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PART-IIA

GOVERNMENT OF MEGHALAYA

NOTIFICATIONS

The 13th March, 2021.

No.RDS.98/2014/Pt/154. - In exercise of the powers conferred under Sub Clause (i) of clause (d) of Section 11 of the Meghalaya Transfer of Land (Regulation) Act, 1971, the Governor of Meghalaya is pleased to specify the Indian Oil Corporation Limited as a Corporation to which the provisions of the said Act, shall not apply in relation to transfer of land measuring 3,465 Square Mtrs. approximately (More specifically described in the Schedule below) by way of Lease for a period of 30 (thirty) years from Smti. Sumankee Suwer to the Indian Oil Corporation Ltd., For the purpose of a Retail Outlet.

SCHEDULE

Location at Amngap Skur, Nongtalang Village, West Jaintia Hills District, Meghalaya.

North: 55 Mtrs. P.W.D. Road N.H. 40 (E)

South: 50 Mtrs. Khlaw Ka Peaceful Rumbui

East: 66 Mtrs. Brisoh Ka (L) Embimai Rumbui

West: 56 Mtrs. Khlaw Ka Seng Kur Rumbui

Letter No.RDS.98/2014/150, dated 3rd December, 2019 issued earlier stand cancelled.

I. MAWLONG,
Joint Secretary to the Govt. of Meghalaya,
Revenue & Disaster Management Department.

The 11th February, 2021.

No.FEG.29/2018/126. - In exercise of the powers conferred by Clause (2) of Article 283 of the Constitution of India and all powers enabling him on this behalf, the Governor of Meghalaya is pleased to make the following Rules to amend the Meghalaya Treasury Rules, 1985 as follows:-

1. **Short Title and Commencement.**

   (a) These Rules may be called the Meghalaya Treasury (Amendment) Rules, 2021.

2. **Amendment of Rule** 3 -

   (1) In Rule 3 of the Meghalaya Treasury Rules, 1985 (hereinafter referred to as the Principal Rules) after clause (m) of Rule 3 of the Principal Rules, the following new clauses shall be inserted as follows, namely:-

   (n) Electronic mode of payment mean payments made from Government Accounts through Treasuries, Sub-Treasuries or Cyber Treasury into the bank accounts of Government employees or beneficiaries against claims made by concerned Drawing and Disbursing Officers through bills - physical or electronic and cheques. Electronic payment shall also encompass the payments made by the agency bank through electronic mode on the strength of Treasury Advice List to Government employees or beneficiaries against claims made by concerned Drawing and Disbursing Officers through bills - physical or electronic and cheques.

   (o) Electronic receipts:- shall mean receipts remitted into Government Account through electronic modes by Government Departments or General Public *via* Cyber Treasury of the State.

   (p) Drawing and Disbursing Officer's Advice List is a list containing bank and amount details of payees against bills or cheques presented for payment from the concerned treasury.

   (q) Treasury Advice is a non-negotiable instrument instructing the agency bank to make payment from Government Accounts for credit to the payees concerned as per Drawing and Disbursing Officer's Advice List.

   (r) SBI-CMP (Cash Management Product) is a Government approved application for electronic mode of payment by Treasuries having State Bank of India as their Agency Bank.

3. **Amendment of Rule 6** - In Rule 6 of the Principal Rules, for the existing sub-rule (2) of Rule 6, the following shall be substituted as follows, namely-

   The Cyber Treasury shall handle all online Government Receipts and collection of Taxes across the state conducted through Departmental Transaction Applications and Government Receipt Accounting System (GRAS) using the following modes of payment as per Reserve Bank of India norms:-

   (a) Debit Cards

   (b) Credit Cards

   (c) Direct Debit Facility or Net Banking

   (d) Over the Counter at any branch of State Bank of India through e-challan.

   Note: (a) System generated challans shall be clearly marked "System Generated Challan: Signature is not required."

   (b) When the electronic data of GRAS is forwarded to the Accountant General (A&E) office during the submission of accounts the Digital Signature on the file being sent shall be required.

4. **Amendment of Rule 20 -** In Rule 20 of the Principal Rules, for the existing Rule 20, the following shall be substituted, namely -

"The Treasury Officer shall be responsible to the Accountant General for acceptance of the validity of a claim against which he has permitted withdrawal.

Provided that the responsibility of providing evidence that the payee has actually received the sum withdrawn lies with the Drawing and Disbursing Officer."

5. **Amendment of Rule 61 -** In Rule 61 of the Principal Rules, for the existing sub-rule (1) of Rule 61, the following shall be substituted, namely-

"A complete list of Treasury Accounts and returns to be rendered on different prescribed dates to the Accountant General, the Currency Officer and other authorities shall be kept at each treasury. The accounts and returns be written up in accordance with the directions contained in this behalf in the Accounting Rules for Treasury, 1992 and such orders and instructions as may be issued by the Collector and Government."

After the existing Rule 61(1), a new Rule 61(1)(a) shall be added as follows-

"61 (1)(a) in case of Accounts rendered to the Accountant General by the Cyber Treasury Officer, only digitally signed data file will be submitted. Submission of Physical Challan will not be required.

6. **Amendment of Rule 105 -** In Rule 105 of the Principal Rules, for the existing Rule 105, the following shall be substituted, namely-

Save as otherwise specifically provided in these rules, money may not be withdrawn from the Government account except by presentation of bills.

The purposes for which and the conditions under which money may be withdrawn by cheques are specified in this and subsequent parts.

Explanation:- A bill is a statement of claim against the Government containing specification of the nature of expenditure and amount of the claim, either in gross or by items and includes such a statement presented in the form of a simple receipt.

A bill or a cheque is deemed to have become a voucher when the Treasury Officer based on the successful payment by the Bank enters the Advice No. and Date on the body of the bill along with the seal indicating the Mode of Payment on the bill or a cheque and then the amount is accounted for in the Treasury Payment Schedule.

The above provision shall apply *mutatis mutandis* to bills or cheques advised for payment through authorized mode of payment e.g. SBI-CMP etc."

7. **Amendment of Rule 106 -** In Rule 106 of the principal Rules, under section 1 part 5 : the existing Rule 106 is to be read as 106(1) and after Rule 106(1), a new Rule 106(2) is to be inserted as follows:-

"In cases of bills submitted through electronic mode with physical copies of the bills and vouchers, the Treasury Officer shall make or authorize payment to the specified payee(s) through the use of electronic mode of payment, i.e. SBI-Cash Management Product or such other electronic mode as may be authorized by Government subject to observation of all other formalities of examining the bills as expressed in Rule 321."

8. **Amendment of Rule 257 -** In Rule 257 of the Principal Rules, for the existing Rule 257, the following shall be substituted, namely-

"257 - Save as otherwise provided and except in the case of any provisional pensions payable through Head of offices, all payments of pension will be made directly to the accounts of Pensioner(s) subject to provisions of Rule 245.

Pensioners who have registered for online self verification and whole fingerprints are stored in the pension database, may opt for online self verification through Kiosk machine provided for the purpose, once in every 6 (six) months. Treasury Officers may also conduct spot or off-line verification of pensioners using fingerprint identification device, if necessary.

Note:- The disbursement of provisional pension drawn by the head of office shall be made in the same manner in which pay and allowances are disbursed by him."

9. **Amendment of Rule 338 -** In Rule 338 of the Principal Rules, for the existing Rule 338, the following shall be substituted, namely-

"Care shall be taken that the Treasury Advice List as returned by the bank shall be conspicuously marked "PAID" by the Agency Bank(s) with seal and signature."

10. **Amendment of Rule 340 -** In rule 340 of the Principal Rules, for the existing Rule 340, the following shall be substituted, namely-

"The Treasury Officer shall maintain a register in electronic form of orders of payment."

P. K. AGRAHARI,
Secretary to the Govt. of Meghalaya,
Finance Department.

The 5th March, 2021.

No.CDD.76/2012/Pt.1/155. - Following the creation of Sohiong C&RD Block by bifurcation of Mawphlang & Mylliem C&RD Blocks *vide* this Department's Notification No.CDD.84/2013/370, dated 31st January, 2017, the Governor of Meghalaya, is pleased to order the Re-organization of the areas, villages & Gram Sevak Circles of Mawphlang C&RD Block under East Khasi Hills District, with immediate effect.

The list of villages of Mawphlang C&RD Block, East Khasi Hills District with Headquarter at Mawphlang and having an approximate population of 46,377 comprising of 12 Gram Sevak Circles is at **Annexure I.**

This supersedes this Department's **Notification No.CDD.76/2012/Pt .1/71, dated 3rd February 2020.**

SAMPATH KUMAR,
Principal Secretary to the Govt. of Meghalaya,
Community and Rural Development Department.

ANNEXURE-I

REORGANISATION OF G. S. CIRCLES WITH VILLAGES UNDER MAWPHLANG C&RD BLOCK, EAST KHASI HILLS DISTRICT.

