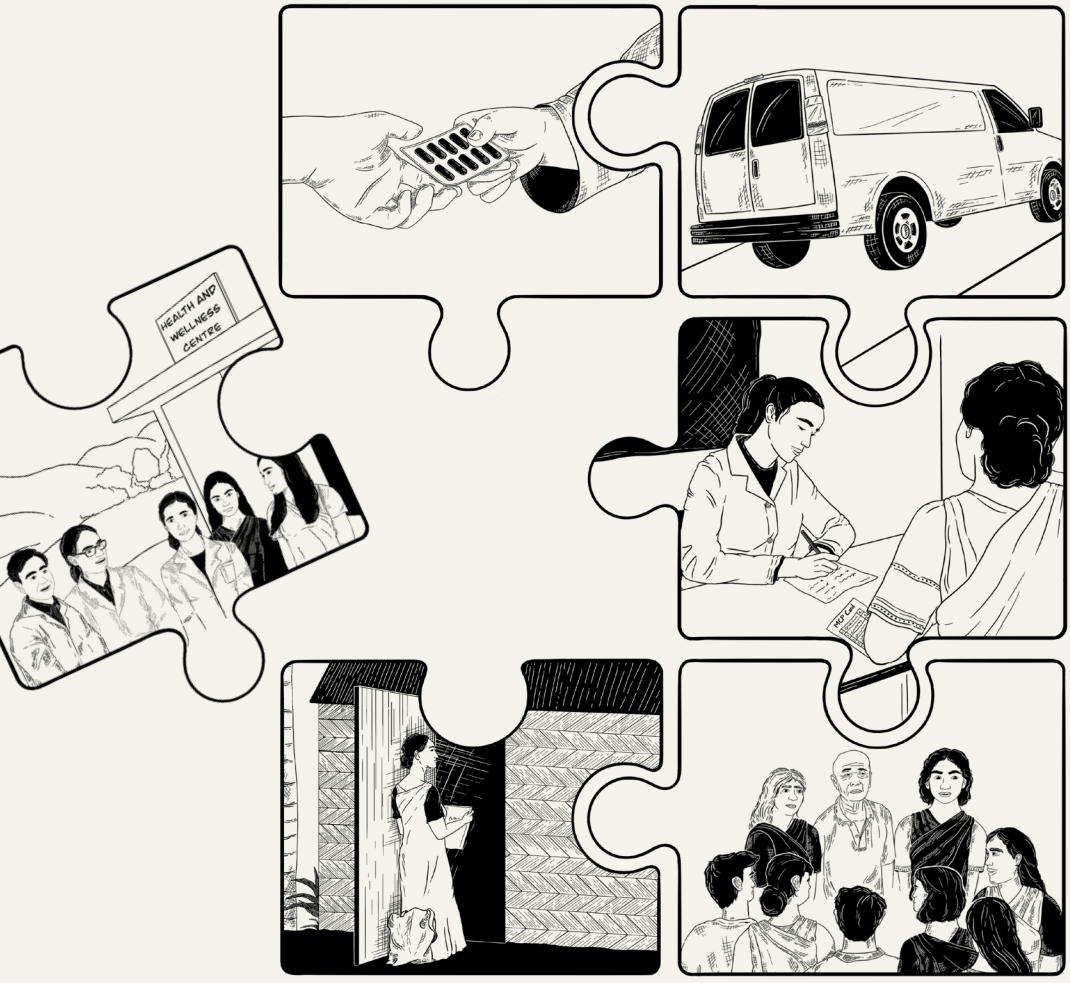
Understanding Comprehensive Primary Health Care: The Meghalaya Way



Government of Meghalaya
सत्यमेव जयते
Shillong

50 MEGHALAYA
Golden Jubilee Celebration

NATIONAL HEALTH MISSION
GOVERNMENT OF MEGHALAYA

Understanding Comprehensive Primary Health Care: The Meghalaya Way

November, 2022
Shillong, Meghalaya

Published by
National Health Mission, Meghalaya & Department of Health & Family Welfare, Meghalaya

Illustrations:
Shubhangi Karia

Layout and Design:
Soumyajit Chakladar & Pankaj Kumar

Suggested citation:
National Health Mission, Meghalaya. (2022). Understanding Comprehensive Primary Health Care: The Meghalaya Way, Government of Meghalaya.

Book released as e-version. November 2022.

These guidelines were jointly authored by a team with members belonging to the National Health Mission, Meghalaya and the State Capacity Initiative at the Centre for Policy Research, New Delhi. Preliminary drafts of the book have been reviewed by officials and public health experts of the directorate of health services and public health, officials from allied departments, and consultants from partner organisations. The officials and partners consulted include District Medical and Health Officers (DMHOs), District Nodal Officers for CPHC, Public Health Specialists, Additional DMHOs, Medical Officers, ANMs, MLHPs, CDPOs (Social Welfare Department), Cluster Coordinators (Meghalaya State Rural Livelihoods Society); and consultants at the Meghalaya Health System Strengthening Project, State Capability Enhancement Project, and JHPIEGO.

Abbreviations

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha And Homeopathy
BCC	Behaviour Change Communication
BMO	Block Medical Officer
BPM	Block Programme Manager
CHC	Community Health Centre
COPD	Chronic Obstructive Pulmonary Disease
CPHC	Comprehensive Primary Health Care
DH	District Hospital
DPM	District Programme Manager
ESI	Employees State Insurance Scheme
FRU	First Referral Unit
GNM	General Nursing And Midwifery
HRH	Human Resource for Health
MHIS	Megha Health Insurance Scheme
MLHP	Mid-Level Health Provider
MO	Medical Officer
MPW	Multi-Purpose Worker
NCDs	Non communicable diseases
OOPE	Out of Pocket Expenditure
OPD	Out Patient Department

Abbreviations

PHC	Primary Health Centre
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PSGs	Patient Support Groups
RCH	Reproductive and Child Health
SC	Sub-Centres
SHGs	Self Help Groups
STGs	Standard Treatment Guidelines
UHC	Universal Health Coverage
VHC	Village Health Council
WASH	Water, Sanitation and Hygiene

Contents

Section 1: Understanding Comprehensive Primary Health Care

Section 2: Implementing CPHC in Meghalaya

Section 3: The care provider as a family friend

Further Reading

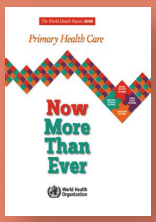
Understanding Comprehensive Primary Health Care

Introduction

Meghalaya has set itself on an aspirational path of development. The Government of Meghalaya recognises the value of investing in its people, which means it believes in growth driven by investment in health and education, and social security of its citizens. It has pioneered initiatives that aim to reduce poverty, promote local employment and improve the accountability of the state to its citizens. Much work has also been done in the field of health. This has culminated in the adoption of the Meghalaya State Health Policy 2021 that lays out a forward-looking framework for providing health services in line with the state's unique context. Building on this work, the Government of Meghalaya is further strengthening its healthcare system by adopting a Comprehensive Primary Health Care (CPHC) approach.

CPHC is about changing the approach of the healthcare system to focus on the entire population and not just those who seek treatment. It treats a wider range of health conditions, and is more expansive in the kinds of care it provides. In addition to maternal and child healthcare, and management of infectious diseases, a comprehensive approach to primary healthcare includes everything from basic oral health, eye care, ear care, mental health to elderly health care services, and emergency medical services. It is concerned with the prevention of illness by addressing risk factors and promoting healthy behaviour. Regular screening and diagnostic tests help in early detection that is then treated through a person-centred primary care approach that includes a robust referral support. CPHC also creates vital links between the community and the health system to co-produce good health outcomes. Nationally, the CPHC approach was launched in 2018 under the Ayushman Bharat scheme through the establishment of Health and Wellness Centres (HWCs). These centres are part of a large and dynamic ecosystem of personnel, institutions and processes that deliver the various health needs of the people with high quality of care.

These guidelines explain the broad scope of CPHC, as well as the systemic and personnel-related shifts that will help realise this approach in Meghalaya. They are a product of a three-stage consultation process involving field visits, state-wide consultations on health systems management, and detailed feedback sessions. In this way, the making of these guidelines has been a process of listening to the providers and communities that make the health system, understanding the challenges of their reality while recognising the values and commitment that make the system work. With these guidelines, Meghalaya moves forward in its journey towards human development and the reduction of inequality by strengthening its healthcare system.



Now More Than Ever

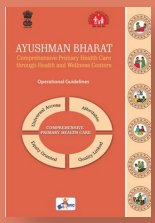
2008

"Person centred care" clinicians address their patients' concerns, beliefs and understanding of illness, and share problem management options with them

National Health Policy

2017

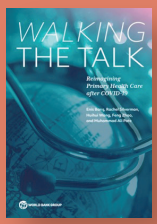
Shift from from Selective to Comprehensive Primary Health Care package (which includes geriatric health care, palliative care and rehabilitative care services) provided through Health and Wellness Centres



Operational Guidelines CPHC

2018

Primary health care should meet communities' health needs across a comprehensive spectrum of services in a continuous, integrated, and people-centred manner



Walking The Talk

2022

CPHC spans preventive, promotive, curative, rehabilitative, palliative care aspects; it reduces morbidity and mortality at much lower costs and reduces the need for higher levels of care

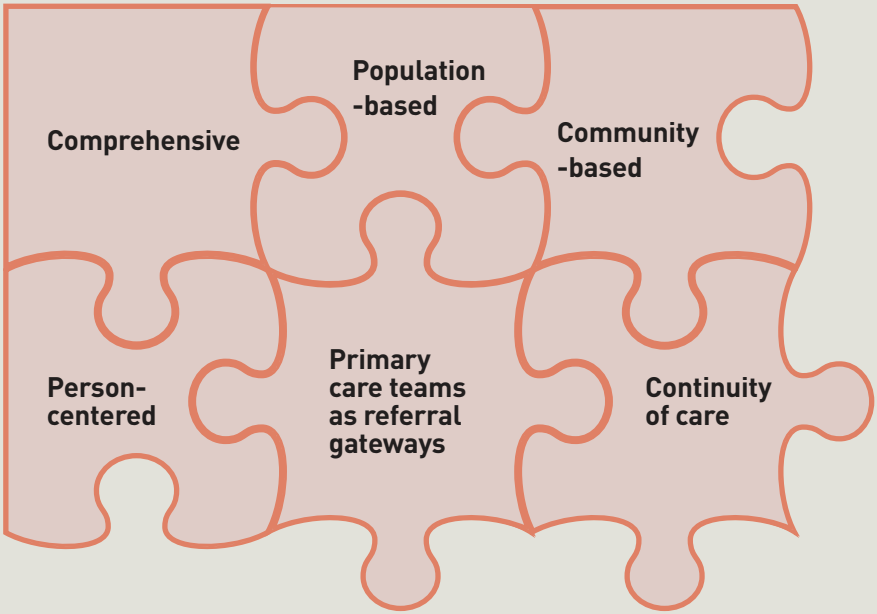
Evolution of CPHC approach

Comprehensive Primary Health Care is a well-known concept. It gained prominence world-wide with the adoption of the Health for All by 2000 AD Declaration at Alma Ata in 1978. This declaration that was accepted by over 178 nations called primary health care the key strategy to the achievement of health as a fundamental right.

Key global and national policy documents that are built on this definition and understanding of CPHC

So what was meant by primary health care?

Primary Health Care is an approach to organization of health care services, which has a set of essential features:



Primary Level Care

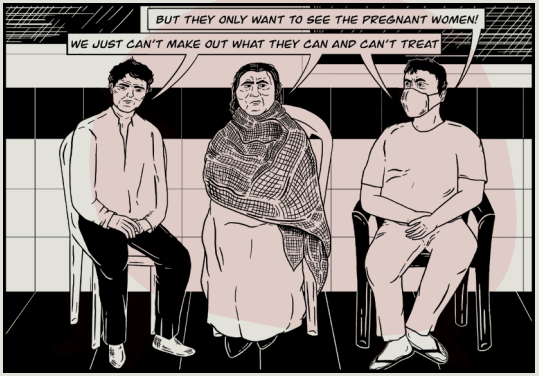
It is one sub-set of primary health care. It describes what happens at the point of first contact and close to community facilities. These are usually managed by a primary care team, who can even be only nurses and paramedicals. It is also referred to as entry point ambulatory care. Primary Level Care should not be confused with primary health care.

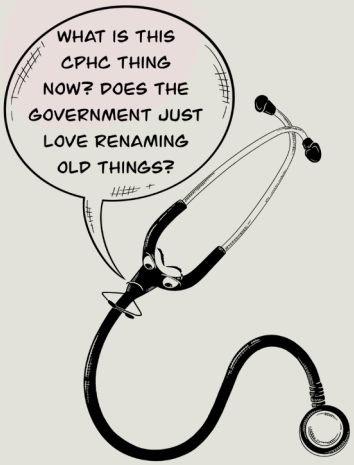
Primary Health Care is an approach

It is a key strategy for achieving 'Health for All'. The emphasis is on prevention and promotion, but the organisation of curative care is also part of it. The contrast to the primary health care approach is the Hospital Centric Approach, where the entire emphasis is given to building hospitals and the reliance is on curative care. There is now considerable evidence that primary healthcare approaches are far more effective and cost-effective in achieving better population health outcomes, and much more accessible and friendly to the majority of the population.

What is "comprehensive"?

Why are we adding comprehensive before the term primary health care?





Comprehensive means that

1. Preventive, promotive, curative, rehabilitative and palliative care is included.

2. We are talking of access not only to primary level care, but secondary and tertiary as well.

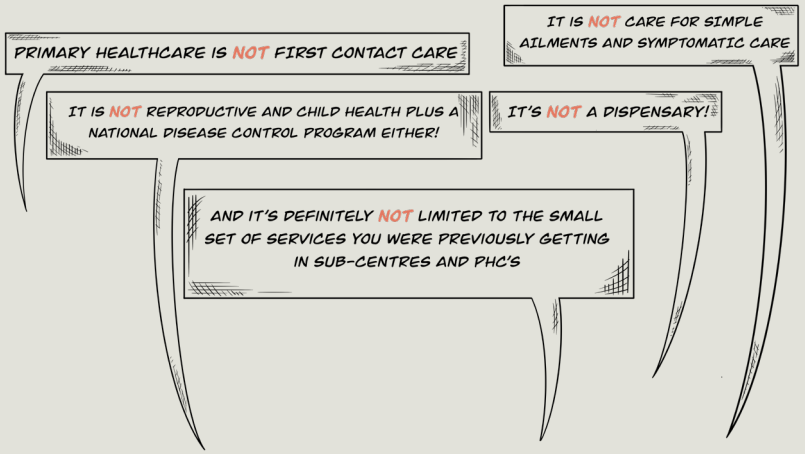
3. We cover most aspects of reproductive and child health and most communicable diseases and most non-communicable diseases would all be included. Indeed 80% or more of all health care needs get covered under this system.

