban and rural areas is calculated to be Rs.3.91 lakhs and Rs.25.86 lakhs for SHCs and PHCs respectively. The support available under this component, if divided among the number of SHCs, PHCs and UPHCs presently functional in the States, is pretty higher than these unit costs per facility. Hence, as re-iterated above, the financial grant under this component has to be utilized – both for recurring expenditure for the provision of diagnostic services at these facilities and improving the diagnostic infrastructure of these facilities to meet the CPHC and IPHS norms.

6.5.3 The support under this component of FC-XV is being provided across various areas like diagnostic equipment for Point of Care Tests, software/ IT Infrastructure, rapid test kits, reagents, etc., sample transportation to hub, equipment maintenance, monitoring,

capacity building and other miscellaneous costs (includes sample storage, test kits, etc.). The cost is not fixed for every facility as fund required for each facility may vary as per the gap analysis.

6.5.4 Allocation by the State to Districts: Based on the resource available and number of functional SHC, PHCs and UPHCs, the State will allocate resources to the Districts. Criterion for prioritizing the districts as given in Chapter-1 need to be followed. States must ensure that that the grants under this component is released to all the Districts of the State. As the resources available under this component are substantial, efforts should be made to saturate the diagnostic requirement of Aspirational, Tribal and backward areas / blocks / districts of the State and accordingly, allocation is to be made.

6.5.5 Apportioning by the Districts: Depending on the grants available to the District, districts have to do a detailed planning.

a. First, districts have to arrive at the recurring expenditure towards provision of diagnostic services at these SHCs, PHCs and UPHCs and this requirement has to be met from the grant under this component of the FC-XV

b. As explained above, as substantial resources are available under this component, the remaining resources are to be proposed for improving the diagnostic infrastructure (non-recurring expenditure) under two broad categories.

    1. Basic diagnostic infrastructure mandatorily available in all SHCs, PHCs and UPHCs
    2. Improved diagnostic infrastructure to be made available depending the availability of HR and other logistic arrangements

6.5.6 All the Districts have to do a detailed gap-analysis facility-wise against the standard list of equipment warranted at the SHCs, PHCs and UPHCs and accordingly, arrive at the list of two categories of diagnostic infrastructure / equipment as mentioned above

1. Basic diagnostic infrastructure / equipment that are immediately required to be provided at these facilities.
2. Advanced diagnostic infrastructure / equipment

6.5.7 Districts have to compile these lists of equipment under two different categories and depending on the resources available, the allocation of resources are to be made for both recurring expenditure and non-recurring expenditure for provision of both types of diagnostic infrastructure (basic and advanced).

6.5.8 The District Level Committee, as elaborated in the DoE's Guidance Note to the States dated 16th July 2021 and as explained in Chapter-1, will take necessary actions.

6.5.9 To ensure equity, facilities located in tribal / backward areas are to be saturated first.

6.5.10 District will be having some of the facilities where due to recent sanctions and execution of diagnostic infrastructure works no allocation may be required from the grant of this component under FC-XV.

6.5.11 Similarly, if the district is adding new public healthcare facilities to cater to needs based on population norms, then the grants of this component of FC-XV may be utilized for providing diagnostic infrastructure to those facilities.

6.5.12 Accordingly, the District will finalize the number of SHCs / PHCs / UPHCs requiring diagnostic infrastructure works (with facility wise requirement) and the strengthening of hub level diagnostic infrastructure upgradation (for this FY 21-22, some support has already been provided by NHM) and accordingly, arrive at the financial requirement of the above, including for the recurring expenditure and based on the financial allocation made by the State for this component of FC-XV, the district may plan for sending the proposals to the State accordingly.

6.5.13 As explained above, with the resources of grant available under this component of FC-XV, all the districts will be in a position to improve the diagnostic infrastructure of the SHCs, PHCs and UPHCs in the districts, including those under construction presently, to the CPHC and IPHS standards.

6.5.14 Districts would send the proposal for approval under this component of FC-XV in the prescribed format given in the Chapter- 1 to the State.

6.5.15 Software is being planned to enable the districts to send the proposal in online-mode, to ensure the easier operations and for effective monitoring.

6.5.16 After the State level and National level approval, the Districts may start utilizing the resources under this component of FC-XV.

6.5.17 **As stated in the DoE's Guidance Note (Para 8 at Page 8), on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other consumables, etc, through a mechanism which include Central purchase at State level and for the centrally procured items, the State level Committee may also work out a mechanism for the payment of such centrally procurement items.**

6.5.18 **Procurement Cell: The RLBs / Zilla Panchayats and Urban Local Bodies would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement.** Such a strategy would

eventually create capacities within the ULBs to handle these responsibilities independently.

6.5.19 **As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities.**

6.5.20 Local Bodies (District and Block) should be actively involved in the monitoring of execution of these diagnostic infrastructure works at SHCs, PHCs and UPHCs, including at the higher-level facilities (where improvement has been attended for referral diagnostic tests), which are supported under this component of FC-XV. To the extent possible, the institutional arrangements such as JAS / VHSNCs should be utilized for this purpose.

6.5.21 Capacity building of the local bodies for all components of the FC-XV will be improved as per the plan in this regard (Detailed plan will be communicated separately). Since the aim is to strengthen the ownership and accountability of the RLBs for delivery of primary health care and essential public health functions, the state/District would work closely with the RLBs through the Department of Panchayati Raj Institute.

6.5.22 District may utilize the resources under this component of FC-XV for infrastructure upgradation / repairs / refurbishment of existing labs /diagnostic facilities including for required furniture and electrical works.

6.5.23 **Negative List for this component of FC-XV:** The funds under this component cannot be utilized for the following:

i. High End equipment such as PET SCAN / CT SCAN to the higher-level facilities.
ii. Construction of boundary walls, entrance, pavements, footpaths etc.
iii. Purchase of Solar panels etc.
iv. Purchase of electronic items like TVs, cameras etc. which are not listed as part of the guidelines.
v. Paying of the electricity bills of the facilities.

Appendix 6.1: Support for diagnostic infrastructure for SHCs

S. No.	State / UTs	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	54.76	54.76	57.5	60.37	63.39	**290.78**
2	Arunachal Pradesh	2.84	2.84	2.98	3.13	3.28	**15.07**
3	Assam	46.93	46.93	49.28	51.74	54.33	**249.21**
4	Bihar	157.11	157.11	164.96	173.21	182.02	**834.41**
5	Chhattisgarh	39.19	39.19	41.15	43.21	45.37	**208.11**
6	Goa	1.61	1.61	1.69	1.78	1.92	**8.61**
7	Gujarat	67.49	67.49	70.87	74.41	78.13	**358.39**
8	Haryana	25.48	25.48	26.75	28.09	29.49	**135.29**
9	Himachal Pradesh	15.38	15.38	16.15	16.8	17.81	**81.52**
10	Jharkhand	49.83	49.83	52.33	54.94	57.69	**264.62**
11	Karnataka	71.85	71.85	75.44	79.22	83.18	**381.54**
12	Kerala	39.61	39.61	41.6	43.68	45.86	**210.36**
13	Madhya Pradesh	102.61	102.61	107.74	113.13	118.78	**544.87**
14	Maharashtra	103.91	103.91	109.11	114.56	120.29	**551.78**
15	Manipur	3.95	3.95	4.15	4.36	4.58	**20.99**
16	Meghalaya	6.05	6.05	6.23	6.68	7.01	**32.02**
17	Mizoram	2.72	2.72	2.86	3.08	3.15	**14.53**
18	Nagaland	3.19	3.19	3.35	3.52	3.69	**16.94**
19	Odisha	61.72	61.72	64.81	68.05	71.45	**327.75**
20	Punjab	26.23	26.23	27.54	29.11	30.36	**139.47**
21	Rajasthan	100.45	100.45	105.47	110.75	116.28	**533.4**
22	Sikkim	1.3	1.3	1.36	1.43	1.5	**6.89**
23	Tamil Nadu	64.16	64.16	67.36	70.73	74.27	**340.68**
24	Telangana	34.93	34.93	36.68	38.51	40.44	**185.49**
25	Tripura	7.16	7.16	7.61	7.89	8.28	**38.1**
26	Uttar Pradesh	255.7	255.7	268.48	281.91	296	**1357.79**
27	Uttarakhand	13.6	13.6	14.28	14.99	15.74	**72.21**
28	West Bengal	97.39	97.39	102.26	107.37	112.74	**517.15**
	Total	**1,457.15**	**1,457.15**	**1,529.99**	**1,606.65**	**1,687.03**	**7,737.97**

Appendix 6.2: Support for diagnostic infrastructure for PHCs

S. No.	State / UTs	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	57.61	57.61	60.49	63.55	66.92	**306.18**
2	Arunachal Pradesh	6.96	6.96	7.31	7.68	8.06	**36.97**
3	Assam	50.65	50.65	53.18	55.84	58.56	**268.88**
4	Bihar	172.79	172.79	181.42	190.5	200.22	**917.72**
5	Chhattisgarh	41.06	41.06	43.11	45.22	47.53	**217.98**
6	Goa	1.17	1.17	1.23	1.29	1.39	**6.25**
7	Gujarat	71.88	71.88	75.48	79.25	83.21	**381.7**
8	Haryana	28.05	28.05	29.45	30.64	32.4	**148.59**
9	Himachal Pradesh	28.54	28.54	29.96	31.46	33.04	**151.54**
10	Jharkhand	52.55	52.55	55.17	57.93	60.83	**279.03**
11	Karnataka	103.58	103.58	108.76	114.2	119.91	**550.03**
12	Kerala	49.58	49.58	52.06	54.66	57.39	**263.27**
13	Madhya Pradesh	108.75	108.75	114.18	119.89	125.89	**577.46**
14	Maharashtra	111.96	111.96	117.56	123.44	129.61	**594.53**
15	Manipur	4.38	4.38	4.6	4.83	5.08	**23.27**
16	Meghalaya	6.04	6.04	6.34	6.46	6.99	**31.87**
17	Mizoram	2.87	2.87	3.02	3.22	3.22	**15.2**
18	Nagaland	6.14	6.14	6.44	6.76	7.1	**32.58**
19	Odisha	65.5	65.5	68.78	72.41	75.83	**348.02**
20	Punjab	28.88	28.88	30.32	31.84	33.51	**153.43**
21	Rajasthan	116.25	116.25	122.06	128.16	134.57	**617.29**
22	Sikkim	1.41	1.41	1.48	1.56	1.64	**7.5**
23	Tamil Nadu	69.25	69.25	72.71	76.35	80.17	**367.73**
24	Telangana	35.6	35.6	37.49	39.48	41.21	**189.38**
25	Tripura	5.26	5.26	5.63	5.8	6.09	**28.04**
26	Uttar Pradesh	281.53	281.53	295.61	310.39	325.91	**1494.97**
27	Uttarakhand	12.52	12.52	13.14	13.8	14.49	**66.47**
28	West Bengal	106.02	106.02	111.32	116.88	122.73	**562.97**
	Total	**1,626.78**	**1,626.78**	**1,708.3**	**1,793.49**	**1,883.5**	**8,638.85**

Appendix 6.3: Support for diagnostic infrastructure for UPHCs

S. No.	State / UTs	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	14.29	14.29	15.21	15.84	16.63	**76.26**
2	Arunachal Pradesh	3.07	3.07	3.3	3.38	3.55	**16.37**
3	Assam	12.66	12.66	13.3	13.96	14.66	**67.24**
4	Bihar	43.2	43.2	45.36	47.63	50.01	**229.4**
5	Chhattisgarh	10.23	10.23	10.74	11.27	11.84	**54.31**
6	Goa	0.24	0.24	0.26	0.27	0.28	**1.29**
7	Gujarat	17.63	17.63	18.51	19.44	20.41	**93.62**
8	Haryana	7.01	7.01	7.36	7.73	8.12	**37.23**
9	Himachal Pradesh	4.24	4.24	4.45	4.67	4.91	**22.51**
10	Jharkhand	13.1	13.1	13.75	14.44	15.16	**69.55**
11	Karnataka	16.02	16.02	16.82	17.66	18.55	**85.07**
12	Kerala	11.05	11.05	11.61	12.19	12.8	**58.7**
13	Madhya Pradesh	27.17	27.17	28.53	29.96	31.46	**144.29**
14	Maharashtra	27.96	27.96	29.35	30.82	32.36	**148.45**
15	Manipur	1.12	1.12	1.17	1.23	1.29	**5.93**
16	Meghalaya	1.51	1.51	1.59	1.67	1.75	**8.03**
17	Mizoram	0.44	0.44	0.46	0.48	0.51	**2.33**
18	Nagaland	1.02	1.02	1.08	1.13	1.19	**5.44**
19	Odisha	18.36	18.36	19.28	20.24	21.26	**97.5**
20	Punjab	7.21	7.21	7.57	7.95	8.35	**38.29**
21	Rajasthan	27.81	27.81	29.2	30.66	32.19	**147.67**
22	Sikkim	0.15	0.15	0.15	0.16	0.17	**0.78**
23	Tamil Nadu	18.75	18.75	19.69	20.67	21.7	**99.56**
24	Telangana	8.86	8.86	9.31	9.77	10.26	**47.06**
25	Tripura	1.27	1.27	1.33	1.4	1.47	**6.74**
26	Uttar Pradesh	70.37	70.37	73.89	77.58	81.46	**373.67**
27	Uttarakhand	3.26	3.26	3.42	3.6	3.78	**17.32**
28	West Bengal	26.49	26.49	27.82	29.21	30.67	**140.68**
	Total	**394.49**	**394.49**	**414.51**	**435.01**	**456.79**	**2,095.29**

Annexure: Department of Expenditure Guidelines Dated 16th July 2021

File No.15 (2) FC-XV/FCD/2020-25
Ministry of Finance
Dept of Expenditure
Finance Commission Division
Block No. 11,5th Floor,
CGO Complex, Lodhi Road,
New Delhi-110003
Dated:-16/07/2021

To

The Chief Secretary,
(All State Governments)

Subject:- Operational Guidelines for implementation of the recommendations of the Fifteenth Finance Commission (FC-XV) on Health Sector grants contained in Chapter 7 (Empowering Local Governments) of FC-XV Final Report.

Sir,

The recommendation of the Fifteenth Finance Commission (FC-XV) contained in Chapter-7 (Empowering Local Governments) of FC-XV Final Report inter-alia, include grant-in-aid for Health Sector to be channelized through Local Governments during the award period 2021-22 to 2025-26.

2. In this regard, the undersigned is directed to forward herewith a copy of the Operational Guidelines for implementation of the recommendations of the FC-XV on Health Sector grants for further necessary action.

Yours faithfully,

Encl.: as above

(Abhay Kumar)
Director(FCD)

Copy to:-

(i)The Secretary, Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.
(ii)The Secretary, Ministry of Panchayati Raj, Krishi Bhavan, New Delhi.
(iii) The Secretary, Ministry of Housing & Urban Affairs, Nirman Bhawan, New Delhi.

No. 15(2)FC-XV/FCD/ 2020-25
Government of India
Ministry of Finance
Department of Expenditure
(Finance Commission Division)
....

Operational Guidelines for implementation of the recommendations of the Fifteenth Finance Commission (FC-XV) on Health Sector grants contained in Chapter 7 (Empowering Local Governments) of FC-XV Final Report.

Introduction

The Fifteenth Finance Commission (FC-XV) in Chapter 7 (Empowering Local Governments) of its Final Report has recommended a total grant amounting to Rs. 4, 27, 911 crore for local governments for the award period 2021-22 to 2025-26 out of which the Commission has inter-alia decided to provide grants amounting to Rs. 70,051 crore to strengthen and plug the critical gaps in the health care system at the primary health care level. FC-XV has also identified interventions that will directly lead to strengthening the primary health infrastructure and facilities in both rural and urban areas.

2. In the Eleventh Schedule to the Constitution, Health and Sanitation including hospitals, Primary Health Centers & Dispensaries, Family Welfare are listed for Panchayats. Similarly, in the Twelfth Schedule to the Constitution, Public Health, Sanitation conservancy and solid waste management are listed for Municipalities. In order to achieve the objective of Universal Health, rural and urban local bodies can play a key role in the delivery of primary health care services especially at the 'cutting edge' level. Strengthening the local governments in terms of resources, health infrastructure and capacity building can enable them to play a catalytic role in health care delivery including in crisis times. Therefore, involving Panchayati Raj institutions as supervising agencies in these primary health care institutions would strengthen the overall primary health care system and involvement of local governments would also make the health system accountable to the people.

3. In the light of aforesaid, the Fifteenth Finance Commission has decided to provide a part of the grants earmarked for the third tier for support to primary healthcare. State-wise and year-wise total fund allocation on health Sector spread over the award period of five years starting from 2021-22 to 2025-26 is given in the **Annexure (I)**. The components identified by the Fifteenth Finance Commission for upgradation of primary health care infrastructure in Rural and Urban areas along with the summary of the amount earmarked year-wise are given below:

For Rural Areas

(Rs. in crore)

S. No.	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	*Support for diagnostic infrastructure to the primary healthcare facilities*	3084	3084	3238	3400	3571	16377
	(i) Sub centres	*1457*	*1457*	*1530*	*1607*	*1687*	*7738*
	(ii) PHCs	*1627*	*1627*	*1708*	*1793*	*1884*	*8639*
2	*Block level public health units*	994	994	1044	1096	1151	5279
3	*Building-less Sub centres, PHCs, CHCs*	1350	1350	1417	1488	1562	7167
4	*Conversion of rural PHCs and sub centres into health and wellness centre*	2845	2845	2986	3136	3293	15105
	Total Health Grants	8273	8273	8685	9120	9577	43928

For Urban Areas:-

(Rs. in crore)

S. No.	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	*Support for diagnostic infrastructure to the PHC facilities in Urban PHCs*	394	394	415	435	457	2095
2	*Urban health and wellness centres (HWCs)*	4525	4525	4751	4989	5238	24028
	Total Health Grants	4919	4919	5166	5424	5695	26123

4. Brief details about each recommended component is given hereunder:

(i) Support for diagnostic infrastructure to the primary healthcare facilities in Rural and Urban Areas

Under the vision of comprehensive primary health care, FC-XV has provided support for diagnostic infrastructure in Sub-Centers & Public Health Centres(PHCs) in rural areas and for Urban PHCs. Diagnostic services are critical for the delivery of health services, and these grants are intended to fully equip the primary health care facilities so that they can provide some necessary diagnostic services. *(State-wise & Year-wise grants allocated for diagnostic infrastructure in Sub-Centers and PHCs in Rural Areas are provided in Annexure-II & III and for Urban PHCs in Annexure-VII).*

(ii) Block level public health units :-

Block public health units (BPHU) would integrate the functions of service delivery, public health action, strengthen laboratory services for disease surveillance, diagnosis and public health and serve as the hub for health-related reporting. The BPHUs will also improve de-centralised planning and the preparation of block plans that feed into district plans. In addition, they will improve accountability for health outcomes. Given that the block health facility is co-terminus with the Block Panchayat /Panchayat Samiti/Taluka Panchayat, this has the potential to facilitate convergence with the panchayati raj institutions and the child development project officer of the Integrated Child Development Scheme (ICDS) programme. The FC-XV proposes to provide support to BHPUs in all the 28 States. *(State-wise & Year-wise grants allocated for Block level public health units in Rural Areas are provided in Annexure-IV).*

(iii) Urban Health and Wellness Centres

Universal comprehensive primary health care is planned to be provided through urban Ayushman Bharat-Health & Wellness Centres (AB-HWCs) and polyclinics. Such urban HWCs would enable de-centralised delivery of primary health care to smaller populations, thereby increasing the reach to cover the vulnerable and marginalised. It is envisaged that the urban HWCs would create a mechanism for representatives of the Medical Administrative Staff and Resident Welfare Associations to disseminate information on public health issues at least once a month. FC-XV has recommended financial support for setting up urban HWCs in close collaboration with urban local bodies *(State-wise & Year-wise grants allocated for Urban Health and Wellness Centers are provided in Annexure-VIII).*

(iv) Building-less Sub centres, PHCs, CHCs

After assessing infrastructure gaps in the rural PHCs/Sub-Centres based on Rural Health Statistics, FC-XV has recommended financial support for development of necessary infrastructure for 27,581 HWCs at the sub-centre level and 681 HWCs at the

PHC level in rural areas in close collaboration with rural local bodies. (State-wise & Year-wise grants *allocated for Building-less Sub centres, PHCs, CHCs are provided in Annexure-V*).

