**UNICEF Regional Office for South Asia**

Terms of Reference fortheConsultancy

**“Engagement of the Private Sector in Primary Health Care in South Asia”**

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| Section/Unit and supervisor of post | Health Section  Health Specialist – Health and Immunization Financing |
| Title of the Position | Consultant – Engagement of the Private Sector in Primary Health Care in South Asia” - National |
| Duty Station | Home-based (remotely) |
| Duration of Position | Six months starting 1st July to 31th December 2023 |
| Expected Travel | No travel is expected |

For temporary staff-like functions, or functions that require daily attendance at the office, the appropriate contract modality is that of an Individual Contractor, not Consultant. Consultants TOR must be delivery-based with tangible products to be completed at set dates. Please choose which category this TOR falls under (*required*):

Individual Contractor:

Individual Consultant:

1. **bACKGROUND and JUSTIFICATION**

Every year, 35.3 million children are born in South Asia. According to 2019 estimates, one in 40 of them – that is, 882,000 babies – tragically die in the first month of life (a neonatal mortality rate of 25 per 1,000 live births). A further 524,000 of them die before the age of five (a total under-5 mortality rate of 41 per 1,000 live births). There are 651,000 stillbirths. According to the latest available estimates (from 2017), 57,000 mothers die annually – a maternal mortality ratio of 163 per 100,000 live births. While more and more children in the region get routinely immunized, challenges with access and equity are still significant. 5.3 million (2021) of the 35 million children born every year remain un- or under-vaccinated. Around 4.3 million of these children are zero-dose children – that is, they receive no immunization at all.

Poor nutritional status among adolescents and women of reproductive age continues to drive the cycle of undernutrition from one generation to the next in most countries in the region. Poor maternal nutrition and low birth weight are consistent predictors of stunting and wasting in the region. South Asia bears more than half of the world’s wasted children under the age of five (25 million). The region has the highest prevalence of low birth weight (LBW) in the world. More than one in four children (27%) have a birth weight of less than 2.5 kg and start their first days small and vulnerable. According to 2020 estimates, 56 million children under the age of five in the region suffer from stunted growth and development (or 40% of the world’s stunted children). At the same time, the prevalence of overweight is rising steadily in children in the region, and currently affects 4 million children under the age of five. The increasing prevalence of overweight in women aged 15-49 years is a cause for concern, and there are signs it is rising in school-age children and adolescents due to unhealthy diets.

All the above issues – newborn mortality, maternal mortality, prevention of vaccine preventable diseases stunting, wasting, non-communicable diseases, mental health, and other conditions – have their own specific set of solutions and approved standards of care. But a strong primary health care (PHC) system provides an evidence-based framework for ensuring efficient use of resources and equitable coverage, and institutionalizing quality improvement and social accountability systems. It provides multiple contact opportunities between parents, caregivers and community level decision-makers with timely and appropriate information on a wide range of health and nutrition preventive and promotive measures, including holistic approaches such as positive parenting and early childhood development. Strong primary health care (PHC) is foundational to ensuring that every child, including adolescents, survives and thrives and that communities and support systems remain resilient in case of emergencies.

It is because of this relevance, that the UNICEF South Asia Regional Office (ROSA) has identified PHC as a pillar in its new plan, formulating it as one of its key outputs that will contribute to the outcome “Every child, including adolescents, survives and thrives”. To deliver on this output, ROSA is undertaking a two-track approach:

* Working across sectors to strengthen Primary Health Care to protect and care for the health and well-being of mothers, newborns, children and adolescents, and promoting early childhood development.
* Working within each sector to address the highest priority specific issues, to improve equitable coverage of high-quality essential services, to accelerate progress towards the SDGs for health and well-being.

As per the WHO technical series on Primary Health Care[[1]](#footnote-2) and recent analyses, countries have faced multiple challenges that provide an incentive for increasingly engaging the private sector (for profit and not for profit)[[2]](#footnote-3). These challenges include fiscal space constraints arising from financial crisis and limited ability to collect taxes, changes in disease burden (increasing NCDs), demographic shifts, population displacement, aftermath of COVID-19 pandemic, and political and economic instability. At the same time, at least half the world’s population still lacks access to essential health services, and almost 100 million people are pushed into extreme poverty each year by the costs of essential healthcare. Governments face several difficult choices on how best to allocate limited funding in view of a long list of priorities. The private sector is well-positioned to contribute to achieving UHC and already provides health products and services for millions of people and communities globally. Most countries have mixed (public and private) health systems. In many LMICS, the private sector is an important source of PHC provision.[[3]](#footnote-4) In the ROSA region, the for-profit private sector offers a diverse range of health and related products, services, and innovation. In some countries, e.g., Bangladesh, the private sector provides over 60% of health services.