How is Comprehensive Primary Health Care different from Selective Primary Health Care?

Primary Health Care was always comprehensive. The reason why the word "comprehensive" is being emphasized is to contrast it from Selective Primary Health Care and other misinterpretations of primary health care.

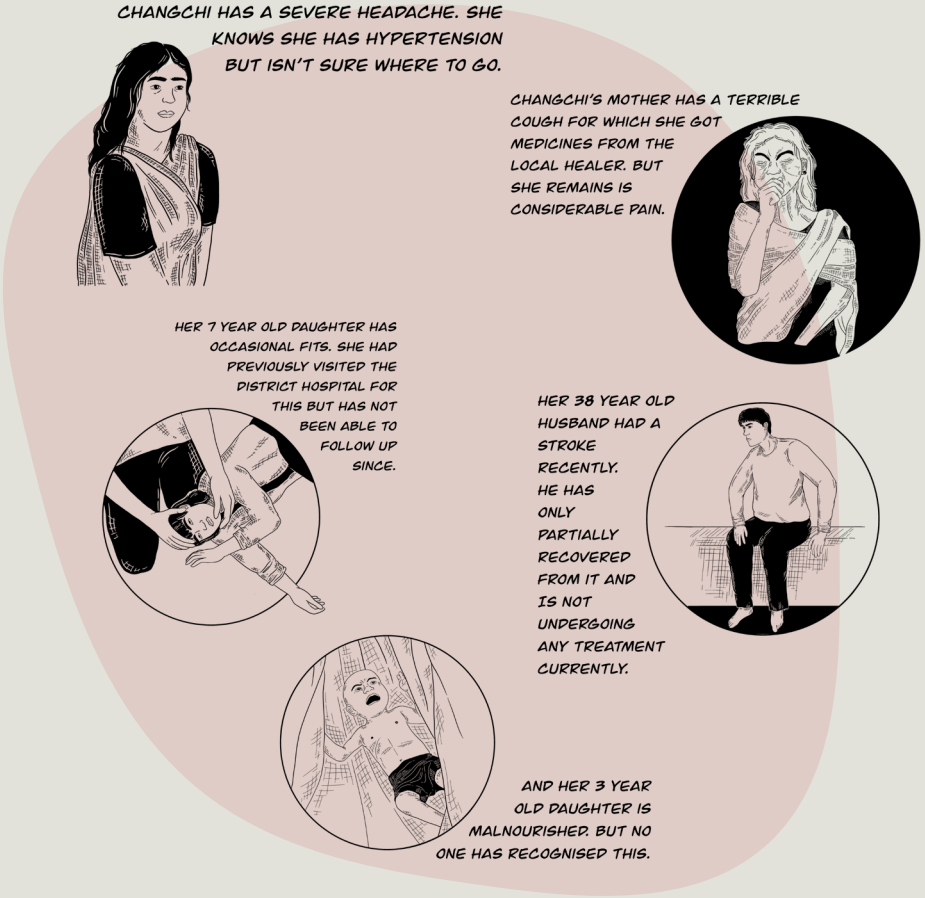
Selective Primary Health Care refers to a policy introduced in the nineties that the district health systems and primary health centers could be limited to providing care in pregnancy, immunization and care for a few infectious diseases and symptomatic care for minor illnesses. Thus, the services available in a sub-center or PHC cover less than 15% of health care needs. For all the other needs the patient had to go to the private providers if they could afford it, or more often just suffer the disease if they could not.

Remember!



The opposite of primary health care approach is a hospital centric approach.

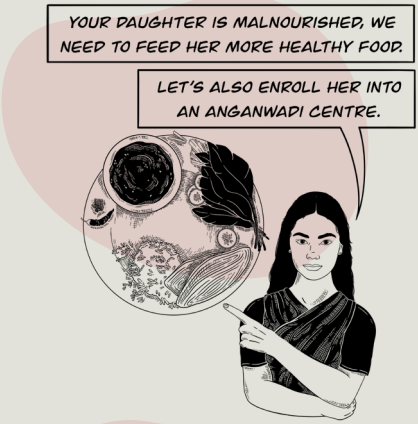
What does the sub-centre and PHC look like in the old system?



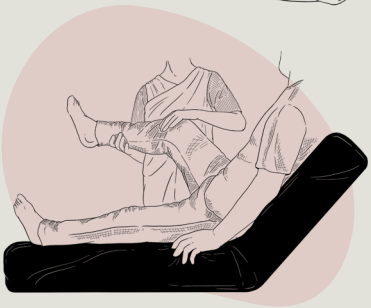
The ANM who comes to the village Sub-Centre only asks about pregnant women and children for immunization. She does have a tablet for Changchi's headache, but that gives only short term relief. She also suggested that Changchi goes to the PHC. The PHC is commonly referred to as a dispensary because it runs like one. You go there, stand in line, tell the complaint to a doctor, who gives you medicines, which you can buy there and go back. Investigations are rarely done, and often have to be done in private sector. Changchi went and stood there and she was given tablets for headache and hypertension and sent back. No one asks about her children or her husband or her mother-in-law. This is why many patients call the PHC a dispensary.

How the new Comprehensive Primary Health Care system looks:

When Changchi has a severe headache, she visits the nearest HWC-SC. The MLHP examines her and finds that she has high BP. He arranges a time for her to meet the PHC MO at the NCD clinic. Over there, the doctor confirms Changchi's hypertension. He gives her a prescription note that she has to show at the HWC-SC. She collects her first round of medicines at the PHC, and for subsequent refills, she goes to the HWC-SC every month.



In addition, the ASHA who visits her home, notes that one child is malnourished and talks to the family about good nutritional habits for children. She ensures the child is enrolled in the Anganwadi and also oranises a medical check-up for her. Further, the ASHA discovers that Changchi's older daughter has epilepsy. She asks the family to take their daughter to the HWC where a referral is organised with the physician in the district hospital. On the appointed day, she takes the child there and is seen by the doctor. The doctor also gives her a note to be given to the HWC staff and a prescription. For these epilepsy medicines also the mother needs to come only to the HWC. Once in three months, the patient is seen on telemedicine with the specialist.



Changchi's husband is also persuaded to go to the HWC. Turns out, he too has hypertension and diabetes. Moreover, he chews tobacco. The doctor gives him a note that prescribes medicines to manage his hypertension and diabetes and arranges for regular BP and blood sugar checks. This is a note they must show at their HWC-SC for refills and future check-ups. The doctor also finds that the husband's recovery post his stroke is slow. He teaches Changchi how to help her husband do physiotherapy at home to strengthen his limbs. The doctor asks the ASHA to make monthly visits to their house for counseling and follow ups.

The elderly lady in the house is checked for Tuberculosis at the PHC and has a follow up at the HWC-SC. Fortunately it is negative and treatment for COPD/ chronic bronchitis is started.

When Changchi fails to come collect her medicines, the ASHA or the MLHP contact her to find out why. They also spend time counselling the family on nutrition, exercise and the need to stop consuming tobacco. The family is not only feeling much better now, they are able to work on their field better and their healthcare costs have reduced. They also do not lose work days in going all the way to the hospital to collect essential medicines. The money they spend on transport is also low because care is available near their house.

The ASHA visits their home monthly. It's the same home visit she made earlier when Changchi was pregnant. But now when she visits, she follows up on whether Changchi and her husband have been screened for NCDs, whether the child with malnutrition is improving, and whether Changchi and her husband her taking their medicines regularly and following through on their scheduled check-up visits. All the details of the care received by each member of the family are maintained in a health record at the HWC-SC. The providers there can use this record to ensure that the family gets its full complement of preventive, promotive, and curative care which is their entitlement.

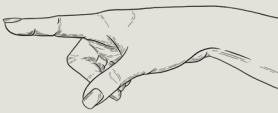
When Changchi fails to come collect her medicines, the ASHA or the MLHP contact her to find out why. They also spend time counselling the family on nutrition, exercise and the need to stop consuming tobacco. The family is not only feeling much better now, they are able to work on their field better and their healthcare costs have reduced. They also do not lose work days in going all the way to the hospital to collect essential medicines. The money they spend on transport is also low because care is available near their house.

How can we make this happen? How do we go from Scenario 1: Selective Primary Care to Scenario 2: Comprehensive Primary Health Care?

HWC-SC: a subcentre, now upgraded as the Health and Wellness Centre
HWC-PHC: a Primary Health Centre, now also upgraded to Health and Wellness Centre

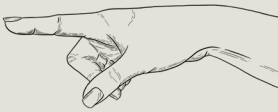
Note: the abbreviation "PHC" is used only to refer to the Primary Health Centre, not Primary Health Care.

Why is "comprehensive" important?



Ethical: Because it is consistent with our sense of values. Because it is the right thing to do. Health and Healthcare are public goods and people's rights. A system where 80% of our health needs cannot be attended to is just not right.

Professional: Because the most important asset of a health system is people with the necessary knowledge, skills, and compassion. If we have a gynaecologist in a DH, why must we limit her to only family planning surgeries or C-sections, when instead she can attend to the entire range of gynaecological patients? She will not feel professionally satisfied and may even move away. If there is a medical officer at a PHC who sees only minor illnesses and refers away cases like diabetes or epilepsy, or cannot diagnose a fever, will they not lose their skills and become like just another "village doctor"? If an ASHA takes the effort to visit a home in a village to see a pregnant woman, should she not in the same effort also enquire about the health of the young children in the family, the adolescents, the working adults as well as the elderly, and provide health education and health promotion for all?



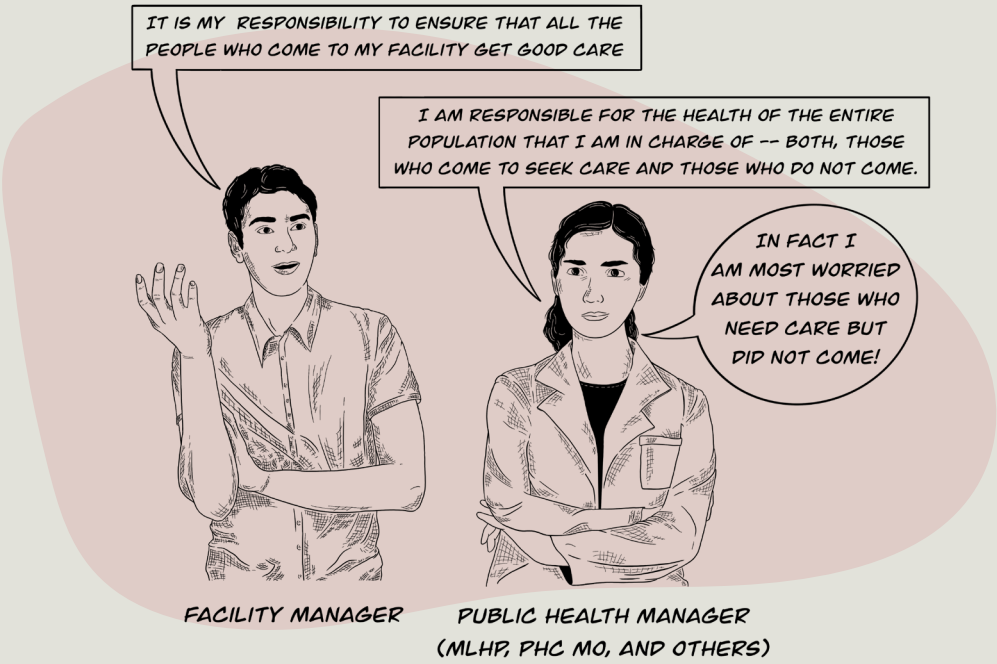
User friendly: Because people who come to seek healthcare do not know that this facility provides only limited components of care. And they have to go from pillar to post searching for the care they need. Soon such a centre loses credibility, and then people do not use it even for the healthcare services that are available.

Economically efficient: Because when we are investing in infrastructure, whether it is a building or an operation theatre, new equipment or simply to repair broken equipment, it is more value for money if one maximises the services that this investment can provide.

Equitable: Certain marginalised groups tend to be left out of the benefits provided by the health system. These people are not able to reach out to the health system or are unable to take adequate care of themselves. They require affirmative action to connect them to the health system.

What is population-based care?

It means that we are working for better health outcomes, health access, and financial protection for the entire population. Not only those who came to the health centre. Therefore, the first step towards this is to enumerate the population under the concerned facility or HWC and empanel all families at the HWC.

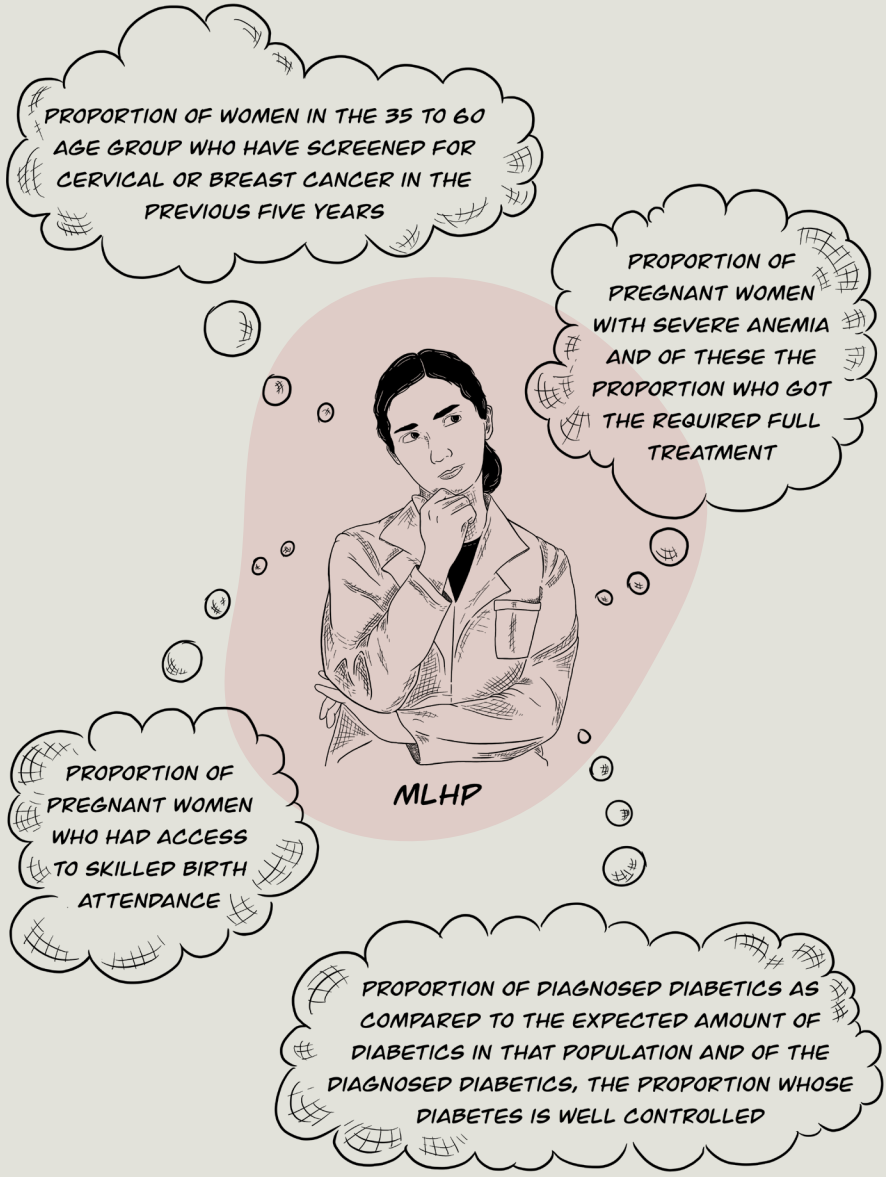


Population based care brings the priority to preventive care:

The overall health of a population is more an outcome of preventive and promotive services than of curative services. See the indicators that follow. For a private doctor, all of these are examples of curative clinical care. But to a primary health care provider, all of these are equally if not more, examples of preventive care. If diabetes is diagnosed early and is well-controlled, deaths due to stroke, heart attacks, and kidney failure will be much less. Today, deaths due to this are very common in men of working age in Meghalaya; similarly, even maternal deaths can be prevented.

