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PART-IIA

GOVERNMENT OF MEGHALAYA

NOTIFICATIONS

The 1st May 2026.

No.Health.217/2025/23: In pursuance of the need to strengthen primary healthcare delivery in remote and dispersed locations of the State, the Governor of Meghalaya is pleased to notify the implementation of the **PHC+ (Primary Health Centre Plus)** model as a cluster-based primary healthcare intervention across identified facilities. The PHC+ model is specifically designed for the PHCs which cannot be upgraded to CHC level but urgently need expanded services, additional beds, and enhanced clinical capabilities to serve their communities effectively.

The objectives of the PHC+ are:

1. To augment PHCs with 10 additional beds to enable basic inpatient care and observation.
2. To deploy one additional Medical Officer and two additional Staff Nurses per PHC+.
3. To institute targeted anemia control interventions, including screening and dietary supplementation.
4. To establish basic PHC+ extensions (infrastructure blocks) through VHC consultation, using low-cost sustainable models.

The guidelines enclosed are therefore, to be strictly followed for all implementation purposes.

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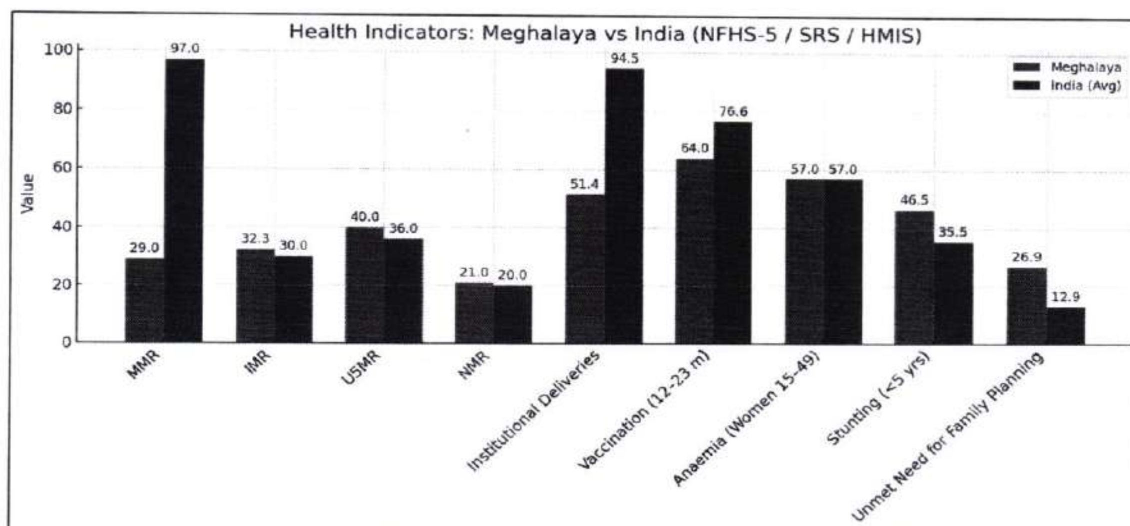
Concept Note: PHC+ (Primary Health Centre Plus) – A Cluster-Based Primary Healthcare Model for Meghalaya

1. BACKGROUND

The State of Meghalaya, with a predominantly rural and tribal population (~86% rural; Census 2011), faces unique public health delivery challenges stemming from its difficult terrain, low population density (132[1] persons per sq. km vs. national average of 492[2]), scattered settlements, and infrastructural constraints. These issues have contributed to suboptimal health outcomes despite the availability of national schemes and funding.



Despite ongoing efforts of the Health & family Welfare Department & the National Health Mission (NHM), many health indicators in Meghalaya remain significantly below the national targets. One of the major structural causes is the inability to establish standard PHCs in remote locations due to small, dispersed populations and terrain challenges, which do not align with the IPHS 2022 Guidelines for PHC/UPHC.

To address these structural and demographic challenges, the PHC+ (Primary Health Centre Plus) model is proposed as a pragmatic and adaptive solution tailored to Meghalaya's unique context. Unlike the standard PHC model, the PHC+ is designed to serve sparsely populated and hard-to-reach areas by offering a scaled-down but functionally robust version of primary healthcare services. It focuses on delivering essential outpatient care, preventive screenings, maternal and child health services, management of non-communicable diseases, and basic diagnostic support—augmented by telemedicine and referral linkages. By constructing modest standalone units (2200 sq. ft.), the PHC+ model ensures healthcare accessibility without compromising on quality or safety. It also aligns with Meghalaya's vision of a decentralized, community-integrated, and cost-effective public health system, particularly in underserved tribal and rural regions.

