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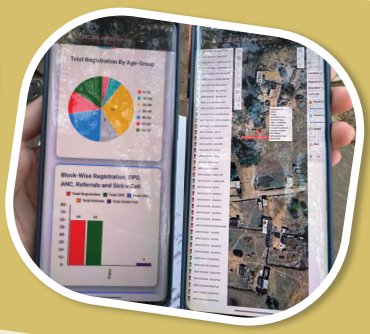
Ministry of Health & Family Welfare
Government of India

NHSRC



2026

REVISED OPERATIONAL GUIDELINES FOR MOBILE MEDICAL UNITS (MMU)

Ministry of Health & Family Welfare,
Government of India

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Revised Operational Guidelines for Mobile Medical Units (MMU)

2026

Ministry of Health & Family Welfare,
Government of India

पुण्य सलिला श्रीवास्तव, भा.प्र.से.
सचिव
PUNYA SALILA SRIVASTAVA, IAS
Secretary

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Message

Making essential healthcare service available to each citizen is fundamental to India's commitment to Universal Health. While Ayushman Arogya Mandirs have expanded our outreach, Mobile Medical Units (MMUs) remain indispensable for reaching remote, tribal, and marginalized populations. These Revised Operational Guidelines update the 2015 framework to reflect current service delivery models, digital health adoption, and evolving disease burdens.

The guidelines respond to national imperatives like PM-JANMAN, positioning MMUs as a primary platform for healthcare saturation in tribal areas. They provide a uniform framework for geographical prioritization, human resources, and diagnostics, while emphasizing integration through tele-consultation and defined referral pathways.

A central principle is the optimal use of public resources. The guidelines articulate a phased approach for redeploying MMUs from areas with functional fixed infrastructure to geographies where such facilities are not yet feasible. States and Union Territories are requested to embed these guidelines into their overall health infrastructure planning to ensure measurable health outcomes and reduced out-of-pocket expenditure.

Punya Salila

(Punya Salila Srivastava)

Date : 30.1.2026
Place : New Delhi

#StopObesity
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Aradhana Patnaik, IAS
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स्वास्थ्य एवं परिवार कल्याण विभाग
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Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

MESSAGE

India's health system has made significant strides in expanding access to comprehensive primary healthcare through the National Health Mission and the successful operationalisation of Ayushman Arogya Mandirs across the country. As this foundation of fixed service delivery platforms has been strengthened, it has become imperative to recalibrate outreach strategies to ensure that populations living in remote, inaccessible, tribal, hilly, conflict-affected and marginalised urban settings are not left behind. In this context, Mobile Medical Units (MMUs) continue to play a vital role in bridging critical access gaps and extending essential healthcare services to the unreached.

The healthcare landscape has evolved considerably over the years since MMUs were first launched. The scale-up of Health and Wellness Centres, changing epidemiological patterns, rising costs of vehicles and medical equipment, advances in point-of-care diagnostics and tele-health, and lessons emerging from field reviews and Common Review Missions have highlighted the need to revisit the scope, deployment strategy, and operational design of MMUs. At the same time, national initiatives such as PM-JANMAN and the Dharti Aabha Janjatiya Gram Utkarsh Abhiyan have underscored the renewed focus on delivering assured healthcare services to Particularly Vulnerable Tribal Groups and tribal populations through targeted outreach mechanisms, with MMUs as a key service delivery platform.

The **Revised Guidelines on Mobile Medical Units** provide a comprehensive and pragmatic framework to address these emerging requirements. They clearly define the geographical prioritization and target populations for MMU deployment, articulate a rational package of preventive, promotive and curative services, and lay down norms for coverage, human resources, diagnostics, drugs, quality of care, monitoring and financing. The Guidelines also place strong emphasis on integration with the broader public health system, including referral linkages and follow-up care to enhance service quality and continuity of care.

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Importantly, the Guidelines outline a balanced and forward-looking approach, strengthening and redeploying MMUs in areas where fixed infrastructure cannot be established, while enabling a phased withdrawal of MMU services from areas where Ayushman Arogya Mandirs and other public health facilities are fully functional. This will ensure optimal use of resources while maintaining equity and access.

I expect States and Union Territories to use these Guidelines to undertake evidence-based planning, rational deployment, and effective monitoring of MMU services, aligned with local contexts and needs. A well-functioning MMU network, integrated with the primary and secondary healthcare system, will significantly contribute to reducing unmet health needs, improving health outcomes among vulnerable populations, and advancing the goal of Universal Health Coverage.

Dated: 14th Jan, 2026

(Aradhana Patnaik)

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Government of India
Ministry of Health & Family Welfare
Kartavya Bhawan-1, New Delhi-110001

Message

India's commitment to Universal Health Coverage rests on the principle that no citizen should be denied timely healthcare because of geography, vulnerability, or circumstance. Over the years, national health initiatives—from the expansion of primary care to the strengthening of secondary services under the National Health Mission—have significantly improved access. Yet, gaps remain for populations living in remote, tribal, migratory, and marginalised settings, where distance and access continue to delay care.

Mobile Medical Units have emerged as a critical instrument to bridge these gaps. The Revised Operational Guidelines for Mobile Medical Units 2026 reflect a renewed national commitment in ensuring that essential healthcare services reach those who are still beyond the effective coverage of fixed health facilities. These guidelines are not merely an update of operational norms; they represent a strategic re-calibration of outreach services in line with India's evolving health system.

For the first time, MMU services are being positioned within a clearly defined continuum of care—linked with Ayushman Arogya Mandirs, referral facilities, digital health platforms, and structured monitoring mechanisms. The expanded scope of services, including care for non-communicable diseases, mental health conditions, geriatric needs, and emergency stabilisation, acknowledges changing disease patterns and demographic realities across the country.

A functional MMU must be understood not simply as a vehicle or a temporary arrangement, but as a guarantee of readiness—bringing trained health personnel, essential diagnostics, medicines, digital connectivity, and referral support directly to communities where healthcare access remains constrained. At scale, this demands strong governance, accountability, and sustained investment by States and Districts.

I urge all States and UTs to adopt these guidelines with urgency and commitment, and to deploy Mobile Medical Units strategically as part of a broader effort to strengthen the public health system. By doing so, we can ensure that outreach services are not only available, but reliable, equitable, and capable of delivering timely care to those who need it most—wherever they live.

(Sibin C)

Dated 25th March, 2026

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MESSAGE

Mobile Medical Units have long served as an important outreach mechanism for delivering primary healthcare services to populations living in remote, hard-to-reach, and underserved areas. As the health system continues to evolve, it is essential that MMU services are guided by updated standards, field evidence, and a clear understanding of where and how they add the greatest value.

The *Revised Operational Guidelines for Mobile Medical Units 2026* have been developed through a careful review of existing operational frameworks, programme experiences, field observations, and feedback from States and implementing teams. NHSRC has supported the Ministry in examining utilisation patterns of MMUs, emerging service needs, cost implications, and alignment with the expanded network of Ayushman Arogya Mandirs and fixed public health facilities.

These guidelines integrate current national standards and programmatic priorities, including Comprehensive Primary Health Care, quality assurance processes, digital health tools, and strengthened referral linkages. Particular emphasis has been placed on defining realistic service packages, appropriate human resource configurations, point-of-care diagnostics, tele-consultation, and structured monitoring systems that are feasible across diverse geographies. The guidance also reflects the need for continuity of care, ensuring that MMUs function as an extension of the public health system rather than as stand-alone service delivery units.

Recognising the varied terrain and population needs across States, the guidelines have been designed to remain flexible while providing clear operational direction. Special consideration has been given to tribal, hilly, and difficult-to-access areas, where MMUs continue to play a critical role in improving access to essential healthcare services.

NHSRC remains committed to supporting States and UTs in operationalising these guidelines through technical assistance, capacity building and ongoing support. I am confident that the effective adoption of these guidelines will help strengthen outreach services, improve service quality, and ensure that Mobile Medical Units continue to deliver timely, appropriate, and people-centred care where these are most needed.

04/02/26

(Dr. Pragya Sharma)

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सत्यमेव जयते

आज़ादी का अमृत महोत्सव

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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAWAN, NEW DELHI-110011

Message

Mobile Medical Units have been an important component of service delivery under the National Health Mission, particularly in reaching populations living in remote, tribal, hilly, underserved urban and unserved areas. Over the years, MMUs have enabled States to extend essential primary healthcare services to communities where access to fixed facilities remains limited or difficult.

At the same time, the health system has evolved significantly. The rapid expansion of Ayushman Arogya Mandirs, improvements in fixed health infrastructure in many areas, rising operational costs, and varying utilization patterns of MMUs across States have made it necessary to review and rationalize the deployment and functioning of MMU services. The objective of these revised guidelines is to ensure that MMUs are used where they are most needed and operate in a predictable, efficient, and accountable manner.

The Revised Operational Guidelines for Mobile Medical Units 2026 provide a clear and practical framework for States and UTs to assess local needs, redeploy MMUs to priority and hard-to-reach areas, and gradually phase out services from locations where fixed public health facilities are functional and accessible. Emphasis has been placed on standardizing service packages, human resources, route planning, monitoring mechanisms, and integration with the existing primary healthcare system.

These guidelines also recognize the continued importance of MMUs in tribal and difficult geographies, including focused interventions under PM-JANMAN and Dharti Aabha Janjatiya Gram Utkarsh Abhiyan. States are encouraged to plan MMU services as part of a broader strategy to strengthen public health infrastructure, ensure effective referral linkages, and improve continuity of care.

The completion of these Guidelines represents commitment of all the stakeholders towards achieving Universal Health Coverage. Successful implementation of these guidelines will depend on strong ownership at the State, District, and Block levels, supported by realistic planning through PIPs, regular review of performance, and close coordination with fixed health facilities. I urge all States and UTs to adopt these guidelines thoughtfully and integrate them into their annual planning and monitoring processes, so that Mobile Medical Units continue to deliver timely, equitable, and people-centered healthcare services where they are most required.