Population-based care also draws attention to equity. It notices those who get left behind.

What kind of indicators do we need for population-based care?



What is community-based care?

"A direct and enduring relationship between the provider and the people in the community served is essential to be able to take into account the personal and social context of patients and their families, ensuring continuity of care over time as well as across services" (p.52 , World Health Report 2008)

Communities are active participants in being healthy. In that sense, the primary care provider and the people are co-producers of healthcare. This involves:

Promotion of healthy behaviors and practices

Safeguarding the local determinants of good health – clean water, sanitation, control of pests, limit air pollution, walkable neighborhoods, road safety, preventing violence- domestic and local-

There is solidarity within the community- the non-sick help the sick. Especially, to help access healthcare.

It is ensured that the weakest and most marginalized sections of the village are able to trust the provider.

People inform the providers of any health events of concern and seek their advice wherever necessary.

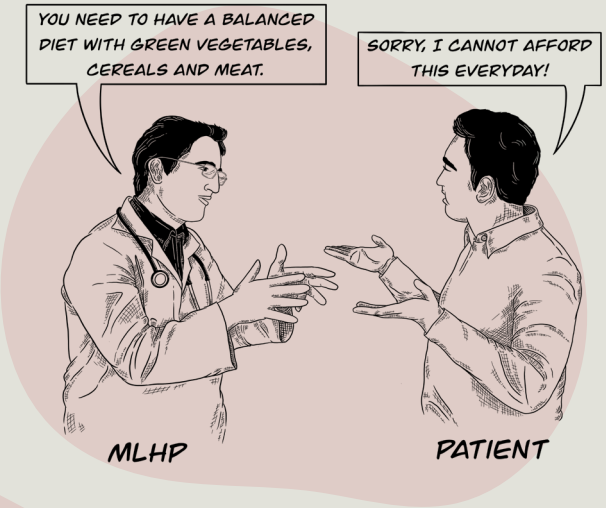
People ensure that providers feel safe, respected and cared for.

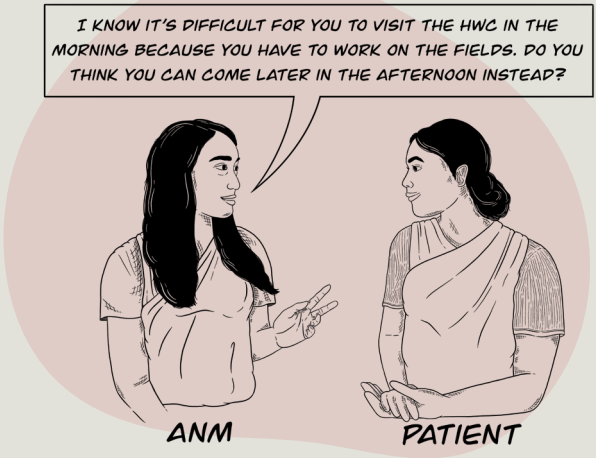
What is person-centred care?

Families and individuals face different barriers to accessing care and being able to follow prescribed treatment and protecting themselves from illness. They also have different preferences and choices regarding their health priorities and what would be considered a treatment for their convenience, dignity and satisfaction.

Providers need to be able to take into account the personal and social context of patients and their families. This is particularly important for ensuring continuity of care over time as well as across services. Health worker as a family friend means that

"People want to know that their health worker understands them, their suffering and the constraints they face." (p. 46, World Health Report 2008)

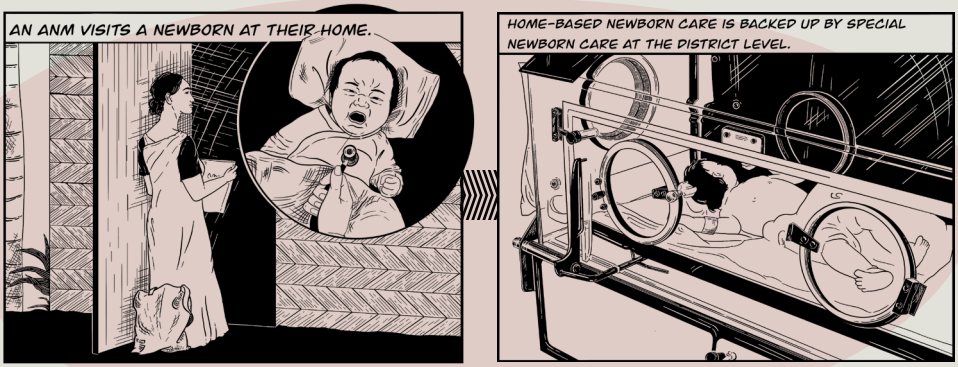




How is this approach inclusive of secondary and tertiary consultations?

Primary care is meaningful and effective only if the secondary and tertiary consultations are assured and if there is feedback enabling continuity of care at the local level.

Primary care providers best detect all these problems. But once it is detected, it requires secondary and tertiary care connectivity. Health outcomes at both the individual and population levels are much better if such problems are detected early and if after the consultation there is good follow-up by primary care providers. Most patients cannot afford to go back to the tertiary care centre for the follow-up requirements.



How best to create the continuity will have to be decided based on specific contexts. But there is one invariable principle. The primary care team and the specialists should feel part of the same team, and be maximizing their cooperation keeping the patient's interest uppermost in mind.

Referral gateways

Tertiary care hospitals are hugely overcrowded due to the lack of primary health care. Even those who just need to collect their weekly medicines for a chronic illness have to line up in the big queue of the city hospital and lose a whole day's wages. Many simple ailments like skin diseases can be treated at the HWC-SC, but because the PHC is oriented towards selective care, they have lost their skills and all of these get referred to the big hospital.

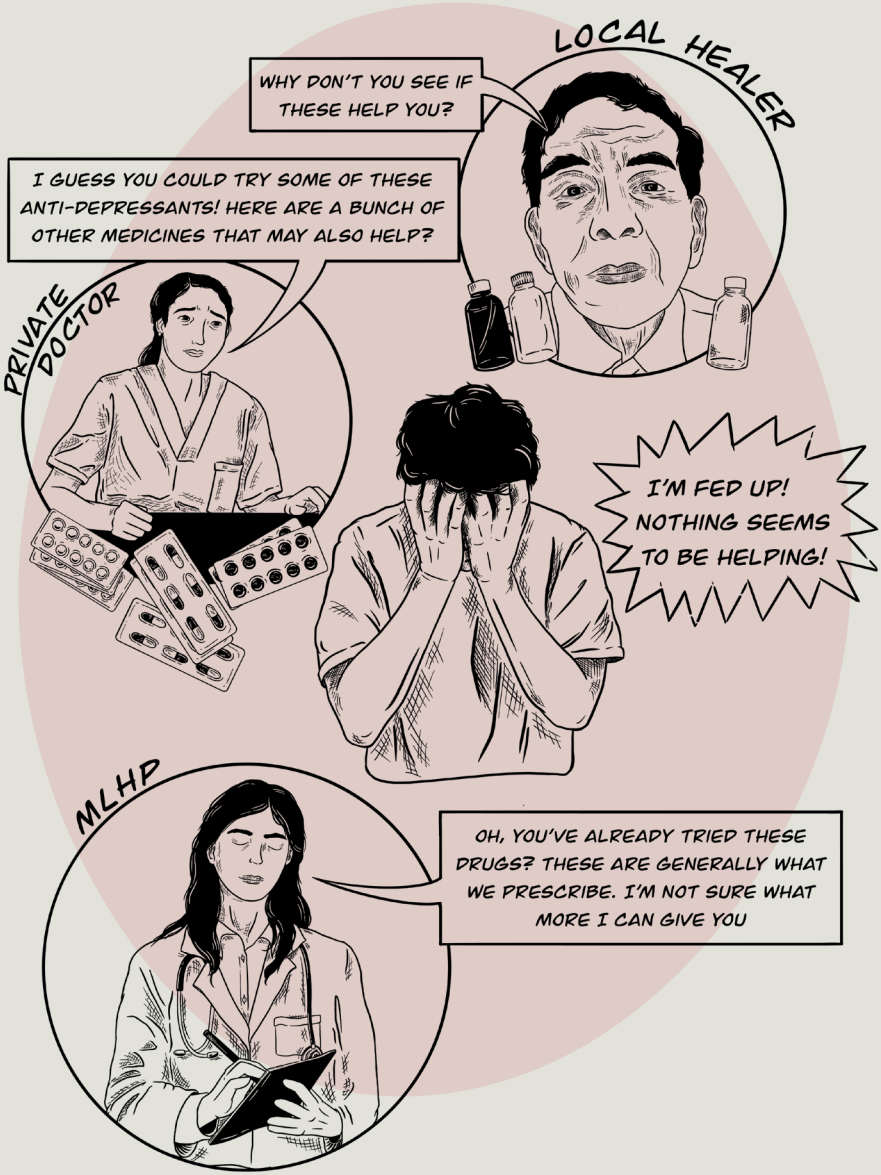
Doctors in the big hospitals complain that they cannot take care of so many patients and not only does the quality of care suffer but also that the care of the very sick patients who need extra time and effort and resources is undermined by having to see so many relatively simple cases that could have been managed at the primary level.

It is not advisable to restrict patients without a referral note written by the primary care centre, from being treated at the big hospital. The public would be resentful of such a rule because the primary care facility has neither the services nor the credibility. It is more appropriate, then, to see the primary health team as facilitators and gateways to all levels of care, instead of thinking of them as gate-keepers or regulators.

As the WHO puts is, in this approach:

> "The primary-care team then becomes the mediator between the community and the other levels of the health system, helping people navigate the maze of health services and mobilizing the support of other facilities by referring patients or calling on the support of specialized services. They can help ensure that people know what they are entitled to and have the information to avoid substandard providers."
>
> (p. 55-56, World Health Report, 2008)

Challang was suffering from depression and on enquiry stated that he was having suicidal thoughts. He was consulting a local healer for several bodily complaints that were not improving. The local private sector doctors too had given several drugs and an anti-depressant but it did not improve. He had gone to PHC but did not fare much better there.



The MLHP advised Challang to go to a special mental health clinic that was functional every Wednesday at a nearby CHC. Since there were no mental health services in his block, the MLHP consulted with the MO in their PHC to refer Challang to a CHC in another block. He was given a note he could carry to the clinic, and an appointment time that was fixed for him.

Challang was told that if he was not satisfied and wanted a different clinic, he could go to the NIMHANS Centre in Shillong. But that was further away from him and would be more crowded. Even though the doctor at the close-by clinic was less senior, this was a more accessible option. When Challang visited the doctor, he was advised not to waste money on different types of providers for his physical pain since this was largely due to his depression. Since Challang was able to trust this MLHP, he followed their advice, improving his health with little inconvenience and cost.

Now he knows that the MLHP is not there only to provide him care. More often he is a like a family friend advising the family on where to go for the necessary care and explaining the options before them.

Implementing CPHC in Meghalaya

Why are we in Meghalaya well placed to achieve CPHC?

How are we going to implement CPHC?

The first step of course is to deliver a much bigger package of services in the HWC-SC. This is the same as what has been said in the Ministry of Health and Family Welfare (MoHFW) guidelines. We seek to take these guidelines seriously and find innovative ways to implement them in Meghalaya.

The basket of services as per the MoHFW guidelines includes:

Neonatal and infant health care services

- This includes home based newborn care
- Preventing and responding to child malnutrition
- Treating common illness using the IMNCI (Integrated Management of Neonatal and Childhood Illness) approach.
- Immunization

Childhood and adolescent health care services including school health.

Care in pregnancy and childbirth.