The role and scope of the private sector in health has grown and evolved in many countries globally and in the ROSA region over the last ten years, and even more so over the last three years when the COVID-19 pandemic provided an impetus for innovation through digital approaches, integrating information flows and optimizing resources. At present, partnerships and/or a mix of public-private entities may be found in the provision of health services, in areas of medicines and medical products, financial products, training of the health workforce, information technology, infrastructure and support services[[4]](#footnote-5). While the private sector demonstrated its role in maximizing efforts to advance Universal Health Coverage (UHC), there have also been critics pointing out that PPPs have led to inequitable outcomes and other issues. The private sector should be properly regulated and integrated in the health system, to ensure resource optimization, accountability/reporting, and access to quality care for all, in accordance with national health policies and targets. Such integration, specifically into PHC platforms for ensuring greater access, equity and quality, requires mechanisms to channel public funds to the private sector through purchasing arrangements, which in turn requires effective regulation, contracting capacity, and a broader set of purchasing institutions, including accreditation.

Recognizing the important role that the private sector can play, UNICEF’s Health Systems Strengthening Approach (2016)[[5]](#footnote-6) highlights, as one of its five areas of focus across national, district, and community levels, “engagement and regulation of the private sector.” As appropriate to the level of the health system and the country context, UNICEF prioritizes “supporting national and development partners to engage and regulate the private health sector in provision of UHC and in monitoring and surveillance systems, and to ensure that private providers and organizations, and the private sector more generally, contribute to equitable and quality health outcomes for children and women.” Some recommended core actions in this area include: strengthen provider regulation and maintenance of standards; inclusion of the private sector in efforts to achieve UHC; engage private providers in data gathering and information management; partnerships with private and non-state sectors to build health sector capacity; and promote corporate social responsibility. In 2020, UNICEF started to revise its 2016 approach. Although not yet finalized, this approach expands the priority areas to 7, of which one is “Governance and Partnerships with Civil Society Organisations and the Private Sector.” This includes efforts to strengthen providers’ capacity in regulation and maintenance of standards, and engaging with private and non-state providers, and suppliers to build health sector capacity and be included in efforts toward UHC.

Engaging with the Private sector (for-profit or not-for-profit) has also been identified as one of the ten policy lessons from the report, “Accelerating progress towards Universal Health Coverage in South Asia in the era of COVID-19[[6]](#footnote-7)” (UNICEF and Chatham House, 2021). This can be done by contracting private health providers and utilizing private facilities to improve access to services which are provided free of cost; regulation, monitoring and oversight of the private sector e.g., Clinical Establishments (Registration and Regulation) Act[[7]](#footnote-8) in India (2010, revised 2018), defining minimum standards, monitoring for performance on quality standards, government sponsored schemes e.g., Ayushman Bharat[[8]](#footnote-9) in India wherein treatment costs are born by the government and services provided at empanelled health facilities for free; development of skills and capacity building for health ministries for partnerships.

Engaging the private sector for PHC for integrated delivery of health services has also been identified as a key Operational lever in the Operational Framework for PHC by WHO and UNICEF[[9]](#footnote-10). A recent WHO survey of 65 Member States showed that over 40% of health care services are provided by the private sector which included services provided to the poorest and most vulnerable, and thus the importance of private sector engagement is recognized as part of a comprehensive approach to PHC. Some examples of engaging the private sector successfully in this area include NGOs contracted to manage primary care and hospital services in Afghanistan, Pakistan and India, Laboratory services (regulating rates and quality standards for COVID-19 RT PCR and rapid testing) across the region, mixed insurance schemes and subcontracting of private providers, use of technology to provide better services and improve access (eHealth and Telemedicine). Complementing this regional overview, more specific examples are provided for the two countries that will be part of the scope of this project. The two countries, Bangladesh and Pakistan, were selected based on expressed interest for engaging the private sector more strategically, as well as the important role the private sector already plays in the provision of PHC.

