FOLLOWING THE SUN

A TRANSFORMATION IN MEGHALAYA'S PUBLIC HEALTHCARE, UPHOLDING SOCIAL EQUITY AND CLIMATE JUSTICE

स्वास्थ्य एवं परिवार कल्याण मंत्रालय
MINISTRY OF HEALTH AND FAMILY WELFARE
सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन
NHM MEGHALAYA

Government of Meghalaya
सत्यमेव जयते
Shillong

SAURA MANDALA
Centre for Accelerated Development

SELCO FOUNDATION

SELCO Foundation

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From the Chief Minister's Desk

Honourable Shri Conrad K. Sangma
Chief Minister of Meghalaya

The Meghalaya Health Systems Strengthening Project stands as a beacon of hope and transformation, reflecting our unwavering commitment to building a resilient, inclusive, and accessible healthcare infrastructure for every citizen. This ambitious initiative was born out of the invaluable lessons learnt during the COVID-19 pandemic — a period that tested our resolve and challenged our healthcare system like never before.

During that unprecedented crisis, our frontline warriors — doctors, Auxiliary Nurse Midwives (ANM), and Accredited Social Health Activists (ASHA) — emerged strong and open to the challenge. They worked tirelessly in Primary Health Centres (PHC), Community Health Centres (CHC), and Sub-Centres (SC), ensuring last-mile connectivity. The challenges underscored the urgent need for a healthcare infrastructure that is not only robust but also adaptable to the evolving needs of our people.

With this vision in mind, we launched the Energy for Health Programme (E4H) in partnership with SELCO Foundation and Sauramandala Foundation. Through this initiative, we have powered ALL primary public health facilities in the state and are constructing 300 new energy-efficient SCs. Our mission is clear: we will ensure that even the most remote and disaster-prone regions have access to healthcare that is resilient, patient-centred, and sustainable. With the help of green energy solutions, we will make certain that every child growing up in the state and for generations to come is safe and healthy, and public health systems are fully equipped to serve the people in every circumstance.

E4H is not just about adding solar panels or constructing buildings; it is about building trust and hope, and creating a healthier Meghalaya. Our partnership with SELCO Foundation and Sauramandala Foundation is a testament to our resolve to create facilities that are more than just medical centres; they are lifelines for our communities. By integrating innovative design and cutting-edge technology, we will see to it that the CHCs, PHCs, and SCs can withstand erratic weather conditions and continue to deliver quality healthcare in the face of adversities.

A critical aspect of this initiative is the participatory design approach. We believe that the best solutions emerge when those who are most affected have a voice in shaping them. The engagement of stakeholders — health workers, district medical officers, civil society, and community members — in the planning and development of the facilities is critical. Their insights, experiences, and needs form the foundation of our healthcare transformation.

This is our moment to redefine healthcare in Meghalaya. With collaboration, perseverance, and an unyielding spirit, we are shaping a future where health is not a privilege but a fundamental right for all. Together, we are building a healthier, stronger, and more resilient Meghalaya.

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E4H would not be possible without the support of

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DECEMBER
Case Selection for sterilization in public health facilities


FREE SERVICES

Preface

Sustainable energy practitioners have long established that lack of access to energy affects rural and urban populations' productivity and well-being, impacting their livelihood-generation capacity, education outcomes, health outcomes, and quality of life.

The Government of India, under its Community Development Programme, 1952, set up Primary Health Centres (PHC) and Sub Centres (SC) at the village level. PHCs are the cornerstone of the last-mile healthcare delivery system. Their main objective is to provide preventive, curative, promotional healthcare and family welfare services to the people. According to Indian Primary Health Standards, there shall be one PHC to serve a population of 20,000–30,000 (depending upon whether the terrain is hilly or plain). Staff at each PHC must include a medical officer, staff nurse, laboratory technician, pharmacist, male and female health workers, Accredited Social Health Activists (ASHA), and administrative staff.

Each PHC is further supported by a network of five to six SCs, which are the most peripheral healthcare units at the village level. SCs provide healthcare to a population of 3,000 in hilly / tribal areas and 5,000 in the plains. The services are related to maternal and child health, family welfare, nutrition, immunisation, diarrhoea control, and communicable diseases. Each SC is run by an Auxiliary Nurse Midwife (ANM) and a Male Health Worker (MHW).

While the efforts of the health sector have focussed on the need for expanded access to skilled care, essential medicines, and medical technologies for priority diseases and health conditions, comparatively less attention has been assigned to the value modern, affordable, and sustainable energy access can bring to the delivery of quality healthcare. Unreliable and unaffordable energy and the lack of energy-efficient appliances reduce the efficacy and impact of healthcare services.

In 2023, in a significant step towards transforming the public health infrastructure, SELCO Foundation and IKEA Foundation, in partnership with India's Ministry of Health and Family Welfare (MoHFW) and various state Health Missions, launched a groundbreaking programme — Energy for Health. By 2026, 100MW of solar energy systems will be installed, complete with energy-efficient medical and electrical equipment, in 25,000 healthcare facilities across 12 states. A first-of-a-kind programme, the massive outreach of Energy for Health is expected to touch 170,000,000 lives and improve the working conditions of over 160,000 frontline health staff.

Energy for Health brings with it positive impact across the spectrum of stakeholders — for last-mile communities in their access to timely healthcare; for health staff in ensuring a conducive work environment; for the health sector in reducing energy consumption, equipment-related costs, wastage of vaccines and critical resources; reinforcing climate resilience and positive health outcomes for all.

The 12 states under the programme throw up a rich diversity in terms of topography, socio-economic vulnerabilities, disease burden, and climate. As we innovate on approaches, models, and processes for this melange, they will emerge a global showcase and knowledge bank for similar contexts in any country.

In this report, **Following the Sun**, hear from the people who are creating the solutions as well as those who are accessing and using them. They are not networks enabled by solar panels and wires; they are a silent, ever evolving grid of hearts, stories, communities, and life itself in all its setbacks, complexities, and glories.

Energy for Health

Government of Meghalaya, SELCO Foundation, and Sauramandala Foundation

Energy for Health (E4H) in Meghalaya is a joint initiative by the Government of Meghalaya, SELCO Foundation, and Sauramandala Foundation. As the state government focusses on decentralising healthcare services as a strategy to enhance healthcare access for the people who have to negotiate Meghalaya's difficult terrains and weather conditions, E4H has ensured reliable energy for sub-centres, thereby enhancing maternal and child health and family welfare services, and immunisation points. In fact, at the time of going to press, E4H has reinforced service delivery across all health facilities in the state, which includes primary health centres, community health centres, as well as sub-divisional and district hospitals. It has also enabled the design and construction of 300 model climate-resilient sub-centres and the upgradation of over 2,200 anganwadis or early childcare and education centres.

Meghalaya's decision to achieve energy independence via E4H has not only benefitted the millions of people who rely on public healthcare but also improved the viability of the modernisation effort and generated savings for the health department. Additionally, the programme has provided engagements to local solar energy service providers, which indirectly contributes to local economies and boosts adoption of solar energy across sectors.

E4H creates systems and processes that demonstrate ownership, management, and maintenance of the systems and appliances. It builds technical knowledge and capacity, as well as informs guidelines and policies that will enable health departments across the country, even beyond, to plan for sustainable public health infrastructure.