Sl. No.	Name of G. S. Circle	Name of Villages	Total Population
1	**Laitjem**	1. Sadew	701
		2. Ritmawniew	185
		3. Nongrimsadew	609
		4. Laitjem	1359
		5. Mawkriah East	666
		6. Mawkriah West	616
		7. Lumsohriew	297
		8. Mawkalum	286
		9. Umthlong	357
			Total : 5076
2.	**Mawngap**	10. Sawlad Marbisu	424
		11. Mawngap Lumparing	817
		12. Traw Saitkhlieh	347
		13. Mawngap Dukan	614
		14. Marbisu Pdengshnong	1622
		15. Sohram Lwai	302
		16. Mawngap Mawsmai	833
		17. Mawngap Rim	699
		18. Mawngap Khliehshnong	650
		19. Mawngap Mawkharshiing	931
			Total : 7239
3.	**Mawreng**	20. Ladmawreng	725
		21. Mawreng	925
		22. Lyngkhwir	114
		23. Mawreng Mihngi	301
		24. Kharnongwah	279
		25. Laitpynter Synrangkaban	980
		26. Kreit Mawshaton	330
		27. Marbisu Mawsmai	404
		28. Ummylle	600
			Total :4658
4	**Mawphlang**	29. Nongrum (Mawphlang)	632
		30. Dongiewrim (Mawphlang)	676
		31. Wahlyngkien Sunei	354
		32. Mawkohmon	944
		33. Ladumrisain	508

		34. Mission Mawphlang	335
		35. Kyiem	548
		36. Wahlyngkien Ramklang	471
			Total :4468
5	**Lyngiong**	37. Mawponghong	431
		38. Nongthymmai Rum	209
		39. Nonglwai	184
		40. Phanniewlahneng	607
		41. Phanniewlahrum	337
		42. Madan Mawser	322
		43. Ummawiong	168
		44. Nongthymmai Neng	369
		45. Mawshyieng	178
			Total :2805
6	**Tyrsad**	46. Mawlum Tyrsad	443
		47. Tyrsad Umkseh	960
		48. Pomsanngut	198
		49. Kyrphei	516
		50. Umlangmar	459
		51. Mawsawrit	193
		52. Wahumlawbah	398
			Total : 3167
7	**Nongwah**	53. Mawsadang	519
		54. Mawrohroh	253
		55. Pyndenumbri	191
		56. Nongmadan	505
		57. Mawliehpoh	307
		58. Lawkhla Mawlong	243
		59. Nongwah	685
		60. Laitryngwai	125
		61. Niamsang	156
		62. Rangshangkham	130
			Total :3114
8.	**Rangshken**	63. Phudmyrdong	672
		64. Jani Mawiong	188
		65. Rangshken	639
		66. Umtyrniut	342
		67. Mawmyrsiang	293
		68. Wahrahaw	354
		69. Kharlakhar Lumparing	169
		70. Lyngkien Tangnew	285
		71. Ur-Ur	418
		72. Khimmurah	144
		73. Kyndong Laitmawbah	175

		74. Mawkohtep	244
		75. Lawshlem	197
			Total :4120
9.	**Laitmawsiang**	76. Nongriwah	206
		77. Wahrisain	106
		78. Laitmawsiang	852
		79. Sohpian	281
		80. Marten	43
		81. Laitniangtlong	243
		82. Lempluh	359
		83. Lawkhla	308
		84. Mawkynroh	448
			Total :2846
10	**Pyndenglitha**	85. Pyndenglitha	982
		86. Pyndengkhah	263
		87. Phanbhur	164
		88. Laitdiker	122
		89. Laitdithuh	148
			Total : 1679
11	**Nongspung**	90. Nongspung	1718
		91. Pyrton Sohphoh	245
		92. Mawmahwar	324
		93. Mawphansnar	350
		94. Laitnongrim	932
		95. Wahsohlait	534
			Total : 4103
12	**Umsawmat**	96. Thainthynroh Mawlum	780
		97. Umkaber	364
		98. Laitmawpen	241
		99. Laitmawhing	259
		100. Umsawmat	569
		101. Lyngdoh Phanblang	411
		102. Laitsohphlang	137
		103. Perkseh	341
			Total : 3102
		Grand Total	**= 46,377**

The 16th March, 2021.

No.LBG.33/87/250. **-** Whereas the Governor of Meghalaya is satisfied that an exemption from the restriction of hours of work including Holidays and Sunday to the Employees of the office of the Deputy Director, Printing & Stationery, Tura is necessary on account of the exceptional pressure of work in connected with the printing of Forms for the forthcoming election to the Garo Hills Autonomous District Council, 2021.

Now, therefore, in exercise of the powers conferred by Sub-section (2) of Section 65 of the Factories Act, 1948 (Act No. 63 of 1948), herein after referred to as said Act, and subject to the conditions laid down in Sub-Section 3 of that section and sub-section (1) of section 66 of the said Act, the Governor of Meghalaya is pleased to exempt office of the Deputy Director, Printing & Stationery, Tura from the provisions of Section 51, 52 (1) , 53 (1), 54 & 56 of the said Act, with effect from 8th March, 2021 including Holidays and Sunday until the Election process gets over since the employees would have to work beyond normal hours for timely printing of Forms for the forthcoming election to the Garo Hills Autonomous District Council, 2021.

S. M. SANGMA,
Under Secretary to the Govt. of Meghalaya,
Labour Department.

The 19th March, 2021.

No.C-7(T)12/94-104. - In exercise of the power conferred by Section 115 and 117 of the Motor Vehicle Act, 1988 (Act 59 of 1988), I Shri B. D. Marak, MPS, Superintendent of Police, West Jaintia Hills, Jowai being satisfied that it is necessary in the interest of public safety and convenience, do hereby impose the below noted traffic arrangements on the areas mentioned with immediate effect from 27th March, 2021.

- **"No Overnight Parking"** on both side of the road starting from **Jowai Junction, Bakur to Integrated Check Point, Tamabil area.**

B. D. MARAK,
Superintendent of Police,
West Jaintia Hills District,
Jowai.

The 9th March, 2021.

No.Health.138/2017/106. - In exercise of the power conferred under Section 21 of the Meghalaya Nursing Council Act, 1992, the State Government is pleased to make the following Rules as follows:-

1. **SHORT TITLE COMMENCEMENT AND EXTENT**:- (1) These Rules may be called "**The Meghalaya Nursing Council Rules, 2021**".
(2) It shall come into force from the date of publication of this Notification in the Official Gazette.

2. **DEFINITION**:- (1) In these Rules, unless there is anything repugnant in the subject or context:-
   (a) "Act" means the Meghalaya Nursing Council Act, 1992;
   (b) "Gazette" means the Gazette of Meghalaya;
   (c) "Member" means a member of the Council;
   (d) "Nurse" means a registered nurse, of different cadre;
   (e) "Registrar" means the Registrar referred to in sub-section (1) of the Section 6 of the Meghalaya Nursing Council Act, 1992;
   (f) "Rules" means the Meghalaya Nursing Council Rules, 2021;
   (g) "State Council" means a Council, by whatever name called, constituted under the law of a State to regulate the registration of nurses, midwives, health visitors in the State;
   (h) 'State Government" means the Government of the State of Meghalaya;
   (i) "Year" means a Calendar Year;

3. **CONSTITUTION OF THE COUNCIL**: (1) The Council shall be constituted with the following members:-
   (a) The Director of Health Services (MI), Meghalaya, Shillong.
   (b) The Principal, State Regional Training Centre(F&W), Shillong.
   (c) Two Medical & Health Officers from Government Hospitals not below the rank of a District Medical & Health Officer of whom one should possess a specialization or experience in obstetric or gynaecology.
   (d) Two Medical & Health Officers from non-government Hospitals.
   (e) The Deputy Director Nursing, O/o the Director of Health Services (MI), Meghalaya, Shillong
   (f) Two Nursing Superintendent and two Matrons, one each from Government and non-Government hospitals
   (g) Two Principals, one each from Government and non-Government Schools of Nursing
   (h) The President Trained Nurses Association of India, Meghalaya Branch

(2) The nomination of members under sub-rule (1) of Rule 3 shall be in as far as possible a manner nominated by the State Government as constituted under sub-section (1) of Section 4 of the Meghalaya Nursing Council Act, 1992. The Members of the Council shall elect the following Office Bearers of the Council:
   1) President.
   2) Registrar shall be appointed by the Government as per Rule 5.
   3) Deputy Registrar.
   4) Secretary-*cum*-treasurer.
   5) Assistant Secretary.

(3) The Members of the Council shall elect the Office Bearers of the Council (except the Registrar) through the following modes:
   (a) The members shall elect the Office Bearer of the Council through a democratic system of voting.
   (b) The Registrar of the Council shall select the Returning Officer and Polling Officer for the purpose of the election.

(c) The candidate eligible for election as Office Bearer of the Council must possess the requisite experience and qualifications as prescribed by the Indian Nursing Council with a minimum of five years of teaching experience and five years of administrative experience.

4. **TERM OF OFFICE AND VACANCIES OF OFFICE BEARERS**:- (1) The term of office of office bearer of the Council shall be for a period of three years from the date on which the member was elected, nominated or appointed to the post.

(2) An outgoing member shall continue in office until the election or nomination, as the case may be of his or her successor.

(3) In the event of any vacancy in the office of the elected or nominated members of the Council, another person shall be nominated in his or her place and such person shall hold office for the remaining period of the term.

(4) An elected or nominated member may at any time resign from his or her post by writing to the President.

(5) The President may resign from his or her office by giving notice in writing to the Council.

(6) When the office of the President or any other elected or nominated member(s) of the Council is vacant, the Registrar or Secretary-cum-Treasurer shall after giving notice of not less than seven day to the Members of the Council convene a meeting for the election or nomination to fill the vacant post(s).

(7) An elected or nominated member shall be deemed to have vacated his or her seat:

(a) On the expiry of the term of office;

(b) On absence, without sufficient ground in the opinion of the Council from three consecutive meetings of the Council, where the interval between the first and the third of the said meetings exceeds six months.

