

**NINTH CONFERENCE OF  
CENTRAL COUNCIL OF  
HEALTH & FAMILY WELFARE**

**Proceedings  
And  
Resolutions / Decisions Taken**

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**Government of India  
Ministry of Health and Family Welfare  
(Bureau of Planning)**



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# **INAUGURAL SESSION**

# **WELCOME ADDRESS BY SHRI NARESH DAYAL, SECRETARY (HEALTH AND FAMILY WELFARE)**

Hon'ble Union Minister of Health and Family Welfare, Dr. Anbumani Ramadoss, Hon'ble Health Ministers of the States, Hon'ble Ministers for Health Education of the States, Secretary AYUSH, Director General Health Services, Principal Secretaries of the States, colleagues from the Ministry and Ladies and Gentlemen :

First of all, let me extend a very warm welcome and thanks to all of you, particularly to the Ministers for Health and Health Education of the State Governments and of course, not the least, our Union Minister for Health and Family Welfare for his constant support and encouragement, because of which we have been able to organize this conference at a short notice.

This conference is taking place after a gap of four years, as was just mentioned. During this intervening period, many policy developments have taken place in the Health and Family Welfare sector. Though in this conference, we would have liked to have discussed many issues concerning Health, Family Welfare and AYUSH, the paucity of time has compelled us to take certain selected subjects in the agenda. This, however, is not to deter the distinguished participants from raising any of the other issues of policy or implementation which they would like to bring to the notice of the Ministry. We would like all of you to share your experiences to enable us to take forward the process of health reforms and build a robust health care delivery system which will cater to all sections of society across the entire country.

The health sector is on the threshold of a major architectural correction. I would like to briefly touch upon a few of the policy changes that have taken place in the health sector over the last four years so as to set the agenda for the meeting today rolling.

In line with the recommendations of the National Health Policy (2002), the National Common Minimum Programme of the UPA Government has accorded a higher priority for the health sector. It has listed as one of its objectives to enhance the level of public expenditure on Health from 0.9% of GDP in 2001 to the level of 2 to 3% of GDP by 2010. This in itself is quite a daunting task.

As you are aware, in the initial years of independent India, perhaps health did not get as much priority as it deserved. But now we realize that this is an area which needs much greater investment, particularly in the public sector. At the same time, our GDP is also growing at a very high rate of around 9%. So if you take the quantum jump which we are required to achieve in spending in the health sector, it is a very large task. As you know, health is a state subject and therefore all programmes in the health sector have to be implemented through the agencies of the State Governments. What becomes of utmost importance here is the absorptive capacity of the States to use all the funds that are now flowing to the States. And this is one of the issues which I

would like to highlight that there is no dearth of money, but this money has to be spent and spent well and in time and we would be able to give various tranches of releases of funds to the States only if we are able to get the utilization certificates and the statements of expenditure from the States. The Finance Ministry keeps a very tight rein on us there. Therefore we have to do this in order to be able to spend this money.

The National Rural Health Mission was launched in 2005 by the Hon'ble Prime Minister to provide accessible, affordable and quality health services to the poorest households in the remotest rural regions. Over the last two years, the Mission has made earnest efforts to put in place a fully functional decentralized health delivery system with inter- sectoral convergence at all levels to ensure simultaneous action under wide range of determinants of health, like water, sanitation, education, nutrition, social and gender equality. There will be a presentation on the operational aspects of NRHM and we look forward to an interesting debate on the subject.

The HIV AIDS has emerged as one of the detrimental communicable diseases in this country in this century. Responding to this immediate challenge, the National AIDS Control Organization (NACO) has articulated a clear and effective response to increase access to services and communicate effectively for behavioural change. The AIDS control programme accounts for about 10% of our national health budget. The efforts for strengthening AIDS control are to be achieved through a variety of means including greater involvement of NGOs, more widespread education and better health care facilities which will be discussed at length during the course of the discussions.

This year we have launched the NACP-III. Also this year, we had the results of the NFHS-III survey which was a household based survey. When the results of this survey came, the figures particularly about the prevalence of AIDS in our country were a surprise because the figures showed a much lower level of prevalence than was earlier thought of. The earlier figures were based on sentinel surveillance data. Now our sentinel surveillance sites, which we have also increased in large numbers and you will see that in the NACO presentation, were basically embedded in the higher risk groups. So data from sentinel surveillance tends to give a higher figure. At that time it was thought that our prevalence rate is about 0.9% and the total number of people affected by AIDS is about 5.52 million in our country. But when the results of the NFHS-III came, we put together experts from all across the world – from the WHO, from the World Bank, from CDS Atlanta, from the Imperial College in London. They all came here and we said, “Look at this data and you tell us what the correct figure is”. After moderating all the data, they came up with an agreed figure which has now been accepted by all the international agencies, that is that our level of prevalence is really not 0.9% but 0.36% and in total terms the figure has come down from 5.52 million to 2.46 million or so. It is partly due to statistics but also partly due to our efforts. Because particularly in some of the states where we had a higher prevalence, like Tamil Nadu and Maharashtra, we have made a significant dent and the goal of NACP-III is not only to arrest this epidemic but also to roll it back. With the decline in birth rate, increase in life expectancy and changing lifestyle, epidemiological transition is taking place resulting in increase in lifestyle disorders and non-communicable diseases, such as cardiovascular ailments, cancer, cataract, diabetes etc. In view of the chronic morbidity and high cost involved in the management of non-communicable diseases, attention is being focused on the prevention, early detection and appropriate management of diseases. The WHO figures show that whereas in the next ten years, there is going to be a reduction in the morbidity and mortality of communicable diseases to the extent of 15% in the country, the morbidity and mortality due to non-communicable chronic diseases is going to increase

by as much as 18%, for diabetes by as much as 35%. So we now have a double burden, a growing burden of chronic non-communicable diseases on one hand and communicable diseases on the other. Government cannot change its focus from the communicable diseases. It cannot change its focus from maternal and child health because we still have got to achieve our goals when it comes to IMR and MMR. But we also have to deal with this growing burden of chronic non-communicable diseases. And to a large extent, it is the advocacy of healthy lifestyles that we will have to emphasize on when it comes to government intervention in this area.

In order to reduce the gaps in the availability of tertiary health care hospitals and medical colleges in the states, the government has drawn up the Pradhan Mantri Swasth Suraksha Yojna for setting up 6 AIIMS like institutions and upgradation of 13 medical colleges in the country. The work relating to establishment of these institutions is in progress and these projects are to be completed in a couple of years.

The conference is expected to address critical issues relating to reproductive and child health programmes and various disease control programmes. Newer strategies have been planned and put in place in programmes of maternal and child health. Programmes like mental health, cancer and tobacco related issues are also receiving a further fillip during the 11<sup>th</sup> Plan.

The government has given approval for introducing the Clinical Establishments (Registration and Regulation) Bill, 2007. This has already been introduced in Parliament and is now under the scrutiny of our Standing Committee. This Bill is expected to provide for registration and regulation of all clinical establishments in the country with a view to provide minimum standards of facilities and services which may be provided by them. The provisions of the bill are applicable to all clinical establishments, including diagnostic centres, not only in the private sector but also in the government sector, except for the military establishments.

The framework for implementation of the National Rural Health Mission (NRHM) categorically states that the NRHM would seek to empower the Panchayati raj institutions at each level to take leadership to control and manage public health infrastructure at district and sub-district levels. The approved delegation of administrative and financial powers under the NRHM mandates transfer of funds, functions and functionaries at various levels of the health system under the PRI setup. State is taking appropriate measures for progressive decentralization of powers and responsibilities for achieving better outcomes. But the pace of these measures needs to be speeded up in order to keep pace with the manner in which the devolution of funds and responsibilities has been envisaged under the Mission.

Today, we have gathered here to have the benefit of your advice and guidance how we strengthen the mechanism, how do we see that these programmes are implemented better. We look forward to a healthy and interesting debate today in the entire area of Health, Family Welfare and Ayush. With these words, I once again extend a very warm welcome to all of you and look forward to your valuable guidance. Thank you very much.

# **PRESIDENTIAL ADDRESS BY DR. ANBUMANI RAMADOSS HON'BLE UNION MINISTER OF HEALTH AND FAMILY WELFARE**

My esteemed colleagues, the Hon'ble Ministers from different States of India, Hon'ble Members of the Central Council for Health and Family Welfare, Hon'ble Member of Parliament and my very good friend, Shri Lalit Kishore Chaturvediji, Secretary Health and Family Welfare, Government of India, Secretary AYUSH, Government of India, Director General of Health Services, Additional Secretary, officers from the Central Government, officers from the State Governments, my other esteemed colleagues, friends, ladies and gentlemen:

I wish you all a very warm morning and I am very happy to be here on the occasion of the 9<sup>th</sup> Conference of the Central Council for Health and Family Welfare. On behalf of the Health Ministry, Government of India, I would like to specially and very warmly welcome everyone for attending this 9<sup>th</sup> Conference.

I would also at this point of time like to apologize for not holding this meeting in the last few years for reasons which I am not able to explain to you now, but then I promise you that the next meeting will be held within the first quarter of next year where it is going to be a two-day more structured meeting and you are going to be informed much earlier and where all the issues are going to be discussed. Today due to lack of time, since it is a one-day meeting, we have given a list of agenda to be discussed. My only appeal to all my colleagues from the States, who are doing very well as responsibility of the health sector lies on them, is, please increase your budget allocation. Please fight with your hon'ble Chief Minister for more budgetary allocation. That is my only humble appeal to you all.

In the early nineties, the percentage of health spending in the States was about 7.5% of the total budget. In the early 2000, it came down to 5.5%. Now it is hovering around 5%. Definitely a lot more needs to be done on that sector. I appeal to you again to fight with your Chief Minister to increase your budget to minimum 8 to 9% of the total budget. That is the only way in which the health sector in India could improve. I have been fighting with my Prime Minister. In fact, when I took over three and a half years ago, my budget was about Rs. 6400 crores. Today in just three years, it has increased to Rs. 15,800 crores. See the intention of the Government of India. Likewise my esteemed colleagues, Hon. Ministers, I am sure, you could do a lot more.

The three sectors which need a lot of focus in our country are –Health, Education and Agriculture. As leaders from the states with responsibilities of the health sector, I am sure all the characters are imbibed in you to have more allocation.

Like my Secretary has said, the public health spending of total GDP was only about 0.9%. When I say 'public', it is both the Central and the State governments. Now, it may have increased to about 1.1% which is definitely not enough. Our goal is to achieve minimum of 2% of total GDP by 2010, which definitely is achievable.

There are a number of programmes which have been happening in the last 3 years, and there are a number of programmes which we have scheduled to happen in the future. On top of that, I am sure all of you by now must have been accustomed to the National Rural Health Mission, the flagship programme of the UPA Government. In this programme, it took my officers and your officers nearly 10 months to work out this programme. In fact, our officers had sleepless nights to work out for the success of this programme and my Prime Minister launched this programme on April 12, 2005. It is nearly two and a half years since then and this programme which, I could say, is the biggest programme ever in India's health sector, is doing wonderfully well because of all your participation and keen support.

This is a huge golden opportunity for you all to take up because there has not been a programme like this in the health sector where there is so much of flexibility. I would say, the success of this National Rural Health Mission is in its flexibility in different states. Due to this flexibility, different states have come out with innovative schemes and programmes, which in fact the Central Government is trying to adopt. There have been numerous states, I don't have time to mention all these. Earlier, we were thinking of better performing states, medium performing states, and the lower performing states. But now we see there has been a surge of activities in all the states put together and I am sure with your collective leadership and participation, we are definitely going to achieve our goal of reducing infant mortality rate to about 30 per thousand live births by 2010 and maternal mortality, today it is nearly 301 per hundred thousand live births, and we have to reduce it to nearly about 100 per hundred thousand live births, and of course the very important problem of the country is the population explosion. There the total fertility rate today is about 2.9, where our target is about 2.1, by, again, 2010. These are some of the things where NRHM focuses on and also the disease burden, and of course increasing the nutrition and increasing the drinking water and sanitation prospects.

I would not like to go in depth into the National Rural Health Mission because we have the main presentation yet to happen after this inaugural session. But I would like to say that today in India, nearly about 5 lakh 30 thousand Accredited Social and Health Activists (ASHAs) and link workers have been put in place which has never happened in any country in the world. We are even thinking of having an additional one, remuneration and all these things we are trying to sort out within ourselves according to the budgetary constraints we have.

Another opportunity for you all is the Village Health and Sanitation Committee. We have about 620,000 villages where till date we have nearly 1 lakh 70 thousand village health and Sanitation Committees put in place. These Committees are one of the most important components of any progress of a state. We are giving Rs. 10,000 to each committee for each year which in fact is a lot of money. In fact, Kerala has used this money last year for the chickengonea outbreak, which has been very successfully countered by the Government of Kerala.

As all of you know, all the health centres in India are being upgraded right from the sub-centres. We have about 146,000 sub-centres. All of them are being upgraded. In fact we have given you one more ANM and we are giving Rs. 25,000 a year untied funds so that this money could be used to purchase essential medicines and other components. In fact, with this money, a lot

of Centres have now bought their BP apparatus, thermometers or stethoscope. They have upgraded so much of facilities. First time it is happening.

Even in empowering ASHAs, in some states you could buy bicycles for ASHAs, you could buy a transistor, a radio for an ASHA. Some of the states are already giving a transistor where in the evening from about 7 to 7-30 every day, seven days a week or may be five days a week, ASHA News by All India Radio has been going out and messages for ASHAs have been put. So a lot of innovations have come from different states. In fact, it is both ways. We are also learning from the States' innovations. Not only we, but you also as peers could learn more from them through discussions.

There are about 23,500 Primary Health Centres in India. All of them are being upgraded. In fact, our target is that in another two years, out of these 23,000 odd PHCs, nearly 10,000 should be FRUs (First Referral Units) by next year and our target is that by 2010 all these PHCs should be working 24 x7 with all these equipment and handling. Till date, nearly 8000 PHCs are working 24 x 7 by your participation. In fact, we are giving you two more nurses per PHC on contract basis. So we are augmenting a lot of manpower for you.

Coming to the Community Health Centre which is again a very, very vital link in the health sector, we are upgrading all the centres. According to the Programme Implementation Plans (PIPs) of all different states and different districts, we are augmenting and increasing the budget for your requirements. There are about 3900 CHCs in our country, and we have planned to upgrade all of them to provide blood storage capacity, modernize the operation theatres, and modernize the labour rooms, build quarters and giving a lot of other facilities like the main component of recruitment of specialists. Before this National Rural Health Mission, the total number of specialists all over the country in the rural areas was only about 3300 or 3400. Today it has increased to nearly 7000 or 7200 in a span of one and a half years. What has not been happening in 60 years, we have, due to your participation, changed the scenario just in about two years, which is something which is going to go a long way.

Under the Janani Suraksha Yojna, I am sure all the states are doing very well. In fact two years back there were about 6 lakh beneficiaries of institutional deliveries. In just one year, it increased to 28 lakhs. Imagine from 6 lakhs to just 28 lakhs, was the increase in the number of JSY beneficiaries which is unprecedented anywhere in the world because of your commitment and your participation.

For Rogi Kalyan Samitis, of course, which again is a golden opportunity for you all, we are giving you funds. For district Rogi Kalyan Samiti we are giving you 5 lakh rupees, for the CHC Rogi Kalyan Samiti about 2 lakh rupees, for PHC we are giving Rs. 75,000, doctors, or bill components or anything, we have given you norms of how to do this, and there has been a tremendous response throughout. Because this is entirely community participation of all our programmes. Of course, we are again modernizing all the district headquarter hospitals, especially in the North East of India, nearly all facilities are being given and maybe in a year's time, all are going to be spankingly new, having the latest technology, latest equipment and facilities.

Also the mobile medical units, lot of state governments have done a lot of innovative schemes on these mobile medical units and in due course of time we are thinking of giving one mobile medical unit to each block. Today it is to each one district, we are planning to give it to each block also.

The next is the disease control programme. Whenever people talk of India, they say, in India you have all the diseases under the sky. It is time that people don't talk like this again any more, so that we have to eradicate and eliminate each disease. We have been able to eliminate small pox and guinea worm and we are on the verge of eliminating Polio which again is a huge, huge problem for us. World over, wherever I go people say, India is one of the few countries which have polio. India, Pakistan, Afghanistan and Nigeria, these are the only four countries in the world which have endemic polio. Other countries have eliminated and eradicated polio. We are spending nearly Rs.1300 crores on eradicating or trying to eliminate polio. With this money, you can imagine what progress we could do; if we do away with polio, we could use lot of this money for other schemes. When I say Rs.1300 crores this year, this comprises nearly seven of my national programmes, the money that we spend on one programme i.e. Polio. And polio is mostly in Uttar Pradesh and Bihar. It is time we do away with polio and use this money wisely on so many other schemes which have been lacking in funding.

Coming to Communicable diseases, we are going through a transformation from communicable to non-communicable. The World Health Organization has been saying to us that India is now going through a transformation where today we have problems of Tuberculosis, Malaria, HIV AIDS (which are the three main problems). Again, WHO has been warning saying that in future India is going to face cardiovascular problems, diabetes problems, strokes problems, mental health disorders, cancer and of course a holistic component of senior citizens because life expectancy is increasing in India. Today it is about 64. It is going to go to 75 in 15-20 years. So there are going to be a lot of senior people around and we have to focus on these issues which they are involved in.

Coming again to the disease control programme, time and again I have been saying, in fact at my ministerial level, that there are a couple of programmes which are doing fairly well, there have been a couple of programmes which are doing okay, there have been some programmes on which I am not satisfied personally. Out of the programmes doing well, one of the main programme is blindness control programme which is doing very well all across the country where, in fact, we have exceeded the target. We had targeted nearly about 46 lakh cataract surgeries, but this year we have done nearly 52 lakh cataract surgeries, which is the highest in the world anywhere. In fact, our target of reducing the blindness prevalence, today it is about 1.1%, by 2010 our target is to bring it down to 0.8%, by 2020 to 0.3%. We are well on target to that.

The TB control programme is doing wonderfully well. We have been getting a lot of appreciation nationally and globally also for this programme. This TB control programme is the largest public health programme in the entire world. Here has been a lot of participation. The entire country has been covered by this programme and our success rate, from 26%, it has gone to nearly 86%, our death rate from 29% has come down to less than 4% and the detection rate has gone up to 75% today. Globally it is only 70%. We have been doing well on that and we need more of your participation because in the future, we foresee multi-drug resistance tuberculosis and extreme drug resistance tuberculosis (HDR, MDR, SDR) which again we shouldn't allow India to become resting place of these issues. We have to tackle that, because it is better that sooner we tackle the normal course, otherwise we will be having the problems of HDR and MDR.

Coming to the Leprosy programme, India has eliminated leprosy in December 2005. The prevalence has come down to below 1 per 10,000 population. But even though India has eliminated, for eradicating leprosy we are about 20-25 years away. We should not be complacent on this and we have to go all out to tackle this problem.

HIV AIDS, as Secretary Health has said, we have been doing well. Some states have been doing wonderfully well, some states are doing okay. But on the whole we have been doing well and I foresee that maybe in two to three years, India will say that HIV AIDS in India has been declining. In fact, in states like Tamil Nadu, in the last 3 years, there has been a glaring decline in HIV AIDS due to the participation and if Tamil Nadu could do, I am sure all other states could follow that example and do that likewise. It has been a huge issue in Andhra Pradesh, Karnataka, Maharashtra, in the North East, Manipur, Nagaland. We are really concerned about Manipur and Nagaland, because initially, it was due to drug usage but now it has come to the general population through sexual route. Also we are trying to warn states like Punjab, Chandigarh, Delhi and Bangalore on the usage of drug pattern by young adults among whom there has been a rampant increase in drug usage.

Coming to the Vector borne disease control programme, this is again a programme on which I am also not satisfied both nationally as well as in the state sector. The programme concerns with Malaria, Filariasis, Kala Azar, Japanese Encephalitis, we have the new problem of Dengue and Chickengunea, which has come after 32 years, we have an outbreak in India which we weren't prepared for. When you say Malaria, almost all the states in the country are affected by malaria. We have a long, long way to go to eradicate it. I have been asking my officers to find me some quick fix solution, a quick fix solution and a long term one, but it is not only an issue of health sector, it is an issue of planning, an issue of sanitation, hygiene. That is why precisely this Village Health and Sanitation Committee, if all the Health Ministers make sure that these committees are set up in all the states in all the villages, I am sure we could do with a lot of factors and if some of the states succeed in this model of village health and sanitation committee, we will be willing to give additional funds to the village health and sanitation committee for other activities – for activities of nutrition. These committees could be used for nutrition, anemia, de-worming and a lot of other activities. They could be empowered because they are imbibed into the community and they are represented by the village headman, by the Self-Help Groups, the Ladies, the ANMs, ASHAs, Anganwadi workers, all are part of this committee. So it is an opportunity for you and we don't want people to say that India is an endemic country for malaria, filariasis. In fact, for filariasis this year the Mass Drug Administration, I think November 16-17, it is going to happen. In the next mass administration, we are going to give Hetrozen plus Albendozol, it is a combination of DEC plus Albendozol, for de-worming, one of the main reasons for anemia, is happening. We are trying to change it.

Only four states in India have Kala-azar, with only 52 districts. We are just at the end of it. These states are Bihar, Uttar Pradesh (eastern Uttar Pradesh), West Bengal and Jharkhand. We have come to the end of it. We have new drugs, new diagnostic RK39 kits and we have paramumycin and a lot of newer drugs coming, Amphotacin also we have an oral one which is just doing trial and I am sure within about a year or two when we have an intense focus, now we have revived the kala-azar programme focusing on blocks, focusing on villages, we can do away with kala-azar.

