



Evaluation of Urban Primary Health Centres in Nagpur

Accessibility, Service Delivery, Infrastructure and WASH Facilities

August 2026



The **Centre for Sustainable Development (CFSD)** works to develop human settlements into equitable living environment where the community has access to health, education, housing, basic infrastructure and livelihood options irrespective of their social and economic status.

This is done by supporting an integrated development approach for the improvement of living conditions in slums by combining various local initiatives, national and regional programmes in the fields of urban environment, social and technical infrastructure, poverty alleviation, education and health.

As part of CFSD's work, this study was carried out.

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कार्यकारी सारांश

शहरी प्राथमिक स्वास्थ्य केंद्रों (UPHC) का मकसद व्यापक प्राथमिक स्वास्थ्य सेवाएँ देना है, जिसमें बीमारी से बचाव, स्वास्थ्य को बढ़ावा देना और इलाज शामिल है। सितंबर 2025 तक, नागपुर में 85 UPHC हैं। 2017 की एक स्टडी में पाया गया कि नागपुर में UPHC का ठीक से इस्तेमाल नहीं हो रहा था, जिसकी वजह मरीजों की कम संतुष्टि, खुलने के समय में गड़बड़ी और खराब इंफ्रास्ट्रक्चर था। आज, UPHC की मौजूदा स्थिति और उनके कामकाज के बारे में कोई ताज़ा जानकारी उपलब्ध नहीं है।

इस स्टडी में नागपुर के UPHCs का आकलन किया गया। इसमें सेवाओं तक पहुँच और उनकी डिलीवरी, हेल्थकेयर स्टाफ़ की क्षमता बढ़ाने और इंफ्रास्ट्रक्चर से जुड़ी चीज़ों की जाँच की गई, जिसमें पानी, साफ़-सफ़ाई और हाइजीन (WASH) सेवाओं पर खास ज़ोर दिया गया। डेटा इकट्ठा करने का काम अप्रैल से जून 2026 के बीच किया गया। इसके लिए मिक्स्ड-मैथड अप्रोच अपनाई गई, जिसमें मरीजों और स्टाफ़ के सर्वे, फ़ैसिलिटी का निरीक्षण और फ़ोटोग्राफ़िक डॉक्यूमेंटेशन शामिल थे। शहर के सभी भौगोलिक क्षेत्रों का प्रतिनिधित्व करने वाले ग्यारह UPHCs को इसमें शामिल किया गया और कुल मिलाकर 103 मरीजों और 44 स्टाफ़ सदस्यों के सर्वे किए गए।

सर्वे में शामिल मरीजों के अनुभव बताते हैं कि UPHC की सेवाओं तक पहुँच आसान है और वे इनका नियमित रूप से इस्तेमाल करते हैं। मरीजों के अनुभव अच्छे रहे; उन्होंने बताया कि इंतज़ार का समय कम था, मिली सेवाओं से वे काफ़ी संतुष्ट थे, स्टाफ़ के साथ उनका व्यवहार अच्छा रहा और उन्हें दी गई देखभाल पर भरोसा था। UPHC में ज़रूरी दवाइयों और मेडिकल सप्लाई जैसी मुख्य स्वास्थ्य सेवाएँ अच्छी तरह उपलब्ध थीं। स्टाफ़ का मानना है कि UPHC प्रभावी ढंग से काम कर रहे हैं, वहाँ का प्रशासन सहयोगी है और स्टाफ़ सेवाएँ देने में आत्मविश्वास महसूस करता है।

कई कमियों और चुनौतियों की पहचान की गई है। अक्सर जगह की कमी के कारण सुविधाओं पर असर पड़ा, जिससे इंतज़ार करने की जगह और सामान रखने की क्षमता अपर्याप्त रही। अवलोकन से पता चला कि उपलब्ध सेवाओं के बारे में जानकारी का प्रसार पर्याप्त नहीं है। कुछ UPHC और उनके आस-पास गर्मी से बचाव के इंतज़ाम एक जैसे नहीं पाए गए। जांच में WASH बुनियादी ढाँचे और सेवाओं में कई कमियाँ भी पाई गईं, जिनमें पीने के पानी तक पहुँच, लिंग, विकलांगता और मासिक धर्म स्वच्छता की ज़रूरतों के लिए स्वच्छता बुनियादी ढाँचा, और हाथ की स्वच्छता सुविधाओं और आपूर्ति में कमियाँ शामिल हैं। UPHCs मरीजों के कंसल्टेशन के लिए दिन में आठ घंटे खुले रहने की ज़रूरतों को पूरा नहीं कर पाए। स्टाफ़ के फ़ीडबैक से कई तरह की ट्रेनिंग की ज़रूरतों और कभी-कभी स्टाफ़ की कमी का पता चला।

सुविधा प्रोफ़ाइल से पता चलता है कि हर UPHC दूसरे से काफ़ी अलग है, जिसके कारण कई तरह की चुनौतियाँ सामने आती हैं और उनसे निपटने के लिए प्राथमिकता के आधार पर कदम उठाने की ज़रूरत होती है। सिफारिशों में बुनियादी ढाँचे और आसपास के वातावरण को अनुकूलित करने, खुलने के समय को समायोजित करने, कार्यबल के लचीलेपन को बढ़ावा देने, पर्याप्त WASH सेवाओं को सुनिश्चित करने और रोगी प्रतिक्रिया तंत्र को मजबूत करने पर ध्यान केंद्रित किया गया है।

यह स्टडी दिखाती है कि नागपुर में UPHCs प्राइमरी हेल्थकेयर देने में अहम भूमिका निभाते हैं और उन्हें बहुत महत्व दिया जाता है और उनका इस्तेमाल किया जाता है। सुविधा-स्तर पर पहचानी गई प्राथमिकताओं और मुख्य सुझावों पर अमल करने से नागपुर की बढ़ती शहरी आबादी के लिए सेवा वितरण को मजबूत किया जा सकता है और स्वास्थ्य परिणामों में सुधार लाया जा सकता है। हालाँकि ये नतीजे चुने हुए UPHC के गहन मूल्यांकन पर आधारित हैं और नागपुर की सभी सुविधाओं का सांख्यिकीय रूप से प्रतिनिधित्व नहीं करते हैं, फिर भी ये मुख्य खूबियों, चुनौतियों और सुधार के अवसरों के बारे में महत्वपूर्ण जानकारी देते हैं। भविष्य में होने वाले शोध के साथ मिलकर, जो सबूतों की कमी को पूरा करेगा, ये नतीजे नीति, योजना और सार्वजनिक स्वास्थ्य कार्यप्रणाली को बेहतर बनाने में मदद कर सकते हैं।

EXECUTIVE SUMMARY

Urban Primary Health Centres (UPHC) are supposed to provide comprehensive primary health care, including preventive, promotive, and curative care. As of September 2025, there are 85 UPHCs in Nagpur. A study in 2017 assessed that UPHCs in Nagpur were not utilized well due to low patient satisfaction levels, discrepancies in functional hours, and poor infrastructure. Today, there is no available up-to-date information on the current status of UPHCs and their functioning.

This study assessed UPHCs in Nagpur by evaluating access to and delivery of services, capacity building of health care staff, and infrastructure components with specific emphasis on water, sanitation, and hygiene (WASH) services. Data collection was carried out from April to June 2026 and consisted of a mixed-methods approach combining patient surveys, staff surveys, facility observations, and photographic documentation. Eleven UPHCs, representing all geographical zones of the city, were included, and a total of 103 patient and 44 staff surveys were carried out.

Findings indicate strong accessibility and regular utilization of UPHC services among surveyed patients. Patient experiences were positive, reporting short waiting times, high levels of satisfaction with services received, positive interactions with staff, and trust in the care provided. UPHCs demonstrated strong availability of core health services, including essential medicines and medical supplies. Staff perceive UPHCs as functioning effectively, with supportive administration and a workforce that is confident in delivering services.

Several gaps and challenges have been identified. Facilities were often constrained by limited space, resulting in insufficient waiting areas and not enough storage capacity. Observations showed that communication of available services is not sufficient. In and around some UPHCs, inconsistent protection from the heat was observed. Findings also identified several gaps across WASH infrastructure and services, including access to drinking water, sanitation infrastructure for gender, disability, and menstrual hygiene needs, and shortcomings in hand hygiene facilities and supplies. UPHCs did not meet the requirements for patient consultation to be open for eight hours a day. Staff feedback identified various training needs and occasional staff shortages.

Facility profiles show that UPHCs vary from another, resulting in a range of challenges and priority actions to address them. Recommendations focus on optimizing infrastructure and surrounding environments, adjusting opening times, promoting workforce resilience, ensuring adequate WASH services, and strengthening patient feedback mechanisms.

This study demonstrates that UPHCs in Nagpur play a vital role in delivering primary healthcare and are highly valued and utilized. Acting on the identified facility-level priorities and overarching recommendations can strengthen service delivery and improve health outcomes for Nagpur's growing urban population. While the findings are based on an in-depth assessment of selected UPHCs and are not statistically representative of all facilities in Nagpur, they provide valuable insights into key strengths, challenges, and opportunities for improvement. Together with future research to address remaining evidence gaps, these findings can inform policy, planning, and public health practice.

ABBREVIATIONS

ASHA	Accredited Social Health Activists
CFSD	Centre for Sustainable Development
HCF	Health Care Facility
IPHS	Indian Public Health Standards
MoHFW	Ministry of Health and Family Welfare
NMC	Nagpur Municipal Corporation
NHM	National Health Mission
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
NQAS	National Quality Assurance Standards
UPHC	Urban Primary Health Centre
WASH	Water, Sanitation and Hygiene

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INTRODUCTION

Urban Health Context

According to the World Health Organization, rapid and unplanned urbanization is linked to most of the top ten causes of death, including communicable and non-communicable diseases, an increase in injuries, environmental factors, and mental health issues [1]. Addressing this burden of disease is key as the “health and well-being of its citizens is perhaps a city’s most important asset” [1]. A healthy community is more resilient, contributes to a productive workforce, and helps to foster a good urban livelihood [1].

In India, over 510 million people lived in cities in 2024 [2], representing 35% of the total population [3], with an annual urban population growth of 1.8% [4]. Providing health care services for this growing urban population continues to be a major challenge, including addressing important social determinants of health such as providing housing, public transport, safe drinking water, and sanitation [5]. To ensure that everyone has the right to the highest attainable level of health, primary health services need to meet people’s health needs, address social determinants of health, and empower communities to be responsible for their own health [6].

