TENTH CONFERENCE OF
CENTRAL COUNCIL OF
HEALTH AND FAMILY WELFARE

Proceedings
and
Resolutions / Decisions Taken

30th January 2009
New Delhi

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

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Subject</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>PART-I INAGURAL SESSION</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Welcome address by Shri Naresh Dayal, Secretary (Health &amp; F.W.)</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Address by Smt. Panabaka Lakshmi, Minister of State for Health &amp; Family Welfare</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Presidential Address by Dr. Anbumani Ramdoss, Hon’ble Union Minister of Health &amp; Family Welfare</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Vote of Thanks by Director General of Health Services</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td><strong>PART II PROCEEDINGS</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Minister of Medical &amp; Health, F.W., Ayurveda &amp; Medical Education, Rajasthan</td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>Minister of Health &amp; F.W., West Bengal</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>Minister of State for Health and Family Welfare, Orissa</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>Minister of Health &amp; Family Welfare, Assam</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>Minister of Health &amp; Social Welfare, Kerala</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>Minister of Health &amp; F.W, Ayurveda, Himachal Pradesh</td>
<td>21</td>
</tr>
<tr>
<td>7</td>
<td>Minister of Health &amp; Family Welfare, Punjab</td>
<td>22</td>
</tr>
<tr>
<td>8</td>
<td>Minister of Medical Education, Punjab</td>
<td>24</td>
</tr>
<tr>
<td>9</td>
<td>Minister of Health and Family Welfare, Uttar Pradesh</td>
<td>24</td>
</tr>
<tr>
<td>10</td>
<td>Minister of Health &amp; Family Welfare, Uttarakhand</td>
<td>25</td>
</tr>
<tr>
<td>11</td>
<td>Minister of Health &amp; Family Welfare, Nagaland</td>
<td>28</td>
</tr>
<tr>
<td>12</td>
<td>Minister of Health and Family Welfare, Puducherry</td>
<td>29</td>
</tr>
<tr>
<td>13</td>
<td>Minister of Health and Family Welfare, Manipur</td>
<td>29</td>
</tr>
<tr>
<td>14</td>
<td>Minister of Health and Family Welfare, Meghalaya</td>
<td>30</td>
</tr>
</tbody>
</table>
15. Minister Health and Family Welfare, Mizoram
16. Shri Lalit Kishor Chaturvedi, Member Parliament (RS)
17. Prof. (Dr.) Ranjit Roy Chaudhury, Eminent Individual
18. Ms. Anjali Gopalan, Eminent Individual
19. Prof. Gouri Pada Dutta, Eminent Individual
20. Briefing by Secretary, AYUSH, Govt. of India
21. Briefing by Secretary, Health Research & DG ICMR, Govt. of India

PART III DECISIONS TAKEN / RESOLUTIONS

PART IV ANNEXURES

Annexure I Power Point Presentations on National Rural Health Mission,
Non-communicable Diseases, Procurement and Supply Chain Management and Medical Education

Annexure II Notification regarding reconstitution of CCH & FW

Annexure III List of Participants
INAUGURAL SESSION
WELCOME ADDRESS BY
SHRI NARESH DAYAL, SECRETARY
(HEALTH & FAMILY WELFARE)

Hon'ble Minister for Health & Family Welfare, Dr. Ambumani Ramadoss, Hon'ble Minister of State for Health & Family Welfare Mrs. Panbaka Lakshmi, Hon'ble Members of Parliament, Hon'ble Ministers from the States, Secretary AYUSH, Secretary Health Research, Secretary Department of AIDS Control, DGHS, colleagues from the Ministry, colleagues from the State Government, Ladies & gentlemen.

I have great pleasure in welcoming you all to the Tenth conference of the Central Council of Health & Family Welfare. The constant support & encouragement by our Hon'ble Ministers, has made it possible for us to organize the Conference at such short notice. We are grateful to all the Hon'ble Ministers coming from the States to participate in these deliberations. This conference is to take on board the progress made in the health sector, share experience of initiatives that have been taken in the State and assist in designing appropriate strategies for providing quality health care services to the citizens at large.