**PHC in Bangladesh**

Bangladesh has performed well in achieving the health-related Millennium Development Goals, by using its limited health spending efficiently and equitably, concentrating on primary care services and advancing the social determinants of health. However, as the population ages and the burden of non-communicable diseases increases, its health system is not well placed to reach the health-related Sustainable Development Goals (SDG) targets including UHC. Furthermore, the COVID 19 pandemic has helped to identify the gaps in the Health system. While the private sector has capacity, it is not well regulated and law enforcement mechanisms fall short of ensuring that standards are met.

Bangladesh has significant infrastructure for delivering PHC services. However, due to challenges in planning and coordination (e.g., fragmented administrative system), lack of trained human resources to provide quality PHC services, lack of community accountability mechanism, fragmented information system, lack of referral system, the full potential of this infrastructure has never been optimized. Moreover, the private sector has very limited contribution to the PHC services. Most of the services in the private sector facilities start from the secondary level outdoor and indoor care, and a large part of untapped service provision happens at private doctor chambers, and unregulated pharmacies selling medicine (even antibiotics) without prescriptions. On top of everything, Bangladesh has neither been able to pass two laws on Accreditation, and on National Health Security Office establishment, which has been one of the bottlenecks in instituting quality of care standards across the board, and establishing a national social health insurance mechanism (all efforts to introduce social insurance has met subpar results and almost no progress).

Bangladesh is one of the countries in the world with the most rapid urbanization and fastest growth of slum areas. Currently around 37 percent (62.5 million) of Bangladeshis live in urban areas; this urban population is growing at the rate of 5 per cent per annum, and in the next 30 years (by 2050) this will almost double, reaching 117.8 million. Social services such as health, nutrition and education are not keeping pace with urbanization, and people - especially the poorest, migrant slum dwellers - are left behind in accessing their basic rights to services, including PHC. Urban Primary Health Care services are fragmented and have been operating in a time-bound project mode through different NGOs for over twenty years with the support of developmental partners and international and national NGOs. In addition, providing Primary health care in urban (especially metropolitan) areas fall under the responsibility of the local government institutes (City Corporations & Municipalities), which has limited capacity, including manpower and infrastructure, which push the people go to the private sector including the poor as there is no other alternative. While in 2020, a government order mentioned a decision to ensure support from the Ministry of Health to strengthen service provision at the facilities operated by the Ministry of Local Government, there has been a general impasse in this regard from both the ministries.

While 35% of the women deliver at home, most of the women who deliver at health facilities, deliver in private health facilities (45% private HF, 18% Public HF). There is an alarmingly high level of Caesarean section deliveries (45%), where the private sector is the highest contributor (a total of 1.35 million children out of 1.6 million C-sections, i.e., 84% of all C-sections in the country; 83% of the deliveries in the private sector are Caesarean Sections).60% of women seek family planning services from the private sector and 3% form NGO sector (DHS2022). 55% of children with ARI sought care from a private provider and only 16% was from a public provider. Households (13%) in Bangladesh are pushed into poverty through increased out-of-pocket (OOP) spending (74%) and inequalities in access are further exacerbated.

Bangladesh has a well performing immunization system and the cold chain is supported by UNICEF through offshore procurement. Private sector in the country produces domestic refrigerators and have capacity to upgrade the quality for vaccine cold chain storage, as per WHO PIC system.

***Existing UNICEF partnerships with Private sector in Health***

* Aalo Clinic, PHC clinics in the urban deprived areas
* Bangladesh Neonatal Forum
* Obstetrical and Gynaecological Society of Bangladesh (OGSB)