(Dr. Saroj Kumar)

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TABLE OF CONTENTS

LIST OF ABBREVIATIONS

1. AAMS: AYUSHMAN AROGYA MANDIRS
2. AFB: ACID FAST BACILLUS
3. AGE: ACUTE GASTRO ENTERITIS
4. AIS: AUTOMOTIVE INDUSTRY STANDARDS
5. ANM: AUXILIARY NURSE MIDWIFERY
6. ARIS: ACUTE RESPIRATORY INFECTIONS
7. ASHA: ACCREDITED SOCIAL HEALTH ACTIVISTS
8. ASOM: ACUTE SUPPURATIVE OTITIS MEDIA
9. AYUSH: AYURVEDA, YOGA AND NATUROPATHY, UNANI, SIDDHA, AND HOMOEOPATHY
10. BWH: BIRTH WAITING HOME
11. CEO: CHIEF EXECUTIVE OFFICER
12. CDMO: CHIEF DISTRICT MEDICAL OFFICERS
13. CHC: COMMUNITY HEALTH CENTRES
14. CHOS: COMMUNITY HEALTH OFFICERS
15. COPD: CHRONIC OBSTRUCTIVE PULMONARY DISEASE
16. CPHC: COMPREHENSIVE PRIMARY HEALTH CARE
17. CRM: COMMON REVIEW MISSION
18. DA JGUA: DHARTI AABHA JANJATIYA GRAM UTKARSH ABHIYAN
19. DH: DISTRICT HOSPITAL
20. DHOS: DISTRICT HEALTH OFFICERS
21. ECPS: EMERGENCY CONTRACEPTIVE PILLS
22. ENT: EAR, NOSE AND THROAT
23. EOI: EXPRESSION OF INTEREST
24. FP: FAMILY PLANNING
25. GBV: GENDER BASED VIOLENCE
26. GPS: GLOBAL POSITIONING SYSTEM
27. GRS: GRIEVANCE REDRESSAL SYSTEM
28. HCG: HUMAN CHORIONIC GONADOTROPHIN
29. HIV: HUMAN IMMUNODEFICIENCY VIRUS
30. HMIS: HEALTH MANAGEMENT INFORMATION SYSTEM
31. HWCS: HEALTH AND WELLNESS CENTRES
32. HR: HUMAN RESOURCES
33. ICDS: INTEGRATED CHILD DEVELOPMENT SERVICES
34. IEC: INFORMATION EDUCATION COMMUNICATION
35. IUCD: INTRA UTERINE CONTRACEPTIVE DEVICE
36. IYCF: INFANT AND YOUNG CHILD FEEDING

37. JE: JAPANESE ENCEPHALITIS
38. LWE: LEFT WING EXTREMISM
39. MBBS: BACHELOR OF MEDICINE AND BACHELOR OF SURGERY
40. MCH: MATERNAL AND CHILD HEALTH
41. MMU: MOBILE MEDICAL UNITS
42. MMUSPA: MOBILE MEDICAL UNITS SERVICE PROCURING AGENCY
43. MOHFW: MINISTRY OF HEALTH AND FAMILY WELFARE
44. MORTH: MINISTRY OF ROAD, TRANSPORT AND HIGHWAYS
45. MPW: MULTI-PURPOSE WORKER
46. MSG: MISSION STEERING GROUP
47. NCD: NON-COMMUNICABLE DISEASES
48. NGOS: NON-GOVERNMENTAL ORGANIZATIONS
49. NHM: NATIONAL HEALTH MISSION
50. NRHM: NATIONAL RURAL HEALTH MISSION
51. NTEP: NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME
52. NUHM: NATIONAL URBAN HEALTH MISSION
53. NVBDCP: NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME
54. OCPS: ORAL CONTRACEPTIVE PILLS
55. OPEX: OPERATIONAL EXPENDITURE
56. PHC: PRIMARY HEALTH CENTRES
57. PM-JANMAN: PRADHAN MANTRI JANJATIYA ADIVASI NYAYA MAHA ABHIYAN
58. POL: PETROLEUM, OIL AND LUBRICANTS
59. PPP: PUBLIC PRIVATE PARTNERSHIP
60. PVTG: PARTICULARLY VULNERABLE TRIBAL GROUPS
61. RCH: REPRODUCTIVE AND CHILD HEALTH
62. RDK: RAPID DIAGNOSTIC KITS
63. RDT: RAPID DIAGNOSTIC TESTS
64. RTI: REPRODUCTIVE TRACT INFECTIONS
65. RVSFS: REGISTERED VEHICLE SCRAPPING FACILITIES
66. SAM: SEVERE ACUTE MALNUTRITION
67. SHC: SUB HEALTH CENTRE
68. STI: SEXUALLY TRANSMITTED INFECTIONS
69. TB: TUBERCULOSIS
70. TE: TENDER ENQUIRY
71. THR: TAKE HOME RATIONS
72. TT: TETANUS TOXOID
73. VHND: VILLAGE HEALTH NUTRITION DAY
74. VHSNC: VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE
75. V-VMP: VOLUNTARY VEHICLE-FLEET MODERNIZATION PROGRAM

INTRODUCTION

India's commitment to ensure Universal Health Coverage to all its citizens has been reflected in many government policies and programmes in the past. The launch of National Health Mission (NHM), covering both National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM), is a major step towards that commitment. India has a diverse population and widely varied geographies. For delivery of healthcare services to remote and inaccessible areas, and to the marginalised communities amid rural and urban populations, the States opt for Mobile Medical Units (MMUs). National Health Policy 2017 also advocates enhanced outreach of public healthcare to the tribal and other marginalised populations through MMUs.

In 2015, the Ministry of Health and Family Welfare (MoHFW) launched operational guidelines on MMU and has been supporting states technically and financially through NHM. The key objective of the MMUs was to reach the population in remote, difficult, underserved and inaccessible areas with a set of preventive, promotive and curative services, including but not limited to Reproductive Child Health (RCH) Services, communicable and non-communicable disease services. These services are free for the patient at the Point of Care. The objective of this strategy is to take healthcare to the doorstep of people, particularly rural, vulnerable and underserved areas. The plan was to continue healthcare services for some time by MMUs, and then develop and operationalise healthcare facilities in these areas and gradually phase out the MMU services.

As per the NHM Health Management Information System (HMIS) report on 30th September 2025, **1453 MMUs** are functional across the States, out of which 178 MMUs are functional in high focus North-Eastern States, 367 MMUs are functional in High-Focus Non-Northeast States, 903 MMUs are functional in Non-High Focus Large States and 5 in Non-High Focus Small States and Union Territories.

In 2018, Ayushman Bharat Scheme was launched, which envisioned creation of 1.5 lakh Health and Wellness Centres (HWCs) across the country. These centres, later upgraded as Ayushman Arogya Mandirs (AAMs), were created to deliver Comprehensive Primary Health Care (CPHC), bringing healthcare closer to the homes of people, both in rural and urban areas. These HWC-AAMs help in providing 12 primary healthcare package services, along with outreach services. India has already achieved operationalisation of these AAMs before the scheduled timeline, in December 2022. As on 30th September 2025, there are 1,72,742 SHC-AAMs, 27,462 PHC AAMs and 5,583 UPHC AAMs are functional across the country. With a large number of AAMs, there is a need to revisit the requirement of MMU services in some areas.

The costing of healthcare equipment, along with vehicle cost, has increased in past few years. The Northeast and Hilly States experience further challenges in the given terrain making it difficult for the vehicles, including MMUs, to reach their destination.

Various reviews, field visits, and Common Review Mission (CRM) findings indicate less-

than-optimal utilisation of existing MMUs in few areas, and good utilisation in various other areas. Therefore, there is also a need for revision of package of services, type of investigations, and human resources deployed in MMUs.

Therefore, an expert group was formed to revisit the need to redeploy MMU services and review the costing norms, HR and services provided.

Honourable Prime Minister launched PM-JANMAN (Pradhan Mantri Janjatiya Nyaya Maha Abhiyan) on Janjatiya Diwas on 15th November, 2023, aiming to target 75 Particularly Vulnerable Tribal Groups (PVTG). Nine Ministries are involved in 11 key interventions. MoHFW has been assigned to provide healthcare services to the PVTG areas through Mobile Medical Units (MMU). To extend services to all tribal populations with enhanced focus, the Prime Minister launched the Dharti Aabha Janjatiya Gram Utkarsh Abhiyan (DA-JGUA) on 2nd October 2024. Dharti Aabha Janjatiya Gram Utkarsh Abhiyan envisions the saturation of critical gaps in social infrastructure, health, education, and livelihood through 25 interventions implemented by 17-line ministries of the Government of India by convergence and outreach, and ensures holistic and sustainable development of tribal areas and communities. Under the health component of DA JGUA, healthcare services are provided to the tribal population through MMUs. The PM-JANMAN and DA-JGUA schemes together with National Health Mission support Mobile Medical Units and improve health care delivery in hard-to-reach areas.

The current guidelines on MMU are being revised to incorporate the recommendations of the expert group and costing norms approved by the Mission Steering Group (MSG). Mobile Medical Units, equipped with GPS tracking, should function as mobile Ayushman Arogya Mandirs, delivering all point-of-care services envisaged under the 12-service CPHC package. The Guidelines also include the need to redeploy MMU services to inaccessible areas and a plan to phase out MMUs from the areas where the Ayushman Arogya Mandirs (AAMs) are already functional. The package of services, human resources, equipment required, point of care testing, etc., are some of the important areas revisited for revision of the guidelines.

Global Insights on Mobile Medical Units (MMUs)

Worldwide, MMUs have demonstrated their efficacy as platforms for providing health services to underserved and remote populations. The Mais Médicos (More Doctors) program in Brazil utilised mobile medical units (MMUs) to improve maternal and infant health outcomes in Amazonian regions. The mobile outreach teams of Thailand provided a combination of health education, screening of diseases and vaccinations to tribal communities in hilly areas, while in Australia, MMUs supported Aboriginal health services by providing culturally competent treatment.

Multi-disciplinary personnel, community engagement, cultural sensitivity, and strong linkages with the fixed health system are common success factors among these international models, despite their distinct contexts. Inadequate route planning and inconsistent monitoring have been critical to their efficacy.

1. GEOGRAPHICAL COVERAGE AND TARGET POPULATION OF MMU

The target geography in both rural and urban areas is:

1. In rural areas, MMUs would continue to be deployed in areas with limited or a lack of access to healthcare services. Such areas include Tribal Areas, Conflict Affected Areas (Insurgency, Left Wing Extremism (LWE), Hilly and Desert Areas/Islands/flood-affected/snow-bound wherein:

    a. Even primary healthcare services cannot be provided since fixed infrastructure could not be established (Hilly, Tribal and conflict-affected areas).

    b. Primary healthcare services are available through functional Sub Health Centre-AAM and PHC-AAM. Still, the reach is limited on account of several habitations that are too small to establish regular fixed services, or are too distant (more than 5 km) or cut off to expect those in need of health care to come to the nearest PHC-AAM for any care.