- This includes antenatal and post-natal care
- Childbirth (where additional facilities are made for it)

Family planning, contraceptive services and other reproductive health care services (for example: reproductive tract illness or post-delivery problems)

Care for common opthalmic and ENT problems

Management of common communicable diseases and general out-patient care for acute simple illnesses and minor ailments

- Fever: the common causes and referring on time
- Diarrhea
- Respiratory infections
- Common skin infections
- Common reproductive tract illnesses
- Body aches and pains

Management of Communicable diseases which are National Health Programs, mainly tuberculosis, HIV, leprosy, hepatitis, and malaria

Healthcare for the elderly and palliative health care services

Screening, prevention, control and management of non-communicable diseases

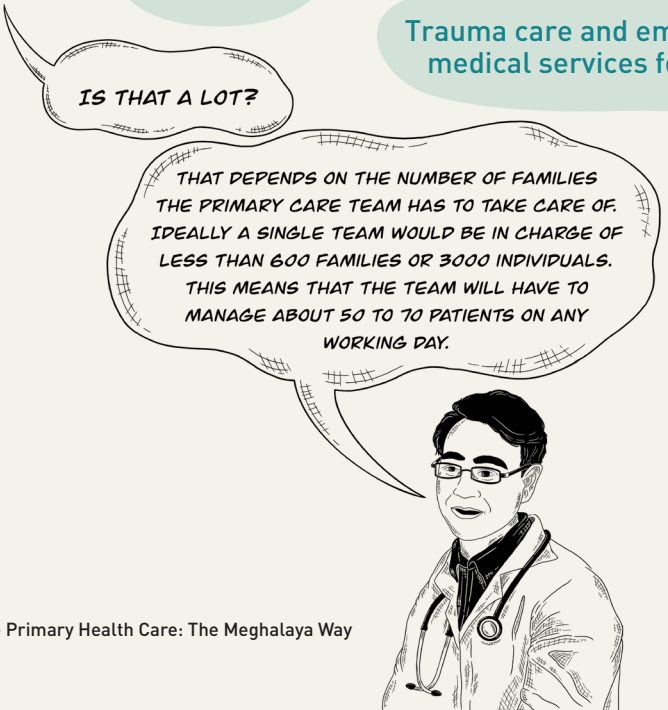
- Behavioural Change Communication (BCC) for diet, exercise, weight management as relevant to prevention of NCDs
- BCC and other measures against tobacco use and alcohol and substance abuse
- Hypertension: early detection, management, and prevention of complications
- Diabetes: early detection, management, and prevention of complications
- Asthma and Chronic Obstructive Pulmonary Disease
- Cancers: including oral, cervical, and breast cancer
- Bone and joint problems
- Epilepsy and common neurological disorders

Screening and basic management of mental health ailments

- Identifying any mental health problem and knowing when to refer
- Depression: what to do and how to follow up
- Identifying psychotic problems and follow-up care for serious mental illness

Basic oral health care

Trauma care and emergency medical services for this level

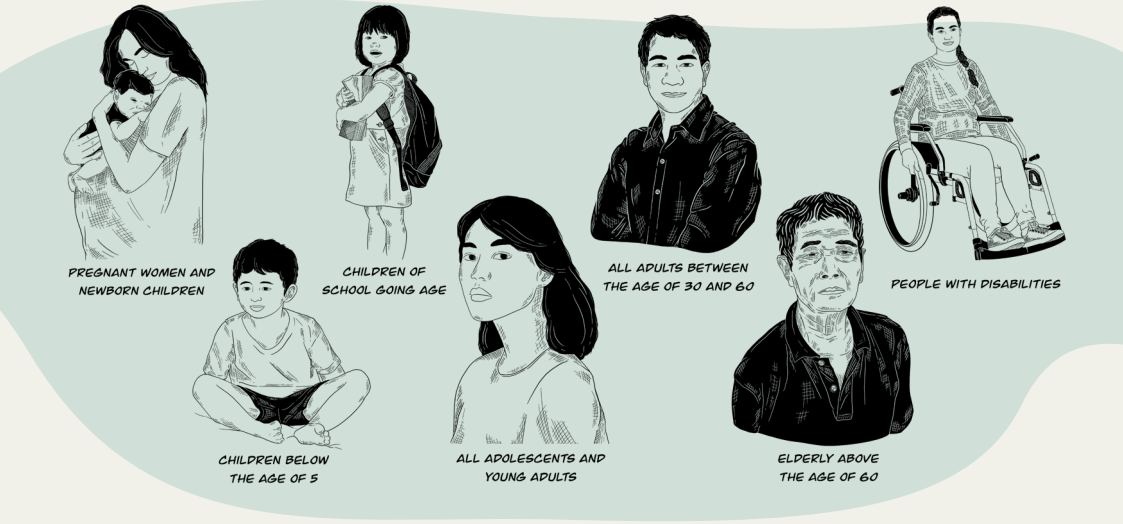


What does it mean to say that a primary care team led by an MLHP can help take care of *all* these illnesses?

We understand that in most of these diseases, it is doctors or specialists who will make a diagnosis and write out the prescription. At no point are we proposing to shift any function that currently belongs to a medically qualified person to any other provider.

But here are the things that a member of the primary care team can do:

01 The team members will screen all persons coming to the health centre for a set of diseases as appropriate to the age and gender. Broadly there are 7 sub-groups:



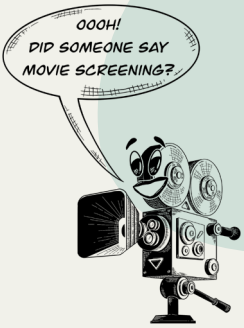
Please refer to Annexure 1 for a list of screening methods for CPHC.

02 The frequency of such screening is once a year or once in 3 to 5 years, depending on what kind of illness we are screening for. But good documentation is important so that we do not screen the same patients again and again. If they test positive for any health condition, then the appropriate care pathway protocol comes into effect.

03 Any person coming to the health centre for care must be registered, asked what their symptoms are and be examined accordingly, and then given the healthcare as instructed in the standard treatment guidelines. These guidelines may require the patient to be referred at once, or to be referred after giving medicines, or to be given treatment as advised by a doctor in a higher centre.

04

When ASHAs visit a house, they check whether anyone has any illness that is not being treated and needs to visit the health centre. They also check whether the people in each of the sub-groups identified have received any screening or other care they need. If not, they encourage them also to visit the centre. Over a period of one or two years, this will ensure that everyone has been screened. If some are reluctant, there is no need to force them.



05

Those with chronic illness will be encouraged to come to collect their monthly medicines and for a health check-up. If there is a complication that has arisen, they can have a tele-consultation arranged by the health centre. Or they may have to be referred to the higher centre. During the follow-up early detection of complications of common NCDs is an important role for MLHP to play.

06

Primary care team members do NOT start or change prescribed drugs for chronic illnesses like hypertension, diabetes, tuberculosis etc. This has to be done by doctors after they have examined the patient. They merely ensure local access to the necessary medicines free of costs. And whatever form of follow-up is required after the doctor or specialist has prescribed.

07

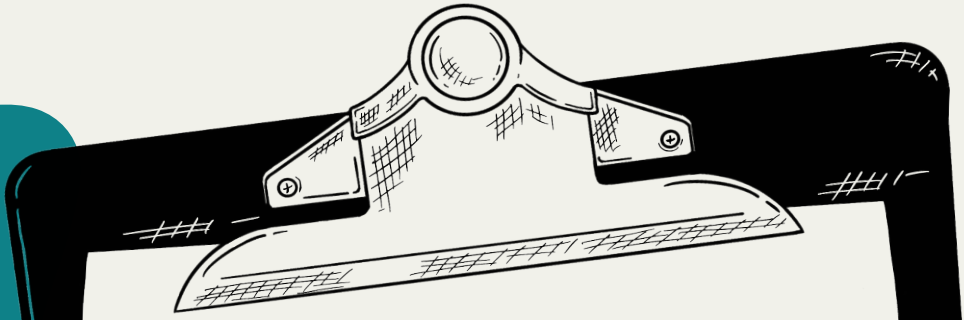
The doctor's prescription is not only for prescribing medicines, but also to indicate the treatment plan. By treatment plan we mean the counselling required, the medicines to be taken, the follow-up visits needed and what should happen on the visits, the early detection of complications for which caregivers should be alert and indications for referral and for the next specialist consultation These must be received in written form by the primary care team so that this treatment plan is followed.

08

Primary care team members should never hesitate to consult or refer. However, it is the effort of all concerned, especially of medical officers in PHCs to manage as much as possible at the PHC and refer only what cannot be managed.

Understand the roles and responsibilities of the team

To deliver all these services in remote areas, one needs a primary health care team. There are two types of teams, one at the HWC-SC and one at the HWC-PHC. The first consists of an MLHP, two or three multipurpose workers (at least one of whom is a nurse with midwifery training), and a number of ASHAs (about 1 per village). The team at the HWC-PHC consists of two MOs with MBBS qualifications and one with AYUSH certifications, five nurses, maybe more depending on the number of functional in-patient beds, along with a laboratory technician, pharmacist, and a data entry operator.



The MLHP is the leader of the HWC-SC team, but they must ensure that the other members (the MPWs and the ASHAs) are treated as equals even though they have varying job descriptions.

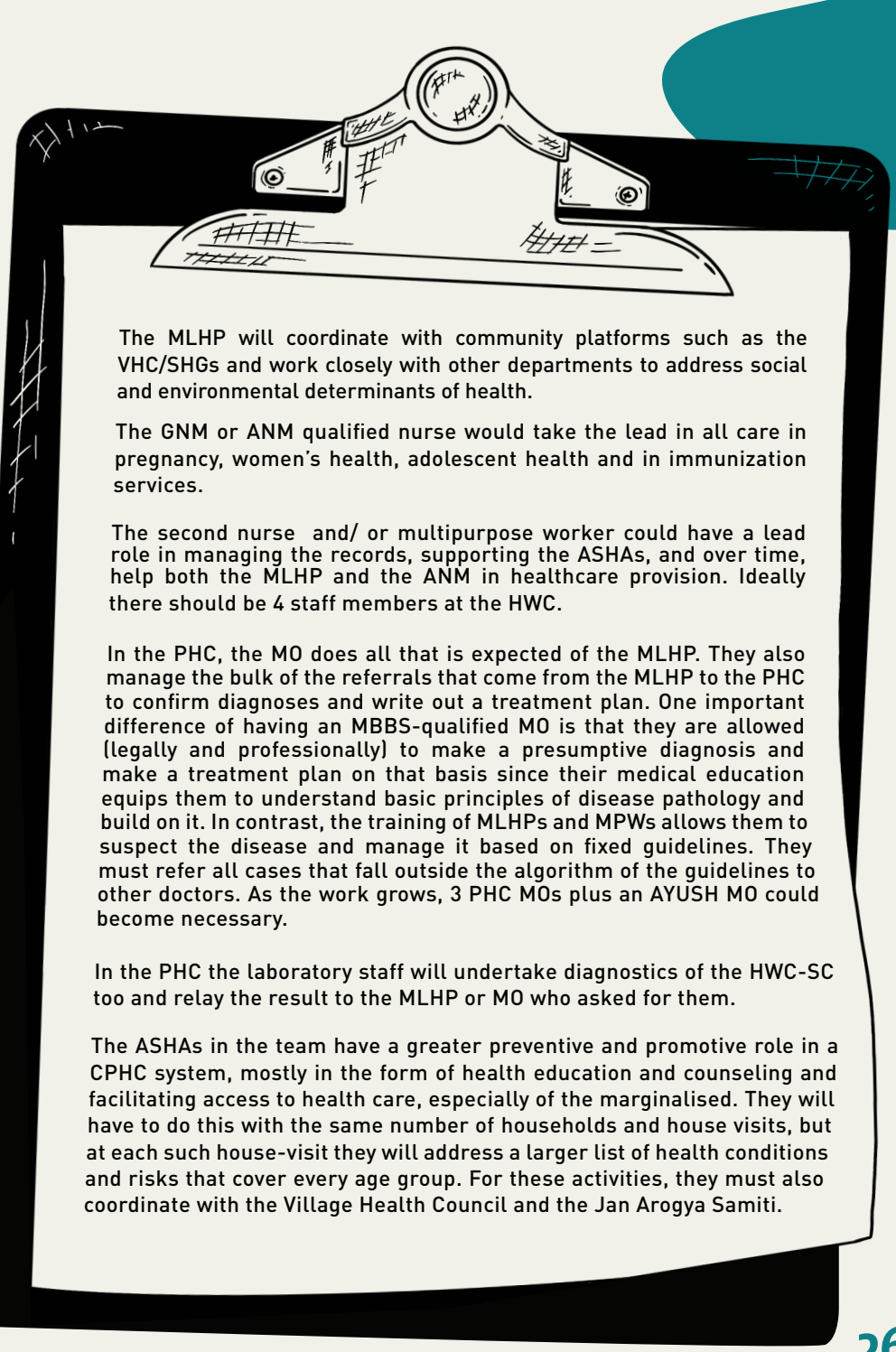
The MLHP must build the skills of the team members to deliver the services expected of them.

The MLHP must ensure that the administrative work of the health center is well done and that records are managed. This will involve ensuring that all households in the service area are listed and empanelled and a database is maintained.

The MLHP is responsible for screening for chronic conditions, that include both NCDs and chronic communicable disease of TB, leprosy and HIV for all target age groups.

The MLHP is the main healthcare provider in the HWC and most communicable diseases and NCDs need to be seen by them. They decide on what care is indicated as per the protocol. This includes coordinating for care and case management for chronic illnesses based on treatment plans provided by the MO/specialist. This coordination can also be facilitated through tele-health.

The MLHP will coordinate and lead local response to disease outbreaks, emergencies and disaster situations to support the medical team.



The MLHP will coordinate with community platforms such as the VHC/SHGs and work closely with other departments to address social and environmental determinants of health.

The GNM or ANM qualified nurse would take the lead in all care in pregnancy, women's health, adolescent health and in immunization services.

The second nurse and/ or multipurpose worker could have a lead role in managing the records, supporting the ASHAs, and over time, help both the MLHP and the ANM in healthcare provision. Ideally there should be 4 staff members at the HWC.

In the PHC, the MO does all that is expected of the MLHP. They also manage the bulk of the referrals that come from the MLHP to the PHC to confirm diagnoses and write out a treatment plan. One important difference of having an MBBS-qualified MO is that they are allowed (legally and professionally) to make a presumptive diagnosis and make a treatment plan on that basis since their medical education equips them to understand basic principles of disease pathology and build on it. In contrast, the training of MLHPs and MPWs allows them to suspect the disease and manage it based on fixed guidelines. They must refer all cases that fall outside the algorithm of the guidelines to other doctors. As the work grows, 3 PHC MOs plus an AYUSH MO could become necessary.

In the PHC the laboratory staff will undertake diagnostics of the HWC-SC too and relay the result to the MLHP or MO who asked for them.

The ASHAs in the team have a greater preventive and promotive role in a CPHC system, mostly in the form of health education and counseling and facilitating access to health care, especially of the marginalised. They will have to do this with the same number of households and house visits, but at each such house-visit they will address a larger list of health conditions and risks that cover every age group. For these activities, they must also coordinate with the Village Health Council and the Jan Arogya Samiti.

Share the work, build the team

Stepping in for each other:

An important concept is that this work is being shared by a primary care team. So, if one member of the HWC-SC is missing on that day the other steps in. But the overall work does not suffer. When all are there, there are areas in which each one of them has more expertise and they can prioritize such work. Thus, an ANM may see the pregnant women but if there are only one or two after seeing them she may support the MLHP.

RESOLVE MORE, REFER LESS!

Never stop training yourself and the team

This requires that the team members also over time acquire the training levels that the MLHP has. This implies that service providers at all levels would be required to be multi-skilled so that the team is able to resolve more at their level with fewer referrals. The MLHP also continues to improve the knowledge and skills. Thus, a person with 5 years of work experience will know substantially more than a person who has just joined. Part of the training happens through structured training camps with a syllabus and a set of guidelines. But much of it should happen when supportive supervisors visit them and work with them in providing care. This concept of supportive supervision or on-the-job training is important. Even telemedicine sessions become opportunities for improving provider skills.