***Ongoing activities with private sector involvement and possibilities for expansion in BCO***

* BCO is building a PHC model using private sector scheme operator for urban PHC. Innovations include empanelment of medical staff, digitization of medical records, evening opening hours, community outreach, among others.
* HMIS currently only captures public health services. UNICEF supported MIS to integrate private and NGO sector data into routine HMIS system and more than 170 NGO facilities from urban areas has already incorporated into the routine HMIS system with limited indicators. In addition, more than 55 private facilities were regularly reporting the COVID information on regular basis during the period of COVID and most of those facilities are still providing the data. However, there is a need to include routine private sector data into the routine HMIS system from all private facilities, to ensure complete data is available to the MoHFW for accurate review of the status of PHC to take decision based on data. UNICEF BCO plays a significant role in HMIS support to MoHFW and could expand that scope of work. In addition, a large number of private sector hospitals have their own HMIS tools, which can be eventually connected to a national shared health record database, which UNICEF is also currently working on.
* Contribute to regulation of private sector PHC. The private sector is poorly regulated, and quality is not assured, while quality of care standards, based on WHO guidance, are introduced to limited scale in the public sector. The Government of Bangladesh currently has efforts to introduce licensing requirements more stringently, and a combination of compliances in quality standards and reporting standards can be one of the key initiatives from the government that can be supported.
* Bangladesh should work on strategic purchasing of quality health care (PHC) yet ensuring quality standards for care are met and complied with, remains challenging as authorities have limited capacity. Initiatives from both the Ministry of Health and Ministry of Local Government to establish quality and reporting standards requirements for the private sector and using these standards as basis for empanelment of private facilities into government’s strategic purchasing agreement will go a long way to ensure quality PHC through the private sector.
* Feasibility of empanelment of health workers and private sector facilities to ensure services in afternoon/evening or 24/7 (CeMONC)
* Cold Chain installation is done with private sector in Bangladesh. In future local production of cold chain equipment for vaccine storage could be planned for.
* Ongoing engagement with professional bodies for setting standards of MNCAH and improving standards in public sector facilities; this could be expanded to private sector facilities.

1. **ObjectiveS**

The aim of this consultancy is to identify potential opportunities for engaging the private sector on Primary Health Care (PHC) in the ROSA region and countries. This means examining the private health sector across the region and within individual ROSA countries and proposing ways to strengthen private sector engagement in PHC planning, financing, quality and delivery to ensure timely access to quality PHC services, without financial hardship for all.

The regional part of the analysis provides the basis for engagement (regional road map) and the country-specific action plans provide an immediate way forward to help jumpstart the private sector engagement (e.g., pilot projects, mechanisms for collaboration, policy reform). The consultancy will specifically explore, conceptualize, and prioritize concrete engagement opportunities in two countries - Bangladesh, and Pakistan, and develop proposals to turn the most promising of those opportunities into viable pilots/policy reform ready for implementation.

1. **assignments and tasks**
2. Preparation of country-specific knowledge products (deep-dives) and strategic documents for private sector engagement in PHC in Bangladesh.

The consultant will proceed with the development of the knowledge products and country action plan under the overall guidance of the ROSA team and country offices. The structure and content of all deliverables (and workshops) will be agreed with ROSA team. The delivery and timeline of country specific action plans will be discussed and agreed with UNICEF country offices and the local government and partners (to the best possible extent).

1. Situation analysis and scoping: understand the national context and background for engaging the private sector (PS) in PHC in Bangladesh. Describe the private sector’s current size, recent growth, scope, and role in healthcare at the country level. For example: % of Health services delivered by PS in the country, (hospital/clinics/pharmacies at various levels, national/local split), contribution of PS towards innovation in health in terms of processes and technologies (digital, eHealth, etc), PS financing, PS contribution to UHC, etc.
2. Conduct landscaping of existing private sector engagement activities by other partners, evaluate options for strategically strengthening existing initiatives.
3. Review of government policy towards private sector engagement and evaluate actual state of implementation. Regulatory, legal and implementation mechanisms for PS sector integration in health services (e.g., accreditation, data sharing with HMIS, purchaser-provider mechanisms, payment, and insurance cover, etc.).
4. Define and prioritize challenges in dealing with private sector and barriers to private sector engagement at country level. Identify opportunities for engagement with PS (feasibility study). Prioritization can be done based (based on urgency, impact, feasibility of resolution, and other factors. Suggest for way forward (regional priorities and roadmap for optimal collaboration with private sector). Focus on actionable recommendations for strengthening private sector participation and engagement.
   * + Define a list of generic engagement opportunities at regional level
     + Design engagement mechanisms (events, publications, etc) and target group
     + Prepare a roadmap for private sector engagement in PHC (including feasibility study, costing of PHC packages of services provided by the PS in the region (the cost can be presented as a range).
5. Bangladesh was selected for a specific country deep-dive, based on expressed interest in PS engagement (by government and stakeholders) and the urgency of engaging the PS since it is already heavily engaged in providing PHC. The country deep-dives should be in the form of action plans that can be integrated with on-going PHC and HSS advocacy activities (at Country Office level) and start being implemented in different formats: pilots, policy and financing reform, advocacy. The action plans can contain the following parts:
   * + Overview and context, describing i) the current role that the private sector holds (size, impact on PHC service, financing contribution, health information system and oversight, etc), ii) government policy, plans and strategies related to private sector engagement in the health sector (e.g. PPP authority in Bangladesh, national health strategy and sector plan), as well as iii) categorization of different types of private sector engagement mechanisms in place (e.g. donor funded, national/international private sector presence, etc).
     + Challenges and solutions. Based on the above overview and in consultation with government, partner and private sector stakeholders, review opportunities and areas of collaboration and provide a prioritised list of areas for private sector engagement. Prioritisation should be based on country needs/interest, private sector capacity/capability, feasibility of implementation, as well as other relevant factors.
6. The consultant will work closely with the international consultant preparing the Regional PS engagement in PHC strategy, as well as the consultant working on the country deep-dive for Pakistan.
7. Testing and finalizing the country action plans.
8. Design engagement mechanisms (events, publications, TA support needs, etc.) and identify targets and potential pilot projects for engagement.
9. Upon completion of the knowledge products (regional strategy and country deep-dives) the consultant will organize a round of ideation workshops to help shape and define concrete engagement opportunities with the private sector in the country. The workshops will target relevant government and private sector stakeholders, UNICEF Country Offices, as well as partners. The workshops will provide a platform for testing the action plan and suggested interventions (pilot, policy change, etc.). The consultant will integrate feedback into the final country action plans on private sector engagement in PHC.
10. Review and dissemination of the knowledge products at country and regional workshops. Upon completion of the knowledge products (regional strategy and country deep-dives) the consultants (from Bangladesh and Pakistan, as well as international) will organize dissemination workshops (1 regional and 1 in each country) to present the plan with a range of relevant regional and national stakeholders (UNICEF Country Offices, government, private sector, academia, ROSA office, etc). Where needed, the plans should be translated into local languages, to ensure that all stakeholders can fully engage
11. **CHILD SAFEGUARDING**