2. In urban areas, MMUs would be deployed where there are habitations of marginalised communities (ragpickers, homeless, migrants) that live on the fringes of cities and towns, alongside highways just outside cities, or along railway tracks and under flyovers and bridges. These are also often areas where dispensaries, Urban AAMs or Urban PHCs do not exist, and even if they do, they are not accessible to such populations. The MMU could also be deployed in slums and places where there is no space for creating fixed infrastructure.

States are expected to map the nature of diversity of their conditions and adopt the most suitable and sustainable model to suit their specific needs. Although the MMU services are required in hilly and tribal areas, and would continue in the present form, the states and districts need to plan for the operationalisation of public health facilities in those areas within the next 5 years. Once public health facilities are operationalised, the services of MMUs can be phased out in such areas. However, the MMUs can be continued for hilly & inaccessible areas.

2. SCOPE OF SERVICES TO BE PROVIDED BY MMU

An MMU is envisaged to saturate primary healthcare services in the unreached population, through:

1. Broader set of clinical services by a Medical Officer and a staff nurse / ANM. Specialist services as per requirement and feasibility. Specialists from CHC can accompany the MMU team on the day of health camp in the area.
2. Outreach services by MPWs in areas where no outreach services exist.
3. Community Health Education and awareness.
4. Facilitate referral to a functional secondary health care system and follow-up.

3. COVERAGE NORMS FOR DEPLOYMENT OF MMU

1. Mobile Medical Units need to provide services in hilly/inaccessible/remote/tribal/ hard-to-reach areas/ urban slums/ habitations of marginalised communities, which do not have public health facilities within a 5 km radius. MMUs need to cover each habitation/village at least twice a month and should have a minimum of 22 field days, conducting 22 to 44 health camps in a month. (Health camp at each location on one day to be counted separately, if more than one health camp is conducted).

   Based on these criteria, the States should map the existing healthcare facilities, identify the number of MMUs required and deploy the vehicles as per the need assessment in the respective district. Each MMU deployed, to be attached with the nearest CHC for route planning, efficient operation and monitoring. The earlier norm based on the density of population has been replaced by the above norm.

2. Deployment of MMU needs to be linked with the plan to operationalise public health facilities in those areas within the next 5 years.

3. States have also been specifically requested to provide MMUs, especially in areas inhabited by Particularly Vulnerable Tribal Groups (PVTGs), to provide a primary health care facility close to their habitations. MMUs are envisaged to provide healthcare services to all PVTG/Tribal habitations. Under PM-JANMAN and DA-JGUA, States can assign up to 10 MMUs per district (including existing MMUs) based on the needs of the district after rationalisation and redeployment of already existing MMUs in the district.

4. MMU services shall only be phased out from an area when the newly operationalised fixed facility (SHC-AAM or PHC-AAM) meets the following minimum criteria, sustained over 12 consecutive months:

   a. Availability of the full Human Resource complement as per IPHS norms.

   b. Availability of essential drugs and diagnostics as per the AAM list.

   c. Functional referral linkage and 24/7 service availability as per the facility type.

5. Asset Redeployment Plan: Upon official phase-out, the MMU vehicle and its equipment must be immediately redeployed to other identified underserved areas within the district or state.

4. TYPE OF SERVICE PROVIDED

1. Type of Service provided

   Mobile Medical Units are envisaged to provide primary care services for common communicable and non-communicable diseases, RMNCAH+N services, screening and referral linkage to appropriate higher facilities. The package of 12 essential healthcare services envisaged to be provided at MMUs are as follows:

   a. Care in Pregnancy and Childbirth

   b. Neonatal and Infant Health Care Services

   c. Childhood and Adolescent Health Care Services

   d. Family Planning, Contraceptive Services, and Other Reproductive Health Care Services

   e. Management of Communicable Diseases

   f. General Outpatient Care for Acute Simple Illnesses and Minor Ailments

   g. Screening, Prevention, Control, and Management of Non-Communicable Diseases

   h. Screening and Basic Management of Mental Health Ailments

   i. Basic Oral Health Care

   j. Care for Common Ophthalmic and ENT Problems

   k. Elderly and Palliative Health Care Services

   l. Emergency Medical Services

   (Please see **Annexure 1** for the set of services).

   The services provided shall be preventive, promotive, and outpatient curative care. Some curative services for common ophthalmic, ENT, dental, mental health, and geriatric health conditions are provided. Screening for common non-communicable diseases, including hypertension, diabetes, cancers, child immunisation, and palliative care, is included under the service provision of MMU. For specialised ophthalmic, ENT and dental services, mental health services and elderly & palliative care, patients could be referred to the nearest health centre equipped to give these services to the patients. Where there are cases needing acute medical care on the day the MMU reaches the site, such care could be provided, and patient referral organised.

13. In addition, the MMU is also expected to provide the following services:

a. Anthropometry: Height, Weight and other nutritional parameters.

b. Provide point of care diagnostics: Haemoglobin (Hb), Blood glucose, Pregnancy testing, Urine microscopy including albumin and sugar, Vision testing, Rapid Diagnostic Tests (RDT).

c. Collect sputum samples.

d. Screen populations over 30 years of age for hypertension, diabetes, and the common cancers annually . For diagnosed cases, line-listing, adequate referral and regular follow-ups during the monthly visits, including providing adequate supply of drugs to the patients.

e. Undertake context-specific IEC (Information Education Communication) sessions on a range of health topics.

f. Improve preventive and promotive behaviours for maternal and child health, communicable diseases, including vector-borne diseases, educate the community on lifestyle changes, screening for NCDs, for early recognition, timely management, appropriate referral and follow-up.

14. Tele-Health Integration

a. All MMUs shall be equipped with a functional tele-consultation platform (included in the required equipment list) to enable remote consultation with secondary or tertiary level specialists (e.g., Pediatricians, Gynecologists, General Surgeons) at least once per week.

b. The MO and Nurse are expected to use tele-health for follow-up of complex or referred cases to ensure post-referral adherence and management.

c. The operational plan must include mandatory training for MMU staff on using the tele-consultation equipment and protocols.

5. MODELS FOR THE RUNNING OF MMU

Capital investment by the states for the purchase of MMUs is discouraged, and the following models are supported:

1. In-house model, where the States will manage all the operations & monitoring, or
2. Outsourcing/PPP model, where the operations will be done by the outsourced agency and the overall monitoring and supervision will be done by the States. The States can explore the option of outsourcing the vehicle through Public-Private Partnership (PPP) with credible partners, which would follow the same norms and be accountable for a similar set of services and outcomes.
3. In both models, only operational cost (Opex) will be supported through NHM.
4. However, there can be case-to-case relaxations for NE and hilly states for the purchase of MMUs if, despite Expression of Interest (EOI) and tendering, there are no service providers willing to support the running of MMUs.

As per the 7th Mission Steering Group (MSG) recommendations, only a single vehicle MMU model would be supported through NHM.

6. MOBILE MEDICAL UNITS: VEHICULAR SPECIFICATIONS

1. The Ministry of Road Transport and Highways (MoRTH) has given AIS-125 standards for Ambulances. The vehicle size and the power envisaged for the MMU vehicle are supposed to be similar to those for the ambulances. Therefore, the vehicular design and other specifications for MMUs can be referred from the AIS-125 standards. However, the fabrication of the vehicle should be in accordance with the services envisaged by the MMU. Single vehicle outfitted as an outpatient clinic, with an examination table, necessary furniture, sufficient facilities for basic point of care lab investigations, immunisation and storage of drugs. The preferred wheelbase for the MMU vehicles can be 3350mm or higher. MMU vehicle should have enough space for all equipment installed in the vehicle and a necessary platform to be provided for the installation and fixing of equipment, and the movement of patients and staff. Mounting plates are to be fitted by the vehicle manufacturer for the installation of equipment. The guidelines for AIS-125 Standards can be accessed using the link below:

   https://morth.nic.in/ais?page=6

2. Global Positioning System (GPS): All MMUs, including PM-JANMAN MMUs, must be fully equipped with a GPS tracking system to enable the real-time monitoring of the MMUs. The Nodal Officer should monitor the real-time location of the vehicle during field days. The monthly support provided for MMUs includes the cost of the GPS tracking system. The GPS data should be regularly uploaded to the MMU portal.

3. States can request permission for flexibility from MoHFW for specialised vehicles for difficult terrains/geographies/inaccessible areas.

4. Scrappage of MMU vehicles: Ministry of Road Transport and Highways (MoRTH) has introduced the Voluntary Vehicle-Fleet Modernization Program (V-VMP)* also known as "Vehicle Scrapping Policy," aimed at promoting an environmental friendly ecosystem to phase out unfit and polluting vehicles. As part of this initiative, a network of Registered Vehicle Scrapping Facilities (RVSFs) has been established across the country to ensure safe and Eco-friendly disposal of these vehicles. Under this Policy, the MoRTH issued a notification (G.S.R. 29 (E) dated 16th January 2023), which mandates the non-renewal of the Certificate of Registration for Government vehicles older than 15 years. Such vehicles must be scrapped exclusively at Registered Vehicle Scrapping Facilities (RVSFs).

7. OPERATIONAL ASPECT OF MMU

1. **Nodal officer:** District Chief Medical Officer (CMO) or a nodal officer appointed by CMO at the district level will be responsible for the operational aspect of the MMU. The planning and dissemination of the MMU route map is the responsibility of the CMO, with support from the district team. The first step would involve mapping of the villages and village clusters that are inaccessible, underserved and do not have a health facility within a 5 km radius. The mapping should also identify referral sites that are the first point of referral for these inaccessible clusters. CMO/ Block Medical Officer/ Block Nodal Officer (BMO/BNO)/ District Nodal Officer (DNO) will provide the supportive supervision and review the functionalities of the MMUs.

2. **Route Map:** The District and Block Nodal Officers should map all the eligible villages, areas and habitation that need MMU services and prepare a route map covering each area twice a month, with a minimum of 22 days of health camps, conducting 22 to 44 health camps in a month. The route map of an MMU would be planned such that no eligible area/habitation/village is left out. The health camp site should be chosen in a way that serves a cluster of habitation/villages that are otherwise inaccessible. The MMU may choose a service site in villages with a weekly market/ haat or where people from nearby area/ village clusters tend to congregate. In urban areas, the MMU should be located in the slums, resettlement colonies/mohallas or localities occupied by the marginalised population. If possible, the services could be conducted in any adequate building with one or two rooms and toilets, such as an Anganwadi centre, Panchayat Bhavan, primary school or a community centre.