(v) Conversion of Rural PHCs and Sub Centres into Health and Wellness Centre

The Union Government has envisaged the creation of 1,50,000 HWCs by transforming existing sub-centers and PHCs as the basic pillar of Ayushman Bharat to deliver comprehensive primary health care. 15th Finance Commission propose to provide support for necessary infrastructure for the conversion of rural PHCs and sub-centers into HWCs so that they are equipped and staffed by an appropriately trained primary health care team, comprising of multi-purpose workers (male and female) and ASHAs and led by a mid-level health provider. PHCs linked to a cluster of HWCs would serve as the first point of referral for many disease conditions (State-wise & Year-wise grants *allocated for Conversion of Rural PHCs and Sub Centers into Health and Wellness Centre are provided in Annexure-VI*).

5. **Institutional mechanism for administration of the Health Sector grants**:-

(i) At the **national level**, a Committee called National Level Committee (**NLC**) headed by the Secretary, Ministry of Health & Family Welfare (MoHFW), and comprising Principal Secretaries of Health of all States shall be set up to draw a time line of deliverables and outcomes for each of the five years along with a definite mechanism for flow and utilisation of these grants. Composition of the NLC and the Terms of Reference shall be decided by the Ministry of Health and Family Welfare (MOH&FW) for which the nodal Ministry will issue separate orders. NLC shall consider and if found fit, approve the State level plans received from State Level Committees. It shall also issue necessary technical guidance to the States from time to time which shall include items to be procured/services to be provided under each recommended component, their specifications, price range, names of the standard brands available in the market

etc. etc. along with the formats in which proposals/information from State Level Committees (SLCs) / District Level Committees (DLCs) is required to be sought.

(ii) Similarly in each State, a **State Level Committee (SLC)** headed by the Chief Secretary and comprising officials of the State Department of Health, Panchayat Raj (or nodal for Autonomous District Councils) and Urban Affairs and select representatives from all three tiers of rural and urban local bodies shall be set up. Based on the Action Plans received from District Level Committee (DLC), SLC shall prepare a State Plan for presentation/consideration/approval to NLC. Composition of the SLC and the Terms of Reference along with the Role and Responsibilities shall be as decided by the Ministry of Health and Family Welfare (MOH&FW) for which the nodal Ministry will issue separate orders/advisory to the States.

(iii) Similarly, in each district, a **District Level Committee (DLC)** shall be set up under the District Collector/Deputy Commissioner. The Committee will comprise of officials of Health, Panchayati Raj and Urban Affairs and select representatives from all three tiers of rural and urban local bodies in the District. Chief Medical Officer of the District shall be the convener of the Committee. Responsibilities of the Committee shall be as decided by the Ministry of Health and Family Welfare (MOH&FW) and the State Government concerned (SLC) for which the nodal Ministry/State Government will issue separate orders/advisory to the States. Based on the plans received from nominated local body entities, the DLC shall prepare a District Level Plan for submission to State Level Committee for consideration/approval.

6. Thereafter, subsequent steps shall be taken at both the Union and State levels in line with plans agreed upon in the National Level Committee / State Level Committee. The Committees shall meet as frequently as required for the early disposal and smooth working of the proposed mechanism so that the objective of the Fifteenth Finance

Commission recommended Health Sector grants are fulfilled in a fair and transparent manner. The persons charged with this responsibility at each level of the Union and State Governments will ensure strict adherence to timelines and outcomes as set out in the agreed policy.

7. **Implementing entities for the Fifteenth Finance Commission recommended Health Sector grants to Local Bodies**:-

The components identified by the Fifteenth Finance Commission for strengthening primary health care infrastructure and facilities in both rural and urban areas are mostly technical in nature and require experience as well as exposure in the relevant subject. Since, in all States, local bodies have not hitherto handled primary public health functions directly therefore, suddenly transferring the responsibility of the delivery of primary health care services to the local bodies especially at the lower levels during these critical times may not produce the desired results. Further, Fifteenth Finance Commission has also recommended that representatives of the urban local bodies and all three levels of Panchayati Raj institutions (wherever applicable) should be involved by entrusting them, in a phased manner, with the responsibility of supervising and managing the delivery of health services.

Therefore, at district level, Zilla Parishad/ Autonomous District Councils shall handle / implement the rural component of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector. The district level Rural Local Bodies/ Zilla Parishad is better equipped in terms of having a health and engineering resources, that could undertake the functions entailed. However, it is emphasized that Rural Local Bodies below the District level(as the case may be) such as Block/Taluk Level Panchayats and Gram Panchayats/Village Councils must be involved in planning and monitoring of these components for the health facilities located in their jurisdiction.

For implementing urban components of health sector grants, the Urban Local body concerned will be entrusted with implementation of these components. The urban bodies shall handle/implement the urban components of health sector grants (as per component-

wise details in para-3 above) in close coordination with the District Health Department under the overall supervision of the District Collector.

8. **Procurement of medicine, medical equipment, diagnostics and other consumables etc.** :-

Procurement of medical equipments/items of stores for providing diagnostic services etc. are essential part of the health services. Like other items of stores, they are also dependant on the economies of scale, standard processes, quality assurance and require technical expertise in addition to adherence to the Rules, practices and procedures on the subject. As local bodies hitherto have largely not handled such public health functions, therefore, the State Level Committee (SLC) may decide about the procurement of the approved components of medical equipment, diagnostics etc. under 'Support for diagnostic infrastructure' component through a mechanism which may include central purchase(at State level) with the aim to ensure purchase of quality products at reasonable/competitive prices in an efficient manner after following the due processes, procedures and practices with the prior approval by the National Level Committee. For the centrally (at State level) procured items, it must be ensured that the selected vendors/companies do deliver the items of store at the intended destination (where these are required to be installed/utilized). State Level Committee may also work out a mechanism for the payment for centrally procured items of stores to the concerned vendors/companies.

9. **Convergence of FC-XV recommended Health Sector Grants**:- The Fifteenth Finance Commission in Chapter 7 of its Final Report for the period 2021-22 to 2025-26 has inter-alia recommended Health Sector Grants (HSG) to strengthen and plug the critical gaps in the health care system at the primary health care level. The Fifteenth Finance Commission has assessed the gaps in the existing health care interventions made through different programmes /schemes like National Health Mission and Ayushman Bharat. After assessment, the Fifteenth Finance Commission has identified interventions that will directly lead to strengthening the primary health infrastructure and facilities in both rural and urban areas. The implementing local bodies/entities may utilise the health sector grant

components in convergence with any other scheme aided by the Union Government with similar outcomes or with other type of funds available with them. While avoiding duplication, the ultimate aim for convergence should be to cover maximum population/area within the jurisdiction of the concerned local body or to improve the quality of the assets proposed to be constructed for the purpose. However, 15th Finance Commission recommended health sector grant should not be used as a State share/contribution towards any particular scheme.

10. **Role of State Health Department** :–

(i) State Health Department (SHD) in collaboration with the State Panchayati Raj Department shall work out the District-wise distribution of funds / resources, including physical deliverables and targets - for all the components (separately for rural and Urban) of the *Fifteenth Finance Commission – Health Grants through Local Governments* as per the public healthcare facilities available in the districts, based on the technical guidance provided by the National Level Committee (NLC) and submit it to State Level Committee for consideration / approval.

(ii) The district-wise allocations for health sector grants as a whole may be done keeping in view the rural population factor and ensuring preferential allocation to the aspirational /Tribal districts/ insurgency affected areas/Hill areas with the aim to make health facilities available to even far flung areas/backward areas.

(iii) State Health Department shall compile the Annual District Health Action Plan-FC-XV (DHAP) received from the District Level Committee (DLC) and after examination will place it before State Level Committee for consideration. It is the responsibility of State Health Department to ensure, before forwarding the Fifteenth Finance Commission proposals to State Level Committee that there is **no duplication between the proposals** submitted to the State Level Committee under Fifteenth Finance Commission grants and proposals for funding under National Health Mission or any other schemes of the Govt. of India/State Government.

(iv) The State Health Department shall forward the **approved** District Health Action Plans / compiled State Action Plan to National Level Committee for concurrence/approval.

(v) After approval by State Level Committee & National Level Committee, State Health Department shall communicate the approved District Health Action Plan to the Panchayati Raj Department (for rural grant components) and the Urban Development Department (for Urban grant components) alongwith other relevant details for smooth implementation of the approved plans/components along with the activities/works to be executed by each entity as decided by the State Level Committee and place the same in public domain within 2 weeks of approval by National Level Committee. The State Health Department shall also inform each District Level Committee / Zila Panchayats/ Urban Local bodies about the works/activities approved for their districts alongwith the year-wise budget for further action at their level.

(vi) The State Health Department shall get monthly progress (physical and financial) from all District Level Committes-FC-XV and submit the progress quarterly to the State Level Committee for review and directions.

(vii) State Health Department shall work in close coordination with State Panchayat Raj(PR) Department / Urban Development Department(UDD) in implementation as well as decision making for Fifteenth Finance Commission recommended Health Grants through Local Governments. On the basis of Utilization Certificates collected from different entities, State Health Department alongwith the Panchayat Raj Department shall prepare a joint Utilization Certificate with the signatures of the Secretaries of both the Departments and submit the same to the State Finance Department for onward transmission to the Department of Expenditure, Ministry of Finance and the Ministry of Health & Family Welfare.

(viii) With the permission of the Chairman, State Level Committee, State Health Department shall convene State Level Committee meetings as frequently as required and shall also function as the Secretariat for State Level Committee.

Annexure

11. **Role of State Panchayat Raj(PR) Department and Urban Development Department(UDD) :-**

(i) State Panchayat Raj Department/Nodal Department for Autonomous District Councils and Urban Development Department(UDD) shall release funds to the local bodies (and to the agency decided by SLC for procurement, if any) and work in close coordination with State Health Department. They will provide all the assistance for implementation of Fifteenth Finance Commission recommended Health Grants through Local Governments ear-marked for Rural Local Bodies/Urban Local Bodies.

(ii) On the basis of information received from State Health Department, State Panchayat Raj Department/ Urban Development Department shall communicate the resource allocation, physical deliverables and targets on a year wise basis, to all the concerned Rural Local Bodies/Urban Local Bodies and shall also seek their Annual proposals in the form of District Health Action Plan (DHAP-FC-XV) from the District/Zila Panchayats and Urban bodies(for their concerned components) .

(iii) State Panchayat Raj Department/ Nodal Department for Autonomous District Councils and Urban Development Department shall pursue with all the Rural Local Bodies/Urban Local Bodies for the proper implementation of the approved District Health Action Plans.

(iv) State Panchayat Raj Department/ Urban Development Department, in active collaboration with the State Health Department, shall take necessary actions for capacity building of the Rural Local Bodies/Urban Local Bodies (officials and elected members) for effective implementation and will utilize all their available resources and institutions for the purpose.

(v) State Panchayat Raj Department/ Urban Development Department shall collect the Utilization Certificates of the amount released to nominated entities (Rural Local Bodies/Urban Local Bodies). It has the responsibility to submit the Utilization Certificates of Fifteenth Finance Commission -Health Grants, with the joint signature of the State Health Department to the State Finance

Department, which will be subsequently submitted to the Department of Expenditure, Ministry of Finance and the Ministry of Health & Family Welfare

12. **Role of District Level Committee (DLC-FC-XV) :-**

(i) District Level Committee (DLC) shall be responsible for providing overall guidance to the Rural Local Bodies/Urban Local Bodies on the implementation of the Fifteenth Finance Commission – *Health Grants through Local Governments*, including preparation of the proposals, component wise as per the Guidelines on the subject and ensuring timely completion of each project.

(ii) The District Level Committee would appraise the proposals received from the Rural Local Bodies/Urban Local Bodies, as per the guidelines on the subject and recommend to the State Level Committee for consideration.

(iii) After receipt of final approved District Health Action Plan -FC-XV from State Level Committee through State Health Department, the District Level Committee shall guide the concerned Rural Local Bodies/Urban Local Bodies and monitor the implementation of the approved activities of various components of District Health Action Plan -FC-XV.

(iv) District Level Committee shall also take necessary steps to guide and handhold the Rural Local Bodies/Urban Local Bodies including capacity building of Rural Local Bodies/Urban Local Bodies (all tiers available within their jurisdiction).

(v) The District Level Committee would mobilize the district health team, (and the state health Department if required) to support Rural Local Bodies/Urban Local Bodies in planning and to provide technical support required in implementation and monitoring.

(vi) The District Level Committee would meet on a monthly basis to review progress and identify issues coming in the way of smooth delivery of primary health care to the intended population and take appropriate remedial measures.

(vii) The District Level Committee shall ensure that the concerned Rural Local Bodies/Urban Local Bodies submit the Utilization Certificates to the Panchayat Raj Department/ Urban Development Department so that further action on these Utilization Certificates can be taken at the appropriate level.

13. Role of Rural & Urban Local Bodies :-

(i) Zila/District Panchayats or District Councils or Municipal Corporations (in case of Urban Local Bodies) shall in collaboration with the District health Department, assess the existing gaps in the health care delivery system within rural and urban areas and prepare a programme for fixing such gaps after taking existing interventions through different centrally sponsored programmes or state sponsored programmes into consideration. On the basis of interventions/components recommended by the Fifteenth Finance Commission as per details given above in para -3 above and District-wise allocations worked out by the State Level Committee, Zila/District Panchayats or District Councils or Municipal Corporations shall prepare annual programmes for a five year period after taking required inputs from all tiers available in the State through their representatives.

(ii) Annual / five year plan thus finalized, shall be submitted to the District Level Committee in the format as prescribed by State Level Committee / National Level Committee for their scrutiny/ approval and further transmission to State Level Committee for necessary action.

(iii) On the basis of the approval received, the Zila /District Panchayats/ Autonomous District Councils or Urban Local Bodies shall implement the activities/projects, in close coordination with the District Health Department, and ensure timely completion, submit UCs to the District Level Committee and Panchayati Raj Department/Urban Development Department (as the case may be).

14. **Release of Grants**:-

On the basis of recommendations received from the Ministry of Health & Family Welfare, Department of Expenditure, Ministry of Finance, Govt. of India shall release Fifteenth Finance Commission recommended health grants to the State Finance Department on PFMS as per the State-wise & component-wise allocation given in **Annexure-II & VIII**. Subsequent installment of the these grants shall be released to the concerned States during the award period of five years on the basis of recommendation received from the Ministry of Health & Family Welfare, submission of Grant Transfer Certificates in the format prescribed at Annexure-IX. A separate Account may be opened for the purpose of monitoring health sector grant transactions. This will also enable in simplification of the processes and ensure no duplication happens with any other scheme for the same subject. The same also needs to be linked with the PFMS.

15. **Distribution of health Sector grants by the States**:-

State Finance Department shall transfer the grant to the Panchayat Raj Department/ Urban Development Department or nodal Department for Autonomous District Councils within ten working days without any deduction.

Panchayat Raj Department/ Urban Development Department or nodal Department for Autonomous District Councils shall transfer the grant to the Zila/District Panchayats/ District Councils or Urban Local Bodies or other tiers in the Panchayati Raj system **based on the items / projects approved by the State Level Committee for execution at their level**.

16. **Mode of payment by the executing entities**:-

Payments made to suppliers/vendors/companies by any executing entity shall be transferred through PFMS or any electronic system fully integrated with PFMS. Therefore, every entity shall have to register either their existing or new bank account with the PFMS or the system integrated with PFMS. Grant transfer and utilization shall be centrally verified through PFMS, therefore, it must be ensured that there is no discrepancy. State Level Committee and District Level Committees shall ensure that all executing entities have linked their bank account with the PFMS.

17. **Capacity Development of the Representatives of local bodies**:-

Consequent upon the enactment of the 73rd & 74th Constitution Amendment Acts, (and as per the Legislation passed by each State), Panchayats were primarily given the responsibility for the delivery of basic services. Involvement of local bodies/third tier in the delivery of primary health care is a new responsibility proposed for transfer in a phased manner and hitherto not managed by the rural local bodies in most of the States. Health being a sensitive subject and the responsibilities required in the delivery of health services require some basic knowledge on the subject. Therefore, Ministry of Health & Family Welfare in coordination with the Ministry of Panchayati Raj / Ministry of Housing and Urban Affairs and the concerned State Governments may consider Capacity Development of the Representatives of local bodies so as to equip them with the new challenges and the new responsibilities being assigned to them.

In order to make the new initiative a success, National Level Committee may consider organizing a short duration training programme for a select group of local body representatives of all the States to be know as 'Training of Trainers' which can further train representatives upto all the available tiers in a State within their jurisdiction or through any other mechanism that National Level Committee may deem fit for their capacity development.

18. **Allocation of State-wise and component-wise health Sector grant for the award period 2021-22 to 2025-26.**

Allocation of State-wise, year-wise and component-wise health Sector grant for the award period 2021-22 to 2025-26 is provided in Annexure-I to VIII.

19. **Accounting procedure**:- A budget line at Budget Stage 2021-22 has been provided under major head 3601, Sub- major head(07). Health Sector Grant being a new addition in the local body grants therefore, new Minor Head for Health Sector grant & Sub-heads is being opened for each component separately. Similarly, while booking expenditure, actual expenditure incurred shall be booked under these newly created Sub-heads under Minor head (Health Sector grant).