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[1] *As per 2011 Census*

[2] *https://worldpopulationreview.com/country-rankings/countries-by-density*

2. RATIONALE FOR PHC+

The Indian Public Health Standards (IPHS) Guidelines, 2022, prescribe the following population norms for health infrastructure:

Facility Type	Population Norm (Plain)	Population Norm (Hilly/Tribal/Difficult Areas)
Sub Centre (SC)	5,000	3,000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

In Meghalaya, the existing PHC network faces a dual challenge that necessitates the PHC+ intervention model:

Challenge 1: Population Shortfall for Standard PHCs

Due to its predominantly tribal and hilly terrain, most village clusters have populations that fall significantly short of the 20,000-threshold required for establishing a standard PHC as per IPHS norms. This has resulted in persistent service delivery gaps in remote rural areas where access to basic primary care remains limited.

Challenge 2: Inability to Upgrade to CHC Level

More critically, many existing PHCs in Meghalaya cannot be upgraded to Community Health Centre (CHC) status due to insufficient catchment populations. The IPHS requirement of 80,000 population for CHCs in hilly/tribal areas means that numerous PHCs remain locked in their current capacity without pathways for enhancement. PHC+ is specifically required for these PHCs which cannot be upgraded to CHC level but urgently need expanded services, additional beds, and enhanced clinical capabilities to serve their communities effectively.

This creates a service delivery paradox where facilities remain underutilized in terms of their potential while communities continue to face access barriers for intermediate-level care that falls between basic PHC services and full CHC capabilities.

An assessment of district-wise population distribution and the availability of PHCs in Meghalaya highlights the extent of both shortfalls:

District	Population	PHCs Required (as per IPHS 2022)	PHCs Available	Gap / Surplus
East Garo Hills	317,917	16	8	-8 (shortfall)
East Jaintia Hills	122,939	6	6	0
East Khasi Hills	825,922	42	27	-15(shortfall)
North Garo Hills	118,325	6	9	+3 (surplus)
Ri-Bhoi	258,840	13	9	-4(shortfall)
South Garo Hills	142,334	8	6	-2(shortfall)
South West Garo Hills	85,936	5	9	+4 (surplus)
South West Khasi Hills	110,152	6	15	+9 (surplus)
West Garo Hills	472,497	24	11	-13(shortfall)
West Jaintia Hills	270,352	14	11	-3(shortfall)
West Khasi Hills	383,461	20	5	-15(shortfall)

Concept Note: PHC+ (Primary Health Centre Plus) – A Cluster-Based Primary Healthcare Model for Meghalaya

The PHC+ model addresses this structural gap by providing a viable upgrade pathway for PHCs that cannot transition to CHC status due to demographic constraints. It offers enhanced inpatient capacity, specialized services (like anemia screening in Garo Hills), additional clinical staff, and expanded service hours—essentially creating an intermediate level of care that bridges the gap between standard PHC services and full CHC capabilities.

This context-sensitive solution ensures that existing PHC infrastructure investments are optimized and that communities receive improved healthcare access without requiring the full population base mandated for CHC establishment. PHC+ thus serves as a pragmatic adaptation of IPHS norms to Meghalaya's unique demographic and geographic realities.

Low health-seeking behavior, dependency on traditional medicine, seasonal inaccessibility, and shortage of health personnel compound the access crisis. There is thus a pressing need for flexible, context-sensitive models that ensure access, equity, and continuity of care without duplicating infrastructure.

3. THE PHC+ MODEL: CONCEPTUAL FRAMEWORK

PHC+ is an innovative, **cluster-based primary healthcare delivery model** that adapts IPHS norms to the unique realities of tribal, hilly states like Meghalaya.

Concept Note: PHC+ (Primary Health Centre Plus) – A Cluster-Based Primary Healthcare Model for Meghalaya

It builds on existing health facilities but **expands their service radius** and **functional scope**, ensuring a full continuum of care through **outreach, local workforce integration**, and **digital technology**.

3.1 Objectives of PHC+

- To augment PHCs with 10 additional beds to enable basic inpatient care and observation.
- To deploy one additional Medical Officer and two additional Staff Nurses per PHC+.
- To institute targeted anemia control interventions, including screening and dietary supplementation.
- To establish basic PHC+ extensions (infrastructure blocks) through VHC consultation, using low-cost sustainable models.