5. **MODE OF APPOINTMENT OF REGISTRAR**:-

The State Government shall appoint a person to the post of Registrar as provided under sub-section (1) of Section 6 of the Meghalaya Nursing Council Act, 1992. The post of Registrar shall be equivalent to the post of Assistant Director Nursing. Appointment to the post of Registrar shall be made by promotion from amongst the member of the service holding the post of Matron or Principal and possessing the requisite experience and qualifications as indicated below:

Must have rendered not less than two years of continuous service in post of Matron or Principal on the first day of the year on which the Selection is made or twenty years of total length of service and possessing Post Basic B.Sc. Nursing, BSc Nursing, M.Sc Nursing, PhD Nursing or similar qualifications from recognized Institution and three years of teaching experience for M.Sc Nursing and five years of teaching experience for B.Sc Nursing or Post Basic B.Sc Nursing.

6. **PROBATION**:- Every person appointed to the post of Registrar under proviso to sub- rule (1) of Rule 5 shall be on probation for a period of 6 (six) months :

Provided that the period of probation may for good and sufficient reason be extended by the appointing authority in any individual case by a period not exceeding two years:

Provided further that where a person appointed to the post in the service could not be placed under probation for want of permanent vacancy, any period which he has rendered in a temporary capacity may, having regard to his performance, be counted towards the period of probation.

7. **DISCHARGE OR REVERSION**:- A probationer shall be liable to be discharged from the post in the service or as the case may be, reverted to the permanent post on which he holds a lien or would hold a lien had it not been suspended under the rules applicable to him prior to his appointment to the post, if:

(1) She or he fails to make sufficient use of the opportunities given during the training or otherwise fails to give satisfactory performance during the period of probation; or

(2) She or he fails to pass the Departmental examination unless the appointing authority permits him to sit for re-examination in the subject or subjects in which he or she failed or

(3) On any information received relating to her or his nationality, age, health, character and antecedents, the Appointing Authority is satisfied that a probationer is ineligible or otherwise unfit for being a member of the service.

8. **FEES STRUCTURE**:- The Fees Structure payable to the Meghalaya Nursing Council shall be as specified by the Indian Nursing Council and prescribed in the Regulation. An appeal may be done as provided under Section 12 or under sub-section (2) of Section 17 of the Meghalaya Nursing Council Act, 1992.

9. **POWER OF THE GOVERNOR TO DISPENSE WITH OR RELAX ANY RULE**:- The Governor, if satisfied that the operation of any of these rules causes undue hardship in any particular case of cases or results in any particular post or posts being left unfilled for want of person(s) possessing the minimum experience as specified by these rules for promotion to such post or posts, may dispense with or relax the requirement of any of these rules to such extent and subject to such condition as it may consider necessary for dealing with the case in a just and equitable manner, or for meeting the exigencies of public interest:

Provided that the case of any person shall not be dealt with in any manner less favourable to her or him than that provided under these rules.

10. **INTERPRETATION**:- If any question arises relating to the interpretation of these rules the decision of the Government with the approval of Personnel & AR Department shall be final.

11. **REPEAL AND SAVINGS**:- All Rules, orders or notification corresponding to and in force immediately before the commencement of these rules are hereby repealed:

Provided that all orders made or action taken under the rules, order or notification so repealed or any action taken in pursuant thereto shall be deemed to have been validly made or taken under the corresponding provisions of these rules.

SAMPATH KUMAR,
Principal & Secretary to the Govt. of Meghalaya,
Health & Family Welfare Department.

The 9th March, 2021.

No.Health 321/2020/39. - The Governor of Meghalaya is pleased to notify "The **Meghalaya Health Policy, 2021**". The Policy will come into effect from the date of publication and is hereby published for general information.

SAMPATH KUMAR,
Principal Secretary to the Govt. of Meghalaya,
Health & Family Welfare Department.

THE MEGHALAYA HEALTH POLICY, 2021

1. INTRODUCTION

Meghalaya has brought out a State Health Policy which is aligned with the National Health Bill, 2009, National Health Policy 2017 (NHP, 2017) and the National Public Health Act, 2018 (draft) but also include provisions which have been tailored to the State's unique context.

The policy sets out a broad framework for providing essential public health services and functions, including powers to respond to public health emergencies, principally through the State and local public health agencies at the village, Block and District level in collaboration with other public and private healthcare providers, including through the cooperation and formal collaborations between the Center and State.

The policy will adhere to the highest professional standards where integrity and ethics will be maintained in the entire healthcare system.

The policy aims to ensure adequate investment in health and to increase the health expenditure *(The NHP, 2017 recommends increase of State health budget to more than 8% of the budget by 2020).* The policy will also address government and private areas investment. Meghalaya has been successful in decreasing the number of malarial deaths significantly by capacitating grassroots frontline workers with a system of testing and treatment at a village level using ASHAs as barefoot doctors. Polio has also been completely eradicated from the State, however, the State fares poorly with regards to other health indicators in comparison to other developed states such as Kerala and the world in general.

The Infant Mortality Rate for Meghalaya is 34 deaths per 1000 live births compared to Kerala with 6 and the world with 29 *(source NHFS-4)*; Maternal Mortality Rate is alarmingly high with Meghalaya registering 197 deaths per 1,00,000 deliveries, Kerala at 43. Mothers who availed antenatal care account for only 53.2 % in comparison to Kerala's 61.2 %. *(SRS 2016-18).* Institutional deliveries in the State are at a very low level of 51.4 % in comparison to Kerala with a record 99.8%. Only 61.4 % of children between the ages of 12 to 23 months have been immunized compared to 82.1 % in Kerala. *(NHFS-4).*

The average life expectancy rate of citizens in Meghalaya is abysmally low at 62.3 years in comparison to the national average of 68.8 *(WHO, 2018)* the world at 72.6 years, United States of America at 78.9 years *(UNDP, 2018 report)* and Kerala at 74.9 *(Human Development Index, 2011).* As per NHP, 2017, the policy will aim to increase life expectancy to 70 by 2025.

The policy aims to address the key health indicators by bringing about a positive healthcare model that would touch upon socio-economic determinants of its residents.

The positive health model will benefit the State and empower communities with the knowledge of how to better take care of their physical, emotional and mental health. Positive health model will work towards producing longer, healthier and productive lives by lowering disease risk and healthcare costs in the long run.

The policy aims to achieve its objectives as per guidelines of WHO's Sustainable Development Goals (SDGs) timeline of 2030 and the NHP, 2017. This would pertain to the State's major health concerns namely decreasing maternal and infant mortality rates by ensuring antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025, reducing Under Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2025. The policy will also aim to reduce Infant Mortality Rate to 28 by 2025 and reduce neo-natal mortality to 16 and still birth rate to "single digit" by 2025.

As per NHP, 2017, the policy will also aim to reduce 40% in prevalence of stunting of under-five children by 2025.

The policy will aim to reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.

The policy realizes that health is a subject that is closely linked to other societal and environmental determinants and it is important to address issues such as gender inequality and poverty which inadvertently results in poor education and can cause a vicious cycle of poor health amongst its citizens.

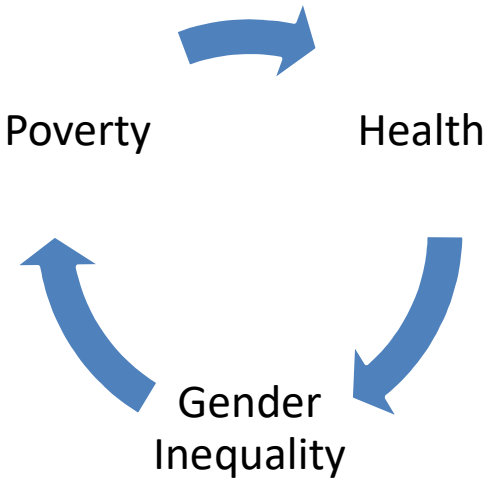

Fig. 1 shows a cyclical relationship between the three areas which need to be addressed simultaneously for significant impact.

1.1 Vision

(i) The policy aims to provide affordable, patient centric universal healthcare to all the residents while also educating the population on their rights and the availability of various preventive health services such as vaccines. The idea is for the population to become informed residents with the Health Department talking a proactive role in dissemination of healthcare services in the State in collaboration with all the stakeholders including the Departments of Social Welfare (ICDS), Education and Rural and Urban Development.

(ii) The policy will use techniques from the State Capability Enhancement Project (SCEP) which uses frameworks such as Problem Driven Iterative Adaptation (PDIA) approach, Adaptive Leadership Building and encouragement of Artificial Intelligence Enabled Decision Making. PDIA has been successfully utilized in the State's efforts with raising the immunization rates. In 2018-19, Meghalaya ranked lowest in terms of

immunization rates; by using the PDIA approach, the State has now achieved 90% immunization (Immunization Dashboard, July, 2020) and ranks second highest in the country.

(iii) The policy will address the supply and demand side of healthcare with the supply side referring to healthcare providers and the demand side referring to the community where community mobilization will be put on the forefront. The policy will ensure that residents are seen and treated as producers of health and not just subjects of health.

(iv) The policy aims to foster an environment where decentralization takes centre stage. The policy will break hierarchical barriers in healthcare administration so as to bring about a platform for open communication to discuss, deliberate and implement ideas.

(v) The current healthcare policy which the State is practicing focuses on curative care; the new health policy will ensure that this focus equally shifts to preventive care in order to bring about a healthy and productive population.

(vi) Although Meghalaya is a largely matrilineal society, persistent gender inequality and poverty are the root causes of many health concerns. The policy will aim to bring about the empowerment of women by ensuring health rights such as birth spacing and other reproductive rights. Creating awareness of women's rights is an important aspect to improving healthcare, and this along with empowering women by facilitating their economic independence will strengthen society as a whole. Women's health is not a standalone issue and needs to be dealt with in a holistic manner in order to remove societal gender barriers.

The health policy will follow a three dimensional model with equal focus on: Preventive Care which encompasses promotive care, Curative Care, and Enabling Dimension which encompasses palliative and rehabilitative care which will be discussed in the following chapters.