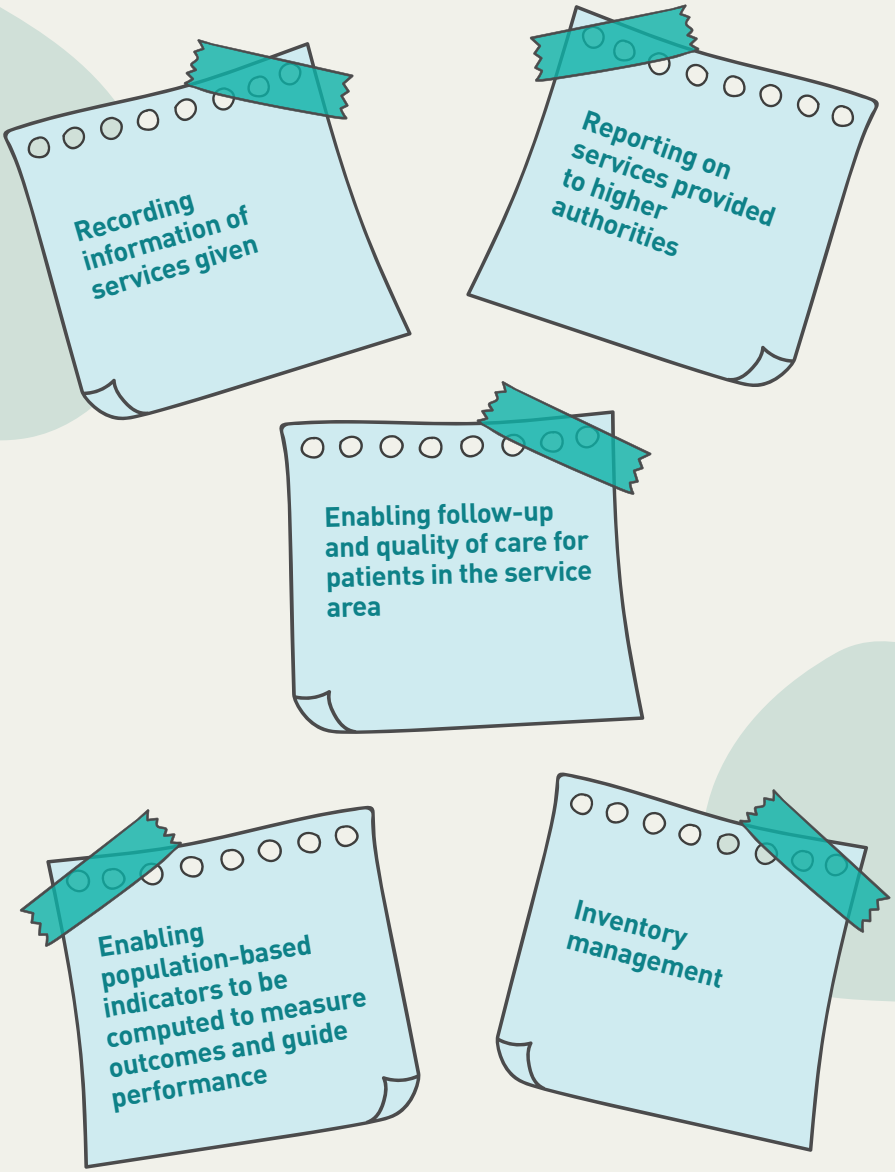
Other than this, the government also proposes to create a website with reference materials that can be referred to even from individuals' phones. Online self certification courses will be made a part of this package. Specific mentors who will give them online support or mobile support whom they can talk to, can also be assigned for each primary care team by the corresponding district team (eg: conjunctivitis that cannot be treated). The important thing is that there is no time when the training stops and anyone who is not in this process even if medically qualified, will begin to lose their skills. Other than knowledge and skills, even being friendly to each other and respecting each other needs some special efforts. A weekly meeting of the primary care team where they discuss their problems in providing services and their own individual problems is a good step. A monthly meeting of the district support group is also necessary. Some of these meetings can have invitees from the community or from higher functionaries. Team building activities and events can also be thought of.

Sharing work equally

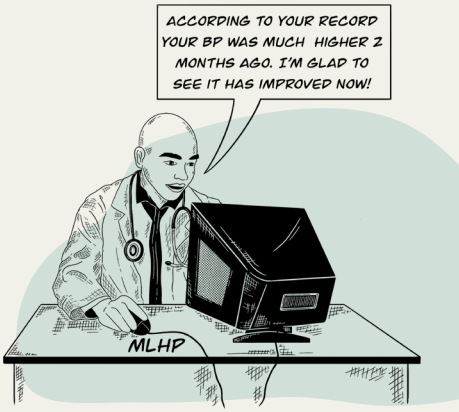
One important thing is not to treat the contractual staff as the main persons to do the work and shift all the work on them or to boss them around. The regular staff must share the work equally or manage a larger share since they are paid much more. The contractual staff must be treated with respect and the regular staff must be seen as supportive to help them continue in their employment with job security and the hope of being regularised.

Document what you do! Use these reports

Documentation is important for five purposes:



There are two important documents for recording the care given:



1. Record of care that patient/patient's family keeps: This could have one page for each visit. A model page is given in Annexure 2. Just name, age, sex and the ID number, date of the visit, diagnosis and treatment plan is recorded. After the consultation if there is a separate referral note given by the health centre to be shown to the hospital or vice versa, this should be indicated.

2. Record of care for each individual kept at the healthcare centre: This is usually a register but in some cases, additional information specific to that individual is kept in case record format. The latter is necessary when a patient is registered for treatment as a chronic illness or a condition that requires regular follow-up. Or if it is a notifiable disease like malaria or typhoid. Ideally this record is digitized and not available on paper at all. If needed the register of all cases seen can be printed out. In practice, such information is currently available on registers and paper case records.

On documentation for reporting on services:

There are multiple formats for reporting the care given. Reporting is usually done as aggregate numbers. The forms have to be filled up and reported on a monthly basis. Data for the reporting formats comes from collating information on the recording documents. Usually, the programs require that the data on the reporting format is filled manually and then entered onto a web portal managed by the program. For some programs, even the individual's case data has to be uploaded (CRCH portal, Mother app, IHIP). This is often quite a challenge for frontline staff. Ideally if the recording of the information happens directly into an electronic device (mobile, tablet, computer) then the computer should be able to generate the required reporting formats and registers. If this is done, the burden of data work on the frontline health worker should reduce. And recording on paper should not be necessary. Meghalaya aspires to reach this stage but currently the effort is to rationalise the number of record and reporting formats and different portals into which entry has to be made. This should reduce the burden of data work on the frontline health worker and give more time for interacting with patients.

On Health ID:

The 'name, age, gender, and the village of residence of the patient' as given on any ID card is enough for most purposes. While the Aadhar number and ration card number or a unique health number is desirable, they need not be insisted upon unless it is a government requirement. For patient's welfare, any ID number is equally useful and can be used. Providers should remember that by both law and ethics, no treatment can be denied or delayed because of the absence of an ID proof.

Ensure the supplies

Each HWC-SC and HWC-PHC must have the medicines and the diagnostics without any interruption. The list of such medicines for these centres can be divided into medicines that can be prescribed locally and medicines which can only be initiated by doctors but dispensed or given access to locally at the HWC. The list of essential medicines for HWC-SCs and the list of doctor initiated drugs that can be given by the HWC have been provided in Annexures 3 and 4 respectively. The list of diagnostic services is provided in Annexure 5, and the list of minor equipment to be kept at the HWC is provided in Annexure 6.

In addition, if there is a specific patient who requires repeat medication for a chronic illness that is available only at the District Hospital, it can be given locally given locally for patient convenience. They can be indented for and supplied from the district or state stores like it is done for MDR-TB or HIV drugs. Such medication should always carry along with it some note of the cautions and interactions in relation to that medicine.

Preventing stock-outs requires that there is a minimum level of drugs in each facility and when they are used up you can indent and get more. A fixed supply of medicines does not work. Supply has to be responsive to different rates of utilization for different drugs in different facilities.

A Meghalaya Health Services corporation is being proposed to ensure such an uninterrupted supply. But even while waiting for it, a few steps can be taken at the local level. Moreover, it is important to note that currently only a small proportion of illnesses are detected—others are latent. Once the HWC is functioning optimally, the demand for services will increase sharply.

Improve analysis and use of data

Every HWC is collecting huge amounts of data but they are using it very poorly. One reason is because data becomes information only when data is used to compute indicators. An indicator is a relationship between two data elements. One is the numerator which is a measure of the service provided or the health event of interest, the other is the denominator, which is the target population. Very often the denominator may have to be estimated.

For example, the provider may know that there are 15 diabetics that the HWC has diagnosed out of the 100 households screened and tested. But they also know that in a population of 3000, approximately half (i.e., 1500) will be above the age of 30 and will need to be screened for diabetes. This means that their denominator, the population to be screened or the target population, is 1500. The numerator, the number of people screened, is only 100. Meaning only 100/1500 or 1/15 people have been screened till now. Once they have this information, the manager/ team leader can plan necessary actions which may include requesting the ASHAs to get more people for screening or to organise a health camp for screening. It does not mean that they have to set a target for total coverage. That may or may not be done, but this helps the team know where they are with the program. Additionally, from the 100 people screened, 15 are found to have diabetes. Of these 15, only 5 are coming for regularly for treatment. This will tell them that only 5/15 (i.e., 33%) of those diagnosed are undergoing treatment, suggesting the need to reach out to the rest and encourage them to come in for treatment regularly.

Based on this example and principle, providers can start working out the health situation and health achievements in their population. The primary health care team already has the information for pregnant women and immunization and will gradually learn to do this for other illnesses as well.

What kind of indicators are required to monitor performance?

Indicator Type	Data to be used and calculated at facility level
Patients with hypertension under primary care	• % of population 30 and above screened for HT • % of those screened for HT who were examined at SC/PHC/CHC • % of those who were initiated on treatment at SC or above who are still under treatment • % of those currently on treatment who have achievement BP control
Patients with Diabetes Mellitus under primary care	• % of population of 30 years and above screened for Diabetes Mellitus (DM) • % of those screened positive for DM who were examined at PHC/ CHC • % of those who were initiated on treatment at PHC or above who are still under treatment, uninterrupted for last 3 months • % of those currently on treatment who have achieved blood sugar control
Individuals screened for common cancers	• % of population of 30 years and above screened for Oral Cancer

	• % of women of 30 years and above screened for Breast Cancer • % of women of 30 years and above screened for Cervical Cancer • % of those who were screened positive for each of the cancers that underwent biopsy at CHC/ DH • % of those who underwent treatment for each of the cancers who are screened periodically
Cardiovascular mortality in the 15 to 60 year age group.	• Mortality disaggregated by gender • Accidental death rates • Mortality disaggregated by type of accident.
Rate of patients with chronic NCDs on regular medication or other follow up at the HWC	• Rates for specific diseases like HT, diabetes, COPD/ asthma, epilepsy, any mental illnesses, etc., where a specialist initiates treatment but regular follow-up and medication continues locally

Indicators to be used for RCH and National disease control programs are provided in their programme guidelines. The important message here is that every HWC should estimate these indicators for the population they serve

All the data we collect must be useful for analysis.
We should not collect data that is not analysed.

Ensure quality of care

Why do we need quality of care?

- **To ensure that the care given is effective:**
  For example, Ante Natal Care (ANC) is being provided to all pregnant women; if it was good quality ANC, about 5-10 percent of women would have been detected and treated for hypertension in pregnancy. If it was of poor quality, these cases would have been missed.

- **To ensure that care given is safe and errors are avoided:**
  For example, after a cataract surgery sometimes a few patients get infected. This reflects quality gaps in health service delivery.

- **To ensure the safety of providers and environment:**
  Important aspects of care should not be missed. Providers also should not get infected or hurt in the process of care provision and the environment should also not be damaged. To ensure such safeties, good bio-waste management to prevent environmental damage that will adversely affect community health is important. In fact, this is an integral element of quality of care.

- **To ensure that the care given is with dignity:**
  It is important to ensure that the patient is comfortable and satisfied. This ensures the trust between providers and the public making it easier to achieve full coverage with effective care.

How do we achieve quality of care?

Some part of it depends on the state government providing the necessary staff, infrastructure, supplies and training. But there are many elements of providing better quality service with the available staff and facilities merely by organizing care better. The state government is already promoting the implementation of the national system of quality improvement called National Quality Assurance Standards (NQAS). Every HWC should get a quality score on this NQAS scale.

Ensuring a good quality score

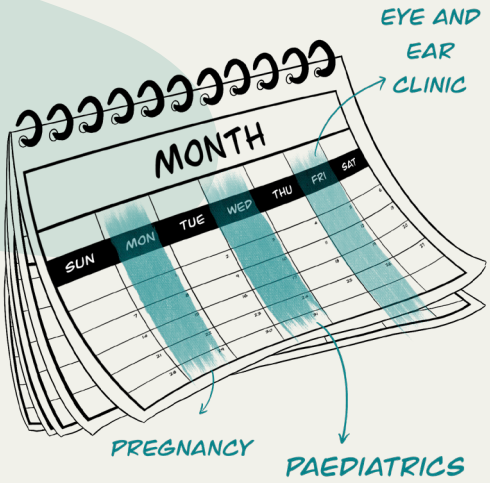
- Clarity on what work each person should be doing
- How should that work be organized so that there is good quality of care?
- Widespread use of standard treatment guidelines for clinical care that the state would be disseminating
- Use of standard protocols for many administrative and organisational functions
- Use of such protocols for both clinical and non-clinical processes, to help identify quality gaps and work out and plan corrective action to close these gaps
- Documentation of key processes and reviewing these so that we can be sure that the quality is being improved constantly. For example, in crowded OPDs with patients having to stand for long and pushing each other, now a system is introduced wherein everyone is registered and gets a token with number and can come in when their number comes up. Or in the labour room, each provider is reminded to wash their hands before and after physically examining the patient. Or needles and syringes are disposed only as per the bio-waste management protocol. These protocols are available in the quality control guidelines.
- Periodic monitoring of these protocols by supervisory staff and quality of care auditors to check adherence and initiate appropriate corrective action.
- Recording of service utilization and disease conditions in the HMIS, which is an important source of information for reviewing the effectiveness of care.

Organisation of the referral at the specialist end

Primary care team should know, for every condition, which is the appropriate place to refer. This should be decided in consultation with the PHC doctor, CHC doctor and district team, and can be modified as and when necessary. For example, in one HWC, a case of pregnancy requiring delivery is referred to the corresponding PHC. If the case is complicated, it should be directly referred to the District Hospital.

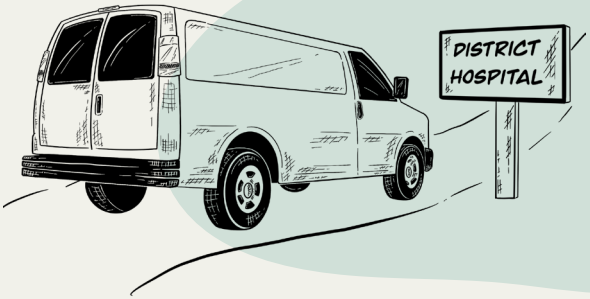
As the number of referrals increase in bulk, the district may resort to increasing the number of referrals more efficiently.

How do we do this? We can choose from a number of options:



- Every PHC could have clinics for different conditions—pregnancy on one day, paediatrics on one day, an eye a ear clinic on another day.
- Specialists from the CHC or District Hospital could attend clinics relating to their specialty organized in the PHC.
- There can be special evening specialist-run polyclinics where referred patients from cluster of PHCs can be seen.

- Tele-medicine consultations could be organised between PHCs and Specialists in District Hospitals at fixed time.
- Patient transport could be arranged to the District Hospital (DH) for specialist consultation.