3.2 Proposed Interventions under PHC+

A. Manpower Augmentation:

Human Resource for Health as per IPHS 2022	PHC Essential Staff(E)	PHC Desirable Staff (D)	Proposed Under PHC+
MO MBBS	1	1	1
Pharmacist	1	0	-
Staff Nurses	2	1	2
Medical Laboratory Technologist/Lab Technician	1	0	-
Optometrist/Ophthalmic Assistant/Vision Technician	0	1	-
Health Worker (Female)/ANM	1	0	-
Health Worker/Health Assistant (Male)	1	0	-
Health Assistant (Female)/Lady Health Visitor	1	1	-
Health Educator/Counsellor	0	1	-
Dental Assistant	0	1	-
Cold chain/Vaccine logistic Assistant	0	1	-
Physiotherapist	0	0	-
Public Health Manager	0	1	-
Dresser	1	0	-
LDC-1/Accountant	1	0	-
Data Entry Operator	1	0	-
Sanitation Staff	1	0	-

Each PHC+ is proposed to include these additional manpower

- 1 additional Medical Officer (MBBS)
- 2 additional Staff Nurses

B. Bed Expansion

Each upgraded PHC+ will be equipped with 10 additional beds, comprising 4 designated for observation and 6 for short-stay admissions, thereby enhancing the facility's capacity to manage non-critical inpatient care. To support emergency preparedness, oxygen supply points and basic emergency drugs will be maintained on-site. To ensure patient dignity and comfort, privacy partitions will be installed between male and female beds, creating a safer and more inclusive care environment within the primary health setting.

- PHC+ to have **10 additional beds** (4 for observation, 6 for short-stay)
- Oxygen supply point and basic emergency drugs to be stocked
- Privacy partitions for male/female beds

C. Anemia Control in Garo Hills

Targeting the high prevalence of anemia—particularly due to the Hemoglobin E (HbE) trait—in West, South, and East Garo Hills, the PHC+ initiative will implement community-level screening using hemoglobinometers for adolescent girls, pregnant women, and lactating mothers. The program will emphasize differentiating between genetic and nutritional causes of anemia through confirmatory testing and appropriate referrals. Tailored Iron and Folic Acid (IFA) supplementation protocols will be adopted for populations with the HbE trait, ensuring safe and effective treatment. School-based screening drives will be conducted alongside follow-up counseling to promote early detection and sustained care. Furthermore, community awareness campaigns will aim to address misconceptions, reduce stigma, and improve compliance with treatment and dietary recommendations.

- Community-level screening using hemoglobinometers for adolescent girls, pregnant women, and lactating mothers.
- Differentiation of genetic vs. nutritional anemia through confirmatory testing and referral.
- Iron & Folic Acid (IFA) supplementation protocols tailored for populations with HbE trait.
- School-based screening drives with follow-up counseling and referral.
- Community awareness campaigns targeting misconceptions, stigma, and treatment compliance.

D. Infrastructure Development

Each PHC+ unit will include the construction of a new annex building of approximately 2200 sq.ft., designed to house a 10-bed inpatient ward, a basic nursing station, and essential amenities such as toilets and safe water supply. Sustainability features like solar lighting and rainwater harvesting systems will be incorporated where technically and geographically feasible. The infrastructure development will be implemented through a community contracting model, with the Village Health Council (VHC) serving as the supervisory body to ensure local ownership, transparency, and alignment with community needs. This approach promotes participatory governance and strengthens the village's role in health system stewardship.

Concept Note: PHC+ (Primary Health Centre Plus) – A Cluster-Based Primary Healthcare Model for Meghalaya

- New **PHC+ annex building (2200 sq.ft.)** per unit, designed as:
  - 10-bed inpatient ward
  - Basic nursing station
  - Toilet & water facility
  - Solar lighting, rainwater harvesting (where feasible)
- Construction through **community contracting model** involving **Village Health Council (VHC)** as **supervisory** body

3.3 Key Features of the proposed PHC+ Concept

i. **Bridging Accessibility Gaps:** PHC+ units will bring essential healthcare closer to hard-to-reach populations. With travel time to the nearest PHC often exceeding 2–3 hours in remote parts of Meghalaya, PHC+ ensures timely access to ANC check-ups, immunization, chronic disease screening, and emergency care stabilization.