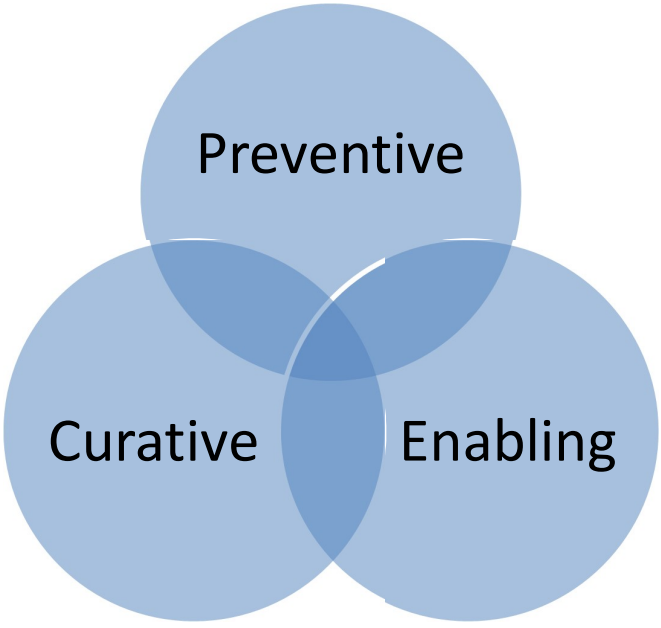

Fig.2 shows the three aspects of healthcare that will create a holistic policy with aspects interlinked with each other for overall wellbeing and creating agency among key stakeholders.

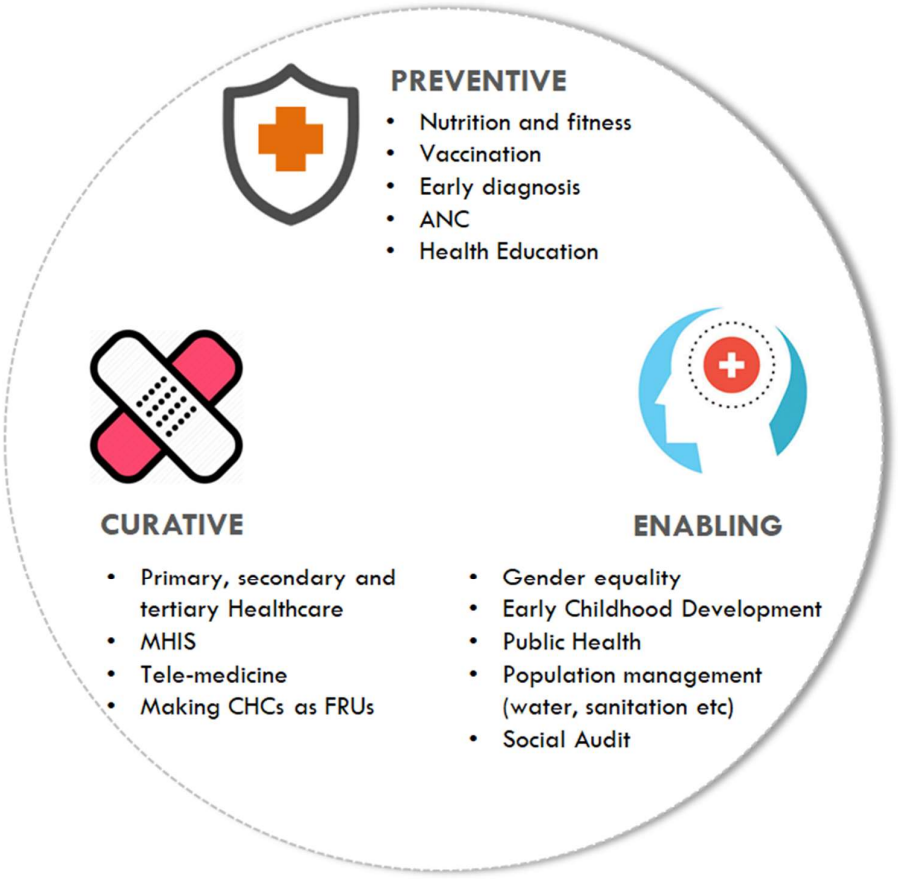

Fig: The illustration above shows the holistic approach of the 3-dimensional positive healthcare model of Meghalaya.

1.3 **Current status of health system in Meghalaya**

The current health system in the State has put priority on curative care, the policy aims to shift this to preventive care which would focus on positive health care. The policy will take steps to ensure that citizens are empowered with the right knowledge to take better care of themselves; citizens will also made aware of various health milestones (check-ups, immunizations) that they should keep track of in order to bring about healthy living.

According to an HMIS report based on the immunization dashboard, ITSU, MoHFW, GoI, in 2018-19, Meghalaya ranked the lowest in immunization rates having achieved 44%. There has been significant improvement in 2019-20, 20-21 with the State achieving 84% and 91% respectively. This has been attributed to the proactive response of the State by using PDIA techniques which the State will propel forward in other aspects of healthcare.

As per State data, only 29 % of children receive proper nutrition and diet and although the Integrated Child Development Services (ICDS) programmes are functioning, it should be noted that the programme only gives supplementary foods and not nutrient rich meals. This has led to micro-nutrient deficiency amongst children. The policy recognizes the importance of the women SHGs which encourages participation and can play a very important role in tackling this problem. As per Saha, Annear, and Pathak (2013), using national

data it has shown that, district level household survey shows the uptake of maternal health services is greater in villages where an SHG is present.

Maternal and Infant Mortality Rates are of great concern to the State with 197 MMR (SRS, 2016-18) and 3.4% IMR (34 deaths per 1000 live births) as per HMIS, Apr-Sept 2020. These can be attributed mainly to teenage pregnancy, multiple gravida and untimely healthcare intervention. The State is proactively taking steps to ensure the safety of mother and child during pregnancy. These issues are thoroughly covered by the policy which are discussed in Chapter 6.1.

It should be noted that State data also shows instances of geographical poverty whereby districts such as South Garo Hills and South West Khasi Hills show poorer health performances in comparison to its counterparts. This can be attributed to poor connectivity to these areas and lack of access to quality healthcare services.

2. DATA AND TECHNOLOGY DRIVEN

The State Health policy will aim to build a robust data architecture that will support development and implementation of health reforms. An electronic Health Information System (HIS) or electronic medical records will be set up to digitalize health records. The policy will combine these health records with other health and socio-economic data collected by the state to present a holistic picture of health outcomes and related factors. Through these records, the State will have a large pool of data available which can be used as an instrument of positive health indicators while also evaluating the data for identifying any areas of concern. This system will be used to analyze data and create future predictions. The HIS will support effective documentation to its process and contents. All information on health related laws, policies, plans of action and programmes will be made available to the public, which should support engagement of both citizens and civil society organizations.

The policy will work towards implementing the Government of India's National Digital Health Blueprint which aims to provide efficient and affordable health coverage through a wide range of data and infrastructure services by leveraging open digital systems that will ensure security and privacy of personal information.

With technology being an integral part of the present and future, the State's health policy will encourage use of Artificial Intelligence (AI) for problem solving and also predicting shortages and health needs of the population. Information Technology and data based decision making is already being used in the State as seen with the launch of the MOTHER App in 2019 which uses data of expecting mothers in the State and tracks the progress of the pregnancy while ensuring proper antenatal care and also encouraging institutional delivery. The app is also being used to alert high risk cases which can drastically reduce mortality rates. So far, grassroots functionaries such as ASHAs and Auxiliary Nurse Midwives (ANMs) have been trained to collect data and track said data.

To better implement the health policy, the State will focus on building a service delivery process which will enable the use of process maps for clear and precise implementation for better outcomes within a specific time period.

Healthcare will be made accessible to the remotest areas in the State with the propelling of services such as telemedicine, teleconsultation and the use of drones.

3. FOCUS ON RIGHTS BASED FRAMEWORK

The ***Rights-based framework*** is a monumental step that the State is taking as it can empower residents and make the State more accountable. This approach will ensure that discrimination on any basis (gender, ethnicity, age, etc.) is unacceptable. The approach can also increase the scope on participation and inclusion and will warrant a more purposive sharing of information in the State. The framework will be strengthened by

the *Meghalaya Community Participation and Public Services Social Audit Act, 2017* which is discussed in Chapter 6.3. This will enable a systematic process to share information to the public by the government. The sharing of information would include yearly household visits to generate awareness on how to access various services provided by the State.

The policy will provide residents with the right to seek and receive appropriate healthcare, right to emergency treatment and care, right to reproductive and sexual health care, right to quality and rational healthcare, right to choice where every user has the right to choose and change his/her health care provider and health care establishment, right to be treated by a named health care provider, referral rights, right to information about health care facilities, goods, services, programmes, conditions and technologies, right to medical records and data, and right to autonomy/ self-determination and prior voluntary informed consent which includes the right to refuse or to halt a medical intervention.

The State will also ensure the right to birth spacing where birth spacing is defined as the time between two consecutive pregnancies which is not less than1000 days from day of conception. This will be implemented through the Mother and Child Protection strategy which is part of the larger State health policy which is elaborated further in Chapter 6.1. (*WHO guidelines states that "After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes."*)

The approach will ensure that importance is placed not only in outcomes but there is a systematic approach in following all the due processes and implementation mechanism. It will put focus on capacity development of both the duty holders (village, Block, District, State level) and residents claiming the rights.

4. PREVENTIVE CARE

4.1 Focus on Public Health

Public health will be the prime focus of this dimension in order to improve and protect community health and well-being. Public health policies such as vaccinations, family planning, water and sanitation can increase life expectancy. There will be a proper regulatory mechanism for implementation of sanitary codes (water, food safety etc.) to bring about positive public health outcomes.