A sample of the referral form is available in Annexure 7.

Ensuring referral feedback:

If the patient goes to the DH or medical college hospital for a consultation, there should be feedback to the referring HWC so that continuity of care can be ensured. This is not so easy to ensure. Therefore, to be assured of this service, there need to be help-desks in each DH and many such desks in a medical college hospital. These helpdesks could be staffed by the social workers directly recruited or through contracting civil society organizations. Their functions would be to help patients find the specialist they have been referred to and after referral further explain the care management plan and ensure that feedback documents are in place. They work at the interface of the doctor and the patient to ensure quality two-way communication.

If no government hospital has the capacity to manage a given patient, then the patient could be referred to an empanelled private hospital. Any patient referred to any private medical college or other tertiary hospital from a DH or government medical college hospital would get free care there, with government re-imbursing the private hospital at MHIS/ PMJAY or other negotiated rates. If there is no private hospital willing to do so, and there is a patient requiring that care, the government can requisition the necessary capacity to provide these services like it was done during Covid-19.

Making use of MHIS/ PMJAY

One strength of the Meghalaya situation is that almost the entire population is covered under the Megha Health Insurance Scheme which at the National Level is also known as the Pradhan Mantri Jan Arogya Yojana.

This means for hospitalizations those who are eligible will get free services in all public hospitals and in private hospitals which are empanelled under the scheme.

This is an important aspect to keep in mind when we refer.

For any referring patient we need to:

1. Ask if they are covered by the MHIS scheme. If yes, they should take the card along. If no and they are eligible, they should get registered.
2. Refer them preferably to those hospitals where the card will ensure that they get free services.
3. Inform them of their entitlement/ right to get free services and how they need to inform the hospital of that. Some hospitals who are empanelled will be happy to provide free services. Some will find some reason to either deny care or make charges. In which case the patient should give feedback to primary provider and to the grievance redressal cell. Primary providers can avoid referring to private hospitals who do not follow their contract terms. Such hospitals may lose their empanelment in future. In public hospitals the district team must step in and ensure that the care provided is free.
4. Just because it is free should not mean that excessive or unnecessary care is given. Remember it is charged to the government and it is deducted from the sum that the patient's family is eligible for. This leaves less money for treating more patients with the government. It also means that if the sum on the card is quickly exhausted, the patient will not have to pay out of pocket. Hence despite the care being free, they should go to most affordable good quality services.
5. Remember the primary care provider is a friend of the family. She or he should guide them to make the best choice for each family. The hospital should be known for good quality care, for not charging the patients, for not providing unnecessary care or denying necessary care and for providing feedback to primary care providers to enable follow up. There should be no effort to convert primary care needs into opportunities for tertiary care merely because they can then bill the government for the same. Patients will find it difficult to know which hospital or referral centre has these qualities, but primary care providers must find out and guide them. This is an important function of the HWC.

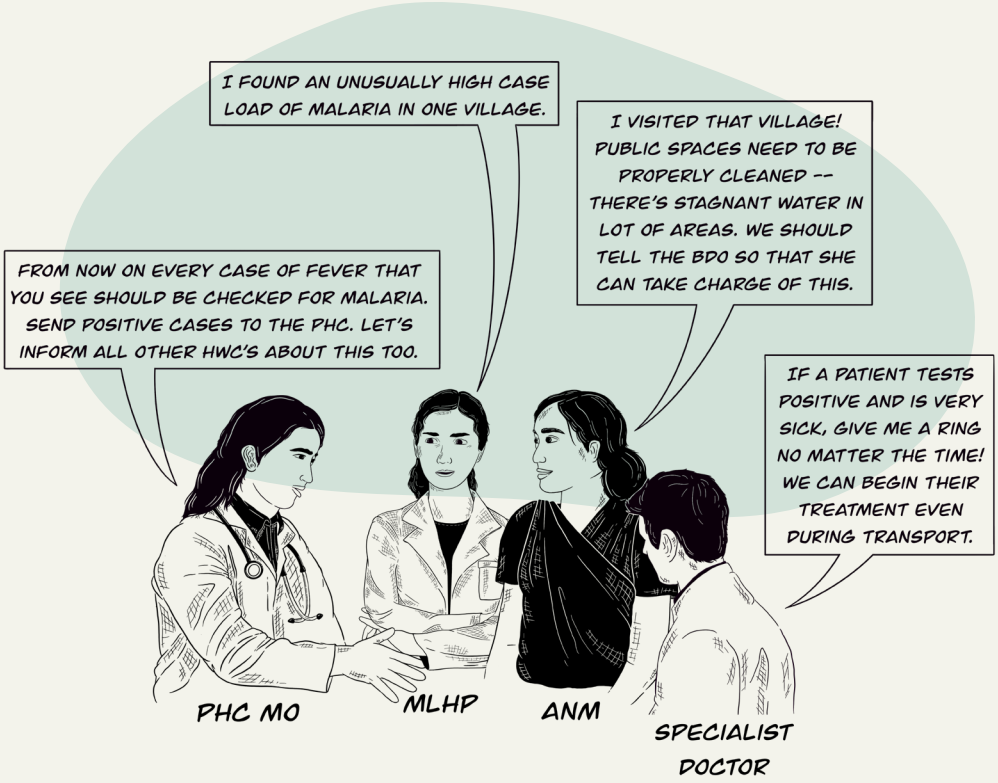
There are many other ways in which the primary care provider acts like a family friend, which we will see in the final section.

Building the district team

One of the challenges for the HWC-SC is that the team members in the HWC-SC as well as the larger district team need to feel part of a common program. Some friendly meetings should be organised and they should all know each other by name and have regular interactions with each other to generate comfort and familiarity.

A review meeting once in six months of the ANMs, MLHP, PHC MO and some specialists from the CHC and DH will collectively discuss and decide on responding to emerging issues relating to health needs in that particular district. This could include emerging epidemics, or a higher load of particular diseases, or discussing establishing referral links.

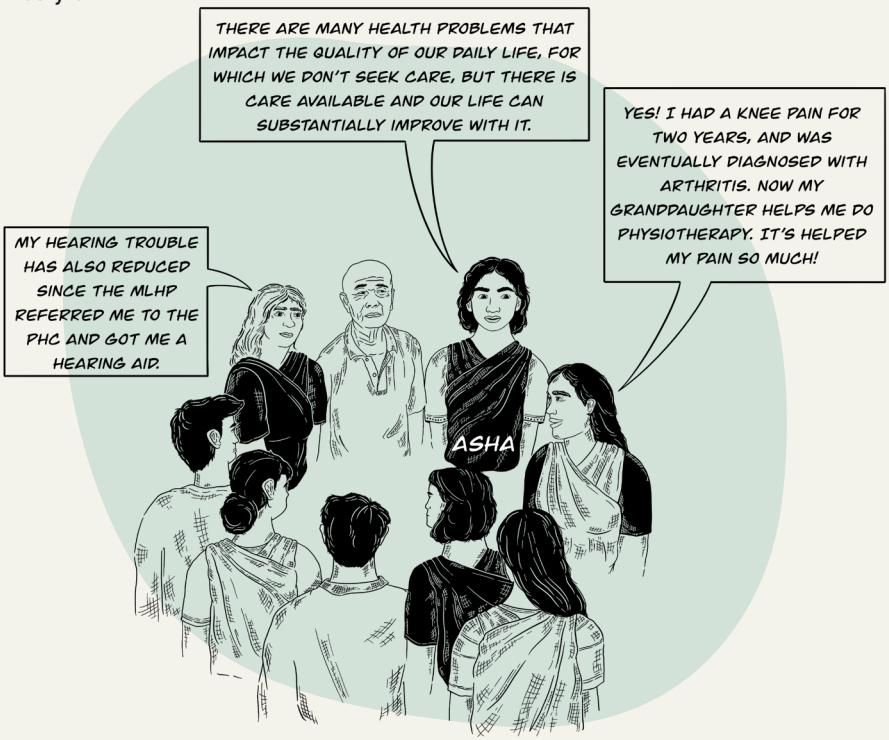
Some training or orientation programs could be organised not around individual providers but for teams of providers. For example, a team consisting of the MLHP, PHC MO, and specialist together be trained on responding to primary care needs on hypertension.



How is this approach community-centred?

Community mobilization through Village Health Councils

The Government of Meghalaya is trying to empower village communities by forming Village Health Councils (VHCs). These councils will play an active role similar to the VHSNCs in every village, with additional functions. One key role of community organisations is to identify healthcare needs that are latent. Latent needs are those needs that people don't know about, or they suffer from it, but do not know that health care is available for it. Some of these like hypertension are undiagnosed conditions that require screening. Some of it is preventive and promotive health care needs like changes in lifestyle.



VHCs will encourage utilization of essential services by creating awareness about latent health needs. They will work together with SHGs and village headmen who will be educated about this and encouraged to persuade people to utilise the health services in HWC-SCs. VHCs will also discuss and identify the important health needs in the village, and work with ASHAs, ANMs, Anganwadi workers, and local health and administrative officials to think about solutions. VHCs can make use of the Meghalaya social audit act to monitor availability of services in the HWC so that comprehensive care is provided. A citizen charter will mention all diseases covered by the HWC and corresponding PHC.

How can we make community mobilisation work?

The VHC should be independent and empowered to set its own goals and priorities.

VHC members should be trained on key health issues so that they can identify local health needs.

The VHC should partner with HWC-SC and PHC to plan and intervene at household level and community level.

Members of the community organisation should be motivated to speak for and serve under-represented, more marginalized groups.

VHCs must have adequate representation of women and must engage with existing women's groups. This would ensure greater participation of women, enable greater attention to women's health concerns, increase access of women to health services, and make the delivery of services more women friendly.

Community mobilisation through Patient Support Groups (PSGs)

PSGs should be facilitated by the ASHA/MPWs/other frontline workers around particular disease conditions and can play an important role in improving treatment compliance.

PSGs are a platform where patients with similar illness and their caregivers can have an open discussion about the disease and the challenges related to illness and its treatment.

They also help counter discrimination and stigma around certain diseases, and their collective nature promotes changes in lifestyle behaviour. People with mental illness, care givers of people with mental illness, and NCD patients benefit from the solidarity that PSGs offer. For instance, patients with Diabetes and other NCDs, especially juvenile diabetics, gain from these collective forums (as children otherwise don't understand the importance of changing lifestyle patterns and taking insulin)

Community mobilisation through Jan Arogya Samitis (JAS)

Jan Arogya Samitis must be oriented to the CPHC Programme and encouraged to provide support to all HWCs. This, they can do by both mobilising resources in kind and as money to close essential gaps and by informing public of extended services available.

Promoting healthy behaviours and protecting from harmful practices

The health of a community or of a family or individual is not produced by the activities of healthcare providers. Being healthy depends much more on the lifestyles and practices followed by families and the community. In that sense, they are co-producers of health and not just consumers. **They are not just passive beneficiaries, they are active participants in producing health outcomes.**

Being healthy depends on socially acceptable habits and practices just as much as it depends on individual choice. The role of primary healthcare providers is to make people aware of ways to improve health practices and discourage unhealthy practices. This requires planning at different levels – block, district and state. Here are some examples of what can be done in the local community:

- **The Swachh Bharat Abhiyan:** for ensuring that every household has and utilises sanitary latrines ensuring that there is safe drinking water access to every household in the village and ensuring that there is disposal of solid and liquid waste.

- **Balanced, healthy diets:** knowledge of what diet is best and how they can best achieve it within local resources. Also, on ensuring access to government schemes related to the right to food.

- **Ensuring regular exercise**: Adults require at least one hour of moderate exercise three or four times a week; young adults require the same amount but more rigorous like running. Many people get exercise as part of their daily work, but those who do not must put aside time for the same. There must be spaces in the neighbourhood where children can play, adults can walk etc.

- **Addressing tobacco, alcohol and substance abuse**: One task is educating people about the harms of such use. Another part is ensuring that the laws restricting availability are followed. A third part is helping those who are already addicted to kick the habit. The health system has a role in all three.

- **Yatri Suraksha:** preventing deaths due to rail and road traffic accidents. There are many things that individuals must do, individual actions include wearing helmets for two wheelers, wearing seat belts and road discipline. Community action includes identifying accident prone areas and population groups (drowning in young children, occupational health hazards like mining).

- **Nirbhaya Nari:** action against gender violence. In many areas domestic violence is a big problem both against women and children. Domestic violence is not a private issue, it is a community responsibility. In some cases, women are particularly unsafe, here the threat of violence and stress associated with this contributes as much as direct violence.

- **Reduced stress and improved safety in the workplace:** places like coal mines, construction work are particularly accident-prone sites. Safety norms need to be followed and one must contact the concerned authorities to ensure this is happening.

- **Reducing indoor and outdoor air pollution**

All these above actions require the VHCs and JASs, facilitated by ASHAs, to educate the community, discourage unhealthy practices and encourage all individuals and families to keep themselves healthy. HWCs and ASHAs need to help build the capacity of VHCs and JASs to play this role.

Similarly, schools and workplaces should also be active in ensuring the above objectives are met.

Home visits by the ASHA can play an important role in identifying and discouraging harmful or unhealthy practices and promoting responsible and healthy behaviours. These home visits for counselling can be organized according to age group, since each age group is susceptible to different health risks.

Age group	Healthy practices to promote	Harmful practices to discourage
Care in pregnancy and new-born children	• Breastfeeding and early identification of illness • Safe hygiene and WASH practices • Family/community education for prevention of infections and keeping the baby warm • Mobilisation and follow-up for immunisation	• Delayed and inadequate weaning • Food taboos on eggs, milk and fruits
Infant children (under 5)	• Safe hygiene and WASH practices • Family/community education for prevention of infections • Mobilisation and follow-up for immunisation • Teaching children swimming and about drowning risks • Ensuring children get adequate play time	• Food taboos on eggs, milk and fruits • Ill-informed dietary practices
School going (5-18)	• Washing hands and personal hygiene • Teaching children swimming and about drowning risks • Ensuring children get adequate play time	

Adolescent and young adults (12-30)	• Healthy and responsible sexual behaviour and reproductive health • Safe personal hygiene practices • Counselling and early identification of suicides	• Substance abuse • Alcohol and tobacco use • Stigma around health issues
Working adults (30-60)	• Exercise for healthy lifestyle and to avoid obesity • Responsible sexual behaviour • Positive reproductive behaviour – birth spacing and use of contraceptives • Adequate diet and nutrition	• Alcohol and tobacco abuse • Violence against women • Stress at workplace and home
Elderly (60 and above)	• Awareness on social security schemes for elderly • Identifying behavioural changes and providing care	• Elderly abuse

The care provider as a family friend

ASHAs help make primary care community-centred

The ASHA is the main contributor to promoting healthy behaviours and practices and discouraging unhealthy practices.