3. **Frequency of visit:** The frequency of the MMU visits must be at least twice a month on a pre-fixed date/day and time. Additional visits will depend upon local conditions such as all-weather roads, access conditions, terrain, and accessibility to the health facility. The community should be aware of the MMU route plan; any deviation in the planned schedule due to unforeseen circumstances should be informed in advance. Cancelled camp must be rescheduled and conducted on another feasible day with prior information to the target community, without disturbing other planned camps. For this, the district should make a monthly and yearly work plan for each MMU with a defined set of monitoring indicators (discussed later in the guidelines).

   Depending on distances, the MMU could make one visit a day to distant areas/ villages, planning for four hours of travel and about four to five hours on a given site. For shorter distances, additional habitations/villages could be covered, thus these need to be planned based on the local context. The principle is regularity, with every area being visited on the same frequency at a fixed date/day in each month and preceded by active mobilisation with a well-publicised monthly schedule of visits through loudspeakers, announcements, etc. MMUs should be functional 5 to 6 days a week, and a weekly off could be used for maintenance of vehicles, refilling supplies, data entry etc.

4. **Supporting Staff:** The Medical Officer in the nearest functional PHC-AAM will provide

support to the MMU team as required. Where there are functional SHC-AAM, the CHOs/ANMs would be available on the day of the MMU visit to provide support. The patient referrals should be made to the nearest PHC/CHC or DH. In case emergency care is needed, Ambulance services will be used, or the patient will be shifted to the nearest facility in MMU, depending on the terrain conditions.

5. **Local collaboration and coordination:** Adequate arrangements for the conduct of the camp and service delivery through MMUs should be made in coordination with the Gram Panchayat/ Community leader/ Influential persons/ Village Health Sanitation and Nutrition Committee (VHSNC). The ASHA and VHSNC would carry out the function of community mobilisation, ensuring that people who need services are informed of the MMU schedule in advance. They can also mobilise individuals eligible for screening of NCDs, those with communicable diseases or chronic conditions for follow-up medical examinations, pregnant women, women in need of family planning services, children in need of immunisation or medical care, follow-up of children discharged from secondary or tertiary care facilities, and those with acute medical conditions. MMUs must follow up with all the patients (on treatment or referred patients).

6. The MMU could also be used for natural or man-made calamities or in disaster situations and epidemics to provide services to the affected population.

7. The MMU must not be seen as a stand-alone service delivery option, but rather as a way of delivering primary care in remote, inaccessible areas, and for establishing a continuum of care with community-level and outreach care, as well as secondary and tertiary level care, by integrating into the public health care system.

8. Regular monitoring of not just the operational issues related to the MMU, but also the number of patients consulted, and types of service delivered must also be recorded to ensure that the MMU is actually serving the purpose and can achieve its objective (provide services for a larger number of people or comprehensive care to a smaller population who would otherwise not receive such care). Regular monitoring will also provide information on other unmet health needs that need to be addressed. The functioning of the MMUs in a district should be monitored regularly by the district and block nodal officers and be an essential part of the review by the head of the Zila Parishad/District Collector.

9. **Formal Convergence Protocol:** For example, Integration with ICDS - MMU visits must be formally scheduled to coincide with Village Health Nutrition Day (VHND) or ICDS Anganwadi functional days at least once a month to ensure maximum coverage for Maternal and Child Health (MCH) services, immunisation, and distribution/follow-up of Take Home Rations (THR). Joint Reporting - The MMU Medical Officer must hold a brief review meeting with the local ASHA and Anganwadi Worker (AWW) at the camp site to verify coverage and update line-lists (e.g., pregnant women, Severe Acute Malnutrition-SAM children, Non-Communicable Disease-NCD cases).

8. HUMAN RESOURCES

1. The suggested HR for an MMU is as follows:

S.No.	Human Resource	Number
1	Medical Officer (MO) (MBBS)	1
2	Staff Nurse / ANM	1
3	MPW (Multi-Purpose Worker)-Male	1
4	Driver-cum-Support Staff	1

2. The operating cost has been calculated on the assumption that MMU would have dedicated HR.

3. If recruited on a contractual basis, staff should receive additional benefits and hardship allowances (if any) in the districts (specifically tribal and LWE-affected) as per the State's policy. In case a medical officer or one of the staff is going on leave, a substitute officer could be appointed on those days. The state should try to minimise attrition of HR working in MMUs.

4. For the MMUs that the State government operates, staff should not be withdrawn from existing and functional facilities, which would adversely affect the functioning of the facility. The roles and responsibilities of the team members are in **Annexure 2.**

5. Staff from CHCs – such as specialists, dentists, counsellors can accompany the MMU team, as per requirements, and provide respective healthcare services.

9. DRUGS, DIAGNOSTICS AND SUPPLIES

1. The cost for the requisite drug and supply (Annexure 6) has been built into the OPEX. However, where States prefer to supply and refill the required drugs and supplies from the nearest facility/warehouse, in such cases, the cost indicated against this head shall be reduced from the OPEX. The list of drugs is given as **Annexure 5.**

2. All point-of-care laboratory investigations as envisaged under AAM-SHC for rendering primary care services are a part of the MMU guidelines. The list of the same is given **(Annexure 3).** The MMUs are also expected to collect samples for sputum, blood or suitable samples for fever, and other such samples of public health importance as and when required.

3. The list of equipment has also been revisited and synchronised with the services to be rendered by MMU. The list is in **Annexure 4.**

4. **All drugs and investigations should be provided free of cost to the beneficiaries.**

10. QUALITY OF CARE

1. The MMU services should meet the technical and service quality standards for at least SHC/PHC-AAM. Every patient is to be treated with respect and dignity, irrespective of gender, economic, cultural, or social status. The health data of the patients must be kept confidential. Patient privacy should be ensured during examination and procedures. Periodic feedback from patients is to be collected (like exit interviews in facilities) and analysed. The phone numbers on which the patients can lodge their complaints will be displayed on the MMU for grievance redressal. Doctor consultation/prescription papers to be provided to all patients coming to the OPD. Continuity of care should be ensured with the tentative date of the next visit to be mentioned on each prescription, along with the details of follow-up with ANM/ASHA, when needed. Chronic patients on regular long-term medications should be able to collect their monthly medications from the MMU. Standard Treatment Guidelines (STGs) must be available in MMUs, and adherence to STGs should be followed mandatorily. MMUs must have the pre-approved referral linkage protocols to public health facilities, and care should be taken to ensure that there is no conflict of interest or pecuniary gain in the way referrals are made.

2. VHSNC and other community-level structures should be actively involved in enabling orderly service delivery. Managing congestion and crowding should be undertaken by such community structures.

3. Meticulous record keeping, compilation and analysis of indicators to be done every month:

- Advance monthly and annual work plans of each MMU shall be prepared, approved and adequately displayed.
- MMUs to ensure creation of ABHA IDs of all beneficiaries. Patient records to be linked with ABHA ID for monitoring and continuum of care.
- A logbook shall be maintained by the MMU driver and supervised by the MMU Medical Officer. Logbook shall be available for verification by the district health society nominee.
- The recording of data related to patients, drugs and diagnostics should be uniform across the state and in accordance with the indicators of the MMU portal of the Government of India. Pre-printed registers to be provided by districts to all the MMUs for recording of data. The data recorded through MMUs should be provided to the nearest AAM (SHC/PHC) and included in the monthly reports of the block.
- The MMU shall adhere to all the provisions of the Motor Vehicle Acts and other applicable acts in this regard.
- In case of an outsourced vehicle, two days of downtime per month is permissible for servicing and maintenance of the vehicle. For all other off-road days, the

penalty clause shall be applicable as per the service level agreement.

- District Health Society will be responsible for parking the MMU vehicle. The vehicle should be parked in the public health facility as assigned by the district/block. The security of the vehicle and the logistics need to be taken care of while deciding on the parking area of MMU.
- Each MMU to be provided with one ABC-type fire extinguisher cylinder as per norms.

4. For MMUs operated via the In-house model (State government), a maximum of two days of off-road time per month is permissible for mandatory servicing, maintenance, and refilling of supplies, consistent with the norms for outsourced vehicles. The District CMO/Nodal officer is responsible for ensuring this maintenance is carried out and documented.
5. Quality Assurance and Clinical Audits. The District Health Society shall conduct a formal, unannounced Quality Assurance (QA) Checklist Audit of each MMU every quarter. The audit will verify clinical adherence to STGs, patient privacy protocols, availability of drugs/diagnostics, proper record-keeping (logbook/ registers), and cold chain maintenance. Findings resulting in non-compliance shall trigger time-bound corrective action and may result in penalties as defined in the Service Level Agreement (for outsourced MMUs)

11. MONITORING AND EVALUATION OF SERVICES

Regular monitoring of the MMU vehicle and the services provided by the MMU should be done by the MMU Nodal and at intervals at the level of CMO/BMO. Staff of attached CHC can also supervise/monitor the MMU whenever accompanied for MMU health camps and report findings to BMO. Based on the findings, a continuous improvement strategy should be adopted with proposed time-bound actions.

The data below, cross-verified by the MMU in charge, should be updated on the MMU portal of MoHFW regularly and periodically monitored by the concerned District and State authorities.

1. Number of MMUs in the District (Sanctioned & Operational).
2. MMU managed by the State Govt. /NGO /Private Provider.
3. If the State Govt operates MMU, is the HR dedicated to MMU or is the existing HR in facilities assigned to MMU?
4. Total number of habitations / villages / areas covered under MMU (with Line list).
5. Number of Villages/habitations visited, with route map.
6. Link with GPS for mobile tracking.
7. Number of trips in a month (22-25 trips/month that is field days, conducting 22 to 44 health camps in a month).
8. Number of cases seen monthly, category-wise, e.g. ANC/PNC, children immunised, FP services provided, patients with HTN/Diabetes, Other categories, followed up, etc., (at least 40 OPD cases/day/trip).
9. No. of Lab tests by MMU (at least 20 tests/day).
10. No. of blood smears collected/RDT tests done for Malaria.
11. No. of the sputum samples collected for TB detection per month by MMU.
12. Number of patients referred and followed up after back referral to higher facilities.

12. GRIEVANCE REDRESSAL

An effective Grievance Redressal System (GRS) for MMUs must be integrated with the GRS of the linked health facility. The districts can use existing GRS platforms (112) for receiving and resolving complaints. The grievance redressal mechanism should be displayed on each MMU, with contact details of the Nodal Officers. In addition to the official GRS platform, a **dedicated, multi-lingual local helpline number** (operated at the Block/District level) must be clearly displayed on the exterior of the MMU to facilitate easier complaint lodging by marginalised and low-literacy communities. The nodal officer must ensure the timely resolution of such complaints.