The programme is supported by the IKEA Foundation, Waverly Street Foundation, Blockchain for Impact, LIC Housing Finance, and HDFC Life. SELCO Foundation would specifically like to thank the innovative spirit and years of commitment contributed by the health practitioners of Meghalaya.

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The Health Democracy

DR. HARISH HANDE

CEO, SELCO Foundation
2011 Ramon Magsaysay Awardee

SELCO Foundation must serve only as a catalyst for transformation, not as the focal point. We must move beyond seeing any one institution as the sole creator of solutions; rather, view the process of bringing about impactful, sustained change as an innovation — one that can be built upon and made open-source. Our goal is not for people to think about how outstanding our work is. Instead, we want them to look at the problem we are solving and think, 'I can do better than that!'

The mission of SELCO Foundation is to use sustainable energy as a catalyst to democratise healthcare and livelihoods. When we speak about renewable energy, we often focus our conversations on the Decentralised Renewable Energy (DRE) technology and the equipment: solar panels, batteries, earthing cables, and charge controllers. The discourse must be about the delivery of health and livelihoods — it must become about the people and the communities who use the solutions we build.

Health is a fundamental right. Without addressing the health crisis, we cannot solve poverty. From the micro point of view, it leads to better education for children, better livelihoods, and a better family life. On a macro level, healthy citizens contribute to the progress of the community, the region, and humanity as a whole.

For the poor, the transaction costs of receiving healthcare are enormous. Accessibility and affordability come in the way of their wellbeing. Medical expenses for a child, mother, or father often consume savings; many families remain trapped in poverty for generations.

SELCO Foundation uses decentralised energy solutions to alleviate this crisis; it enables healthcare to be accessible to the poor, near their homes, in the most affordable manner from their perspective. For the end-user, the focus is on accessibility and affordability. For the government, it is about building systems that are reliable and cost-effective. We deliver services that should reduce the burden on the state while boosting the number and quality of services available to the end-users over time.

Currently, healthcare services are pushed upwards to the

overburdened district and city hospitals. We are bringing in innovations in technology and energy delivery systems to push affordable and efficient services back down to the last mile. Our Energy for Health (E4H) programme is not just about solar powering health centres; It's about rethinking healthcare delivery itself.

Technology and DRE allows us to accept that not all services require a brick-and-mortar space. With advancements in healthcare teleservices and the growing sophistication of communication technologies, the only few physical needs are a space for the delivery of a child, for instance. Let us imagine a scenario in 2035. What if a high-quality pop-up tent, powered by solar energy, is set up in front of a house a few days before a delivery? The tent includes everything from an incubator to a high-quality television, manned by a midwife. The television is connected to any specialist doctor in the world. Once the delivery is complete, the tent is dismantled and moved to the next location. Why should a woman have to walk even a kilometre to give birth?

SELCO Foundation takes the initial risk of piloting new models on the ground and showcasing their efficacy. This allows the governments to observe the interventions over a period of time and scale once they see impact. For instance, here in Meghalaya, we redesigned maternal labour rooms with solar energy. Once we demonstrated its success, the state government embraced the idea and scaled it.

Delivery of health services cannot take place in isolation. A high-quality baby warmer in a rural health centre is ineffective without trained personnel to operate it. Similarly, a trained healthcare worker cannot offer services if she / he / they does not have the

necessary technology or infrastructure. Our role is that of an ecosystem builder that brings together all the stakeholders — the governments, the policymakers, the implementers, the technology providers, and the systems.

One of the barriers is the time it takes to understand the social nuances in any geography. For example, trust plays a significant role in rural healthcare. If someone has had a negative experience with the healthcare system, she / he / they may not return to it. Certain beliefs or customs may conflict with modern healthcare practices. Some communities may be reluctant to allow a male doctor to attend to childbirth. Solar energy solutions are relatively simpler; designing an effective, culturally sensitive healthcare delivery system is far more complex.

Another deterrent is the perception that solar energy technology is complicated and difficult to maintain. In reality, it is far simpler than a mobile phone. Anyone interested in the technology in a village can easily repair it, just as many young people repair mobile phones in rural areas. So, we bring the right local ownership into play. When we install a solar energy infrastructure, we involve different community members — from, say, community health workers to the school principals to the village committee members to the community leaders. Once they understand why the energy infrastructure is being installed and how it works, they develop a sense of ownership and responsibility, and the energy system becomes part of the fabric of the community.

However, the biggest challenge we face today is not posed either by the end users or the government. It lies in the gaps within the systems we have inherited. Current models are designed with an assumption of abundant resources, which is simply not true of rural areas. In urban areas, innovative dental chairs have made it possible to provide dental care for free. The rural communities cannot access that technology because they have to travel for hours, sometimes days, to receive healthcare. The problem lies in the lack of innovations designed for resource-poor areas. Major global manufacturers have never considered adapting their products to resource-poor regions. Why can't a foldable, solar-powered dental chair be developed to be deployed in difficult-to-reach areas such as the forest hamlets in the Western Ghats?

Our journey thus far has been made possible through collaborations with health practitioners, philanthropies supporting equity and sustainability, enterprises working in far-flung geographies to install and maintain solar energy infrastructure at health facilities, and state governments without whose support no public health intervention can sustain and scale. The journey has also been inspired by the people we meet on the ground, like the Accredited Social Health Activists (ASHA). Many of them have been working for 20 to 25 years despite the innumerable challenges and frustrations that come with the job. Their work hours are long and unstructured. They almost never get vacations. They are from the communities they work for, so they have to be available for any health crisis or emergency. I have asked so many ASHAs why they continue to do what they do. Most of them say, 'It's a calling.' Come floods or cyclones, they stay committed because they believe in their work.

If we look at the history of technology, it is clear that tools and systems develop through iterations, with different players contributing their part. SELCO Foundation must serve only as a catalyst for transformation, not as the focal point. We must move beyond seeing any one institution as the sole creator of solutions; rather, view the process of bringing about impactful, sustained change as an innovation — one that can be built upon and made open-source. Our goal is not for people to think about how outstanding our work is. Instead, we want them to look at the problem we are solving and think, 'I can do better than that!' The aim is to make India a model for the two billion people in the Global South who don't have access to affordable healthcare. The goal is to show the world that it is possible to democratise health — that it is not just a privilege for the wealthy, but a right for all.

The Future is Lit

HUDA JAFFER

Director, SELCO Foundation

"Meghalaya has been unparalleled in terms of championing the cause we serve. It was the first state to showcase the efficacy of E4H models. Here, we see a lot of initiative in the top leadership and a lot of drive in the local governments to ensure that the state actually looks at sustainability and climate justice as a development mandate of the highest priority. At the time of going to print, in December 2024, all of Meghalaya's health centres would have been solar powered."

SELCO Foundation's Energy for Health (E4H) programme addresses the energy needs of India's last-mile health centres — Primary Health Centres (PHC), Sub Centres (SC), and Health and Wellness Centres (HWC) — with a special emphasis on the remote and difficult-to-access regions. Deep-diving into the energy and systemic gaps, we provide health centres with Decentralised Renewable Energy (DRE) systems or distributed solar energy infrastructure that not only enables them to become energy-sufficient, but also energy-efficient, more productive in the human aspect of healthcare delivery, and climate-resilient. We believe, designing DRE into the healthcare delivery system has become a no-brainer from the climate disaster perspective. We cannot have a health centre failing any time a calamity hits; in fact that is exactly the time when we cannot have it fail.