Coming to the Non-Communicable diseases, I would say on blindness, we have been doing well. Cancer control is something on which we have a long, long way to go. In India we have nearly 1 million new cancer cases every year. Imagine 10 lakh people are affected by cancer every year! These are the known cases. There are so many cases which we don't know and they die like that without knowing. At some point of time, we have 25 lakh cases of cancer. We don't have much infrastructure, we don't have awareness concepts and I urge upon my colleagues here to play a vital role because the cancer control programme will go out of control if we do not control

cancer. In fact, in this the situation in the North East has been very, very alarming. So we are trying to set up more facilities. In the 10<sup>th</sup> Plan, the allocation for Cancer control was only about Rs. 280 crores. In the 11<sup>th</sup> Plan, I fought out with the Planning Commission and Prime Minister and Finance Minister so that we are now getting an allocation of about Rs. 2500 crores. From Rs. 280 crores to Rs. 2500 crores in the 11<sup>th</sup> Plan, where we are going to set up lot of state of art infrastructure. But early detection and awareness is the important concept, going to the rural areas, going to the community. There is a lot of competition in the Cancer control programme in which we are trying to assist the states.

Another programme which has not been doing well is the Mental Health diseases programme. In fact, in India there have been a lot of problems on mental health. In fact nearly 7.5% of the people are affected by some sort of mental health disorder. When I say 7.5%, it is stress or depression. Anybody could go through these disorders but then nearly 1.5% of people have severe disorders like scyzhophrenia. This is neither accepted by the community nor the government at any point. We are trying to have a modified Mental Health disease control programme. Today we have 100 districts, in the modified programme, 500 districts are going to be covered. We are going to train them in the use of ordinary essential medicines to treat Mental Health disorder. We are going to have these in the PHCs. Doctors are going to be trained for about 3 to 6 months so that 60% of the disorders could be addressed at that primary level itself.

We are starting two new programmes – the National programme on Control of Diabetes, Cardiovascular Diseases and Strokes and the second National programme on Speech and Hearing. These two programmes are very, very important programmes and as and when we have these launched and expanded throughout the states, I need your keen participation. My Secretary has already said that today because of the burden of diseases, India has lost 6 billion US dollars worth of revenue in the last three years because of the cardiovascular diseases. Imagine 6 billion US dollars, and people say that by 2015 or maybe 2017, we are going to lose out 200 billion US dollars because of cardiovascular diseases. If we don't tackle this problem of loss of productive days and awareness of treating and operations, it is going to be highly expensive component. So a massive programme with your participation and involvement needs to be initiated on cardiovascular diseases and diabetes because India today is the diabetic capital of the world. India has the most diabetic patients in the entire world. India has the second most cardiovascular patients. India has the second most hypertension patients. India has the second most obesity people and childhood obesity and childhood diabetes, juvenile diabetes, gestational diabetes that women have during pregnancy. So all these problems will be addressed in this new programme and I want your keen participation so that this will go a long way into strengthening our country and giving more resources to our country.

Coming to Medical Education, I have been getting a lot of representations from my colleagues. This sector needs a lot of revival and a lot of transformation which we are trying to do. The problem is we have about 264 medical colleges. Out of that, nearly 137 are in the government sector. The rest are in the private sector. But the problem is, out of these 260 odd colleges about 170 colleges are only in six states—Tamil Nadu, Kerala, Karnataka, Andhra Pradesh, Maharashtra and Gujarat, and of course including Pondicherry. And the rest of the country has about 80 or 90 colleges. Population wise it is just nothing. So I want you to exert pressure your Chief Minister to set apart more budgets for these colleges. That is the only way your health sector is going to improve. The state of Uttar Pradesh is having a population of about 18 crores, but it is having only 12 or 13 medical colleges. This is definitely not enough. Uttar Pradesh needs 50 medical colleges. Bihar with

a population of nearly 11 crores is having only 8 medical colleges. It needs nearly 30-40 medical colleges. So I want you to start a lot of these colleges and that is why we are trying to change the regulations of Medical Council also to make it simpler for these high focused NRHM states and of course the North-Eastern part of the country. Even though we are trying to decrease the criteria keeping the quality and standards in mind, but then we want you to start. In fact we have been thinking of all your district headquarter hospitals having 300 or 400 beds with about 25 acres of land, so that you start a college on PPP (Public-Private Partnership) model wherein you could ask some private sector to invest money and take over that hospital and then have a 50:50 sharing or whatever of the students. There are some models like that. After going through the amendments to the regulations in due course of time, we are going to have them. There are a lot of things like that. Then we are trying to decrease the professor: student ratio for PG, not for the UG, but for the PG so that pre-clinical you will be having more students and more professors. Because this problem of health human resources in the future is going to be one of the biggest problems in India. The population is more than a billion. In fact, in the last census the population was about 102 crores. Today the population is about 111 crores. Imagine 111 crores of population in India! India has one-sixth of the world population and we have only 2.4% of the world's land. It is a huge problem and this population I want you to focus in a big way. There hasn't been much of a focus. I want you to take up this issue.

Coming back to health human resources. nurses, I am sure a lot of your states could start more nursing colleges. It is easier to start nursing colleges than medical college. Each of your district headquarter hospital should have a nursing college. We are giving you money, we are assisting you with money, in fact in the North East we are giving you hundred per cent money to build a new state of art nursing college, produce lot more nurses. India needs about 1.5 million nurses. We have only about 1 million nurses. We have nearly 700 thousand modern system doctors. We have nearly 600 thousand Indian system of medicine doctors. We need nearly 4 lakh more because the Indian system of medicine is our own system. Our forefathers imbibed and brought this system and we are trying to propagate the system. Our Ayurveda, Siddha, Unani traditional systems of medicine, Homeopathy—across the world these systems have been accepted. America has accepted this, Canada has accepted, UK, Germany and France have accepted it, Chile, Argentina, Australia, and everybody has accepted this system. It is such a cost effective system. I want you to take up this project. I could say that today Kerala and Tamil Nadu are one of the best states in the health sector. It is not because I am coming from Tamil Nadu, but it is a fact. Kerala has the best indices in India of infant mortality, maternal mortality, because of the literacy. In Tamil Nadu, 98 per cent of deliveries are institutional deliveries. It is because of infrastructure. Nothing prevents you, all the other states, from following that example and getting the infrastructure. We are giving you what you want. Out of my budget of Rs. 15,800 crores, nearly Rs.12,000 crores are being spent on the NRHM. This is a golden opportunity which hasn't happened all these 60 years. I want you to take up this and plan out your health human resources, start a lot of nursing colleges, start a lot of GNM schools, start a lot of medical colleges in your State, dental colleges and for Indian system doctors. The doctor: patient ratio in our country in the modern system is about 1 doctor per 1700 people. Developed countries have nearly 300 people for 1 doctor. We have 1700 people for 1 doctor. In the Indian system, we have again 700 people for 1 doctor, which is again a long, long way to go.

Another issue which is very, very concerning because any international forum I go, I put my head down in shame—is the issue of declining sex ratio. This is one very, very important issue which we have not been addressing. I want my colleagues from the States to play a very, very active, very participatory role, in fact do a leadership role in this. Today the sex ratio in our country is declining. Today chronically we are progressing. We have 9.4% growth in IT sector, biotechnology sector, pharmaceutical sector and all those sectors. But on the other side we say that the sex ratio is declining. I am ashamed because of declining sex ratio when you say 929 per thousand boys. In Punjab, it is nearly 800 and odd. In one district in Punjab, Fatehgarh, it is 740 or 750. In Haryana, in Delhi, in fact in South Delhi, in Gujarat, it is declining. I want to tell my colleagues here, whatever assistance you want, whatever money, whatever financial resources you want, please we are there to support you and help you out. This is not only my problem, not only your problem, it is India's problem. And this is not only a health problem, it is a social problem. So involve the social sector, involve the NGOs, involve the religious leaders, involve the community. Everybody should play a major role. You are the leader, you have to lead. When you go back, each should immediately sit with your officers and please sort out this issue.

Coming to Drugs and Food Safety and Standards, in India again there have been a lot of issues on drugs, on their efficacy, on the spurious drugs, on the substandard drugs, on the fake drugs in the market. When somebody says that India has 30% of Indian manufactured drugs are spurious or fake and all that, it is definitely not true. I want you to sit with your regulatory authority, take it up and clean up the whole mess, put out signals, have more drug inspectors involved, have more regulatory mechanism put in place. Recently there have been issues of fixed drug combination, the State Governments giving permission just like that which we are not even aware of. So I think we need to streamline this process because of the system that we have. We are doing that National Drug Authority, we are reviving it. It is a long pending demand and we are spending nearly 400 crores of rupees on capacity building of all the drugs and food labs. All the State Government labs and Central Government drugs and food labs, we are modernizing, training your people, training your drug inspectors, giving a lot of modern inputs into the structure. Of course, food structure also, we have now set up under a new bill, Food Safety Standards Authority, a Food Commissioner. So we are trying to professionalize the entire sector. Only professionals will be there in those bodies and I want your participation and support. In fact, the Codex Alimentarius harmonization globally, we are moving forward on that. The Secretary has already said about the Pradhan Mantri Swasth Suraksha Yojna where there will be 6 new AIIMS like institutions and we are upgrading about 13 other institutions, all across the country. I am sure all the states will have at least one institution in the state being upgraded. In fact, the construction work on the six new AIIMS like institutions will be starting in end of December or early January and it will take about 3 years for it to be completed. Again we are trying to have a second series of upgradations. Some of the states have been left out, some difficult states need more also. So we are trying to consider those activities also.

Tobacco programme again is something in which I want your participation because we have a national Act but then I am not satisfied with the enforcement activities on tobacco, when we say that 40% of India's problem is due to tobacco in the health sector. Imagine 40% of India's health sector problem is due to tobacco. It is not only due to cancer, diabetes, cardiovascular diseases, brain, deformities, abortions, passive smoking, children and so many activities like that. So we are trying to take a lot of measures to prevent people from tobacco. In fact, 57% of tobacco is bidis, about 16% is cigarettes, and the rest 30-35% is eating tobacco, chewing tobacco. I want you to

be very proactive in this. In fact, we are trying to have a series of steps in the next two or three months. We are going to have a National Tobacco Programme where we are going to spend nearly Rs.100-200 crores every year into creating awareness, into enforcing the regulations. We are going to have a Tobacco Regulatory Authority also. We are going to have some 'smoke free workplace' policy. We are going to implement it where nobody could smoke in any workplace where there are employees so that I will be giving you more information on those slides.

Coming to the Indian system of medicine, again as I have already said, it is a very vibrant system, we are going to have a presentation on that. My budget on ISM, in the 10<sup>th</sup> Plan it was only about Rs. 900 crore. Now in the 11<sup>th</sup> Plan, it is increased to Rs. 5000 crore. Out of that Medicinal Plant Board is something you could take up in a very, very big way. In Medicinal Plant Board we have nearly Rs. 900 crore allocated in the 11<sup>th</sup> Plan which could play a very major role. When I say Tamil Nadu and Kerala have been doing well, it is because they have merged (in Tamil Nadu) this Indian system, the Siddha system and the modern system is under one roof. In Kerala, the Ayurveda system, the Siddha and the modern system are under neighbouring roofs. And that is the success of this. In Tamil Nadu you could see more queues for Siddha system than for the modern allopathic system. That is the acceptance and that is why these states are doing well. I want you all to follow that model.

There is another programme which we have started called the IDS (Integrated Disease Surveillance) project. This is a programme for surveillance activities. Unfortunately, our country does not have any surveillance. We know—not only we, you also know—of any outbreaks in your state due to the media. I have been knowing it through the media till few years ago. Since now we are setting up the system, after it is set up (in fact some of the states have already set up), you will be knowing of any outbreak in your state within 5 hours. Imagine, any cholera outbreak, in 5 hours you will be knowing. Next day you could send a team to tackle that issue. Today we are sending teams after one week after about a hundred people die. We are into IT, IT revolution has started in India and still we don't know. I mean India is a large country. We have tribal areas in the North East which are inaccessible. All that is there. But then please cooperate in this IDS project, where you are the ones who are going to be benefited, you are going to be the leaders, you are going to tackle this immediately. As soon as you tackle, you are going to get good name in that.

Coming to some of the programmes which we want to do in the future, one is the Clinical Establishments Act. This is making standardized all the establishments, clinical and diagnostic, in our country. I have already introduced that Act in the Parliament and it is with the Standing Committee and I am sure when it comes out, I want you all to adopt that. All hospitals, whether it is one bedded or a thousand bedded or five hundred bedded hospital, all the diagnostic labs will all be registered with the state authority and you will be the registering authority.

We are going to start a National Urban Health Mission. We have already the National Rural Health Mission. We are on the verge of starting a National Urban Health Mission where there is going to be a lot of participation. Almost all the states have urban areas and India is now moving towards the concept of urbanization where the villagers, the farmers, are all going towards urban areas and urban health facilities are all clogged. So we are trying to do that.

Another programme which is going to be a landmark programme of India is the National Emergency and Trauma Programme. This programme should have been in India 20-30 years ago. In a few months we are going to launch it and by end of 2010 or early 2011 entire India is going to be covered by this programme, where they are going to have one telephone number and

anybody, anywhere, in any part of the country can call up this number in any emergency and immediately the person will be responded and if there is a trauma or any emergency, ambulance will be sent in about 8 to 12 minutes. It is a huge programme. It is going to be a landmark programme which is going to save millions and millions of lives and I want all your participation in this. Andhra Pradesh is number one state which is doing really well. Satyam Computers and these people have been doing a public-private partnership EMRA concept and I want you all to adopt that. In fact, we are going to sign a MoU with Satyam Computers and they are going to assist us in setting up and running these training modules and all that. In fact, Andhra Pradesh and Gujarat has now taken up, Madhya Pradesh, Maharashtra, Tamil Nadu, Kerala, all these states have taken up. You could take it up and we would be giving you resources. I have already moved a Cabinet Note of nearly Rs. 800 crores, upgrading all the trauma centres on national highways in the golden quadrilateral and all these things. All the centres will upgrade having specialists and a lot of things will be happening in that programme.

Also we are going to launch a National School Health Programme. These young kids are the future of our country and we need to take care of them. In consonance with the HRD Ministry we are working out a programme where you are the ones who are going to implement the programme in participation. Some States like Maharashtra, Gujarat, Tamil Nadu have been doing school health programmes but then this is a national programme where all school children in India will be screened every year. They will get a Smart Health Card and every year that card will be upgraded stating the weight, height, any anemia status or ENT or hearing problem, or eyesight, or heart problem, diabetes all that will be put up in this programme. And also we are saying that all doctors in the country should undergo mandatory 60 hours of continuing medical education. Whether it is a MBBS doctor or a specialist, they have undergone 60 hours in five years. Every five years, all the doctors will be re-registered after undergoing 60 hours on one hour a month

As regards rural posting of doctors, I have been saying in the last few months, that after the internship, when a MBBS doctor completes the house surgeon's internship, the doctor who is fully qualified has to do one year mandatory rural posting, in the sense that we are trying to work out 4 months in a PHC, 4 months in a CHC, 4 months in a district HQ hospital and we will be sharing the burden with you of giving a stipend of minimum of Rs. 8000. Under the NRHM project we will be sharing it with you so that every year out of these 264 medical colleges, 30,000 doctors are coming out. These 30,000 doctors you could use them in your rural areas. So at some point of time there are going to be doctors throughout the rural areas. It is going to be a two-way benefit. They are going to benefit by experience, you are going to be benefited by manpower as qualified doctors are going to be there. I want you to support this programme because it is going to go a long way. This lacuna of unavailability of doctors in the rural areas is going to be removed.

Then, of course, we are thinking of a concept of nurse practitioners. Because doctors aren't going there, due to that we are having issues of quacks and fake doctors. But if even the fake doctor is not there, then the system is going to collapse. Because these are the only guys who are there serving the rural people.

We have started a new department of health research recently, I think one of the first in the world where ICMR and a lot of other institutes are going to be a part of health research activities and we will be sustaining you in those activities.

With these words, once again, I welcome you all. I am sorry I have taken a little more time but then I want to have a lot more discussions. There are a lot of issues, but as time is short and we

are running behind schedule, I need a lot of your comments, even though we have only 3 or 4 main issues today. In fact, I have already promised you by first quarter of next year, a larger structured meeting which is going to be a two day meeting and the agenda and all that is going to be circulated much earlier, so that it will be a wider meeting. With these words, I again welcome my colleagues and officers to this 9th Conference of the Central Council. Thank you very much.

# PROCEEDINGS

# Department of Health and Family Welfare and Department of AYUSH

Presentations were made on Medical Education, AYUSH, NRHM, Disease Burden and AIDS control programme. These are at Annexure-I.

After the presentations the Union Minister for Health and Family Welfare invited comments of members of the Council and requested Shri Lalit Kishore Chaturvedi, Member of Parliament (Rajya Sabha) to initiate the discussion.

— श्री ललित किशोर चतुर्वेदी, सदस्य राज्य सभा ने अपने भाषण के दौरान स्वास्थ्य एवं परिवार कल्याण मंत्री भारत सरकार, राज्यों से आये स्वास्थ्य मंत्री एवं सभी विश्व बंधुओं को अभिनंदन व्यक्त किया है।

उन्होंने अपने वक्तव्य में स्पष्ट किया है कि दो बार स्वास्थ्य एवं परिवार कल्याण मंत्री रहने का मौका मिला है और कंसल्टेटिव कमेटी का सदस्य होने के नाते दो विषय सामने रखना चाहते हैं। जैसा कि भारतीय जीवनशैली है उसमें “सर्वे संतु निरामया, सर्वे भवंतु सुखंता” की चर्चा की गई है। उन्होंने कहा कि चर्चित प्रोग्राम में निरामया को भी जोड़ें। यह बहुत ही महत्वपूर्ण प्रोग्राम है। उन्होंने व्यक्त किया कि मनुष्य तन-मन से पूर्ण स्वस्थ एवं चैतन्य रहे। जब तन या मन रोगी हो जाये तो रोगी का उपचार किया जाये। अपने स्वास्थ्य एवं परिवार कल्याण विभाग का यह काम होना चाहिए। परंतु आज इस प्राथमिकता को उलट दिया है। उन्होंने निरामया को पहली प्राथमिकता देने का विनम्र प्रार्थना की है। जिसकी ओर सरकार और विभाग को बहुत अधिक ध्यान देने की जरूरत है। उन्होंने विभिन्न राज्यों से आये हुए मंत्री महोदयों से निश्चित रूप से इस विषय पर विस्तार से अपना दृष्टिकोण रखने को कहा।

उन्होंने कहा कि ग्रामीण हो या शहरी क्षेत्र मात्र रिसोर्सज दिये जाने से हैल्थ सिस्टम नहीं बनेगा। ग्रामीण स्वास्थ्य के लिए पहली आवश्यकता पी.एच.सी. की है। परंतु लगता है कि हैल्थ डिजलीवरी सिस्टम के लिए बीस हजार आबादी पर एक स्वास्थ्य केंद्र हो। श्री चतुर्वेदी का सुझाव है कि स्वास्थ्य केंद्रों पर डॉक्टरों की संख्या बढ़ा कर कम से कम तीन गुणा किया जाये जिसमें एक महिला डॉक्टर हो। जब तक ये नहीं अपनाया जायेगा तब तक लक्ष्य की पूर्ति नहीं कर पायेंगे। इससे मृत्यु दर, शिशु मृत्यु दर कम होने में सहायता मिलेगी।

पी.एच.सी. के साथ-साथ जिस एक 100000 की आबादी पर एक सामुदायिक केंद्र की चर्चा की गई है उन्होंने निवेदन किया है कि अगर अनुस्थैसीस्ट की नियुक्ति नहीं हुई तो छोटे-छोटे आपरेशन भी पी.एच.सी. के माध्यम से करना संभव नहीं होगा। वर्तमान में जिस तरह दुर्घटनाएं बढ़ रही हैं पी.एच.सी. में आर्थोपेडिशियन का होना आवश्यक है। मूत्र रोग व अन्य बीमारियों के उपचार लिए भी जिलास्तर पर स्पेशलिस्ट लगने की आवश्यकता है।

उन्होंने कहा है कि वे राजस्थान से आते हैं। जैसा कि देखा गया है कि डॉक्टरों की रुचि गाँव जाने की नहीं रहती है। उन्होंने कहा आपने जो नियम बनाया है एक समय तक गाँव में रहो तब डिग्री देंगे परंतु मानिट्रिंग की कमी के कारण उसके साथ-साथ जो आवश्यकताएं हैं उसकी पूर्ति नहीं हुई है। और राज्यों को सबसे अधिक आवश्यकता बिजली की है। अगर बिजली की आपूर्ति 8 घंटे मिलती है तो डॉक्टर कभी वहां नहीं

जायेंगे। अतः चिकित्सा के लिए आवश्यक है डॉक्टर और उसके परिवार के लिये मूलभूत आवश्यकताओं की पूर्ति की जाये। उन्होंने इसके लिए विचार करने की प्रार्थना की है।

उन्होंने ग्रामीण क्षेत्र के विषय में कहा है कि राजस्थान के पानी में फ्लोराईड बड़ी मात्रा में पाया जाता है जिससे कितनी बीमारियां हो रही हैं। जो नमकीन पानी है इसमें केटलिस्टिक एजेंट के नाते विभाग को खड़ा होकर पानी के दोनों अवगुणों को एक फ्लोराईड और दूसरी क्षारीयता को दूर करने पर विचार करना चाहिए।

## **KERALA**

Health and Social Welfare Minister of Kerala thanked the Hon'ble Union Minister of Health and Family Welfare for appreciating the efforts made by the State and also acknowledged the timely help provided by the Ministry in controlling Chickengunea.