..*.*.*

Annexure-I

Total Health Grants for the award period 2021-22 to 2025-26

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	490.00	490.00	514.00	540.00	567.00	**2601.00**
2	Arunachal Pradesh	49.00	49.00	51.00	54.00	56.00	**259.00**
3	Assam	280.00	280.00	293.00	308.00	323.00	**1484.00**
4	Bihar	1133.00	1133.00	1190.00	1249.00	1312.00	**6017.00**
5	Chhattisgarh	339.00	339.00	356.00	373.00	392.00	**1799.00**
6	Goa	31.00	31.00	33.00	35.00	37.00	**167.00**
7	Gujarat	629.00	629.00	661.00	694.00	728.00	**3341.00**
8	Haryana	305.00	305.00	320.00	335.00	352.00	**1617.00**
9	Himachal Pradesh	98.00	98.00	103.00	108.00	114.00	**521.00**
10	Jharkhand	446.00	446.00	469.00	492.00	517.00	**2370.00**
11	Karnataka	552.00	552.00	579.00	608.00	638.00	**2929.00**
12	Kerala	559.00	559.00	587.00	616.00	647.00	**2968.00**
13	Madhya Pradesh	923.00	923.00	969.00	1018.00	1069.00	**4902.00**
14	Maharashtra	1331.00	1331.00	1397.00	1467.00	1541.00	**7067.00**
15	Manipur	44.00	44.00	46.00	49.00	51.00	**234.00**
16	Meghalaya	59.00	59.00	61.00	64.00	68.00	**311.00**
17	Mizoram	31.00	31.00	33.00	35.00	36.00	**166.00**
18	Nagaland	57.00	57.00	60.00	63.00	66.00	**303.00**
19	Odisha	462.00	462.00	485.00	510.00	535.00	**2454.00**
20	Punjab	401.00	401.00	421.00	443.00	465.00	**2131.00**
21	Rajasthan	833.00	833.00	875.00	918.00	964.00	**4423.00**
22	Sikkim	21.00	21.00	22.00	23.00	24.00	**111.00**
23	Tamil Nadu	806.00	806.00	846.00	889.00	933.00	**4280.00**
24	Telangana	419.00	419.00	441.00	463.00	486.00	**2228.00**
25	Tripura	85.00	85.00	90.00	94.00	99.00	**453.00**
26	Uttar Pradesh	1830.00	1830.00	1921.00	2017.00	2118.00	**9716.00**
27	Uttarakhand	150.00	150.00	158.00	165.00	174.00	**797.00**
28	West Bengal	829.00	829.00	870.00	914.00	960.00	**4402.00**
	Total	**13192.00**	**13192.00**	**13851.00**	**14544.00**	**15272.00**	**70051.00**

Annexure-II

Support for diagnostic infrastructure to the primary healthcare facilities- Sub centres

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	54.76	54.76	57.50	60.37	63.39	**290.78**
2	Arunachal Pradesh	2.84	2.84	2.98	3.13	3.28	**15.07**
3	Assam	46.93	46.93	49.28	51.74	54.33	**249.21**
4	Bihar	157.11	157.11	164.96	173.21	182.02	**834.41**
5	Chhattisgarh	39.19	39.19	41.15	43.21	45.37	**208.11**
6	Goa	1.61	1.61	1.69	1.78	1.92	**8.61**
7	Gujarat	67.49	67.49	70.87	74.41	78.13	**358.39**
8	Haryana	25.48	25.48	26.75	28.09	29.49	**135.29**
9	Himachal Pradesh	15.38	15.38	16.15	16.80	17.81	**81.52**
10	Jharkhand	49.83	49.83	52.33	54.94	57.69	**264.62**
11	Karnataka	71.85	71.85	75.44	79.22	83.18	**381.54**
12	Kerala	39.61	39.61	41.60	43.68	45.86	**210.36**
13	Madhya Pradesh	102.61	102.61	107.74	113.13	118.78	**544.87**
14	Maharashtra	103.91	103.91	109.11	114.56	120.29	**551.78**
15	Manipur	3.95	3.95	4.15	4.36	4.58	**20.99**
16	Meghalaya	6.05	6.05	6.23	6.68	7.01	**32.02**
17	Mizoram	2.72	2.72	2.86	3.08	3.15	**14.53**
18	Nagaland	3.19	3.19	3.35	3.52	3.69	**16.94**
19	Odisha	61.72	61.72	64.81	68.05	71.45	**327.75**
20	Punjab	26.23	26.23	27.54	29.11	30.36	**139.47**
21	Rajasthan	100.45	100.45	105.47	110.75	116.28	**533.40**
22	Sikkim	1.30	1.30	1.36	1.43	1.50	**6.89**
23	Tamil Nadu	64.16	64.16	67.36	70.73	74.27	**340.68**
24	Telangana	34.93	34.93	36.68	38.51	40.44	**185.49**
25	Tripura	7.16	7.16	7.61	7.89	8.28	**38.10**
26	Uttar Pradesh	255.70	255.70	268.48	281.91	296.00	**1357.79**
27	Uttarakhand	13.60	13.60	14.28	14.99	15.74	**72.21**
28	West Bengal	97.39	97.39	102.26	107.37	112.74	**517.15**
Total		**1457.15**	**1457.15**	**1529.99**	**1606.65**	**1687.03**	**7737.97**

Annexure-III

Support for diagnostic infrastructure to the primary healthcare facilities- PHCs

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	57.61	57.61	60.49	63.55	66.92	**306.18**
2	Arunachal Pradesh	6.96	6.96	7.31	7.68	8.06	**36.97**
3	Assam	50.65	50.65	53.18	55.84	58.56	**268.88**
4	Bihar	172.79	172.79	181.42	190.50	200.22	**917.72**
5	Chhattisgarh	41.06	41.06	43.11	45.22	47.53	**217.98**
6	Goa	1.17	1.17	1.23	1.29	1.39	**6.25**
7	Gujarat	71.88	71.88	75.48	79.25	83.21	**381.70**
8	Haryana	28.05	28.05	29.45	30.64	32.40	**148.59**
9	Himachal Pradesh	28.54	28.54	29.96	31.46	33.04	**151.54**
10	Jharkhand	52.55	52.55	55.17	57.93	60.83	**279.03**
11	Karnataka	103.58	103.58	108.76	114.20	119.91	**550.03**
12	Kerala	49.58	49.58	52.06	54.66	57.39	**263.27**
13	Madhya Pradesh	108.75	108.75	114.18	119.89	125.89	**577.46**
14	Maharashtra	111.96	111.96	117.56	123.44	129.61	**594.53**
15	Manipur	4.38	4.38	4.60	4.83	5.08	**23.27**
16	Meghalaya	6.04	6.04	6.34	6.46	6.99	**31.87**
17	Mizoram	2.87	2.87	3.02	3.22	3.22	**15.20**
18	Nagaland	6.14	6.14	6.44	6.76	7.10	**32.58**
19	Odisha	65.50	65.50	68.78	72.41	75.83	**348.02**
20	Punjab	28.88	28.88	30.32	31.84	33.31	**153.43**
21	Rajasthan	116.25	116.25	122.06	128.16	134.57	**617.29**
22	Sikkim	1.41	1.41	1.48	1.56	1.64	**7.50**
23	Tamil Nadu	69.25	69.25	72.71	76.35	80.17	**367.73**
24	Telangana	35.60	35.60	37.49	39.48	41.21	**189.38**
25	Tripura	5.26	5.26	5.63	5.80	6.09	**28.04**
26	Uttar Pradesh	281.53	281.53	295.61	310.39	325.91	**1494.97**
27	Uttarakhand	12.52	12.52	13.14	13.80	14.49	**66.47**
28	West Bengal	106.02	106.02	111.32	116.88	122.73	**562.97**
Total		**1626.78**	**1626.78**	**1708.30**	**1793.49**	**1883.50**	**8638.85**

Annexure-IV

Financial Requirement for establishing Block Level Public Health Units

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	134.42	134.42	141.14	148.20	155.61	**713.79**
2	Arunachal Pradesh	22.94	22.94	24.09	25.29	26.56	**121.82**
3	Assam	5.31	5.31	5.58	5.86	6.15	**28.21**
4	Bihar	49.47	49.47	51.94	54.54	57.27	**262.69**
5	Chhattisgarh	13.56	13.56	14.24	14.95	15.70	**72.01**
6	Goa	2.41	2.41	2.53	2.66	2.79	**12.80**
7	Gujarat	50.31	50.31	52.82	55.46	58.24	**267.14**
8	Haryana	28.58	28.58	30.00	31.50	33.08	**151.74**
9	Himachal Pradesh	1.85	1.85	1.95	2.05	2.15	**9.85**
10	Jharkhand	24.44	24.44	25.66	26.95	28.29	**129.78**
11	Karnataka	38.23	38.23	40.15	42.15	44.26	**203.02**
12	Kerala	30.59	30.59	32.12	33.72	35.41	**162.43**
13	Madhya Pradesh	28.99	28.99	30.44	31.96	33.56	**153.94**
14	Maharashtra	70.83	70.83	74.37	78.09	82.00	**376.12**
15	Manipur	14.09	14.09	14.79	15.53	16.31	**74.81**
16	Meghalaya	9.25	9.25	9.72	10.20	10.71	**49.13**
17	Mizoram	5.23	5.23	5.49	5.77	6.06	**27.78**
18	Nagaland	14.89	14.89	15.63	16.42	17.24	**79.07**
19	Odisha	29.08	29.08	30.53	32.06	33.66	**154.41**
20	Punjab	30.18	30.18	31.69	33.28	34.94	**160.27**
21	Rajasthan	27.40	27.40	28.77	30.21	31.72	**145.50**
22	Sikkim	6.44	6.44	6.76	7.10	7.45	**34.19**
23	Tamil Nadu	77.47	77.47	81.35	85.42	89.69	**411.40**
24	Telangana	118.52	118.52	124.45	130.67	137.21	**629.37**
25	Tripura	11.67	11.67	12.26	12.87	13.51	**61.98**
26	Uttar Pradesh	76.53	76.53	80.36	84.37	88.59	**406.38**
27	Uttarakhand	2.22	2.22	2.33	2.44	2.57	**11.78**
28	West Bengal	69.22	69.22	72.69	76.32	80.14	**367.59**
Total		**994.12**	**994.12**	**1043.85**	**1096.04**	**1150.87**	**5279.00**

Annexure-V

Grants for Building-less sub-centres, PHCs, CHCs

(Rs crores)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	1.17	1.17	1.23	1.29	1.36	**6.22**
2	Arunachal Pradesh	1.06	1.06	1.10	1.16	1.22	**5.60**
3	Assam	13.32	13.32	13.98	14.69	15.41	**70.72**
4	Bihar	329.29	329.29	345.6	363.00	381.10	**1748.28**
5	Chhattisgarh	10.75	10.75	11.28	11.85	12.45	**57.08**
6	Goa	1.54	1.54	1.61	1.70	1.78	**8.17**
7	Gujarat	1.17	1.17	1.24	1.29	1.36	**6.23**
8	Haryana	29.51	29.51	30.97	32.53	34.15	**156.67**
9	Himachal Pradesh	2.68	2.68	2.81	2.96	3.11	**14.24**
10	Jharkhand	118.54	118.54	124.41	130.67	137.19	**629.35**
11	Karnataka	10.06	10.06	10.56	11.09	11.64	**53.41**
12	Kerala	0.50	0.50	0.52	0.55	0.58	**2.65**
13	Madhya Pradesh	30.03	30.03	31.52	33.10	34.75	**159.43**
14	Maharashtra	50.07	50.07	52.55	55.21	57.96	**265.86**
15	Manipur	2.03	2.03	2.12	2.24	2.35	**10.77**
16	Meghalaya	3.21	3.21	3.37	3.54	3.72	**17.05**
17	Mizoram	0.56	0.56	0.58	0.61	0.64	**2.95**
18	Nagaland	1.03	1.03	1.08	1.13	1.19	**5.46**
19	Odisha	72.83	72.83	76.43	80.28	84.29	**386.66**
20	Punjab	20.26	20.26	21.26	22.33	23.45	**107.56**
21	Rajasthan	191.39	191.39	200.87	210.98	221.51	**1016.14**
22	Sikkim	0.53	0.53	0.55	0.58	0.60	**2.79**
23	Tamil Nadu	71.21	71.21	74.75	78.50	82.41	**378.06**
24	Telangana	2.81	2.81	2.96	3.11	3.26	**14.95**
25	Tripura	0.25	0.25	0.26	0.27	0.29	**1.32**
26	Uttar Pradesh	333.68	333.68	350.22	367.84	386.18	**1771.60**
27	Uttarakhand	1.43	1.43	1.49	1.57	1.65	**7.57**
28	West Bengal	49.04	49.04	51.46	54.05	56.75	**260.34**
	Total	**1349.95**	**1349.95**	**1416.76**	**1488.12**	**1562.35**	**7167.13**

Annexure-VI

Financial requirement for Conversion of Rural PHCs and SCs into Health and Wellness Centre

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	124.67	124.67	130.55	137.45	144.32	**661.66**
2	Arunachal Pradesh	6.67	6.67	7.01	7.36	7.72	**35.43**
3	Assam	80.70	80.70	84.74	88.98	93.42	**428.54**
4	Bihar	195.81	195.81	205.60	215.88	226.68	**1039.78**
5	Chhattisgarh	90.13	90.13	94.64	99.37	104.34	**478.61**
6	Goa	4.00	4.00	4.20	4.41	4.63	**21.24**
7	Gujarat	160.01	160.01	168.01	176.41	185.23	**849.67**
8	Haryana	46.61	46.61	48.94	51.38	53.95	**247.49**
9	Himachal Pradesh	44.13	44.13	46.34	48.65	51.08	**234.33**
10	Jharkhand	68.71	68.71	72.14	75.75	79.54	**364.85**
11	Karnataka	188.86	188.86	198.3	208.22	218.63	**1002.87**
12	Kerala	105.43	105.43	110.70	116.23	122.04	**559.83**
13	Madhya Pradesh	197.76	197.76	207.64	218.03	228.93	**1050.12**
14	Maharashtra	191.95	191.95	201.54	211.62	222.2	**1019.26**
15	Manipur	8.73	8.73	9.17	9.63	10.11	**46.37**
16	Meghalaya	9.29	9.29	9.75	10.24	10.75	**49.32**
17	Mizoram	7.36	7.36	7.73	8.11	8.52	**39.08**
18	Nagaland	8.19	8.19	8.60	9.03	9.49	**43.50**
19	Odisha	125.33	125.33	131.6	138.18	145.09	**665.53**
20	Punjab	46.70	46.70	49.04	51.49	54.06	**247.99**
21	Rajasthan	263.19	263.19	276.35	290.17	304.67	**1397.57**
22	Sikkim	2.96	2.96	3.10	3.26	3.42	**15.70**
23	Tamil Nadu	148.61	148.61	156.04	163.85	172.04	**789.15**
24	Telangana	85.09	85.09	89.34	93.81	98.5	**451.83**
25	Tirpura	17.89	17.89	18.78	19.72	20.71	**94.99**
26	Uttar Pradesh	387.35	387.35	406.72	427.05	448.4	**2056.87**
27	Uttarakhand	35.52	35.52	37.29	39.16	41.11	**188.60**
28	West Bengal	192.98	192.98	202.63	212.76	223.40	**1024.75**
Total		**2844.63**	**2844.63**	**2986.49**	**3136.20**	**3292.98**	**15104.93**

Annexure-VII

Support for diagnostic infrastructure to the primary Healthcare facilities - UPHCs

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	14.29	14.29	15.21	15.84	16.63	**76.26**
2	Arunachal Pradesh	3.07	3.07	3.30	3.38	3.55	**16.37**
3	Assam	12.66	12.66	13.30	13.96	14.66	**67.24**
4	Bihar	43.20	43.20	45.36	47.63	50.01	**229.40**
5	Chhattisgarh	10.23	10.23	10.74	11.27	11.84	**54.31**
6	Goa	0.24	0.24	0.26	0.27	0.28	**1.29**
7	Gujarat	17.63	17.63	18.51	19.44	20.41	**93.62**
8	Haryana	7.01	7.01	7.36	7.73	8.12	**37.23**
9	Himachal Pradesh	4.24	4.24	4.45	4.67	4.91	**22.51**
10	Jharkhand	13.10	13.10	13.75	14.44	15.16	**69.55**
11	Karnataka	16.02	16.02	16.82	17.66	18.55	**85.07**
12	Kerala	11.05	11.05	11.61	12.19	12.80	**58.70**
13	Madhya Pradesh	27.17	27.17	28.53	29.96	31.46	**144.29**
14	Maharashtra	27.96	27.96	29.35	30.82	32.36	**148.45**
15	Manipur	1.12	1.12	1.17	1.23	1.29	**5.93**
16	Meghalaya	1.51	1.51	1.59	1.67	1.75	**8.03**
17	Mizoram	0.44	0.44	0.46	0.48	0.51	**2.33**
18	Nagaland	1.02	1.02	1.08	1.13	1.19	**5.44**
19	Odisha	18.36	18.36	19.28	20.24	21.26	**97.50**
20	Punjab	7.21	7.21	7.57	7.95	8.35	**38.29**
21	Rajasthan	27.81	27.81	29.20	30.66	32.19	**147.67**
22	Sikkim	0.15	0.15	0.15	0.16	0.17	**0.78**
23	Tamil Nadu	18.75	18.75	19.69	20.67	21.70	**99.56**
24	Telangana	8.86	8.86	9.31	9.77	10.26	**47.06**
25	Tripura	1.27	1.27	1.33	1.40	1.47	**6.74**
26	Uttar Pradesh	70.37	70.37	73.89	77.58	81.46	**373.67**
27	Uttarakhand	3.26	3.26	3.42	3.60	3.78	**17.32**
28	West Bengal	26.49	26.49	27.82	29.21	30.67	**140.68**
Total		**394.49**	**394.49**	**414.51**	**435.01**	**456.79**	**2095.29**

Annexure-VIII

Grants for Urban Health and Wellness Centres (UHWCs)

(Rs crore)

Sl. No.	State	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Andhra Pradesh	102.88	102.88	108.02	113.48	119.17	**546.43**
2	Arunachal Pradesh	5.24	5.24	5.50	5.78	6.07	**27.83**
3	Assam	69.93	69.93	73.43	77.10	80.95	**371.34**
4	Bihar	185.43	185.43	194.71	204.44	214.66	**984.67**
5	Chhattisgarh	133.88	133.88	140.58	147.60	154.99	**710.93**
6	Goa	20.48	20.48	21.50	22.58	23.71	**108.75**
7	Gujarat	260.73	260.73	273.76	287.45	301.83	**1384.50**
8	Haryana	139.33	139.33	146.30	153.62	161.30	**739.88**
9	Himachal Pradesh	1.41	1.41	1.48	1.56	1.64	**7.50**
10	Jharkhand	119.21	119.21	125.17	131.42	138.00	**633.01**
11	Karnataka	122.93	122.93	129.08	135.54	142.31	**652.79**
12	Kerala	322.22	322.22	338.34	355.25	373.01	**1711.04**
13	Madhya Pradesh	427.83	427.83	449.22	471.68	495.27	**2271.83**
14	Maharashtra	774.13	774.13	812.84	853.48	896.16	**4110.74**
15	Manipur	9.83	9.83	10.32	10.84	11.38	**52.20**
16	Meghalaya	23.30	23.30	24.47	25.69	26.98	**123.74**
17	Mizoram	12.01	12.01	12.61	13.24	13.90	**63.77**
18	Nagaland	22.61	22.61	23.74	24.93	26.18	**120.07**
19	Odisha	89.19	89.19	93.65	98.34	103.25	**473.62**
20	Punjab	241.75	241.75	253.83	266.52	279.85	**1283.70**
21	Rajasthan	106.49	106.49	111.82	117.41	123.28	**565.49**
22	Sikkim	8.19	8.19	8.60	9.03	9.48	**43.49**
23	Tamil Nadu	356.48	356.48	374.30	393.01	412.67	**1892.94**
24	Telangana	133.60	133.60	140.28	147.29	154.66	**709.43**
25	Tripura	41.68	41.68	43.76	45.95	48.25	**221.32**
26	Uttar Pradesh	424.55	424.55	445.83	468.07	491.47	**2254.47**
27	Uttarakhand	81.57	81.57	85.65	89.93	94.42	**433.14**
28	West Bengal	287.92	287.92	302.31	317.43	333.30	**1528.88**
Total		**4524.80**	**4524.80**	**4751.10**	**4988.66**	**5238.84**	**24027.50**

Annexure -IX

GRANT TRANSFER CERTIFICATE FOR THE FIFTEENTH FINANCE COMMISSION RECOMMENDED HEALTH SECTOR GRANTS (contained in Chapter 7) DURING ITS AWARD PERIOD 2021-22- TO 2025-2026.