To roll out E4H, we chose certain regions very deliberately — the South, the East and the Northeast. While we play the role of technical knowledge partners in the rest of India, we chose the states based on three criteria:

- The difficulty of terrains and remotenesses;
- proneness to disasters such as floods and cyclones, droughts and earthquakes;
- and extremely rich cultural, linguistic, social, and ethnic diversity.

These regions perform poorly on the human development indices. The infant mortality rate and the maternal mortality rate is high and so is the disease load. They are developmentally backward areas. We felt we would really be able to develop champions, and processes and methodologies that can be a learning for people from anywhere in the world. It is here that they can truly understand what it takes to successfully deploy

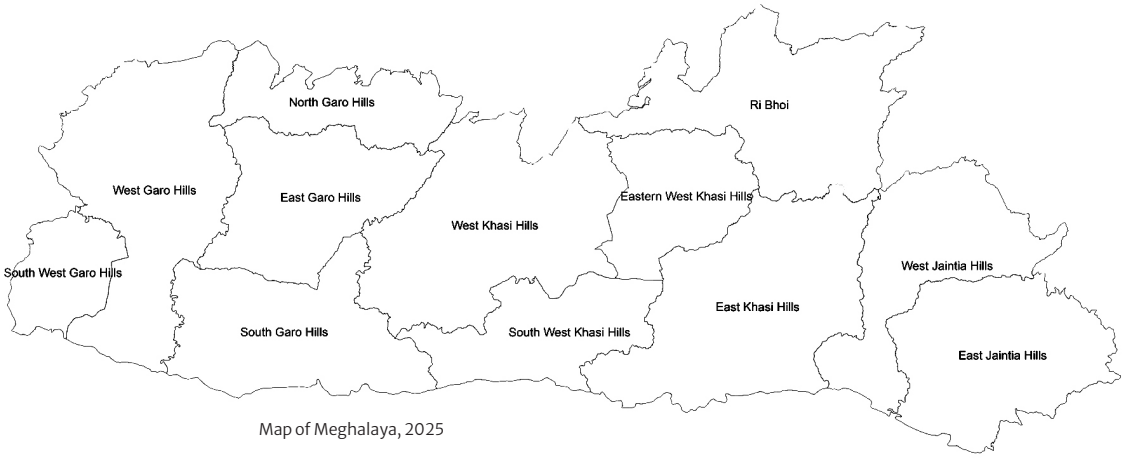
a DRE system, to own it, and to run it under the most challenging conditions.

Meghalaya has been unparalleled in terms of championing the cause we serve. It was the first state to showcase the efficacy of E4H models. Here, we see a lot of initiative in the top leadership and a lot of drive in the local governments to ensure that the state actually looks at sustainability and climate justice as a development mandate of the highest priority. At the time of going to print, in December 2024, all of Meghalaya's health centres would have been solar powered. DRE has become an integral part of the offering of its health system and the health infrastructure. The state already has a toll-free emergency response number for it. The health centres have begun to take ownership of the use and maintenance of the systems just like it does with its computers and medical equipment. In addition, the DRE systems have been designed to withstand Meghalaya's tough climate typology, which includes the most intense rains, cyclones, and lightning; the level of servicing and maintenance the health workers and the local governments have been able to offer makes it a model case study.

The priority of E4H is not to power every single facility and every last health centre as quickly as possible. It is to build DRE into the existing healthcare delivery and maintenance systems so that governments are able to own the programme and expand the systems on a need basis. Before installing the systems, we ensure that the health centre staff not only understands the entire concept and what it can do for them, they also run and maintain the systems and feel a sense of ownership. So, say, if a panel breaks or a charge controller stops working, decision makers and officials in the internal and local systems can decide how to fix it and how quickly. Only this kind of deeper engagement can ensure the sustenance of programmes such as E4H. However, we cannot depend on processes and systems alone. The investment in the local champions is equally critical. Whether it is a doctor, a teacher, a village elder, a night nurse, a district health officer, or a health secretary, when they see the true merit of E4H, they become invested in the programme, and turn into natural influencers and guardian angels.

Our DRE system batteries come with a warranty of five years as mandated by the Ministry of New and Renewable Energy (MNRE); if maintained very well, they run for about eight to ten years. Panels also come with a similar warranty, but they typically last about 20–25 years. So, capacity building for maintenance is a core focus area. It includes pre-installation, installation, and post-installation training for local enterprises and technicians. We cannot expect anyone to provide this service for free. So, we prioritise local enterprises with a good service network to install the systems, and the payment comes, and this is a systemic innovation, from untied funds with local Rogi Kalyan Samitis (RKS). These are patient welfare committees enabled by the NHM that act as trustees for hospitals and health centres. They are free to prescribe, generate, and use their funds as per their judgment for the smooth functioning and maintenance of services.

E4H DRE systems have a standard built-in autonomy of two to three days, but if we are implementing them in an area with very heavy rainfall or high cloud cover, we extend it to five to six days. If our systems can function well in Meghalaya's Cherrapunji (Sohra), one of the world's wettest places, then they can work anywhere. We have collaborated with the state governments to ensure that when they procure new equipment, like baby warmers, oxygen concentrators, and freezers, they acquire the most energy-efficient appliances available. This could potentially result in reduction in energy requirement by 60% to 80%, and therefore a reduction in the solar energy capacity needed for the smooth functioning of the health facilities, reducing the costs by 60-80% as well. For newer health centres, we have also been pushing for green building designs. When combined, these elements provide an energy-optimised, futuristic pathway for public health.



Map of Meghalaya, 2025

Meghalaya

The Energy for Health (E4H) Journey

2017

Pilots commence in association with Karuna Trust as a public-private partnership (PPP). Health centres are powered and equipped with energy-efficient medical technologies.

2020 - 2021

Initiation of partnership with the National Health Mission (NHM), Government of Meghalaya, and Sauramandala Foundation. E4H powers and strengthens maternal and child health and family welfare services delivery in 100 sub-centres.

2020

Babadam public health centre in West Garo Hills is upgraded in partnership with NGO Bakdil and inaugurated in the presence of a deputy commissioner and a state legislator.

Solar energy powers PPP-based health centres run by the Voluntary Health Association of Meghalaya and the Citizens Foundation.

In collaboration with the West Garo Hills deputy commissioner's office and the Sauramandala Foundation, six sub-centres in West Garo Hills are powered by solar energy and equipped with medical appliances.

2022

Coverage of Ri Bhoi and West Garo Hills districts complete.

2023

Partnership with the NHM scales to cover remaining sub-centres and primary health centres.

Partnership scales to design and construct 300 model sub-centres.

2024

Initiation of partnership with the Meghalaya government to design and upgrade over 2,000 anganwadis.

100% of health facilities are solar-powered.

At this juncture, we are working to power 25,000 health centres in 12 states by 2026-2027. The goal is not to do all of it ourselves. To ensure that the best possible DRE systems and synergies emerge, we will also leverage resources and work with public and private partners, while we play the role of a strong technical and knowledge advisory. The goal is to ensure that the learnings from this programme enrich and augment other programmes in India and also Africa because it has similar terrains and challenges. To think that India has taken the global leadership in the 'energy for health' sector both in terms of depth and scale is inspiring and enlightening. In the long run, we will similarly strengthen 100,000 health centres, and many more across the African subcontinent and the world, which the first 25,000 can influence, inspire, and transfer learnings to. This is just the beginning.