In his speech, the Health Minister, brought to the notice of the Chairman the following issues and requested for the centre's assistance.

- 1) For duplicating the EMRI model of AP in Kerala as Kerala has the second largest number of people dying in road accidents.
- 2) For extending Mental Health programme to to all 14 districts. from 5 districts as suicide rate in the State is three times the national average.
- 3) For Early detection of cancer and cancer care.
- 4) To control diabetics in the state
- 5) For integration of modern medicine with Ayurveda and Homeo Institutions through NRHM.
- 6) For release of funds under NRHM.
- 7) For sanctioning of the Institute of Virology at Allapuzha.
- 8) Financial Assistance to set up nursing colleges in all the 14 districts and upgrade nursing schools.
- 9) To provide Financial Assistance to set up Medical Services Corporation on the lines of Tamil Nadu Corporation.
- 10) Financial assistance to 1500 Ayurveda and Homeo institutions located in Kerala under NRHM.
- 11) To tackle the health problems of Aged in the in the state. Percentage of people over 50 years which is 11% at present is expected to rise to over 20% by 2030 and to 30% by 2050. With the higher life expectancy, the number of women among the aged population will be naturally higher with their own problems.
- 12) To tackle the problem of growing communicable and non-communicable diseases in the state. chickengunea, dengue and other killer diseases like encephalitis, have posed a great challenge threatening the public health achievements in the state. On the other hand, non-communicable diseases like diabetes, heart diseases, hypertension, cancer etc. are on the increase accounting for about 40% of cases of morbidity and death.

## RAJASTHAN

Rajasthan's Minister for Medical, Health & F.W., Ayurveda complemented the Union Minister for the successful implementation of NRHM in the country and stated that implementation of NRHM has changed the total scenario of Medical and Health Department in Rajasthan. He added that in the past, there were two health workers in each sub-centre; one male worker and one female ANM. Now that the MPW scheme is not in existence, only ANM is working in the Sub-centre under the NRHM. Due to shortage of ANMs the State Govt. had taken permission to deploy GNM diploma holders in the sub-centres, about 2500 have already been deployed and many are expected to be deployed soon. However, the Centre is raising an objection to this process and insisting for filling up of the posts of MPWs before posting a GNM at the Sub centre. He urged the Chairman to consider the request of the State Government in view of the fact that the job chart of MPW is merged with the job chart of GNM and trained MPWs are not available in the state.

Intervening in the discussion, the Chairman observed that the salaries of the male health workers are to be paid by the State while the salary of ANM is to be borne by the Centre. However, only 55% to 60% of the male health worker posts are filled in by the states leaving the rest as vacant to limit the financial burden.

Continuing the discussion, the Health Minister expressed his deep concern about the prevailing unfavorable sex ratio in the country and favoured strict action to rectify the imbalance. During the course of discussion, the following issues were brought to notice of the Chairman:-

- The strategy followed in implementation of Malaria Eradication Programme in the country especially, in the context of the prevailing norms for insecticide sprays and availability of insecticides.
- The cost of construction of PHC (Rs. 9 Lakhs) and CHC (Rs. 24 lakhs) needs to be suitably increased.

## MAHARASHTRA

The Public Health and F.W. Minister of Maharashtra presented an overview of the health sector in the state and the achievements made under NRHM. The following are the important achievements brought to the notice of the Chairman and other members of the council.

### Under NRHM:

- Established 10605 Village Health and Sanitation Committees.
  - Rogi Kalyan Samitis established at 1508 PHCs, 432 CHCs and 26 district level hospitals.
- Each district has established a separate infrastructure development wing, to accelerate the construction activity in the state by appointing contractual staff at the sub-divisional level and district level. Support staff is also provided to the technical wing. These wings have started functioning and have prepared plan estimates for repair work of 280 PHCs, 27 rural hospitals. All works are expected to be completed by December, 2007. The construction of new buildings will start by January 2008. Plans and estimates are put in place.
- In all 33 districts, district management unit consisting of district programme manager, district accounts manager and data entry operator, has been established and is functioning. Regular monthly monitoring meetings are organized at the state level to

review the performance. The block management unit has started functioning with the block medical officer, data entry operator and an accountant at block level. The block medical officer has been sanctioned out of state's own funds. Monthly audit system on the lines of Madhya Pradesh is expected to start functioning from February, 2008.

- Under NRHM, 7959 ASHAs have been appointed, accounting for about 88% of the total target of 9000 ASHAs and the training programme has started.

### **Other important achievement:**

- The state has doubled the admission capacity in all 22 nursing schools for this year. Efforts are being made to establish a few new nursing schools in the district hospitals. A new B.Sc.(Nursing) college has been sanctioned for Marathwada region.
- For the first time, a full-fledged hospital & research centre for Mental Illness is being set up in Maharashtra at an initial cost of Rs. 16 crores.
- Started a scheme, "Doctor apna gadi", doctor-at-your-village, where a doctor from the system will visit twice a month. This doctor is assisted by an ANM at each visit.
- The state has announced an innovative scheme to encourage Marriages at higher age. The scheme envisaged cash prize of up to Rs. 1.5 lakh to the gram panchayat which has the highest age at marriage.
- Preparing a comprehensive scheme of awarding cash prize to the best health village from each block. All the 33 districts have prepared and submitted district health action plan for the year 2007-08 and the state PIP has also been submitted to Government of India. Preparation for the next year's PIP is under way.
- For establishment of an eye centre in 8 major districts Rs. 1.5 crores have already been distributed to health centres.
- The state is planning to provide homeopathic treatment facilities at 16 hospitals.
- The state has also pioneered the activities in blood collection in blood banks, the maintenance of which has given great relief to patients requiring blood especially those with rare blood groups.
- Under district control programme, the state has started surveillance centres at district hospital levels and medical colleges at 15 places and these centres are contributing successfully for the diagnosis of virus caused diseases.

### **WEST BENGAL**

Expressing gratitude to the Chairman, the Health & Family Welfare Minister of West Bengal referred to the problems associated with the passing of the proposed two Bills viz. Clinical Establishments Regulation Bill and the Drug and Food Control Bill. The Health Minister requested the Chairman to see that introduction of the Bills in the parliament should not go against the interests of the states. There should not be any inroads into the States' authority because that will make things very difficult to operate in a country like India. He highlighted the fact that even in the past, several instances had come up where, the state had objections to certain drug formulation and license was refused, but the companies manufacturing these medicines procured licences from other states and sold their stock in West Bengal.

Referring to implementation of NRHM, the Minister brought to notice of the Chairman the following:

- The number of sub-centres in each state should be on the basis of the 2001 population census instead of 1991 population as is being followed now.
- Instead of having a male health worker in the sub-centres, it is advisable to have a male nursing practitioner.
- The Nursing Council has to take initiatives to get approval of the Government to introduce Nursing Practitioner course in the country.

On Medical Education front, the Minister insisted for an amendment for relaxation of norms in respect of:

- Minimum requirement of 25 acres of land for establishing a medical college / institution as the state Govt. is finding it difficult to procure such a big piece of land at one place.
- Population norm of one million for setting up of a medical institution needs to be relaxed as West Bengal does not have cities satisfying the criteria and the State needs at least 10 medical colleges.

Concluding his speech, the minister requested the Chairman to pass a resolution favoring increase in the strength of doctors in the country so that the demand supply gap could be reduced.

## MADHYA PRADESH

The Public Health & F.W. and Medical Education Minister of Madhya Pradesh made admiring comments for introduction NRHM in the country as it is changing the health scene in the state. The minister highlighted various achievements made in the health sector especially the measures taken to upgrade the hospitals under NRHM, overcome shortage of doctors, improve the services of mobile hospitals, mobile sonography units, regional diagnostic labs etc. He narrated some of the innovative schemes taken up in the state under the NRHM for the information of the Chariman and other members of the council.

- **'Janani Express' Scheme.** This scheme has been launched at every block level. Under this scheme, a two-way transportation service is made available to the pregnant women. An outsourced vehicle is arranged by incurring Rs. 250 under the NRHM for this purpose. The vehicle will pick up the pregnant women from her door step and leave the women, child and others accompanying her on third day at their residence. This facility would be made available on receiving a phone call.
- **"Swavlamban Yojana"**- This scheme has been launched to overcome the shortage of staff nurses in the state. Under this scheme, 500 girls from schools have been picked up for nursing training in Private / Govt. institutions by providing financial assistance to the tune of Rs. 50,000 per annum as education fees. Similar schemes are being taken up to overcome the shortage of radiographers, ANMs.
- **'Matru Shakti'** – a pilot scheme covering 7 blocks has been taken up in the state. Under this scheme, pregnant women diagnosed with more than one expected complication during the delivery are identified and given them a red card. With that red card they will be identified at each and every level and given special care. For giving that special care, an amount to the tune of Rs. 5500 will be spent wherever it is required for providing various facilities.

- **Deendayal Antodaya Upchaar Yojana**- though it is not directly linked to NRHM, the State, under this scheme is providing free medicines to BPL families. An amount of Rs. 20,000 per year per family would be spent whenever they need it.
- **'Bal Shakti'**. Under this scheme natural rehabilitation centres are set up in the state to provide treatment to malnourished children. Each centre is provided with a pediatrician and a ward to admit the malnourished children. In the centre, mothers are being trained to prepare nutritious food and maintain clean surroundings. The child is provided free treatment and free food to mother. An amount of Rs. 65 is paid to mother to compensate loss of wages.

The following issues were brought to the notice of the Chairman for consideration:

- **Location of setting up of trauma centres** - to be decided in consultation with state Govt.
- To Supply user-acceptable quality condoms.
- Policy facilitating AYUSH doctors to prescribe Allopathic medicines.
- Insufficient funds provided under "School Health "programme.
- Providing subsidy to ASHAs to purchase mopeds or some support for meeting fuel cost instead of providing bicycles.

## PUNJAB

श्रीमती लक्ष्मी कांता चावला, स्वास्थ्य एवं परिवार कल्याण मंत्री पंजाब ने धन्यवाद देते हुए बताया है कि पंजाब में मार्च, 2007 में उनकी पार्टी की सरकार बनने के बाद अगस्त 07 में एन.आर.एच.एम. का कार्य शुरू हुआ है। उसके बाद ग्रामीण स्वास्थ्य और सैनेटेशन समिति 12,000 गांवों में बन गयी है बाकी 15,000 गांवों के लिए इन्होंने काम शुरू कर दिया है। राज्य में रोगी कल्याण समितियां बन चुकी है। राज्य के स्वास्थ्य सामुदायिक केन्द्र जिला स्तर एवं खंड स्तर पर बन गये हैं। 20 जिलों में दिसम्बर के अंत तक पूरी तरह सुसज्जित 20 गाड़ियां पहुँच जायेंगी। तीन अभिघात केंद्र मंजूर हुए थे जिसमें से दो का काम शुरू हो चुका है तीसरे का दिसम्बर में शुरू हो जायेगा। उन्होंने बताया कि उच्च पथ (Highway) पर ज्यादा मौतें दुर्घटना से हो रही है अतः पंजाब को ज्यादा अभिघात केंद्र देने को कहा है।

उन्होंने बताया है कि जितने पी.एच.सी. में उनमें 80 में आर.सी.एच. स्तर पर काम शुरू हो गया है बाकी 134 में पंजाब स्वास्थ्य पद्धति कारपोरेशन काम कर रहा है। राज्य स्तर पर व्यवस्था इकाई पहले से है। जिला और ब्लॉक स्तर की जो समितियां हैं उनको मजबूत किया जा रहा है। इंटीग्रेटिड सर्विलेंस कार्यक्रम पंजाब में शुरू हो चुका है। उन्होंने निवेदन किया है कि जिला स्तर पर कैंसर, टी.बी., कुष्ठ रोग का जितना भी काम है उसके साथ-साथ दृष्टिहीनता को रोकने के लिए पूरा काम एन.आर.एच.एम. के अंतर्गत शुरू कर दिया जाये।

उन्होंने बताया है कि 400 बहूदेशीय स्वास्थ्य कर्मियों की भर्ती कर ली गयी है। सिविल अस्पताल और पी.एच.सी. में आयुर्वेद के डॉक्टर आ गये हैं अथवा आ रहे हैं उनके लिए कंसेप्ट है कि आयुर्वेद का एक विंग तब चलाया जाये जब सुबह 8 AM से 2 PM वाले डॉक्टर जाते हैं उसके बाद आयुर्वेद डॉक्टर को दोपहर में रखे ताकि डॉक्टर अस्पताल में हर समय उपलब्ध रहें।

उन्होंने माननीय मंत्री महोदय से निवेदन व्यक्त किया है कि कठिनाइयों के कारण डॉक्टर, स्पेशलिस्ट गांव में जाने के लिए बिलकुल नहीं मिलते हैं। उन्होंने निवेदन किया है कि गांव में काम करने वाले डॉक्टरों व स्पेशलिस्टों को यू.जी.सी. नियम के तहत वेतन या इनसेंटिव, एच.आर.ए. ज्यादा दिया जाये।

उन्होंने निवेदन किया है कि एन.आर.एच.एम. के सारे कार्यक्रम का प्रमुख जिलाधीश डी.सी. को न बना कर सिविल सर्जन को बनाया जाये जो रोगी कल्याण समिति का प्रमुख है। वो इस काम को अच्छी तरह से देख सकते हैं।

उन्होंने कहा कि पंजाब में कन्या-भ्रूण हत्या की स्थिति शर्मनाक है। इसके सुधार के लिए अभियान शुरू किया है जिसमें संतों, समाज सुधारकों की सेवाएं ली गयी हैं।

### **ASSAM:**

Congratulating the Government of India for launching NRHM, the Health and F.W. Minister of Assam highlighted the progress made in health sector especially the improvement made in the indicators viz. MMR and IMR. The Minister in this speech touched upon the following issues:

- Relaxation in the existing norms for establishing medical institutions.
- Conflicting role of MCI in promoting medical education and in augmenting manpower resources.
- Relaxation to contribution of 50% specialists to Central Pool by North East States

### **MEGHALAYA:**

The Health & F.W. Minister of Meghalaya gave brief account of the achievements made under NRHM focusing on appointment of ASHAs, formation of Sanitation Committees, Registration of Rogi Kalyan Samithis, upgradation of hospitals, selection of the personnel for the block programme management units, preparation of District Health Plans, setting up of two GNM training schools etc.

He expressed his deep concern about the high prevalence rate of Cancer and AIDS in Meghalaya and requested the Chairman to provide necessary assistance to control these two dreaded diseases in the state. Other issues raised by the Minister where Central Government's assistance is required, include:

- To increase in number of seats at post-graduate level to meet the increased demand of specialists.
- To conduct short term training programmes for doctors and paramedical staff.
- To develop health infrastructure facilities in the state.

### **BIHAR:**

Health and Medical Education Minister of Bihar appreciated the Union Government and the Health Ministry for launching the National Rural Health Mission (NRHM) and giving special status to Bihar so that it could catch up with the national health standards. He elaborated on the existing health infrastructure facilities available in the state and the tasks to be achieved in next five years, as per the details given below:

- In addition to the existing 533 Primary Health Centres, the state shall create 135 new Primary Health Centres and upgrade about 133 additional PHCs to the level of PHCs.
- As against 101 sub-divisional hospitals required, at present only 23 hospitals are available.

- Out of 38 district hospitals, the state is having 24 at present and 14 new district hospitals are to be established.
- The state has to construct at least 350 additional PHCs per year to achieve our target.
- As against a requirement of 8500 doctors, the state is having a working strength of about 3800 doctors.
- Against the requirement of 34,000 ANMs, the state is having 11,000 ANMs.

The Minister also highlighted various measures taken by the State Govt. to develop health sector in the state, which includes creation of additional infrastructure facilities, appointment of doctors, specialists, nurses, recruitment of doctors and nurses, supply of medicines, setting of medical institutions, nursing colleges, and establishment of a corporate medical college at Patna etc.

He requested the Chairman to relax the MCI guidelines for setting up of three medical colleges at Betia, Madhepura and Pawapuri by utilizing facilities available at the existing 300 bedded district hospitals till the infrastructure facilities are created at respective places.

## **PUDUCHERRY:**

The Health Minister of Puducherry in his speech briefly narrated the achievements made in the health sector especially the prevailing favourable sex ratio and achievement of 99.56% institutional deliveries in the state. He also brought to the notice of the Chairman about the innovative Health Insurance Scheme launched for BPL families for the services provided in the private and corporate hospitals.

While referring to the vacant teaching posts in the Medical institutions in the state, the Minister requested the Chairman to advise the MCI to treat the DNB qualified doctors at par with MS / MD qualified doctors for appointment as teaching faculty in the medical colleges of the state.

## **UTTARAKHAND:**

स्वास्थ्य एवं परिवार कल्याण मंत्री, उत्तराखण्ड ने माननीय मंत्री एवं विभिन्न राज्यों के मंत्रीगण एवं अधिकारियों को संबोधन करते हुए बताया है कि 27 अक्टूबर, 2005 से उत्तराखण्ड में एन.आर.एच.एम. की शुरूआत हुई थी तब से स्वास्थ्य क्षेत्र में प्रगति एवं सुधार हुआ है। कुष्ठ रोग, अंधापन, मृत्युदर, सकल प्रजनन में काफी गुणात्मक प्रगति हुई है। उन्होंने बताया है कि ढांचागत सुधार में तेजी से प्रगति हुई है जिससे शत-प्रतिशत लक्ष्य एवं ग्रामीण स्वास्थ्य और स्वच्छता समितियों के समन्वय में तेजी आयी है। स्वास्थ्य केंद्रों का निर्माण तेजी से हुआ है। एन.आर.एच.एम. के तहत जननी सुरक्षा योजना के तहत हर जिले के दो विकास खण्डों में अभिपालक दिये गये हैं जो सफल रहा है।

उन्होंने कहा है कि चिकित्सा प्रबंध समितियों का गठन कर रहे हैं जिससे पहले की अपेक्षा शिशु मृत्युदर 52 से घटकर 41 तथा अब लक्ष्य 30 है। मातृ मृत्युदर को 450 प्रति लाख से 300 पर लाया गया है, इसे 100 करने का लक्ष्य है और संपूर्ण प्रतिरक्षण 47 से 50 प्रतिशत पर आया है इसे 100 प्रतिशत करने का लक्ष्य है। उन्होंने कहा एच.आई.बी. पॉजीटीव की दिशा में काम चल रहा है। संस्थागत प्रस्ताव जननी सुरक्षा काफी प्रगति पर है।

उन्होंने बताया है कि कर्मियों में न डॉक्टर है न पैरामेडीकल स्टाफ है। अतः तत्काल ढांचे में सुधार की बात की है। बेहतर एवं दोष मुक्त करने के लिए एस.टी.ओ. एवं पैरामेडीकल स्टाफ को बढ़ाने की बात कही है।

उन्होंने कहा है कि जैसे चीन में ग्राम स्तर पर अपनी स्थानीय चिकित्सा पद्धति को प्रोत्साहन दिया जा रहा है ऐसे जो आयुर्वेदिक चिकित्सा की स्वीकृति सर्वोच्च न्यायालय के आदेश पर हुई है उसके लिए आवश्यक एक्ट बनाया जाये। जिसमें प्राथमिक उपचार में सम्मिलित इंटीग्रेटेड (Integrated) चिकित्सा का होम्योपैथी प्रबंध किया जाये। उन्होंने कहा है कि केन्द्र सरकार को एक्ट में परिवर्तन करके आयुर्वेद एवं होमियोपैथी को प्राथमिकता के आधार पर संयुक्त रूप से आपरेशन करने का प्रावधान किया जाये। उन्होंने बताया है कि 5 हजार किस्म की जड़ी-बूटियां उत्तराखण्ड में पायी जाती है। हम 5 हजार वर्ष पहले की पद्धति को छोड़कर नई पद्धति की ओर जा रहे हैं जबकि पूरी दुनिया के लोग वैकल्पिक चिकित्सा पद्धति की ओर आकर खड़े हैं जबकि भारतवर्ष की चिकित्सा पद्धति आयुर्वेदिक, होम्योपैथी और प्राकृतिक चिकित्सा है। उन्होंने आगे कहा है कि इस संदर्भ में हम भारत का झण्डा पूरी दुनिया में उठा सकते हैं जिसे पूरी दुनिया को जरूरत है अतः एक्ट में परिवर्तन को नितान्त आवश्यक बताया गया है। उन्होंने बताया है कि कैंसर यूनिट की दो संस्थाएँ एक हरिद्वार में दूसरा देहरादून में है। कुमाऊं का बहुत बड़ा क्षेत्र है इसलिए उन्होंने अनुरोध किया है जो धनराशि किस्तों में दी जाती है उसे एक मुक्त देने की बात कही है ताकि भवन निर्माण एवं उपकरण खरीदने में आसानी हो सके।

उन्होंने कहा है कि उत्तराखण्ड में विषम परिस्थितियां हैं यहां की आबादी एक करोड़ है जबकि उत्तराखण्ड चार करोड़ को चिकित्सा प्रदान करता है। उन्होंने बताया है दर्जनों धार्मिक एवं पर्यटक स्थलों पर साल में एक से डेढ़ करोड़ पर्यटक आते हैं तथा एक से डेढ़ करोड़ धर्मानुयायी आते हैं। अतएव इन सबकी चिकित्सा उपलब्ध कराना आवश्यक है। उन्होंने कहा कि हम पूरे देश एवं दुनिया के लोगों को चिकित्सा सुविधा देते हैं।