Primary Health Care has been foundational to India’s health system and was adopted in the Alma-Ata Declaration in 1978 [7], with its principles being reaffirmed in the Declaration of Astana in 2018 [8]. The National Health Mission (NHM), launched in 2005, aims to translate these goals into strengthening service delivery on the ground [9]. Implementing the NHM into diverse state, district, and subdistrict contexts is not easy in a large, federally structured country, as it “requires consensus, joint learning efforts, sharing of lessons and drawing from successes” [10].

National Urban Health Mission

The National Urban Health Mission (NUHM), as one key part of the NHM, aims “to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community-based mechanism with the active involvement of the urban local bodies” [11].

In Maharashtra, the NUHM is being implemented in 397 cities and towns with a population of more than 15,000 and a total of 2,498 functional facilities [12].

The NUHM Implementation Framework defines goals, objectives, strategies and outcomes, including eight core strategies which guide the mission [11]:

- Improving the **efficiency of the public health system** in the cities by strengthening, revamping and rationalizing existing government primary urban health structure and designated referral facilities
- Promotion of access to **improved health care at household level** through community-based groups
- Strengthening public health through innovative **preventive and promotive action**
- Increased **access to health care** through creation of revolving fund, IT-enabled services and e-governance for improving access, improved surveillance, and monitoring
- **Capacity building** of stakeholders
- Prioritizing the **most vulnerable** amongst the poor
- Ensuring **quality health care services**



Figure 1: Khamla UPHC Building

While the NHM presents the structural and operational foundation, there are other initiatives that either build on it or are enabling mechanisms for achieving the minimum standards for NHM services (see Figure 2).

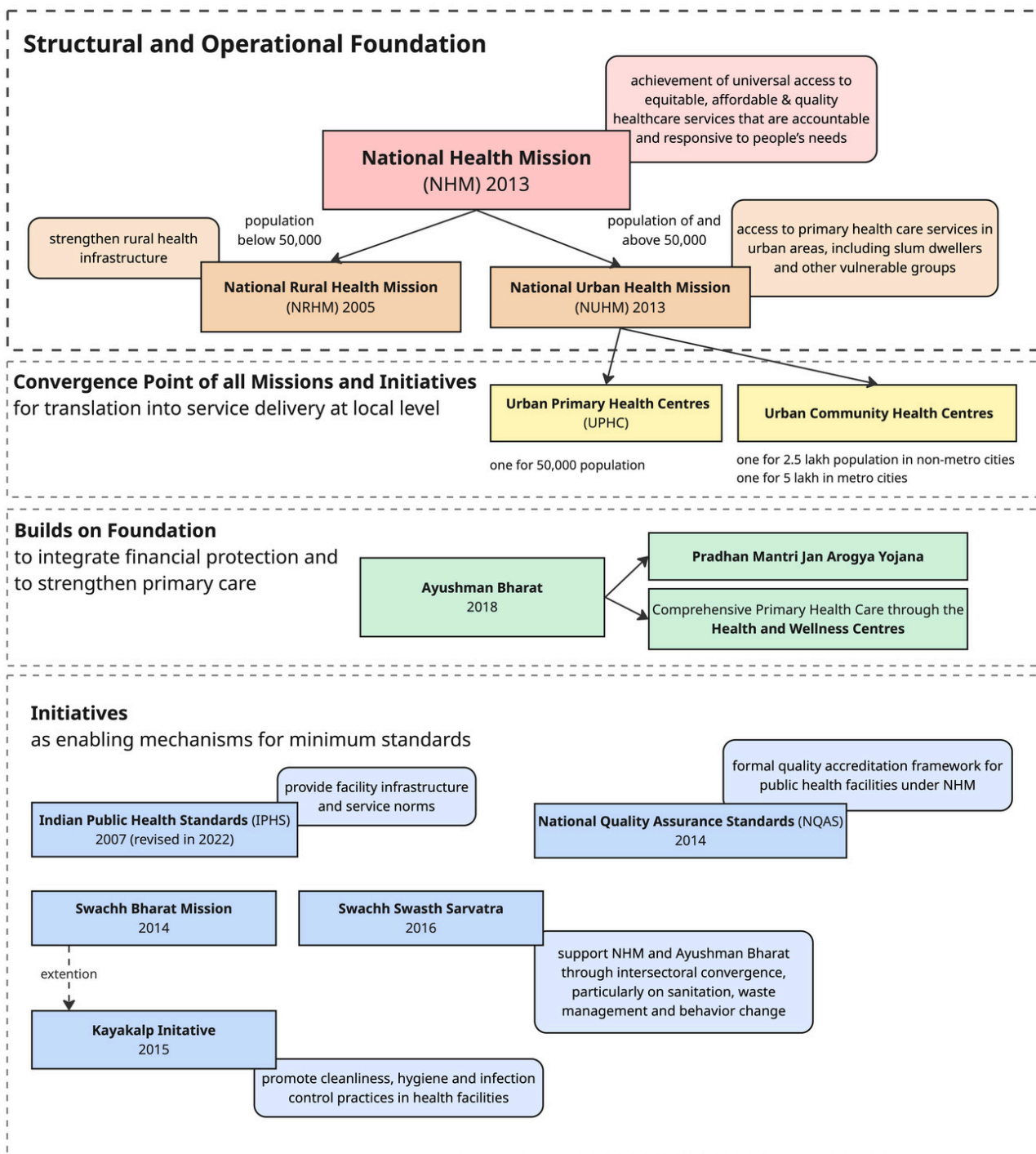


Figure 2: Overview of Missions and Initiatives related to the National Health Mission [9, 11,13-19]

The Ayushman Bharat, a flagship health programme with two main components, was launched in 2018 by the Government of India to strengthen primary health care and provide financial protection for secondary and tertiary care, building on public health infrastructure developed under NHM [14]. On one hand, the Pradhan Mantri Jan Arogya Yojana, also often called Modicare, provides health insurance coverage for secondary and tertiary care. On the other hand, Health and Wellness Centres focus on comprehensive primary health care by upgrading existing facilities to include services such as mental health care.

The Indian Public Health Standards (IPHS) are the uniform standards for public health facilities in India to ensure basic infrastructure, staffing, equipment, drugs and services are in place [15]. To go beyond infrastructure, the National Quality Assurance Standards (NQAS) were developed to measure and improve the quality of services delivered in public health facilities [16]. By ensuring quality and patient satisfaction, as well as minimum service delivery and capacity, the IPHS and NQAS help to achieve NHM aims. In return, the NHM provides the framework and needed resources to implement these standards in India.

In 2015, the MoHFW launched the Kayakalp Initiative, which complements the IPHS and NQAS as a quality improvement and cleanliness initiative for public health facilities [17]. Facilities are assessed and high-performing facilities receive awards, financial incentives, and public recognition. This initiative can be seen as an extension of the Swachh Bharat Mission (SBM), the nationwide cleanliness and sanitation programme which was launched in 2014 [18]. The SBM supports the NHM as it addresses key social determinants of health and therefore reduces diseases and promotes health and well-being. To strengthen the link between SBM and NHM, the Swachh Swasth Sarvatra was launched in 2016 and aims to ensure cleanliness, sanitation and hygiene in and around health facilities [19]. Two key components include the improvement of WASH services at health centres and promoting infection control and hygiene practices.

As outlined in the NUHM, two main facilities are established: Urban Primary Health Centres (UPHCs) and Urban Community Health Centres. The UPHC is the basic primary-level HCF under NUHM and is supposed to provide comprehensive primary health care in urban areas, including preventive, promotive and curative care. Urban Community Health Centres are higher-level referral facilities for several UPHCs. Here, more comprehensive care including specialist services and secondary level care is provided. One Urban Community Health Centre acts as a first referral unit for a population of 2.5 lakh (250,000) in non-metro cities and a population of 5 lakh (500,000) in metro cities.

Role of Urban Primary Health Centres

The Guidelines for Organizing UPHC Services [20] and the Quality Standards for UPHC [21] outline its objectives, purpose, and functions. One UPHC should cover ~50,000 urban residents and is primarily intended for urban poor and vulnerable populations such as but not limited to slum dwellers and workers in the informal sector. UPHCs should be located in proximity to urban slums. As a first point of contact to the community, UPHCs should provide accessible and quality-assured services, as well as reduce out-of-pocket expenditures – making health care more affordable. This approach aims to go beyond traditional services to include rising urban health threats such as non-communicable diseases. Minimum requirements for UPHCs outline information about the staffing, layout and infrastructure, basic amenities including WASH services, as well as lists of essential equipment, instruments, and drugs.

There are nine key principles for care in urban areas according to the Guidelines for Organizing UPHC Services [20]:

- Universal provision of **basic preventive and promotive care**.
- An assured **minimum package of services** is to be delivered to the population, as **close to home** as convenient and necessary, to ensure universal access with quality.
- Increased focus on **preventive and promotive care** at the community level.
- Improved **management** at UPHCs to reduce patient load at secondary and tertiary centers.
- Reduction of **out-of-pocket expenditure** on drugs and diagnostics.
- Provision of **culturally appropriate health care** and counselling through trained frontline health staff.
- **Integration and collaboration** with ULBs and other departments for improved convergent actions for social and environmental determinants of health.
- Enhanced focus on **screening** of non-communicable diseases, **early identification** of communicable diseases and early **outbreak identification** and management.
- Special efforts to identify, reach out to and address healthcare needs of **urban marginalized populations**.

UPHCs are supposed to develop strong upward (with higher facilities) and downward (with community) linkages to promote the health and well-being of the target populations. Therefore, in addition to basic health services mentioned above, UPHCs are supposed to address social and environmental determinants of health through community outreach. This is mainly done by Accredited Social Health Activists (ASHAs) and Mahila Aarogya Samiti. One ASHA is responsible for 200 to 500 vulnerable households by conducting home visits and providing a direct link between the UPHC and the community. Mahila Aarogya Samiti are community women's groups which are formed for every 50 to 100 households in slums and slum-like settlements. These groups provide a platform for the community for health needs and they monitor Urban Health and Nutrition Days. ASHAs and Auxiliary Nurse Midwives are also responsible for identifying issues related to water supply and quality, garbage collection, drainage, and sanitation faced by the community.

Situation in Nagpur

Studies from across India have shown that there are common gaps and needs of rural and urban primary health centers such as structural constraints, unsuitable opening times, and not meeting patients' expectations [22-27]. Apart from this, while being based on data from 2018, the trend of smaller HCFs being more likely to have gaps in water, sanitation, and hygiene (WASH) services persists in India [28].

In July 2017, a baseline assessment conducted by Tata Trusts found three main reasons for low utilization of 26 UPHCs in Nagpur: reduced patient satisfaction levels, reduced functional hours, and poor infrastructure [29] (see Figure 3). As a result of these findings, a public-private partnership was formed between the Nagpur Municipal Corporation (NMC) and Tata Trusts to develop a "Model UPHC Project".