Is this project/assignment considered as “[Elevated Risk Role](https://unicef.sharepoint.com/sites/DHR-ChildSafeguarding/DocumentLibrary1/Guidance%20on%20Identifying%20Elevated%20Risk%20Roles_finalversion.pdf?CT=1590792470221&OR=ItemsView)” from a child safeguarding perspective?

Yes  No If yes, check all that apply:

Direct contact role?  Yes  No

If yes, please indicate the number of hours/months of direct interpersonal contact with children, or work in their immediately physical proximity, with limited supervision by a more senior member of personnel:

Child data role?  Yes  No

If yes, please indicate the number of hours/months of manipulating or transmitting personal-identifiable information of children (name, national ID, location data, photos)

More information is available in the [Child Safeguarding SharePoint](https://unicef.sharepoint.com/sites/DHR-ChildSafeguarding/SitePages/Amendments-to-the-Recruitment-Guidance.aspx) and [Child Safeguarding FAQs and Updates](https://unicef.sharepoint.com/sites/DHR-ChildSafeguarding/DocumentLibrary1/Child%20Safeguarding%20FAQs%20and%20Updates%20Dec%202020.pdf).

1. **Planned BUDGET**
2. Professional Fee (Lump Sum): 90 days x USD currency \_USD\_

This estimate is based the following considerations: Click or tap here to enter text. Consultants fees are based on all deliverables. For contractors with attendance requirements, assume a 21 day work week for fee calculation, minus anticipated time-off.

1. Travel cost
2. Travel cost estimate (Lump Sum): currency USD\_\_

OR

1. Best estimate of required travel at the time of TOR preparation:

If not lump sum: the travel cost estimate is based the following considerations:

Itemize planned travel and costs here. Click or tap here to enter text.

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| Note: Due to the Regional Office role, exact travel needs may vary throughout the consultancy/contract.  Air travel will be in economy class. DSA, Terminal, etc, will be as per UNICEF travel policy for consultants/contractors. Consultants/contractors on travel status must complete the BSAFE course prior to travel. No DSA is payable for consultants/contractors to be based in a particular location/duty station as those costs should be included in the fee lump sum.  If travel costs are not based on the preferred lump sum approach, reimbursement will be based on actual costs, not to exceed standard travel costs applicable to staff travel (economy class).  If there is a high likelihood of change-in-travel plans, the TOR budget estimates should aim at the highest potential travel costs to avoid cost-based extensions.  Total Estimated Cost of the Consultancy/Contract: |

Total Estimated Cost of the Consultancy/Contract:

Payments are due upon timely completion of each deliverable or contracted function certified as

satisfactory by the supervisor/manager.