प्रतिवर्ष सैकड़ों लोग दुर्घटना में मरते हैं अतः उन्होंने अनुरोध किया है कि हर 50 कि.मी. पर ट्रामा सेंटर की आवश्यकता है। राज्य सरकार ट्रामा सेंटर खोलने के लिए कटिबद्ध हैं। उन्होंने केन्द्र सरकार से और अधिक डॉक्टर देने का अनुरोध किया है ताकि देश के कोने-कोने से आने वाले यात्रियों एवं दुर्घटनाग्रस्त व्यक्तियों का जीवन बचाया जा सके।

उन्होंने बताया है कि उत्तराखण्ड में दो राजकीय और दो प्राईवेट आयुर्वेदिक कॉलेज हैं और तीन मेडिकल कॉलेज हैं। मेडिकल कॉलेज खोलने का जो मानक है उसके अंदर जमीन-आसमान का अंतर है विशेष कर पर्वतीय क्षेत्र में 25 एकड़ जमीन एक ही जगह नहीं मिल सकती है। उन्होंने अनुरोध किया कि इस मानक में परिवर्तन किया जाये। अतः इसे 25 एकड़ के जगह परिस्थिति के अनुरूप बनाया जाये। जैसाकि मानक रखा गया है 100 शैयों पर 30 ए.एन.एम. की ट्रेनिंग सेंटर खोलने की बात कही गयी है। इसका अर्थ है कि ए.एन.एम. कभी भी प्रशिक्षित नहीं हो सकते हैं। उन्होंने बताया है कि सफाई कर्मी व रसोइयों को 750 रुपये महीना देते आ रहे हैं जो न्यूनतम मजदूरी से भी कम है इसको बढ़ाने के लिए निवेदन किया है।

उन्होंने बताया है कि प्राथमिक स्वास्थ्य केन्द्र जो तीस हजार जनसंख्या पर देने की बात है, उसे 10 हजार पर निर्धारित किया जाये, क्योंकि इसके सहारे शिशु मृत्युदर में कमी लाना है। उन्होंने अनुरोध किया है कि शिक्षा एवं चिकित्सा हर आदमी का अधिकार है। हर गाँव में एक विद्यालय है तो हर गाँव में चिकित्सालय होने की बात आवश्यक है। शिक्षा से पहले चिकित्सा आवश्यक है।

आयुर्वेद, यूनानी होम्योपैथी, योग, सिद्धा की चिकित्सा एक-दो कमरे में संभव नहीं है इसके लिए उन्होंने व्यवस्था का अनुरोध किया है।

उन्होंने कहा है कि पल्स पोलियो, ब्लड बैंक और मोबाईल अस्पताल राज्य के दूरस्थ क्षेत्रों के लिए 13 जिलों में 13 टीमों भेजी गयी है। इसके लिए डेढ़ लाख रुपये की सीमा को समाप्त कर इसे बढ़ाने का अनुरोध

किया है। उन्होंने श्रीनगर एवं अल्मोड़ा मेडीकल कॉलेज को कम से कम सौ-सौ करोड़ रुपये देने का अनुरोध भी किया है।

उन्होंने व्यक्त किया है कि उत्तराखण्ड को आयुष् प्रक्षेत्र घोषित किया जाये जो पूरे देश और दुनिया के लिए सुखद होगा ऐसा कहकर उन्होंने सभी का आभार व्यक्त किया है।

## **ORISSA:**

The Health & F.W. Minister of Orissa complemented the Government of India for launching a very good path breaking scheme of NRHM with special focus on Under Developed states. He also thanked the MCI and Government of India for agreeing to increase the number of seats in medical colleges in the State. The Minister in his speech mentioned about the achievements made in the health sector especially the MMR and IMR and the institutional deliveries after the launch of NRHM. He also referred to various initiatives taken by State Govt. to improve health sector in the state which include:

- Appointment of AYUSH Doctors in place of Allopathic Doctors to man the health sector at sub-CHC level.
- Utilizing the services of retired doctors by paying a consolidated salary of Rs. 25,000 per month to overcome the shortage of doctors in the state.
- Providing special incentives to encourage doctors posted in rural areas.

The Minister requested the Central Govt. to set up fully funded government medical colleges on the principle of cost sharing by the centre and the state.

## **ARUNACHAL PRADESH**

Health & F.W. and Medical Education Minister of Arunachal Pradesh endorsed the views expressed by his counter part, Health Minister of Assam in so far as N-E state Health sector problems are concerned. Referring to the specific problems faced by Arunachal Pradesh, the Minister brought the following to the notice of the Chairman for redressal.

- Expedite release PPP funds amounting to Rs. 122.78 lakhs sanctioned for the operation and maintenance of 16 PHCs in the state.
- Release of balance funds amounting to Rs. 559.17 lakhs to carry out the 18 approved activities under NRHM. The Central Govt. released Rs. 323.87 lakhs out of Rs. 883.587 lakhs sanctioned to carry out these activities during 2006-07 leaving a balance of Rs. 559.17 lakhs.
- Sanction of 33 dental surgeons to the state under NRHM.
- Sanction of 51 numbers of ambulances under NRHM for the year 2007-08.
- Setting up of North Eastern Regional Research Institute of AYUSH.

## **PUNJAB**

स्वास्थ्य शिक्षा मंत्री, पंजाब ने केंद्रीय स्वास्थ्य एवं परिवार कल्याणमंत्री एवं अन्य सभी सम्मिलित व्यक्ति को धन्यवाद किया है। उन्होंने बताया है जिन लोगों ने अपने बहुमूल्य विचार रखें उनसे सीखने का एवं

साझा करने को मिला है। उन्होंने पंजाब से आई बहन लक्ष्मी कांता और उत्तरांचल से आये भाई स्वास्थ्य मंत्री की तरह उन्होंने राष्ट्रभाषा को गौरव देते हुए हिंदी में विचार व्यक्त किया।

उन्होंने बताया है कि राज्य में जो चिकित्सक जनसंख्या अनुपात है वह एक के लिए 1600 है। अभी तक प्रदेश में 8 मेडिकल कॉलेज, 13 डेंटल, 12 आयुर्वेद, 4 होम्योपैथ एवं 150 पेरामेडिकल इंस्टीच्युट हैं उसमें से तीन सरकारी मेडिकल कॉलेज, तीन इंस्टीट्यूशन और दो प्राइवेट चल रहे हैं। राज्य में मेडिकल कॉलेज व तीन डेंटल कॉलेज बनने वाले हैं। अतः बीस हजार छात्रों को चिकित्सा शिक्षा देने में समर्थ हैं लेकिन पंजाब के लिए यह कम है। पंजाब से बाहर जो छात्र जाते हैं, समय एवं पैसे की बर्बादी होते हैं साथ में रिस्क भी होता है। इसलिए पंजाब के लिए कुछ अच्छी कार्य योजना बनायी है।

उन्होंने बताया है कि पंजाब की संरचना ऐसी है कृषि योग्य भूमि 84 प्रतिशत है और 6 प्रतिशत वन है बाकी 10 प्रतिशत बचती है। कुछ दिन पहले सर्वोच्च न्यायालय ने कृषि योग्य भूमि का अधिग्रहण निरस्त कर दिया है। मंत्री महोदय ने मेडिकल संस्थानों को अस्पतालों के 30 कि.मी. के दायरे में खोलने के वर्तमान नियमों में परिवर्तन करने का भी अनुरोध किया है। मंत्री महोदय ने अवकाश प्राप्त मेडिकल शिक्षकों की सेवा लेने हेतु आवश्यक नियमों में परिवर्तन करने का भी अनुरोध किया है।

उन्होंने नर्सिंग में अल्प अवधि के क्रोसेज को बढ़ावा देने का भी अनुरोध किया ताकि इस क्षेत्र में कमी दूर की जा सके। उन्होंने बताया है कि इनसर्विस प्रशिक्षण जो चिकित्सा शिक्षा से जुड़े लोग हैं उनके लिए आई. ए.एस., आई.एफ.एस. की तर्ज पर अंतर्राष्ट्रीय स्तर की शिक्षा देना एवं रीफ्रेशर कोर्स का प्रशिक्षण होना चाहिए। पंजाब की सरकार की ओर से ऑफर है कोई इंस्टीच्युट खोलना चाहते हैं तो स्वागत किया है। राज्य में टी. आई.एम.एस. का भवन तैयार है जिसके लिए उन्होंने निवेदन किया है कि इसे एम्स के होल्ड में ले लें ताकि यह पंजाब के लिए पहला पोस्ट ग्रेजुएट सेंटर होगा।

उन्होंने आयुष की चर्चा करते हुए बताया है कि विश्व में आयुष की मांग बढ़ रही है। एक पाईनर राज्य के रूप में केन्द्र की तर्ज पर जो आयुष एजुकेशन डायरेक्टर है सीधे सरकार से बात कर सकते हैं उसके माध्यम से पंजाब में आयुर्वेद विश्वविद्यालय की स्थापना के लिए एक्ट का ड्राफ्ट तैयार कर लिया गया है। उन्होंने बताया है कि पंजाब के होशियारपुर में जहां सब-माऊंटन हैं, वहां जड़ी-बूटियां होती हैं। वहां विश्वविद्यालय बनाया जाये। इसके लिए केन्द्र का सहयोग अपेक्षित है। उन्होंने जोर दिया है कि जड़ी-बूटियां और औषधि वाले पौधों के लिए वन विभाग से समन्वय की बात चल रही है। सौभाग्य से इनका यहां वन विभाग ने निर्देश जारी किया है कि आगे के वर्षों में जो पौधे लगेंगे वे मेडिसिनल प्लांट ही लगेंगे और प्रत्येक वन मंडल पर एक हरबल पार्क बनाने की बात कही गयी है तथा ऐसा अगर समन्वय केन्द्र के निर्देशानुसार बन जायेगा तो आयुर्वेद को बढ़ावा मिलेगा। इस संदर्भ में उन्होंने बताया है कि दादी-नानी और माता जब भी छोटी बीमारी में जड़ी-बूटी बताती हैं जैसे अजवायन खालो। पंजाब में अकेले पचास हजार हर्बल प्रेकटिसनर हैं। उन्होंने कहा है कि ये हर्बल प्रेकटिसनर छिपकर काम करते हैं और उनके लिए पंजीकरण अनिवार्य हो जिससे वे इनलिस्टमेंट हो जायेंगे अर्थात् इस पद्धति के लिए कॉमन प्लेटफार्म पर सोचने के लिए अनुरोध किया जाना है। उन्होंने अंत में केंद्रीय मंत्री को धन्यवाद ज्ञापन दिया है।

## HFM's Remarks

Expressing his satisfaction over the implementation of various Health Schemes especially the NRHM by various states, the Chairman informed the members that during the course of remaining five years of the NRHM, the Government is committed to provide more nursing facilities and give an additional doctor through rural posting in the PHCs. Hiring of specialists, orthopedics, anesthetist and gynecologist to serve in CHCs on contract basis is also under consideration. To improve the

communication network and thereby provide better health facilities in the rural areas, he suggested to the State Governments to initiate schemes to provide bicycles, transistors and Cell Phones to ASHAs under NRHM.

Reacting to the comment made by a Member regarding non-inclusion of preventive measures to control various diseases, the Chairman informed the members that all health initiatives under NRHM do have preventive component as a part of the programme. There is nothing called a particular preventive concept because it is engaged in the programme itself. He further asserted that, immunization, increasing the checkup, improving sanitation in the villages, prevailing nutrition schemes etc. constituted part and parcel of prevention programme. In all the national programmes, prevention is an in build mechanism to tackle the disease burden. The National Programme for Prevention and Control of Diabetes, the cardiovascular awareness concepts, screening, early detection, that are the concepts which are inbuilt in the programme.

Reacting to the issues raised by the Members, the Chairman informed the following:

- National Drug Authority is being set up in the country to achieve global pattern of harmonization of pharmaceutical industry and to tackle the problem of sub-standard drugs being made available in the country.
- Clinical Establishments Act is being promulgated to harmonize the establishments in the country and it is under the consideration of Standing Committee of Parliament.
- To overcome shortage of doctors in the rural areas, utilizing the services of Ayurvedic, Siddha, Unani and Homeopathy (AYUSH) doctors is being under consideration. According to the Supreme Court verdict, AYUSH doctors can prescribe allopathic drugs after undergoing concept training.
- The curriculum of MBBS to be made more practical oriented, rural oriented, social oriented and by keeping the basic parameters of quality and standards in tact.
- Health Facilities for the North East states would be made available not only on population basis, but also on need basis, distance basis and on caseload basis

**RESOLUTIONS /  
DECISIONS TAKEN**

# RESOLUTIONS /DECISIONS TAKEN

## RESOLUTION I:

### PREVENTION AND CONTROL OF MICRONUTRIENT DEFICIENCY DISORDERS

- 1) To ensure supply, distribution and consumption of iron folic acid tablets to all pregnant and lactating mothers and adolescent girls in the country through the NRHM and the ICDS Scheme.
- 2) To ensure supply, distribution and consumption of iron folic acid tablets and Vitamin - A syrup to children up to 5 years through the NRHM and the ICDS Scheme.
- 3) To ensure supply, distribution and consumption of iron folic acid tablets to all anemic school children up to the level Secondary School along with Mid-Day meal Programme of Primary, Upper Primary Schools.
- 4) To ensure supply and consumption of adequately iodized salt at household level in the entire country through ASHA/ Anganwadi Workers /Panchayati Raj Institutions/ PDS system.

## RESOLUTION II:

### MEDICAL AND NURSING EDUCATION

1. To support the proposal of MoH&FW to amend the MCI regulations relating to minimum standards to set up Medical Colleges in the country with the modification to the extent that the distance between the District/ State Civil Hospital and the Medical College be stipulated as 15 kms instead of 10 kms in respect of North-eastern States, Uttarakhand , Himachal Pradesh and J&K so as to enable them to go in for Public Private Partnership model Medical Colleges.
- 2 . That the District Hospitals be converted into teaching hospitals so as to set up Medical Colleges through Public-Private Partnership mode and that the District Hospital be allowed to be within a radius of 10 kms from the proposed Medical College and other essential infrastructure in States other than North-eastern States, Uttarakhand, Himachal Pradesh & J&K. These norms will also be applicable to Medical Colleges to be set up by State Government.

That the requirement of contiguous chunk of 25 acres of land for setting-up of medical colleges be relaxed in respect of metropolitan cities with population more than 10 million, in view of acute scarcity of land in such metropolitan cities and medical colleges and hospital be allowed to be established on two separate chunks of land within a distance of 10 Km.

3. That the GNM/ANM schools be set up in District Hospital campus in deficient States with central assistance.
4. To fully support the move of the MoH & FW in making 'Rural Service of one year' mandatory after an under-graduate completes his internship and before getting permanent registration of his medical degree.
5. That all the State Governments bring out an enabling legislation on the lines of Acts passed by Chhattisgarh and Assam States so as to introduce a three year diploma course in Medicine and Public Health in order to provide manpower to address rural health care needs.

### **RESOLUTION-III:**

#### **INTEGRATED DISEASE SURVEILLANCE PROGRAMME (IDSP)**

1. States should give priority to IDSP and must appoint dedicated State and District Surveillance Officers and develop a team of epidemiologists and microbiologists.
2. States must ensure properly trained and dedicated rapid response teams.
3. A system of information must be built up so that triggers of possible outbreaks can be detected and immediate preventive and control action taken.
4. States must **try to** develop atleast 3-4 labs which can confirm the diagnosis of common epidemic prone diseases locally. These should serve as model labs.

### **RESOLUTION IV**

#### **NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME FOR MALARIA**

1. States need to fill up vacant posts of male MPWs and lab technicians to ensure early detection and prompt treatment. The staff is primary responsibility of State Government, hence the State should ensure to fill-up regular vacancy as per norms i.e. one MPW (male) per sub-centre. However, Government of India may provide assistance for high malaria endemic areas to appoint MPW (male) on contractual basis during the 11<sup>th</sup> Plan period.
2. There is need to prepare micro action plan based on GIS mapping in malaria endemic districts for appropriate spray coverage.
3. For indoor residual spray, States should also ensure advance information to the community and supervision of spray teams to improve its coverage.
4. Rapid diagnostic kits being distributed by Government of India to Pf endemic areas should be used in remote inaccessible areas by trained ASHA.

## **RESOLUTION V.**

### **REVISED NATIONAL T.B. CONTROL PROGRAMME (RNTCP)**

1. Recognizing that TB is a major public health problem and noting the commitment shown by Government of India in mobilizing long term funding for Revised National TB Control Programme (RNTCP), States/UTs would prioritize TB control and demonstrate it by assigning full time dedicated programme managers at State and District levels, by ensuring that all contractual staff positions sanctioned under RNTCP are always filled by ensuring active participation of general health staff in RNTCP activities.
2. Aware of the need for implementation of high quality DOTS services under RNTCP in order to control TB and prevent drug resistance and recognizing the importance of effective monitoring and supervision of RNTCP, commit to take steps for intensification of the supervision and monitoring of RNTCP in respective States/UTs.
3. Concerned about the potential for spread of multi-drug resistant TB (MDR-TB) and the risk of emergence of virtually untreatable forms of extensively drug resistant TB (XDR-TB), states to commit adequate human resources and infrastructure to the intermediate Reference Laboratories in order to accelerate their accreditation for diagnosing MDR-TB, and facilitate further the early start of second line anti-TB treatment for MDR-TB patients under DOTS-Plus.

## **RESOLUTION VI.**

### **NATIONAL RURAL HEALTH MISSION**

1. All States to set up Village Health and Sanitation Committees for every revenue village with appropriate delegation of powers within the umbrella of PRIs.
2. All States agreed to speed up utilization of funds for approved activities of NRHM as per their PIP.
3. All States agreed to fully operationalize all Rogi Kalyan Samitis for effective delegation of powers.

### **ASHA**

1. State Governments may wherever not so far completed, put in place the ASHA Support Mechanism at State/ District /Block level, Supply of Drug kits after 1st phase of induction training and ensure timely payment of incentive, TA/DA.
2. The time gap between training of module 1 and modules 2,3 &4 needs to be reduced.
3. State Governments should ensure monitoring of progress at the field level by the community/panchayats.

## **RESOLUTION VII.**

### **NATIONAL AIDS CONTROL PROGRAMME**

1. The Central Council of Health and Family Welfare reiterated its continued support and commitment to the National AIDS Control Programme (NACP) and resolved to constitute State Legislative Fora so that members of the Legislature Assembly and Panchayati Raj Institutions in the State are involved in various activities to mainstream HIV prevention and care & support programmes.
2. The Council resolved to take adequate measures to fill up the regular sanctioned posts and 187 posts of District Programme Officers (DPO) in A&B Districts and 835 contractual posts.
3. Considering the need of specialized trained personnel to maintain high quality of services in the cadre of "Transfusion Medicine", as a specialty to be developed as Post Graduate Course. The Medical Council of India may be involved to develop uniform curriculum for PG Course in Transfusion Medicine.
4. The Council recommended that immediate steps be taken to promote voluntary blood donation programme through involvement of various stakeholders.
5. The Council noted that young adults were at the highest risk of acquiring HIV infection through unsafe sexual practices and intravenous drug use and recommended that the Adolescent Education Programme being implemented in the schools should be continued in a culturally sensitive manner.
6. The Council reiterated its commitment to fight against stigma and discrimination of HIV infected persons at workplace and in health care facilities.
7. The Council strongly recommended that access to condoms be increased by installing condom vending machines in high use area, social marketing and free supply through various NGOs implementing targeted interventions.
8. The Council directed that joint working groups be constituted at the State level with representatives of both NACP & NRHM to review action taken and monitor progress of work related to the priority areas of convergence.

## **RESOLUTION VIII.**

### **AYUSH**

1. Urgent need to bring transparency and accountability in the functioning of CCIM and CCH for proper enforcement of Indian Medicine Central Council and Homoeopathy Central Council Acts. A regulatory mechanism will be put in place to bring transparency and accountability in the functioning of CCIM and CCH for proper enforcement of Indian Medicine Central Council and Homoeopathy Central Council Acts.
2. State Governments to ensure that immediate time bound action is taken to upgrade the infrastructure and fill up the vacancies in teaching and non-teaching posts on all Government and Government aided Ayurveda, Siddha, and Unani and Homoeopathy

colleges in the country. Central Government is already providing liberal grants to the states for infrastructure upgradation of AYUSH colleges. State Governments will have to find resources for creation of required number of teaching and non-teaching posts and to fill them up in a time bound manner. Since Post graduates are not available in some disciplines, a list of allied subjects will be identified for filling up of vacant posts for those subjects.