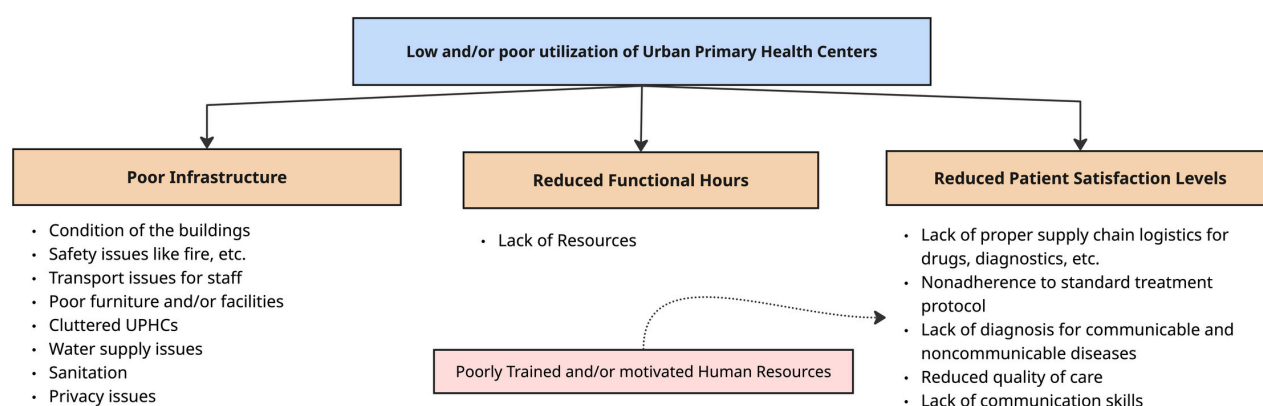


Figure 3: Reasons for Low Utilization of UPHCs in Nagpur according to Tata Trusts [Reproduced from 29]

NMC identified six key priorities for transforming UPHCs in Nagpur [29]:

- Upgrading the **infrastructure** of the health centers,
- Realigning workflow processes and enhancing **service quality**,
- Strengthening human resources through **capacity building**,
- Establishing a robust **supply chain management** system for better provisioning of drugs,
- Setting up of a centralized **laboratory facility**, and
- Maintaining **electronic medical records** and other innovations by leveraging technology.

The public-private partnership has improved the functioning of UPHCs in Nagpur [29]. However, there is no publicly available up-to-date information on the current status of the utilization of Nagpur's 85 UPHCs [30] and their functioning. Therefore, this study focused on assessing UPHCs in Nagpur by evaluating access to and delivery of services, capacity building of health care personnel, and infrastructure components with specific emphasis on WASH services. While this is not an all-encompassing evaluation, the research examined critical determinants of quality and safety in UPHCs and is based on the Guidelines for Organizing UPHC Services and the Quality Standards for UPHC.

METHODOLOGY

Study Design

This study was carried out from April to June 2026 and used a mixed-methods approach combining patient surveys, staff surveys, facility observations, and photographic documentation. All field visits were conducted by two staff members of the Centre for Sustainable Development (CFSD).

Facility Selection

A total of eleven UPHCs were included. Ten facilities were selected to provide geographic representation across Nagpur, with one UPHC included from each municipal zone (see Figure 4). Out of these UPHCs, some have previously been supported by NMC and Tata Trusts as part of their “Model UPHC Project”, while some UPHCs have been established after this project. In addition, the UPHC in Chikhali was purposely included because it was established with support from CFSD one year prior and represented an opportunity to review a recently established facility.

This research was not designed to provide statistically representative findings for all 85 UPHCs in Nagpur. Instead, the selected facilities were intended to provide insight into common strengths, challenges, and opportunities across different areas of the city.

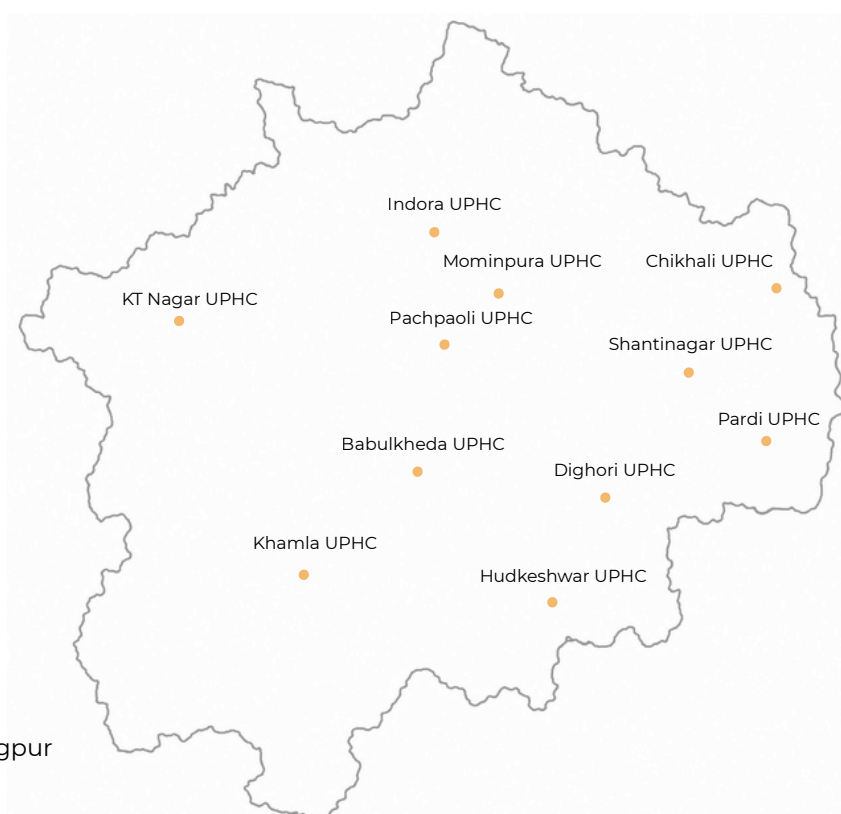


Figure 4: Outline of Nagpur and UPHC Locations

Data Collection

Data collection included three components: patient surveys, staff surveys, and observations including photographic documentation. Additional anonymized and not traceable notes were taken throughout all data collection methods. For patients and staff, two separate surveys were used. Both consisted primarily of closed-ended questions with some open-ended questions. Only non-identifiable demographic data (age, gender, occupation, years of education for patients, years of work for health care staff) were collected.

The study aimed to conduct surveys with ten patients per facility. A total of 103 patient surveys were carried out in ten facilities. The survey explored UPHC access, quality of services, WASH infrastructure as well as patient satisfaction and suggestions.

The aim was to survey approximately four staff members per facility, including a mix of clinical and support staff as well as ASHA workers where possible. A total of 44 surveys were completed in ten facilities, focusing on service delivery, WASH facilities, outreach and community, training and capacity as well as challenges and suggestions.

Structured facility observations were conducted in all eleven UPHCs using a standardized observation checklist. Observations focused on infrastructure and accessibility, availability and condition of WASH facilities as well as the general facility environment (including for instance the provision of shade and the presence of any clutter). Photographs were collected to support documentation of key observations.



11 Urban Primary
Health Centres



103 Patient
Surveys



44 Staff
Surveys

Special Considerations: Chikhali UPHC

At the time of the study, the UPHC in Chikhali was operating under atypical conditions. According to staff, there has not been a regular medical officer since March and the facility was relying on intermittent staffing arrangements. On the day of the visit, a medical officer was in the facility to conduct a maternal health camp. As patients attending the facility were participating in the programme activity and were not regular patients, no surveys were conducted. Despite these limitations, the facility was kept within the assessment because its circumstances provide important insight into challenges of service delivery in a newly established UPHC. Findings from Chikhali are presented through facility observations and qualitative notes only.

Data Analysis

Survey data were collected using Google Forms and exported to Microsoft Excel for analysis. An inductive coding approach was used to analyze the qualitative and quantitative data. Through several rounds of reviewing the survey responses and observation notes, a set of 44 indicators was developed across six thematic areas: access and utilization, facility services and availability, health system functioning, infrastructure, patient experience, and WASH.

Data from patient surveys, staff surveys, and facility observations were summarized and organized according to these indicators. Information collected from ASHAs was separated from the broader staff dataset and analyzed independently. Photographs and field notes collected during site visits were reviewed and incorporated where relevant to support interpretation of findings.

A joint display matrix was constructed to triangulate data across the three sources: patients, staff, and observations. The data was then compared, which led to identification of convergent and divergent patterns across data sources. Patterns were recorded and interpreted to establish system-level recommendations. For each health facility, a facility-specific matrix was developed in Microsoft Excel using the same set of indicators mentioned above. Key strengths, challenges, and priority actions for each facility were formulated.

Limitations

Several limitations should be considered when interpreting the findings. The assessment included only eleven UPHCs out of a total of 85 UPHCs in Nagpur and therefore does not provide statistically representative estimates for all facilities. Due to limited space inside some facilities and high temperatures outside, it was not always possible to have a secluded space for the duration of the survey. Also, some survey responses may be influenced by social desirability bias, particularly among staff respondents. To address this limitation, survey findings were supplemented with direct observations and photographic documentation where possible.

Information gathered from ASHAs was collected opportunistically through staff survey questionnaires, informal conversations, and observations during facility visits when ASHAs were present at UPHCs, often accompanying patients. As such, this component was not systematically sampled and should be considered supportive to the main study. The findings are exploratory and illustrative and do not represent a comprehensive assessment of ASHA experiences across all UPHC catchment areas. Within the findings, the answers from surveys conducted with three ASHA workers are only included in the sub-section: *Community Outreach and ASHA Engagement*. Otherwise, findings relate only to other surveyed staff with a sample size of 41.

Patient and staff surveys were not conducted at Chikhali UPHC due to atypical service delivery conditions during the assessment period. Findings related to this facility should therefore be interpreted separately from the survey results.

Study Participants

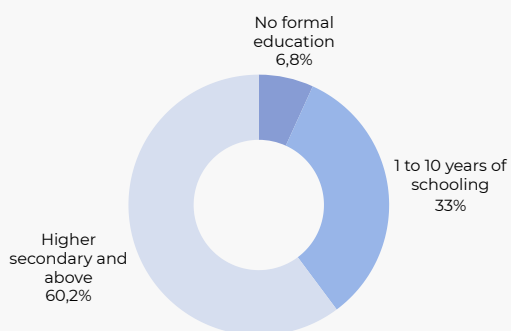
A total of 147 participants were surveyed for this study, consisting of 103 patients and 44 staff.