The current COVID-19 pandemic has proven that there needs to be special emphasis on public health as this can protect residents from health threats and prevent disease. Healthcare systems need to be strengthened by not only upgrading infrastructure but also ensuring qualified healthcare workers at every level and by building a public health cadre. Skill development programmes will also be conducted and a system will be put in place to ensure career progression of healthcare workers.

The policy will address the five pillars of public health namely *Epidemiology, Environmental Health, Health administration, Biostatistics and Health promotion and education.*

The State will proactively take measures to ensure the prevention of diseases and in cases where prevention is not an option, the State will facilitate care to manage illnesses and ensure that residents are equipped with measures and information to avail smooth palliative care.

4.2 Human Resources

The policy will focus on human resource development, capacity building and will ensure that all vacancies in the health department are filled with capable, determined individuals.

The policy will address issues related to human resources and form guidelines for attracting and retaining doctors serving in remote areas, guidelines for specialists attraction and their retention. There will also

be focus on leadership development in order to strengthen the healthcare system and motivate the workforce to reach their full potential.

4.3 Public Private Partnerships

The State will explore innovative models for preventive healthcare similar to the Megha Health Insurance Scheme (MHIS)which covers curative care. Here, the State will encourage Public Private Partnerships (PPP) where there will be collaboration between public health institutions and private sector institutions to cover preventive care. The policy will allow for private insurance companies to enter the positive healthcare market on a trial basis.

Aspects such as immunization will be wholly covered by such partnerships and all players will be held accountable for achieving targets set by the State. The model will enable better population wide management and all aspects related to it.

The policy will lay down non-derogable principles to guide the public private partnerships with the objective to improve the quality of services delivered through public health systems. The State shall set conditions of service, monitoring, evaluation criteria, assessment and cancellation of PPP projects, which should be implemented by the State Public Health Authority.

It should be noted that a few PHCs and CHCs in the State are following the PPP model which has proven beneficial to the citizens. The policy will expand this partnership to other PHCs and CHCs.

The policy will also ensure that the State provides "***promotive care"*** by addressing social and environmental issues and promoting health programmes and interventions that will benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health and not just focusing on symptomatic treatment and cure.

4.4 Strengthening the role of communities

Initiative will be taken to strengthen the health cadres which will not only include healthcare workers but also grassroots mobilization of Self Help Groups (SHGs) which can have a vital role in strengthening healthcare in the State and will act as a last mile delivery institution for participation. SHGs can be trained to give awareness programmes and can serve as an important platform where community members participate in discussions on positive health practices and to improve health seeking behaviours for accessing the services provided by public health institutions. The policy will provide appropriate training for health personnel, including education and sensitization on health rights.

The policy will outline **Rights and Responsibilities** of the residents, which will encourage citizens to become active partners with the state rather than just beneficiaries of the system. The State aims to pioneer a bottom-up health system which is driven by the community and village organizations. Emphasis will be put on strengthening village health and sanitation bodies. Issues relating to gender inequality, gender violence and health will be taken up where various forums will be constituted at the village level and public health institution level.

There will be emphasis put on developing mechanisms for creating and empowering the decentralized monitoring committees at all levels, both rural and urban and seeking their feedback in a structured manner. The policy shall lay down rules for and establish community-based monitoring frameworks, to strengthen the direct accountability of the health system to the community and beneficiaries, through a number of methods that shall include, formation of social audit and community health monitoring committees, preparation of annual public reports on health at Village, Block, District and State level.

The policy will strengthen Village Health and Nutrition Days (VHNDs) with proactive restructuring by enabling measures such as better infrastructure along with basic amenities such as stethoscopes, weighing machines, waiting chairs etc. This will create a better environment which will encourage citizens to avail services even more.

The policy will also facilitate and activate sectoral meetings which is good consensus building measure.

The policy will put emphasis on training on vital issues such as Early Child Development (ECD) and will give awareness and training to expecting and lactating mothers to ensure the overall development of the child. By emphasizing on ECD, the issue of stunting will also be addressed. Stunting is a major cause of concern for the world as more than 220 million children are stunted or living in extreme poverty. 40 % of children under 5 are stunted in India. According to *NHFS-4*, 43.8 % of children under 5 are stunted in Meghalaya. Factors that contribute to stunted growth and development include poor maternal health and nutrition, inadequate infant and young child feeding practices, and infection. Stunting has long-term effects on individuals and societies, including diminished cognitive and physical development, reduced productive capacity, poor health, and an increased risk of degenerative diseases. ECD training is a long-term measure and investment that can combat stunting and reduce the number of future healthcare problems in the population.

4.5 Mental Health:

With a growing prevalence of mental health, this State policy will also address mental health and enable the creation of a network of community members to provide psycho-social support to strengthen mental health services at PHCs and will use digital technology (teleconsultation) where access to qualified psychiatrists is unavailable.

4.6 Inter-departmental convergence

Issues such as nutrition, water, sanitation, poverty and gender will also be taken up as these are directly linked to various health problems in the State. The policy aims to foster a spirit of cooperation and collaboration between departments. Currently departments work in silos; the policy will encourage inter-departmental convergence in order to holistically tackle health concerns in the State. Through this convergence, the policy will ensure the adequate supply of safe water; ensure sanitation through appropriate and effective sewerage and drainage systems, waste disposal and management systems, pollution control systems, control of ecological degradation, control of insects and rodents and other carriers of infections.

The policy will highlight the importance of efforts to reduce poverty and gender inequality for removing barriers of social determinants of healthcare.

4.7 Focus on nutrition and encouraging agro-ecological farming

Nutrition is one of the most important contributors to human health. In addition to managing weight, blood pressure and cholesterol, a healthy diet can help prevent and manage of a number of non-communicable diseases (NCDs) such as diabetes, heart disease, stroke, and some cancers. The Food and Agricultural Organization (FAO) of the United Nations predicts that by 2030, NCDs will account for almost three-quarters of all deaths worldwide. Therefore, ensuring people have proper nutrition is becoming even more important in both developed and developing countries.

Poor nutrition among children is one of the primary health problems facing the State. Other nutritional problems include maternal nutritional anaemia, Vitamin A deficiency, lactation failure and inadequate preparation and use of artificial milk products. All these factors contribute to problems like low birth weight, night blindness, nutritional deficiency and other related health issues.

Addressing the problems due to nutrition deficiency can be met by supplementing the diet of children and mothers with healthy food. However, it is to be understood that the underlying problem of poor nutrition among women and children is not only inaccessibility to adequate food or lack of dietary diversity, but it also depends on the nutritional integrity of the foods they consume. The nutritional value of food nowadays is hugely compromised. Conventional ways of farming, where high rates of chemical inputs are given to crops to improve their yield, have led to decrease in the nutritional density of food. Therefore, it is highly likely that the same amount of food consumed will not provide the nutritional requirement to an individual.

In order to tackle these issues, citizens are encouraged to eat locally grown food, eating seasonal foods, and foods items which are not chemically treated. A sustainable approach to the issue of low nutrition dense food would be to encourage healthy farming practices like agro-ecological farming systems which discourage the use of chemical inputs and thus helps in providing food of high nutritive value which would go a long way in preventing people, and children and women in particular, from various health issues.

On a smaller scale, the concept of nutri-gardens will be encouraged where locally available vegetables and fruits are grown in the backyard following the principles of agro-ecology, thus helping in supplementing the nutritional requirements and building the health of the children and the family as a whole.

The population in Meghalaya relies on a carbohydrate rich diet of predominantly rice and potatoes, the State would proactively encourage the consumption of nutritious foods and indigenous greens which are widely available in the State*)*. Apart from encouragement of healthy eating, the policy aims to also include propagating healthy lifestyles with awareness on the dangers of alcohol abuse, smoking and tobacco and the benefits of exercise. The policy will also take steps to encourage the growing of herbal and medicinal plants and engage communities to work proactively towards growing food forests.

The policy will ensure equitable distribution of and access to essential health facilities, goods, drugs, services and conditions to all, and especially for vulnerable or marginalized groups. The policy will also ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger and malnutrition for everyone.

4.8 Focus on Physical Fitness

The policy will put importance on promotion of healthy lifestyle habits such as physical fitness and exercise such as yoga, walking, cycling etc. which can protect residents from heart disease, stroke, diabetes, obesity and high blood pressure. It can also aid in memory and brain function and improve mental health by reducing anxiety.

The policy will also address indoor and outdoor pollution and will take steps to reduce stress and improve safety in work spaces.

4.9 Ensuring workplace safety

The policy as per NHP, 2017 will ensure safe working environments with minimal risks from physical, chemical, and other workplace hazards. Work-sites and institutions would be encouraged and monitored to ensure safe health practices and accident prevention.

5. CURATIVE CARE

This is provided by strengthening and promoting public health institutions and all other healthcare institutions including the private sector. Efforts will be made to bring Indian Public Health Standards (IPHS) to provide quality services in all 3 levels of healthcare namely primary, secondary and tertiary care.

The policy will ensure that CHCs are the First Referral Unit (FRU). Trauma centres will also be given special importance and will be made available.

Curative care is largely covered in spirit by MHIS which provides universal healthcare to all residents. MHIS utilizes the existing RSBY framework to provide health insurance to all persons that are residents of the State excluding state and central government employees. The Scheme provides insurance cover of up to ₹ 5,00,000 per family on a floater basis meaning that the total amount can be used by one person or jointly with other members of the family.

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) has had certain limitations in Meghalaya as its definition of "deprivation" covers only 3,47,000 residents of the population. Because of this reason, MHIS has converged with PMJAY to offer a wide range of health benefit packages that can be availed by the entire population.