3. CCH&FW takes note of liberal assistance provided by Government of India to the States for upgradation of AYUSH teaching institutions in 9<sup>th</sup> and 10<sup>th</sup> Plans and the revision proposed in the 11<sup>th</sup> Plan for scaling up the assistance for upgradation of AYUSH teaching institutions. Standard protocol for establishment of quality control laboratories will be developed by Govt. of India.
4. Keeping in view the global resurgence of demand for natural medicinal products and domestic resurgence of interest in Indian System of Medicine, the CCH&FW resolves that the provisions of the Drugs and Cosmetic Act 1940 and Rules 1945 in respect of ensuring standardization and quality control of Ayurveda, Siddha and Unani drugs should be strictly enforced. Central Government has already constituted Pharmacopoeial Committee of experts of AYUSH systems and modern science disciplines like Phyto-Chemistry, Pharmacognosy and Pharmacy for lying down of Pharmacopoeial standards of Ayurveda, Siddha, Unani and Homeopathy medicines.
5. CCH&FW takes note of the liberal assistance provided by the Central Government for up-gradation of State Drug Testing Laboratories and Pharmacies in the 10<sup>th</sup> Plan and the revision proposed in the Scheme in the 11<sup>th</sup> Plan for providing 30% subsidy to Ayurveda, Siddha, Unani and Homoeopathy manufacturing units for establishment of their in-house quality control laboratories, up-gradation of manufacturing facilities to WHO standards and assistance to States for strengthening Ayurveda, Siddha and Unani drugs enforcement machinery.

# ANNEXURES

## **LIST OF POWER POINT PRESENTATIONS**

1. Medical Education and Manpower Needs
2. AYUSH - A Sunrise Sector
3. Meeting Peoples' Health Needs - National Rural Health Mission
4. Issue of Disease Burden - Non Communicable Diseases & Disease Surveillance
5. National AIDS Control Programme

## *Medical Education and Manpower Needs*

1

### *Medical Colleges in India*

- 271 Medical Colleges with capacity of 31,172 students per year
- Govt. Medical Colleges – 138 with admission capacity of 15,947 students
- Private Medical Colleges – 133 with admission capacity of 15,225 students

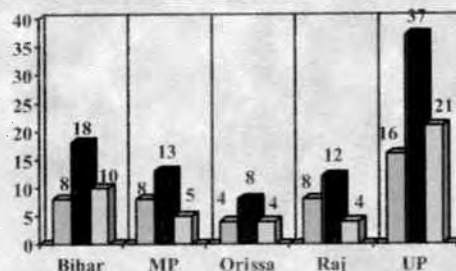
2

- Skewed distribution of Medical Colleges in South India – 162, in other parts – 109
- Imbalance in distribution of medical colleges has a serious bearing on achievements in NRHM objectives

3

### *Acute shortage of medical colleges in the States like UP, Bihar, Rajasthan, MP and Orissa*

■ Existing Medical Colleges ■ Required Medical Colleges  
□ Shortage



4

### *Shortage of teaching faculty*

- Acute shortage of teaching faculty in pre and para-clinical subjects such as Anatomy, Pharmacology, Bio-Chemistry, Physiology, Forensic Medicine and Community Medicine

5

### *Proposed initiatives by the Ministry*

- Amendment to following MCI Regulations: -
  - Minimum Standard requirement for medical college having 50, 100 and 150 seats Regulations
  - Under Graduate Medical Regulations
  - Post Graduate Medical Regulations
  - Minimum qualification for Medical Teachers Regulations

6

- Relaxing norms in setting up of new medical colleges – Unitary campus concept not applicable to NRHM States
- Public-Private Partnership in adopting district hospitals as teaching hospitals
- Relaxation of the teacher-student ratio for PG courses
- Superannuation of age of medical teachers from 65 to 70 years.

- Mandatory Rural Service
- Central assistance to State Govt. Medical/ Dental Colleges @ Rs. 10 crore (one-time grant)
- Central assistance for setting up of 230 Nursing Schools

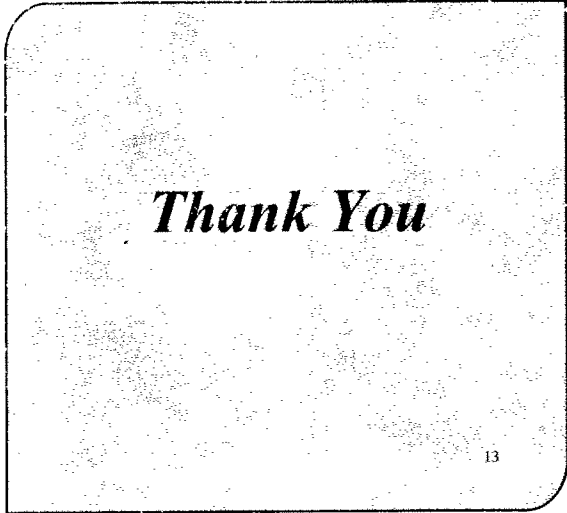
- Central assistance for setting up of Centres of Excellence in Nursing
- Central assistance for setting up of Nursing Colleges
- Central assistance for upgradation of Diploma and Pharmacy Colleges

***Suggested Resolutions for consideration by the Council***

- Deficient States to adopt Public-Private Partnership to set up Medical Colleges and Nursing Schools (NHRC has recommended this)
- Like Assam and Chhattisgarh, other State Govts<sup>3</sup> to introduce a -year diploma course in Medicine and Public Health (NHRC has recommended this)

- States to support mandatory Rural Health Service (NHRC has recommended this)
- States to start more PG courses in the pre and para-clinical subjects
- States to motivate student community to seek admission in pre and para-clinical subjects
- States to give incentives to attract the Academicians for teaching in the medical colleges.

- States to support the new scheme of Central Assistance to upgrade the State Govt. Medical/Dental Colleges
- States to post more doctors, particularly specialists in the subjects of Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, and Anesthesiology in CHCs to serve rural population
- States to set up Nursing Schools in each district hospital with Central assistance



## AYUSH – A SUNRISE SECTOR

Presentation  
by  
Department of AYUSH  
Government of India

### GLOBAL RESURGENCE OF INTEREST IN NATURAL MEDICINAL PRODUCTS

- Global market for natural medicinal products estimated at US \$ 62b
- Yoga and Panchkarma Therapy of Ayurveda gaining popularity worldwide
- Indian herbs like Brahmi, Ashwagandha, Amala, becoming popular like Ginseng
- Constant demand for Ayurvedic teachers from foreign countries
- Indian Experts being sent to medical schools / universities for orientation programmes

- Proposal to set up year-long courses in Ayurveda in foreign universities
- Due to large network of teaching institutions, treatment centres and R&D facilities, AYUSH systems attaining global visibility
- Mainstreaming of AYUSH under NRHM also attracting attention of other developing countries

### INCREASING DEMAND FOR INDIAN AYUSH PRODUCTS AND SERVICES

- India exports 40,000 tons of medicinal plants annually whereas China exports 1,50,000 tons
- Great demand for Ayurveda practitioners, Panchkarma Therapists and Yoga Trainers
- Demand for standardized and quality Ayurveda, Siddha and Unani medicines
- Considerable scope for employment generation and income for Indian farmers by promoting cultivation of medicinal plants.
- Tremendous potential for employment generation for educated youth by increasing domestic use and export of quality AYUSH products and services.

### AYUSH A SUNRISE SECTOR

- To develop full potential of AYUSH Sector in domestic and global market strategic partnership between Government and private sector vital
- Need for strengthening/activating of AYUSH infrastructure at the State level;

Commissionerates / Directorates  
State Medicinal Plants Boards

- Need to streamline enforcement of Drugs & Cosmetics Act and Rules pertaining to Ayurveda, Siddha and Unani medicines for confidence building among consumers and meeting safety/quality norms for increasing exports of ASU drugs
- Upgradation of AYUSH educational institutions essential
- State Boards of Indian Medicine and Homoeopathy need to be activated and update registers of practitioners.

### NEW AYUSH INITIATIVES IN 11<sup>th</sup> PLAN

- National Campaigns on select AYUSH themes:
  - Kshar Sutra for Ano-rectal disorders
  - Homoepathy for Mother & Child Health Care
  - Ayurveda for Geriatrics Care
  - Unani for Skin Disorders
  - Yoga for Mental Health
- Active participation of State Governments/Institutions – National Workshops to be followed by State Level Workshops and District/Sub-district level awareness camps

7

- Existing Centrally Sponsored Schemes revamped and scaled-up
- Rs.500 crore programme for upgradation of AYUSH manufacturing Clusters
- 30% subsidy upto Rs.30.00 lakh to ASU&H companies for establishing in-house quality control laboratory and upgradation of production facilities to WHO/US FDA GMP level

8

- Setting up of Medicinal Plants Processing Zones/ value addition/ marketing facilities
- Financial support to Centres of Excellence in Government/ Non-Government sector engaged in local health traditions/ public health/ drug standardization/quality control/ medicinal plants sector etc

9

*Thanks*

10

# Meeting People's Health Needs

The Progress so far  
The Way Ahead  
13<sup>th</sup> November 2007

Presentation before CCHFW

Ministry of Health & Family Welfare,  
Government of India

## NATIONAL GOALS & MDG

	X FY Plan 2007	NPP 2010	MDG 2015	Current
Infant MR	45	<30	27	58 (SRS 2005)
Maternal MR	200	<100	100	301 (SRS 01-03)
Total fertility R		2.1	2.1	2.9
Institutional deliveries	80%	80%		40.7 (NFHS III)



## India's Health Indicators

### Large inter state variations

State/UT	IMR SRS 2005	MMR SRS 01-03	TFR SRS 2005
Kerala	14	110	1.7
Madhya Pradesh	76	379	3.6
Orissa	75	358	2.6
Tamil Nadu	37	134	1.7
Uttar Pradesh	73	517	4.2
All India	58	301	2.9

## National Rural Health Mission launched in April, 2005

Rejuvenate the Health delivery System

Universal Health Care

Access  
Affordability  
Equity  
Quality

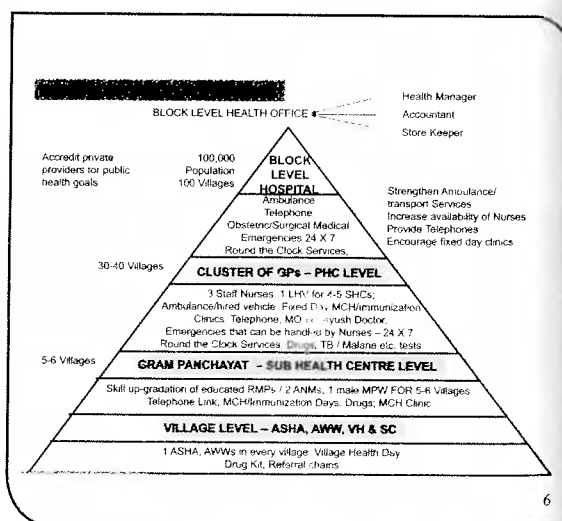
Reduce IMR, MMR, TFR  
Improve Disease control

4

## Goals of the Mission

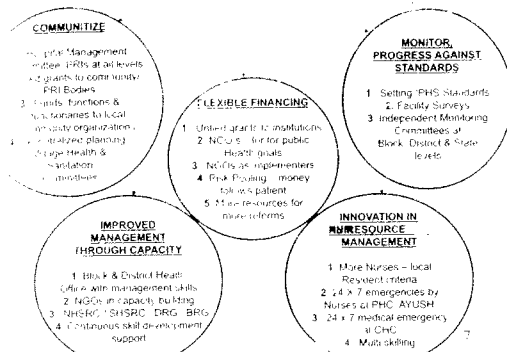
- Universal Health care, well functioning health system.
- Reduce IMR to 30/1000 live births by 2012
- Reduce MMR to 100/100,000 live births by 2012
- TFR reduced to 2.1 by 2012
- Reduce & sustain Malaria Mortality to 60% by 2012
- Kala Azar eliminated by 2010, Filariasis reduced by 80 % by 2010
- Dengue Mortality reduced by 50% by 2012
- TB DOTS maintain over 70 % case detection & 85% cure rate
- 46 lakh cataract operations annually by 2012.
- Upgrading all health facilities to IPHS
- Increase utilization of FRUs from 20% bed occupancy to 75%

5

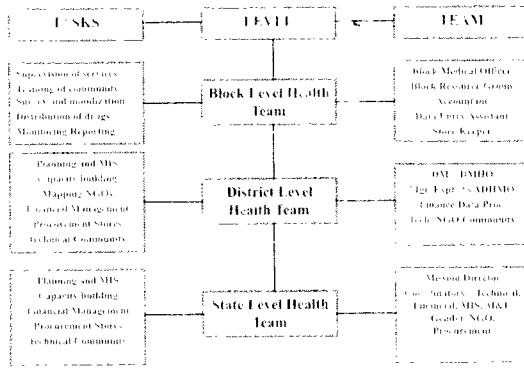


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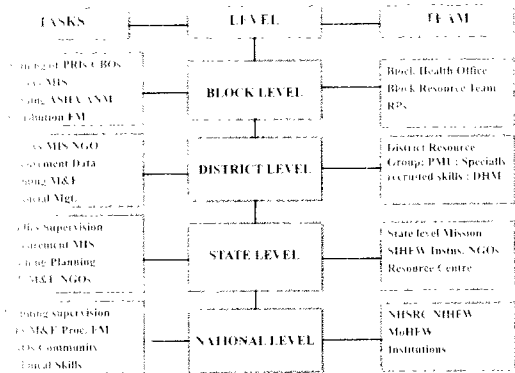
### NRHM 5 MAIN APPROACHES



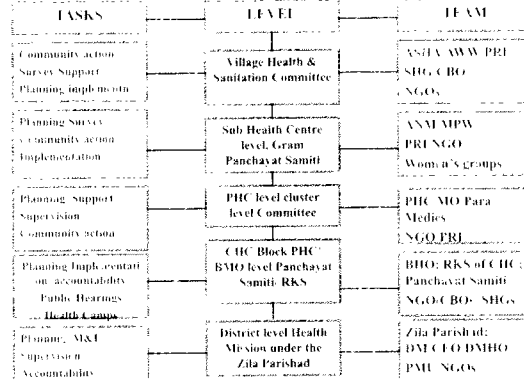
### MANAGEMENT OF HEALTH SYSTEM



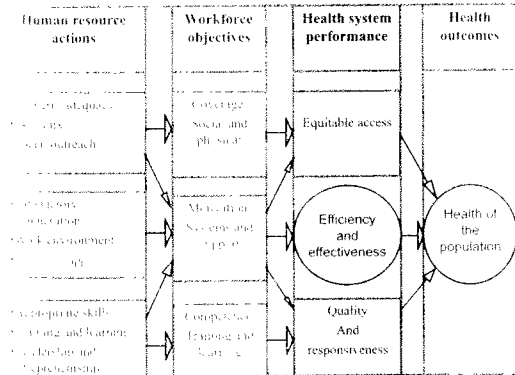
### BUILDING CAPACITY THROUGH RESOURCE GROUPS



### COMMUNITIZATION OF HEALTH CARE



### Managing for performance



Key interventions

## Village level

13

### Improving the Health care Delivery -Village level

- Operationalise Village Health & Sanitation Committees.
- Optimally utilise Untied grant of Rs. 10,000 for every VHSC.
- Select and mentor the Community link workers selected.  
(ASHA in high focus states & tribal & underserved areas of other states, Mitranis in Chhattisgarh, RCH link workers in other states)
- Village Health Plans and Annual Household surveys.
- Monthly Health Days at Anganwadi Centres.

14

## Sub Centre level

15

### Improving the Health care Delivery Subcentres (1,44,988)

- Optimize setting up as per population / geography / accessibility / epidemiology
- Road map for upgradation to IPHS
- Operationalise joint accounts of ANM and Pradhans.
- Productive utilisation of Untied fund of Rs. 10,000  
(Rs. 142.49 crore during 2005-06 & Rs. 61.05 crore during 2006-07)
- Ensure presence of locally recruited contractual second ANM.
  - 17,689 ANMs recruited on contractual basis during 2006-07
- Expand ANM training capacity in the state

16

## Primary Health Centre level

17

### Improving the Health care delivery System PHC (22,669)

- Optimize setting up as per population / geography / accessibility / epidemiology
- Operationalise PHCs on 24x7 basis.
- Road map for upgradation to IPHS, Operationalise Rogi Kalyan Samitis.
- Optimum utilisation of Annual Untied grant @ Rs 25,000 & Annual Maintenance Grant @ Rs. 50,000 per PHCs.
- Positioning Three staff nurse, contractual HR, AYUSH
- Expanding Nursing and Paramedic Training Capacity
- NGO partnerships (Arunachal, Karnataka , Bihar)

18

## Block Level

19

### **Improving the Health care delivery System CHCs (3910)**

- CHCs upgraded to First referral Units and eventually to IPHS.
- Seven specialists, Nine nurses in place of seven
- Management support
- Complete Facility survey
- Operationalise RKS (corpus fund Rs. 1 lakh).
- Optimal utilisation of Annual Maintenance Grant @ Rs. 1 lakh and Annual Untied funds @ Rs. 50,000.

20

## District Level

21

### **Improving Health care delivery System District Hospitals**

- Operationalise the District Health Mission.
- Integrated District Health Action Plans.
- Set up and upgrade all District Hospitals.
- Road Map for upgradation to IPHS.
- Operationalise the RKS (annual corpus Rs. 5 lakh).
- Open ANMTCs with all DHS.
- Medical colleges with large DHS

22

## State Level

23

### **Interventions at State level**

- Strategic guidance by State Health Mission & State Health Society
- Integrated State Health Society
- Common Funding channel
- Delegation of Administrative & Financial powers
- Capacity Building
  - Medical colleges
  - Nursing Colleges
  - Other paramedical training institutions
  - Rationalisation of Human Resource policies
- Community Monitoring

24

# The Way ahead

25

## Resident Health Workers

- Selecting ASHAs as Community Workers with drug kit.
- ANMs on contract and local criteria; Improved governance.
- More Nurses at PHC to make it 24X7
- Incentives for remote PHCs/CHCs
- Decentralized public recruitments with flexibility & Local Accountability – Local Government/Society
- Improved cadre management of doctors/nurses.
- Incentives for services of Specialists.
- Developing benchmark for performance – blended payments at all levels – fixed salary and performance based payments.
- Institutionalizing money following the patient in Government Hospitals – use of cashless services for BPL through Community Health Insurance.

26

## Reforms in Medical Education

- Reforms in Medical Education – Making the MBBS programme even more relevant to Rural Health Service.
- Developing three year programme for Basic Medical Practice.
- Compulsory rural posting of Doctors.
- Developing Nurse practitioner programmes.
- Strengthening Nursing Education at all levels.
- Opening Nursing Colleges in all Medical Colleges.
- Addressing shortage of Medical Colleges in deficient States
- Cadre of Nursing with career progression – ASHA, AWW, ANM, Staff Nurse, Nurses in Districts, Nurse Managers.
- Co location of AYUSH;
- Training/certification of RMPs legal framework and supervision.
- Weeding out 'crookery and quackery'

27

## Making Communitization Work

- Community Organizations established/being established at all levels – Village Health, Sanitation, Nutrition Committees; Sub Centre level PRI Committee, PHC, CHC, District Hospital level Hospital Development Committees, District Health Mission, State Health Mission.
- Resources available for local health action.
- Making community leaders active in management of health facilities and in convergent health action.
- Making ASHAs effective through constant resource support.
- Improved Hospital Administration and Management.
- Capacities for decentralized planning at all levels – Analyzing local indicators – Panchayats and human development issues.

28

## Skill Development

- Skill Training at all levels – Skilled Birth Attendants, Home Based New Born Care, IMNCI, Training for National Health Programmes.
- Training institutions at all levels.
- Involvement of Non Governmental Hospitals in building capacity.
- Strengthening ANM Training Schools, RRCs, SIHFWs, NIHFW.
- Building new skills in health management – District, State and National level Health System Resource Centres.
- Resource Groups at various levels.

29

## TNMSC like systems in States

- System reforms and capacity building at all levels.
- TNMSC like model for States.
- Work in progress in many States – need to strengthen capacities in States.
- Linking procurement and logistics.
- Improved systems of generating demand for drugs.
- Procurement quality and utilization audits.

30

## Strong Management

- Decentralised with untied resources at all levels.
- Convergence and integration in action – water; sanitation, HIV/AIDS/School Health, Education, Nutrition, ICDS, etc.
- Leadership of States – GoI to facilitate reform with additional financial resources; monitor agreed standards and benchmarks (MoUs) with States; support capacity building .
- District and Block level Health Mission and Resource Groups.
- SHC/PHC/CHC/District Hospital provide functional platform for all other interventions.

31

## Effective Monitoring

- Key priority in NRHM. Monitoring against IPH standards at all levels – SHC, PHC, CHC, Sub Divisional/District Hospital level.
- District Health Action Plan to provide specific health facility wise commitment on service guarantees against resources.
- Independent monitoring committees at block, district and state levels – Pilot in Community Monitoring through JSA
- Independent evaluation / surveys- system getting in place.
- Annual State and District Health Report Cards.
- Public hearings, MIS, Audit, PRIs, RKSSs, etc.
- Review Missions to States and Districts.

32

## Immediate priorities

- Institutionalize community ownership.
- Create confidence to spend.
- Monitor institution -- wise.
- Put systems in place for faster implementation – civil works, procurement of goods and services, human resources.
- Seek service guarantees.

33

# THANK YOU

web : [mohfw.nic.in\nrhm.htm](http://mohfw.nic.in/nrhm.htm)  
email : [healthmission@nic.in](mailto:healthmission@nic.in)

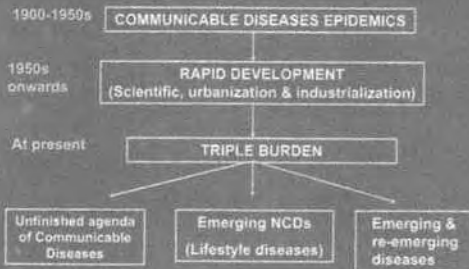
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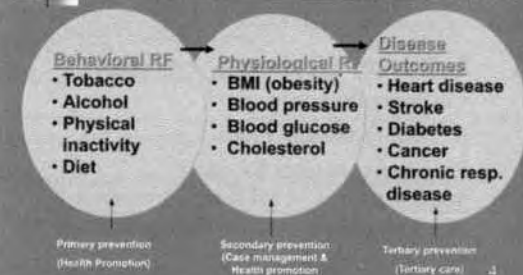
ISSUES OF DISEASE BURDEN  
NON COMMUNICABLE DISEASES &  
DISEASE SURVEILLANCE

DR. R. K. SRIVASTAVA  
Director General of Health Services  
Ministry of Health & Family Welfare  
Government of India  
November 2007

Health transition in developing world  
including India.