13. FINANCING

The revised guidelines only give financial support to single vehicle MMU on an In-house (state-operated) or an outsourcing basis. The OPEX cost per month is up to ₹1,98,700; the OPEX cost, including Management Cost, per month is up to ₹2,28,505. This cost includes the cost of Human resource salaries, POL (Petrol, Oil, Lubricants), maintenance of vehicles, GPS tracking charges, Drugs and Diagnostic costs.

Revised cost norms for single vehicle MMU

Cost	Revised Financial norms (for single vehicle)
Monthly OPEX	Up to ₹1,98,700
Monthly OPEX (including 15% Management Cost)	Up to ₹2,28,505

For North-East/hilly areas where vendors are not available, even after flouting the tender thrice, capital expenditure for procuring an MMU vehicle (in installments) may be supported on a case-by-case basis.

14. UNIFORM COLOUR CODING AND BRANDING OF MMU

1. Under the National Health Mission, a universal name 'National Mobile Medical Unit' along with the colour coding has been prescribed. Adoption of a universal nomenclature with a common colour scheme and design is intended to enhance its visibility and create better awareness amongst the target population.

Figure: Illustration of branding

2. Branding of the MMUs is an important initiative. The MMUs can be branded like the National Ambulance Services, which are clearly visible. This will help in generating awareness and better utilisation by the population in need.

ANNEXURE 1 - SERVICE PACKAGE IN MMUS

Service package in MMUs		
1	Care in Pregnancy and Childbirth	Early diagnosis of pregnancy, early registration, MCH cards, birth planning (and preparing mothers and families in remote areas to shift to a facility at least one week before the due date, or to a Birth Waiting Home), regular Ante-natal check-ups, including screening for hypertension, diabetes, anaemia, TT immunisation for mother, iron-folic acid & calcium supplementation, identification and referral of high-risk pregnancy, post-natal care, counselling, support and motivation for institutional delivery, nutrition, enabling Take Home Rations (THR) for pregnant woman through Anganwadi worker.
2	Neonatal and Infant Health (0 to 1 year old)	Examination of low birth weight/preterm newborn/ other high risk newborns and management or referral as required, counselling and support for early breastfeeding, improved weaning practices, identification of congenital anomalies, other disabilities and appropriate referral, family/community education on prevention of infections, timely & complete immunisation, vitamin A supplementation, care of common illnesses in newborns, AGE with mild dehydration, pneumonia case management.
3	Child and Adolescent Health	Growth monitoring, prevention through IYCF counselling, access to food supplementation – convergence with ICDS, deworming, immunisation, prompt and appropriate treatment of diarrhoea/ ARI, referral where needed, detection of Severe Acute Malnutrition (SAM), referral and follow up care for SAM, prevention & management of anaemia, use of iodised salt, prevention of diarrhoea, for pre-school and school-going child: biannual screening, school health records, eye care, de-worming; early detection of growth abnormalities, , delays in development and disability, adolescent health services: personal hygiene, detection and treatment of anaemia and other deficiencies in children and adolescents, immunisation for JE (in endemic areas).

Service package in MMUs		
4	Family Planning, Contraceptive Services, and Other Reproductive Health Care Services	Identifying eligible couples, and motivating for family planning – delaying first child, spacing between two children, access to spacing methods – OCP, ECP, condoms, IUCD insertion and removal, RTI/STI treatment – syndromic management/partner treatment, first aid for GBV – link to referral centre and legal support centre.
5	Management of chronic communicable diseases.	Tuberculosis, HIV, leprosy, malaria, kala-Azar, filaria-sis, other vector-borne disease identification, use of RDT/prompt treatment initiation, vector control mea-sures, sputum collection for TB, RDK + lab testing and treatment for all vector-borne disease examination, follow-up medication compliance, prevention – mass drug administration in filaria.
6	Management of Common Communicable Diseases & Basic OPD care (acute illness)	Diagnosis and management of common fevers, ARIs and diarrhoeas, Urinary Tract Infections, and skin in-fections. (scabies, abscess), indigestion, acute gas-tritis. Symptomatic care for aches and pains
7	Screening, Prevention, Control, and Management of Non-Communicable Diseases	Undertake screening for over-30 age group at MMU on regular basis at least once an year and/or opportunistic screening for diabetes, hypertension and common cancers; hypertension/diabetes mellitus – medication, follow up diagnostics, refer for specialist consultation time to time and early referral for complications, Silicosis, Fluorosis – follow-up care, diagnosis of common respiratory morbidities (COPD and bronchial asthma) and treatment in all "chest symptomatic", epilepsy- early case identification, enable specialist consultation through referral.
8	Management of Common Mental Illness	Community education for preventive measures against tobacco and substance abuse, identification of people needing support and referral to de-addiction centres, two-way timely referral of cases with mental illness, follow-up medication, counselling/support.
9	Basic Oral Health Care	Education on oral hygiene and prevention of substance abuse in the community and schools, prevention and management of common dental problems, including dental caries, treatment for glossitis, candidiasis, fever blisters, aphthous ulcers, identification and referral of patients for conditions like dental fluorosis - gingivitis, oral cancers, etc.

Service package in MMUs		
10	Care for Common Ophthalmic and ENT Problems	**EYE CARE:** School: screening for blindness and refractive errors; Community: screening for congenital disorders and referral, counselling, support and management of preventable blindness and other eye related problems, eye care in newborn, screening for visual acuity, cataract and for refractive errors, identification and treatment of common eye problems – conjunctivitis, spring catarrh, xerophthalmia, first aid for injuries, referral. **ENT:** First aid for nosebleeds, recognising congenital deafness, other common ENT conditions and referral, management of common cold, Acute Suppurative Otitis Media (ASOM), injuries, pharyngitis, laryngitis, rhinitis, URI, sinusitis
11	Elderly care	Management of common geriatric ailments such as NCDs, age-related illnesses, counselling and support for mental health, and pain management for musculoskeletal problems
12	Emergency Medical Services	Snake bites, scorpion stings, insect bites, dog bites, stabilisation care in poisoning, pain management and first aid before referral, trauma of any cause, minor injury, abscess management, acute chest pain, acute gastrointestinal conditions

ANNEXURE 2 – DUTIES AND RESPONSIBILITIES OF STAFF IN MMU

Cost	Revised Financial norms (for single vehicle)
Monthly OPEX	Up to ₹1,98,700
Monthly OPEX (including 15% Management Cost)	Up to ₹2,28,505

The suggested HR for an MMU is as follows:

S.No.	Human Resource	Number
1	Medical Officer (MO) (MBBS)	1
2	Staff Nurse / ANM	1
3	MPW (Multi Purpose Worker)	1
4	Driver-cum-Support Staff	1

1. Medical Officer

a. MO will be in charge and responsible for the effective functioning of the MMU. The other staff of the MMU will work under their supervision.

b. MO will provide clinical services to the patients and supervise the work of subordinate staff, including recording and reporting of data.

c. In case of referral to the nearest facility, the MO shall maintain suitable records (address and the cause of emergency in the register and logbook of the vehicle) and issue a clear descriptive referral slip. MO and MO i/c of the PHC shall take immediate appropriate actions during outbreaks of diseases and epidemics and inform the concerned DHO and RCH officer, as well as render assistance as required and feasible.

d. MO shall work in collaboration with the MO i/c of the nearest/linked PHC under whose area services are being rendered.

e. MO shall work in coordination with the health staff of the department, local authorities, VHSNC, etc.

f. MO is responsible for the conduct of health awareness sessions, including preventive healthcare.

2. Staff Nurse / ANM

a. To assist the MO of the MMU in providing the health care services as listed.

b. To conduct immunisation as per UIP and maintain the cold chain for vaccines.

c. To maintain all records and help MO in reporting data daily in MMU portal.

d. To maintain all adequate stock, inventory, and issue registers.

e. To dispense the medicines to the patients prescribed by the MO in the MMU.

f. To draw blood samples for laboratory tests of patients.

g. To take appropriate action for biomedical waste management with the MO.

h. To carry out all other tasks as ordered by the MO of the MMU.

3. MPW

a. To carry out outreach activities, including HBNC, and family planning services.

b. To coordinate with ASHAs and the mobilisation of the community including children requiring immunisation.

c. To assist MO in conduction of community health awareness sessions (IEC)

d. To assist the Staff Nurse/ANM in maintaining all adequate stock, inventory, and issue registers.

e. To carry out the POC diagnostic tests.

f. To maintain the cleanliness and sanitation inside the MMU.

g. To set up and dismantle the OPDs when conducted outside the vehicle.

h. To assist the Staff Nurse / ANM in carrying logistics during outreach activities.

i. To assist the staff nurse / ANM in biomedical waste management.

j. To carry out all other tasks as ordered by the MO of the MMU.

4. Role of ASHAs in VHSNC in MMUs

a. Generate awareness regarding the availability of MMU, including date and timing of visit, services provided and frequency of visit.

b. Mobilisation through home visits and VHSNC meetings.

c. Disseminate IEC in coordination with the MMU staff and ANM/AWW.

d. Identify community groups/patients who would particularly benefit from the services of MMU.

e. It is important for ASHAs to have clarity on how to assist the service user to choose

between SHC-AAM/PHC/MMU as the site of referral based on what the referral is for, where there is greater assurance of service, and which is more convenient to access.

f. To undertake preliminary screening or bring in suspected cases of chronic diseases, e.g., TB, blindness, HIV, leprosy, diabetes, hypertension, asthma, epilepsy, childhood disability, severe malnutrition.

g. To ensure regular follow-up of patients who are on long-term treatment for chronic diseases.

h. To enable easy access to referral services in emergency cases.

i. ASHA should coordinate with VHSNC to organise village-level activities of the MMU visit.

j. VHSNC members should help ASHAs/ANMs in the mobilisation of patients to access services from MMU.

5. Role of Driver in MMUs:

a. To maintain the general condition and functionality of the vehicle and ensure cleanliness.

b. Maintain a logbook of driving assignments for each trip to record each transport officially, noting patient name, address, travel time, mileage and service performed.

c. Maintain a professional, pleasant, and polite demeanour to all contacts while on duty.

d. Any other duties as assigned by the medical officer.