ii. **Customized for Low-Density Populations:** Unlike standard PHCs, PHC+ does not require a 20,000 catchment population, making it viable for village clusters of 5,000–10,000 population. This helps operationalize health services where establishing a full PHC is not justifiable.

iii. **Enhanced Preventive and Community Health Focus:** PHC+ centres can prioritize NCD screening, adolescent health, anemia control (especially relevant due to high Hemoglobin E trait prevalence in Garo Hills), family planning, TB/HIV surveillance, and early referral—functions critical for preventive public health.

iv. **Leverages Digital Health Infrastructure:** Integration with **eSanjeevani, ABHA IDs, Telemedicine,** and **Health Management Information Systems (HMIS)** ensures continuity of care and real-time data-driven decision-making, aligning with the NDHM/Digital Health Mission framework.

v. **Cost-Efficient, Modular, and Scalable:** PHC+ facilities are low-capital, prefabricated or retrofitted structures, supported by a lean but trained workforce. This model can be **piloted and scaled** based on epidemiological priorities and geographical need, with significantly lower per-unit cost than PHCs.

vi. **Strengthening Referral Pathways:** PHC+ facilities can act as feeder nodes to full-fledged PHCs/CHCs, optimizing the referral load and ensuring that secondary and tertiary facilities are not overburdened with primary care cases.

vii. **Community Ownership through VHSNCs:** PHC+ can be supported by **Village Health Sanitation & Nutrition Committees** (VHSNCs), fostering local ownership, accountability, and community-led monitoring, which aligns with Meghalaya's focus on decentralized governance.

4. SELECTION PROCESS:

To ensure that the PHC+ expansion is both need-based and resource-efficient, a facility-level assessment was undertaken across priority districts. The evaluation covered service utilizatior (OPD/IPD load, bed occupancy), diagnostic availability, and human resource/infrastructure gaps in

alignment with IPHS requirements. By expanding the planned 24 PHCs, the State can add 230 new functional beds, directly reducing the referral burden on higher facilities.

The selection process adheres to the following principle:

a. **Evidence-Based Selection:** Caseload based on data on OPD attendance, IPD admissions, deliveries, diagnostics, and MHIS utilization have been corroborated to prioritize facilities with demonstrated demand and unmet service capacity.

   The selection of facilities for PHC+ expansion has been undertaken through a systematic evidence-based process, with caseload indicators (OPD/IPD admissions, institutional deliveries, diagnostics, and MHIS utilization) corroborated to prioritize facilities with demonstrated demand and unmet capacity.

   Analysis of high-priority PHCs such as **Salmanpara, Mellim, and Garobadha** highlights strong community reliance, high service utilization, and pressure on limited resources of such facilities. Collectively, they register substantial OPD and IPD volumes, with institutional delivery rates exceeding 90% in Salmanpara and Garobadha. Bed occupancy is notably high in Mellim (59.27%) and remains significant in the others, despite each having only 10 beds. Diagnostics are broadly aligned with IPHS norms, and all selected facilities have confirmed land availability, ensuring feasibility for expansion.

Facility	% of Institutional Delivery	No. of Villages	OPD	IPD	Bed Occupancy Rate	Beds Available	Diagnostics Available (per IPHS)	Land Availa ility
Salmanpara PHC	95.4	30	11506	626	34.93%	10	40	Yes
Mellim PHC	79.6	51	5568	538	59.27%	10	30	Yes
Garobadha PHC	94.7	64	16500	760	41.31%	10	45	Yes

5. IMPLEMENTATION ROADMAP

5.1 Augmentation of Existing Health Infrastructure through PHC+ Expansion

To ensure a balanced approach, the PHC+ model will not only establish new annexes but also strategically augment **existing PHCs** that demonstrate high service load and pressing infrastructural gaps.

a. **Facility Identification:**
   Facilities with high patient load, moderate-to-high bed occupancy, and identified service delivery gaps were prioritized for immediate PHC+ augmentation. Land availability and feasibility assessments were also factored in while deciding upon the same (refer Table 1).