Those 25 Minutes of Solar Energy

BANDASHISHA DIENGDOH

Auxiliary Nurse Midwife (ANM)
Mawtawar Health and Wellness Centre
East Khasi Hills District,
Meghalaya

"A few months ago, a woman gave birth to her first child just before dawn. Because of a raging thunderstorm, there was a power cut, but the solar backup was on. The newborn was not crying; she needed intensive care. We called for an ambulance, which we knew would take some time to arrive. Meanwhile, we began the neonatal resuscitation process using the oxygen concentrator, the suction machine, and the radiant warmer. After a lengthy 25 minutes, she revived and started breastfeeding. As we turned the ambulance away because the parents no longer wanted to go to the hospital, I cannot convey how relieved we were that we had all the equipment at hand, running."


22.9
36.5

I have been an ANM for 18 years, the last eight of which I have served at this sub-centre in the quiet outskirts of Shillong. I live in the adjoining quarters with my family. The government creates these accommodations so that the health staff can be at hand for patients who need emergency care.

I primarily work for expectant women, new mothers, and babies and provide them with vaccinations, antenatal care, and family planning services. Nowadays, there is also a lot of focus on non-communicable diseases such as diabetes, hypertension, and cancer; I conduct screenings for these.

The sub-centre serves a population of approximately 12,600. We are not equipped to meet the needs of such a large population. The staff is overburdened. For slightly complicated tests, like blood grouping or hepatitis, we have to send the samples to the higher centres. We don't have a doctor; the mid-level health provider teleconsults with doctors on a case-to-case basis. However, for the villagers, we are the go-to place because the nearest referral hospital and primary health centre are about six kilometres away. Our outpatient department is open all week, from 9 am to 2 pm, and the centre operates 24/7 as far as emergencies are concerned.

Most days are cloudy, especially during the monsoons. In the winters, the days are shorter. The sub-centre does not receive enough natural light. Working during power cuts used to be extremely challenging. The situation would worsen at night, as the duration of the outages would increase. We had to rely on candles and torches to deliver babies and treat accident cases. Generally, two staff members manage the night shift. During rains and storms, the compound and the road outside would be pitch dark. We felt apprehensive about venturing outside or allowing anyone to enter without checking multiple times.

The solar infrastructure is nothing less than a blessing. It has resolved so many issues. We can charge our phones and laptops. We also have continuous WiFi connectivity, which is helpful for online reporting and video consultations. We don't feel unsafe, whatever the weather conditions or the time of night. The patients don't have to wait for services anymore.

At Mawtawar, we perform about 40 deliveries each year, and some of them are inevitably critical. A few months ago, a woman gave birth to her first child just before dawn. Because of a raging thunderstorm, there was a power cut, but the solar backup was on. The newborn was not crying; she needed intensive care. We called for an ambulance, which we knew would take some time to arrive. Meanwhile, we began the neonatal resuscitation process using the oxygen concentrator, the suction machine, and the radiant warmer. After a lengthy 25 minutes, she revived and started breastfeeding. As we turned the ambulance away because the parents no longer wanted to go to the hospital, I cannot convey how relieved we were that we had all the equipment at hand, running.

More Work, More Light

DERIFULLY MAWTHOH

Chowkidar
Mawlyngad Health and Wellness Centre
East Khasi Hills District,
Meghalaya

"Although my workload has increased since the installation of the solar infrastructure, I cannot begin to tell you how proud I feel. After all, this sub-centre is part of my legacy."

I became the chowkidar of this sub-centre five years ago, when my father passed away. He used to be the original chowkidar. My grandmother had donated this land to the Health Department. As an honorarium, the post of the chowkidar was given to my family to keep.

I come to work daily at 9 am, open the centre and begin by cleaning the premises. The security, maintenance, and the upkeep of the building and the compound rests with me. When the other staff members arrive by 10 am, I assist them with any tasks they assign me. The rest of the time, I remain at the entrance as a guard should. Once everyone leaves, usually by 3 pm, I clean the place again, lock up everything, and head back home, which is close by. If there are emergency cases at night, we may have to come back.

When I started this job, the centre had not been solar powered. We didn't conduct too many deliveries because the electricity supply was very unreliable. The number of outpatients was a little lower. So, my workload was significantly lighter. There were no batteries or radiant warmers to take care of, nor any solar panels to maintain. However, the change has been wonderful for my people, especially mothers and children.

Power cuts were an everyday nightmare for the staff. They had to deliver babies by candlelight and burn charcoal in portable stoves to keep the newborns warm. The arrival of solar energy makes it possible for them to use infant radiant warmers after every delivery. They can charge their phones and laptops for administrative work. They can use the photocopier and printer. They can see the patients in a brightly lit room.

I have learned how to clean the solar panels and refill the batteries with distilled water. The mid-level health provider, who is in charge, has received training in equipment maintenance, and she has taught me how to carry out these tasks. Sometimes, if I am not feeling well enough to climb the ladder, I ask my younger brother to clean the panels. Mostly, I can manage it by myself.

Although my workload has increased since the installation of the solar infrastructure, I cannot begin to tell you how proud I feel. After all, this sub-centre is part of my legacy.


MAWLYNGNGAD SUB CENTER
East Khasi Hills, Meghalaya
Constructed Under NHM for the Year 2019-2020

An Oasis of Light

EVAN MARBOH

Mid-Level Healthcare Provider (MLHP)
Syntung Health and Wellness Centre
East Khasi Hills District,
Meghalaya

"Dark and heavy clouds come and go all the time. As winter nears, daylight fades quickly too. After the outpatient hours, we often see children from the village gathering in the front yard to play, as this area is always well-lit. We think of solar power only as technology. Looking at the kids play, you might think differently."

In my short professional life, I have never worked in any facility that didn't have backup systems to deal with power cuts. Therefore, when I hear tales of sub-centres operating without solar power, I shudder to think how distressful those times must have been for patients and health workers.

If you look at the profile of our sub-centre, you will realise why electricity is critical at any given point in time. There are four of us here. I am the MLHP. There is an Auxiliary Nurse Midwife (ANM) and two support staff. We also have ten Accredited Social Health Activists (ASHA), who report to the centre, but their primary work is on the ground in the five villages we serve. Now, juxtapose our numbers with the population we care for: 4,800. Emergencies and deliveries are inevitable, occurring either daily or every other day. Or night. You can see for yourself how cloudy it gets all the time. Sometimes, we can't function without lights, even in the daytime. The rains are the norm, and the weather is cold. So, it is extremely risky to deliver babies without radiant warmers or treat patients with severe respiratory conditions without oxygen concentrators.

As an MLHP, I am trained to work autonomously. We are trained to diagnose and treat patients and provide preventive and promotive medications. Although our scope of work is narrower than that of a doctor, our cadre has been created to deal with the shortage of qualified medical doctors in rural areas. I supervise the emergency cases and the outpatient department and screen patients for communicable and non-communicable diseases. People are compelled to walk long distances for consultations because transportation services are inadequate and most settlements are far-off, even from each other. It would be unfair to turn them away because some equipment is not working due to a power cut.