ANNEXURE 3 – DIAGNOSTIC SERVICES TO BE PROVIDED IN MMU

S.No	Tests	Equipment Required for Testing
1	Haemoglobin	Digital Haemoglobinometer
2	HCG (Urine Test for Pregnancy)	Rapid Card test (Dip stick)
3	Urine Test for pH, Specific gravity, Leukocyte esterase, glucose, bilirubin, urobilinogen, ketone, haemoglobin, protein, nitrate	Multiparameter urine strip (dipstick)
4	Blood Sugar	Glucometer
5	Malaria Test	Rapid Card test
6	HIV (Antibodies to HIV 1 & 2)	Rapid card test
7	Dengue	Rapid card test for NS1 antigen and IgM antibody
8	Visual Inspection-Acetic acid for Cervical Cancer	To be referred to the nearest centre
9	Test for Iodine in food (used for food)	Iodine in Salt testing kit
10	Syphilis	Rapid kit-based
11	HbsAg test for Hepatitis B	Rapid kit-based
12	Sputum for AFB (Sample collection only)	Sample collected and transported to the nearest referral facility
13	Sickle Cell Disease	Rapid kit-based
14	Locally endemic disease (Eg, Filariasis)	Varies based on disease

ANNEXURE 4 – LIST OF MEDICAL EQUIPMENT AND INSTRUMENTS FOR MMU

S. No	List of Equipment as per MMU guidelines	Quantity for MMU
1	Steriliser 38 cm with electric drums	1
2	Dressing Drum (11x9)	2
3	Weighing Machines Adults Simple	1
4	Weighing Machines Infant Simple	1
5	Stethoscope	2
6	B.P. Apparatus	2
7	Haemoglobin meter (Manual & digital)	1
8	Nebulizer	1
9	Ambu bag Adult	2
10	Ambu bag Paediatric	2
11	Suction apparatus with accessories	1
12	Spotlight	1
13	Glucometer	1
14	Refrigerator (capacity 50 to 60 litres)	1
15	Needle cutter (manually operated)	1
16	Laboratory table- Portable	1
17	Computer- laptop preferred	1
18	Laser Printer	1
19	Broadband Internet Data Card	1
20	Foldable Half Bench	2
21	Foldable seats for staff	4
22	Waste collecting bins, as per Biomedical Waste Management specifications	1 each
23	Stool	4
24	Cot	1
25	Examination table	1

S. No	List of Equipment as per MMU guidelines	Quantity for MMU
26	Oxygen Cylinder (with provision to keep - 2 brackets and adjustable straps)	1
27	Detachable stretcher	1
28	Hooks for an intravenous bottle	4
29	Chairs	5
30	Generator	1
31	AC Fan	1
32	Transfusion Bottle Hook	2
33	12 Lead ECG Machine	1
34	Fire Extinguisher	1
35	View Box	1
36	Digital clock	1
37	Height Measurement Instrument	1
38	Stainless Steel Cabinet	3
39	Water Storage Tank	1
40	Extension box	2
41	Screen (for privacy)	2
42	Emergency light	2
43	Soap Container	3
44	Towel Holder	2
45	Test Tubes	1
46	Otoscope	1
47	Examination torch	2
48	Ophthalmoscope	1
49	Portable X-ray	1
50	TRUENAT Machine	1
51	Laryngoscope (Adult)	1
52	Laryngoscope (Child)	1
53	LCD TV with provision for pen drive	1

ANNEXURE 5 - LIST OF DRUGS AND CONSUMABLES

Type of medicine	Name of medicine/consumables
Anaesthetic Agents	1. Oxygen gas for inhalation 2. Lignocaine Topical form 5% (Plain Lignocaine Injection can be kept at SC if enough case load is there)
Analgesics, antipyretics, non-steroidal anti-inflammatory medicines, medicines used to treat gout and disease-modifying agents used in rheumatoid disorders	1. Aspirin (Acetylsalicylic acid) Tablet 75 mg (Not to be used in suspected dengue patients and other clinical conditions without prescription) 2. Diclofenac Tablet 50 mg Diclofenac Injection 25 mg/ml 3. Ibuprofen Tablet 200 mg (Not to be used in suspected dengue patients and other clinical conditions without prescription) 4. Paracetamol tablet 250 mg, Paracetamol Syrup 125 mg/5 ml, Paracetamol Syrup 250 mg/5 ml
Anti-allergens and medicines used in anaphylaxis	1. Levocetirizine 5 mg Tablet Levocetirizine Oral Liquid 2. Hydrocortisone Succinate Injection 100 mg 3. Pheniramine Injection 22.75 mg/ml 4. Adrenaline Injection 1mg/ml (Should be part of all emergency drugs) 5. Prednisolone Tablet
Antidotes and other substances used in poisoning	1. Atropine Injection 1 mg/ml (Ampoules should be made available) 2. Activated Charcoal 3. Inj. Anti-Snake Venom serum
Anti-convulsant/ Anti-epileptic/ Anti-psychotic	1. Magnesium Sulfate Injection (50% solution), 2 ml ampoule 2. Diazepam Tablet 5 mg Diazepam Tablet 10 mg Diazepam rectal suppository* (Controlled medicine) 3. Midazolam Nasal Spray* (For emergency purposes) 4. Phenobarbitone Tablet 30 mg Phenobarbitone Tablet 60 mg Phenobarbitone Oral liquid 20 mg/5 ml 17 Phenytoin Tablet 50 mg Phenytoin Tablet 300 mg

Type of medicine	Name of medicine/consumables
	5. Sodium valproate Tablet 200 mg Sodium valproate Tablet 500 mg Sodium valproate Syrup each 5 ml contains 200 mg
Intestinal Anthelmintics	1. Albendazole Tablet 400 mg Albendazole Oral liquid 200 mg/5 ml
Anti-filarial	1. Diethylcarbamazine Tablet 100 mg Diethylcarbamazine Oral liquid 120 mg/5 ml
Anti-bacterial	1. Amoxicillin Capsule 250 mg, Amoxicillin Capsule 500 mg, Amoxicillin Oral liquid 250 mg/5 ml, Amoxicillin Dispersible Tablet 250 mg 2. Gentamicin Injection 10 mg/ml Gentamicin Injection 80 mg/m 3. Tab Co-trimoxazole [Sulphamethoxazole 80 mg +Trimethoprim 400 mg] Tab. 20 mg trimethoprim + 100 mg sulphamethoxazole Co-trimoxazole Oral Liquid [Sulphamethoxazole 200 mg + Trimethoprim 40 mg/5 ml] 4. Doxycycline Capsule 100 mg 5. Metronidazole Tablet 200 mg Metronidazole Tablet 400 mg 6. Norfloxacin tab/ oral Liquid 7. Ciprofloxacin + Tinidazole tab 8. Framycetin sulphate (Ointment)
Anti-leprosy medicines	1. As per Program Guidelines (Adults and Paediatrics)
Anti-tuberculosis medicines	1. As per Program Guidelines (Adults and Paediatrics)
Anti-fungal medicines	1. Clotrimazole Ointment Clotrimazole Cream 1% Clotrimazole Vaginal Tablet Clotrimazole Drops 1% Clotrimazole Oral Solution 2. Miconazole Ointment 3. Fluconazole 150 mg Tablet
Anti-malarial medicines	1. As Per Program Guidelines (Adults and Paediatrics)
Medicines used in Palliative care	1. Lactulose Oral liquid 10 g/15 ml 2. Povidone Iodine Lotion and Ointment

Type of medicine	Name of medicine/consumables
Anti-anaemic medicines	1. Ferrous salt 100 mg + Folic acid 500 mcg Tablet Ferrous salt 20 mg + Folic acid 100 mcg Table Ferrous salt 60 mg + Folic acid 500 mcg Table Ferrous salt 45 mg + Folic acid 100 mcg Table Ferrous sulphate + Folic acid Syrup 2. Folic acid Tablet 5 mg Folic acid Tablet 400 mcg 3. Vitamin K Injection 1 mg/ml
Cardiovascular medicines (Medicines used in angina)	1. Isosorbide-5-mononitrate Tablet 5 mg 2. Atenolol Tablet 50 mg 3. Metoprolol Tablet 25 mg Metoprolol SR Tablet 25 mg 4. Isosorbide dinitrate Tablet 5 mg (Sublingual)
Anti-hypertensive medicines	1. Amlodipine Tablet 2.5 mg Amlodipine Tablet 5 mg 2. Enalapril Tablet 5 mg 3. Telmisartan Tablet 40 mg 4. Hydrochlorothiazide Tablet 12.5 mg Hydrochlorothiazide Tablet 25 mg
Hypolipidemic medicines	1. Atorvastatin Tablet 10 mg
Medicines used in Dementia	1. Alprazolam Tablet 0.25 mg Alprazolam Tablet 0.5 mg
Dermatological medicines (Topical)	1. Silver sulphadiazine Cream 1% 2. Betamethasone Cream 0.05% 3. Calamine Lotion 51 Benzyl benzoate ointment/ lotion 4. Mupirocin (anti-bacterial cream) 5. Potassium Permanganate 0.1% 6. Zinc Oxide Cream 10%
Disinfectants and antiseptics	1. Ethyl alcohol (Denatured) Solution 70% 2. Hydrogen peroxide Solution 6% 3. Methylrosanilinium chloride (Gentian Violet) 4. Bleaching powder containing not less than 30% w/w of available chlorine (as per I.P) 5. Gama Benzene Hexachloride
Ear, nose and throat medicines	1. Ciprofloxacin Drops 0.3 % Ciprofloxacin Tablet 250 mg Ciprofloxacin Tablet 500 mg 2. Boro-Spirit ear drop 3. Ear wax solvent drops (combination of Benzocaine, Chlorbutol, Paradichlorobenzene and Turpentine Oil)

Type of medicine	Name of medicine/consumables
Gastrointestinal medicines	1. Ranitidine Tablet 150 mg Ranitidine Injection 2. Omeprazole capsule 20 mg 3. Ondansetron Tablet 4 mg Ondansetron Oral liquid 2 mg/5 ml Ondansetron Injection 2 mg/ml 4. Ispaghula Granules/ Husk/ Powder (Herbal Medicine) 5. Oral rehydration salts (ORS) 6. Zinc sulphate Dispersible Tablet 20 mg Zinc Sulphate Syrup 7. Dicyclomine Tablet 10 mg Dicyclomine Injection 8. Dioctyl sulfosuccinate sodium 9. Magnesium Hydroxide liquid 10. Senna Powder (Herbal Medicine) 11. Domperidone Tablet Domperidone Syrup
Contraceptives	1. Ethinylestradiol (A) + Levonorgestrel Tablet 0.03 mg (A) + 0.15 mg (B) 2. Male Condom 3. Ormeloxifene Tablet 30mg 4. Emergency contraceptive Pill Levonorgestrel 1.5 mg 5. Medroxyprogesterone Acetate Injection 150 mg 6. FP Commodities: Pregnancy Test Kit
Medicines used in Diabetes Mellitus	1. Glimepiride Tablet 2 mg 2. Metformin Tablet 500 mg Metformin SR Tablet 500 mg 3. Glibenclamide Tablet 2.5 mg/ Glibenclamide Tablet 5 mg
Thyroid and Anti-thyroid medicines	1. Levothyroxine Tablet 25 mcg Levothyroxine Tablet 50 mcg Levothyroxine Tablet 100 mcg
Vaccines	1. As per the Current National Programme Guidelines 2. Rabies vaccine 3. Inj. Tetanus Toxoid
Oxytocics & Abortifacient Medicine	1. Misoprostol Tablet 200 mcg (Should be used with caution)