Concept Note: PHC+ (Primary Health Centre Plus) – A Cluster-Based Primary Healthcare Model for Meghalaya

Table 1: The H&FWD has identified these 24 priority PHCs based on high case load and scarcity of space for immediate expansion to PHC+:

Sl. No.	District	Block	Facility
1.	East Garo Hills	Rongjeng Block	Mangsang PHC*
2.	East Garo Hills	Songsak Block	Songsak PHC
3.	East Jaintia Hills	Khliehriat Block	Pamra Paithlu PHC*
4.	East Khasi Hills	Pynursla Block	Pongtung PHC
5.	East Khasi Hills	Mawkynrew Block	Jatah PHC
6.	East Khasi Hills	Mawkynrew Block	Jongksha PHC*
7.	North Garo Hills	Kharkutta Block	Wageasi PHC
8.	South West Garo Hills	Betasing Block	Mellim PHC
9.	South West Garo Hills	Betasing Block	Garobadha PHC
10.	South West Garo Hills	Zikzak Block	Salamanpara PHC
11.	West Garo Hills	Rongram Block	Asananggiri PHC
12.	West Jaintia Hills	Laskein Block	Iooksi PHC
13.	South Garo Hills	Chokpot Block	Silkigre PHC
14.	South Garo Hills	Gasuapara Block	Sibbari PHC
15.	North Garo Hills	Resubelpara Block	Rari PHC
16.	North Garo Hills	Adokgre Block	Adokgre PHC
17.	North Garo Hills	Resubelpara Block	Mendipathar PHC
18.	North Garo Hills	Resubelpara Block	Dainadubi PHC
19.	West Khasi Hills	Mairang Block	Donki-Ingding PHC
20.	West Khasi Hills	Nongstoin Block	Rambrai PHC
21.	West Khasi Hills	Mawshynrut Block	Shallang PHC
22.	Ri Bhoi District	Umsning Block	Kyrdem PHC
23.	Ri Bhoi District	Umsning Block	Mawhati PHC
24.	Eastern West Khasi Hills	Mawthadraishan block	Pariong PHC*

5.2 Additional Facilities for Consideration:

In addition to the above exercise, the Department has received representations from Hon'ble Ministers, MLAs and community leaders for upgradation of existing SCs to PHCs or upgradation of PHCs to CHCs. The matter was examined based on IPHS 2022 standards, administrative requirements & ground realities accordingly accordingly DHS (MI) has submitted the feasibility report as follows:

SL. No	Proposal	Name of Representative	Views & Comments from HEW
1.	Setting up of two SC in Border Area Raid Nongtung	Shri. Charles Marngar	Setting up of Sub Centre may be taken up under PM-ABHIM/Grant under XV Finance Commission
2.	Upgradation of Pamra Paithlu PHC to CHC	Shri. Kyrmen Shylla	Already Included in PHC+
3.	Extension of the PHC in Pariong by adding 20 additional beds	Shri. Shakliar Warjri	Already Included in PHC+
4.	Upgradation of Muktapur SC to PHC, West Jaintia Hills	Headman Muktapur Village	Since the current area of the existing facility is only 4800Sqm (~1.1 acre). Hence it is not feasible for upgradation to PHC
5.	Expansion of Nongthliew PHC, Eastern West Khasi Hills	Shri. Metbah Lyngdoh	No Space for expansion except vertical expansion which is not feasible for additional maternity Ward
6.	Upgradation of Mawrong SC to PHC	Chairman, Synjuk ki Nongialam Shnong, Mawrong	Since Upgradation of Umsaw Nongbri SC to PHC is under process, the proposal for upgradation of Mawrong can be kept in abeyance at present as it is only 5KM away from Umsaw Nongbri.
7.	Sohryngkham SC to PHC, East Khasi Hills	Shri. Heavingstone Kharpran	May be taken up from State Plan.
8.	Jongksha PHC to CHC	Dorbar Shnong, Jongksha	Already Included in PHC+
9.	Setting up of PHC at Rynso	Shri. Kyrmen Shylla	Since there is no existing SC, upgradation to PHC may not be feasible
10.	Creation of SC at Demdema village, West Garo Hills	Shri. A.T Mondal	Setting up of Sub Centre may be taken up under PM-ABHIM/Grant under XV Finance Commission
11.	Renovation and Upgradation of Mangsang PHC, East Garo Hills	Shri. Jim M Sangma	Already Included in PHC+
12.	Full Renovation of Kalaichar PHC, South Garo Hills	Shri Sanjay A Sangma	Under Review
13.	Sibbari PHC to CHC	Shri Kartush R Marak	Under Review
14.	Gasuapara SC to PHC	Shri Kartush R Marak	Under Review
15.	Upgradation of Betasing PHC to CHC	Secretary Achik Progressive Approach	Under Review
16.	Raksamgre SC to PHC	Shri Limison D Sangma	Under Review

5.3 Rollout Plan

The rollout of the PHC+ model will follow a phased, adaptive approach spanning over three years. The strategy emphasizes concurrent strengthening of infrastructure, workforce, and service delivery mechanisms, with a strong monitoring and feedback loop. Each phase is logically sequenced to address existing gaps, prepare ground-level systems, and build momentum toward sustainable, community-led primary healthcare transformation.