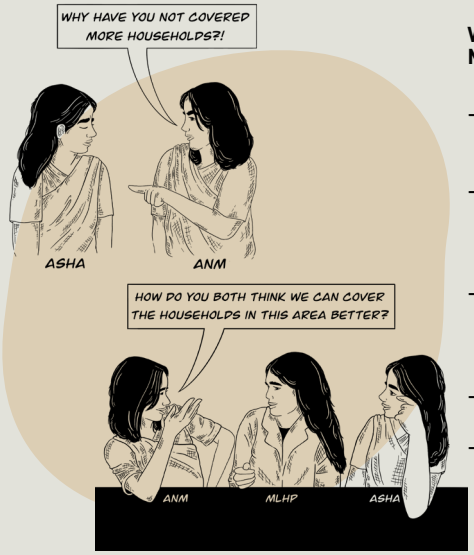
The ASHA fulfils this role through her schedule of home visits, where she will find out which members of each household are ill, refer them to the HWC and also give age and gender-based counselling. She can do 15-20 visits in a day, which adds up to about 1000 household visits in 2 months.

The ASHA is the bridge between the HWC and each household, ensuring that every household knows about the expanded basket of services and making use of these.

After a basic annual visit to all households, she can then prioritise her visits to those households with greater needs and risks such as chronic illness, new-born children etc.

The ASHA is an important mobilizer of the community, and enables interaction with and capacity building of community-based organizations. To fulfil her role as community mobilizer, the ASHA ensures that the meetings of local committees are held regularly and participation is good and important concerns are discussed.

The ASHA can identify which households need visits by a doctor or a nurse and facilitate these visits.



What is the role of the ASHA in our CPHC approach for Meghalaya?

- ASHAs must feel a part of the primary care team, with a strong sense of cooperation between the ASHA, ANM and MLHP.
- Periodic training of ASHAs on new services and activities required of them under CPHC. For example, training on NCD screening will empower them to perform better.
- Provision of proper equipment to make her home visits more effective. Equipment should include the medicines kit, digital thermometer, a glucometer, BP apparatus etc.
- Proper respectful response to her referrals, with feedback as necessary
- Ensuring adequate terms of employment and encouraging friendly and respectful behaviour towards her by other staff and community leaders.

Reaching out to the weakest

Who are the marginalised groups? And why should we reach out to them?

Some population groups are more at risk than others. Some population groups have higher healthcare needs than others. The cruel reality is the greater the need for healthcare, the less likely they are to have access. This is termed the 'inverse care law'.

Some population groups are marginalised due to geography, they are the farthest from the capital and near the border, or even with the village they are cut off by streams. Some are marginalised due to their occupation, for example coal miners, sanitation workers and rag pickers. Some are marginalised due to their social status, they could be migrants, they could be lower caste, or minority groups. Many are marginalised due to economic circumstances; they are just too poor.

Gender also plays a role in marginalisation. Women and sexual minorities are often affected much more by disease.

In Meghalaya, years lost due to COPD is significantly higher in women than men (Source: Meghalaya Disease Burden Profile, 1990 to 2016). **This is due to many factors: biological vulnerability, lack of health seeking (due to stigma, due to household responsibilities, health infrastructure not being women friendly), social factors (nutrition, sanitation), environmental factors (women are more exposed to indoor air pollution through chulhas).**

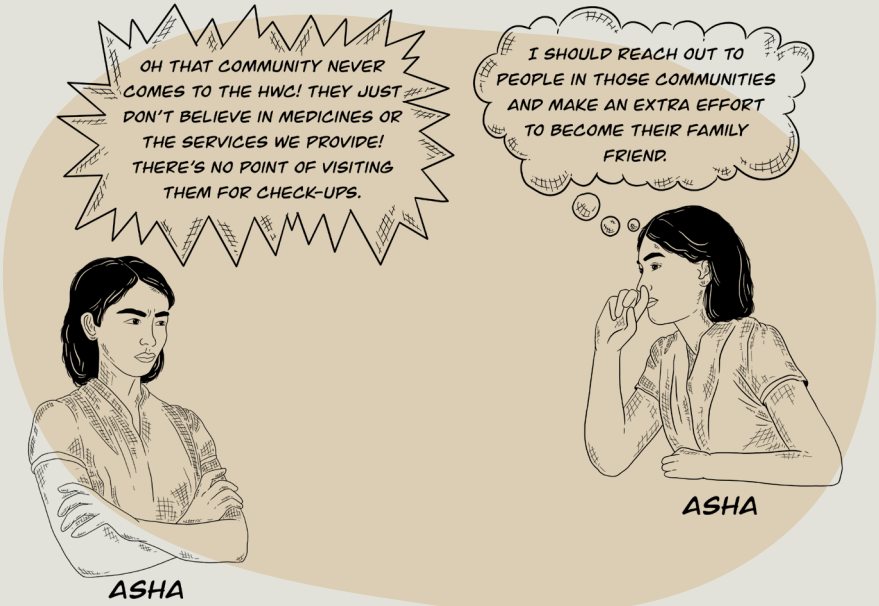
Across genders, people with disabilities also face marginalisation, due to issues related to accessibility and awareness about treatments available.

How can we reach out to these marginalised groups?

Every VHC must identify who is most marginalised and ensure that their access to government provided services is no less than that of the dominant hamlets. In fact, they need to have greater access to these services.

All ASHAs must start their home visit circuits from such households, so that they don't get missed out. For many such households, free care is not enough, they will require further affirmative action like compensation for transportation or livelihood loss compensation. By carefully linking with ESI (Employees State Insurance), MHIS/ PMJAY and the resources that Rogi Kalyan Samitis have, one can provide the necessary affirmative action. Sometimes, dominant groups who themselves are deprived compared to the urban middle class, may resent this prioritisation of the poorest. But serving the poorest is an act of compassion and justice, and also fulfils the constitutional principle of equity.

Equity is a basic constitutional principle. When people are unequal, they should be treated unequally to attain fairness. Or in other words the government and public providers' first duty is to the poorest and most marginalised.



Protection from unnecessary expenditure on healthcare and from exploitation

One of the objectives of CPHC is to prevent Out of Pocket Expenditure (OOPE) on healthcare. It is no secret that the second biggest cause of poverty in the country is healthcare costs. But even more shocking, a large part of these healthcare costs is completely unnecessary and wasteful expenditure. This makes for private profits but not for better health. Meghalaya's CPHC approach prevents such wasteful health expenditure and promotes prosperity among the people by the following measures:

Ensuring that 70-80% of healthcare needs are met as close to their residence as possible and are free. This includes the cost of medicines and diagnostics. This is achieved through the network of HWCs to which every single household and individual must be registered so as to be entitled to such free care.

If the HWC is unable to extend care, it promotes facilities on terms where there is no payment required even for secondary and tertiary care. This can be done through referral to a public provider or to a private provider empanelled under PMJAY/MHIS.

The primary care team which includes the ASHA also ensures this by educating people against irrational use of drugs and irrational remedies and guiding them on appropriate choice of provider.

Some costs are difficult to cover, like transport costs, the costs of attenders, the costs due to loss of livelihood. There are other government schemes and social security schemes like the ESI that provide for this. Gradually, such social security coverage will extend to the entire population.

I KNOW THAT WORLD OVER, A HEALTH SYSTEM WHERE PATIENTS ARE REQUIRED TO PAY A FEE FOR SERVICES WHEN THEY ARE SICK IS CONSIDERED UNJUST. BUT WHY IS THIS THE CASE?

THIS IS BECAUSE NOBODY CAN ANTICIPATE WHEN THEY WILL FALL SICK. MOREOVER, PEOPLE DON'T HAVE THE NECESSARY INFORMATION TO PURCHASE THE RIGHT SERVICES IN SITUATION, UNLIKE IF THEY WERE BUYING ANY OTHER COMMODITY. SEE, WHEN A PATIENT IS SICK AND URGENTLY NEEDS CARE, THEY DO NOT HAVE THE ABILITY TO BARGAIN WITH ANYONE, MUCH LESS SOMEONE AS POWERFUL AS A MEDICAL PROFESSIONAL. THAT'S WHY ALL DEMOCRATIC NATIONS ASPIRE TO HAVE A HEALTH SYSTEM WHERE THE COSTS FOR CARE ARE ALREADY PAID USING THE TAXES COLLECTED. MEGHALAYA TOO IS ON THIS PATH.

What else makes for a good provider?

1. The provider must respect the patient's right to:

   - Adequate and relevant information about the nature of the illness, treatment options proposed, expected costs of treatment and possible complications.
   - Access to case papers, patient records, investigation reports and detailed bills.
   - Informed consent prior to potentially hazardous treatment: before giving the patient treatment, especially surgeries, the treatment must be explained and permission taken before proceeding.
   - Choosing alternative treatment if the option is available.
   - Seeking redressal in case of grievance.
   - Discharge summary, or in case of death, death summary.
   - Consult other doctors or refuse a particular treatment before deciding on a particular course of treatment.

2. Women and adolescent friendly service
   - Create spaces that are accessible to women; for example healthcare facilities must have women's toilets, space for nursing babies.

   - Privacy: for example, a screen should be available to ensure privacy during a clinical examination.
   - Sensitivity: when a male health care provider is attending to a female patient, it is essential to ensure that a female attender is present. This could be a nurse or an attender of the patient. If no one is available, any other woman can be asked to be present.
   - Informed consent before treatment.
   - Encourage women's participation in Jan Arogya Samitis.
   - Gender based violence needs to be recognized as a public health issue, so that survivors have access to comprehensive healthcare. The primary care team should actively screen, document and refer cases of gender-based violence. The team can also work with VHCs to organize campaigns on gender-based violence.
   - Create spaces that are comfortable for adolescents so that they come to the HWC for counseling and consultation on health matters.

3. The provider should be aware of their own biases and not discriminate between patients of different backgrounds.

4. The provider must assure patients of their right to confidentiality (providers should not reveal information about the patient).

5. The provider must assure patients of right to privacy (patient's right not to share their personal information with others).

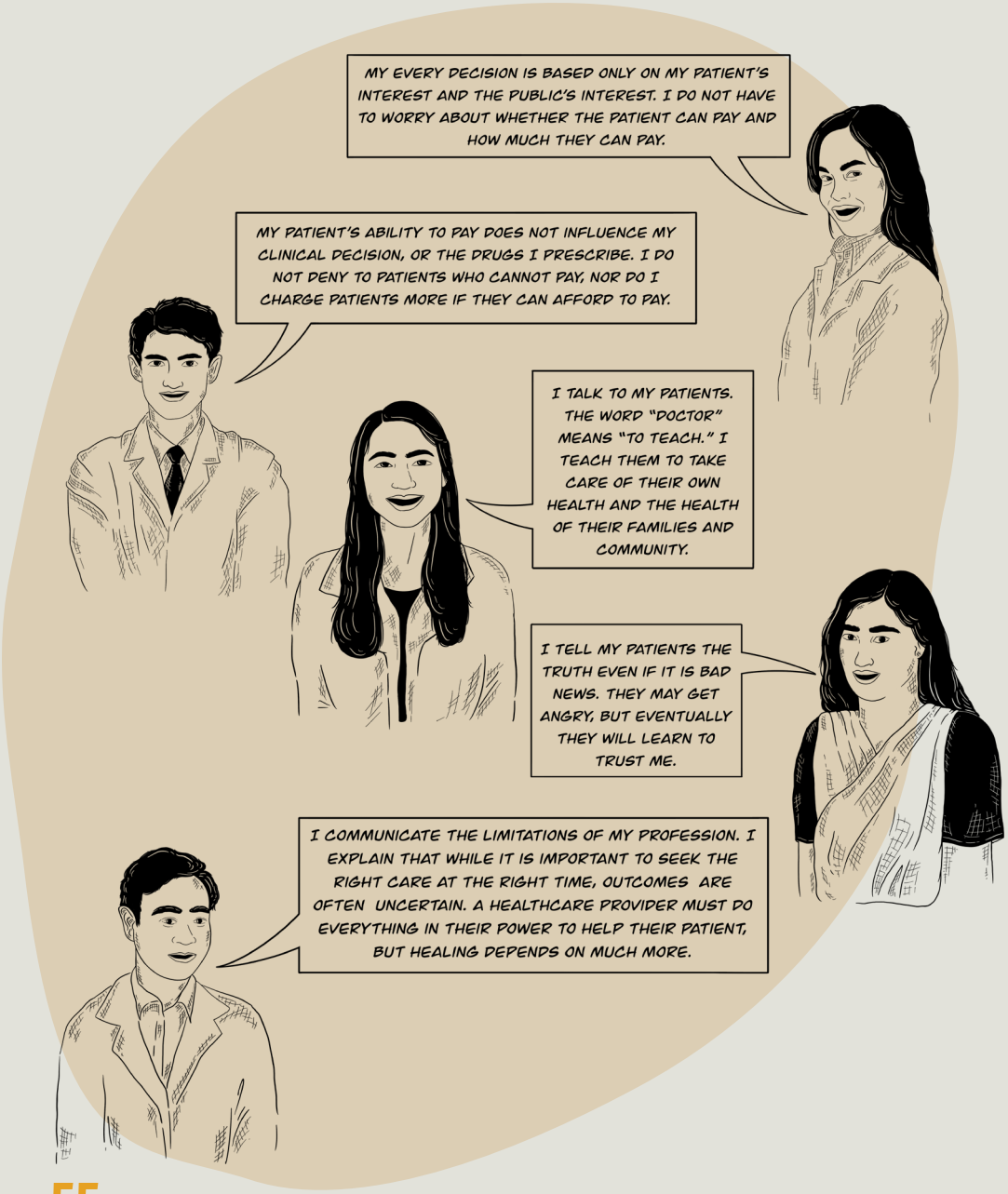
6. The provider must assure the right of the patient to be spoken to politely and treated as an equal and their personal dignity respected.

7. The provider must assure the patient's right to be protected from any unnecessary pain, suffering or discomfort during care.

8. The provider must assure the patient's right to die with dignity.

Taking pride in public service

There are many values that health services in Meghalaya must be associated with.



These values are easier to obtain in the public services, when the provider's income has no link with the clinical decisions they make. The government takes care of the material needs of the providers; they can then focus on giving the best in public services.

Sometimes friends and even family members ask us public providers why we are not making larger profits like in the private sector. But we know that many of us have chosen to work in public services because we are proud to do so and because we get great joy from serving people. It is a choice we have made.