Type of medicine	Name of medicine/consumables
Medicines acting on the respiratory tract	1. Budesonide Respirator solution for use in a nebuliser 0.5 mg/ml (Nebuliser Essential) 2. Salbutamol Tablet 2 mg Salbutamol Oral liquid 2 mg/5 ml Salbutamol Respirator solution for use in nebuliser 5mg/ml (Nebuliser Essential) 3. Normal Saline Drops 4. Dextromethorphan oral Syrup 5. Hyoscine butyl bromide Tablet 10 mg 6. Etofyllin B Plus (A), Anhydrous Theophylline IP (B) combination injection 84.7 mg/ml (A) + 25.3 mg/ml (B)
Solutions correcting water, electrolyte disturbances and acid-base disturbances	1. Ringer's Lactate Injection 2. Sodium chloride injection 0.9% 3. Dextrose 5% Dextrose 2
Vitamins and minerals	1. Ascorbic acid (Vitamin C) Tablet 100 mg 2. Calcium Carbonate Tablet 500 mg 3. Cholecalciferol Tablet 60000 IU 4. Pyridoxine Tablet 25 mg Pyridoxine Tablet 50 mg Pyridoxine Tablet 100 mg 5. Vitamin A Oral liquid 100000 IU/ml 6. Vitamin B Complex Tablet 7. Inj. Calcium Gluconate 10% 8. Inj. Iron Sucrose
Ophthalmological Medicines	1. Sodium Cromoglycate 2% Eye Drop 2. Methylcellulose eye drops
Diuretics	1. Furosemide Injection (Lasix) Furosemide Tablet 40 mg
Other Consumables	1. Surgical gloves 2. Scalp Vein set 3. Kidney tray (Plastic) 12" 4. Scalpel Blade 5. Cotton roll 500gm 6. Rolled bandages 7. Paper Adhesive tape 8. Elastic crepe bandages, non-sterile-10 cm 9. Sterile water for injection 10. Disposable Syringes- 2cc, 5cc 11. IV set 12. Disposable Needle-22G, 24G, 23G

ANNEXURE 6 - DETAILS OF COSTING

Human Resource	Number	Costing as per MMU operational guideline 2015	Costing as per Revised OG on MMU 2022
Doctor	1	40000 (MBBS)	60,000 (MBBS)
Nurse / ANM	1	15000 (Pharmacist)	30000 (20000 FOR ANM)
MPW (Multi-Purpose Worker)	1	15000 (Lab Technician)	13000
Driver cum Support Staff	1	10000	13000
POL	-	15000	15000
Maintenance of Vehicle, including Servicing, Insurance, Road taxes, Tyres, Batteries, etc	-	20000	10000
GPS tracking charges	1	0	200
Diagnostic Recurring	-	0	32500
Drugs	1	25000	25000
TOTAL		**155000**	**198700**

*The operational cost (OPEX) allocated for Human Resources shall include a provision for a **Hardship Allowance** for staff dedicated to MMUs operating in high-priority difficult areas (e.g., LWE-affected, PVTGs, remote hilly/desert locations). This is designed to minimise attrition and compensate for challenging working conditions.*

ANNEXURE 7 – SAMPLE SERVICE LEVEL AGREEMENT

No .....

SERVICE LEVEL AGREEMENT

Between

.....

(MMU Service Procuring Agency (MMUSPA)

AND

.....

(Service Provider)

To maintain and operate the Mobile Medical Units (MMU) infrastructure to provide primary healthcare in identified regions.

Sample Service Level Agreement

DECLARATION BY SERVICE PROVIDER

1. BACKGROUND

1.1 <NAME OF THE MMUSPA> herein after referred to as MMUSPA (MMU Service Procuring Agency) desirous of outsourcing the services relating to operation of Mobile Medical Units in <name of the identified region> had invited tenders from eligible bidders vide Tender Enquiry (TE) No _____ dated _____. <Name of the Service Provider>, having submitted his bid in response to the tender enquiry and having been found technically qualified as per the conditions in the same TE, has been awarded the agreement by the competent authority in the <MMUSPA>.

<Name of the Service Provider> has also performed the required obligations after the award of the agreement was communicated to him.

1.2 Both <Name of the MMUSPA> and <Name of the Service Provider>, herein after referred to as Service Provider, hereby willingly enter into this agreement and agree to abide by all obligations enjoined on them by this agreement.

2. SERVICE AIMS

2.1 The primary obligation of the Service provider will be to procure, deploy, operate, maintain, manage and monitor the Mobile Medical Unit(s) to provide primary health care, ensuring that such MMU:

- Is fully equipped with equipment and instruments listed in "Annexure 3" of the Service Agreement list;
- Is manned by adequate workforce resources as per the requirements enumerated in "Annexure 1" of the Service agreement list.
- Is provided with the essential diagnostics and medicines as provided in Annexure 2 and Annexure 4, respectively. Supplies of good quality shall be ensured within 3 days of requisitions.

2.2 The Service Provider categorically states that if he avails of any loan to procure, lease or hire purchase vehicles from any Banks, financial institutions, other agencies or individuals, he will not make the MMUSPA a party in any manner in such transaction nor will use this agreement as a guarantee of any manner nor will use future revenue expected to him from this agreement to hypothecate such procurement of vehicles.

3. SERVICE DESCRIPTION AND RESPONSIBILITIES

Outpatient services:

3.1 The Mobile Medical Units will provide only outpatient services. These units will function as mobile clinics and are not meant to transport patients.

3.2 The Service provider shall follow the Service Plan/Route plan/Calendar for MMU as approved by the District Health officer/CMO and accordingly make the services of the MMU available at the desired spot on the appointed days.

3.3 The Service Provider shall provide primary health care as per the standard operating procedures approved by the Service procuring agency.

3.4 The Service provider hereby agrees that the Mobile Medical Unit must always operate under the supervision of a qualified Medical Officer. The Service provider further agrees that at any time and under any circumstances, patient care would not be carried out by unauthorised personnel.

3.5 Service provider agrees that failure to adhere to the Service Plan/Route Plan/ Calendar referred to Paragraph 3.2 above would constitute a variation in terms of Paragraph 11.1 of this Agreement and a default of an obligation in terms of Paragraph 14.2 of this Agreement.

Service Component:

3.6 A qualified Medical Officer will clinically lead the service at the MMU. Patients will have access to primary and selective clinical management by a qualified Medical Officer. The other personnel deployed in the MMUs must also be well-qualified and trained for the duties assigned.

3.7 Ailments which shall not normally require further referral/ specialist care will be treated at the MMU only. Patients will be treated and provided with drugs free of cost. No charges of any kind will be recovered from the patients.

4. REFERRAL PROCESS & ELIGIBILITY

4.1 It will be the responsibility of <Name of the MMUSPA> to provide the Service provider with an "information matrix" for the nearest facilities, including their capacity in terms of existing Laboratory services, diagnostic services, and human resources available.

4.2 It will be the responsibility of the Service Provider to keep the Medical Officer(s) in charge of the MMU informed of the information matrix. For services not available at the MMU, patients can be referred to the nearest facility in accordance with the "information matrix".

4.3 Both parties hereby agree that no patient will be referred to any private medical establishment, either formally or informally, without specific prior approval of the <Name of the MMUSPA>.

5. INFORMATION AND REPORTING REQUIREMENTS

5.1 The Service provider shall ensure that information, records and documentation necessary to monitor the agreement are maintained and are available at all times to the <Name of the MMUSPA> or its authorised representative. The Service Provider hereby agrees that he and all his staff shall at all times co-operate with the reasonable processes of the Service procuring agency for the monitoring,

evaluation and carrying out quality audit and financial audit by any third party authorised by <Name of the MMUSPA>.

5.2 The Service provider hereby agrees to maintain all relevant data and records of all patients treated at the MMU.

5.3 The Service provider further agrees to maintain the confidentiality of these data and records and commits that such data and records will not be shared with any third party for any purpose.

5.4 The Service provider agrees to provide data to <Name of the MMUSPA> as per the reporting format provided by the MMUSPA every month. Failure to do so may entail cancellation of the agreement.

5.5 The Service provider hereby agrees to maintain a logbook showing all movements of the MMU vehicle and keep a record of the consumption of POL. The logbook should be maintained as per the format in vogue in any government office. Logbook shall be made available for verification by any authority nominated by the Service procuring agency.

5.6 The Service provider agrees that the MMU vehicles will not be used to advertise any product or organisation, including the Service provider's own branding. The branding needs to be ensured as per the guidelines given by the State Government/ Government of India.

5.7 The Service provider agrees to display copies of this agreement, a list of medical equipment available with the MMU, stocks of drugs and consumables, patient rights and important Information Education Communication (IEC) materials at a prominent place in the MMU. The names of the Medical Officer and other personnel on duty must also be displayed during duty hours.

5.8 The service provider must also ensure that the records about the training of the deployed personnel are timely shared with the service procuring agency.

6. PERFORMANCE

6.1 A quarterly review meeting will be held and attended by appropriate levels of officials of the Service procuring agency and the Service providers to consider the performance, the anticipated outcome of the agreement and future service developments and changes. Further meetings may be arranged at any time to consider significant variation in the terms or conduct of the agreement, and where corrective action on either party is indicated.

Both the Service procuring agency and Service Provider agree to consider the introduction of any further service in line with any new initiative of the government or in response to local demand, which could not be anticipated earlier.

6.2 Both the Service procuring agency and Service Provider agree that such services should be provided without extra cost. However, if it is felt by both parties that the additional services would require additional resources/workforce, the Service procuring agency agrees to consider reasonable increases in the amount

disbursed to the Service provider.

7. HEALTH AND SAFETY

7.1 The Service Provider agrees to adequately train, instruct and supervise staff to ensure, as is reasonably practicable, the health and safety of all persons who may be affected by the services provided under the agreement. The service provider will also ensure sensitivity to the social and cultural needs of the beneficiaries.