Phase	Key Activities	Justification
Phase 1: Mapping & Planning (Months 0–3)	- Identification of 22 PHCs for upgradation to PHC+ clusters based on disease burden, population underserved, and travel time to existing facilities. - Facility readiness assessment and service gap analysis.	This phase establishes the geographical and operational blueprint. Accurate mapping ensures resources are allocated to the most underserved communities and that each PHC+ cluster is optimally located for maximum population coverage.
Phase 2: Facility Strengthening (Months 3–12)	- Construction of PHC+ annex buildings (2200 sq.ft.) using community-contracting.	Physical infrastructure is a critical enabler for care delivery. Ensuring that PHC+ hubs and spokes are functional, well-equipped, and community-friendly is foundational before deploying additional manpower or services.
Phase 3: Workforce Deployment (Months 6–15)	- Recruitment of one additional doctor (MBBS/AYUSH/Dental) and two nurses per PHC+. - Refresher training for existing PHC staff on PHC+ protocols and data reporting.	With enhanced infrastructure in place, the next step is to augment human resources to enable service delivery. Training ensures teams are competent in using point-of-care devices, handling digital systems, and engaging with the community.
Phase 4: Service Rollout (Months 12–24)	- Begin weekly outreach visits in each PHC+ cluster. - Launch school and community-based screening drives (e.g., anemia, NCDs). - Operationalize telemedicine consultations with district-level specialists.	This phase marks the commencement of community-level health services. PHC+ must offer consistent and predictable care touchpoints to build public trust and improve utilization of services across age groups.
Phase 5: Monitoring & Feedback (Months 18–36 and ongoing)	- Real-time dashboards for service delivery, outreach metrics, and health indicators. - Monthly review meetings at PHC level; quarterly at district/state levels. - Community feedback mechanisms, including grievance redressal portals and VHC review meetings.	Measurement and adaptive feedback are critical to course-correct, build transparency, and maintain accountability. Regular reviews help in early identification of implementation bottlenecks and ensure citizen participation.

Concept Note: PHC+ (Primary Health Centre Plus) – A Cluster-Based Primary Healthcare Model for Meghalaya

1. **RESOURCE ENVELOPE AND FUNDING POSSIBILITIES**
   - **National Health Mission (NHM)**: Flexi-Pool and tribal health components
   - **15th Finance Commission Grants**: For health infrastructure in aspirational districts
   - **AB-HWC Budget Lines:** For mid-level health provider and telehealth infrastructure
   - **State Budget and External Support**: Leverage CSR, NGO, or World Bank/ADB-supported hea interventions

2. **EXPECTED OUTCOMES (BY YEAR 3 OF IMPLEMENTATION)**

   The **PHC+ model** aims to strengthen last-mile service delivery, improve community trust in public health systems, and reduce preventable morbidity and mortality. Based on current health indicators in the targeted districts and Garo Hills region, the following measurable outcomes are projected by the **end of the third year** of implementation:

Indicator	Baseline (Latest Available)	Target by Year 3	Rationale
Institutional Deliveries	58.4%	85%+	Strengthened facility-based care, improved trust in PHC+, and availability of inpatient beds with midwifery support are expected to drive a shift from home to institutional deliveries.
Full Antenatal Care (ANC) Coverage	22.6%	90%+	Regular outreach and screening, additional manpower (MO/Nurses), and targeted ANC tracking through community health workers will improve coverage.
Immunization Coverage (12–23 months)	70.5%	>90%	PHC+ will act as a fixed outreach hub for immunization, while school and VHND drives will help close remaining gaps.
Infant Mortality Rate (IMR) (per 1,000 live births)	32	<20	Early identification and referral of high-risk pregnancies, newborn care at PHC+, and postnatal home visits will contribute to lowering IMR.
Proportion of Villages with Regular Outreach Services	<30%	100% in PHC+ Clusters	Expansion of PHC+ services with outreach scheduling, Village Health Council engagement, and robust monitoring systems will ensure every village in the catchment area is covered regularly.