The majority of patients were female (65%). Patients were most commonly self-employed (55.62%) or categorized themselves as housewives (37.9%). Most of the patients (60.2%) have completed higher secondary education and above. Staff surveys were done with nurses (25%), pharmacists (22.7%), medical officers (22.7%), lab technicians (13.5%), ASHAs (6.75%), ANMs (4.5%) and support staff (4.5%). The majority of staff were female (77.3%) and most of the staff had been working at UPHCs for more than ten years (42.9%) or more than five years (28.6%).

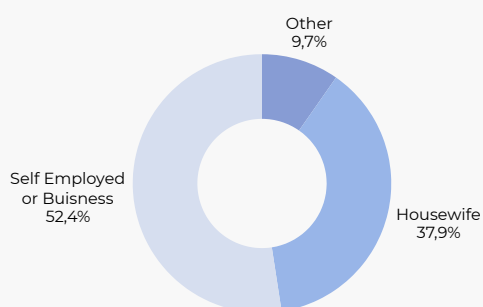
Patients Demographics

Age	Female	Male
18-24	5	2
25-34	15	1
35-44	13	12
45-54	11	9
55-64	14	9
65 or older	9	3
Total	67 (65%)	36 (35%)

Level of Education



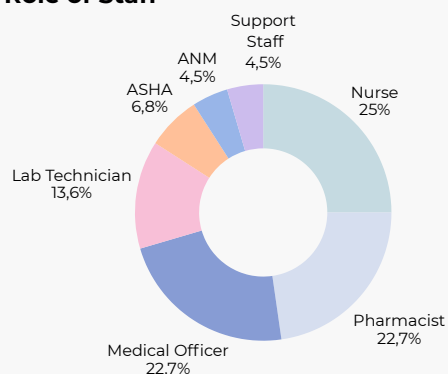
Occupation



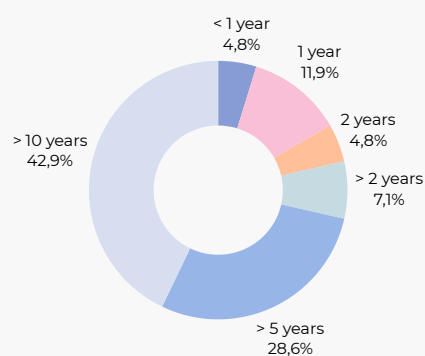
Staff Demographics

Age	Female	Male
18-24	-	-
25-34	14	5
35-44	14	4
45-54	5	-
55-64	1	-
65 or older	-	1
Total	34 (77.3%)	10 (22.7%)

Role of Staff



Years of Working at UPHC



KEY FINDINGS

This chapter presents the key findings across all UPHCs, providing an overview of the common trends, recurring challenges, and notable differences observed across facilities. It also compares staff and patient feedback with observations to highlight areas of alignment as well as discrepancies. Some few pictures from observations have been selected and added throughout. The chapter is followed by detailed facility profiles, which provide in-depth findings and context for each individual UPHC, including pictures.

Access and Utilization

Overall, findings indicate strong accessibility and regular utilization of UPHC services among surveyed patients. However, there are observed gaps in facility opening hours.

Accessibility

The majority of patients lived within proximity to the facility, with 61.7% living less than 1 km away and 27.4% living between 1–3 km from the UPHC. Consistent with this, nearly 90% of patients reported experiencing no challenges in reaching the facility. Among those who did report difficulties, mobility challenges, particularly among patients experiencing leg pain, were the most common barriers.

more than

60 %

of patients live less than 1 km away

almost

90%

of patients reported no difficulties in reaching the facility



Figure 5: Pachpaoli UPHC Entrance

Awareness and Use

Patients most commonly learned about the facility through family members (39.2%), community members (30.4%), and ASHA workers (29.4%). This highlights the important role of informal community networks and community-based outreach in promoting health care services.

The majority of surveyed patients were frequent users of UPHC services, with almost 90% having visited the facility previously. Many respondents reported coming to the facility, either weekly (40%) or monthly (51.6%), while only a small number reported infrequent visits (8.4%). These findings suggest that UPHCs are well-established sources of care and are being used regularly by the surveyed patients.

Opening Times

Patient perceptions of operating hours were generally positive, with 89% reporting that the opening times were convenient. For patients who said that opening times were not convenient, reasons given varied between the need for earlier opening times on the one hand, and longer opening hours beyond 1 PM due to household responsibilities in the morning. Throughout observations, UPHCs were most busy in the morning hours from 9 to 11 AM.

89%

of patients reported
that opening times
are convenient

Facility observations identified potential discrepancies between operating hours and service availability. While nine of the eleven observed UPHCs were open for approximately eight hours per day (8 AM to 4 PM), patient consultation services were only available for five hours (8 AM to 1 PM) (see Figure 6). Dighori UPHC in Nehru Nagar provides only four hours of consultation services (9 AM to 1 PM) (see Figure 7), while consultation hours at the Chikhali UPHC could not be confirmed due to the absence of a regular Medical Officer. According to UPHC guidelines, each facility should operate for eight hours a day with suggested timings from 12 PM to 8 PM or dual shifts from 8 AM to 12 PM and 4 PM to 8 PM. Morning and evening outpatient department openings should be given.



Figure 6: Mominpura UPHC Opening Times



Figure 7: Dighori UPHC Opening Times

Service Delivery

Overall, UPHCs demonstrated strong availability of core health services, including pharmacies, laboratories, essential medicines, and medical supplies. Nevertheless, observations and patient feedback identified important areas for improvement, including continuous supply of drugs, sufficient pharmacy infrastructure such as dispensers, more laboratory space, adherence to infection prevention practices as well as better communication of available services.

Essential Medical Supplies

Most staff reported that essential medical supplies were consistently available, with 85.4% indicating that supplies were always available, 12.2% reporting they were sometimes available, and 2.4% reporting they were rarely available. These findings suggest somewhat reliable supply chains and stock management across facilities.

However, observations raised concerns regarding the use of infection prevention and control practices. Across all facilities, healthcare staff was rarely observed using gloves or disinfection during patient interactions (see Figure 8), despite the reported availability of medical supplies. While the assessment did not specifically evaluate the availability of personal protective equipment, this recurring observation suggests a need to understand whether the issue relates to supply availability, mainly of disposable gloves and disinfection, or adherence to infection prevention protocols.

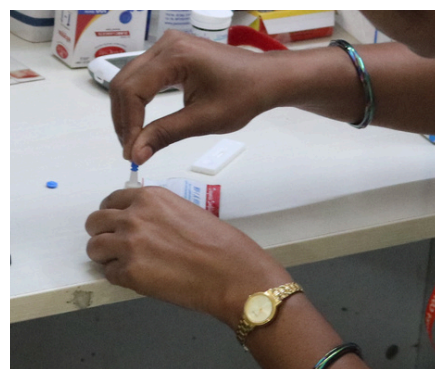


Figure 8: Hudkeshwar UPHC Laboratory

Laboratory Services

Laboratory services were available in ten facilities, with staff respondents reporting that essential laboratory tests were always available. While this indicates confidence in the availability of services, several patient and staff feedback highlighted demand for additional diagnostic investigations, particularly sonography during pregnancy, X-ray services, and expanded blood testing. Facilities had lists of available tests, but in all facilities these lists looked different (see Figure 9). Isolated patient feedback also indicated occasional shortages of vaccination-related supplies. These findings suggest that while core laboratory services are functioning well, patient expectations and healthcare needs may exceed the services currently available at the UPHC level. Additionally, observations have revealed that due to limited space within the facility, laboratory services were carried out in hallways, open rooms or only partly secluded areas, directly impacting patient privacy.

A photograph of a printed list of laboratory tests posted on a wall. The list is titled 'KT NAGAR UPHC NMC' and 'FREE OF COST'. It contains a table with two columns: 'SR NO.' and 'NAME OF TEST'. The tests listed include HB, HIV, HBSAG, VDRL, SICKLING, BLOOD GROUPING, OGCT, MALARIA ANTIGEN, DENGUE, WIDAL, CHEST X-RAY, SPUTUM FOR AFB, RBS, FBS, PMBS, CBC, LFT, KFT, TFT, LIPID PROFILE, UPT (URINE PREGNANCY TEST), URINE ROUTINE AND MICROSCOPY, CALCIUM, and URIC ACID.

SR NO.	NAME OF TEST
1	HB
2	HIV
3	HBSAG
4	VDRL
5	SICKLING
6	BLOOD GROUPING
7	OGCT
8	MALARIA ANTIGEN
9	DENGUE
10	WIDAL
11	CHEST X-RAY
12	SPUTUM FOR AFB
13	RBS
14	FBS
15	PMBS
16	CBC
17	LFT
18	KFT
19	TFT
20	LIPID PROFILE
21	UPT (URINE PREGNANCY TEST)
22	URINE ROUTINE AND MICROSCOPY
23	CALCIUM
24	URIC ACID

Figure 9: KT Nagar UPHC List of Free of Cost Tests

Pharmacy Services

All facilities had an operational pharmacy. However, pharmacists and facility observations highlighted several infrastructure challenges. Reported concerns included inadequate storage and workspace, the lack of cupboards and appropriate dispensing counters (see Figure 10).

Often, patients had to access the pharmacies from an outside window due to the limited space inside facilities. All of these issues were observed across multiple facilities, suggesting that pharmacy infrastructure is not optimized to support efficient medicine storage and dispensing.



Figure 10: Dighori UPHC Laboratory

Availability of Drugs

Most staff reported that essential drugs were always available (87.8%). However, patient responses were less favorable, with only 65.7% reporting that drugs were always available and 31.4% indicating that drugs were only sometimes available. One patient reported an occasion where medicines for diabetes and hypertension were unavailable, requiring them to wait 10 to 15 days or purchase medicines from private pharmacies. Several patients said that drugs prescribed through the UPHC should be available at the facility. As per guidelines, facilities had lists of available drugs within the pharmacy areas. However, in all facilities these lists looked different, as some were printed in different versions, and many were handwritten (see Figure 11). Most of the time, these lists of available drugs were not visible to patients.

The discrepancy between staff and patient perceptions suggests that while overall medicine availability may be adequate, periodic stock-outs of specific drugs may significantly impact patient experience, and available drugs at UPHCs might not be communicated well enough for patients.