Name of State:-

S. No.	Components of Health Sector Grants	Year/ Installment	Amount received from GOI (Rs. in lakh)	Date of Receipt (00/00/00)	Date of transfer by SFD to Local Body Nodal Department	Amount transferred (Rs. in lakh)	Amount transferred by Nodal Depart. to Local Bodies
1	Support for diagnostic infrastructure to the Sub centres in rural areas.						
2	Support for diagnostic infrastructure to the PHCs in rural areas.						
3	Block level public health units in rural areas.						
4	Building-less Sub centres, PHCs, CHCs in rural areas.						
5	Conversion of rural PHCs and sub centres into health and wellness centre in rural areas.						
6	Support for diagnostic infrastructure to the primary healthcare facilities in Urban PHCs						
7	Urban health and wellness centres (HWCs).						

Certified that the grants have been utilized / proposed to be utilized for the purpose for which these have been provided and if any deviation is observed, the same will be intimated.

Signature with seal of Secretary (Nodal department)

Countersigned: Signature with seal of the Finance Secretary

List of Contributors:

Ministry of Health and Family Welfare	
Name	**Designation**
Mr. Rajesh Bhushan	Secretary, HFW
Ms. Vandana Gurnani	AS&MD, NHM
Mr. Vikas Sheel	Additional Secretary
Ms. Preeti Pant	Joint Secretary, NUHM
Mr. Vishal Chauhan	Joint Secretary, Policy
Dr. N.Yuvaraj	Director – NHM
Dr. Sachin Mittal	Director – NHM
Dr. Rajani R. Ved	Advisor
Ms. Asmita Jyoti Singh	Senior Consultant, NHM
Dr. Rakshita Khanijou	Consultant HSS,WHO
Ms. Rajni Tomar	NUHM, Senior Consultant, ADB
Ms. Seema Pati	NUHM, Senior Consultant, ADB
Ms. Isha Rastogi	NUHM, Senior Consultant, ADB
Ms. Ramya Ramakrishnan	Consultant, IIC/Jhpeigo
Mr. Nilav Kumar Pyne	Consultant, IIC/Jhpeigo

National Health Systems Resource Centre	
Name	**Designation**
Maj Gen (Prof) Atul Kotwal, SM, VSM	Executive Director
Dr (Flt Lt) M A Balasubramanya	Advisor, CP-CPHC Division
Dr. Himanshu Bhushan	Advisor, PHA Division
Air Cmde(Dr.) Ranjan Choudhury VSM	Advisor, HCT Division
Ms. Mona Gupta	Advisor, HRH Division
Dr Ashoke Roy	Director, RRC-NE
Dr Neha Singhal	Senior Consultant, CP-CPHC Division
Dr. Anantha Kumar Srinivasaiyer	Senior Consultant, CP-CPHC Division
Dr Suman Bhardwaj	Senior Consultant, CP-CPHC Division
Mr Arun Srivastava	Consultant, CP-CPHC Division
Dr Anwar Mirza	Consultant, CP-CPHC Division
Dr Atul Rairker	Consultant, CP-CPHC Division
Ms. Ima Chopra	Consultant, CP-CPHC Division
Dr Vijaya Salkar	Junior Consultant, CP-CPHC Division
Dr Swarupa Kshirsagar	Junior Consultant, CP-CPHC Division
Dr. Neha Dumka	Lead Consultant, Knowledge Management Division
Ms. Sweta Roy	Senior Consultant, HRH-HPIP Division
Dr Ankur Shaji Nair	Consultant, HRH-HPIP Division
Ms. Isha Sharma	Consultant, HRH-HPIP Division
Mr. Prasanth KS	Senior Consultant, PHA Division
Dr. Smita Shrivastava	Senior Consultant, PHA Division
Mr. Ajit K Singh	Senior Consultant, PHA Division
Dr. Aashima Bhatnagar	Consultant, PHA Division
Dr. Poonam	Consultant, PHA Division
Dr. Ashutosh Kothari	Consultant, PHA Division
Ms. Neelam Tirkey	Consultant, PHA Division

National Health Systems Resource Centre	
Name	**Designation**
Dr. Aditi Joshi	Junior Consultant, PHA Division
Ms. Diksha Rathee	Junior Consultant, PHA Division
Dr. Diksha Dhupar	Senior Research Associate, PHA Division
Dr. Musarrat Siddiqui	Fellow, PHA Division
Dr. Sonali Bhattacharya	Fellow, PHA Division
Ms. Aashu Ranga	Fellow, PHA Division
Mr Anjaney Sahi	Senior Consultant, HCT Division
Ms Vertika Agarwal	Senior Consultant, HCT Division
Ms. Pumani Kalita	Consultant, CP, RRC NE
Sh. Bhaswat kr. Das	Senior Consultant HCT, RRC NE
Dr. Joydeep Das	Lead Consultant, RRC NE

FORM-2911

Issued to (Bidder): ……
Postal Address with Contact No. & e-mail ……..

Price – Free of Cost

West Bengal Form No. 2911

Applicable For Works of value up to Rs 25 (Twenty Five) Crore

Tender No._____,Sl. No._____of _____(Year)

TENDER AND CONTRACT FOR WORKS
GENERAL RULES AND DIRECTIONS FOR GUIDANCE OF BIDDERS/CONTRACTORS

(A) Applicable for off-line tenders up to Tender Value of Rs. 5.0lakh

1. All work proposed for execution by contract will be notified in the form of invitation to tender posted in concerned departmental website, e-procurement portal of the Government of West Bengal (https://wbtenders.gov.in) and to be published in local news paper for wide circulation also in the notice boards at public places signed by the Tender Inviting Authority.

This form will state the work to be carried out, the date for submitting and opening of tenders as well as the time allowed for carrying out the work; also the amount of earnest money to be deposited with the tender, the amount of security deposit to be deposited by the successful bidder and the percentage, if any, to be deducted from bills. Copies of the specification, design & drawings and other documents required in connection with the work, signed for the purpose of identification by the Authority inviting Tender shall also be open for inspection by the contractor at the office of the Tender Inviting Authority during Office hours.

2. In the event of the tender being submitted by a firm, it must be signed separately by each member thereof, or, in the event of absence of any of the partners, it must be signed on his/her behalf by a person holding a Power-of-Attorney authorizing him/her to do so. Such power-of-attorney is to be produced with the tender, and in the case of a firm carried on by one member of a joint family; it must disclose that the firm is duly registered under the Indian Partnership Act.

3. Acceptance of measurements entered and bills raised on account of a work, when executed by a firm, must also be signed by the several partners, except where the contractors are described in their tender as a firm in which case the receipts must be signed in the name of the firm by one of the partners or by some other person havingauthority to give effectual receipt for thefirm.

4. Any person who submits a tender shall fill up the usual printed form, stating at what rate he or she is willing to undertake the work. Tenders which propose any alteration in the work specified in the said form of invitation to tender, or in the time allowed for carrying out the work, or which contain any other conditions of any sort, will be liable to rejection. No single tender shall include more than one work, but contractors who wish to tender for two or more works shall submit a separate tender for each. Tenders shall have the name and number of the work to which they refer, written outside the sealed envelopes.

5. The Tender Inviting Authority or his/her duly authorized representative will open tenders in presence of intending contractors/bidders who may be present at the time,and

will enter the bid amounts as percentage rates above or below or at par of the tender BOQ of several tenders in a comparative statement in a suitable form. In the event of a tender being accepted, a receipt shall thereupon be given to the contractor/bidder who shall thereupon for the purpose of identification, sign copies of specifications and other documents mentioned in the Rules. In the event of a tender being rejected, the earnest money with such unaccepted tender shall be refunded within 10 days from the date on which the tender is decided, provided the contractor(s) present himself/herself before the Tender Inviting Authority to take the earnest moneyrefund.

6. The accepting authority reserves the right to reject any or all of the tenders without assigning any reasons to the participating bidders and he/she will not be bound to accept eitherthelowesttenderoranyoftheothertenders.

7. Receipt of an accountant or clerk for any money paid by the contractor/bidder will not be considered as an acknowledgement of payment to the Tender Inviting Authority and the contractor shall be responsible for ensuring that he/she procures a receipt signed by the Tender Inviting Authority, or a duly authorizedrepresentative.

8. The Memorandum of work tendered for, and the schedule of materials to be supplied by the executing Department at their supply/issue rates, shall be filled in and completed in the office of the Tender Inviting Authority before the tender form is issued. If a form is issued to an intending bidder/contractor without having been so filled in and completed, he/she shall request the office to have this done before he/she completes and delivers his/hertender.

(B) Applicable for <u>e-tenders</u> of value above Rs. 5.0Lakh

1. All works of tender value above Rs. 5.00 lakh proposed for execution through this contract document are to be notified and published in the form of notice inviting e-tender (e-NIT) in the designated official tender website of Government of West Bengal having URL https://wbtenders.gov.in, and uploaded simultaneously in the URL of concerned Department inviting Tenders. Thus the tender may be seen and downloaded by logging into the"e-procurement"linkprovidedtherein,digitally signedbytheconcernedTenderInviting Authority and its corresponding abridged notice also published on the same date in the printmedia.

2. This e-Notice Inviting Tender (e-NIT) will state the work to be carriedout, the date for encrypting (submitting) and decrypting (opening) of e-tenders, the time allowedfor carrying out the work; amount of earnest moneyto be deposited with the e-tender; procedure for submission of EMD, amount of security to be furnished by the successful bidder/contractor, security/ performance securityto be deducted from running account bills, copies of specifications, Bill ofQuantities, design and drawings and any other document required in connection with the work, digitally signed for the purposeof identification by the Tender InvitingAuthority.

3. Intending contractors/bidders are required to download the e-tender documents directly from the website stated above. Tender is required to be submitted online by the intending bidders by authorized e-Tokens provided as DSC. This is the only mode of e-submission of tender and document(s). All information posted in the website consisting of e-NIT, WB Form No. 2911, Tender Bill of Quantities (BOQ), corrigenda notices and drawings etc., if any, shall form part of the Contract. Details of procedure of submission have been explained under "General Terms & Conditions" and Annexure attached with the notice of e-tender(e-NIT).

4. All the documents uploaded by the Tender Inviting Authority forms an integral part of the tender contract/agreement. Contractors/bidders are required to upload the entire set of tender documents along with other related documents as asked for in the e-tender through the above website(s) within the stipulated date and time as given in the e-NIT. Tenders are to be submitted in two folders at a time for each work, one being the 'Technical Bid' and the other 'Financial Bid'. The contractor/ bidder shall carefully go through all the documents and prepare to upload the scanned documents in Portable Document Format (PDF) in the designated link in the web portal as their Technical Bid. He/she needs to fill up the rates of items/percentage in the BOQ downloaded for the work in the designated cell and upload the same again in the designated link in the portal as their Financial Bid. Documents uploaded are virus scanned and digitally signed using the Digital Signature Certificate (DSC). Contractors/bidders should especially take note ofall

the addenda and corrigenda related to the e-tender and upload all of these documents alsoasapartoftheirtenderdocument.

5. Documents uploaded by the contractors/bidders with all information & rates comprising Technical and Financial bids cannot be changed after last/end date for submission of thee-tender.

6. Deed of Consortium/Partnership Firm, and documents of their registration in the form of certified copy of 'Form No. VIII,' issued under the Indian Partnership Act, 1932 (Act-IX of 1932), GST, & PAN (Permanent Account Number) as per RBI guidelines/above Rs. 50,000/- may be compulsorily furnished for all contracts and all other statutory clearances defined in thee-NIT.

7. The tender evaluation and accepting authorities reserve the right to reject any or all of the tenders without assigning any reasons and he/she will not be bound to accept either the lowest tender or any of thetenders.

8. Withdrawal of e-Tender once the bid has been submitted online and after passing of end date for submission which has been accepted for further processing is not allowed. EMD will be forfeited by the Government and the bidder/contractor penalized in terms of provisions in the notice of thetender.

9. Generally Bids will be valid for 120 days from the date of opening of the financial proposal. However, extension of bid validity may be suitably considered by the Tender Inviting Authority, if required, subject to obtaining a written confirmation of the contractor/bidder(s) to thateffect.

TENDER FOR WORKS

I/We on behalf of the Governor hereby tender for the execution of the work specified in the underwritten "Memorandum" within the time specified in such " Memorandum" at the rates specified therein, and in accordance, in all respects within the Rules contained in clauses hereinafter, in all of the annexed Ge ne r al C onditions of Contract (GCC), Special C onditions of Contract (SCC) and with such other materials as are provided for, by and in all other respects in accordance and with such conditions so far asapplicable.

MEMORANDUM

(a) General description of work.....

(a) If several sub-works are included, they should be detailed in a separatelist

(b) Estimated cost put to Tender ... Rs

(c) Earnest Money Deposit ... Rs.

(d) Security Deposit (including earnest money)..... Rs

(e) Percentage, if any, to be deducted from bill ..... Rs .....
(Rupees.....
Percentage.....)

(f) Time allowed for the work from date of written order to Commence ..... calendar months.

For offline tender during submission of bid and during execution of Agreement for online tender

Name of Work Tendered	Amount Put to Tender	Rate Quoted by the Bidder (% above or less or at par)	Tendered Amount (Contract Price both in words & figures)

Should this Tender be accepted, I/we hereby agree to abide by and fulfill all of the terms and provisions of the said conditions of contract annexed hereto so far as applicable, or in default thereof to forfeit and pay to the Governor or his/ her successions in office, the sums of money mentioned in the said conditions.

**Give particulars and numbers*

Strikeout (a) or (b) as applicable.

A sum of Rs ..... * has been furnished through online net banking/RTGS/NEFT transfer as earnest money deposit [(a) the full value of which is to be absolutely forfeited to the Governor or his/her successors in office, without prejudice to any other rights or remedies of the said Governor or his successors in office. Should I/we not deposit the full amount of security specified in the above 'Memorandum' in accordance with clause I(A) of the said conditions of contract, the said sum of Rs ..... shall be retained by the Government as on account of such security as aforesaid:(b) the full value of which shall be retained by Government on account of the security deposit specified in clause I (B) of the said conditions of contract].

T Signature of Contractor before submission of tender

X Signature of Witness to Contractor's signature

Datedthe Dayof 20

X T

(Witness)
Address
Occupation

XX Signature of the Executive Engineer/AE on behalf of the Department.

The above tender is here by accepted by me for and on behalf of the Governor of the State of westBengal

XX

Datedthe_____Dayof_____(Month)_____(Year)

GENERAL CONDITIONS OF CONTRACT

Clause 1 1.1 Earnest Money - The person/persons who intend to participate in the Tender for an Estimated Amount up to Rs. 25 (Twenty Five) Crore shall have to deposit Earnest Money @ 2% (Two percent) of the Estimated Amount put to Tender or Rs 10 Lakh, whichever is lower.

In case of offline tender earnest money is to be submitted in the form of Bank Draft or BankersCheque.

In case of Online Tender (e-Tender) earnest money is to be deposited through e-tender portal (https://wbtenders.gov.in**)** by selecting from either of the following payment modes:

i) Net banking (any of the banks listed in the ICICI Bank Payment gateway) in case of payment through ICICI Bank PaymentGateway.
ii) RTGS/NEFT in case of offline payment through bank account in any Bank with his/her tender/quotation as per Memorandum No. 3975-F(Y) dated: - 28.07.2016 of Secretary to the Government of West Bengal, Finance Department. The L1 bidder shall make the Formal Agreement after getting the Letter of Acceptance (LOA) issued by the Tender Accepting Authority. Failure to make the Formal Agreement within the time period as prescribed in the Letter of Acceptance (LOA) for the purpose, may be construed as an attempt to disturb the tendering process and will be dealt with accordinglyinalegalmannerasdeemedfitincludingblacklistingthebidder.

1.2 Security Deposit - While making any payment to the person(s) whose tender has been accepted (hereinafter shall be called the contractor) for work done under the contract, the authority making payment shall deduct such sum which together with the Earnest Money already deposited and converted into security deposit, shall amount to 10% of the value of works executed at the material point of time and paid during the progressive running accounts bills, so that total deductiontogether with

Earnest Money constitute 10% of the tendered value of work actually done.

In case of excess/and supplementary work over the tendered amount, additional security @ of 10% of such additional amount is to be deposited for all such excess/ and supplementaryworksbeyondthetenderedamountbeforepaymentoffinalbill.

Compensation of all other sums of money payable by the contractor to the Government under the terms of the contract may be deducted from the security deposit.

However, even though the earnest money deposited exceeds the prescribed percentage, due to reduction of tendered amount due to any reason whatsoever, such additional earnest money shall be deemed to have been converted into security and further deductions from progressive bills shall be made, taking into consideration the enhanced component of earnest money so converted into security.

Security deduction will not normally be required for hiring of inspection vehicles and boats etc., supply of tools & plants, furniture and computer peripherals. Separate agreement may be required in those cases, particularly for consultancy and RFP for EPC, whichshallbemadeinstandardformatstobeapprovedbytheGovernment.

After completion of the work, the Contractor may opt for refund of the Security Deposit by replacing equal amount of Bank Guarantee of scheduled Bank valid up to 3 months beyond the defect liability period.

Additional Performance Security @ 10% of the tendered amount in the form of Bank Guarantee from a Scheduled Bank, valid up to the date of completion of work, shall be obtained from the successful bidder, if the accepted bid value is 80% or less than the estimated amount put to tender.

If the bidder fails to submitAdditional Performance Security within 7 (seven) working days from the dateof LoA or the time period as approved by the Tender inviting Authority,hisEarnestMoneywillbeforfeited.

If the bidder fails to complete the works successfully, the Additional Performance Security along with Security Deposit lying with the Government shall be forfeited at any timeduringthependencyofcontractperiodasperrelevantClausesoftheContract.

Necessary provisions regarding deductions of Security Deposit from the progressive bills of the Contractor as per relevant clauses of the contract will in no way be affected/ altered by this Additional PerformanceSecurity.

Compensation for delay

Clause 2. The time allowed for carrying out the work as entered in the tender shall be strictly observed by the contractor and shall be reckoned from the date on which the order to commence work is given to the contractor. The work shall throughout the stipulated period of the contract be proceeded with all due diligence. Time being deemed to be the essence of the contract on the part of the contractor, the contractor shall be bound in all cases, to achieve the 'Milestones' as defined under Clause 5 and specified in the NITinto various 'Identifiable and quantifiable construction related stages' pertaining to the work. In the event of the contractor failing to comply with any of the conditions related to achieving the 'Milestones' within the specified time period prescribed for such 'Milestone' plus one month, he/she shall be liable topay compensation.

If the contractor fails to commence and/or maintain required progress viz. Milestones defined in the Notice Inviting Tender over the total time allotted for its full completion and in terms of clause 5 or fails to complete the work and clear the site on or before the end of contract period or extended date of completion, he/she shall, without prejudice to any other right or remedy available under the law on account of such breach,payasagreedcompensationtotheimplementingDepartment.

This will also apply to items or group of items for which a separate period of completion has beenspecified.

Compensation for delay of work: @ 2% (Two percent) of the tendered value of work arrived for each month of delay to be computed on per day basis subject to the ceiling limit of security deposit already withheld or due to be withheld during imposition of the said clause and minimum payable compensation equivalent to the Earnest Money deposited(EMD).

Provided always, that the total amount of compensation for delay, to be paid under this clause shall not exceed 10% of the tendered value of work or the tendered value of the item or group of items of the work, for which a separate period of completion is originally given.