MHIS offers 2,382 services to its users in comparison to PMJAY which offers 1,400 services. Both schemes use the same IT platform. An ambitious aim of the policy is to address the invisible costs which are borne by residents after the exhaustion of the MHIS cap.

The links to the services offered by MHIS are attached below:

..\Downloads\SCHEDULE3.8f6e503d.pdf

..\Downloads\SCHEDULE4.e94c2ab6.pdf

With the policy, the State will address the issue of health seeking behaviours of residents. Resident usually visit healthcare establishments only after their illnesses have significantly progressed, which makes cure difficult and adds significant burden on tertiary facilities; the policy will encourage residents to visit healthcare facilities more often and establish a relationship with local health service providers who can detect and address ailments early and effectively. The aim is to inculcate a culture of regular checkups. Milestones can be used for encouraging this behaviour; for *eg.* Women on reaching a certain age can be encouraged to get a yearly mammogram checkup. Men can also be encouraged to get a prostrate exam on reaching a certain age.

A **lifecycle approach** will be adopted by the State whereby healthcare will be ensured for all residents from the time of conception and will be categorized into different categories such as neonatal, new born, toddler, pre-schooler, school age child, adolescent, adulthood. Various health parameters have been identified which will used as indicators to measure positive health and cognitive skills *(Annexure 1).*

Training of doctors on public health and all critical specialties

The policy will aim to address the critical gap of lack of public health cadre in the State by setting up of a Public Health Academic and Research Institution in collaboration with the Public Health Foundation of India. The policy will encourage research and evaluation to form a continuous cycle of feedback and improvement. The State through the *Design and **AD**option of **A**lternate models for **R**esponding to **SH**ortage of medical specialists (ADARSH)*project will facilitate the training of specialists in district hospitals which will act as training institutes for post graduate courses.

6. ENABLING DIMENSION

6.1 Maternal and Child health Protection Policy

The policy will include a strategy to deal with the unacceptably high Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR); the policy will address all issues regarding pregnancy and delivery with special emphasis on clinical, public health and socio-economic solutions to help reduce the number of fatalities. The State has already developed the innovative MOTHER app which tracks the pregnancy of women in the State; through this app, expecting mothers are getting proper antenatal care which can then facilitate safe deliveries.

The three important dimensions for reducing the maternal and child deaths that will be addressed through the policy are:

i. Clinical Management: This implies availability of trained birth attendants and specialists to cater to pregnancies in remote areas. This also implies the availability of medicines and other clinical management tools and capabilities to prevent and reduce maternal and child deaths. The policy will ensure high quality antenatal care needs to be given to all the expecting mothers during all 3 trimesters and after the birth of the child. Data has shown that many deaths occur due to untimely intervention by healthcare professionals due to delayed visits to health institutions. Such evidence can be used to formulate and test interventions that can work in the local context. For instance, a simple instruction of requesting expecting mothers to visit the local PHC/CHC or any healthcare institutions on their expected date of delivery (EDD) irrespective of whether they are having labour pains can greatly reduce the risk to both mother and unborn child. The policy will also ensure timely availability of ambulances, improvement of referral system and training of available manpower.

ii. **Public Health Dimension**: AAA convergence model of public health action will be strengthened; in addition to ANMs and ASHAs, Anganwadi workers are essential in tackling the problem of high maternal mortality rates. They currently provide supplementary nutrition to pregnant women but their role could be expanded to respond to local challenges. Trainings will be imparted to AAAs to expand their role where they are able to cater to various other needs of expecting mothers including counselling on family planning. This aspect will lay emphasis on improving the quality of ANCs to ensure reduction in MMR as well as IMR. Through this team of frontline workers, a number of local issues can be addressed such as correction of anaemia in pregnant women, compulsory registration of first pregnancies, regular VHNDs, and use of various forms of contraceptives to practice birth spacing.

Public health infrastructure will be revamped to ensure proper equipment, hygienic beds and labour rooms are available at all levels of healthcare services. Data has shown that the State has a high number of home births which is also a cause of concern and it is imperative that institutional deliveries be encouraged so that mother can receive proper care during and after childbirth. One of the avenues for encouraging institutional deliveries is to improve the quality of health institutions from sub-centre level.

iii. **Socio-Economic Dimension**: This implies the need to make people aware of the prevailing situation while providing proper counselling services and initiating dialogue and conversation around two main issues- Teenage Pregnancy and Multiple Gravida. Both types of pregnancies fall under the category of unintended pregnancies and are high risk. Around 40 percent of deliveries in the State fall under this category. The sensitization process should be driven by the concept that every child as well as mother requires at least 1000 days of undivided time and care. This will not only ensure a holistic development of the child's brain but also increase his/her chances of survival in future. In the meantime, the mother will also be able to regain her health before another pregnancy.

The modalities to implement the policy to save the lives of mothers and children are as under:

1. Need for maintaining a 1000 day window and significance of Birth Spacing measures to effect the same.
2. Convergence between different grassroots healthcare workers including ASHAs and Anganwadis as well as various government departments.

3. Constitution of Health and Gender forums involving village level women SHG federations.
4. Constitution of PDIA committees in each District headed by the DCs, which would have participation of district level heads from all the concerned Departments and the NGOs/ Missionaries working for the health sector. The committee will be responsible to diagnose problems and implement ideas in an iterative manner. All the district committees will convene together quarterly to share experience and ideas and measure the objective and key results.
5. Setting up of Counselling Camps and necessary training to teachers and counsellors on how to sensitize masses about sex education and the right message to be spread.
6. Training grassroots healthcare workers as well as doctors so they are able to give out effective messages to people in terms of birth spacing, significance of 1000 day window as well as diet diversity.

The State Government's main objective with regards to this policy is to save the lives of mothers and infants with a larger objective of improving the life expectancy of people in the State while attempting to break the social stigma associated with use of birth control measures as well as the taboo surrounding discussion of teenage pregnancies.

6.2 Awareness and capability building

The enabling aspect will include counselling camps and centers will be set up which will educate the public on various issues such as teenage pregnancy, multigravida, right to birth spacing, child care, nutrition, immunity etc. A curriculum will be developed by relevant experts in consultation with Medical Experts. Sex Education will also be made mandatory and topics such as birth spacing will be discussed so that the public can be made aware of the dangers and consequences of consecutive births. Teenage pregnancy and Multiple Gravida has been identified as key factors for high maternal and infant mortality rates. As per the State data, teenage pregnancy accounts for 10% and Multiple Gravida accounts for 30 % of the total pregnancies in Meghalaya. It is important that during teenage years, high quality teaching and learning about a broad variety of topics related to sex, exploring values and beliefs about topics and gaining the skills that are needed to navigate relationships and manage one's own sexual health. This will enable the individual to understand the dangers of teenage pregnancy and gain knowledge on the physical, mental and emotional consequences of sex.

The policy will also enable counselling for sexually active couples by Medical Officers/public health nurses/ trained counsellors; this will ensure that residents are made aware of issues such as family planning, contraceptives, sexual health and consent. This will bring about better overall health and wellness and a more socially conscientious population.

Given the complex, multidimensional nature of the problem, it is imperative that the State mobilize several departments and stakeholders to make meaningful progress. The Education Department will have a proactive role in spreading awareness and ensure that the curriculum is taught in all schools across the State. Communities will also be sensitized along with grassroots organizations such as SHGs to ensure that the wider public is informed and educated on the above mentioned topics. In order to further spread awareness, youth camps will be held periodically by the Youth and Sports Department.

The policy will provide education and access to information concerning the main health issues in the communities, including methods of preventing and controlling them, and promoting healthy lifestyles, through sustained, and regularly updated National, State and local level IEC programmes.

The policy will devise, adopt, implement, and periodically review, health policies, strategies and plans of action, on the basis of epidemiological, sociological and environmental and evolving scientific evidence, addressing the health concerns of the whole population.

The policy will address other public health measures towards ensuring health and wellbeing of all, including physical, emotional and mental health.

6.3 Meghalaya Community Participation and Public Services Social Audit Act, 2017

Under this Act, village and locality level Social Audit Committees (SAC) have been formed to bring about transparency and accountability in healthcare. The SAC will monitor and evaluate healthcare related programmes which can lead to better performance. The Social Audits shall be conducted at village and institutional levels including the PHCs/CHCs to improve the quality of services and to increase the awareness and uptake of services by the communities with special focus on helping the poor and marginalized in accessing their due health entitlements. This social audit mechanism would enable the general public and various groups and organizations to give free and independent feedback about health care services.

The Social Audit body would record the issues and where possible immediately recommend actions regarding cases of denial of health care or violation of rights enumerated herein or suggest follow-up actions by the parties; similarly it would recognize service providers acknowledged for providing exemplary good services.

The concept of Granular Performance Monitoring may be used to ensure accountability by clearly identifying roles, responsibilities and deliverables for every duty holder.

6.4 Early Childhood Development (ECD) Mission

ECD apart from being a preventive measure is also has an enabling dimension. It is important to note that the period of ECD (prenatal to age 8) determines physical, socio- emotional, motor and cognitive development in a child. It is imperative that the child be provided with proper nutrition and care; the environment of the child is also equally important where it should be taken into account the child's emotional needs. Toxic stress in children is an aspect which needs to be properly addressed as this can cause lifelong problems in learning, behaviour along with physical and mental health problems. It has been found that maltreatment of children in the early years precipitated physiological changes in the body that continues into adult life.

Sensitization and awareness programmes can be given on the importance of care during this crucial time at the grassroots level with focus on issues such as stunting, malnutrition with emphasis on micronutrient deficiencies special needs and cognitive development.