We not only have solar infrastructure that ensures a constant electric supply; we also have all the critical care equipment that is compatible with the solar

infrastructure. The power backup not only keeps our phones charged, but also keeps our computers and Wi-Fi operational for paperwork and teleconsultations. It enables us to be a functional centre for emergencies 24/7.

Dark and heavy clouds come and go all the time. As winter nears, daylight fades quickly too. After the outpatient hours, we often see children from the village gathering in the front yard to play, as this area is always well-lit. We think of solar power only as technology. Looking at the kids play, you would think differently.

More Power to Us

FULGIDA DKHAR

Accredited Social Health Activist (ASHA)
Mawtawar Health and Wellness Centre
East Khasi Hills District,
Meghalaya

"I believe all public health facilities must have a mandatory solar power supply. It allows the health services to maintain their natural flow. Taking this idea a step further, I would argue that even an ASHA worker's house, which is like a mini health centre, requires round-the-clock electric supply so that we can keep our phones charged and our lights on for the next person who calls or turns up at our doorsteps."

In 2008, the village headman had persuaded me to become an ASHA worker as he felt I was a capable caregiver. The salary was only ₹50 a month, but the workload was light. All I had to do was visit every household, gather data on young children and expectant mothers, and conduct a few surveys. I would also advise people on vaccinations and checkups and accompany them to the sub-centre when required.

In 16 years, the workload of ASHA workers has more than doubled. The job requires us to be the first responders in many emergencies, particularly those related to maternal and neonatal health. The hour of the day does not matter. There are times I feel overwhelmed. However, I am unable to resign until I find a replacement, which is proving to be challenging as this job requires a strong inner calling. You have to truly want to serve the people. If the government increases the incentives for ASHA workers, not only will it benefit existing workers, it may also attract many more capable women to the cadre.

Working in the same place for a long time has its advantages. Many of the patients, such as expectant mothers who are due for delivery or parents with children in need of vaccinations, know me well enough to reach out directly. When I had started work, awareness about public healthcare services was low. Nowadays, pregnant women come to register themselves at the centre well within the first trimester. Patients with communicable diseases make it a point to finish their course of treatment. It is a wonder how many patients return for follow-ups without prompts. Last year, I collected a sputum sample from a mother with young children, suspecting she had tuberculosis. When she tested positive, she took the treatment very seriously and made a full recovery.

When the level of initiative among patients is so high, you cannot possibly respond with sub par services. However, with the sub-centre reeling under power cuts most of the time, ever so often we had to divert delivery, accident, and emergency cases to alternative facilities. Now people know we have solar power during power cuts, so they do not hesitate to come even at night. We are able to refrigerate the vaccinations. We provide timely medical support. In fact, local ASHA workers recommend this centre to any patient in need of teleconsultations with doctors because it has 24/7 WiFi too.

I believe all public health facilities must have a mandatory solar power supply. It allows the health services to maintain their natural flow. Taking this idea a step further, I would argue that even an ASHA worker's house, which is like a mini health centre, requires round-the-clock electric supply so that we can keep our phones charged and our lights on for the next person who calls or turns up at our doorsteps.

Picture Perfect

MONICA KHARKAMNI

Auxiliary Nurse Midwife (ANM)
Syntung Health and Wellness Centre
East Khasi Hills District,
Meghalaya

" Unlike urban and peri-urban areas, awareness levels in the villages are low. The Accredited Social Health Activists (ASHA) have to visit individual houses to bring babies and mothers to the centre for vaccinations and checkups. Many people refuse because they have not yet adapted to modern healthcare. It takes a lot to convince them. When they finally do come, if they find us delivering babies by candlelight and torches just like they do at home, they will not have any confidence in us."

This is my first rural posting; in fact, it's my third month here. Prior to this, I have worked in big city hospitals. I live with my daughter in the staff quarters; my husband works in the capital city of Shillong and visits us on the weekends. Syntung is a remote, rural area. It takes him three hours to get home. Even though the actual distance from the city is only 68 kilometres, and the roads are excellent, mountain travel always takes longer. Just a few minutes away lies the magnificent Wahrashi Falls — a very popular weekend picnic spot for tourists. But there are no reliable transport services or businesses to speak of, nor any shops, with the exception of a weekly market. Mobile connectivity is very weak, especially during heavy rains, which is a given since it's Meghalaya — the land of the clouds. The villagers are either marginal farmers or labourers. They have many children.

As an ANM, I attend to expectant women, new mothers, and infants. The birth rate in the area is high. This used to be a matter of concern because the power cuts are unrelenting, sometimes lasting for days during heavy rains. Many mothers gave birth at home due to the inability of their families to either get a network signal to call the ambulance services in time or find a cab to get to the nearest hospital. After the sub-centre's construction in 2020, some mothers began to come here for deliveries, but the lack of lights and basic delivery equipment during power cuts caused significant stress among the health staff. We were unable to insist that

patients visit the public health centre due to the high cost and frequent unavailability of taxi services. I regret having to refer a few patients to a private hospital due to our inability to relieve their pains because of power cuts.

Unlike urban and peri-urban areas, awareness levels in the villages are low. The Accredited Social Health Activists (ASHA) have to visit individual houses to bring babies and mothers to the centre for vaccinations and checkups. Many people refuse because they have not yet adapted to modern healthcare. It takes a lot to convince them.

When they finally do come, if they find us delivering babies by candlelight and torches just like they do at home, they will not have any confidence in us.

Powered with solar energy 24/7, we offer a much better quality of service. Whether it's the use of medical equipment, storage of medicines, preparation and uploading of reports, making calls, or even brewing a much-needed cup of tea, all of it is possible. Over time, small difficulties and disruptions can significantly impact work standards and staff morale. Patients suffer too. That is the space our gratitude comes from.

Just hours after the documentation team left, the power went out. The days had been filled with clouds, and the nights even more so. Suddenly, multiple delivery cases arrived. The mothers are safe, and the babies are in the radiant warmers, and I have enough charge on my

The Will to Climb

EBRINA WARLARPIH

Member, Mawlyngad Jan Arogya Samiti (JAS)
East Khasi Hills District,
Meghalaya

"The committee receives ₹50,000 in untied funds from the NHM annually to attend to unforeseen or minor requirements of the health centre. So far, we have spent this money on basic maintenance, wall painting, and tiling in the labour room. Today I have come to the sub-centre to discuss an important matter. The ladder we use here has disappeared. Therefore, the committee has purchased a new ladder."

I am a farmer and a mother of four. My husband and I grow cabbage, potatoes, peas, and some seasonal vegetables. Like us, most people here are small farmers; some work in stone quarries, and a few have office jobs.

I live less than five minutes away from this sub-centre. This is convenient because I am a member of the Jan Arogya Samiti (JAS) committee. JAS is a platform for community participation in the management and governance of healthcare services. We have 20 members. We report to the mid-level health provider of the sub-centre, and take guided action on health promotion activities on the ground. The committee receives ₹50,000 in untied funds from the NHM annually to attend to unforeseen or minor requirements of the health centre. So far, we have spent this money on basic maintenance, wall painting, and tiling in the labour room. Today I have come to the sub-centre to discuss an important matter. The ladder we use here has disappeared. Therefore, the committee has purchased a new ladder. It will be delivered shortly. The arrival of solar energy at the centre means a lot to the community, and maintenance of the panels is not possible without a ladder. We did not want any delays.