Indicators and level of NCD prevention and management



NCD morbidity profile - India

Cancer :	2.5 million
Diabetes:	35 million
Coronary Artery Disease:	30 million
Cerebro-vascular Disease:	2 million
Chronic Obstructive Lung Disease:	39 million
Road Traffic Accidents:	5 Lakhs*
Mental Illness (severe):	2 million*

All figures are estimates only

Obesity

- Risk Factor for
- Diabetes
  - Stroke
  - Heart Disease / Hypertension
  - Gall Bladder Disease
  - Osteoarthritis
  - Sleep Apnoea
  - Cancers
  - Kidney/Uterine/  
Breast/Colon



### Alcohol

- Increased risk of cardiovascular diseases (Coronary Heart Disease, Stroke, Hypertension)
- Increased risk of cancer: (liver, stomach, colon, pancreas, breast, mouth, throat)
- Impaired immune system
- Malnutrition/Obesity
- Reproductive problems
- About 50 % motor accident deaths
- Risky behaviour
- Violence
- Poor academic performance



### Tobacco



- 18.4 Crore Tobacco users in India
- About 0.8 million die every year due to tobacco use related diseases in India
- Total economic cost of the 3 tobacco related diseases (CVD, Cancer & COPD) is Rs. 27,760 crore per annum
- Health consequences of tobacco
  - Cardio-Vascular Diseases, Peripheral vascular disease
  - Cancer: bladder, cervix, oesophagus, oral cavity, lungs, stomach, leukemia, kidney etc.
  - Respiratory diseases: COPD etc.
  - Reproductive effects: Abortion, low birth weight etc.
  - Osteoporosis, cataract, caries, early ageing etc.

### What are we doing? 11<sup>th</sup> Plan NCD Prgm. Budget

National NCD Programs	Rs. (in Crore)
Cancer	1390
Blindness	1500
Mental Health	570
Drug De-addiction	75.5
Iodine Deficiency Disorder	155
Telemedicine	183
CVD, Diabetes & Stroke	1620
Organ Transplantation	51
Oral Health	50
Fluorosis	10.7
Geriatrics	400
Deafness	125
Medical Rehabilitation	50
Trauma	732
Tobacco Control	472

### What can be done for NCD Control ?

#### WHO Strategy on Diet, Physical Activity and Health

- National strategies on diet and PA: healthy choices
- National dietary guidelines
- National Physical activity guidelines
- Information environment: health claims, marketing, labelling, nutrition education
- National food and agriculture policies: pricing, food programmes
- Building prevention into health services
- Surveillance, research and evaluation
- Institutional capacity
- Specific reference to international standards like CODEX

### Healthy Lifestyle Initiatives

- Health Awareness Drive for Parliamentarians carried out in 2005 & 2006; Booklet sent to all States
- Healthy India Website started recently  
website - <http://healthy-india.org/>

Welcome to

### National Action Plan

- Developing a consensus on national action plan for promotion of healthy diet and physical activity
- Creating an appetite for a healthy diet
- Strategic pathways including capacity building
- Policy measures
  - Neighbourhood availability of fruits and vegetables
  - Affordability
  - National laboratories for nutritive value of foods
  - Discourage restaurants from promoting junk food
  - Food labels (calories, salt content, type of fat, unhealthiest of food etc)
  - Nutrition labelling for ingredient communication
  - Type of fat in bread and bakery items
  - Colour coding (to overcome literacy barriers)

### Key scientific recommendations for action in the area of diet

DIET - preferred changes in the population

- ↑ Fruit and vegetable intake
- ↓ Unhealthy fats (Saturated fats e.g. Animal fats, milk products; trans fats - hydrogenated vanaspati)
- Substitute with healthy fats
  - PUFA e.g. Fish oil;
  - MUFA e.g. pea nut oil
- ↓ Salt intake
- ↓ Consumption of simple sugars

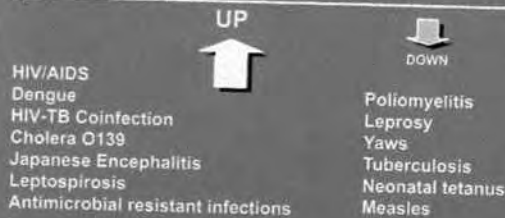


### Physical activity

At least 30 minutes of regular moderate-intensity physical activity on most days reduces the risk of cardiovascular diseases and diabetes, colon cancer and breast cancer. More activity may be required for weight control. Physical activity good for mental health, bones & joints and respiratory system etc.



### Changing Scenario of Communicable Diseases in India



Eradicated : Smallpox , Guinea worm

### Tuberculosis

**Incidence of TB disease:** 1.8 million new TB cases annually (0.8 million new infectious cases)

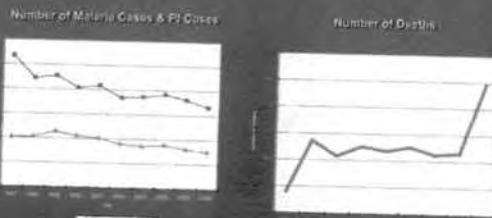
**Prevalence of TB disease:** 3.8 million bacteriologically positive (2000)

**Deaths:** about 370,000 deaths due to TB each year

**TB/HIV:** >5 million people with HIV; >2 million co-infected with HIV & TB

About 5% of TB patients estimated to be HIV positive  
RNTCP programme performance as per global targets 70% New sputum positive case detection rate and 85% cure rate  
Till date, more than 7.8 million patients have been placed on DOTS under RNTCP

### MALARIA SITUATION IN INDIA (1997-2006)



Report up to	Positive cases	Pf cases	Deaths
2006 (up to Aug.)	0.68 million	0.35 million	711
2007 (up to Aug.)	0.59 million	0.30 million	586

### Dengue - 2006 - Chikungunya



Total no of states/UTs affected :21  
No of confirmed cases of Dengue fever : 12317, No of deaths : 185

Total no of states/UTs affected :16  
No of suspected cases of Chik fever: 1990322  
No of samples sent for sero-diagnosis : 15961 confirmed : 2001 (12.5%)

### Why should we have disease surveillance?

- Determine disease trends, seasonality of diseases
- Recognize clustering to trigger investigations
- Identify high risk groups or geographical areas
- Estimation of disease burden
- Monitor effectiveness of prevention and control measures
- Provide essential data to plan, implement, and monitor intervention programmes to reduce morbidity and mortality

### Weaknesses in Disease Surveillance

- 'Felt need' but inadequate capacity
- Limited epidemiological capacity to undertake analysis and response at district level
- Poor laboratory capacity
- Slow, inefficient sharing of surveillance data
- Lack of integration of private sector

### Integrated Disease Surveillance Project

- Major Objective:
  - Early detection and response to outbreaks
- Major components:
  - Integrating and decentralization of surveillance activities
  - Strengthening of public health laboratories
  - Human Resource Development – Training of SSO, DSO, RRT, other medical and paramedical staff
  - Use of Information Technology for collection, collation, compilation, analysis and dissemination of data

### IDSP Phase I -III

Phase-I (2004-05)	Phase-II (2005-06)	Phase-III (2006-07)
Andhra Pradesh Himachal Pradesh Karnataka Madhya Pradesh Maharashtra Uttaranchal Tamil Nadu Mizoram Kerala <u>2 STATES</u>	Chhattisgarh Goa Gujarat Haryana Rajasthan West Bengal Manipur Meghalaya Orissa Tripura Chandigarh Pondicherry Delhi Nagaland	Uttar Pradesh Bihar Jammu & Kashmir Jharkhand Punjab Arunachal Pradesh Assam Sikkim A & N Nicobar D & N Haveli Daman & Diu Lakshadweep <u>22 STATES</u>

### Information Flow

#### Weekly Surveillance System



### What needs to be done by States to improve disease surveillance?

- States should own IDSP, realize its need and importance and monitor it at a high level
- Strong coordination between DHS and DME
- Dedicated State and District Surveillance Officers
- Strengthen Public Health Capacity at State-District levels
- Doctors record diagnosis in OPD registers, OPD data collected from major Hospitals
- Data are compiled, analyzed and used at all levels
- Effective convergence with other National Health Programmes

### Challenges

- Huge magnitude of morbidity
- Competing priorities
- Health is a State subject and States have their priorities
- Health system challenges
  - Infrastructure
  - Personnel
- Limitations in public health approach to Disease surveillance & control
- Limited public health capacity
- Market forces



THANK YOU



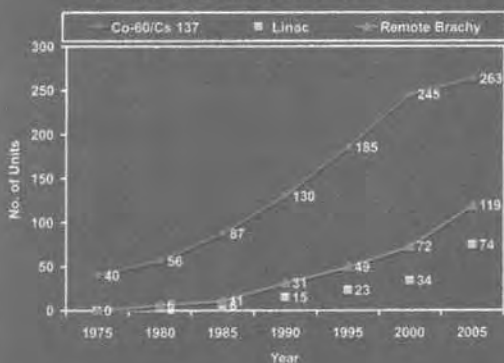
THANK YOU

### CHANGE IN RANK ORDER OF DALYs (Disability Adjusted Life Years) FOR TEN LEADING CAUSES IN THE WORLD, 1990-2020

No.	1990	No.	2020
1	LOWER RESPIRATORY TRACT INFECTIONS	1	ISCHEMIC HEART DISEASE
2	DIARRHOEA	2	DEPRESSION
3	PERINATAL CONDITIONS	3	ROADSIDE ACCIDENTS
4	DEPRESSION	4	C.V.A.
5	ISCHEMIC HEART DISEASE	5	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
6	C.V.A.	6	LOWER RESP. INF.
7	TUBERCULOSIS	7	TUBERCULOSIS
8	MEASLES	8	WAR (DISEASES AND INJURIES)
9	ROADSIDE ACCIDENTS	9	DIARRHOEA
10	CONGENITAL ANOMALIES	10	HIV/AIDS

Source: The Global Burden of Disease; WHO 1996

Year-wise Distribution of Radiotherapy Machines in India



### Cancer Scenario - India

- Estimated 2.5 million cases of cancer
- Estimated 9 lakh new cases detected every year
- Estimated 4 lakh die each year due to cancer
- Tobacco related cancers 50%(m) & 25% (f)
- 2/3<sup>rd</sup> are advance at the time of diagnosis. One third can be detected early and cured by appropriate measures.
- 11<sup>th</sup> plan budget allocation 1350; requirement more than 3000 Crores

## CARDIO-VASCULAR DISEASES



- CHD Deaths = 8 lakhs
- Stroke Deaths = 6 lakhs
- Hypertension = 10-15 %
- Rheumatic Heart Disease (RHD) deaths = 1.5 lakhs
- RHD prevalence = 1-5/1000 ( 5-15 years)
- CVD & Stroke Deaths = 23%

## Diabetes



- Global increase in prevalence of type 2 diabetes
- Alarming increase in Indians
- Prevalence 2-5 % rural & -11 % urban population
- Type 2 diabetes associated with increased risk of Coronary Heart Disease
- WHO predicts by 2020 India will have 20% of Diabetics out of estimated 60 million in the world
- National CVD prevention and control program initiated; pilot under implementation

## Deafness



- Prevalence of 291 per lakh population of severe to profound Hearing Loss (NSSO, 2001)
- Over 50% of causes of Hearing Impairment are Preventable.
- Severe loss of productivity (Physical & Economic)
- Inadequacy of existing Health Resources
- Treatable, Rehabilitation possible
- Rs. 124 Crores allocated for five year plan

## Mental Disorders

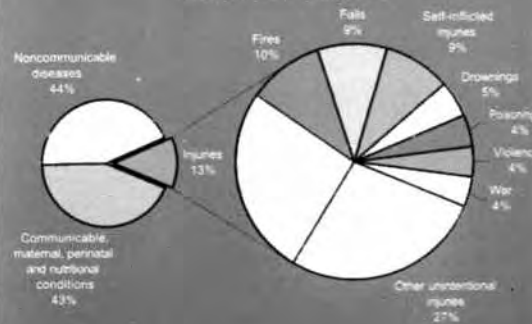
- Prevalence : 6-7 % of the population
- World Health Report (2001) estimate: prevalence- 10%
- Preliminary Data from ECA multicentric study (India): 9.6 %
- Neuropsychiatry disorders account for 12% of the global disease burden (World Health Report, 2001)
- Burden of these disorders is likely to increase to 15% by 2020 (World Health Report,2001)
- Estimated that a minimum of 7 crore persons would need immediate care for severe and moderate (easily recognizable ) problems
- Total allotment for 11<sup>th</sup> plan period is Rs.1000 crore

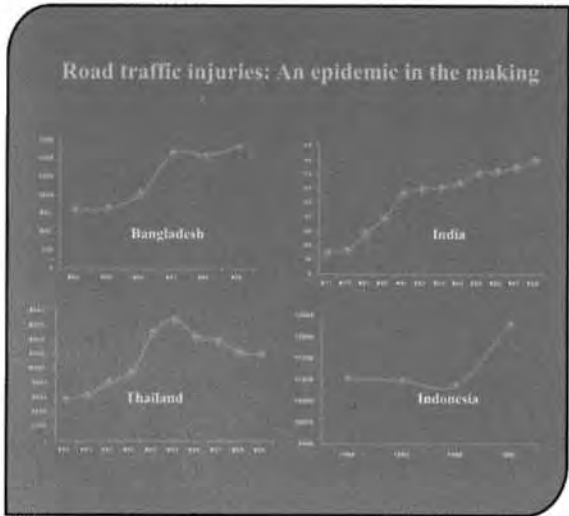
## ESTIMATED BURDEN OF NEUROLOGICAL DISORDERS IN INDIA

Disorder	Estimated Burden (India) (in Lakhs)
Total Neurological Disorders	335
Epilepsy	88.2
C.V.A.	15.1
Dementia	1.3
Parkinsonism	2.7
Post traumatic disorders	2.0
Post encephalitic sequelae	3.6
Mental Retardation	14.1
Anterior Horn cell Disorders	11.0
Intracranial lesions	1.7

BURN Survey ; Gourie Devi et al ICMR1995

## Distribution of Burden of Injuries in South East Asia Region, 2000 Estimates





### Trauma deaths by causes in India according to the police records and the survey of Causes of Death in 1990.

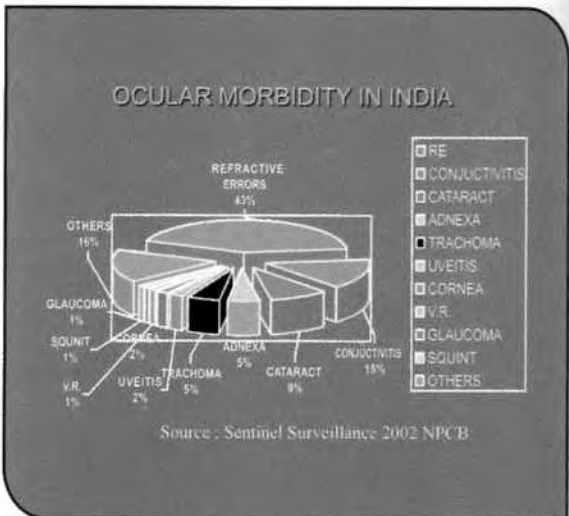
(Figures in thousands)

Cause	Police (NCRB)	Survey (RGI)
Vehicular accidents (road,rail,air,water)	57.7	162.8 (23.9%)
Suicides	73.9	127.3 (18.7%)
Burns	20.5	92.6 (13.6%)
Drowning	24.4	80.4 (11.8%)
Snake bites	4.5	60.6 (8.9%)
Falls	3.7	40.2 (5.9%)
Natural Calamities	4.6	18.4 (2.7%)
Homicides	39.3	27.9 (4.1%)
Other	not stated	Remaining (10.4%)
Total	287.6	681.0 (100%)

### Projected No. of Road Accidents in India (Method of Linear Regression)

YEAR	FATALITIES	INJURIES
2001	86,630	4,03,183
2011	1,16,802	5,47,761
2021	1,46,972	6,92,339

Source : Health care – Technology Vision 2020, Department of Science and Technology



### National Programme for Control of Blindness

Prevalence of Blindness as per Survey during November 2006 :- 1.00%

50.40 lakh Cataract Surgery reports from the Country during 2006-07 out of which 93% were IOL Implantation.

Plan outlay for 2007-08 - Rs. 140 crore.

### Osteoporosis

- 150 million worldwide
- 61 million in India
- Life span increase result in increase of disease
- 60% fractures due to Osteoporosis
- One out of eight males and one out of three females in India has osteoporosis
- Indians lower bone density & osteoporotic fractures occur 10-20 yrs earlier in Indians
- 2<sup>nd</sup> highest post menopausal women in India by 2030; increase osteoporosis burden
- Economic and social burden high; example in USA 60 billion per annum cost

### Iodine deficiency Disorders (IDD)

- 1.5 billion at risk in the world
- 200 million at risk in India
- 263 out of 324 districts surveyed are endemic
- > 71 million suffering from IDD
- CCHFW 1984 advised to iodate entire edible salt by 1992
- 11<sup>th</sup> plan goal – 100 % consumption of iodised salt

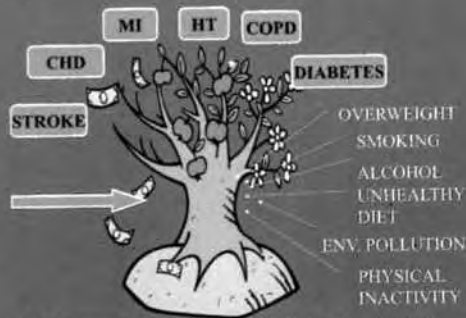
### Other Non Communicable Diseases

- 51.8% women suffer from **Anaemia** (<11.0 g/dl)
- 74.3% new born babies (6 months to 35 months) were found to be Anaemic. (<11.0 g/dl)
- 2468 persons suffer from **Asthma** per lakh population
- Rural prevalence is more than urban.
- Children and adolescents suffer more than others

Source: National Family Health Survey II (98-99)

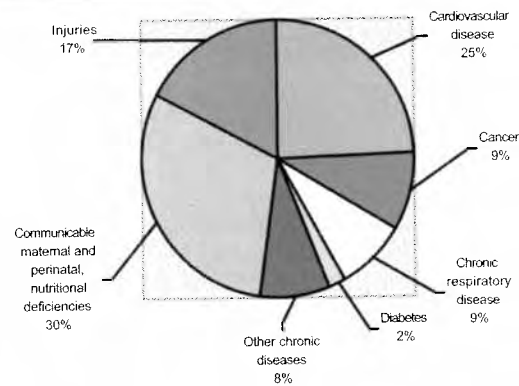
Sample size 91196 representative households in 26 states

### Disease Prevention and Health Promotion



“Hit the trunk; branches will fall automatically”

### Projected deaths by cause, 30-59 yrs, India, 2005



### THE WAY FORWARD: STRATEGIC ACTIONS

- Improving social determinants
- Rural Health Delivery
- Community Participation
- Health spending
- Insurance and Risk Pooling
- Disease Prevention and Health Promotion
- Infrastructure strengthening
- Institutional regulation
- Control of triple disease burden
- Research and technology



### Reaching out to the people: The role of the media and models

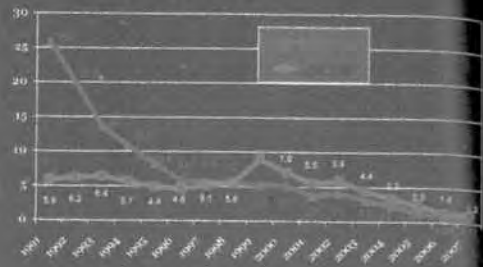
- Strategies for health awareness
- Partnership with television production houses
- Celebrity endorsements
- Advertising industry
- Media's role
- Public awareness programmes
- Role of health professionals
  - Motivation, awareness, adoption of healthy behaviours



### LEPROSY

- 0.83 lakh cases on record (PR - 0.72/10,000)
- 1.39 lakh new cases detected year 2006 - 07
- 7 States/UTs viz. Bihar, Chhattisgarh, West Bengal, Jharkhand, Delhi, D & N Haveli and Chandigarh had PR > 1/10,000 population.
- 28 States/UTs have achieved the elimination level.
- Out of 1.52 lakh cases deleted, 1.37 lakh (90.6%) completed treatment within time
- Eleventh plan allocation 268.70

### Decreasing New Case Detection Rate



PR- Prevalence ANCDR - Annual New Case detection Rate

### Emerging Pathogens

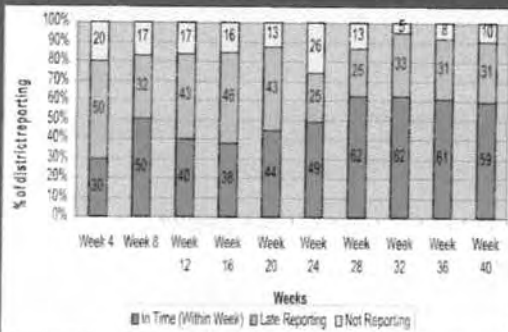
- New pathogens are emerging at an appropriate rate of one per year.
- Poses serious diagnostic, treatment, prevention & control threat.
- Changing character of existing pathogens: H5N1 (Avian Flu) poses an imminent pandemic threat.
- SARS, Nipah virus infection are some of the recent examples.
- Genetic modification of existing pathogens for deliberate use as bio-weapons.