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| * consultant will be paid upon satisfactory completion of assigned tasks and receipt of key deliverables and as certified by the Supervisor/Manager. A contractor will be paid as per the agreed schedule for performance of the contracted functions or activities. * UNICEF reserves the right to withhold payment or partial payment for deliverables that are of poor quality or that do not meet the deadline stated in the contract. * If deliverables are submitted before the end of the contract, payment will be processed * Final payment may not be less than ten per cent of the total value of the contract. * The final payment will be processed within 30 days of the expiry date of the contract upon confirmation of satisfactory delivery of services |

1. **WORKING CONDITIONS**

The consultant will

Work remotely and no office space is required.

Work from ROSA office and office space is required (hiring office must contact Operations Section before committing to contract dates).

Has particular IT, logistics, transport, insurance, and security requirements that apply:

Preference will be given to country consultants (in Bangladesh) who can also complete the regional analysis and roadmap.

Provide details here on the particular needs marked above

Budget code for ICT equipment: Click or tap here to enter text.

1. Minimum requirements

The Consultant(s) should have:

* Minimum 8-10 years of experience and expertise in global health, health systems, health economics and the politics of health reforms for PHC including health care financing.
* Proven experiences of working with government, UN agencies, private sector/industry/thinktanks and other partners in the South Asian region on primary health care.
* Proven record of undertaking qualitative and quantitative research and assessments with reputed organizations, governments, giving details of jobs undertaken and completed, name of the organizations with their contact numbers, duration, coverage of such survey work, etc.
* Proven experience in designing and facilitating co-creation sessions with multiple stakeholders.
* Proven experience in designing and shaping multi-stakeholder (government, international agencies, private sector) implementation pilots that address complex societal outcomes.
* Proven project management and coordination skills.
* Work experience with UNICEF is a strong asset.

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| Please note that the hiring manager is required to review profiles of eligible candidates from the spouse and partner employment/dual career support roster maintained by ROSA. Recommended |

1. World Health Organization. (‎2018)‎. The private sector, universal health coverage and primary health care. World Health Organization. <https://extranet.who.int/iris/restricted/handle/10665/312248>. License: CC BY-NC-SA 3.0 IGO [↑](#footnote-ref-2)
2. The private health sector is the individuals and organizations that are neither owned nor directly controlled by governments and are involved in provision of health services. It can be classified into subcategories as for profit and not for profit, formal and informal, domestic and international. [↑](#footnote-ref-3)
3. Mackintosh M. et al, What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. *Lancet.* 2016; 388: 596-605. ; Basu S. et al., Comparative performance of private and public healthcare systems in low- and middle-income countries: a systematic review. PLoS Med. 2012; 9e1001244. [↑](#footnote-ref-4)
4. Brugha R, Zwi A. Global approaches to private sector provision: where is the evidence? In: Lee K, Buse, K, Fustukian S, editors. Health policy in a globalising world. Cambridge: Cambridge University Press; 2002. [↑](#footnote-ref-5)
5. The UNICEF Health Systems Strengthening Approach. UNICEF (2016). [www.unicef.org/media/60296/file](http://www.unicef.org/media/60296/file) [↑](#footnote-ref-6)
6. Accelerating progress towards Universal Health Coverage in South Asia in the era of COVID-19. How universal primary care can tackle the inseparable agendas of the universal health coverage and health security. UNICEF (2021): https://www.unicef.org/rosa/media/17021/file/Accelerating%20progress%20towards%20Universal%20Health%20Coverage%20in%20South%20Asia%20in%20the%20era%20of%20Covid-19.pdf [↑](#footnote-ref-7)
7. The Clinical Establishments (Registration and Regulation) Act, 2010, Ministry of Health and family Welfare, Governent of India: http://clinicalestablishments.gov.in/cms/MoreNews.aspx [↑](#footnote-ref-8)
8. Ayushman Bharat – Health and Wellness Centre, Ministry of Health and Family Welfare, Government of India (2018): http://ab-hwc.nhp.gov.in [↑](#footnote-ref-9)
9. Operational Framework for Primary Health Care. Transforming Vision to Action. WHO and UNICEF (2020): https://www.who.int/publications/i/item/9789240017832 [↑](#footnote-ref-10)