Since the formation of the committee, we have been able to hold monthly meetings and take several decisions related to specific requirements. This is crucial because we rely heavily on the services provided by the sub-centre. There was a time when mothers had to travel all the way to the Ganesh Das Hospital, about 25 kilometres away, to give birth. After the sub-centre was built, most mothers chose to come here, despite the challenges posed by power cuts. Families had to carry candles from home to light up the delivery table and light charcoal stoves to keep the newborns warm. Now that solar power is available, the health staff does not have to scramble to make things work; they have the mindspace to take care of each patient. We can switch on the infant radiant warmers at any time, eliminating the unhealthy practice of burning charcoal.

Then and Now

SNGURBHA MYNSONG

Postnatal Mother
Syntung Village
East Khasi Hills District,
Meghalaya

"I know there are bigger centres elsewhere, but this is where I find comfort. I gave birth to three of my children here, the last one under the glow of solar electricity. This was in 2023, exactly 20 years after I delivered my eldest at home."


NONGJRONG
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SPEED HUNTER

I was born in Syntung and have lived here all my life. Most of my people are farmers; we grow betel nuts, oranges, vegetables, strawberries, and broom grass. It's challenging for us to increase the crop yield as land holdings are small. We grow enough to feed our families. Some of us earn a small profit by selling strawberries and brooms.

The village has an adequate water supply. The roads are excellent too. However, transportation services are next to nil, and the electricity supply is very poor. Even mobile networks are weak. We have become used to it.

My husband and I are from the same village. We have been together for 25 years. We had ten children; two of them did not survive. I gave birth to my oldest in 2003, at home. Back then, there was no sub-centre in Syntung, and the primary health centre was 14 kilometres away, in Jatah. My second, third, fourth, and fifth children were also born at home. Occasionally, I did go to the Roberts Hospital in Shillong city for checkups and medications, but I preferred home deliveries. Fortunately, none of the births were long-drawn or complicated.

In 2020, the government built a sub-centre in the village. Since then, I have gone there for my deliveries. I know there are bigger centres elsewhere, but this is where I find comfort. I gave birth to three of my children here, the last one under the glow of solar electricity. This was in 2023, exactly 20 years after I delivered my eldest at home.

It is very helpful for the entire community to have a sub-centre in the village. We don't have to travel for health checkups. All the vaccines, medicines, and injections are readily available and securely stored, as the centre remains unaffected even in the event of a power outage. This also means healthcare is available for us in emergency situations.

The Baby Whisperer

MADIRA SYNJONE

Auxiliary Nurse Midwife (ANM)
Narang Health and Wellness Centre
Ri Bhoi District,
Meghalaya

"As an ANM, I cover 15 villages and one hamlet. A typical day includes attending to outpatients at the centre as well as visiting the villages to check in with expecting mothers. Home deliveries have become rare. Mothers want institutional deliveries. Our centre is new, fully equipped, and solar-powered. People are aware that we can deliver babies even during power cuts. Since the solar infrastructure has been activated, I have delivered 12 babies here, five of them at night."

In 29 years as an ANM, I have delivered hundreds of babies and continue to do so. For those who might not know, the government created the ANM cadre in 1950 to improve the condition of maternal and neonatal health in the country. The launch of the National Rural Health Mission in 2005 — 55 years later— recognised ANMs as essential frontline health workers.

I started working at this sub-centre in 1995. Back then, there was only one other staff — the chowkidar. The centre itself was a cramped, old building. The roads were terrible. Public transport was next to nil. Power outages lasted longer than the power supply. We could provide only the most basic medical services. Family members of women in labour would come to the centre to take me along. They came during heavy rains. They came without notice. They came late at night. I would walk anywhere between five and ten kilometres to deliver each baby; for night deliveries, I depended on small lamps and torches.

Currently, ANMs are required to strictly monitor all antenatal care (ANC) cases within their operational areas. In the 1990s, the system was not so structured. Once, a woman in advanced pregnancy had gone to Umling to get a traditional massage. She couldn't find any transportation for the return journey, so she took a shortcut through the forest. Halfway across, she went into labour. A few passersby who found her called me. It was Christmas, and I left the church in a rush. By that time, it was so late that I had to conduct the delivery in a safe spot in the forest, with the assistance of some nearby people.

Another day, a man came to find me at the centre because his wife was in labour. This was a woman who had a strong disbelief in modern medicine and actively avoided me. That day, I was experiencing such severe pain in my legs that I could barely walk. He transported her to the centre. By this time, she was in a critical stage. After the delivery, the woman's attitude toward me and public healthcare changed. She started coming to the centre with her baby for checkups and vaccine shots. Now, she brings her grandchildren. These are the kind of cases that prompted the Union Ministry of Health and Family Welfare to award me the National Florence Nightingale Award in 1999; it is conferred on nurses and nursing professionals in recognition of their transformational service.

As an ANM, I cover 15 villages and one hamlet. A typical day includes attending to outpatients at the centre as well as visiting the villages to check in with expecting mothers. Home deliveries have become rare. Mothers want institutional deliveries. Our centre is new, fully equipped, and solar-powered. People are aware that we can deliver babies even during power cuts. Since the solar infrastructure has been activated, I have delivered 12 babies here, five of them at night.

Long ago, a couple had come here to vaccinate their newborn. After decades, they brought their grandchildren for checkups. The new building and all its amenities left them in awe. Many people ask how we have electricity while they don't; then we explain to them all about solar power.

Uploading Change

OLIDIA NONGRUM

Mid-Level Healthcare Provider (MLHP)
Narang Health and Wellness Centre
Ri Bhoi District,
Meghalaya

"Most villages lack mobile connectivity. Often, we are unable to contact patients. This forces us to travel, which, in Narang, is a significant challenge. Another challenge is the mindset of the people: they are fearful and sceptical of modern medicines. Additionally, many mothers and babies do not come for antenatal checkups and even vaccination shots because the public transportation system is inadequate. Now that we have solar power infrastructure, we can concentrate on ways to offset these gaps. Earlier, most of our energy went into figuring out how to deal with patients during power cuts."

Narang is remote and also difficult to reach because the road network and transportation services are extremely poor. Power supply depends entirely on the weather conditions. Trees that fall in heavy rains and storms pull down electric lines; villages deal with outages that last three to four days at a stretch.

Our sub-centre covers 15 villages and a small hamlet. Their total population is 6,419. Apart from me, the staff comprises three auxiliary midwife nurses, a casual worker, a chowkidar, and a surveillance worker responsible for monitoring vector-borne diseases. We also have 15 Accredited Social Health Activists (ASHA) and 12 anganwadi (rural childcare centre) workers.

As an MLHP, it is my responsibility to support the staff and inform the villagers about the seven medical packages we offer related to immunisation, antenatal care, emergency care, and communicable and non-communicable diseases.

Most villages lack mobile connectivity. Often, we are unable to contact patients. This forces us to travel, which, in Narang, is a significant challenge. Another challenge is the mindset of the people: they are fearful and sceptical of modern medicines. Additionally, many mothers and babies do not come for antenatal checkups and even vaccination shots because the public transportation system is inadequate. Now that we have solar power infrastructure, we can concentrate on ways to offset these gaps. Earlier, most of our energy went into figuring out how to deal with patients during power cuts. I can remember several monsoon seasons, during which we had to run the centre without electricity for up to two weeks. Even in favourable weather, working without power for two to three hours a day was not unusual. Our administrative work includes online reporting on case files. Long power cuts would force us to sit until late at night, writing reports by candlelight. We couldn't print or copy anything. Computers and printers are operating now, and online reporting is almost always up-to-date.