Action when whole of security deposit is forfeited

The amount of compensation may be adjusted or set-off against any sum payable to the contractor under this contract, if the contractor catches up with the progress of work subsequently, part or full of the desired progress as per the contract in accordance with the decision of the Tender Accepting Authority, under powers delegated by Government to be communicated by the Engineer-in-Charge, the withheld amount shall be released. However,nointerest,whatsoever,shallbepayableonsuchwithheldamount.

Force majeure :-If the work(s) be delayed for the following reasons:-
Due to war, internal emergency and other conditions such as abnormally bad weather, flood, cyclone natural calamity or serious loss or damage by fire or civil commotion, the contractor shall immediately give notice thereof in writing to the Engineer-in-charge but shall nevertheless use constantly his/her best endeavors to prevent or make good the delay and shall do all that may be reasonably required to the satisfaction of the Engineer- in-charge to proceed with theworks.

Contractor remains liable to pay compensation, if action is not taken under Clause3

Clause 3. Subject to other provisions contained in this clause, the Engineer-in-charge with the prior approval of Tender Accepting Authority, may, without prejudice to his/her any other rights, remedy against the Contractor in respect of any delay, inferior workmanship, any claims for damages and/or any other provision of the contract or otherwise, and whether the date of completion has or has not been elapsed, by notice in writing, absolutely determine the contract in any of the following cases:

(i) If the Contractor has been given by the Engineer-in-Charge a notice in writing to rectify, reconstruct or replace any defective work or that work is being performed in an inefficient or otherwise improper or un-workman like manner, shall omit to complywiththerequirementsofsuchnoticeforaperiodofsevendaysthereafter;

(ii) If the Contractor has without reasonable cause suspended the progress of work, or has failed to proceed with the work with due diligence so that, in the opinion of the Engineer-in-Charge he/she will be unable to secure completion of the work by the schedule date for completion, and continues to do so after a notice of seven days in writing from theEngineer-in-charge;

(iii) If the Contractor fails to complete the work within the stipulated date or the Milestones/items of work within individual dates of completion, if any, stipulated on or before such date(s) of completion and does not complete them or reach the defined Milestones within the period specified in the notice given in writing to that effect by theEngineer-in-charge;

(iv) If the Contractor persistently neglects to carry out his/her obligations under the contract and/or commits default by not complying with any of the terms & conditions of the contract and does not remedy it, or take effective steps to remedy it, within seven days after a notice in writing is given to him/her to that effect by theEngineer-in-Charge;

(v) If the Contractor being an individual, or a firm, or any partner thereof, shall at any time be adjudged insolvent or have a 'Receiving Order' or Order for administration of his/her Estate made against him/her, or take any proceedings for liquidation or composition (other than a voluntary liquidation for the purpose of amalgamation or reconstruction) under any Insolvency Act for the time being in force, or make any conveyance or assignment of his/her effects or composition or arrangement for the benefit of his/her creditor or purport to do so, or if any application be made under Insolvency Act for the time being in force for the sequestration of his/her Estate, or ifatrustdeedisexecutedbyhim/herforbenefitofhis/hercreditors;

(vi) If the Contractor being a Company pass a resolution or the court delivers an order of judgement that the Company shall be wound up, or if a receiver or a manager on behalf of a creditor be appointed, or if a circumstance arise which entitle the Court or the creditor to appoint a receiver or a manager or which entitle the court to issue a winding uporder;

(vii) If the Contractor shall suffer an execution order being levied on his/her goods and allowsittobecontinuedforaperiodof21days;

(viii) If the Contractor assigns without prior written approval of the TenderAccepting

Authority,transfers, sublets (engagement of labour on piece work basis or of labour with materials not to be incorporated in the work, shall not be deemed to be subletting) or otherwise partswith or attempts to assign, transfer, sublet or otherwise parts with the entire work or any portion thereof without prior writtenapproval of theEngineer–in–charge;

(ix) AND THEREFORE, the Contractor has made himself/herself liable for action under any of the cases aforesaid, the Engineer-in-charge on behalf of the Government with the prior approval of Tender Accepting Authority, shall have the powers to adopt any of the following actions, as he/she may deem best suited to the interest of theGovernment:-

(a) To determine the contract as aforesaid, of which rescission notice in writing and costs to be recovered for works since executed subject to a minimum of the amount of Earnest Money deposited by the Contractor under the hand of Engineer-in-charge, shall be the conclusive evidence. Upon such determination, the Earnest Money Deposit, Security Deposit already recovered for executed works and performance guarantee, if any under the contract shall be liable to be forfeited and shall be absolutely at the disposal of the Government.

(b) After giving notice to the Contractor to measure up the work executed and to take such whole or the balance or part thereof, as shall be un-executed out of his/her hands, and to give it to another Contractor to complete the balance work. The Contractor, whose contract is determined or rescinded as above, shall not be allowed to participate in the tendering process for the balance work.

(c) To employ labour paid by the implementing Department, and to supply materials, to carry out the works or any part of the work, debarring the contractoranddebitingthecostoflabourandpriceofmaterials(oftheamountof which cost and price determined by certificate of the Engineer-in-Charge shall be final and conclusive against the contractor) and crediting him/her with the value of the work done, in all respects in the same manner and at the same rates as if it had been carried out by the contractor under the terms of his/her contract; the certificate of the Executive Engineer as to the value of the work done shall be final and conclusive against thecontractor.

Contractors remains liable to pay compensation if action not taken under Clause 3

In the event of above course being adopted by the Engineer-in-charge, the Contractor shall have no claim of compensation for any loss sustained by him/her by reason of his/her having purchased or procured any material or entered into any engagement ormade any advances on any account or with a view to execute the work or the performance of the contract. In case, action is taken under any of the provisions aforesaid, the contractor shall not be entitled to recover or be paid any sum for any work thereof actually performed under this contract, unless and until the Engineer-in-charge has certified in writing that the performance of such work and value payable in respect thereof,andhe/sheshallonlybeentitledtobepaidthevaluesocertified.

Clause 3A. In case, the work cannot be started due to reasons not within the control of the Contractor within 1/4th (one fourth) of the stipulated time for completion of the work or 45 days whichever is less, which is accepted as a valid &justified reason by the Tender Accepting Authority, either party viz. Contractor &the Engineer-in-Charge may close the contract with the approval of Tender Accepting Authority. In such an eventuality, the earnest money deposited and the security of the contractor shall be refunded, but no payment on account of interests, loss of profit or damages etc. shall be payable atall.

Clause 3B. In case a continuing work cannot be completed due to reasons beyond the control of the contractor, like Force Majeure enumerated later under Clause 5, the contract may be terminated as stated in clause 3A above by the Engineer-in-Charge withtheconsentofthecontractorandapprovaloftheTenderAcceptingAuthority.

Clause 4. In cases in which any of the powers conferred upon the Engineer-in-ChargeunderClause3hereofshallhavebecomeexercisableandthesamehadnot

Power to take possession of or require removal of or sell Contractor's plant

been previously exercised, non-exercising thereof shall not constitute as a waiver of any of the conditions hereto, and such powers shall, notwithstanding be exercisable in the event of any future case of default by the contractor, for which by any clause or clauses hereof, he/she is declared liable to pay compensation amounting to whole of his/her security deposit, and the liability of the contractor for past and future compensation shall remain unaffected. In the event of the Engineer-in-Charge putting in force either of the powers under ix (a) or (c) vested with him/her under the preceding clause, he/she may if he/she so desires, take possession of all or any tools & plant, materials and stores, in or upon the work, or the site thereof, or belonging to the contractor, or procured by him/her and intended to be used for execution of the work, or any part thereof, paying or allowing for the same in account at the contract rates or in case of these not being applicable, at current market rates to be certified by the Engineer-in-Charge whose certificate thereof, shall be final and binding. Otherwise, the Engineer-in-Charge may deliver notice in writing to the contractor or his/her clerk, foreman or other authorized agent, requiring him/her to remove such tools & plant, materials or stores from the premises within a time to be specified in such notice; and in the event of the contractor failing to comply with any such requisition, the Engineer-in- Charge may remove them at the contractor's expense or sale them by p u b l i c auction or private sale on account of the contractor and at his/her risk, in all respects, and the certificate of the Engineer-in-Charge as to the expense of any such removal, and the amount of the proceeds and expense of any such sale shall be final and conclusive against thecontractor.

Clause 5. The time allowed for execution of a work as specified in the 'Schedule of Work' or in the extended time inaccordance with the terms and conditions shall be the essence of the contract. Execution of work shall commence from such time period as mentioned in the said schedule, or from the date of handing over of the site to the contractor whichever is later. If the contractor commits default in commencing execution of the work as aforesaid within thirty days, without justifiable reasons included under Force Majeure or other such reasons beyond the control of the contractor, in which case to be reported within seven days by the contractor, considered valid and cogent by the Engineer-in-Charge, the Engineer-in-Charge shall after passing of thirty days from the date of scheduled commencement of work as per work order, with the prior approval of the Tender Accepting Authority, without prejudice to any other right to remedy available in law, be at liberty to apply clause 2 and subsequently clause 3 of the tenderdocument.

As soon as possible after the contract is executed, signed and agreed, the contractor shall submit a 'Time and Progress Chart' for each broad activity (Milestone) and get it approved by the Engineer-in-Charge. The chart shall be prepared in direct relation to the time slated in the Notice Inviting Tender (NIT) document, for completion of items or group of items of the work. It shall indicate the forecast of the dates of commencement and completion of various trades of sections of the work. This may be amended, as necessary, by an agreement between the Engineer-in-Charge and the contractor within the limitations of time imposed in the NIT document. Further, to ensure good progress during execution of work, the contractor shall in all cases, in which the time allowed for any work exceeds one month (save and except for special jobs for which a separate programme has been agreed upon) to complete the work as per defined 'Milestones' given in such 'Schedule of Work' defined clearly in the NIT itself into various 'Identifiable and quantifiable construction related stages' related with the type and nature of work, and that the 'total time allowed for completion of work' is to be broken up against achievement of those stages during the construction / progress of work to ensure a periodic monitoring of progress and enable the contractor and the Engineer-in-Charge to take corrective measures from time totime.

If the work(s) be delayedby:

Force majeure, due to war, internal emergency and other conditions such as abnormally bad weather, flood, cyclone natural calamity or serious loss or damage by fire or civil commotion, strike or lockout affecting procurement of construction materials or any of the trades employed in the work, or any other cause which in the absolute discretion of the Engineer-in-Charge is beyond the contractor's control, then upon happening of any such event causing delay,the

contractor shall immediately give notice in writing to the Engineer-in-Charge but shall nevertheless use constantly his/her best endeavors to prevent or make good the delay and shall do all that may be reasonably required to the satisfaction of the Engineer-in-Charge to proceed with theworks.

Request for rescheduling of 'Milestones' of various activities and extension of time, to be eligible for consideration, shall be made by the contractor in writing within fourteen days of the happening of the event causing delay in the prescribed form. The contractor may also, if practicable, indicate in such a request the period for which extension isdesired.

If any such case the Engineer-in-Charge, with the approval of TenderAccepting Authority, may give a fair and reasonable extension of time and reschedule the activity wise 'Milestones' for completion of the work. Such extension shall be communicatedtothecontractorbytheEngineer-in-Chargewiththeapprovalof Tender Accepting Authority in writing within maximum 1 (one) month of the date of receipt of suchrequest.

Final Certificate

Clause 6. On completion of work, the contractor shall be furnished with a certificate by the Engineer-in-Charge of such completion, but no such certificate shall be given, nor shall the work be considered to be completed until and unless the contractor shall have removed from the work premises on which the work is executed, all scaffolding, surplus materials and rubbish, and cleaned off the dirt from wood works, doors, windows, floors, or other parts of any building, upon or about which the work is executed, or of which he may have had possession for the purpose of the execution thereof, nor until the work shall have been measured by the Engineer-in-charge whose measurements shall be binding and conclusive against the contractor. If the contractor shall fail to comply with the requirements of this clause as to removal of scaffolding, surplus materials and rubbish and cleaning off dirt on or before the date fixed for completion of the work, the Engineer-in-charge may at the expense of the contractor remove such scaffolding, surplus materials and rubbish, and dispose of the same as he/she thinks fit, and clean off such dirt as aforesaid; and the contractor shall forthwith b e b o u n d t o pay the amount of all expense so incurred, and shall have no claim in respect of any such scaffolding or surplus materials as aforesaid, except for any sum actually realized by the salethereof.

Payment on inter- mediate certificates to be regarded asadvances

Clause 7. No running account bill payment shall be normally made for works less than 30 (Thirty) percent of Tendered Value or up to Rs 25.00 lakh, whichever is less, till after the whole of the work shall have been completed and certificate of completion given. For works of tendered value above Rs 25.00 lakh, for running account bill payment, the contractor shall on submitting a bill of at least Rs 25.00 lakh there for, be entitled to receive a payment proportionate to the part thereof, approved and passed by the Engineer-in-charge, whose certificate of such approval and passing of the sum so payable shall be final and conclusive against the contractor. But all such intermediate payments shall be regarded as payments by way of advance against the final m e a s u r e d b i l l payment only and not as payments for work actually done and completed, and shall not preclude the bad, unsound, and imperfect or unskillful work which is to be removed and taken away and reconstructed, or re-erected or to be considered as an admission of the due performance of the contract, or any part thereof, in any respect, or the accruing of any claim, nor shall it conclude, determine or affect in any way the powers of the Engineer-in-charge under these conditions or any of them as to the final settlement and adjustment of the accounts or otherwise or in any other way vary or affect the contract. The final bill shall be submitted by the contractor within one month of the date fixed for completion of the work, otherwise the Engineer-in-charge's certificate of the measurement and of the total amount payable for the work accordingly shall be final and binding on allparties.

Bills to be submitted monthly

Clause 8. W o r k s bill shall be submitted by the contractor each month, after fulfilling above clause, on or before the date fixed by the Engineer-in-charge, for all works executed during the previous month, and the Engineer-in-charge shall take or cause to take the requisite measurement for the purpose of having the same verified, and the claim as far as admissible adjusted, if possible, before the expiry of fourteen days from the presentation of the bill. If the contractor does not submit the bill within the time fixed as aforesaid,theEngineer-in-chargemaydeputeaJuniorEngineertomeasureupthesaid

work in presence of the contractor, whose countersignature in the measurement book will be sufficient warrant; and the Engineer-in-charge may prepare a bill from such list which shallbebindingonthecontractorinallrespects.

Within 10 (Ten) days of completion of work, the contractor shall give notice of such completion to the Engineer-in-charge and within 14 (Fourteen) days of receipt of such notice, the Engineer-in-charge shall inspect the work, and if there is no defect in the work, he/she shall furnish to the contractor a final certificate of completion. Otherwise, a provisional certificate of physical completion indicating defects (a) to be rectified by the Contractor and/or (b) for which payment will be made at reduced rates, shall be issued. Such reduced rate is to be imposed with the approval of Superintending Engineerconcerned.

Clause 8A. When annual repair and maintenance work is carried out, the splashes and droppings from white washing, colour washing, painting etc., on walls, floors, windows shall be removed and the surface cleaned simultaneously with the completion of these items of work in the individual rooms, quarters or premises etc. where the work is done without waiting for the actual completion of all the other items of work in the contract. In case, the contractor fails to comply with the requirements of this clause, the Engineer-in-Charge shall have the right to get this work done at the cost of the contractor either Departmentally or through any other contractor. Before taking such action,theEngineer-in-Chargeshallgivetendaysnoticeinwritingtothecontractor.

Clause 8B. The Contractor shall submit completion Plan/Drawing as required in the 'General Specification' for Civil as well as Electrical Works as applicable within 30 days of completion of thework.

Clause 9. The Contractor shall submit all bills in printed forms, as per format prescribedbyGovernmentofWestBengal,intheofficeoftheEngineer- in-Charge, and the charges in the bills shall always be entered at the rates specified in tender or in case of any extra work ordered in pursuance of these conditions, and not mentioned or provided for in the tender at rates thereinafter provided for suchwork.

Payments of contractor's bills to Banks

Clause 9A (1) Payments due to the contractor may, if so desired by him/her be made to his bank through e-Pradan, details of which has to be directly furnished to the Engineer- in-charge.
While the online receipt given by such Banks shall constitute a full and sufficient discharge/acquittance for the payment, the contractor should wherever possible present his/her bills duly receipted and discharged through his/herBanker/s.

(2) In the case of bills, which the contractor presents for payment direct, and which are not endorsed in favour of the Bank, while efforts will be made to secure payment to the financing Bank, payments made to the contractor should be accepted as full acquittance so far as the Government is concerned. As a part of the arrangement, the financing Bank should give the Government a letter to thiseffect.

Note1. The procedure will not affect the usual rights of the Government to deduct from contractor's bill, (whether endorsed in favour of a Bank or not) any sum due to Government of account of penalties, over-payments etc., on this or any other contract with the Governor of the State of WestBengal.

Note2. Nothing contained herein shall operate to create in favour of the Bank any rights, claims or equities vis-à-vis theGovernor.

Stores supplied by Government

Clause 10. If the specification or estimate of the work provides for use of any special description of material to be supplied by the Engineer-in-Charge, (such materials & stores and the prices to be charged there for as hereinafter mentioned being so far as practicable for the convenience of the contractor, but not so as in any way to control the meaning or effect of this contract specified in the schedule or 'Memorandum' hereto annexed), the contractor shall be supplied with such materials and stores as is required from time to time to be used by him/her for the purpose of the contract only, and the value of the full quantity of materials and stores so supplied at the rates specified in the said schedule or Memorandum may be set off or deducted from any sums then due, or thereafter to become due to the contractor under the contract, or otherwise or against or from the security deposit, or the proceeds of sale thereof; if the same is held in Governmentsecurities,thesameorasufficientportionthereofbeinginthiscasesoldfor

the purpose. All materials supplied to the contractor shall remain the absolute property of Government, and shall not on any account be removed from the site of the work, and shall at all times be open for inspection by the Engineer-in-charge. Any such material unused and in perfectly good condition at the time of the completion or determination of the contract shall be returned to the Engineer-in-charge's store, if by a notice in writing under his/her hand, he/she shall so require; but the contractor shall not be entitled to return any such material unless with such consent, and shall have no claim for compensation on account of any such material so supplied to him/her as aforesaid being unusedbyhim,orforanywastageordamagetoanysuchmaterial.

Work to be executed in accordance with specifications, drawings, orders, etc.

Clause 11. The Contractor shall execute the whole and every part of work in the most substantial and workman like manner, and both, as regards to materials and otherwise, in every respect, in strict accordance with the specifications. The contractor shall also conform exactly, fully and faithfully to the design and drawings, and instructions in writing relating to the work signed by the Engineer-in-Charge and lodged in his/her office, to which the contractor shall be entitled to have access at such office, or on the site of the work for the purpose of inspection during office hours, and the contractor shall, if he/she so require, be entitled at his/her own expense to make or cause to be made copies of the specifications, and of all such design, drawings and instructions as aforesaid.