### Emerging Infectious Diseases

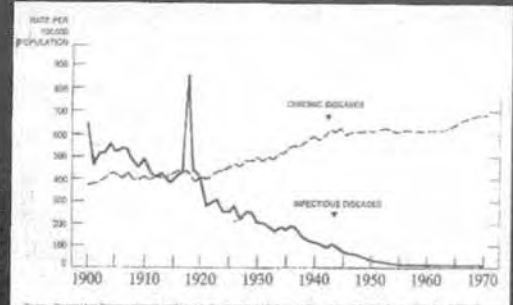
Emerging Infectious Diseases (EIDs) are those that have either newly appeared or are rapidly increasing in incidence.



### Status of Reporting under IDSP - Phase I



### Chronic and Infectious Diseases Rates (1900 - 1970)





## National AIDS Control Programme

Central Council for Health & Family Welfare  
13 November 2007

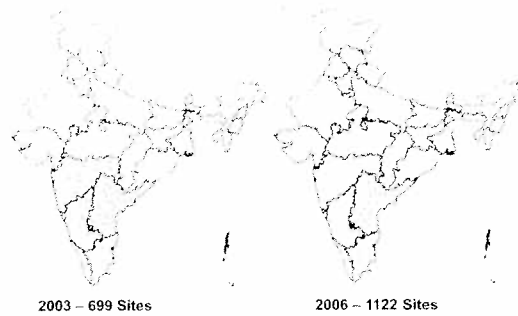
National AIDS Control  
Organization  
Ministry of Health & FW  
Government of India

### Outline

- Situational analysis
- Prevention
- Care and support
- Program management
- Issues and challenges

## Situational Analysis of HIV/AIDS in India

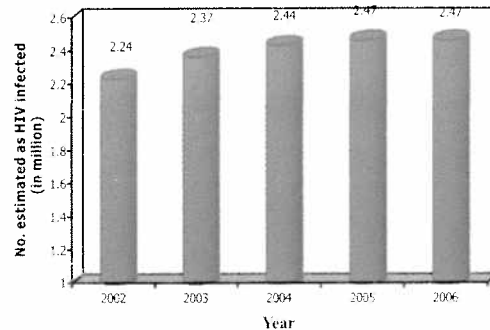
### RICHER DATA SETS



### Revised Estimates: 2006

- Prior to 2006 HIV estimation: Sentinel surveillance Adult HIV prevalence estimated at 0.9%; number of HIV infected adults 5.2 million
- During 2006: Two data sources:
  - Sentinel surveillance-1122 sites; 3.4 lakh blood samples
  - Population-based National Family Health Survey-III-1.03 lakh blood samples
- In addition, IBBA data (30,000 sample) & BSS survey (1.2 lakh persons)
- 4 National and 2 international consultations held
- Current estimates: Prevalence 0.36%; 2-3.1 million HIV infected persons

### Revised HIV Estimates: India 2002-06





## National AIDS Control Programme

Central Council for Health & Family Welfare

13 November 2007

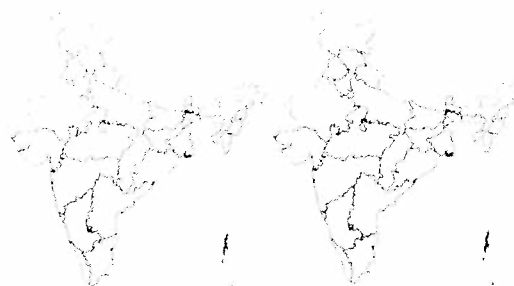
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## Situational Analysis of HIV/AIDS in India

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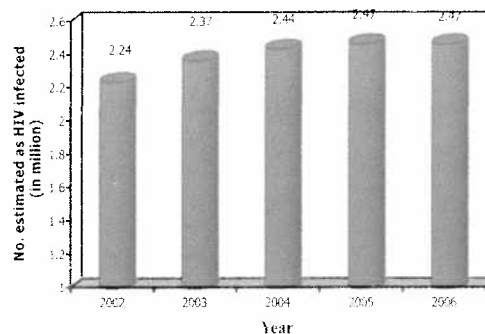
2003 – 699 Sites

2006 – 1122 Sites

### Revised Estimates: 2006

- Prior to 2006 HIV estimation: Sentinel surveillance  
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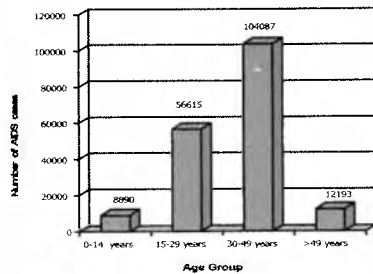
### Revised HIV Estimates: India 2002-06



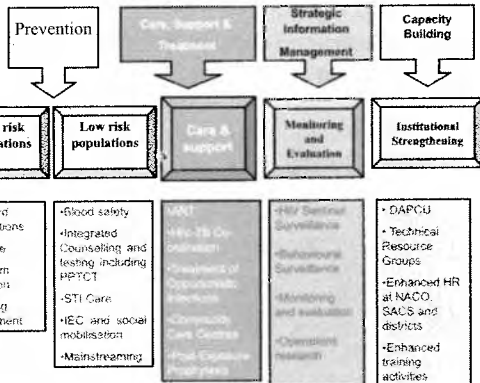


### Age distribution of reported AIDS cases in India

A total of 181785 AIDS cases reported till June 2007: 31.2% female



### National Response



### Prevention

### Saturation of High Risk Groups....

- From 764 interventions in 2007 to 2100 in 2012
- Saturation of 80% High Risk Groups
- Increase coverage of underserved groups like MSM and IDU & Bridge Populations
- Shift to community led structures - target of 50% TIs to be Community Based Organisations



### Sexually Transmitted Infections

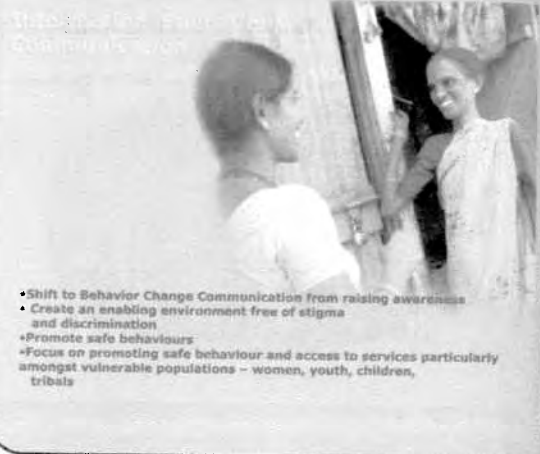
- About 30 million episodes of STI per year
- Integration with NRHM
- Support to private sector care providers
- Linkages for high risk groups
- Target to cover 10 million episodes per yr.



### Condom Promotion

Increasing condom usage from 2.1 billion in 2007 to 3.5 billion annually by 2012

- Expand condom marketing
- Up-scale social marketing from current 0.6 billion to 2 billion annually
- Condom stocking outlets from 1 million – 3 million
- Promote female condom especially amongst FSW
- Special condoms for vulnerable groups
- non-traditional outlets to increase availability in rural areas



- Shift to Behavior Change Communication from raising awareness
- Create an enabling environment free of stigma and discrimination
- Promote safe behaviours
- Focus on promoting safe behaviour and access to services particularly amongst vulnerable populations – women, youth, children, tribals

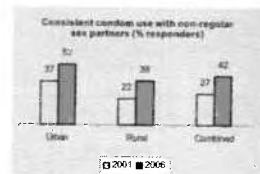
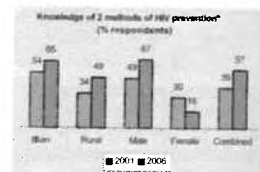
### New Initiative: Red Ribbon Express



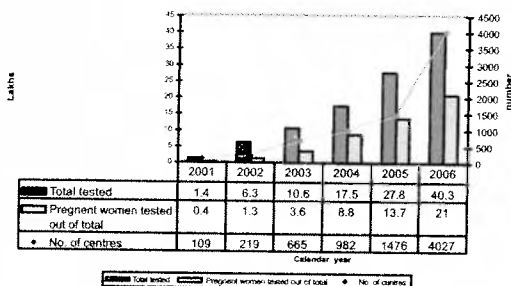
- Red Ribbon Express approved in collaboration with Rajiv Gandhi Foundation
- Proposed to be launched on World AIDS Day 2007
- The train starting from Delhi will traverse India in a Bharat Parikrama Pattern covering 180 stations in 21 states
- Bus Caravans to run along with the train to organise outreach programmes in the far flung areas
- The train will have provision of exhibition on HIV, counseling and referral services to ICTCs, along with cultural troops for IEC

Awareness about HIV is increasing, but is still low

Unsafe sex is common among general population



### Year wise progress in Integrated Counseling Testing Services



From tests in 2007 to tests annually in 2012

Only 30% of the total estimated PIHA know their status. During Jan-July 2007, about 3.1 million people have been counseled and tested.

- Single window access for services: Voluntary testing, PPTCT, STI care, Condom, ART referral & HIV-TB referral
- Collaboration and partnerships with private and NGO sector
- EQAS



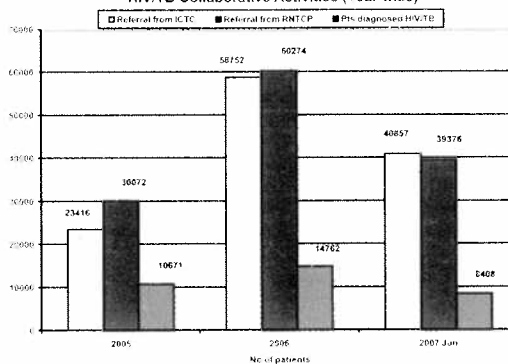
## Prevention of Parent to Child Transmission



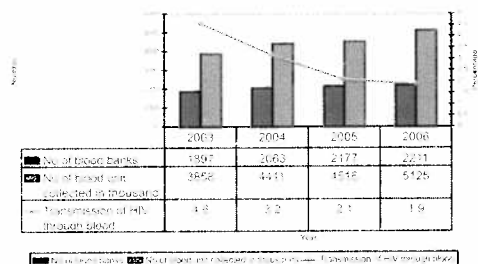
Towards providing antiretroviral drug prophylaxis to 75,000 HIV+ mothers in 2012

Year	Tested (in lakhs)	Positive
2003	1.3	3173
2004	1.4	6446
2005	6.5	3775
2006	23	11817
2007	21	10566

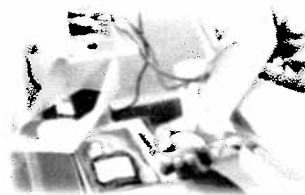
## HIV/TB Collaborative Activities (Year wise)



## Blood safety



## Blood Safety



From 1.92% transmission in 2007 to 0.5% in 2012

- Establishment of National Blood Transfusion Authority under process.
- Draft "law" addressing all issues related to Blood Transfusion Services on the anvil
- Establishment of Centre of Excellence in Transfusion Medicine in four metro cities with capacity to handle 1 lakh units of blood annually.
- Networking of blood banks with Blood Storage Centres to maintain supply of blood to far flung areas.
- voluntary blood donation to 90% of requirement
- Setting up of 4 Metro & 32 model blood units

## Care, Support and Treatment

## Community Care centers (CCC)

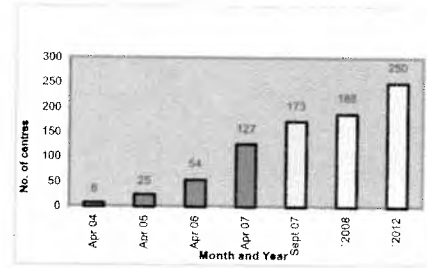
- The role of CCC has been changed from a hospice taking care of terminally ill patients under NACP II.
- Under NACP III, the CCC shall be linked to ART centers and will have role in treatment of opportunistic infections (OI), drug adherence and psycho social support.
- Plan to operationalise 350 CCC by 2012 (presently, only 96 are functional).
- NACO support to CCC increased from Rs 10 lakhs to Rs 17.5 lakhs per year in addition to one time grant of Rs. 4 lakh

## ART Programme

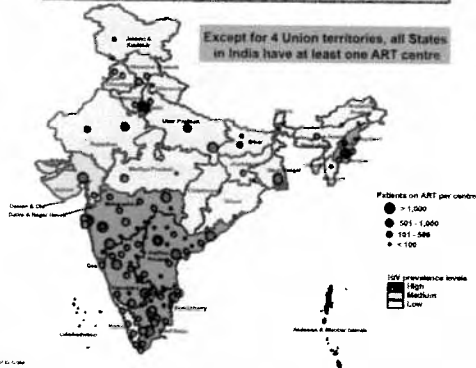
- Started on 1<sup>st</sup> April 2004 at 8 institutions, Presently, 127 centres covering 31 States. Planned for 250 centres by 2011. In addition, 650 link ART centers also planned
- Aim to provide free access to ART to 100,000 PLHA by 2007; 300,000 adults by 2012 and 40000 children
- Over 1,08,000 patients are receiving free ART at these centers. In addition, 35,000 patients receiving ART in private sector
- 10 Centre of Excellence to be established under NACP – III.
- Presently only first line regimen available under the National program

## Number of ART Centers

2,70,000 HIV positive cases registered



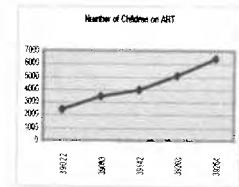
Number of patients currently on ART by centre, India, July 2007



## Paediatric ART Roll Out

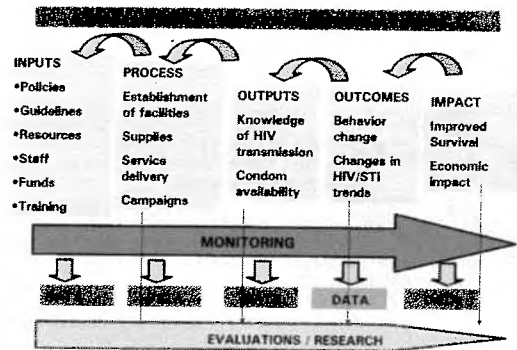
22,117 HIV Positive children registered

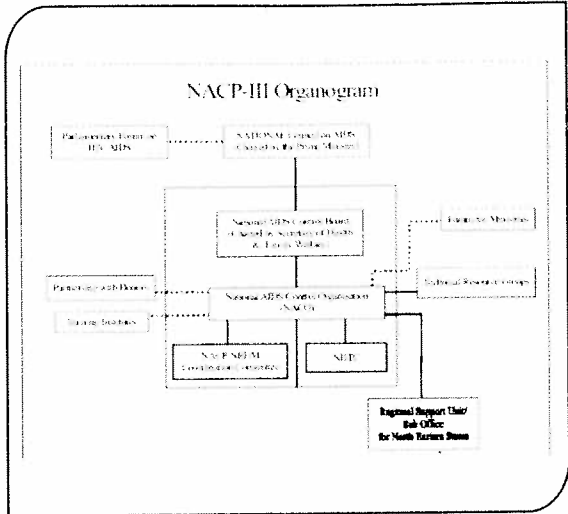
- Treatment Protocol & Training Module for Paediatric ART prepared for the first time by NACO/AP/UNICEF/WHO
- National Paediatric AIDS Initiative launched on 30<sup>th</sup> November 2006. The number of children on ART increased from 1800 to more than 7,000
- Paediatric ARV Drugs supplied for 17,000 children
- Process of setting up 7 Regional Paediatric ART Centres of excellence initiated (Delhi, Bangalore, Chennai, Mumbai, Hyderabad, Kolkata, Kohima).



## Programme Management

## M&E Framework





### STRENGTHENING OF NACO

DIVISION	NACP II		NACP III	
	Technical Manpower Available	Technical Manpower (Proposed)	Technical Manpower (Filled)	Technical Manpower (Filled)
Basic Services	6	15	13	
Blood Safety & Lab Services	2	9	7	
Treatment, Care & Support	1	12	11	
Surveillance, M&E, R&D	3	7	8	
IEC & Mainstreaming	2	10	10	
NGO & Targeted Interventions	1	16	14	
Administration & Procurement	2	8	3	
Finance & Audit	1	13	8	
<b>Total Doctors</b>	<b>11</b>	<b>29</b>	<b>26</b>	
<b>Total Other Professionals</b>	<b>7</b>	<b>55</b>	<b>42</b>	

### STAFF REQUIREMENT

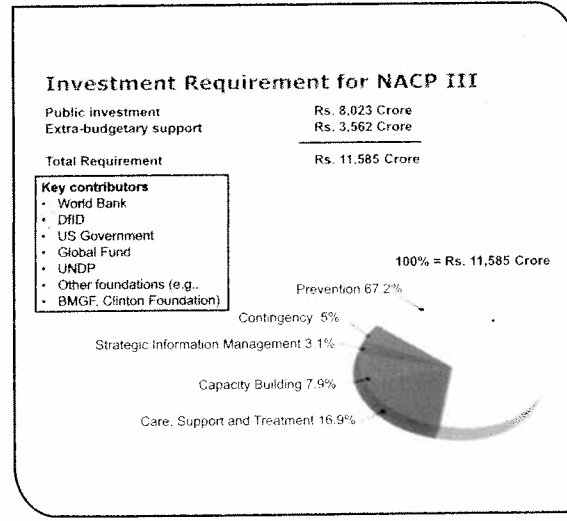
LEVEL	NACP II			NACP III		
	Regular	Contract	Total	Regular	Contract	Total
<b>NACO</b>	53	28	81	78	107	185
<b>STATE</b>	748	461	1209	984	537	1521
<b>DISTRICT</b>	-	-	-	611	1333	1944
<b>ART CENTRE</b>	-	500	500	500	-	500
<b>TOTAL</b>	<b>801</b>	<b>989</b>	<b>1790</b>	<b>2173</b>	<b>1901</b>	<b>4150</b>

### Achievements as on date and Targets for NACP-III

Activity/Component	Baseline Sept 1999	Achievements June 2007	NACP III Targets
Establishment of Sentinel Sites for HIV trends	180	1122	1318
Consistent condom use among female sex workers (%)	50.4	73.4	>90%
Coverage of schools and colleges for AIDS awareness	0	1,12,000	1,53,000
Condom vending machines installed through NACO	0	11,025	22000
Condoms distributed	-	2,24 b	3.5b
Seroreactivity among blood donors (%)	-	0.28	< 0.5
Voluntary Blood donation (%)	20	59.9	90

### Achievements as on date and Targets for NACP-III

Activity/Component	Baseline Sept 1999	Achievements June 2007	Targets for NACP-III
Strengthening of STI clinics	504	845	25,000 private providers
TI projects	300	1220	2100
Establishment of ICTC (for high risk population & pregnant women)	0	4132	4955 (5000 in 24 hr PHCs, 5000 in pvt sec.)
No. of HIV tests conducted per year	0	4 million	22 million
ART Centres	0	127	250
Patients on ART	0	85,915	3 lac
Community Care Centres/Drop in centres/ PLHA network	0	101/84/90	350/-



### Component-wise Budget in NACP-III

Programme Component	Amount (Rs. crore)	Percentage to total
Prevention	5886	73.4
Care, Support & Treatment	1584	19.7
Programme Management	450	5.6
Strategic Information Management	103	1.3
Total	8023	100.00

### Programme Management at all levels – National, State & District

- Decentralization to district level
- Strengthening Financial Planning
- Improved Donor Coordination
- Integration with NRHM
- Mainstreaming
- Monitoring and Evaluation

### Key Issues

1. Political commitment at all levels
2. Capacity building for sustained action and filling up of vacant posts
3. Capacity building for Transfusion Medicine & increase in proportion of voluntary blood donation
4. Convergence with NRHM
5. Adolescent Education Programme
6. Stigma and Discrimination
7. Promotion of and increased access to condoms

**Thank you**

  
 सत्यमेव जयते  
**भारत का राजपत्र**  
**The Gazette of India**

असाधारण  
 EXTRAORDINARY  
 भाग II—खण्ड 3—उप-खण्ड (ii)  
 PART II—Section 3—Sub-section (ii)  
 प्राधिकार से प्रकाशित  
 PUBLISHED BY AUTHORITY

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नई दिल्ली, मंगलवार, नवम्बर 22, 2005/अग्रहायण 1, 1927  
 NEW DELHI, TUESDAY, NOVEMBER 22, 2005/AGRAHAYANA 1, 1927

स्वास्थ्य एवं परिवार कल्याण मंत्रालय

अधिसूचना

नई दिल्ली, 16 नवम्बर, 2005

केन्द्रीय स्वास्थ्य एवं परिवार कल्याण परिषद् का गठन

का.आ. 1633(अ).—राष्ट्रपति, संविधान के अनुच्छेद 263 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए और भारत के राजपत्र असाधारण भाग-2, खंड-3, उपखंड (ii), तारीख 13 अगस्त, 2003 को प्रकाशित इस मंत्रालय की अधिसूचना संख्या जैड 16011/3/2003-बी.पी., तारीख 13 अगस्त, 2003 को अधिकांत करते हुए, केन्द्रीय स्वास्थ्य और परिवार कल्याण परिषद् का गठन करते हैं और इसके द्वारा किए जाने वाले कार्यों की प्रकृति तथा उसके गठन और प्रक्रिया को निम्नलिखित रूप में परिभाषित करते हैं अर्थात्-