Though we are not a 24-hour centre, we do operate round the clock for emergencies, many of which involve deliveries. It's such a relief to know that the radiant warmer, suction machine, oxygen concentrator, and spotlight are available whenever we need to use them. Additionally, when we are required to keep patients overnight, we can provide a light, a fan, and a bathroom with running water. For decades, we couldn't offer even these most basic facilities.

The Mother Who Asked for More

ONICA WANKHAR

Mid-Level Healthcare Provider (MLHP)
Mawlyngad Health and Wellness Centre
East Khasi Hills District,
Meghalaya

" At 2:30 am, I received a call from the family of a woman who was in labour. It was pouring. There was no electricity. The sub-centre was pitch-dark. I suggested they take her to the hospital. The woman refused. We only had one emergency light. Using that, a candle, and the torch on my phone, we delivered the baby. This behaviour is common among people here; they prefer to receive treatment from familiar faces. They trust us even more since the centre has 24/7 green energy."

Five years ago, I quit my posting at a district hospital in Assam to be able to work in my village; my house is literally ten minutes from the primary health centre. I love the job and my colleagues; we function well as a team. In addition to me, we have an auxiliary nurse midwife, a chowkidar, four Accredited Social Health Activists (ASHA), and six anganwadi (rural childcare centre) workers. Together, we work in six villages for a population of 3,788 people. On days when the weather is favourable, we receive between 25 and 30 patients. In inclement weather, the number decreases by nearly half. A workday may stretch to any number of hours if an emergency arises. In my free time, I cook and garden.

Most of the villagers are workers and labourers. They struggle to provide for their families and educate their children. Only a few people have white-collar jobs. The roads, public transport, and water supply are good. Power supply is yet another matter. To give you an example, this monsoon season we experienced power cuts that lasted up to seven hours a day. A few affluent houses have solar power, but most people have to use candles and old-style spirit lamps at home. Before our centre transitioned to solar power in 2023, we had to rely on battery-operated emergency lights.

Mawlyngad is a full-fledged primary health centre; four years ago it was only a sub-centre. At that time, our primary focus was on maternal and neonatal health, excluding deliveries. There were no services available for the elderly, nor were there screenings for non-communicable diseases (NCDs). Since 2020, we have provided 12 extended healthcare services, including NCDs, mental health, eyecare, and oral screenings. We offer family planning services and promote yoga

for general wellness. Most importantly, we conduct deliveries. 130 babies have been born at the centre. The rate of home births, which have the potential to be fatal, has reduced drastically.

I recall a night in 2022 when, at 2:30 am, I received a call from the family of a woman in labour. It was pouring. There was no electricity. The sub-centre was pitch-dark. I suggested they take her to the hospital. The woman refused. We only had one emergency light. Using that, a candle, and the torch on my phone, we delivered the baby. This behaviour is common among people here; they prefer to receive treatment from familiar faces. They trust us even more since the centre has 24/7 green energy.

When the centre switched to solar power, I was on leave. I returned to find a battery-powered spotlight, an infant radiant warmer, a suction machine, a medicine and equipment trolley, and a footstep for the labour table. I was told that the SELCO Foundation, responsible for installing the solar infrastructure, provided all these items to enhance the efficiency of our service delivery. I felt a profound sense of relief when I realised I wouldn't ever again have to ask families to bring charcoal stoves to warm a space for the newborn, which is clearly not advisable. After we conducted the first delivery using solar power, under the new spotlight, with shiny new equipment at my disposal, I was told by the patient that the centre looks as impressive as the delivery room in the district hospital.

A Warm Shift

OSIKA WANKHAR

Antenatal Care Patient
Mawlyngad
East Khasi Hills District,
Meghalaya

" By the time I gave birth to my fourth child, the centre had solar electricity. As usual, there was a power cut. But the availability of solar power made it possible for the staff to lay my baby in the radiant infant warmer. "


ORIGINAL SPORTSWEAR

I am a homemaker from Mawlyngad village. I am one of nine siblings. My father is no more. My mother lives close by. I have four children of my own, three girls and a boy.

I gave birth to my first child at Ganesh Das Hospital and my second child at home. My third and fourth children were delivered at this centre. During my third delivery, we had to bring a portable charcoal stove to be able to keep the newborn warm.

By the time I gave birth to my fourth child, the centre had solar electricity. As usual, there was a power cut. But the availability of backup power made it possible for the staff to lay my baby in the radiant infant warmer.

The medical service at the centre was always very good. The availability of solar power has made it excellent. These days, expectant mothers don't go to the hospital for deliveries. There is no need to do so. The staff at the centre is prompt, efficient, and very thorough. Their care of me and my babies continues to be excellent.

Light to Light

BATEMON RIAHTAM

Auxiliary Nurse Midwife (ANM)
Umsong Health and Wellness Centre
Ri Bhoi District,
Meghalaya

"I have seen a definite change in people's attitudes. Antenatal women hesitated to register at the centre; now a significant number of them turn up on their own. About five antenatal women use the Patharkhmah community health centre transit home near us every month. The impact is beginning to show in earnest."