6. **FINANCIAL ESTIMATE PROJECTION (PER PHC+)**

The projected financial outlay for establishing each PHC+ unit has been structured to ensure prudent use of public funds while upholding service quality and functionality. Each unit is designed as a 2,200 sq.ft. facility with 10 inpatient beds, essential diagnostic capabilities, solar power backup, and basic

utilities. The total projected capital investment per PHC+ amounts to ₹1.06 crore, with an additional recurring expenditure of ₹34.55 lakh annually for operations and maintenance.

6.1 CAPITAL EXPENDITURE (One-time — Per PHC+)

Sl.	Item (one-time)	Description / purpose	Amount (INR)
1.	Infrastructure — 2,200 sq.ft. annex building	Construction: ward, screening, consultation, toilets, accessible features.	75,00,000
2.	10 beds + furniture	Beds, mattresses, bedside lockers, curtains/partitions, reception/office furniture.	3,00,000
3.	Medical equipment (starter)	BP apparatus, glucometer(s), suction, nebulizer, oxygen concentrator(s), minor OT items, ancillaries.	2,00,000
4.	Point-of-care / diagnostic devices (startup)	Hemoglobin analyzer/hemoglobinometer(s), rapid test kits platform & accessories.	2,00,000
5.	IT / Telemedicine setup	Computers, tele-consult cart / webcam, router/modem, eSanjeevani integration, ABHA/HMIS station.	3,00,000
6.	Solar lighting & backup	Panels, inverter, battery bank sized for basic backup.	1,00,000
7.	Water & sanitation	Bore/tank/plumbing, accessible toilets, basic water treatment where required.	1,50,000
8.	Initial drugs & consumables stock (startup)	Essential medicine kit, IFA stock, emergency drugs, disposables (startup buffer).	4,00,000
9.	Minor civil/accessibility works & boundary/repairs	Ramps, disabled access, minor compound works, courtyards, small staff quarter repairs.	5,00,000
10.	BMW storage & safe disposal setup	Small fenced storage, temporary treatment measures and handover logistics.	1,00,000
11.	Community contracting / supervision setup	One-time community mobilisation, VHC/VHSNC capacity building, procurement administration.	2,00,000
12.	Contingency (construction & procurement)	10% reserved for price escalation / local adaptations.	6,50,000
Total Capital Expenditure			1,06,00,000

The proposed capital investment of ₹1.06 crore per PHC+ has been structured to ensure that each unit functions as a complete and self-reliant facility, equipped with essential clinical services, diagnostic capabilities, and short-stay care infrastructure tailored to the needs of remote and underserved areas. Of this, ₹75 lakh is earmarked exclusively for infrastructure development (2,200 sq.ft. annex building with wards, consultation spaces, and utilities), ensuring durability and

accessibility. Further expansion or customization may subsequently be undertaken through additional support from centrally sponsored schemes, development partners, or CSR contributions.

6.2 RECURRING EXPENDITURE (Annual — Per PHC+)

Item	Basis/Note	Annual amount (INR)
Medical Officer (1 additional MO)	Annexure 1 — grand total (salary + allowances + winter allowance)	9,04,128
Staff Nurses (2 additional)	Annexure 1 — total for 2 staff nurses (salary + allowances + winter allowance)	11,69,778

6.3 Other recurring costs (annual)

Item	Purpose	Annual amount (INR)
1. Data Entry Operator (1)	HMIS/ABHA/eSanjeevani data capture & admin	1,80,000
2. Sanitation / housekeeping (1)	Cleaner / ward attendant / contract wages	96,000
3. Medicines & consumables (recurrent)	OP drugs, IFA, emergency drugs replenishment	3,00,000
4. Diagnostic consumables	Glucometer strips, Hb strips, RDT kits, lab reagents	1,50,000
5. Utilities & connectivity	Electricity, water, internet (telemedicine), phone	1,20,000
6. Outreach transport & fuel	Weekly outreach, school screening drives, patient referral support	2,40,000
7. Equipment AMC & calibration	Annual maintenance for concentrators, lab devices, telemedicine kit	75,000
8. Building / minor repairs	Routine maintenance of annex / furniture / fittings	1,00,000
9. Telemedicine subscription & IT services	Software support, eSanjeevani connectivity, dashboard hosting	60,000
10. Biomedical waste disposal	Periodic collection / safe disposal charges	60,000
11. Training & capacity building	Refresher trainings, CHO/ANM upskilling, community trainings	50,000
12. Monitoring & HMIS analytics	Local dashboard, data validation, review meetings	50,000