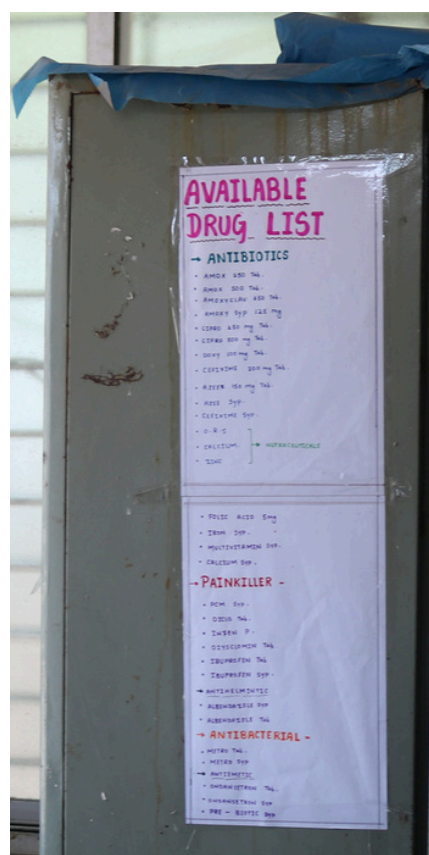


Figure 11: Khamla UPHC Available Drug List

Health System Functioning

The findings indicate that staff perceive UPHCs as functioning effectively, with supportive administration and a workforce that is confident in delivering services. Nevertheless, staff feedback highlights the importance of having a resilient workforce and training systems that are responsive to learning needs. Findings suggest that community outreach mechanisms and ASHA engagement are functioning as a key entry point into UPHC services.

Workforce Capacity and Staffing

Among staff across ten UPHCs, 87.8% reported that staffing levels were sufficient to manage patient demand. This suggests that, overall, facilities are perceived as adequately staffed to provide routine services. However, qualitative feedback highlighted important operational challenges. Several staff members reported difficulties managing workloads when colleagues are absent due to illness or leave, indicating limited surge capacity. Others noted that patient volumes can at times exceed available human resources.

The situation observed at the UPHC in Chikhali provides an important counterpoint to these generally positive findings. The prolonged absence of a regular Medical Officer, as well as other staff, and the reliance on intermittent staffing arrangements suggest that staffing adequacy varies substantially between facilities.

Training and Capacity Building

Most staff (85%) reported that they had received training within the last year. At the same time, 46.3% of staff members identified additional training needs. Requested training varied considerably (see Figure 12), suggesting that knowledge gaps are role-specific rather than reflecting a single common area requiring improvement.

85%
of staff reported
they received training
in the last year

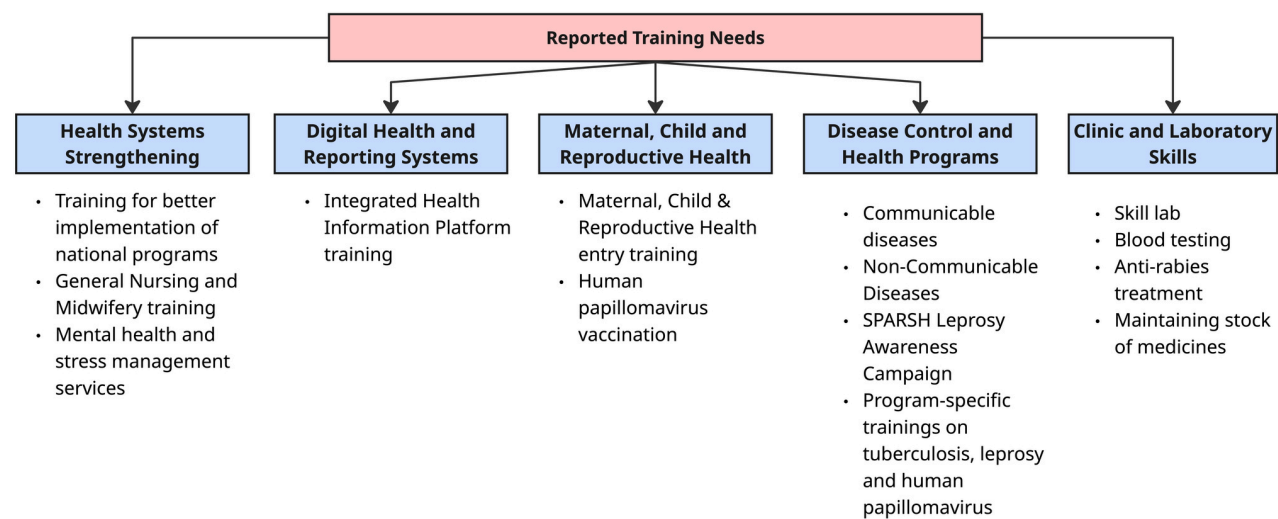


Figure 12: Reported Training Needs of UPHC Staff

Management Support and System Performance

The majority of staff (87.8%) reported that the local health administration is always supportive. While this finding suggests positive relationships between facilities and the administration, responses may be influenced by social desirability bias and should therefore be interpreted with some caution.

Staff confidence was universally high, with 100% reporting confidence in their ability to perform their duties. Similarly, all surveyed staff felt that their UPHC was meeting the healthcare needs of slum-dwelling populations within its catchment area. These findings reflect strong staff commitment to service delivery and confidence in the role of UPHCs within their communities.

almost

88%

**of staff reported
that the local health
administration is
always supportive**

100%

**of staff reported
confidence in
their work**

Community Outreach and ASHA Engagement

Overall, staff responses reflected a high level of confidence in community outreach systems with the majority of staff (87.5%) reporting that health outreach sessions are regularly conducted. In addition, 95% of staff indicated that coordination with ASHA workers always functions well. Most staff (92.5%) also reported that vulnerable groups within the catchment area are being effectively reached through existing outreach activities.

Patient responses further highlight the importance of ASHAs and community networks in generating awareness of UPHC services. As mentioned previously, 29.4% of patients had learned about UPHCs through ASHA workers. This pattern reinforces the critical role of informal social networks and community health workers in promoting awareness and facilitating service utilization.

Three surveys were conducted with ASHA workers from UPHC catchment areas in the Mangalwari and Dharampeth Zone. In addition, small informal interactions were held with ASHA workers accompanying patients at other UPHCs during facility visits. Also, ASHA workers were observed to help out in the UPHC by guiding or accompanying patients, such as children or the elderly, to the UPHC in the first place.

Overall, ASHAs reported that UPHCs are generally responsive to community health needs and coordination between ASHAs and UPHC staff was reported to function well. Health outreach sessions were reported to be taking place regularly. Two ASHAs shared two different training needs on the home-based newborn care program and general induction training.

Patient Experience

Most patients reported short waiting times, high levels of satisfaction with services received, positive interactions with staff, and trust in the care provided. Nevertheless, findings suggest opportunities for improvement, particularly relating to waiting areas, sanitation facilities, feedback mechanisms, and strengthening communication with patients.

UPHC as the Preferred Source of Care

The majority of patients reported that the UPHC was their first point of contact when seeking healthcare. 64.7% of respondents indicated that they would first visit a UPHC when experiencing a health concern. A further 20.6% of patients said they would either visit UPHCs or private clinics and hospitals depending on their needs. Only a small number reported primarily seeking care from government hospitals and medical colleges, or private facilities. These findings suggest that UPHCs play a central role in primary healthcare delivery within the communities they serve.

Satisfaction

Levels of patient satisfaction were high. Overall, 89.2% of patients reported being either satisfied (80.4%) or very satisfied (8.8%) with the services received, while 10.8% reported feeling neutral. No patients reported being dissatisfied. These findings indicate that most patients view the quality of care provided by UPHCs positively.

almost

90%

of patients are
either satisfied or
very satisfied with
UPHC services

Waiting Time

Waiting times were short, with 89.2% of patients reporting that they waited less than 30 minutes before receiving services. This suggests that UPHCs are largely able to provide timely access to care while often serving large patient populations.

almost

90%

of patients reported
waiting less than
30 minutes

Communication, Respect, and Trust

Patient perceptions of staff interactions were largely positive. Most reported that staff were polite and respectful, with 70.6% of patients indicating this was always the case and 25.5% reporting it occurred sometimes. Only a small number of patients reported that respectful treatment was rare. Similarly, trust in healthcare providers was high. 67.9% of patients reported that they always trusted the staff providing care, while 27.2% reported trusting them sometimes. Patients also generally felt that health concerns were explained adequately. 65% of respondents reported that staff always explained their health problems and treatment, while 31% reported this occurred sometimes. These findings suggest strong provider-patient relationships overall, although there remains room for improvement.

92%

of patients reported
having no problems
during their visit

Patient Concerns and Suggestions

Most patients (92.1%) reported experiencing no problems during their visit. The small number of concerns raised included a lack of adequate seating while waiting for services, exposure to heat and sunlight while waiting, the availability and cleanliness of toilets, perceived shortcomings in treatment quality, and perceptions that some staff were not sufficiently cooperative or responsive. These concerns align with issues observed during facility visits, particularly relating to patient comfort and infrastructure.

Patient Feedback Mechanisms

Facility observations identified feedback boxes in seven of the eleven assessed UPHCs. Among staff respondents, 75.6% reported that patients were able to provide feedback. Despite these mechanisms, patient awareness was low. Only 22.1% of patients reported knowing that they could provide feedback, while 73.7 % of patients reported they were not aware of any feedback process and 4.2% of patients did not know if there was a feedback mechanism in place or not.

Observations identified practical barriers to submitting feedback. No feedback box was accompanied by paper or pens (see Figure 13), requiring patients to actively request these from staff. In several facilities, feedback boxes were not prominently displayed, clearly labelled or provided with instructions. These findings suggest that while feedback mechanisms exist, they are not consistently visible, accessible, or understood by patients.



7/11

UPHCs had
feedback boxes

almost

74%

of patients reported
they cannot give
feedback

Figure 13: Khamla UPHC Complaint Box

Water, Sanitation and Hygiene

Findings identified several gaps across WASH infrastructure and services including inconsistent access to water, limited patient awareness, inadequate sanitation infrastructure for gender, disability, and menstrual hygiene needs, and significant shortcomings in hand hygiene facilities and supplies.

Across multiple indicators, observations revealed poorer conditions than those reported by staff. Patient responses often fell between staff perceptions and observational findings, suggesting that the existence of facilities does not necessarily translate into effective access or use.

Water

Water during working hours was available in ten of the eleven facilities on the day of the field visit. However, 12.2% of staff reported that water was not consistently available throughout working hours, indicating some occasional water shortages. The water source for the UPHC in Chikhali is an underground water storage with no connection inside the facility. The quality of water from this storage needs to be checked, as there was no lid covering it during the observation.

UPHC guidelines mandate facilities to provide safe drinking water facilities. However, access to drinking water was inconsistent across facilities. Three UPHCs did not have drinking water available. Staff perceptions reflected these findings, while patient awareness of drinking water facilities was considerably lower. While 57.3% of patients reported that drinking water was available, 29.1% of patients stated that they did not know whether drinking water was provided. Many patients visibly searched the facility for a water filter when asked about drinking water availability. Observations and feedback made clear that some drinking water stations were difficult to access, infrastructure such as filters or coolers was broken, one facility had no drinking cups available and another had a visibly dirty water unit.