Further Resources

Annexure 1: Indicative List of Screening Methods for CPHC

This list has been adapted from Ayushman Bharat's "Comprehensive Primary Health Care through Health and Wellness Centres: Operational Guidelines" (2018) to suit Meghalaya's context

	At Hub	At HWC-SCs
Non communicable diseases – general		Weighing Machines for different age groups and Stadiometers for Body Mass Index Blood Pressure Peak flow meter Questionnaire for detection of risk factors like smoking, substance abuse, and for chronic respiratory disease (CBAC)
Cervical cancer	Colposcope/ Cryotherapy Equipment	Visual Inspection through Acetic Acid
Mental disorders		Questionnaire algorithm for mental disorder detection and epilepsy
Eye care		Snellen's and Near vision Chart
Malnutrition		Weight Charts and weighing machine
New born and Child Screening for development delays and disabilities		RBSK Screening Tools
Disability and Palliative care		Questionnaire to assess requirement

Annexure 2: Sample Record for Patient

Name of Patient

Full Name of Doctor **Age:**

Date & Time of Examination

Time of Payment: **Payment ID:**

Referring HWC-SC (name of HWC-SC village):

Complaints and Symptoms of Patient:

Height (in cm)

Weight (in kg)

Pulse (per min)

Blood Pressure

Body Temperature

Anaemia

Tests Recommended by Doctor

Prescription

Doctor's Signature or Stamp

Annexure 3: Essential Medicine List for HWC-SCs

This list has been adapted from Ayushman Bharat's "Comprehensive Primary Health Care through Health and Wellness Centres: Operational Guidelines" (2018) to suit Meghalaya's context

Sr.No.	Name of Medicine	Dosage Type
Analgesics, antipyretics, non steroidal anti inflammatory medicines, medicines used to treat gout and disease modifying agents used in rheumatoid disorders		
1	Diclofenac	Tablet 50 mg
		Injection 25 mg/ ml
	Paracetamol	Tablet 500 mg
		Tablet 650 mg
		All licensed oral liquid dosage forms and strengths
Anti allergic and medicines used in anaphylaxis		
	Cetrizine	Tablet 10 mg
	Chlorpheniramine	Tablet 4 mg
		Oral liquid 2 mg/ 5 ml
Intestinal anti helminthes		
	Albendazole	Tablet 400 mg
	Diethylcarbamazin (Antifilarial)	Tablet 50 mg
		Tablet 100 mg
Anti bacterial		
	Ciprofloxacin	Tablet 250 mg
		Tablet 500 mg
	Gentamicin	Injection 10 mg/ ml
		Injection 40 mg/ ml
	Metronidazole	Tablet 200 mg
		Tablet 400 mg
	Amoxicillin	Capsule 250 mg
		Capsule 500 mg
		Oral liquid 250 mg/ 5 ml
Anti-fungal medicines		
	Fluconazole	Tablet 100 mg

	Name of Medicine	Dosage Type
Anti Malarial		
	Chloroquine	Tab 150 mg
	Primaquine	Tablet 2.5 mg
		Tablet 7.5 mg
		Tablet 15 mg
	Artesunate (A) + Sulphadoxine – Pyrimethamine (B). Combi pack (A+B)	1 Tablet 25 mg (A) + 1 Tablet (250 mg + 12.5 mg) (B)
		1 Tablet 50 mg (A) + 1 Tablet(500 mg + 25 mg) (B)
		1 Tablet 100 mg (A) + 1 Tablet(750 mg + 37.5 mg) (B)
		1 Tablet 150 mg (A) + 2 Tablet(500 mg + 25 mg) (B)
		1 Tablet 200 mg (A) + 2 Tablet(750 mg + 37.5 mg) (B)
Anemia		
	Ferrous salts	Tablet equivalent to 60 mg of elemental iron
		Oral liquid equivalent to 25 mg of elemental iron/ml
	Ferrous salt (A) + Folic acid (B)	Tablet 45mg elemental iron (A) +400 mcg (B)
		Tablet 100 mg elemental iron (A) + 500 mcg (B)
		Oral liquid 20 mg elemental iron (A) + 100 mcg (B)/ml
	Folic acid	Tablet 5 mg
Dermatological medicines (Topical)		
	Clotrimazole	Cream 1%
	Methylrosanilinium chloride (Gentian Violet)	Topical preparation 0.25% to 2%
	Povidone iodine	Solution 4% to 10%
	Silver sulphadiazine	Cream 1%
	Framycetin	Cream 0.5%
Disinfectants and antiseptics		
	Ethyl alcohol (Denatured)	Solution 70%
	Hydrogen peroxide	Solution 6%
	Methylrosanilinium chloride (Gentian Violet)	Topical preparation 0.25% to 2%
	Povidone iodine	Solution 4% to 10%
	Bleaching powder	Containing not less than 30% w/w of available chlorine (as per I.P)
	Potassium permanganate	Crystals for topical solution
Gastrointestinal medicines		
	Ranitidine	Tablet 150 mg
	Domperidone	Tablet 10 mg

	Name of Medicine	Dosage Type
	Dicyclomine	Tablet 10 mg
	Oral rehydration salts	As licensed
	Zinc sulphate	Dispersible Tablet 20 mg
Contraceptives		
	Ethinylestradiol (A) + Norethisterone	Tablet 0.035 mg (A) + 1 mg (B)
	Hormone releasing IUD	Contains 52 mg of Levonorgestrel
	IUD containing Copper	As licensed
	Condom	As per the standards prescribed in Schedule R of Drugs and Cosmetics rules, 1945
	Ethinylestradiol	Tablet 0.01 mg
		Tablet 0.05 mg
	Levonorgestrel	Tablet 0.75 mg
Anti-infective medicine		
	Ciprofloxacin	Drops 0.3 %
		Ointment 0.3%
Oxytocics and antioxytocics		
	Methylergometrine	Tablet 0.125 mg
	Misoprostol	Tablet 100 mcg
Solutions correcting water, electrolyte disturbances		
	Water for Injection	Injection
Vitamins and minerals		
	Ascorbic acid (Vitamin C)	Tablet 100 mg
	Cholecalciferol	Tablet 1000 IU
		Tablet 60000 IU
		Oral liquid 400 IU/ ml
	Vitamin A	Capsule 5000 IU
		Capsule 50000 IU
		Capsule 100000 IU
		Oral liquid 100000 IU/ ml
	Phytomenadione (Vitamin K1)	Injection 10 mg/ ml

additional medicines*

	Name of Medicine	Dosage Type
	Antidotes and other substances used in poisoning	
	Activated charcoal	Powder (as licensed)
	Atropine	Injection 1 mg/ ml
	Snake venom antiserum	a) Injection
	Lyophilized polyvalent	b) Powder for Injection
	Pralidoxime chloride (2-PAM)	Injection 25 mg/ ml
	Analgesics	
	Acetylsalicylic Acid	Tablet 300 mg to 500 mg
		Effervescent/ Dispersible/ Enteric coated Tablet 300 mg to 500 mg
	Ibuprofen	Tablet 200 mg
		Tablet 400 mg
		Oral liquid 100 mg/ 5 ml
	Mefenamic acid	Capsule 250 mg
		Capsule 500 mg
	Ear, nose and throat medicines	
	Ciprofloxacin	Drops 0.3 %
	Clotrimazole	Drops 1%
	Normal Saline nasal drops: sodium chloride	Drops 05% w/ v
	Xylometazoline nasal drops	pediatric (0.05%), adult (.1%)
	Wax-solvent ear drops: benzocaine, chlorbutol, paradichlorobenzene, turpentine oil	
	Boro-spirit ear drops	0.183 gm boric acid in 2.08 ml of alcohol
	Combo ear drops	(Chloramphenicol (5% w/ v) + Clotrimazole (1%) + Lignocaine hydrochloride (2%)
	Liquid paraffin – menthol drops	(Menthol 10 gm + Eucalyptus 2 ml + Camphor 10 gm + Liquid paraffin to 100 ml)

Emergency Medicine Kit
Inj. Adrenaline
Inj. Hydrocortisone
Inj. Dexamethasone
Glyceryl trinitrate: Sublingual tablet 0.5 mg

Additional medicines are included as suggested by the task forces and will be updated after approval.

Annexure 4: Doctor-initiated Drugs that can be given by the HWC-SC for Ensuring Easy Access

This list has been adapted from Ayushman Bharat's "Comprehensive Primary Health Care through Health and Wellness Centres: Operational Guidelines" (2018) to suit Meghalaya's context

	Name of Medicine	Dosage Type
Antihypertensive medicines		
	Amlodipine	Tablet 2.5 mg
		Tablet 5 mg
		Tablet 10 mg
	Atenolol	Tablet 50 mg
		Tablet 100 mg
	Enalapril	Tablet 2.5 mg
		Tablet 5 mg
	Propanalol	Tablet 40 mg
		Tablet 80 mg
		Tablet 10 mg
Cardiovascular medicines (Medicines used in angina)		
	Isosorbide dinitrate	Tablet 5 mg
		Tablet 10 mg
	Aspirin	Tablet 75 mg
Diuretics		
	Furosemide	Tablet 40 mg Oral liquid 10 mg/ ml
	Hydrochlorothiazide	Tablet 25 mg
	Spironolactone	Tablet 25 mg Tablet 50 mg
	Glimepiride	Tablet 1 mg Tablet 2 mg
	Insulin (Soluble)	Injection 40 IU/ ml
	Intermediate Acting (NPH) Insulin	Injection 40 IU/ ml
	Premix Insulin 30:70 Injection (Regular: NPH)	Injection 40 IU/ ml
	Metformin	Tablet 500 mg Tablet 750 mg Tablet 1000 mg

	Name of Medicine	Dosage Type
Anticonvulsants/ antiepileptic		
	Carbamazepine	Tablet 100 mg
	Diazepam	Oral liquid 2 mg/ 5 ml
	Phenobarbitone	Tablet 30 mg Tablet 60 mg
		Oral liquid 20 mg/ 5 ml
	Phenytoin	Tablet 50 mg
		Tablet 100 mg
		Tablet 300 mg
		ER Tablet 300 mg
		Injection 25 mg/ ml
		Injection 50 mg/ ml
	Sodium valproate	Tablet 200 mg
		Tablet 500 mg
CoPd		
	Salbutamol	Tablet 2 mg
		Tablet 4 mg
		Oral liquid 2 mg/ 5 ml
		Respirator solution for use in nebulizer 5mg/ ml
		Inhalation (MDI/DPI) 100 mcg/ dose

Annexure 5: Indicative List of Diagnostic Services for CPHC

This list has been adapted from Ayushman Bharat's "Comprehensive Primary Health Care through Health and Wellness Centres: Operational Guidelines" (2018) to suit Meghalaya's context

	At the Central Diagnostic Unit-Hub (can be block PHC/CHC/SDH/DH)	PHC	HWC-SC
	Haemoglobin	Haemoglobin*	Haemoglobin*
	Complete Blood Count	Total Leucocyte Count* Differential Leucocyte Count* Platelet count*	
	Peripheral smear	Peripheral smear	
	ESR	ESR*	
	Bleeding and Clotting time	Bleeding and Clotting time* (CT where snake bites are common)	
	Blood grouping and typing	Blood grouping and typing*	
	Urine Pregnancy Rapid Test	Urine Pregnancy Rapid Test*	Urine Pregnancy Rapid Test*
	Urine Dipstick	Urine Dipstick*- urine albumin and sugar	Urine Dipstick*- urine albumin and sugar
	Blood Glucose & HBA1C	Blood glucose* (biochemistry)	Blood glucose* (biochemistry)
	Malaria Smear Rapid Diagnostic Kit (RDK)	Malaria smear* RDK*	Malaria smear* RDK*
	Serology for vector borne disease- Dengue, Chikungunya, Filariasis, Malaria, Kala-Azar (some of this at a higher hub)	RDK for Dengue*	RDK for Dengue*
	Rapid Syphilis Test	Rapid Syphilis Test (Rapid Plasma Reagin, RPR Kit Test)*	
	HIV Serology: Rapid Test	HIV Serology: Rapid Test*	
	Typhoid serology	Typhoid serology	
	Hepatitis testing – basic HBs Ag (more advanced at a higher hub)		
	Sickle Cell testing- (other blood tests at higher hub)	Sickle Cell rapid test	Sickle Cell rapid test
	TB Microscopy – AFB Smear	Collection of sputum samples* and AFB smear where PHC serves as designated microscopy centre	Collection of sputum samples
	Wet Mounts – Direct Microscopy (RTI/ STD)	Wet Mounts – Direct Microscopy (RTI/ STD)	

	Liver Function Tests (enzymes)	Serum bilirubin*	
	Blood urea, creatinine		
	Lipid profile		
	Stool for OVA and cyst	Stool for OVA and cyst*	
		Water Quality Testing- H2S Strip test for Faecal Contamination*	
	X ray		
	Ultrasound		
	ECG		

Annexure 6: List of Essential Minor Equipment in Sub-Centre

1. Haemoglobinometer
2. Weighing scale – baby, infant and adult
3. Blood pressure monitoring machine
4. Clinical thermometer (digital)
5. Stethoscope
6. Ambu bag
7. Measuring tape
8. Snellen vision chart
9. Near vision chart
10. Examination lamp
11. Mirror
12. Glucometer

Annexure 7: Sample Referral Form

1. **Name of Patient** _____

   Age _____ **Sex** _____

2. **ID/ Address** _____

3. **Is patient covered under MHIS/ PMJAY** **Yes/ No**

4. **Referring HWC (name of HWC village):** _____

5. **Referring health care provider (name and designation):** _____

6. **Date of Referral:** _____

7. **Referred to (name of center/ hospital)** (indicate time if relevant)

8. **a. Is the appointment fixed?** **Yes/ No**
   b. If yes, please indicate with whom and when: _____

9. **Reason for Referral:**
   a. **For Diagnosis and treatment** ☐
   b. **Confirmed Diagnosis for follow-up**

   i. **Routine** _____

   ii. **New findings/ complications** _____

10. **Relevant details including main symptoms, duration, suspected diagnosis, investigations done, treatment already given; (please add attachments for the same)**

    _____

    _____

    _____

Signature of referring provider

To be filled in by referred provider

11. **Has the feedback form on the next page been filled out?** **Yes/ No**

12. **Facility/ Provider for whom the feedback is intended:**.....

13. **If referral is forwarded to another centre, please provide reasons for the same (this slip is to be kept with patient. Higher center can make/ask for a copy)**

    _____

Signature

Annexure 7: Referral Feedback Form

1. **Referring HWC (name of HWC village): .....**
2. **Referring health care provider (name and designation):.....**
3. **Date and time when referral was seen:.....**
4. **Referral seen by:.....**
5. **Diagnosis:.....Provisional/ Confirmed:.....**
6. **Relevant details including main symptoms, duration, suspected diagnosis, investigations done, treatment already given: (please add attachments for the same):.....**
   .....
   .....
7. **Treatment plan (medicines, investigations, behavioural changes, follow ups required, etc.):.....**
   .....
8. **Follow up required at primary care:**
   a. **Regular access to medication indicated above.....**
   b. **Counselling, reminders for follow up.....**
   c. **Specify if others**

Signature of consultant

Name, Date

To be filled in by facilitator (where relevant)

- **Feedback explained to patient: Yes/ No-.....**
- **Has parallel communication been sent to primary care provider?.....**
- **Were benefits of MHIS/ PMJAY communicated?.....**
- **If yes, was it provided?**

Signature of facilitator

Name, Date