7.2 The Service provider agrees that he will collect periodic feedback from the patients through a structured questionnaire at his cost. The periodicity will not be less than once every three months. Responses to the questionnaire will be submitted in the original to the Service procuring agency. Telephone numbers where patients can lodge their complaints will be displayed on MMU.

8. DATA PROTECTION, CONFIDENTIALITY AND RECORD KEEPING

8.1 All Service users have a right to privacy, and therefore, all information and knowledge relating to them and their circumstances must be treated as confidential. The Service Provider must advise all staff on the importance of maintaining confidentiality and implement procedures which ensure that the Service User's affairs are only discussed with relevant people and agencies.

8.2 The Service Provider shall comply with all legislation that would otherwise have been applicable had the services been run directly by the Government agencies.

9. STAFFING

9.1 The Service provider will ensure that it always has sufficient suitably trained staff to ensure that services comply with all the statutory requirements and meet patient needs.

9.2 The Service provider agrees that he will ensure that a minimum complement of staff mentioned at Annexure 1 of this Agreement would be in position in each MMU.

9.3 The Service provider agrees that a record of qualifications shall be maintained by the provider and available for inspection.

9.4 The Service provider hereby expresses his commitment to training and staff development and the maintenance of professional knowledge and competence.

10. FINANCE ARRANGEMENTS

10.1 Both parties agree that the payment arrangements as quoted by the Service provider in his bid against the above-mentioned tender enquiry and/or subsequent bid submitted by him as a result of negotiations shall be adhered to.

10.2 It is agreed that payments will be made every month. To facilitate this, the

Service provider will submit invoices with all documents in support of their claims on the last working day of the month. Based on such invoices, the Service procuring agency agrees to provisionally transfer the amount electronically to the Service provider's bank account with respect to the attainment of key performance indicators prescribed by the Service procuring agency. The Service procuring agency has the right to impose a penalty if any/all of the key performance indicators/services are not complied with by the service provider as per the norms agreed upon by the two parties.

10.3 The Service procuring agency or any other agency, as per existing rules of the government, will have the right to examine the invoices as required under relevant rules. If such an examination reveals any extra payment already provisionally made, the extra amount will be adjusted from the next payment due to the Service provider under intimation to him.

10.4 In case the last day of the month is a holiday, as a result of which invoices cannot be submitted, the Service procuring agency agrees to make payment of an equivalent amount of the last invoice submitted. An additional amount, if any, based on actual invoices submitted later and examination thereof, will be adjusted from subsequent payments under intimation to the Service provider.

10.5 The Service provider hereby agrees to maintain all required books of accounts and agrees to provide them to such audit as may be required to be carried out.

10.6 The Service provider hereby agrees that the Service procuring agency will deduct from all payments such amount of statutory taxes and duties as he is required to deduct under the provisions of law.

11. VARIATION

11.1 This Service Level Agreement may not be varied unless a variation is agreed in writing and signed by all parties.

12. DISPUTES

12.1 The agreement shall be governed by and interpreted in accordance with the laws of India for the time being in force. The Court located at the place of issue of the agreement shall have jurisdiction to decide any dispute arising out of or in respect of the agreement. It is specifically agreed that no other Court shall have jurisdiction in the matter.

12.2 Both parties agree to make their best efforts to resolve any dispute between them by mutual consultation.

13. ARBITRATION

13.1 If the parties fail to resolve their dispute or difference by such mutual consultations within thirty days of commencement of consultations, then either the Service procuring agency or the Service provider may give notice to the other party of its intention to commence arbitration, as hereinafter provided. The applicable

arbitration procedure will be as per the Arbitration and Conciliation Act 1996 of India and the amendments that may have already been brought in or may be introduced in the near future. In that event, the dispute or difference shall be referred to the sole arbitration of an officer as the arbitrator to be appointed by the <Name of the MMUSPA>. Suppose the arbitrator to whom the matter is initially referred is transferred, vacates their office, or is unable to act for any reason. In that case, they shall be replaced by another person appointed by <Name of the MMUSPA> to act as Arbitrator.

13.2 Work under the agreement shall, notwithstanding the existence of any such dispute or difference, continue during arbitration proceedings, and no payment due or payable by the MMUSPA or the firm/contractor shall be withheld on account of such proceedings unless such payments are the direct subject of the arbitration.

13.3 Reference to arbitration shall be a condition precedent to any other action at law.

13.4 Venue of Arbitration: The venue of arbitration shall be the place where the agreement has been issued.

14. TERMINATION

14.1 Either party may terminate this agreement by giving not less than 3 months' notice in writing to the other. This notice shall include reasons as to why the agreement is proposed to be terminated.

14.2 The Service Procuring agency may terminate the agreement, or terminate the provision of any part of the Services, by written notice to the Service provider with immediate effect if the Service Provider is in default of any obligation under the agreement, where

a. The default is capable of being remedied. The Service Provider has not remedied the default to the satisfaction of the Service procuring agency within 30 days of at least two written advices, or such other period as may be specified by the Service procuring agency, after service of written notice specifying the default and requiring it to be remedied; or

b. The default is not capable of remedy; or

c. The default is a fundamental breach of the agreement

14.3 If the Service procuring agency terminates the agreement and then makes other arrangements for the provision of the Services, it shall be entitled to recover from the Service provider any loss that had to be incurred due to such sudden termination of the agreement.

14.4 Both parties agree that no further payment will be made to the Service provider, even if due till settlement of anticipated loss as a result of premature termination of the agreement.

14.5 The MMUSPA reserves the right to terminate the agreement without assigning

any reason if the services of the MMU create serious adverse publicity in the media and prima facie evidence emerges showing negligence of the Service provider.

15. KEY PERFORMANCE INDICATORS

(i) Number of trips in a month (22-25 trips/month).

(ii) All MMUs should be linked with GPS for mobile tracking.

(iii) Compliance with the Route Plan (>=90%)

(iv) Number of cases seen monthly categorised by ANC, children immunised, FP services provided, patients with HT/Diabetes followed up, (at least 40 OPD cases/ day/trip).

(v) No. Of Lab tests/month by MMU (at least 20 tests/day/trip).

(vi) Availability of drugs (at least 90%) as per the Agreement.

(vii) Availability of diagnostics (100%) as per the Agreement.

(viii) Availability of HR as per the Agreement (100%).

The list is not exhaustive. The Service Procuring Agency may add KPIs based on requirements from time to time.

The monthly payment for the services to the vendor should be based on a monthly review and attainment of these KPIs, and exercising a penalty as per the Agreement if KPIs are not achieved.

PENALTY CLAUSE:

Sl No.	KPI	Target	Penalty
1	Number of trips in a month	**22-25 trips/month**	Loss of Operational Cost of the day for each day missed, for 20-22 field days. Loss of Operational Cost of the day + ₹1,000 penalty for each day missed if fewer than 20 field days.
2	All MMUs are linked with GPS for mobile tracking.	**MMU to be linked with GPS**	₹10,000 penalty each month for a maximum of 2 months; thereafter, Operational costs will not be supported.
3	Compliance with the Route Plan	**(>=90%)**	₹5,000 penalty for 80% – 90% compliance; below that ₹10,000 penalty up to 50%. Below 50% OPEX will not be supported.

Sl No.	KPI	Target	Penalty
4	Number of cases seen monthly categorised by ANC, children immunised, FP services provided, and patients with HT/Diabetes followed up.	**(at least 40 OPD cases/day)**	If <20 patients are consulted in a day, the MMU staff must justify the lower number, and if found unreasonable, the district may impose a penalty of ₹ 5000 per day.
5	No. of Lab tests/month by MMU	**(at least 20 tests/ day)**	If <10 lab tests are conducted in a day, MMU staff are to justify the lower number, and if found unreasonable, the district may impose a penalty of ₹ 1000 per day.
6	Availability of drugs as per the Agreement.	**At least 90%**	75% to 90% compliance – penalty of ₹ 10,000; 50% to 75% compliance - penalty of ₹ 20,000; <50% - OPEX will not be supported.
7	Availability of diagnostics as per the Agreement.	**100%**	80% to 99% compliance – penalty of ₹ 10,000; 50% to 80% compliance - penalty of ₹ 20,000; <50% - OPEX will not be supported.
8	Availability of HR as per the Agreement	**100%**	If eligible MO if not available, OPEX will not be supported. If HR is not as per the Agreement, OPEX will not be supported.

16. INDEMNITY

16.1 By this agreement, the Service provider indemnifies the Service procuring agency against damages of any kind or for any mishap/injury/accident caused to any personnel/ property of the Service provider while performing duty.

16.2 The Service provider agrees that the Service provider shall bear all liabilities, legal or monetary, arising in any eventuality.

17. PERIOD OF AGREEMENT

17.1 This Service Level Agreement shall take effect on ..... until .....

The period may be extended for another period of three years with the agreement of both parties after mutual negotiations.

18. SERVICE AGREEMENT LIST

1. Signed for and on behalf of the MMU Service Procuring Agency (MMUSPU).....

Signed: .....

Name: .....

Designation: .....

Date: .....

2. Signed for and on behalf of the Service Provider:

Signed: .....

Name: .....

Designation: .....

Date: .....

Witnesses:

1) .....

2) .....

3) .....

LIST OF CONTRIBUTORS

S No	Name	Designation /Organisation
Ministry of Health & Family Welfare		
1.	Ms. Aradhana Patnaik	AS & MD, MoHFW
2.	Shri Sibin C.	JS (Policy)
3.	Dr. Saroj Kumar	Director, NHM
4.	Dr Rahul Sushil Jain	Senior Consultant, NHM
National Health Systems Resource Centre		
1.	Dr. Pragya Sharma	Executive Director, NHSRC
2.	Dr. K Madan Gopal	Advisor, PHA
3.	Mr. Prasanth K.S	Lead Consultant, PHA
4.	Dr. Harioum Sharma	Senior Consultant, PHA
5.	Dr. Priyanka S Shenoy	Senior Consultant, PHA
6.	Dr. Kalpana Pawalia	Senior Consultant, PHA
7.	Dr. Swarnika Pal	Senior Consultant, PHA
8.	Dr. Arpita Aggarwal	Senior Consultant, PHA
9.	Ms. Deepali	Consultant, PHA
10.	Mr. Kannan P	Consultant, PHA
11.	Dr. Ipsa Kutlehrria	Consultant, PHA
12.	Dr Sruthi M	Consultant, PHA
Others		
1.	Shri Saurabh Jain	Former JS (Policy)
2.	Maj. Gen. Dr Atul Kotwal	Former Executive Director, NHSRC
3.	Mr. Herratdeep Singh	Former Consultant, PHA, NHSRC

For more information :

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