8/11

UPHCs had drinking water available

almost

30%

of patients did not know if drinking water was available



Figure 14: Dighori UPHC Drinking Water Outside

Figure 15: Pardi UPHC Drinking Water Filter



Sanitation

Toilet quality and accessibility varied considerably across all UPHCs. For example, one facility had a toilet without a functional water supply and two facilities had only one toilet each which was reserved for staff, with one also being obstructed (see Figure 16). Observations showed that only four of the eleven facilities had consistently clean toilets. In three facilities, toilets were assessed as unclean, and in four facilities some toilets were clean and others were not (see Figure 17). By contrast, nearly all patients who had used the toilet during their visit, 31 out of 32, reported that it was clean. This discrepancy may reflect a mismatch between the cleanliness of toilets from visit and use, or differing expectations.

Patient awareness was low. While 57.8% of patients reported that toilets were available, 36.3% of patients stated that they did not know whether a toilet existed within the facility. Patients' feedback suggests that poor visibility and inadequate signage contribute to this lack of awareness.

Infrastructure for equitable and inclusive sanitation was limited. While 87.8% of staff reported that separate toilets existed for staff and patients, observations confirmed this in only six facilities. Similarly, although 75.6% of staff reported the presence of gender-specific toilets, only four facilities had separate toilets for men and women. Only five facilities had at least one barrier-free toilet.

Facilities supporting menstrual hygiene management were particularly limited. 70.7% of staff reported that bins were available in toilets. However, observations identified a bin in only one facility, located in the women's patient toilet. Notably, this toilet did not have a nearby handwashing station.

36%

of patients did not know whether a toilet existed in the UPHC

6/11

UPHCs had separate toilets for staff and patients

only

1 toilet

in all UPHCs had a bin inside



Figure 16: Khamla UPHC Staff Toilet



Figure 17: Hudkeshwar UPHC Patient Toilet

Hygiene

Significant discrepancies were observed between staff perceptions and observed hygiene infrastructure. Almost all staff respondents (97.6%) reported that soap was always available. However, observations found that soap was unavailable at key hand hygiene locations in five out of the eleven facilities, including two facilities where soap was absent altogether and three facilities where availability was limited. After inquiring, staff in one facility shared with us that the soap supply is not adequate and therefore used only with restrictions. A similar pattern was observed in toilet facilities (see Figure 18). Only one UPHC had soap available at all toilets, while eight facilities had no soap available at toilet handwashing stations. The remaining two facilities had soap available in some but not all toilet areas.

Patient awareness and use of hand hygiene facilities was limited. When asked whether patients had been able to wash their hands with soap during their visit, only 30.6% of patients responded yes, while 21.8% responded no and 47.5% stated they did not know.

Availability of handwashing infrastructure was inconsistent. All staff reported that handwashing points were available at points of care. However, observations confirmed this in only four UPHCs. Two facilities had no handwashing points at points of care, while five had only limited availability (see Figure 19). Handwashing stations near toilets were available in eight facilities, but two facilities lacked them entirely and one had handwashing stations at some but not all toilets.

UPHC guidelines require the display of handwashing instructions at points of use, but only three facilities displayed posters consistently. In four facilities, no posters were observed, while another four had only limited signage. In some cases, posters were present only in selected areas or had fallen off the walls. These findings are particularly noteworthy given the observation that gloves were rarely used by staff during patient interactions, suggesting broader challenges related to infection prevention and control practices.

4/11

UPHCs had
handwashing points
at point of care

3/11

UPHCs had
handwashing
instructions at all
points of use



Figure 18: Indora UPHC Handwashing Point Patient Toilet



Figure 19: Dhantoli UPHC Handwashing Point Laboratory (Not in Use)

Infrastructure and Layout

Across the UPHCs, infrastructure was functional but often constrained by limited space. Observations highlighted overcrowded layouts, insufficient waiting areas, limited storage capacity, and challenges accommodating both patients and staff within facilities, especially for persons with mobility difficulties. Additionally, in and around some facilities inconsistent protection from the heat was observed.

Overall Space Constraints

Limited space emerged as one of the most consistent infrastructure challenges across facilities. In several UPHCs, consultation rooms, pharmacies, laboratories, waiting areas, and administrative work areas were accommodated within small or shared spaces (see Figure 20 and 21). Space limitations also affected the organization of equipment and supplies, with chairs, benches, and other areas occasionally being used for storage or clutter (see Figure 22 and 23). As patient demand increases, these constraints may limit the ability of facilities to expand services or improve patient flow.



Figure 20: Pardi UPHC Hallway



Figure 21: Shanti Nagar UPHC Outside Area



Figure 22: Babulkheda UPHC Registration Area



Figure 23: Hudkeshwar UPHC Storage Area

Waiting Areas

All facilities had a designated waiting area with some form of seating available. However, in eight facilities, seating capacity was insufficient for patient demand. Common observations included patients waiting outside due to lack of indoor seating, seating located in narrow hallways that restricted movement, as well as benches and chairs being partially occupied by equipment or stored items (see Figure 24). These findings align with patient feedback which identified a need for additional seating and more comfortable waiting areas.



Figure 24: Shanti Nagar UPHC Waiting Area

Staff Facilities and Workspace

Dedicated staff facilities were limited in several UPHCs. Nine facilities had designated staff rooms. However, in many UPHCs, they often served multiple functions, including administrative work or general storage (see Figure 25). Almost all staff areas were small and lacked sufficient space for breaks, changing, or storage of personal belongings. This is why throughout observations, staff belongings were stored in consultation rooms, workspaces, and common areas, contributing to cluttered environments and reducing available working space (see Figure 26). In one facility without a dedicated staff room, cooking equipment was observed being stored on top of a refrigerator due to the absence of alternative space.

While these issues may appear minor, they reflect broader infrastructure limitations and may affect staff wellbeing, workplace organization, and the professional appearance of healthcare environments.



Figure 25: Pachpaoli UPHC Registration and Staff Room



Figure 26: Mominpura UPHC Storage and Work Area

Accessibility and Mobility

Only six facilities had a barrier-free entrance. Even where entrances were accessible, mobility challenges often remained within the facility due to steps, uneven surfaces, narrow corridors, and other physical barriers. Observations highlighted several examples of accessibility concerns including patients with mobility limitations experiencing difficulties navigating facility spaces (see Figure 27). In one facility, access to the laboratory area required stepping on stacked bricks. During the visit, a child fell when one of these bricks became unstable, illustrating the potential safety risks associated with inadequate infrastructure.

6/11

**UPHCs had a
barrier-free
entrance**

Environmental Conditions

Nine of the eleven facilities had functioning cooling mechanisms including fans and coolers in place. While several consultation rooms across facilities had air conditioning, they were only turned on in specific rooms in two facilities.

In two facilities, cooling provision was limited. In one UPHC, the waiting area lacked adequate cooling entirely and a cooler was placed at the entrance outside to blow cold air inside, as there was no space in the narrow corridor. The other UPHC operated laboratory services from a container structure where cooling equipment was present but due to the large open door the conditions remained uncomfortable, including the presence of flies. Outdoor conditions were similarly variable. Eight facilities provided adequate shaded areas around the facility, while three had only limited protection from sun exposure (see Figure 27). In some locations, patients waiting for laboratory services were required to sit in partially exposed areas (see Figure 28), while another facility had direct sun exposure at the entrance (see Figure 29).

These findings are important given that they were carried out during the hottest months of the year in Nagpur. Prolonged exposure to heat may not only affect patient comfort but also increase health risks for vulnerable groups and create challenging working conditions for staff.



Figure 27: Dighori UPHC Entrance



Figure 28: Indora UPHC Waiting Area for Laboratory



नागपूर महानगरपालिका, नागपूर
(आरोग्य विभाग)



आयुष्मान आरोग्य मंदिर



आरोग्यं परमं धनम्
नागरी प्राथमिक आरोग्य केंद्र

खामला

आयुष्मान
भारत



Figure 29: Khamla UPHC Entrance

FACILITY PROFILES

Overarching findings cannot fully capture the unique context of each facility, as the eleven UPHCs included in this assessment differ considerably. As a result, broad findings alone do not provide a complete picture of the strengths, challenges, and opportunities present at each facility.

Several of the UPHCs previously received support from the NMC and Tata Trusts through the “Model UPHC Project”, which remains visible in some facilities through infrastructure improvements and project signage. Other facilities were established after the completion of this initiative or have since been relocated, resulting in different levels of development and varying operational contexts.

The following eleven facility profiles provide a closer look at each assessed UPHC. While selected strengths are highlighted, particularly those that stood out during field visits, the primary focus lies on the challenges observed and priority actions identified for each facility.

Priority actions are intended to support practical improvements in the quality, functionality, and patient experience of each UPHC. **Many of the recommendations require only modest resources and can be implemented with relatively low cost and effort, while others may require greater planning or investment.**

Regardless of the level of input required, all priority actions represent issues that need consideration. Collectively, they identify essential improvements that would strengthen UPHCs and better support both the communities they serve and the health care staff who serve them.

Pachpaoli UPHC (Aashinagar)

50-100 Patients daily
Patient Consultation from 8 AM - 1 PM

Strengths

- A long corridor with benches provides adequate waiting space for patients.
- Staff toilets are especially clean, equipped with soap and have a dustbin very close.

Key Challenges

- Lack of clear signage for registration and patient navigation, including toilets, due to ongoing renovations. Signs are stored in a storage area as of now.
- Open windows in waiting areas with only curtains and posters hung up. While constructions are on-going, warm air and rain can come through.
- The drinking water facility has not been functional for at least the last year.
- Patient toilets are unclean, with foul odor and no soap or nearby waste bins. No barrier-free toilet available.
- Absence of a feedback/complaint box.

Priority Actions

- Install clear and visible signage for registration, toilets, and key service points.
- Repair or replace the drinking water system to ensure continuous access to drinking water.
- Improve cleanliness and maintenance of patient toilets; ensure availability of soap and waste bins. Ensure there is at least one barrier-free toilet.
- Address the open windows in the patient waiting area.
- Install a feedback/complaint box including instructions, pen, and paper.



Babulkheda UPHC (Dhantoli)

~ 200 Patients daily

Patient Consultation from 8 AM - 1 PM

Strengths

- Patient flow is well managed through staff and in ventilated and shaded outdoor waiting areas.
- Privacy is maintained during consultations as the door to the Medical Officer is kept closed.