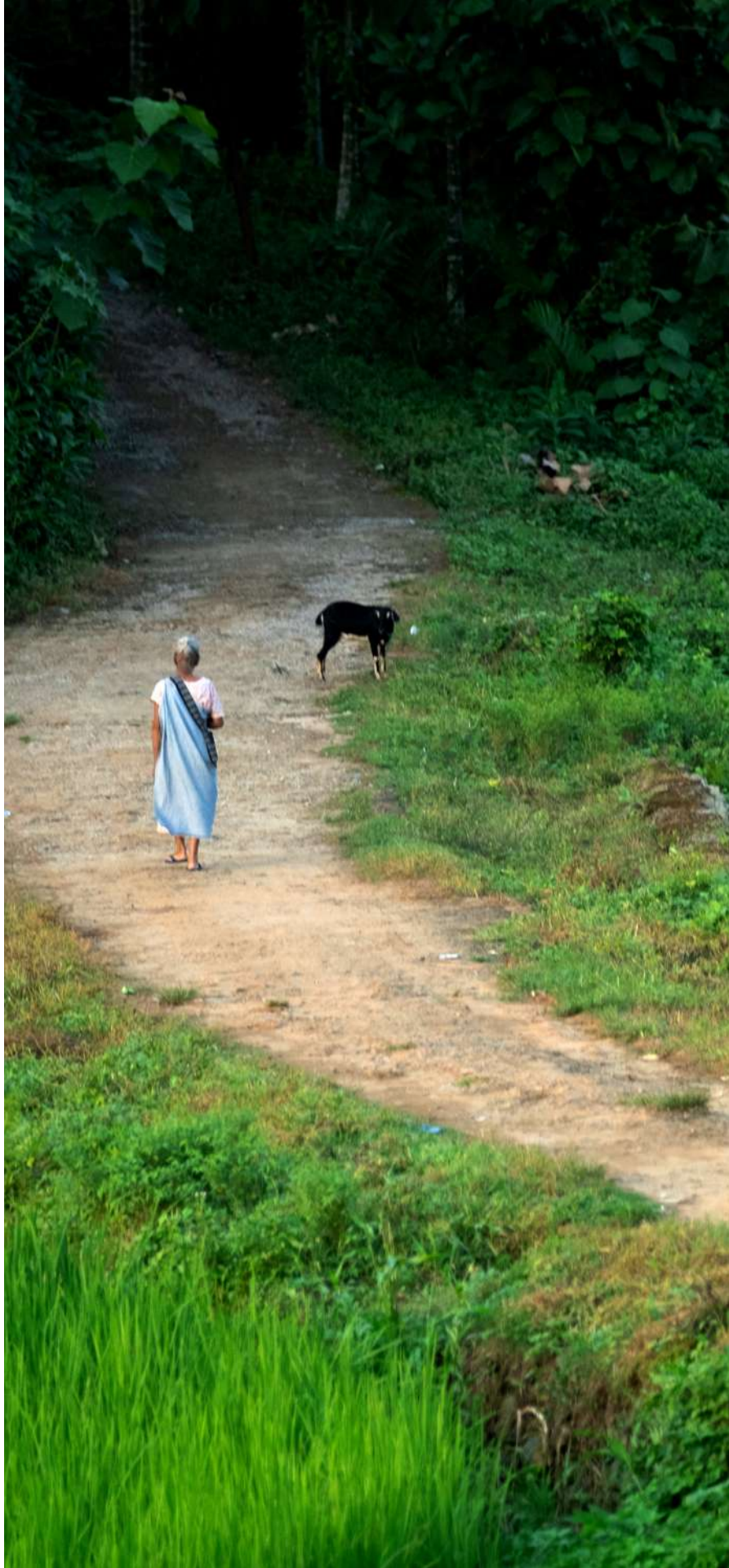
I live in the staff quarters of this sub-centre and, in a sense, take care of it round the clock because emergency cases may come in at any time. This is a 24/7 public health centre. We serve 10 villages, with a population of 5,750.

Mobile connectivity in Umsong is very poor. Since five of the villages under our care are situated in difficult-to-reach category areas, very often residents are unable to travel to us for consultations, medicines, vaccinations, or even deliveries without assistance. We try to provide as much logistical help as possible. We also co-opt some residents for surveys, data collection, and awareness drives on vaccinations, hygiene,

and institutional deliveries. Via these volunteers, we disseminate information about new schemes, like the Chief Minister Safe Motherhood Scheme (CMSMS), which is especially relevant to remote areas. Launched in 2022 to accelerate the reduction in maternal mortality, the scheme offers transit homes to antenatal women near health centres ten days before their due dates. It also offers ANMs mobility support to organise Village Health and Nutrition Days, on which we provide 100% antenatal checkups for all pregnant women.

For a long time, our quality of work suffered because of power cuts. Many of the machines at the centre, such as the baby warmer, the suction catheter, the oxygen concentrator, and the refrigerator, require electricity to operate. Naturally, conducting delivery cases without them, especially during power cuts at night, used to be extremely challenging. I recall the case of a woman who underwent prolonged labour and gave birth just before dawn broke. We had to manage those eight-nine hours and her actual delivery with mobile torches and candles. We swaddled the baby in three blankets because the infant radiant warmer was off. This was a success story. However, despite our best efforts to treat delivery and emergency cases locally, on many occasions we have been unable to manage them and have had to transfer them to referral hospitals.

By the time the CMSMS scheme was launched, the government and SELCO Foundation had already solar powered our center. I think the combination of the two worked. I have seen a definite change in people's attitudes. Antenatal women hesitated to register at the centre; now a significant number of them turn up on their own. About five antenatal women use the Patharkhmah community health centre transit home near us every month. The impact is beginning to show in earnest.



After Sunrise

EVAKORDOR MARNGAR

Mid-Level Healthcare Provider (MLHP)
Mawtawar Health and Wellness Centre
East Khasi Hills District,
Meghalaya

"One night a stormy downpour had triggered a massive power cut, but the lights at the centre were on. A couple drove in with their newborn. Prematurely born at a regional hospital, the baby had been discharged just a few days ago. Now, he was unable to breathe properly. We knew we had to rush him to a neonatal intensive care unit. As fate would have it, their car wouldn't start."

I opted out of working at the paediatric ICU at Neigrihms Hospital in Shillong to work in this rural posting. It is not uncommon for staff in public healthcare to move closer to home. Our work life is intense, so living near our families can be a source of comfort and support for us and our children. I have been working at this sub-centre for four years now, after having completed a six-month bridge course to serve in my current role.

The Mawtawar sub-centre attends to a population of 12,747 people in seven villages. Most of them are small and marginal farmers. In recent years, as people from other regions migrate to this area for work, we find our patient pool is becoming diverse.

Apart from me, the sub-centre staff comprises two auxiliary nurse midwives, one basic health worker, and one chowkidar. We maintain regular connections with the village anganwadis (rural childcare centres) and collaborate closely with seven Accredited Social Health Activists (ASHA) who offer on-ground support in the villages. The sub-centre reports to the Mawroh Primary Health Centre, which is 20 to 30 minutes by road. The roads are excellent, including the one that leads to Mawroh. The issue lies in our susceptibility to inclement weather, which leads to challenging travel conditions, high transport costs, unreliable grid electricity supply, and inconsistent mobile connectivity.

We receive a large number of outpatients suffering from non-communicable diseases such as hypertension and diabetes. As far as the children are concerned, the most common ailments are acute respiratory infections and acute gastroenteritis. Antenatal and delivery patients are also high in numbers, as are accident and injury cases. For efficiency, we need electricity at all times to run all the machines and equipment. At the very least, adequate lighting is crucial for deliveries, emergencies,

and escalation in respiratory conditions. These cases tend to arrive at night when power outages are routine.

For years, we have had to work without a power supply. Given the volume of delivery cases, they have been some of the hardest to manage. We would try to refer night delivery cases to hospitals, because conducting them in darkness, without electric infant warmers, is fraught with risks. However, many mothers would arrive in advanced stages of labour or would refuse to go elsewhere. We would then have to deliver the baby at the centre itself by emergency lights and torches. It may not sound scary, but these kinds of situations are a health staff's nightmare. The margin for error is negligible. I am so thankful that those days are behind us.

One night a stormy downpour had triggered a massive power cut, but the lights at the centre were on. A couple drove in with their newborn. Prematurely born at a regional hospital, the baby had been discharged just a few days ago. Now, he was unable to breathe properly. We knew we had to rush him to a neonatal intensive care unit. As fate would have it, their car wouldn't start. The couple was in tears. We didn't have a minute to lose. We powered up all the machines. Before the ambulance arrived, we had managed to stabilise the baby. Without the solar power supply, this case could have gone out of control very fast.

We are a 24-hour medical facility. Anyone can visit this centre at any time. The majority of the staff members are women, and we felt uneasy when someone walked in during the night and we couldn't see their faces in the dark. Those are concerns of the past. We have stepped into the light.

FOLLOWING THE SUN

A TRANSFORMATION IN MEGHALAYA'S PUBLIC HEALTHCARE, UPHOLDING SOCIAL EQUITY AND CLIMATE JUSTICE