Alteration in specification and designs do not invalidate contract

Clause 12. The Engineer-in-Charge shall have powers to make any alteration in, omission from, addition to, or substitution for, the original specifications, drawings, designs and instructions, that may appear to him/her to be necessary or recommended by Superintending Engineer or the Chief Engineer during the progress of work, and the contractor shall be at all times be bound to carry out these works, in accordance to any instructions which may be given to him/her in writing, signed by the Engineer-in-charge, and such alterations, omissions, additions or substitutions, shall not invalidate the contract but shall be deemed to have formed a part of the work included in the original tender and any altered, additional or substituted work which the contractor may be directed to do in the manner specified above as a part of the work shall be carried out by the contractor on the same conditions in all respects on which he/she agreed to do the main work, and at the same rates, if any, may be specified in the tender for the main work. Time for the completion of the work shall be extended in the proportion that the altered, additional or substituted work bears to the original work contract, and the certificate of the Engineer-in-charge shall be conclusive as to such proportion. And, if the altered, additional or substituted work includes any class of work, for which no rate is specified in the contract, then such class of work shall be carried out at the rates entered in the schedule of rates of concerned Works Department applicable in the district, which was in force at the time of acceptance of the contract, minus/plus the percentage which the total tendered amount bears to the estimated cost of the entire work put to tender; and if the altered, additional or substituted work is not entered in the said schedule of rates, payment thereof shall be made by the Engineer-in-charge by determining the rates on analysis worked out from (a) the basic rates of materials and labour provided in the aforesaid schedule of rates, or (b) the current market rates of materials and labour when even basic rates for the work are not available in the schedule. In cases when such rates are determined on analysis by the Engineer-in-charge under (a) above, the stipulated percentage above or below schedule of rates as provided in the contract shall also apply, and in case of rates worked out on analysis under (b) above, payment shall be made at the rates so determined without application of the said stipulated percentage. In the event of any dispute regarding rates determined on analysis for any altered, additional or substituted work under this clause, the decision of the Superintending Engineer shall be final andbinding.

Rates for works not in tender BOQ/SoR

No compensation for alternation in or restriction of work to be carriedout.

Clause 13. If at any time after the commencement of the work the Governor shall for any reason whatsoever not require the whole thereof as specified in the tender to be carried out, the Engineer-in-charge shall give notice in writing of the fact to the contractor, who shall have no claim to any payment or compensation whatsoever on account of any profit or advantage which he might have derived from execution of the work in full, but which he/she did not derive in consequence of the full amount of the work not having been carried out; neither shall he/she have any claim for compensation by reason of any alterations having been made in the original specifications, drawings, designs and instructionswhichshallinvolveanycurtailmentoftheworkasoriginallycontemplated.

Action and compensation payable in case of bad work

Clause 14. If it shall appear to the Engineer-in-charge or his/her subordinate engineer in-charge of the work, that any work has been executed with unsound, imperfect, or unskillful workmanship, or with materials of any inferior description, or that any materials or articles provided by the Contractor, for the execution of the work are unsound, or of a quality inferior to that contracted for, or otherwise not in accordance with the contract, the contractor shall on demand in writing from the Engineer-in-charge specifying the work, materials or articles complained of notwithstanding that the same may have been inadvertently passed, certified and paid for, forthwith rectify or remove and re-construct the work so specified in whole or in part, as the case may require, or as the case may be remove the materials or articles so specified and provide other proper and suitable materials or articles at his/her own proper charge and cost; and in the event of his failing to do so within a period to be specified by the Engineer-in-charge in his/her demand aforesaid, then the contractor shall be liable to pay compensation at the rate of one percent on the amount of the estimate put to tender / on up to date executed work value for every day not exceeding ten days, while his/ her failure to do so shall continue and in the case of any such failure, the Engineer-in-charge may rectify or remove, and re-execute the work or remove and replace with others, the materials or articles complained of as the case may be at the risk and expense in all respects of thecontractor.

Work to be open to inspection

Contractor or his/her responsible agent to be present

Clause 15. All work under or in course of execution or executed in pursuance of the contract shall at all times be open to inspection and supervision of the Engineer-in-Charge and all his/her subordinates and also higher Officers / Authority of the Government and the contractor shall at all times during the normal working hours, and at all other times at which reasonable notice of the intention of the Engineer-in-charge or his/her subordinates to visit the work site shall have been given to the contractor, either himself/herself be present to receive orders and instructions, or have a responsible agent duly accredited in writing present for that purpose. Orders given to the contractor's agent shall be considered to have the same force as if it had been given to the contractorhimself/herself.

Notice to be given before work is covered up

Clause 16. The Contractor shall give, not less than five days notice in writing to the Engineer-in-charge or his/her subordinate in-charge of the work, before covering up or otherwise placing beyond the reach of measurement any work, in order that the same is so covered up or placed beyond the reach of measurement, and shall not cover up or place beyond the reach of measurement any work without the consent in writing of the Engineer-in-charge or his/her subordinate, in-charge of the work; and if any work shall be covered up or placed beyond the reach of measurement without such notice having been given or consent obtained, the same shall be uncovered at the contractor's expense, or, in default thereof no payment or allowance shall be made for such work or the materials with which the same wasexecuted.

Contractor liable for damage done and for imperfections for 180 days after certificate

Clause 17. If the Contractor or his/her workers or authorized representatives shall break, deface, injure or destroy any part of the structure in which they may be working or any building, road, road curbs, fence, canals, water pipes, cables, drains, electric or telephone posts or wires, trees, grass or grassland or cultivated ground contiguous to the premises on which the work or any part of it is being executed, or if any damage shall happen to the work from any cause whatever or any imperfections become apparent in it at any time, whether during its execution or within a period of six months after issuance of a certificate of its completion by the Engineer-in-Charge, the contractor shall make the same good at his/her own expense, or in default, the Engineer-in-Charge may cause the same to be made good by other workers, and deduct the expenses (of which the certificate of the Engineer-in-Charge shall be final and binding) from any sums, whether under the contract or otherwise, that may be then, or at any time thereafter become due to the contractor by the Government or from his/her security deposit, or the proceeds of sale thereof, or of a sufficient portion thereof, and if the cost in the opinion of the Engineer-in-Charge whose opinion shall be final and conclusive against the contractor, making such damage or imperfections good shall exceed the amount of such security deposit and/or such sums, it shall be lawful for the Government to recover the excess costs from the contractor in accordancewiththeprocedureprescribedbyanylawforthetimebeinginforce.

Clause 17A. The Contractor shall also supply without charge the requisite number of persons with the means and materials necessary for the purpose of setting out works, and counting, weighing, assisting in the joint measurement or examination at any time and fromtimetotimeoftheworkormaterials.Failinghis/hersodoingthesamemaybe

provided by the Engineer-in-Charge at the expense of the Contractor and the expenses may be deducted from any money due to the contractor under the contract or from his/her Security Deposit or the proceeds of sales thereof or of a sufficient portion thereof. The Contractor shall also provide all necessary fencing / barricading / providing caution boards etc. and light required to protect the public from accident, and shall be bound to bear the expenses of defence of every suit, action or other proceedings at law that may be brought by any person for injury sustained owing to neglect of the above precautions and to pay any damage and costs which may be awarded in such suit, actions or proceedings to any such persons or which may with the consent of the Contractor be paid to compromise any claim by any suchpersons.

Clause 18A. In every case in which by virtue of the provisions under sub-section (1) of Section 12, of the Workmen's Compensation Act, 1923, the implementing Department is obliged to pay compensation to a workman employed by the contractor, in execution of the works. The implementing Department will recover from the Contractor the amount of compensation so paid; and without prejudice to the rights of the Department under sub-section (2) of section 12, of the said Act, implementing Department shall be at liberty to recover such amount or any part thereof by deducting it from the security deposit or from any sum due by implementing Department to the Contractor whether under this contract or otherwise. The implementing Department shall not be bound to contest any claim made against it under sub-section (1) Section 12, of the said Act, except on the written request of the contractor and upon his/her giving to the implementing Department full security for all costs for which the Department might become liable in consequence of contesting suchclaims.

Clause 18B. In every case in which by virtue of the provisions under 'The Contract Labour (Regulation & Abolition) Act 1970', and its amendments and rules, the implementing Department is obliged to pay amount of wages to a workman employed by the Contractor in execution of the works, or to incur any expenditure in providing welfare and health amenities required to be provided under the above said Act and the rules framed by Government from time to time for the protection of health and sanitary arrangements for workers employed by Contractors, executing Department will recover from the Contractor, the amount of wages so paid or the amount of expenditure so incurred; and without prejudice to the rights of the executing Department under sub- section(2) of Section 20, and sub-section (4) of Section 21, of the Contract Labour (Regulation and Abolition) Act, 1970, executing Department shall be at liberty to recover such amount or any part thereof by deducting it form the security deposit or from any sum due by Executing Department to the Contractor whether under this contract or otherwise and the executing Department shall not be bound to contest any claim made against it under sub-section (1) of Section 20, sub-section (4) of section 21, of the said Act, except on the written request of the Contactor and upon his/her giving to the implementing Department full security for all costs for which the Department might become liable in contesting suchclaim.

Clause 19. The Contractor shall obtain a valid license under the Contract Labour (Regulation and Abolition) Act, 1970, before the commencement of the work, and continue to have valid licenses until the completion of the work. The contractor shall also abide by the provisions of the Child Labour (Prohibition and Regulation) Act, 1986, Fatal Accident Act,1855,PersonalInjuries(CompensationInsurance)Act,1970.

The Contractor shall also comply with the provisions of the 'Building and Other Construction Workers (Regulation of Employment & Conditions of Service) Act, 1996' and 'The Building and Other Construction Workers Welfare Cess Act, 1996'. Failure to fulfill these requirements shall attract penal provisions of the contract, arising out of the resultant non-implementation of suchprovisions.

Labour

Clause 19A. No labour/s below the age of eighteen years shall be employed in the work and the contractor shall abide by the provisions of the Child Labour (Prohibition & Regulation) Act, 1986. Employment of female labour/s in works in the neighborhoods of sensitive barracks should be avoided as far as possible.

Payment of minimum Wages to Labour

Clause 19B. The Contractor shall pay to labours employed by him/her either directly or through Sub-Contractors, wages not less than fair wages as defined by the Labour Commissioner of the State Government under 'Minimum Wages Act, 1948', Contractor's Labour Regulations or as per the provisions of the Contract Labour (Regulation and

Abolition) Act, 1970, wherever applicable.

The contractor shall, notwithstanding the provisions of any contract to the contrary, cause to be paid fair wage to labour indirectly engaged on the work, including any labour engaged by his sub-contractors in connection with the said work, as if the labour had been immediately employed byhim/her.

In respect of all labourers directly or indirectly employed in the works for performance of the Contractor's part of the contract, the contractor shall comply with or cause to be complied with the contractor's Labour Regulations made by the State Government/ Government of India, from time to time in regard to payment of wages, wage period, deductions from wages, recovery of wages not paid and deductions made without authority, maintenance of wage books or wage slips, publication of scale of wage and other terms of employment, inspection and submission of periodical returns and all other matters likewise in nature or as per the provisions of the Contract Labour (Regulation and Abolition) Act, 1970, and the Inter-State Migrant Workmen (Regulation of Employment andConditionsofService)Act,1979,MinimumWagesAct,1948,whereverapplicable.

a) The Engineer-in-Charge concerned shall have the right to deduct from the money due to the contractor any sum required or estimated to be required for making good the loss suffered by a worker or workers by reason of non-fulfillment of the conditions of the contract for the benefit of the workers, non-payment of wages or of deductions made from his/her/their wages which are not justified by their terms of the contract or non-observance of theregulations.

b) Under the provision of Weekly Holidays Act, 1986, the contractor is bound to allow to the labours, directly or indirectly employed in the work, one day rest for 6 days of continuous work, and pay wages at the same rate as for duty. In the event of default, the Engineer-in-charge shall have the right to deduct the sum or sums not paid on account of wages for weekly holidays to any labour and pay the same to the persons entitled thereto from any money due to the contractor by the Engineer-in-charge concerned.

The contractor shall also comply with the provisions of the 'Employees Liability Act, 2008', Workmen's Compensation Act and 'Maternity Benefits Act' or the amendments thereof or any other law relating thereto, and the rules made there under from time to time.

The Contractor shall indemnify and keep indemnified the implementing Department against payments to be made under and for the observance of the laws aforesaid and PW Contractor's Labour Regulations without prejudice to this right to claim indemnity from his/hersub-contractors.

The laws aforesaid shall be deemed to be a part of this contract and any breach thereof shallbedeemedtobeabreachofthiscontract.

Whatever is the minimum wage for the time being, or if the wage payable is higher than minimum wage, such wage shall be paid by the contractor to the workers directly without the intervention of any Dafadar, and that Dafadar shall not be entitled to deduct or recover any amount from the minimum wage payable to the workers as and by way of commission orotherwise.

The contractor shall ensure that no amount by way of commission or otherwise is deductedorrecoveredbytheDafadarfromthewageofworkers.

Clause 19C. In respect of all labours directly or indirectly employed in the work for the performance of the contractor's part of this contract, the contractor shall at his/her own expenses, arrange for the safety provisions as framed from time to time by the competent authority, and shall at his/her own expense provide all facilities in connection therewith. In case the contractor fails to make arrangement, and fail to provide necessary facilities as aforesaid, he/she shall be liable to pay a penalty of Rs. 2000/- for each default, and in addition the Engineer-in-Charge shall be at liberty to make arrangement and provide facilitiesasaforesaidandrecoverthecostsincurredintheirbehalf,fromthecontractor.

Clause 19D. For the works above Rs. 2.0 crore, the Contractor shall submit by the 4th and 19th of every month to the Engineer-in-charge, a true statement showing in respect of the second half of the preceding month and the first half of the current month respectively-

The number of labourers employed by him/her on the work, their working hours, and the

wages paid to them;

Accidents that had occurred during the said fortnight showing the circumstances under which it had happened, and the extent of damage and injury caused by them, and the number of female workers who have been allowed maternity benefits according to Clause 19F of the contract and the amount paid to them;

Failing which the contractor shall be liable to pay to the Department, a sum not exceeding Rs. 2000/- for each default or materially incorrect statement. The decision of the Engineer-in-charge shall be final in deducting from any bill due to the contractor; the amount levied as fine and would be binding on the contractor.

Clause 19E. In respect of all labours directly or indirectly employed in the work for the performance of the contractor's part of this contract, the contractor shall comply with or cause to be compiled with all the rules framed by the Government from time to time for the protection of health and sanitary arrangements of workers employed by the contractor.

Clause 19F. In the event of the contractor(s) committing a default or breach of any of the provisions of the Contractor's Labour Regulations and Rules for the protection of health and sanitary arrangement for the workers as amended from time to time or furnishing any information or submitting or filing any statement under the provisions of the above Regulations and Rules which is materially incorrect, he/she shall, without prejudice to any other liability, pay to the Department a sum not exceeding Rs. 2000/- for every default, breach or furnishing, making, submitting, filing such materially incorrect statements and in the event of the contractors defaulting continuously in this respect, the penalty may be enhanced to Rs. 200/- per day for each day of default subject to a maximum of five per cent of the tendered value. The decision of the Engineer-in-charge shallbefinalandbindingontheparties.

Should it appear to the Engineer-in-charge that the contractor(s) is/are not properly observing and complying to the provisions of the Contractor's Labour Regulations and Rules, The Minimum Wages Act, 1948 and Contract Labour (Regulation and Abolition) Act 1970, for the protection of health and sanitary arrangements for work-people employed by the contractor(s) (hereinafter referred as 'the said Rules') the Engineer-in-charge shall have the power to give notice in writing to the contractor(s) requiring that the said Rules be complied with and the amenities prescribed therein be provided to the work-people within a reasonable time to be specified in the notice. If the contractor(s) shall fail within the period specified in the notice to comply with and/or observe the said Rules and to provide the amenities to the work-people as aforesaid, the Engineer-in-charge shall have the power to provide the amenities herein before mentioned at the cost of the contractor(s). The contractor(s) shall erect, make and maintain at his/her own expense and to approved standards all necessary hutments and sanitary arrangements required for his/her/their work-people on the site in connection with the execution of the works, and if the same shall not have been erected or constructed, according to approved standards, the Engineer-in-charge shall have power to give notice in writing to the contractor(s) requiring that the said hutments and sanitary arrangements be remodeled and/or reconstruct such hutments and sanitary arrangements according to approved standards, and if the contractor(s) shall fail to remodel or reconstruct such hutments and sanitary arrangements according to approved standards within the period specified in the notice, the Engineer-in-charge shall have the power to remodel or reconstruct such hutments and sanitary arrangements according to approved standards at the cost of the contractor(s).

Clause 19G. The contractor shall comply with all the provisions of The Minimum Wages Act, 1948, Contract Labour (Regulation and Abolition) Act, 1970, Employees Liability Act, Industrial Dispute Act and Maternity Benefit Act, 1961, as amended from time to time and rules framed thereunder and other labour laws affecting contract labour that may be broughtintoforcebytheappropriateauthorityfromtimetotime.

Clause 19H. The Engineer-in-charge may require the contractor to remove from the site of work, any person or persons engaged/assigned or employed by the contractors upon the work who may be determined as insane or incompetent or misconducts himself/herself,andthecontractorshallforthwithcomplywithsuchrequirements.

Clause 19I. It shall be the responsibility of the contractor to see that the

building/structure under construction is not occupied by anybody unauthorized during construction, and is handed over to the Engineer-in-charge with vacant possession free from encumbrances in entirety, If such buildings/structures through completed is occupied illegally, then the Engineer-in-Charge shall have the option to refuse to accept the said building/structure in that position. Any delay in acceptance on this account will be treated as the delay in completion and for such delay a levy up to 5% of tendered value of work may be imposed by the Engineer-in-charge whose decision shall be final both with regardtothejustificationandquantumandshallbebindingonthecontractor.

However, the Engineer-in-charge, through a notice, may require the contractor to remove the illegal occupations, any time on or before construction and delivery.

Work onSundays

Clause 20. No work shall be done on Sundays without the p r i o r sanction of the Engineer-in-charge.

Work not to be sublet. Contract may be rescinded and security deposit forfeited for subletting, bribing, or if contractor becomesinsolvent

Clause 21. The contract shall not be assigned or sublet without specific orders from Government in respect of a specified sub-contractor. And if the contractor shall assign or sublet his contract, or attempt so to do, or become insolvent or commence any in insolvency proceedings or make any composition with his creditor, or attempt to do so, or if any bribe, gratuity, gift, loan, perquisite, reward or advantage, pecuniary or otherwise, shall either directly or indirectly be given, promised, or offered by the contractor, or any of his servants or agents to any public officer or person in the employ of Government in any way relating to his office of employment, or if any such officer or person shall become in any way directly or indirectly interested in the contract, the Divisional Officer may thereupon by notice in writing rescind the contract, and the security deposit of the contractor shall thereupon stand forfeited and be absolutely at the disposal of Government and the same consequences shall ensure as if the contract had been rescinded under the Clause 3 hereof, and in addition the contractor shall not be entitled torecoverorbepaidforanyworkthereforactuallyperformedunderthecontract.

Sum payable as compensation to be considered as reasonable without reference to actual loss

Clause 22. All sums payable by way of compensation under any of these conditions shall be considered as reasonable compensation to be applied to the use of Government without reference to the actual loss or damage sustained and whether or not any damage shall have beensustained.

Changes in constitution of firm

Clause 23. Where the contractor is a partnership firm or a consortium, prior approval in writing of the Engineer-in-Charge shall be obtained for any change made in the constitution of the firm/consortium. Where the contractor is an individual or a Hindu Undivided Family (HUF) business concern, such approval as aforesaid shall likewise be obtained, before the contractor enters into any partnership agreement/Memorandum of Articles whereunder the partnership firm/ consortium would have the right to carry out the works hereby undertaken by the contractor. If previous approval as aforesaid is not obtained,thecontractisliabletoberescinded.