Stunting can happen in the first 1000 days of life and is caused mainly by severe under-malnutrition which is most common in middle or low income countries and harm children's physical and cognitive development. Prenatal nutrition is of utmost importance along with proper nutrition for the mother. It can be noted that there should be due importance given on a mother's touch. The concept of kangaroo mother care which emphasizes on skin to skin care and touch is to be encouraged for the development of a child. Exclusive breast feeding in the first 6 months is also an important aspect of development as this leads to stronger immunity, lower diarrheal and other GI infections, greater growth in weight and height, a lower likelihood of transmission of HIV to the child; all these factors are in turn linked to higher cognitive skills.

It should be noted that micronutrient deficiencies during the critical period of pregnancy, lactation, early childhood, adolescence and old age are particularly severe and can be irreversible. The policy will address this by encouraging, intensifying and increasing supplements.

With regards to motor skill development, there are two aspects: fine skills which involve small muscles which are linked to functions such as grasping and gross skills linked to functions such as crawling. The timing of when children reach these motor milestones measures their development which will be addressed by the ECD Mission.

6.5 Palliative and Rehabilitative Care

The policy will ensure the provision of ***palliative care*** which is specialized care for patients that are terminally ill. It focuses on providing patients relief from pain and other symptoms of a serious illness.

The policy shall also address ***rehabilitative care*** by ensuring healthcare services that will enable patients to regain any physical, mental or cognitive abilities that have been lost. The purpose is to return a patient back to a normal, healthy condition, whether it is following an illness, injury, surgery or certain disorders. The policy will also cover drug rehabilitation and care for mental illness.

7. IMPLEMENTATION STRATEGY

7.1 Problem Driven Iterative Adaptation (PDIA) and Adaptive Leadership Building

The State will use an adaptive development approach inspired by frameworks such as PDIA and Adaptive Leadership Building. This approach aims to actively engage at a cutting edge level government functionaries including Medical Officers, frontline workers, civil society, grassroots organizations and CHCs & PHCs, and build their capability to collaborate with the State on all aspects of the decision-making process such as problem diagnosis, policy design, implementation and evaluation.

Both frameworks will work in tandem with one another and the focus will remain on identifying local problems which matter to residents and coming up with local solutions. The process allows for learning and adapting on a real-time basis. This approach will help build a healthcare system that is more accountable and responsive to the needs of the population.

7.2 Decentralized Catalytic Leadership approach

The policy will follow a Decentralized Catalytic Leadership (DCL) approach which will be implemented at the CHC and PHC level. Maternal and Child Mortality reduction plans will be developed at this level and there will be monthly reviews of objectives and key results.

The Block Development Officers (BDO) will act as enablers who will oversee matters related to poverty and gender inequality. The Medical Officers (MO) will provide the supply side interventions whereby the focus is on clinical management and public health action. The Child Development Project Officer (CDPO) will ensure that demand side interventions are fulfilled. The CDPO will focus on key issues such as nutrition, anaemia, immunization and ASHAs and Anganwadi workers will conduct joint visits to ensure proper antenatal and postnatal care.

The DCL approach will be anchored by women SHGs known as MOTHER community platforms. Women will take up leadership roles and demand for services will be created through Health and Gender forums which will be formed at every village. Through this approach, an auto catalytic leadership process will be facilitated within communities where health social capital will be built in a systematic manner over a period of time through the women SHGs which will promote positive health within their families and communities. This approach will promote massive community participation where women will drive the change in health seeking behaviours and assist in improving health indicators.

7.3 State Public Health Authority (SPHA)

In accordance with the National Health Bill, 2009 (draft), the State shall also set up a State Public Health Authority (SPHA) which shall lay down the rules for its own functioning and discharge of its responsibilities and shall carry out a wide number of functions as laid out in the said draft Bill.

The State Government shall adopt appropriate measures to promote public health in the State; provide adequate budget at the State, District, Block and village level for purposes of implementation of the policy. The State shall evaluate effectiveness, accessibility and quality of personal and population based health services and programmes. In accordance with the National Public Health Act, 2018, the State Government may, on the recommendation of the SPHA, from time to time, define the powers to be exercised,

and the duties to be performed, by any department of the State, the Director of Health Services/Deputy Commissioners or any member of his staff or public health officers, for the purposes of implementation of the policy. The SDSDO/DSEO in the district will play a Catalyst Role in the field of IEC and education; teachers will be encouraged to constitute "Health Literacy Clubs" in all educational institutions for effective management of health programmes and to address various health issues in the District.

The policy will encourage maximum decentralization and localization of planning and implementation process. To facilitate this process, the State Authority along with the respective District Authority will organize consultations with the grassroots organizations with the objective to identify the local health needs through the platform of Village Health Sanitation and Nutrition Committee (VHSNC), which would assist in formulation of the Block, District and State Public Health plans.

7.4 Disability Adjusted Life Year

The policy will enable the use of Disability Adjusted Life Years (DALY) which is a metric that assesses the overall burden of disease and calculates years lost due to disability. The metric will be used to assess the gap between current health status of residents and the ideal/ optimal health status.

There will be focus on healthcare to see maximum impact where data and AI will be used to assess areas for prioritization. There will be prioritization of investments based on DALY and cost-effectiveness evaluation to promote healthy and productive lives for residents in the State.

8. OTHER FOCAL POINTS OF THE POLICY

8.1 Addressing Tuberculosis

Meghalaya has a number of endemic diseases that need immediate addressing. The policy will address issues such as tuberculosis which is a major concern in the State and come up with comprehensive solutions to bring the disease under control. Although the State follows the National TB elimination programme (NTEP), it has been noted that at a field level, the programme has raised certain concerns with treatment adherence among patients due to multiple reasons like inadequate monitoring, lack of community participation, myths, misconceptions and issues related to alcoholism. Death rate due to T.B. in the year 2019 and 2020 is 4% (245 deaths out of 5674 total notified T.B cases & 139 deaths out of total 3775 notified TB cases respectively (*source NIKSHAY).* The policy will enable better transmission of information from frontline workers to state leadership so that NTEP could be customized and adapted to the specific needs of the State to achieve the vision of Government of India on T.B. elimination by 2025.

8.2 Sensitization and awareness creation against stigmatization of HIV and Sexually Transmitted Infections

According to a report by NACO, 0.54% of the population in Meghalaya are living with HIV. Stigmatization against HIV patients is still a great source of concern in Meghalaya. The policy will address the issue by taking measures to disseminate information and creating awareness. Sensitization of communities will also play a major factor in removing the fear of HIV; this will involve a greater involvement of grassroots organizations.

The policy will also aim to achieve the "**global target of 2020**" (in alignment to the NHP, 2017) which is also termed as target of 90:90:90, for HIV/AIDS where 90% of all people living with HIV know their HIV status, 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.

Meghalaya has one of the highest percentage of syphillis cases in the country and as per HIV Surveillance Sentinel, 2017, 1.03% of all pregnant women have tested positive for the infection; the policy will address the issue by creating awareness and sensitizing the public on the sexually transmitted infection.

8.3 Addressing Cancer in the State

According to the ***Cancer Statistics, 2020: Report from National Cancer Registry Programme, India***, it been shown that the East Khasi District in the State has the highest relative proportion of cancers associated with the use of tobacco (70.4 per cent for males and 46.5 per cent for females) in the country. The report also states that the sites of cancer in the North East region are nasopharynx, hyphopharynx, esophagus, stomach, liver, gall bladder, larynx, lung and cervix uteri. Because of the lack of infrastructure for specialized treatment of cancers in the region, patients prefer to travel outside the region. This is a great matter of concern for the State and the policy will aim to address this by strengthening the health infrastructure and propelling a mechanism for quality healthcare services for cancer patients.

As cancer is not a notifiable disease, there are many challenges that are faced during in data collection. The report suggests that data can be linked with Ayushman Bharat and the HIS can improve cancer registration, follow up and outcome.

The report also suggests that local cultural and lifestyle choices may have contributed to heterogeneity in cancer incidence patterns and differences in India (as seen with widespread tobacco use in Meghalaya). The policy would proactively give awareness and sensitization to the population and through various campaigns, make the residents aware of the dangers of certain dangerous habits that could lead to cancer.

8.4 Addressing non-communicable diseases (NCDs):

As specified in the NHP, 2017, there is growing burden on account of non-communicable diseases and infectious diseases. This will be addressed in the state health policy where NCDs like hyper tension, diabetes which are growing in numbers in Meghalaya will be addressed through planned early detection.

There will be special emphasis put on medication and access for select chronic illnesses on a “round the year” basis.

ASHAs and other grassroots health workers will be trained to undertake primary prevention for non-communicable diseases. They would also provide community or home based palliative care and mental health services through health promotion activities with the support of Village Health Sanitation and Nutrition Committee (VHSNC).

8.5 Disaster Management and epidemics such as COVID-19

The entire world is witnessing the havoc wreaked by COVID-19 and this has shown that there is an immediate need to have a policy which addresses deadly outbreaks and diseases. The policy aims to take effective measures to prevent, treat and control epidemic and endemic diseases and will lay down specific standards and norms for safety and quality assurance of all aspects of healthcare. It will address issues such as disease outbreaks and public health emergencies and ensure that the State is prepared for any emergency care in a disaster situation.

With Meghalaya prone to natural disaster deaths such as lightning strikes, the policy will include provisions for treatment of persons that have been affected by various natural disasters (floods, earthquakes).

Issues such as snake and animal bites are largely common in the rural landscapes, the policy will address these issues by ensuring that medication and treatment is easily and readily available in CHCs and PHCs. CHCs will keep stock of Anti Snake Venom, Anti Rabies Vaccine and Immunoglobulin which would be of great help to the people residing in the rural areas in order to receive timely intervention.