Key Challenges

- The drinking water facility is placed in a corner that is not very visible. No glass or cup available to drink water.
- No instruction is displayed for the feedback/complaint box and there is no pen or paper.
- Laboratory located in a temporary container with poor ventilation and high fly presence. Access is not barrier-free but via stacked bricks. Patients are seated in partial shade and without fans. The handwashing station in the laboratory is not accessible and not used.
- One single toilet inside the facility labeled as “ladies toilet” is serving both staff and patients. No nearby handwashing station for the toilet inside. External patient toilets run by NMC and located next to the UPHC were closed during the visit. Due to the closure, a nearby corner was being used as a urinal, and the surrounding area contained garbage, flies, and unpleasant odors.

Priority Actions

- Upgrade laboratory infrastructure to a permanent, clean, and well-ventilated space. Ensure barrier-free access, a handwashing point and adequate waiting arrangements (shade, seating, fans) for laboratory patients.
- Provide separate toilets for staff and patients with handwashing facilities. If NMC toilets will be used for patients, ensure that facilities are open throughout UPHC opening times.
- Improve the visibility of the drinking water point and provide cups or glasses.
- Make feedback/complaint mechanisms more accessible by providing pen and paper.



KT Nagar UPHC (Dharampeth)

100 - 150 Patients daily

Patient Consultation from 8 AM - 1 PM

Strengths

- Adequate infrastructure including a large waiting area and staff room, multiple consultation rooms, a laboratory and a well-organized pharmacy.
- Consultation room equipped with a functioning air conditioner.
- Dedicated breastfeeding corner with curtain and chair ensuring privacy.

Key Challenges

- The facility is not easily visible from the main road due to faded exterior signage. There is also no sign downstairs pointing patients upstairs to the UPHC.
- Entrance accessible only by stairs, limiting access for persons with disabilities, elderly patients, and those with mobility issues.
- No paper and pen are provided with the feedback/complaint box.
- Lack of soap in all patient and staff toilets. Toilets are not clean. Poor hand hygiene promotion in toilets with posters absent or lying on the ground.

Priority Actions

- Replace or refurbish the signboard to improve visibility from the main road. Add a signboard at the stairs to point patients upstairs to the facility without confusion.
- Explore options to improve accessibility to the facility (e.g., ramp installation or alternative entry solutions).
- Ensure continuous availability of soap in all patient and staff toilets.
- Clean toilets appropriately.
- Install clear and durable hand hygiene posters in all toilets at appropriate locations.
- Make feedback/complaint mechanisms more accessible by providing pen and paper.



Mominpura UPHC (Gandhibagh)

~ 50 Patients daily

Patient Consultation from 8 AM - 1 PM

Strengths

- Drinking water was available near the entrance.

Key Challenges

- Limited seating and waiting space for patients.
- No separate consultation room for children; vaccination and checkup were conducted in a hallway area without privacy.
- ORS corner was signposted but not actually in place.
- Toilet arrangement was not clearly separated for staff/patients or males/females. The handwashing point at one toilet lacked soap and a hand hygiene poster.
- Toilets and access routes inside were not barrier-free.
- The pharmacy space was small and the signage was confusing.
- The storage area behind the laboratory had unclear use and signage.
- No paper and pen are provided with the feedback/complaint box.

Priority Actions

- Provide additional seating arrangements for patients.
- Create a separate, private consultation space for children.
- Set up the ORS corner as indicated by signage.
- Improve toilet access, signage, and accessibility.
- Ensure soap and hand hygiene posters are available at all handwashing points.
- Clarify pharmacy and storage signage to avoid confusion.
- Promote accessibility by setting up a ramp inside the facility.
- Make feedback/complaint mechanisms more accessible by providing pen and paper.
- Review space use in the laboratory area and nearby rooms for better organization.



Hudkeshwar UPHC (Hanuman Nagar)

100 - 150 Patients daily

Patient Consultation from 8 AM - 1 PM

Strengths

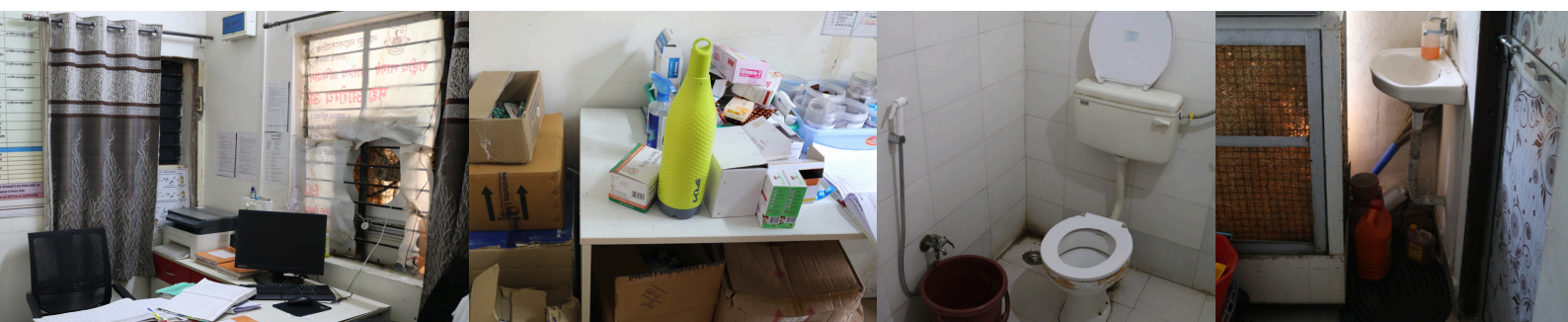
- Numbering system in place, with patients called according to assigned numbers.

Key Challenges

- Small facility size made service organization difficult and caused crowding.
- Very limited seating in the initial waiting area. Additional seating outside was shaded but had no fans.
- The staff room had limited space.
- The registration counter was not clearly labeled.
- Toilets were poorly maintained, especially the patient toilet. No waste bins near toilets.
- Handwashing point near toilets obstructed by a cooler.
- Pharmacy dispensing counters were unorganized and storage space was insufficient.
- The back-room storage area was cluttered and not well organized.
- Absence of a complaint/feedback box, even though a sign was there.

Priority Actions

- Provide additional seating arrangements for patients.
- Clearly label the registration counter.
- Improve toilet cleanliness and ensure garbage bins are available.
- Reorganize the pharmacy dispensing area and improve storage space, including additional racks or shelves.
- Review space use within the facility to improve patient flow and service organization.
- Use racks or shelves for better organization in the storage corner. Remove the obstructions in that area to ensure easy access for the handwashing point.
- Install a complaint/feedback box including instructions, pen, and paper.



Pardi UPHC (Lakadganj)

100 - 150 Patients daily

Patient Consultation from 8 AM - 1 PM

Strengths

- Family planning IEC corner available.
- Facility layout and fire evacuation plan clearly displayed.
- Breastfeeding corner available with a curtain.

Key Challenges

- The water filter and glass appeared unclean.
- The abandoned handwashing point outside was dirty, cluttered, and without a water connection.
- Premises outside and inside were cluttered with unnecessary junk materials.
- Two toilets inside were not clearly separated or labeled.
- The outdoor toilet was very dirty, had an odor, and had no soap.
- Cable in the Medical Officer's room obstructed the handwashing basin.
- The breastfeeding corner lacked a chair and was partly used as a storage area.
- Complaint boxes were confusing, with two different boxes hanging and no pen or paper available.

Priority Actions

- Clean up and remove all unnecessary items from the premises, inside and outside. Use available space on the second floor for organized storage with shelves or racks.
- Clean and maintain the drinking water point and glasses.
- Restore or remove the abandoned handwashing point and ensure proper water connection if kept in use.
- Clearly label and separate toilets for users. Improve cleanliness and maintenance of the outdoor toilet, and provide soap.
- Remove the cable blocking the handwashing basin in the Medical Officer's room.
- Provide a chair in the breastfeeding corner and clean the area.
- Make feedback/complaint mechanisms clear by taking one box down and providing a pen and paper.



Chikali UPHC (Lakadganj)

At the time of the assessment, the UPHC was not functioning due to no medical officer being in charge. However, the facility has strong potential. The building is spacious and the location is highly accessible for slum dwellers. Patients and community members want the UPHC to function properly. Patient load had been high, with around 50 to 100 patients per day before the medical officer left in early 2026.

Key Challenges

- No water connection inside the facility; water access is only available from outside through an underground water storage. No lid closes this water storage, leaving it open and affecting water quality (see Figure 28).
- No soap available anywhere in the facility.
- No laboratory services.
- No signage for registration or pharmacy.
- Very warm indoor environment, with limited cooling and no fans.
- No staff room.
- Only one toilet was open for both staff and patients; the other toilet was locked.
- Limited indoor waiting space, with some outdoor seating but no fans or coolers.
- Absence of a feedback/complaint box.



Figure 30: Access to the Underground Water Storage located next to the UPHC

Priority Actions

The facility needs a medical officer in place so the UPHC can function properly and provide regular services. Besides this, the most urgent action is to ensure a water connection inside the facility is being installed.

- Provide soap throughout the facility.
- Install clear signage for registration and pharmacy.
- Reorganize the large unused storage room and repurpose part of it as a staff room, waiting area, or laboratory.
- Improve cooling and comfort in the waiting area by adding fans and better seating.
- Ensure both toilets are usable and appropriately allocated.
- Install a feedback box in a visible location with instructions, a pen, and paper.



Khamla UPHC (Laxminagar)

50 - 100 Patients daily

Patient Consultation from 8AM - 1 PM

Key Challenges

- There is no shade in the entrance area in front of the UPHC. It is also not protected from rain.
- The facility was limited in space, creating overcrowded rooms and a cluttered environment.
- No staff room available; staff belongings were stored throughout the premises.
- Small waiting area near registration, with no dedicated waiting room.
- No drinking water available at the facility.
- There was only one toilet reserved for staff but access was obstructed by a cooler and storage box placed in front of the door. Patients were told via a sign not to use the toilet.
- Of the three handwashing stations, only one had soap, while the station near the toilet lacked soap.
- No paper and pen are provided with the feedback/complaint box.

Priority Actions

- Provide a roof at the entrance to protect patients and staff from sun and rain.
- Provide drinking water at an accessible location.
- Improve toilet access for staff and provide a patient toilet.
- Provide additional seating for patients.
- Ensure soap is available at all handwashing stations.
- Reorganize the facility using shelves or racks to reduce clutter and improve space use.
- Make feedback/complaint mechanisms more accessible by providing pen and paper.



Indora UPHC (Mangalwari)

100 - 150 Patients daily

Patient Consultation from 8 AM - 1 PM

Strengths

- Barrier-free entrance with clean, green, and well-maintained surroundings. A cloth is providing additional shade for patients walking towards the UPHC.
- The facility is well organized, spacious, and free of clutter.
- Spacious and organized staff room.
- Dedicated contraceptive corner with family planning supplies.
- ORS corner available for management of mild to moderate dehydration.