Works to be under direction of Engineer-in-Charge

Clause 24. All works to be executed under the contract shall be executed under the direction of Engineer-in-Charge. Further instructions/advices, if felt necessary by Superintending Engineer/ Chief Engineer, shall also be binding to be communicated by theEngineer-in-Charge.

Clause 25. Settlement of Disputes and Arbitration:

Settlement of disputes - Dispute Redressal Committee'

Except where otherwise provided in the contract, all questions and disputes relating to the meaning of the specifications, designs, drawings and instructions hereinbefore mentioned and as to the quality of workmanship or materials used on the work or as to any other question, claim, right, matter or thing whatsoever, in any way arising out of or relating to the contracts, designs, drawings, specifications, estimates, instructions, orders or these conditions or otherwise concerning the works, or the executions or failure to execute the same, whether arising during the progress of the work, or after the completion orabandonmentthereofshallbedealtwithasmentionedhereinafter:

If the contractor considers any work demanded of him/her to be outside the requirements of the contract, or disputes any drawings, record or decision given in writing by the Engineer-in-Charge or any matter in connection with or arising out of the contract or carrying out of the work to be unacceptable, he/she shall promptly within 15 days requesttheChairmanoftheDepartmentalDisputeRedressalCommittee,inwriting,for

written instruction or decision. Thereupon, the Dispute Redressal Committee shall give its written instruction or decision within a period of three months from the date of receipt of the Contractor's letter.

The Dispute Redressal Committee in each of the Works Departments shall be constituted with the following officials as Members:

1	Secretary / Engineer-in-Chief of the Department concerned	Chairman
2	Joint Secretary / Deputy Secretary / any Officer of equivalent rank of the Department	Member
3	One Designated Chief Engineer / Engineer of the Department to be nominated by the Department concerned.	Member Secretary and Convenor
4	One representative of Finance Department of the Government not below the rank of Joint Secretary or Financial Advisor in case of the Works Department where FA system has been introduced.	Member

This provisions will be applicable irrespective of the value of the works to which the dispute mayrelate.

Clause 26. The contractor shall fully indemnify and keep indemnified the implementing Department against any action, claim or proceeding relating to infringement or use of any patent or design or any alleged patent or design rights and shall pay any royalties which may be payable in respect of any article or part thereof included in the contract. In the event of any claims made under or action brought against implementing Department in respect of any such matter as aforesaid, the contractor shall be immediately notified thereof by the implementing Department and the contractor shall be at liberty, at his/ her own expense, to settle any dispute or to conduct any litigation that may arise therefrom, provided that the contractor shall not be liable to indemnify the implementing Department if the infringement of the patent or design or any alleged patent or design right is thedirectresultofanorderpassedbytheEngineer-in-Chargethisbehalf.

Lump sum as in estimates

Clause 27. When the estimate on which the tender is made includes lump sums in respect of parts of the work, the contractor shall be entitled to payment in respect of the items of works involved or the part of the work in question at the same rates as are payable under this contract for such items, or if the part of the work in question is not, in the opinion of the Engineer-in-charge, capable of measurement, certificate in writing of the Engineer-in-charge shall be final and conclusive against the contractor with regard to any sum or sums payable to him under the provisions of thisclause.

Action where nospecification

Clause 28. In the case of any class of work for which there is no such specifications as referred to under Clause 11, such work shall be carried out in accordance with the latest Bureau of Indian Standards (BIS) specifications. In case there are no such specifications in Bureau of Indian Standards, the work shall be carried out as per reputed manufacturer's specifications if accepted by the Engineer-in-Charge. If not available, then as per State Government / Union Government accepted and approved specifications. In case there are no such specifications as required above, the work shall be carried out in all respects in accordance with the instructions and requirements of the Engineer-in-Charge which is approved by the Tender Accepting Authority.

Definition of works

Clause 29. The expression "works" or "work" where used in these conditions shall, unless there be something either in the subject or context repugnant to such construction, be constructed and taken to mean the works by or by virtue of the contract constructed to be executed, whether temporary or permanent and whether original, altered, substituted or additional.

Clause 30. The Contractor(s) shall at his/their own cost provide his/their labour with hutting on an approved site, and shall make arrangements for conservancy and sanitation in the labour camp to the satisfaction of the local Public Health and Medical Authorities. He/they shall also at his/their own cost make arrangements for thelaying

of pipe lines for water supply to his/their labour camp from the existing mains wherever available, and shall pay all fees, charges and expenses in connection with there and incidentalthereto.

Clause 31. The contractor(s) shall make his/their own arrangements for water required for the work and nothing extra will be paid for the same. This will be subject to the followingconditions:-

i) That the water used by the contractor(s) shall be fit for construction purposes to the satisfaction of theEngineer-in-charge;

ii) The Engineer–in-Charge shall make alternative arrangements for supply of water at the risk and cost of contractor(s) if the arrangements made by the contractor(s) for procurement of water are, in the opinion of the Engineer-in-Charge,unsatisfactory.

Clause 32. The contractor undertakes to make arrangement for the supervision of the work by the firm supplying the construction materials. The Contractor shall collect thetotal quantity of materials as per approved programme required for the work as per approved programme, before the work is started and shall hypothecate it to the Engineer- in-Charge. If any material remains unused on completion of the work on account of lesser use of materials in actual execution for reasons other than authorized changes of specifications and abandonment of portion of work, a corresponding deduction equivalent to the cost of unused materials as determined by the Engineer-in-Charge shall be made and the material returned to the contractor. Although the materials are hypothecated to Institute, the contractor undertakes the responsibility for their proper watch, safe custody and protection against all risks. The materials shall not be removed from site of workwithout the consent of the Engineer-in-Charge inwriting.

The contractor shall be responsible for rectifying defects noticed within Defect Liability Period from the date of completion of the work and the portion of the security deposit relating to work shall be refunded after the expiry of Defect Liability Period.

Clause 33. The contractor shall provide all necessary superintendence during execution of the work and as long thereafter as may be necessary for proper fulfilling of the obligations under thecontract.

Contractors Superintendence, Supervision, Technical Staff & Employees

The contractor shall immediately after receiving letter of acceptance of the tender and before commencement of the work, intimate in writing to the Engineer-in-Charge, the name(s), qualifications, experience, age, address(es) and other particulars along with certificates, of the principal technical representative to be in charge of the work and other technical representative(s) who will be supervising the work. The Engineer-in-Charge shall within 3 days of receipt of such communication intimate in writing his/her approval or otherwise of such representative(s) to the contractor. Any such approval may at any time be withdrawn and in case of such withdrawal, the contractor shall appoint another such representative according to the provisions of this clause. Decision of the tender accepting authority shall be final and binding on the contractor in this respect. Such a principal technical representative shall be appointed by the contractor soon after receipt of the approvalfromtheEngineer-in-ChargeandshallbeavailableatsitebeforestartofworK.

If the contractor (or any partner in case of firm/company) himself/herself has such qualifications, it will not be necessary for the said contractor to appoint such a principal technical representative but the contractor shall designate and appoint a responsible agent to represent him and to be present at the work whenever the contractor is not in a position to be so present. All the provisions applicable to the principal technical representative under the clause will also be applicable in such a case to the contractor or his responsible agent. The principal technical representative and/or the contractor shall on receiving reasonable notice from the Engineer-in-Charge or his designated representative(s) in charge of the work in writing or in person or otherwise, present himself/herself to the Engineer-in-Charge and/or at the site of work, as required, to take instructions. Instructions given to the principal technical representative or the responsible agent shall be deemed to have the same force as if these have been given to the contractor. The principal technical representative and/or the contractor or his/her responsible authorized agent shall be actually available at site especially during important stages of execution of work, during recording of measurement of works and whenever so required by the Engineer-in-Charge by a notice as aforesaid and shall also note down instructions conveyed by the Engineer-in-Charge or his/her designated representative in the siteorder

book and shall affix his signature in token of noting down the instructions and in token of acceptance of measurements.

If the Engineer-in-Charge, whose decision in this respect is final and binding on the contractor, is convinced that no such technical representative(s) is/are effectively appointed or is/are effectively attending or fulfilling the provision of this clause, a recovery (non-refundable) shall be effected from the contractor as specified in Schedule and the decision of the Engineer-in-Charge as recorded in the site order book and measurement recorded checked / test checked in Measurement Books shall be final and binding on the contractor. Further if the contractor fails to appoint a suitable technical representative and/or other technical representative(s) and if such appointed persons are not effectively present or are absent by more than two days without duly approved substitute or do not discharge their responsibilities satisfactorily, the Engineer-in-Charge shall have full powers to suspend the execution of the work until such date as suitable other technical representative(s) is/are appointed and the contractor shall be held responsible for the delay so caused to the work. The contractor shall submit a certificate of employment of the technical representative(s) along with every running account bill / final bill and shall produceevidenceifatanytimesorequiredbytheEngineer-in-Charge.

The contractor shall provide and employ on the site only such technical assistants as are skilled and experienced in their respective fields and such foremen and supervisory staff as are competent to give proper supervision to the work.

The contractor shall provide and employ skilled, semi-skilled and unskilled labour as is necessary for proper and timely execution of the work.

The Engineer-in-Charge shall be at liberty to object to and require the contractor to remove from the works any person who, in his opinion, misconducts himself, or is incompetent or negligent in the performance of his duties or whose employment is otherwise considered by the Engineer-in-Charge to be undesirable. Such person shall not be employed again at works site without the written permission of the Engineer-in-Charge and the persons so removed shall be replaced as soon as possible by competentsubstitutes.

Clause 34. "Levy / Taxes Payable by Contractor"

(i) GST, Building and other Construction Workers' Welfare Cess or any other tax or Cess in respect of this contract shall be payable by the Contractor and Engineer-in-Chargeshallnotentertainanyclaimwhatsoeverinthisrespect.

(ii) The contractor shall deposit Government Royalty and obtain necessary permit for supply of the sand, stone chips, red bajri, sand stone, river bed materials etc. from localauthorities,ifthosearedirectlyprocuredfromquarrysites.

In case materials are procured from secondary sources, certificates of quarry owners to the effect of payment of royalties and Cess would have to be furnished. In absence of such certificates towards payment of Royalties and Cess such components shall be deducted from the contractor's bills at prescribed rates and deposited through 'GRIPS' portal or otherwise, in the designated GovernmentTreasuries/PAO.

If pursuant to or under any law, notification or order, any Royalty, Cess or the like becomes payable by the implementing Department and does not at any time become payable by the contractor to the State Government/Local appropriate authorities in respect of any material used by the contractor in the works then in such a case, it shall be lawful to the Department and it will have the right and be entitled to recover the amount paid in thecircumstancesasaforesaidfromduesofthecontractor.

Clause 35.

(i) All tendered rates shall be inclusive of statutory taxes and levies payable under respective statutes. However, if any further tax or cess is imposed by Statute, after the last stipulated date for the receipt of tender including extensions if any and the contractor thereupon necessarily and properly pays such taxes/levies/cess, the contractor shall be reimbursed the amount so paid. Provided such payments, if any, is not, in the opinion of the Engineer-in-charge (whose decision shall be final and binding on the contractor) attributable to delay in execution of work within the control of thecontractor.

(ii) The contractor shall keep necessary books of accounts and other documents for the purpose of this condition as may be necessary and shall allow inspection of the same byadulyauthorizedrepresentativeoftheDepartmentand/ortheEngineer-in-Charge

and further shall furnish such other information/document as the Engineer-in-Charge may require from time totime.

(iii) The contractor shall, within a period of 30 days of the imposition of any such further tax or levy or cess, give a written notice thereof to the Engineer-in-Charge that the same is given pursuant to this condition, together with all necessary information relatingthereto.

Clause 36. Without prejudice to any of the rights or remedies under this contract, if the contractor dies, the Engineer-in-charge shall have the option of terminating the contract without compensation to the contractor, but would be liable to clear full dues and claims on work done to his/her legalsuccessor/s.

Clause 37. The contractor shall not be permitted to tender for works in which his near relative is posted as in any capacity between the grades of the Executive Engineer and Junior Engineer (both inclusive). He shall also intimate the names of persons who are working with him/her in any capacity or are subsequently employed by him/her and who are near relatives to any Official in the Institute. Any breach of this condition by the contractor would render him/her liable to be removed from the approved list of contractors of the Department. If however the contractor is registered in any other Department, he/she shallbedebarredfromtenderingintheDepartmentforanybreachofthiscondition.

NOTE: By the term "near relatives" is meant wife, husband, own parents and grandparents, own children and grandchildren, own brothers and sisters, own uncles, aunts and first cousinsand their corresponding in-laws.

Clause 38. No engineer of Gazetted Rank or other Gazetted Officer employed in engineering or administrative duties in the Government shall work as a contractor or employee of a contractor for a period of one year after his/her retirement from Government service without the previous permission of Government in writing. This contract is liable to be cancelled if either the contractor or any of his employees is found at any time to be such a person who had not obtained the permission of Government as aforesaid, before submissionofthetenderorengagementinthecontractor'sservice,asthecasemaybe.

Clause 39. The work (whether fully constructed or not) and all materials, machines, tools and plants, scaffolding, temporary buildings and other things connected therewith shall be at the risk of the contractor until the work has been delivered to the Engineer-in-Charge and a certificate from him/her to that effect obtained. In the event of the work or any materials properly brought to the site for incorporation in the work being damaged or destroyed in consequence of hostilities or warlike operation, the contractor shall when ordered (in writing) by the Engineer-in-Charge to remove any debris from the site, collect and properly stack or remove in store all serviceable materials salvaged from the damaged work and shall be paid at the contract rates in accordance with the provision of this agreement for the work of clearing the site of debris, stacking or removal of serviceable material and for reconstruction of all works ordered by the Engineer-in-Charge, such payments being in addition to compensation up to the value of the work originally executed before being damaged or destroyed and not paid for. In case of works damaged or destroyed but not already measured and paid for, the compensation shall be assessed by the Engineer-in-Charge concerned. The contractor shall be paid for the damages/destruction suffered and for the restoring the material at the rate based on analysis of rates tendered for in accordance with the provision of the contract. The certificate of the Engineer-in-Charge regarding the quality and quantity of materials and the purpose for which they were collected shall be final and binding on all parties to this contract.

Provided always that no compensation shall be payable for any loss in consequence of hostilities or warlike operations (a) unless the contractor had taken all such precautions against air raid as are deemed necessary by the Air Force Officers or the Engineer-in-Charge (b) for any material etc. not on the site of the work or for any tools, plant, machinery, scaffolding, temporary building and other things not intended for thework.

In the event of the contractor having to carry out reconstruction as aforesaid, he/she shall be allowed such extension of time for its completion as is considered reasonable by the Engineer-in-charge.

Clause 40. The contractor shall comply with the provisions of the Apprentices Act, 1961 and the Apprenticeship Rules, 1992 and orders issued thereunder from time to time. If

he/she fails to do so, his/her failure will be a breach of the contract and the Engineer-in-Charge may, in his/her discretion, cancel the contract. The contractor shall also be liable for any pecuniary liability arising on account of any violation by him/her of the provisions of the saidAct.

Clause 41. Procedure For Suspension and Debarment of Supplier, Contractors and Consultants

The procedure as laid down below shall govern the suspension/debarment of Suppliers/Contractors/Consultants (Contractors for brevity) involved in Government procurement for offences or violations committed during competitive bidding and contract implementation, for the works under different Departments of Government of West Bengal.

Grounds for Suspension and Debarment:-

(1) Submission of eligibility requirements containing false information or falsified documents.

(2) Submission of Bids that contain false information or falsified documents, or the concealment of such information in the Bids in order to influence the outcome of eligibilityscreeningoranyotherstageofthebiddingprocess.

(3) Unauthorized use of one's name/digital signature certificate for the purpose of biddingprocess.

(4) Any documented unsolicited attempt by a bidder (**APerson/Contractor/Agency /Joint Venture/Consortium/Corporation participating in the procurement process and/or a person / Contractor / Agency / Joint Venture / Consortium / Corporation having an agreement/contract for any procurement with the department shall be referred as Bidder**) unduly influencing the outcome of the bidding in hisfavour.

(5) Refusal or failure to post a self–declaration to the effect of any previous debarment imposed by any other department of State Government and/or CentralGovernment.

(6) All other acts that tend to defeat the purpose of the competitive bidding such as lodging false complain about any Bidder, lodging false complain about any Officer duly authorized by the Department, restraining any interested bidder to participate in the bidding process,etc.

(7) Assignment and subcontracting of the contract or any part thereof without prior written approval of the procuringentity.

(8) Whenever adverse reports related to adverse performance, misbehaviour, direct or indirect involvement in threatening, making false complaints etc. damaging the reputation of the department or any other type complaint considered fit by the competent authority of the department, are received from more than one Officer or on more than one occasion from individualOfficer.

(9) Refusal or failure to post the required performance security / earnest money within the prescribed time without justifiablecause.

(10) Failure in deployment of Technical Personnel, Engineers and/or Work Supervisor having requisite license / supervisor certificate of competency as specified in the contract.

(11) Refusal to accept an award after issuance of "Letter of Acceptance" or enterinto contract with the Government without justifiable cause.

(12) Failure of the Contractor, due solely to his fault or negligence, to mobilize and start work or performance within the specified period as mentioned in the "Letter of Acceptance", "Letter of Acceptance cum Work Order", "Work Order", "Notice to Proceed", "Award of Contract",etc.

(13) Failure by the Contractor tofully and faithfully comply with its contractual obligations without valid cause, or failure bythe Contractor to comply with any written lawful instruction of the Procuring Entity/Authority (the Officer authorizedby the Administrative Department, Government of West Bengal for procurement) or itsrepresentative(s)pursuanttotheimplementationoftheContract.

(14) For the procurement of Consultancy Service/Contracts, poor performance by the Consultant of his services arising from his fault or negligence. Any of the following actsbytheConsultantshallbeconstruedaspoorperformance.

(i) Non deployment of competent technical personnel, competent Engineers and/or worksupervisors;

(ii) Non-deployment of committed equipment, facilities, support staff and manpower;

(iii) Defective design resulting in substantial corrective works in design and/or construction;

(iv) Failuretodelivercriticaloutputsduetoconsultant'sfaultornegligence;
(v) Specifying materials which are inappropriate and substandard or way above acceptable standards leading to high procurementcost;
(vi) Allowing defective workmanship or works by the Contractor being supervised by theConsultant.

(15) For the procurement of goods, unsatisfactory progress in the delivery of the goods by the manufacturer, supplier, or distributor arising from his fault or negligence and/or unsatisfactoryorinferiorqualityofgoods,vis-à-visaslaiddowninthecontract.

(16) Willful or deliberate abandonment or non-performance of the project or Contract by the Contractor resulting in substantial breach thereof without lawful and/or just cause.

CATEGORY OF OFFENCE :-

(A) First degree of offence: 1 to 16 of the above Clause-41 to be considered as First degree ofoffence.

(B) Second degree of offence: Any one of the offences as mentioned under 'A' above, committed by a particular Bidder/Contractor/Supplier on more than one occasion, be considered as Second degree ofoffence.

In addition to the penalty of suspension/debarment, the bid security / earnest money posted by the concerned Bidder or prospective Bidder shall also be forfeited.

PENALTY FOR OFFENCE :-

(I) For committing First degree of offence: Disqualifying a Bidder from participating in any procurement process under the Administrative Department of Government of West Bengal up to 2 (two)years.

(II) ForcommittingSeconddegreeofoffence:DisqualifyingaBidderfromparticipatingin any procurement process under the Administrative Department of Government of West Bengal up to 3 (three)years.