The policy will also allow for training of the village communities on how to quickly respond to such threats so as to minimize any health risks.

ANNEXURE 1

The table below shows the different stages of life along with a general summary of health parameters that should be followed by all residents.

INDICATORS TO MEASURE POSITIVE HEALTH AND COGNITIVE SKILLS

Stages	Period	Description	Health parameters
Neonatal	0 to 4 weeks	The neonatal period is the first four weeks of the child's life. It is the time where changes are very rapid. Many critical events can occur in this period.	To ensure that every child thrives to reach their full potential, we must focus on improving care around the time of birth and the first week of life. **1.** Skin to Skin Care or Kangaroo Mother Care of 6 to 8 hours for 28 days continuously should be encouraged. **2.** Extensive Breast feeding. **3.** Immunization. *At Birth - BCG, OPV-0, Hepatitis B-0. **4.** Wash practices should be according to the advice of the health practitioners. **5.** Clean dry cord care is recommended for newborns born in health facilities and at home.
Newborn	4 weeks to 1 year	During this development stage, babies' bodies and brain are learning to live in the outside world.	**1.** Breast feeding. **2.** After 6 months the baby can be fed with (formula), should also include certain nutritionally-dense semi-solids. At this stage, the baby's body is efficiently producing an apt amount of digestive enzymes to digest starch. After the completion of six months babies can be introduced to other soft food such as banana puree, mash potatoes, etc. **3.** Immunization. *At 6 weeks - fIPV-1, OPV-1, Penta-1, Rotavirus-1, PCV-1. *At 10 weeks-OPV2, RVV-2, Penta2, *At 14 weeks-OPV3, RVV-3, Penta3, fIPV-2, PCV-2. *At 9 months - MMR-1 /MR/Measles, JE Vaccine-1, PCV-3, Vit. A-1.
Toddler	12 months to 24 months	Children reach milestones in how they play, learn, speak, behave, and move (like crawling, walking, or jumping). During the second year, toddlers are moving around more, and are aware of themselves and their surroundings. Their desire to explore new objects and people also is increasing.	**1.** Investing in the first 1,000 days from conception to a child's second birthday shapes the future of the State. Ending stunting and other forms of malnutrition saves lives, improves health and prospects for children, and improves overall development progress. This makes the fight against malnutrition a national imperative. **2.** Immunization. *At 16 to 24 months - OPV Booster, DPT 1st Booster, Measles/MR/MMR-2, JE Vaccine-2.

Pre-Schooler	2 to 5 years	The period of the most rapid development of motor behaviors is between the ages of 2 to 5 years.	**1.** The ages between 2 and 5 are often called the preschool years. During these years, children change from clumsy toddlers into lively explorers of their world. A child develops physically, emotionally and socially. **2.** Learning what is normal for children, this age can help you spot problems early or feel better about how your child is doing. **3.** Routine medical visit. The best thing to do for the child is to show love and affection but there are many other ways to also help preschoolers grow and learn: • Offer your child healthy and nutritious foods. • Make time for your child to be active. • Read and talk to your child. • Help your child get enough rest. • Help your child play with other children. • Teach different skills. • Set limits that help your child feel safe. **3.** Immunization. *At 5 to 6 years - DPT 2nd Booster.
School age child	6 to 12 years	School-age children want to be independent, but family relationships are still the most important influence on development. At 6-12 years, expect sophisticated play, stronger friendships, tricky emotions, improved thinking and physical skills, and more.	**1.** Ages 6 to 12, is characterized by a slow, steady rate of physical growth. However, cognitive, emotional, and social development occurs at a tremendous rate. To achieve optimal growth and development, children need to eat a variety of healthy foods and participate in physical activity. **2.** Physical activity can give children a feeling of accomplishment, reduce the risk of certain diseases (e.g. coronary heart disease, hypertension, colon cancer, diabetes mellitus), if children continue to be active during adulthood. • Promote mental health. As children grow and develop, their motor skills increase, giving them an opportunity to participate in a variety of physical activities. Children may try different physical activities and establish an interest that serves as the foundation for lifelong participation in physical activity. **3.** Immunization. *At 10 years - Td-1

Adolescent	13 to 19 years	Adolescence—the transition period between childhood and adulthood—encompasses ages 13 to 19. It is a time of tremendous change and discovery. During these years, physical, emotional, and intellectual growth occurs at a dizzying speed, challenging the teenager to adjust to a new body, social identity, and expanding world view.	**1.** For adolescents' future lives – support for establishing healthy behaviours in adolescence (e.g. diet, physical activity and, if sexually active, use of contraceptives) and reduction of harmful exposures, conditions and behaviours (e.g. air pollution, obesity and alcohol and tobacco use) will help set a pattern of healthy living for adolescents. **2.** Immunization. *At 16 years - Td-2. **3.** During the adolescent period it is also necessary to teach them life skills which include: • Critical thinking and creative thinking. • Decision making and problem solving. • Communication skills and interpersonal relations. • Coping with emotions and stress. • Self-awareness and empathy. **4.** Yearly health checkup is also important for adolescents.
20 to 60 years	**Adulthood**, the period in the human lifespan in which full physical and intellectual maturity have been attained.	Adulthood	**1. Screening test and immunization scheduled for men ages 50 and older.** • Yearly general exam. • Thyroid (TSH) test - Every year after 50 years. • Person with no history of high Blood Pressure (BP) should check their BP twice a year and that with known history of High BP should have regular BP monitoring (at least once a month). • Regularly check cholesterol level. • Bone density Screening - to discuss with clinician if they are at increased risk because of previous bone fractures or other factors which are not necessary for other men. • Diabetes screening - to discuss with clinician for type 2 of diabetes. If the blood pressure is higher than 140/80 or if they can use medication to control blood pressure. • Blood glucose test - Every 6 months on reaching 50 years. • Digital rectal exam should be done once a year during • To discuss with the clinicians on other health related issues such as mental health screening, hearing test.

	Adulthood is divided into three stages beginning at age 20 or 21 years. Middle age, commencing at about 40 years, followed by old age at about 60 years.		• Routine dental exam and cleaning. • At age 65 on time pneumonia vaccine. • Yearly influenza vaccine. • Get a Td booster every 10 years; one booster after age 50 should be with Tdap, and the rest with Td. • Herpes zoster vaccine for shingles - Once only at age 60 or later; discuss with clinician. • Mole exam - Have this done during your routine physical or separately by a dermatologist. • Sexually transmitted infection (STI) tests- Both partners should be tested for STIs and HIV before initiating intercourse. **2.** Healthy eating habit. **3.** Physical exercise. **4.** Adequate Sleep. **Screening tests and immunization schedule for WOMEN.** **1. TESTS/IMMUNIZATIONS for women ages 50-64.** • General exam; weight and height- to discuss with clinician. • Thyroid (TSH) test- Every year after 50 years. • HIV test - At least once to find our your HIV status; ask your clinician if repeat testing is necessary. • Person with no history of high BP should check their BP twice a year and that with known history of High BP should have regular BP monitoring (at least once a month). • Cholesterol test- Discuss with clinician; many groups recommend screening every 5 years. • Bone density screen- Discuss with clinician and at age 65 years and older bone density screen should be done at least once and consult the clinician if repeated screening is required. • Blood glucose test- Every 6 months on reaching 50 years. • Mammogram - Every 2 years; discuss with clinician. • Clinical breast exam- Discuss with clinician. • Pap smear-Every 5 years; if HPV screening is unavailable, undergo pap smear every 3 years and for ages 65 and older to discuss with clinician. • Pelvic exam- Every 1–3 years.

			• Chlamydia test - Obtain if you have new or multiple partners. • Sexually transmitted infection (STI) tests- Both partners should be tested for STIs and HIV before initiating intercourse. • Mental health screening - Discuss with clinician. • Colorectal health; use one of the following three methods: 1. Fecal occult blood test should be done on a yearly basis and for those 65 years and older to discuss with clinician. 2. Flexible sigmoidoscopy to be done Every 5 years and for those 65 years and older to discuss with clinician. 3. Colonoscopy should be done Every 10 years and for those 65 years and older to discuss with clinician. • Complete eye exam- Every 2–4 years or as advised by clinician and for those 65 and older every 1–2 years. • Hearing test - Every 3 years. • Mole exam- Clinical exam or physical; self-exam monthly. • Dental exam- Routinely; discuss with dentist • Influenza vaccine- Yearly. • Pneumococcal vaccine - Not applicable and for those 65 years and above one time only. • Tetanus-diphtheria (Td) or tetanus-diphtheria-pertussis (Tdap) booster. Every 10 years; one booster after age 50 should be with Tdap, and the rest with Td. • Herpes zoster vaccine for shingles •Once only at 60 or later; discuss with clinician. **2.** Healthy eating habit. **3.** Physical exercise. **4.** Adequate Sleep.
	From conception till birth (40 weeks)		• Patient should see a doctor at least four times during pregnancy; the first at around 12 weeks, second between 24 to 28 weeks, third visit at 32 weeks and the fourth visit at 36 weeks. • Patient should be given folic acid supplementation to prevent Neural Tube defects. • Patient should visit health facility on due date irrespective of labour pains.

Pregnancy			**Patient should undergo routine tests such as:** • Haemoglobin estimation. • Routine examination of urine every 3 months • Serological test for syphilis, HIV and Hep-B. • Monitoring of blood glucose levels with testing of blood glucose levels 3 months. • ABO and Rh grouping. • Thyroid functioning test at least once during pregnancy. • Patient should undergo tetanus immunization (2 doses of Td during pregnancy).

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