Key Challenges

- Laboratory located in a separate building, requiring patients to wait outside with only a partly shaded or covered area.
- Patient toilets located outside the facility; only one was accessible, while the female toilet was locked. The toilet had an unpleasant odor, was not barrier-free, and lacked soap.
- One treatment area lacked privacy as it was located in the waiting area.
- No paper and pen were provided with the feedback/complaint box.

Priority Actions

- Open the female patient toilet and ensure both toilets remain accessible. Clean and maintain the patient toilet and handwashing area regularly, and provide a dustbin.
- Improve the laboratory waiting area by adding fans and ensuring adequate shade or cover from rain.
- Improve privacy by changing one of the treatment locations away from the waiting area.
- Make feedback/complaint mechanisms more accessible by providing pen and paper.



Dighori UPHC (Nehru Nagar)

100 - 200 Patients daily

Patient Consultation from 9 AM - 1 PM

Strengths

- Token-based registration system with visible patient numbers in place.

Key Challenges

- The opening times are shorter for patient consultations.
- Severe space constraints affect seating, storage, and overall organization. The staff room is used as a computer room, with staff working in storage areas. Personal belongings and supplies are stored throughout the facility.
- A hallway with benches was the waiting area. No fans, but a cooler at the entrance was directed indoors. The outdoor area was shaded and had some benches, but no fans.
- Signage was confusing and in inappropriate locations. No clear directions to toilets. Registration and pharmacy windows not clearly marked.
- Entrance to the facility is not barrier-free.
- The drinking water filter is not easily visible or accessible, as it is located in the registration room. Drinking water was made available outside on a bench only.
- There was only one handwashing basin installed inside the facility, and not at the point of use. Soap was only available at the medical officer's desk.
- Toilets were not separated for males and females, not barrier-free, poorly maintained, and without soap or bins.
- No feedback box was put in place and the sign was left in the registration room.

Priority Actions

- Improve patient waiting conditions by providing fans and better seating arrangements.
- Clarify signage for registration, pharmacy, toilets, and other key service points.
- Align opening times with applicable guidelines.
- Improve accessibility by adding a ramp at the entrance.
- Reposition the drinking water point so it is visible and accessible for patients and staff.
- Clean and maintain toilets, ensure soap is available, and provide bins and handwashing facilities.
- Separate staff, computer, and storage functions more clearly where possible.
- Reorganize storage and staff areas with racks and proper space allocation.
- Install a feedback box in a visible location with instructions, pen, and paper.



Shanti Nagar UPHC (Satranjipura)

100 - 200 Patients daily

Patient Consultation from 8 AM - 1 PM

Strengths

- Hand-drawn facility layout map displayed.
- Dedicated emergency room available.
- Handwashing station with soap available at the main entrance with easy access for patients and staff
- Patient toilets and staff toilets were separate for males and females, with a bin available in the female patient toilet.

Key Challenges

- Limited patient seating, with much of the indoor bench space occupied by stored boxes.
- No fans or coolers available in the outdoor waiting area.
- The facility layout was difficult for patients to navigate.
- Junk was present in outdoor areas, and some posters were loose or on the ground.
- No directional sign for patient toilets outside and no handwashing point available for the patient toilet.
- Drinking water point located in the emergency consultation room near a separate entrance and therefore not easily visible to patients, resulting in low awareness.
- Soap was missing at some handwashing stations, including the emergency room basin.
- Limited parking space reported by patients.
- No paper and pen are provided with the feedback/complaint box.

Priority Actions

- Provide a handwashing point for the patient toilet.
- Ensure soap is available at all handwashing stations.
- Relocate the drinking water point to the main entrance or main patient waiting area.
- Install or repair fans for patients waiting outside.
- Reorganize stored boxes to free up seating space inside the facility.
- Clean up outdoor areas and secure posters properly.
- Improve signage, including directions to patient toilets.
- Increase parking space if feasible.
- Make feedback/complaint mechanisms more accessible by providing pen and paper.



RECOMMENDATIONS

1

Optimize layouts and infrastructure: Address space constraints through regular cleaning, the removal of junk and unnecessary items, more efficient use of available space, and the provision of adequate storage areas. Each facility should have a dedicated staff room. Ensure barrier-free access at the facility entrance and throughout the entire facility.

2

Review facility operating hours: Ensure that all facilities meet the requirement of operating for at least eight hours per day, with patients having access to consultations during the full period of operation. Regular monitoring should verify that essential services and staffing remain available and accessible during all operating hours.

3

Improve patient information and wayfinding: Ensure that all UPHCs have clear, accurate, and well-positioned signage that reflects available services and guides patients through the facility. Display hand hygiene posters at all handwashing points and provide a standardized list of available drugs and services in a visible location for patients.

4

Ensure safe and comfortable environments: Provide adequate shade, ventilation, and cooling in waiting areas and outdoor service points. Ensure that entrances, waiting spaces, and outdoor service points are protected from rain.

5

Promote workforce resilience and capacity development: Monitor staffing levels and vacancies regularly and establish contingency arrangements to maintain essential services during periods of staff absence or fluctuating patient demand. Establish a structured mechanism through which staff can regularly identify and communicate their training needs to the local health administration.

6

Provide water in all facilities: Ensure a reliable water supply and that drinking water points are fully functional, not just installed. Place water filters in visible, accessible, and clearly labeled locations for both patients and staff, and ensure they are cleaned and maintained regularly. Keep cups or glasses available and clean.

7

Strengthen sanitation infrastructure: Provide separate toilets for staff and patients, as well as gender-specific facilities. Maintain regular cleaning, keep facilities accessible during service hours, and install clear signage to direct patients to facilities. Where UPHCs rely on NMC facilities, ensure that these are open and accessible during service hours.

8

Strengthen infection, prevention and control: Conduct a refresher training on using personal protective equipment and the importance of hygiene, including the use of soap. Follow up on whether learnings are applied. Ensure an adequate supply of soap at all handwashing points and that hand hygiene posters are displayed at every station.

9

Strengthen patient feedback mechanisms: Increase awareness of the patient feedback mechanism. Ensure that feedback boxes are hung up in visible locations, clearly labeled, and provided with paper and pens.

CONCLUSION

This study demonstrates that **UPHCs in Nagpur play a vital role in delivering primary healthcare** and are **widely trusted, valued, and utilized** by the communities they serve. **High levels of patient satisfaction, frequent service use, and the preference of many patients to seek care first at UPHCs** highlight their importance within the implementation of the NUHM. Staff findings reflect **strong commitment to service delivery** and confidence in the role of UPHCs within their communities.

The findings suggest that progress has been made toward several of the priorities identified by the NMC and Tata Trusts in their 2017 **“Model UPHC Project”**. Good infrastructure, workflow organization, and service delivery were evident in several facilities that had previously been part of the initiative. However, many challenges which were identified in 2017 as contributors to poor utilization are still evident. Also, comparing this study's findings to the IPHS and NQAS shows that many standards are not fulfilled.

Observed challenges include:

- **Cluttered** environments, **space constraints**, and inconsistent facility maintenance,
- Facilities being **not barrier-free**,
- **Inconsistent protection from the heat** within and surrounding UPHCs,
- **Inadequate** or inconsistently maintained **WASH infrastructure**,
- Concerns regarding **infection prevention and control practices**,
- Patient **consultation hours** not being available for eight hours a day,
- Gaps in **patient awareness** of available services,
- Gaps in availability and accessibility of **feedback mechanisms**,
- Insufficient **staff facilities** and workspaces,
- Vulnerability to **staffing shortages**.

The **Chikhali UPHC** was **not functioning due to prolonged staffing shortages**. The decline in patient attendance underscores the importance of maintaining adequate human resources for continuity of care. Furthermore, the neglect of ensuring a water supply inside the facility illustrates a critical gap between planning and implementation of UPHCs.

This study also highlighted that the **availability of services and resources on paper does not always translate into availability from the patient's perspective**. Although several services and systems were formally in place, patients were often unaware of them or faced challenges in accessing and using them. By triangulating data from patient surveys, staff surveys, and facility observations, this study was able to identify **critical differences in stakeholder perspectives**, contribute to the understanding of **UPHCs as complex systems**, and demonstrate the importance of incorporating multiple viewpoints to evaluate health care service availability, accessibility, and quality.

A key consideration arising from this study is the need for further research in several important areas that were beyond its scope:

- Interviews were conducted among patients attending UPHCs, meaning the study population was composed of individuals who were aware of and able to access services. Consequently, these findings cannot be used to infer the level of awareness, accessibility, or utilization of UPHCs within the broader community. Future community-based studies should assess **population-level awareness, barriers to access, and reasons for non-utilisation** to provide a more representative understanding of UPHC reach and coverage.
- Despite the “Model UPHC Project’s” vision of leveraging technology, electronic medical records were not observed. Patient registration and record-keeping relied entirely on paper-based systems, highlighting an important **gap in digital health implementation**. This needs further investigation.
- Although observations suggested that patient privacy in consultation rooms was limited, this study did not assess privacy practices or their impact on patient comfort, dignity, and care-seeking behaviour. Future research should investigate the extent to which **consultation room design and clinical practices protect patient privacy** and how this influences patient experiences and utilization of services.
- This study did not examine how patient feedback is collected, reviewed, or translated into improvement measures. Future research should evaluate the **functionality and effectiveness of patient feedback mechanisms**, including the processes through which concerns are documented, addressed, and incorporated into service improvements.
- This study did not examine healthcare waste management. As a critical component of WASH in healthcare facilities, future studies should evaluate **waste segregation, handling, storage, treatment, and disposal practices** to provide a more comprehensive assessment and identify opportunities to strengthen environmental and patient safety.
- Future research should investigate **infection prevention and control practices**, such as hand hygiene, environmental cleaning, and the availability and appropriate use of personal protective equipment, to better understand their role in reducing healthcare-associated infections and improving quality of care.

Finally, the findings of this study should be interpreted in light of its purposive, non-probability sampling design. **The assessment provides an in-depth understanding of the selected UPHCs but was not intended to produce statistically representative estimates for all UPHCs in Nagpur.** Consequently, the findings should not be assumed to reflect conditions across all facilities without further investigation.

Nevertheless, the study provides important insights into the functioning of UPHCs and identifies practical areas for strengthening services. **Facility-level and nine overall recommendations** spanning across infrastructure, opening times, capacity development and WASH services have been formulated. It is now **key to act** upon these recommendations to improve service delivery.

Together with future research addressing the identified evidence gaps, **the findings can inform policy, planning, and public health practice** to support improvement of services.

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