The projected recurring expenditure per PHC+ unit is estimated at ₹34.55 lakh annually. This includes ₹20.74 lakh towards personnel costs for one additional Medical Officer and two Staff Nurses, and ₹13.81 lakh towards operational expenses such as medicines, diagnostics, utilities, outreach, equipment maintenance, biomedical waste disposal, and IT/telemedicine support. These provisions are essential to ensure uninterrupted service delivery, functionality, and sustainability of the PHC+ model."

7. CONCLUSION

The **PHC+ model** represents a pragmatic, scalable, and locally responsive innovation tailored to the unique topographic, demographic, and infrastructural realities of Meghalaya. It is not just a marginal enhancement of the current PHC system but a **strategic redesign**—integrating additional inpatient capacity, mobile outreach, diagnostics, and digital health infrastructure within a cluster-based service delivery framework.

By decentralizing access to essential primary healthcare services and embedding **community-led governance mechanisms** through Village Health Councils (VHCs), PHC+ promotes not only better service uptake but also sustained local accountability. Its modular design ensures that investments—whether in manpower, diagnostics, or infrastructure—are **pooled and optimized across clusters**, rather than duplicated in fragmented silos.

Moreover, the model aligns with national and international priorities: it advances **India's commitment under SDG 3 (Good Health & Well-being)**, meets the **National Health Policy 2017** goals of achieving universal primary healthcare access, and supports tribal and underserved populations in accordance with the **15th Finance Commission recommendations**. Importantly, it provides a **cost-effective pathway** to reducing preventable maternal and infant deaths, improving population-level health indicators, and future-proofing Meghalaya's public health system for evolving disease burdens.

By adopting and scaling the PHC+ model, the Government of Meghalaya can make **transformational progress** in strengthening primary healthcare as the foundation of its health system—one that is **people-centric, inclusive, and resilient.**

Concept Note: PHC+ (Primary Health Centre Plus) – A Cluster-Based Primary Healthcare Model for Meghalaya

Annexure 1: Salary Calculation for the MO & Staff Nurse

Sl. No	Category of Posts	No. of Posts	Scale of Pay	Total of Pay	D.A. 49%	H.A.	H.R.A. 12.5%	M.A.	Total for 1 month	Total for 12 months	Winter Allowance	Grand Total
1	Medical & Health Officer	1	L-15	₹45,600	₹22,344	₹500	₹5,700	₹1,000	₹75,144	₹9,01,728	₹2,400	₹9,04,128
2	Staff Nurse	2	L-8	₹30,300	₹29,694	₹1,000	₹3,788	₹2,000	₹97,082	₹11,64,978	₹4,800	₹11,69,7[illegible]

Annexure 2: Draft Floor Plan For 10 Bedded Maternity Wing In Existing PHCs

Schedule of Window/Ventilator			
Type	Size	[illegible]	Lintel
W/V	[illegible]	[illegible]	[illegible]
W1/V1	[illegible]	[illegible]	[illegible]
W2/V2	[illegible]	[illegible]	[illegible]
V1	[illegible]	—	[illegible]
V2	[illegible]	—	[illegible]
SW1/SV1	[illegible]	[illegible]	[illegible]
SW2/SV2	[illegible]	[illegible]	[illegible]

Schedule of Doors		
Type	Size	Detl.
D	[illegible]	PVC
D1	[illegible]	Flush Door
D2	[illegible]	panel
AD	[illegible]	Aluminium
AD1	[illegible]	Aluminium

Notes:
- This drawing is the property of the Directorate and shall not be reproduced in any form without prior permission.
- All drawings are to be read and not measured.
- Any change/if necessary are to be made in consultation with the Engineer in charge.
- All dimensions are in centimetres

PROJECT NAME

PROPOSED ADDITIONAL 10 BEDDED MATERNITY WARD AT PHCS IN MEGHALAYA.

CONTENT: FLOOR PLAN

Scale:1:80 | Drg. No:2

Drawn by:

Sub-Divisional Officer
Health Engineering Wing,
East Khasi Hills District

Approved by:

Shri R.A Wanniang,
Executive Engineer,
Health Engineering Wing,
Shillong.