1. परिषद् का गठन

(i) परिषद् निम्नलिखित से मिलकर बनेगी-

- |  |           |
|--|-----------|
| (क) केन्द्रीय स्वास्थ्य एवं परिवार कल्याण मंत्री   | अध्यक्ष   |
| (ख) स्वास्थ्य और परिवार कल्याण मंत्रालय में केन्द्रीय राज्यमंत्री  | उपाध्यक्ष |
| (ग) सदस्य, योजना आयोग  | सदस्य     |
| (घ) विधानमंडलों वाले राज्यों/संघ राज्य क्षेत्रों में स्वास्थ्य और परिवार कल्याण, चिकित्सा शिक्षा और लोक स्वास्थ्य मंत्रालयों के प्रभारी मंत्री | सदस्य     |

(ङ) दादरा व नगर हवेली, चंडीगढ़, अंडमान और निकोबार द्वीप समूह, दमण व दीव और लक्षद्वीप के एक एक प्रतिनिधि

(च) संसद-सदस्य सदस्य

- |                         |           |
|-------------------------|-----------|
| 1. डा. अरविन्द शर्मा    | लोकसभा    |
| 2. डा. वल्लभभाई कथोरिया | लोकसभा    |
| 3. श्रीमती बिम्बा रायकर | राज्य सभा |

## (छ) गैर सरकारी

1. स्वास्थ्य और परिवार कल्याण क्षेत्रों के प्रतिनिधि सदस्य
1. अध्यक्ष, भारतीय आयुर्विज्ञान संघ (पदेन)
  2. अध्यक्ष, भारतीय परिवार नियोजन संघ, मुंबई (पदेन)
  3. अध्यक्ष, भारतीय शिशु कल्याण परिषद्, नई दिल्ली (पदेन)
  4. अध्यक्ष, केन्द्रीय समाज कल्याण बोर्ड, नई दिल्ली (पदेन)
  5. अध्यक्ष, फैडरेशन आफ इंडियन चैबर्स आफ कामर्स एंड इंडस्ट्री, नई दिल्ली (पदेन)
  6. महानिदेशक, भारतीय आयुर्विज्ञान अनुसंधान परिषद्, नई दिल्ली (पदेन)
  7. अध्यक्ष, अखिल भारतीय नियोक्ता संघ, नई दिल्ली (पदेन)

## (ii) विख्यात व्यक्ति -

सदस्य

1. डा. (सुश्री) मीरा शिवा, भारतीय स्वैच्छिक स्वास्थ्य संघ, बी-40, कुतुब इंस्टीट्यूशनल एरिया, नया महरौली मार्ग, नई दिल्ली - 110016.
2. डा. आर.एस. अरोले, व्यापक ग्रामीण स्वास्थ्य परिचर्या, जामखेड़, जिला अहमदनगर - 413201, महाराष्ट्र.
3. वैद्य देवेन्द्र त्रिगुणा, आयुर्वेदिक चिकित्सक, महासचिव, अखिल भारतीय आयुर्वेदिक कांग्रेस, धन्वंतरी भवन, पंजाबी बाग, नई दिल्ली.
4. प्रो. डा. बी. पालानिअप्पन, पूर्व अध्यक्ष, भारतीय प्रसूति एवं स्त्री रोग वैज्ञानिक सोसाइटीज परिसंघ (एफ ओ जी एस आई), ए आई-83, अन्ना नगर, चेन्नई 600 040.
5. डा. एन. एच. अंतिया, निदेशक, सामुदायिक स्वास्थ्य अनुसंधान न्यास, मुंबई.
6. डा. प्रताप चंद्र रेड्डी, अध्यक्ष, अपोलो अस्पताल.
7. डा. नरेश त्रेहन, एस्कोटर्स हृदय रोग संस्थान, नई दिल्ली.
8. डा. हंस राज प्रेम सचदेव, एल. गेला राम स्मारक दंत क्लीनिक व विकलदंत केंद्र, नई दिल्ली.
9. डा. (श्रीमती) मालती थापर, बी-325, न्यू, फ्रेंड्स कॉलोनी, नई दिल्ली.
10. डा. पुरुषोत्तम लाल, निदेशक, अंतराक्षेपी हृदयरोग विज्ञान, मैट्रो अस्पताल व हृदय संस्थान.
11. एम. एस. वलियाथान, मानद् सलाहकार, मनीपाल उच्च शिक्षा अकादमी, माधव नगर, मनीपाल-576 104.

12. डा. वी. शांता, अध्यक्ष, कंसर सस्थान (डब्ल्यू आई ए), अडयार, चेन्नई.

( ज ) सरकारी

- |   |            |
|---|------------|
| 1. सचिव, स्वास्थ्य एवं परिवार कल्याण विभाग  | सदस्य      |
| 2. सचिव, आयुर्वेद, योग एवं प्राकृतिक चिकित्सा, यूनानी, सिद्धा और होम्योपैथी (आयुष). | सदस्य      |
| 3. सचिव, शिक्षा विभाग, मानव संसाधन विकास मंत्रालय                                   | सदस्य      |
| 4. सचिव, महिला तथा बाल विकास विभाग  | सदस्य      |
| 5. स्वास्थ्य सेवा महानिदेशक   | सदस्य      |
| 6. उप महानिदेशक (चिकित्सा)  | सदस्य-सचिव |

- (II) पैरा छ (ii) में 1 से 12 तक विख्यात व्यक्ति साधारणतया तथा दो वर्ष की अवधि के लिए परिषद् के सदस्य होंगे। लोकसभा के सदस्य तब तक परिषद् के सदस्य होंगे जब तक वे या तो लोकसभा के सदस्य हैं या दो वर्ष के लिए, जो भी पहले हों।
- (III) राज्य सभा के सदस्य तब तक परिषद् के सदस्य होंगे जब तक वे राज्यसभा के सदस्य हैं अथवा 15 नवम्बर, 2007 तक, जो भी पहले हो।
- (IV) परिषद् की बैठकों में भाग लेने वाले गैर सरकारी सदस्यों के यात्रा भत्ते, दैनिक भत्ते, एस.आर. 190 के उपबंधों तथा भारत सरकार द्वारा उनके अधीन समय-समय पर जारी किए आदेशों के अनुसार नियमित किए जायेंगे।
- (V) उस पर होने वाले व्यय की पूर्ति इस प्रयोजन के लिए स्वीकृत बजट अनुदान में से की जाएगी।
- (VI) केन्द्रीय सरकार और राज्य सरकारों के विशेषज्ञ तथा तकनीकी सलाहकार, परिषद् के सदस्य नहीं होंगे और परिषद् द्वारा निर्णय लिए जाते समय उन्हें मत देने का अधिकार नहीं होगा। किन्तु यदि परिषद् द्वारा अपेक्षित हो तो वे परिषद् की बैठक में हाजिर होंगे।
- (VII) परिषद् का सचिवीय कर्मचारीवृन्द होगा जिसमें एक सचिव होगा तथा उतने अधिकारी और पदधारी होंगे जितने अध्यक्ष, केन्द्रीय सरकार के अनुमोदन से नियुक्त करना उचित समझे।

2. इस परिषद् द्वारा किए जाने वाले कार्यों की प्रकृति-

- परिषद् एक सलाहकार निकाय होगा और उस हैसियत से यह निम्नलिखित कार्य करेगी, अर्थात्
- (क) स्वास्थ्य एवं परिवार कल्याण के मामले में संबंधित सभी पहलुओं पर नीति की मोटी-मोटी रूपरेखा

पर द्विचार-विमर्श तथा सिफारिश करना जैसे- उपचारी, स्वास्थ्यवर्धक और रोग रोधी उपचार का प्रबंध करना, पर्यावरणिक सफाई, पोषण, स्वास्थ्य शिक्षा एवं प्रशिक्षण एवं अनुसंधान के लिए सुविधाओं को बढ़ावा देना ।

- (ख) चिकित्सा तथा लोक स्वास्थ्य तथा परिवार कल्याण के मामलों से संबंधित क्रियाकलाप के क्षेत्रों में विधायन के लिए प्रस्ताव तैयार करना और समस्त देश के विकास के लिए प्रतिमान अभिकथित करना ।
- (ग) त्योंहारों के अवसर पर अंतर-राज्यिक संगरोधन, महामारियों के फैलने और विपत्ति की स्थिति में जैसे भूकंप तथा सूखे की स्थिति में व्यापक आधार पर यथासंभव सहयोग की संभावना का पता लगाना और सामान्य कार्यक्रम तैयार करना ।
- (घ) स्वास्थ्य और परिवार कल्याण प्रयोजनों के लिए उपलब्ध सहायता अनुदानों को राज्यों में वितरित करने के संबंध में केन्द्रीय सरकार को सिफारिशें करना और इन सहायता अनुदानों के उपयोग द्वारा विभिन्न क्षेत्रों में हुए कार्य की आवधिक समीक्षा करना ।
- (ङ) केंद्र और राज्यों के स्वास्थ्य और परिवार कल्याण प्रशासनों के बीच सहयोग और उसको बढ़ावा देने के लिए ऐसे संगठन अथवा संगठनों की स्थापना करना जिन्हें उपयुक्त कार्य सौंपे जायें ।

### 3. परिषद् की कार्य प्रक्रिया -

परिषद् अपने कामकाज के संचालन के लिए निम्नलिखित प्रक्रिया अपनायेगी, नामतः -

- (क) परिषद् हर वर्ष एक या अधिक बार अपनी बैठक करेगी ।
- (ख) इस परिषद् की बैठक उस समय और उस स्थान पर होगी जो अध्यक्ष द्वारा इस निमित्त नियत किया जायेगा ।
- (ग) इस परिषद् की बैठक के लिए पांच सदस्यों (अध्यक्ष सहित) का कोरम होगा ।
- (घ) अध्यक्ष और उनकी अनुपस्थिति में उपाध्यक्ष या कोई ऐसा सदस्य जिसे पैरा-1 के उप पैरा (i) के खंड (घ) में विनिर्दिष्ट सदस्यों में अध्यक्ष द्वारा इस निमित्त अभिहित किया जाये, बैठक की अध्यक्षता करेगा ।
- (ङ) इस परिषद् की बैठक में उठाये जाने वाले सभी प्रश्नों का विनिश्चय बैठक में उपस्थित सदस्यों (अध्यक्ष सहित) के बहुमत से किया जाएगा ।
- (च) मतों के बराबर होने की दशा में अध्यक्षता करने वाले व्यक्ति का दूसरा अथवा निर्णायक मत होगा ।
- (छ) परिषद् अपने कामकाज के लिए ऐसी अन्य प्रक्रिया का पालन करेगी जो वह केन्द्रीय सरकार के अनुमोदन से समय-समय पर अधिकथित करे ।

[सं. जैड-16011/3/2004-बी.पी.]

पी. के. होता, सचिव

**MINISTRY OF HEALTH AND FAMILY WELFARE**

**NOTIFICATION**

New Delhi the 16th November, 2005

**Constitution of Central Council of Health and Family Welfare**

**S.O. 1633 (E).**—In exercise of the powers conferred by the Article 263 of the Constitution and in supersession of this Ministry's notification No. Z.16011/3/2003-B.P., dated 13<sup>th</sup> August, 2003 published in the Gazette of India: Extraordinary Part - II Section 3 Sub-Section (ii) dated 13<sup>th</sup> August, 2003, the President hereby constitutes the Central Council of Health and Family Welfare and defines the nature of duties to be performed by it and its organisation and procedure as follows, namely :-

**1. Organisation of the Council:**

(I) The Council shall consist of :-

- |     |   |   |                |
|-----|---|---|----------------|
| (a) | The Union Minister for Health and Family Welfare  | : | Chairman       |
| (b) | The Union Minister of State in the Ministry of Health and Family Welfare  | : | Vice- Chairman |
| (c) | Member, Planning Commission   | : | Member         |
| (d) | Ministers in charge of the Ministries of the Health and Family Welfare, Medical Education and Public Health in the States/ Union Territories with Legislatures. | : | Members        |
| (e) | A representative each of the Dadar Nagar Haveli, Chandigarh, Andaman and Nicobar Islands, Daman and Diu and Lakshadweep   | : | Members        |
| (f) | <b>Members of Parliament:</b>   | : | Members        |
|     | 1. Dr. Arvind Sharma  |   | Lok Sabha      |
|     | 2. Dr. Vallabhabai Kathiria   |   | Lok Sabha      |
|     | 3. Smt. Bimba Raikar  |   | Rajya Sabha    |
| (g) | <b>Non-Officials:</b>   |   |                |
| (i) | Representatives from Health and Family Welfare Sectors  | : | Members        |
|     | 1. President, Indian Medical Association (ex-officio)   |   |                |

2. President, Family Planning Association of India. Mumbai. (ex-officio)
3. President, Indian Council of Child Welfare, New Delhi. (ex-officio)
4. Chairperson, Central Social Welfare Board, New Delhi. (ex-officio)
5. The President, Federation of Indian Chambers of Commerce and Industry, New Delhi. (ex-officio)
6. Director General, Indian Council of Medical Research, New Delhi (ex-officio)
7. The President, All India Organisation of Employers, New Delhi (ex-officio)

(ii) Eminent Individuals: Members

1. Dr. (Ms.) Mira Shiva, Voluntary Health Association of India B-40, Qutab Institutional Area, New Mehrauli Road, New Delhi - 110 016
2. Dr. R. S. Arole, Comprehensive Rural Health Care, Jamkhed, District Ahmednagar - 413201, Maharashtra
3. Vaidya Devendra Triguna, Ayurvedic Physician, General Secretary, All India Ayurvedic Congress, Dhanwantri Bhawan, Punjabi Bagh, New Delhi.
4. Prof. Dr. B. Palaniappan, former Chairman Federation of Obstetric and Gynaecological Societies of India, AI-83, Anna Nagar, Chennai 600040
5. Dr. N.H. Antia, Director, Foundation for Research in Community Health, Mumbai.
6. Dr. Pratap Chandra Reddy. Chairman, Apollo Hospitals.
7. Dr. Naresh Trehan, Escorts Heart Institute, New Delhi.
8. Dr. Hans Raj Prem Sachdev, L. Gela Ram Memorial Dental Clinic & Orthodontic Centre, New Delhi
9. Dr. (Mrs.) Malti Thapar, B - 325, New Friends Colony, New Delhi.
10. Dr. Purushotam Lal, Director Interventional Cardiology, Metro Hospitals & Heart institute.
11. Dr. M.S. Valiathan, Hony. Advisor. Manipal Academy of Higher Education, Madhav Nagar, Manipal - 576104
12. Dr. V Shanta. Chairman. Cancer Institute (WIA) Adyar, Chennai.

**(h) Officials:**

- |    |  |   |                   |
|----|--|---|-------------------|
| 1. | Secretary, Department of Health & Family Welfare   | : | Member            |
| 2. | Secretary, Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) | : | Member            |
| 3. | Secretary, Department of Education Ministry of Human Resource Development                      | : | Member            |
| 4. | Secretary, Department of Women and Child Development   | : | Member            |
| 5. | Director General of Health Services  | : | Member            |
| 6. | Deputy Director General (Medical)  | : | Member- Secretary |

(II) Eminent individuals at (g) (ii) 1 to 12 shall normally be members of the Council for a period of two years. The Members of Lok Sabha shall be Members of the Council so long as they are members of Lok Sabha or two years whichever is earlier.

(III) The Members of Rajya Sabha shall be Members of the Council so long as they are members of Rajya Sabha, or till 15<sup>th</sup> November, 2007 whichever is earlier.

(IV) The travelling and daily allowances of the non-official members for attending the meetings of the Council shall be regulated in accordance with the provision of Supplementary Rule 190 and orders of the Government of India there-under as issue from time to time.

(V) The expenditure involved will be met from within the sanctioned budget grant for the purpose.

(VI) Expert and technical advisers to the Central Government and State Governments shall not be members of the Council and shall not have any right to vote when any decision is taken by it but shall, if so required by the Council, be in attendance at its meetings.

(VII) The Council shall have a Secretarial staff consisting of a Secretary and such officers and officials as the Chairman may, with the approval of the Central Government, think fit to appoint

**2. Nature of the duties to be performed by the Council:**

The Council shall be an advisory body and in that capacity shall perform the following duties, namely -

- (a) to consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects, such as the provision of remedial, promotive and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research;
- (b) to make proposal for legislation in fields of activity relating to medical and public health and Family Welfare matters, laying down the pattern of development for the country as a whole;
- (c) to examine the whole field of possible co-operation on a wide basis in regard to inter-State quarantine during times of festivals, out-break of epidemics and serious calamities such as earth-quakes and famines and to draw up a common programme of action;
- (d) to make recommendations to the Central Government regarding distribution of available grants-in-aid for Health and Family Welfare purposes to the States and to review periodically the work accomplished in different areas through the utilisation of these grants-in-aid; and
- (e) to establish any organisation or organisations invested with appropriate functions for promoting and maintaining co-operation between the Central and State Health and Family Welfare administration.

3. Procedure of the Council :-

The Council shall in its conduct of business observe following procedures, namely:-

- (a) the Council shall meet once or more each year;
- (b) it shall meet at such time and place as the Chairman may appoint in this behalf;
- (c) five members (including the Chairman) shall form the quorum for a meeting of the Council;
- (d) the Chairman and, in his absence vice-chairman, vice-chairperson or such member as may be designated by the Chairman in this behalf from among the members referred to in clause (d) of sub-paragraph (i) of paragraph I shall preside at the meeting;
- (e) all questions which may come up before the Council at meeting shall be decided by a majority of vote of the members (including the Chairman) present at the meeting,
- (f) in case of equality of votes, the person presiding shall have a second or casting vote;
- (g) the Council shall observe in the conduct of its business such other procedure as it may, with the approval of the Central Government, lay down from time to time.

[No Z-16011/3/2004-BP]

P. K. HOTA, Secy.



# भारत का राजपत्र The Gazette of India

असाधारण

EXTRAORDINARY

भाग II—खण्ड 3—उप-खण्ड (ii)

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## स्वास्थ्य और परिवार कल्याण मंत्रालय

(केन्द्रीय स्वास्थ्य एवं परिवार कल्याण परिषद का गठन)

## अधिसूचना

नई दिल्ली 28, जुलाई 2006

का.आ. 1236(अ). - जबकि भारत सरकार, स्वास्थ्य और परिवार कल्याण मंत्रालय की दिनांक 16 नवम्बर, 2005 की अधिसूचना संख्या का.आ. 1633(अ) में राष्ट्रपति ने केन्द्रीय स्वास्थ्य और परिवार कल्याण परिषद का गठन किया है;

और जबकि श्रीमती बिम्बा रायकर को उक्त परिषद् का सदस्य नामित किया गया था;

और जबकि उक्त सदस्य का कार्यकाल 2 अप्रैल, 2006 को समाप्त हो गया है;

और जबकि राष्ट्रपति ने राज्य सभा सदस्या सुश्री सुशीला तिरिया को उक्त परिषद के सदस्य के रूप में नामित किया है;

इसके अतिरिक्त राष्ट्रपति ने राज्य सभा सदस्य श्री ललित किशोर चतुर्वेदी को उक्त परिषद का सदस्य नामित किया है;

अतः, अब, संविधान के अनुच्छेद 263 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए राष्ट्रपति एतद्वारा उक्त अधिसूचना में निम्नलिखित संशोधन करते हैं, अर्थात् :-

संसद सदस्यों से संबंधित उल्लिखित अधिसूचना की उप मद् (च) के पैरा 1 (झ) में क्रम संख्या 3 से संबंधित प्रविष्टियों के स्थान पर निम्नलिखित रखी जाएगी; अर्थात् :-

"3. सुश्री सुशीला तिरिया-राज्य सभा"

और क्रम संख्या 3 के बाद निम्नलिखित को अंतःस्थापित किया जाएगा-

"4. श्री ललित किशोर चतुर्वेदी-राज्य सभा"

[सं. जेड-16011/3/04-बीपी]

पी. के. होता सचिव

## MINISTRY OF HEALTH AND FAMILY WELFARE (Constitution of Central Council of Health and Family Welfare) NOTIFICATION

New Delhi, the 28th July, 2006

S.O. 1236 (E).- Whereas in the notification of Government of India, in the Ministry of Health and Family Welfare Number S.O. 1633 (E) dated 16th November, 2005, the President has constituted the Central Council of Health and Family Welfare;

And whereas Smt. Bimba Raikar was nominated as member of the said Council;

And whereas the tenure of said member has expired on 2nd April, 2006;

And whereas the President has nominated Ms. Sushila Tiria Member of Rajya Sabha as member of the said Council;

Further President has nominated Shri Lalit Kishore Chaturvedi, Member of Rajya Sabha as member of the Council;

Now, therefore in exercise of the powers conferred by article 263 of the Constitution, the President hereby makes the following amendment in the said notification namely :-

In the aforesaid notification para 1(I) in sub-item (f) relating to the Members of Parliament for serial number 3 the entry relating thereto, the following shall be substituted, namely:-

"3. Ms. Sushila Tiria-Rajya Sabha"

And after Serial No.3 the following shall be inserted :-  
"4. Shri Lalit Kishore Chaturvedi-Rajya Sabha"

[No. Z-16011/3/04-BP]

P.K. HO/TA. Secy.

2360 GI/2006

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Union Minister for Health & Family Welfare **Chairman**

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Education in the States/UTs**

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Arunachal Pradesh

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Member of Parliament (Rajya Sabha)

Member

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