PROCEDURE OF SUSPENSION AND DEBARMENT DURING THE PROCUREMENT PROCESS

(1) Initiation of Action, Notification andHearings:
Any Bidder or procurement authority on his own or based on any other information made available to him may invite the process of suspension/debarment proceedings byfilingawrittenapplicationwiththe**BidEvaluationCommittee**andsuchfiling of written application has to be done within forty eight hours from the date and time of publication of the result of technical evaluation of anybid.

(a) Upon verification of the existence of grounds for suspension/debarment, the Chairpersonof**BidEvaluationCommittee**shallimmediatelynotifythebidder concerned either electronically through his registered e-mail or in writing to his postal address, advising himthat:
i) A complaint has been filed against him and prima facie material has been found, which may lead tosuspension/debarment.
ii) He has been recommended to be placed under suspension/debarment by the suspension committee (as constituted by the respective Administrative Department) stating the ground forsuch.
iii) The said bidder, within three days from the date of issue of such notification by the Bid Evaluation Committee, may approach the Chairperson of Suspension Committee by submitting all required documents in his favour for hearing. Any application made thereafter would not beentertained.

Such notice should contain the e-mail id and the postal address of the Chairperson of the Suspension Committee.

(b) After receiving the recommendation for suspension from Bid Evaluation Committee, Suspension Committee shall issue a notice to the alleged bidder electronically through his registered e-mail id, to submit all relevant documents in support of his defense within three working days after issuance of the notice of the Suspension Committee. The Suspension Committee will conduct the hearing within seven working days from the date of receipt of the documents from the alleged bidder. If no appeal has been received from the alleged bidder or if after hearing sufficient ground for suspension is found, the Suspension Committee, will suspend the alleged bidder from participating in the procurement process under the Administrative Department for a period of six monthsfromthedateofissuanceofsuspensionorder.TheChairpersonofthe

Suspension Committee shall issue the suspension order within seven days from the last date of hearing and shall notify the bidder concerned either electronically through his registered e-mail id or in writing to his postal address. The Chairperson of Suspension Committee shall also inform the decision to allconcerned.

If sufficient reason for suspension is not found, the Suspension Committee wouldrejecttherecommendationofBidEvaluationCommitteeandwouldallow the bidder to take part in the tenderingprocess.

If the bidder is suspended, the Suspension Committee would recommend debarment of the bidder and forward the case with all documents to the Debarment Committee for furtheraction.

(c) The Debarment Committee upon receipt of the recommendation of the Suspension Committee shall scrutinize the documents. The Debarment Committee will hold a hearing of the alleged bidder and issue necessary order within ten working days from the last date of hearing. The Debarment Committee, if satisfied after hearing, shall forward the case to the Department for orders of Debarment. The Department in due course will issue Debarment Order disqualifying/prohibiting the erring bidder from participating in the bidding/procurement of all projects under the Administrative Department for a specified period. The alleged bidder shall be intimated accordingly either electronically through his registered e-mail id or in writing to his postal address. Otherwise the Debarment Committee may reject the recommendation of the Suspension Committee. The Chairperson of Debarment Committee shall also inform the decision to allconcerned.

PROCEDURE FOR DEBARMENT DURING THE CONTRACT IMPLEMENTATION STAGE:-

(A) Upon termination of contract due to default of the Bidder, the Engineer-in-Charge shall recommend for debarment to the Bid Evaluation Committee. The Bid Evaluation Committee shall submit his recommendation of debarment of the alleged Bidder along with a detailed report stating clearly the reasons for debarment to the Debarment Committee within 30 (thirty) days from the date of termination of contract. The alleged Bidder shall be intimated accordingly either electronically to his registered e-mail id or in writing to his postal address. The Chairperson of Bid Evaluation Committee shall also inform the decision to allconcerned.

(B) The Debarment Committee upon receipt of the recommendation of Bid Evaluation Committee shall scrutinize the documents. The Debarment Committee will hold a hearing about the matter from the Bidder and issue necessary order within 10 (ten) working days from the last date of hearing. The Debarment Committee, if satisfied after hearing, shall forward the case to the Department for the order of debarment. The Department in due course will issue debarment order disqualifying/prohibiting the erring Bidder from participating in the bidding/procurement of all projects under the Administrative Department, Government of West Bengal for a specified period. The alleged Bidder shall be intimated accordingly either electronically to his registered e-mail id or in writing to his postal address. Otherwise the Debarment Committee may reject the recommendation of the Bid Evaluation Committee. The Chairperson of Debarment Committee shall also inform the decision to allconcerned.

STATUS OF SUSPENDED / DEBARRED BIDDER :-

(a) Bidder placed under Suspension/Debarment by the competent authority will not be allowed to participate in any procurement process under the Administrative Department within the period of suspension/debarment. The earnest money of the suspended Bidder shall stand forfeited to theGovernment.

(b) If the Suspension/Debarment Order is issued prior to the date of issue of "Letter of Acceptance", "Letter of Acceptance cum Work Order", "Work Order", "Notice to Proceed", "Award of Contract" etc. for any Bid, the Suspended/Debarred Bidder shall not be qualified for Award for the said Bid and such Procurement Process will be dealt with as per existing norms by simply excluding the erringBidder.

(c) If the Suspension/Debarment Order is issued after award of a Government Project/Contract to the Debarred Bidder, the awarded Project/Contract shall not be prejudiced by the said Order provided that the said offence(s) committed by the Debarred Bidder is not connected with the awardedproject/contract.

Clause 42. Executive Engineer of the concerned Division will be the Engineer-in-Charge inrespectoftheTendercontractandallcorrespondencesconcerningrates,claims,change

in specifications and/or design and similar important matters will be valid only if accepted/recommended by the Engineer-in-Charge. If any correspondence of above tender is made with Officers other than the Engineer-in-charge for speedy execution of works, the same will not be valid unless copies are sent to the Engineer-in-Charge and also approved by him. Instructions given by the Assistant Engineer and the Junior Engineer on behalf of the Engineer-in-Charge (who have been authorized to carry out the work on behalf of the Engineer-in-Charge) regarding specification, supervision, approval of materials and workmanship shall also be valid. In case of dispute relating to specification and work, the decision of Engineer-in-Charge shall be final and binding. The Engineer-in-Charge will however invariably take decisions relating to tender contract or as mentioned in the relevant rules and clauses of the contract document with the approval of the Tender AcceptingAuthority.

Clause43. Acceptance of the Tender will rest with the Tender Accepting Authority without assigning reason thereof to the bidder. The accepting authority reserves the right to reject anyoralloftheten derswithoutassigninganyreasonthereoftothebidder/contractor.

Clause 44. In the event of acceptance of Lowest Rate, no multiple Lowest Rates will be considered for acceptance by the Department. In such cases, the Tender will be cancelled.

Clause 45. In the event of conflicting different clauses,the clauses in the e-NIT will prevail.

Clause 46. Engineer-in-Charge shall not entertain any claim whatsoever from the Contractor for payment of compensation on account of idle labour on such grounds including non-possession of encumbrance free land.

Clause 47. Engineer-in-Charge shall not be held liable for any compensation due to machines becoming idle or any circumstances including untimely rains, other natural calamities, like strikes etc.

Clause 48. Imposition of any Duty/Tax/Octroi/Royalty etc. whatsoever of its nature (after work order / commencement and before final completion of the work) is to be borne by the contractor/bidder. Original challan of those materials, which are procured by the bidder, may be asked to be submitted for verification.

Clause 49. Cess @ 1% or as amended time to time of the cost of construction works shall be deducted from the Gross value of all Works Bill in terms of Finance Department order. Also it is instructed to register his/her establishment under the Act, with the competent registering Authority, i.e. Assistant Labour Commissioner / Deputy Labour Commissioner of theregion.

Clause 50. No Mobilization/Secured Advance will be allowed unless specified otherwise in thecontract.

Clause 51. Valid PAN issued by the Income Tax Department, Government of India, valid 15 digit Goods and Services Tax Payer Identification Number (GSTIN) under GST Act 2017, Cess, Royalty of Sand, Stone Chips, Stone Metal Gravel, Boulders, Forest product etc., Toll Tax, Income Tax, Ferry Charges and other Local Taxes, if any, are to be paid by the Contractor/Bidder. No extra payment will be made as a reimbursement or as compensation for these. The rates of supply and finished work items are inclusive of these taxes andcharges.

Clause 52. All working Tools & Plants, Scaffolding, Construction of Vats & Platforms and arrangement of Labour Camps will have to be arranged by the Contractor at his/her own cost.

Clause 53. The Contractor shall supply Mazdoors, Bamboos, Ropes, Pegs, Flags etc. for laying out the work and for taking and checking measurements for which no extra payment will bemade.

Clause 54. The Contractor/Bidder should see the site of works and Tender Documents, Drawings etc. before submitting e-Tender and satisfy himself/herself regarding the condition and nature of works and ascertain difficulties that might be encountered in executing the work, carrying materials to the site of work, availability of drinking water and

other human requirements & security etc. Work on river banks may be interrupted due to a number of unforeseen reasons e.g. sudden rises in water levels, inundation during flood, inaccessibility of working site for carriage of materials. Engineer-in Charge may order the contractor to suspend work that may be subjected to damage by climate conditions. No claim will be entertained on this account. There may be variation in alignment, height of embankment or depth of cutting, location of revetment, structures etc. due to change of topography, river condition and local requirements etc. between the preparation and execution of the scheme for which the tendered rate and contract will not stand invalid. TheContractorwillnotbeentitledtoanyclaimorextrarateonanyoftheseaccounts.

Clause 55. A machine page numbered Site Order Book (with triplicate copy) will have to be maintained at site by the Contractor and the same has got to be issued from the Engineer-in-Charge before commencement of work. Instructions given by inspecting officers not below the rank of Assistant Engineer will be recorded in this book and the contractor must note down the action to be taken by him in this connection as quickly as possible.

Clause 56. The work will have to be completed within the time mentioned in the e-NIT. A suitable Work Programme based on time allowed for completion of work as per e-NIT is to be submitted by the contractor within 7 (seven) days from the date of receipt of work order which should satisfy the time limit of completion. The contractor should inform in writing, within 7 (seven) days from the date of receipt of work order, the names of his authorized representatives who are to remain present at site daily during work execution who will receive instructions of the work, sign measurement book, bills and other Government papersetc.

Clause 57. No compensation for idle labour, establishment charge or on other reasons such as variation of price indices etc. will be entertained.

Clause 58. All possible precautions should be taken for the safety of the people and work force deployed at worksite as per safety rule in force. Contractor will remain responsible for his labour in respect of his liabilities under the Workmen's Compensation Act etc. He must deal with such cases as promptly as possible. Proper road signs as per PWD practice or any other sign board for safety purpose as per requirement by the concerned Administrative Department will have to be erected by the Contractor at his own cost while operating in publicthoroughfares.

Clause 59. The Contractor will have to maintain qualified technical employees and/or Apprentices at site as per prevailing Apprentice Act or as stipulated in the contract.

Clause 60. The Contractor will have to accept the Work Programme as per modifications and priority of work fixed by the Engineer-in-Charge so that most vulnerable reach and/or vulnerable items are completed before impending monsoon or rise in river flood water level or for other suitable reasons.

Clause 61. Quantities of different items of work mentioned in the tender schedule or in work order are only tentative. In actual work, these may vary considerably. Payment will be made on the basis of works actually done in different items and no claim will be entertained for reduction of quantities in some items or for omission of some items. For execution of quantitative excess in any item or supplementary new items of work as decided by the Department, approval of the Superintending Engineer / Chief Engineer / Government would be required, depending on whosoever be the Tender Accepting Authority, before making suchpayment.

Clause 62. In order to cope up with the present system of e-billing, supply of departmental materials is generally not allowed. However, if in special circumstances, Departmental materials may be issued to the Contractor/Bidder to the extent of requirements as assessed, those may be recovered from the Running Account Bill and/or Final Bill, asapplicable.

Clause 63. Any material brought to site by the contractor is subject to approval of the Engineer-in-Charge. The rejected materials must be removed by the contractor from the site at his own cost within 24 hours of issue of the order to that effect. The rates in the schedule are inclusive of cost and carriage of all materials to worksite. The materials will havetobesuppliedinphasewithdueintimationtotheAssistantEngineerconcernedin

conformity with the progress of the work. For special type of materials, i.e. Geo Synthetic Bags, HDPE Bags, Geo Textile Filter, Geo Jute Filter etc., if any, relevant Data Sheet containing the name of the Manufacturers, Test Report etc. will also be submitted on each occasion. Engineer-in-Charge may conduct independent test on the samples drawn randomly before according approval for using the materials at site. In this regard decision of Engineer-in-Charge shall be final andbinding.

Clause 64. For all items of contract jobs requiring skilled labour, the contractor shall have to employ 70% (Seventy Percent) of skilled labour locally. In case the Contractor fails to recruit skilled local labour, the Contractor shall employ skilled labour locally secured by Government in the manner indicated above. For bridge works, highly technical works of labour, the contractor may, with the prior permission in writing of the Engineer-in-charge to whom full facts must be placed for such permission, import and employ skilled labour up to 30% (Thirty Percent) of the total requirement. In this case the expression "Imported labour" shall mean "labour imported primarily from other States and secondarily, from the distant districts of the State of West Bengal." In case where the contactor fails to secure unskilled local labour or to engage imported labour, the contractor shall employ labour locally recruited by Government or labour imported by Government at the rate to be decided by the Superintending Engineer of the works concerned, whose decision as to the circumstances in which employment of such labour is of mutual advantage to Government andthecontractor,willbefinalandbindingontheparties.

Clause 65. All queries and disputes arising out of the works tender contract is to be brought to the notice of the Chairman of the 'Department Dispute Redressal Committee' in writing for decision within 15 days.

Clause 66. The contractor shall have to make his own arrangements for water, both for the work and use by his workers, etc., for road rollers and for all tools and plant, etc., required on thework.

Clause 67. Contractor will be responsible for the payments of all water charges payable to the Corporation Municipality / Panchayat or any other water works authority including a Government Department concerned.

Clause 68. If the contractors shall desire an extension of the time for completion of the work under clause 5 of the contract, no application for such extension will be entertained if it is not received in sufficient time to allow the Executive Engineer to consider it and the Contractor will be responsible for the consequences arising out of his negligence in this respect.

Clause 69. The Contractor will have to leave ducts in walls and floors to run conduit or cables, where necessary, and he will not be entitled to any extra payment on this account.

Clause 70. Contractors in the course of their work should understand that all materials obtained in the work of Dismantling, Excavation, etc., will be considered Government property and will be disposed of to the best advantage of Government.

Clause 71. In case of very special case of circumstances, if any Departmental materials are issued, there may be delay in obtaining the materials by the Department and the Contractor is, therefore, required to keep himself/herself in touch with the day to day position regarding the supply of materials from the Engineer-in-charge and to so adjust the progress of the work that his labour may not remain idle nor may there be any other claim due to or arising from delay in obtaining the materials. It should be clearly understood that no claim whatsoever shall be entertained by the Department on account of delay in supplyingmaterials.

Clause 72. No compensation for any damage done by rain or traffic during the execution of the work will be made.

Clause 73. Whenever a work is carried out in municipal area, electric lights or electric danger signals whenever available shall be provided by the contractors on the barriers as well as paraffin lights. Facilities for the electric connection will be made by this Department but the Contractor will bear all the expenses.

Clause 74. The Contractor should quote through rate inclusive of cost of materials and carriage to place of working.

Clause 75. The Contractors should give complete specifications showing the method of execution and the quantity and quality of materials they intend to use per hundred square metre area.

Clause 76. In cases where water is used by the Contractor he will be required to deposit in advance with the Executive Engineer the charges for water which are to be calculated in accordancewiththescheduleofmiscellaneousratesintheCanalAct.

Clause 77. It must be clearly understood by the Contractor that no claim on account of enhanced rates on those already accepted, due to fluctuations arising out of any situation will be entertained during the currency of this contract for the work as per schedule attachedtotheagreementandtheadditionalwork,ifany,underClause12ofthecontract.

Clause 78. In the event of emergency the Contractor will be required to pay his labour everyday and if this is not done, Government shall make the requisite payments as would have been paid by the contractor and recover the cost from the contractors.

INCONVENIENCE OF THE PUBLIC

Clause 79. The Contractor(s) shall not deposit material on any site which will seriously inconvenience the public. The Engineer-in-charge may require the Contractor(s) to remove any materials, which are considered by him to be a danger or inconvenience to the public orcausethemtoberemovedatthecontractor'scost.

Clause 80. The Contractor undertakes to have the site clean, free from rubbish to the satisfaction of the Engineer-in-charge. All surplus materials, rubbish etc. will be removed totheplacesfixedbytheEngineer-in-chargeandnothingextrawillbepaid.

Clause 81. The Contractor shall not allow any rubbish or debris to remain on the premises during or after repairs, but shall remove the same and keep the place neat and tidy during the progress of the work. The Engineer-in-charge may get the site premises cleared of debris etc. And recover the cost from the bill of the contractor, if the latter shows slackness in observing thisclause.

Clause-82. Construction materials brought at site shall not be stacked at random. The contractor shall stack all these materials as directed by the Engineer-in-charge.

INTERPRETATION OF CLAUSES

Governor means the Governor of the State of West Bengal and his/her successors.

The Government means Government in the concerned Works Department.

The Department means the Secretary of the concerned Department or his/her authorized representative.

The Divisional Officer means the Executive Engineer of the concerned Works Department for the time being of the Division concerned, also identified as the Engineer-in-Charge.

The Sub-divisional Officer means the Assistant Engineer of the concerned Works Department for the time being of the Sub-division concerned. Junior Engineer equivalent to Section Officerof the Section concerned.

Superintending Engineer in the concerned works Department is the final Authority regarding Schedule of Rates and also the acceptance of Non-scheduled item rates arrived on the basis of market rate analysis for supplementary items, and the authority for approval of Reduced Rates and Part Rates. He is also the Tender Accepting Authority for works of value above Rs. 45.00 lakh and up to Rs. 2.00 crore under existing delegated power.

Chief Engineer in the concerned Works Department is the technical head of the DirectorateandisalsotheTenderAcceptingAuthorityforallworksofvalueaboveRs.

2.00 crore. Excess work over individual items comprising theoriginal tender may be exceeded beyond 10% with the approval of concerned tender accepting authority andverified by the Superintending Engineer/ Chief Engineer subject to the total value of workupon completion is within the technically sanctioned cost and that there is no major deviation from original scope of work in the tender. **Any supplementary tender/item/work in connection with the main tender is to be taken up with the approval of the Tender Accepting Authority not below the rank of Executive Engineer**. Such supplementary tenders above 10% of BOQ are to be executed only withtheapprovalofappropriateGovernmentirrespectiveofthevalueoftender.

Words importing the singular number only include the plural number and vice versa.

Irrespective of the accepting authority, Divisional officer shall be the authority signing agreement for all tenders of value more than Rs. 3.00 lakh up to any amount on behalf of theState.

Schedule showing (approximately) materials to be supplied by the Engineer-in-Charge under clause 10:

Particulars	Rates at which the materials will be charged to the contractor			Place of delivery
	Unit	**Rs.**	**P.**	

Note 1- The person or firm submitting the tender should see that the rates in the above schedule are filled up by the Engineer-in-charge on the issue of the form prior to the submission of the tender.

(Name in full)
*Signature of Contractor/Agency
with official seal containing
Principal office address

(Name in full)
*Signature of Executive
Engineer/Assistant Engineer
on behalf of the Governor of the
State of West Bengal with officialseal
containing designation &address

* To be authenticated on each and every page of the contract document by all parties.