As all of you are aware, the global economy is passing through a phase of economic recession & the impact is felt across the various countries in the world. India cannot be insulated from this global financial crisis and indications are that there may be slowing down of economic parameters in the country specially exports. The meltdown is trickling to the bottom of the pyramid and the heart of rural India and unorganized sectors are also feeling its implications. Reports suggest that thousands of workers may become unemployed due to reduction in export orders & cutting down of business plans. This is likely to cause severe social & economic consequences. In fact this issue was important enough to merit discussion in the WHO's executive board meeting recently in Geneva, where this issue was highlighted and the general consensus was that there would be an impact on health due to global financial crisis. One of the recommendations was that government must ensure that health care is fully funded and that there is no reduction in our funding of health care. Since States are the major providers of the health care, it is a State subject under our constitution, I would like to draw attention to this fact and request States to ensure that they continue to increase the funding of public health care institutions in their budget.

The flagship programme of the Government, the National Rural Health Mission (NRHM), to provide accessible, affordable and quality health services to the poorest house holds in the remotest rural regions has become well entrenched in the health system. Health being a State subject, the Central Government can only play a facilitator's role for implementation of the programme in the States. The experience of NRHM has been very encouraging. Organization structures are now in position and the absorptive capacities of the States are steadily increasing.
The large allocation under the NRHM with over 90% funds released only adds to this confidence that States are now in a position to plan, absorb funds & implement programs according to their priorities. The other day we had the recommendations of the Common Review Mission which have just come in and all the State Secretaries were also present there and it was very heartening to note the progress that has been made in revamping the entire rural health infrastructure. However, certain critical gaps have also been pointed out in the Common Review Mission. There is a shortage of human resources in the health sector in most states and this is one of critical gaps which are now impeding further progress of the NRHM. The second issue where there is a critical gap and pointed by the Common Review Mission is in Procurement and in supply chain management. Here, I would like to mention examples of good practices in some of the States, particularly Tamil Nadu, where the TNMC has been doing a tremendous job. We have been holding workshops from time to time and encouraging States to adopt systems such as that of TNMC. There is going to be a presentation on this issue here in this conference today and there will also be one on the increasing of human resources on medical education. I would like to briefly discuss the other major activities that we are embarking in the health sector to give a broad idea of the issues we are likely to deliberate. However, I must add that though there is a structured agenda; issues concerning health not specifically mentioned can also be taken up for discussion.

We have devoted much time in preparation of the National Health Bill which attempts for legal recognition & protection of health rights for creating health obligation on the part of Centre & State Government and laying down the broad principles & standards of health to be observed across the country. The draft is presented to you at this conference for your consideration & valued comments. Over the years, new diseases and infections such as SARS, HIV etc. have emerged as major public health problems. In addition, the threat of bio-terrorism and impact of disasters on human health is serious and needs to be tackled. A need has been felt for a comprehensive legislation which could provide for better management of various types of public health emergencies in this country. We have drafted a public health act for replacing the present epidemic diseases act (1897). With a view to enforce strict control on commercial transaction of human organs & tissues, we have also incorporated some modifications on the bill on Transplantation of Human Organs & Tissues. Both these bills are being placed before you during this conference to solicit the comments & suggestions of the State Governments.

Use of tobacco is one of the main causes of cancer. Over the years, we have been making efforts for controlling tobacco use for ensuring better health to our population. Recently the Govt. has banned smoking in public places and made provision for penalty in case of violations. The new strategies on Tobacco control & cancer control are timely, given the growing menace of the non-communicable diseases. With regard to development in medical education, we have taken important decisions to amend some of its provisions which we hope will facilitate not only opening of medical colleges but also solve the problem of human resources in health sector. We also propose to effect changes in minimum qualification for admission in PG courses, enhance post graduate level seats in certain disciplines etc. & these will be discussed in detail at the conference.
ADDRESS BY
SMT. PANABAKA LAKSHMI,
HON'BLE UNION MINISTER OF STATE
FOR HEALTH & FAMILY WELFARE

Very good morning, all of you. My senior colleague Dr. A Ramadoss ji, Hon’ble Ministers for Health, Family Welfare & Medical Education from the States, senior MP Sh. Lalit Kumar ji, Eminent Personalities, Secretary Health & Family Welfare Sh. Naresh Dayal ji, Secretary AYUSH, Smt S. Jalaja ji, Secretary Health Research Dr. Katoch ji, Secretary AIDS Control Ms. Sujatha Rao ji, DGHS Dr. R.K. Srivastava ji, senior officers of the Health Ministry, Govt. of India, Secretaries of health from the States, colleagues, ladies & gentlemen, I extend a warm welcome to all of you gathered here to attend this conference despite your busy schedule. This conference as in the past is an important event as it provides interaction with the States through whom our major health programmes are implemented.

As you all know, the Central Council of Health Family Welfare (CCH&FW) is the advisory body for the Ministry to consider and recommend broad lines of policy in regard to all matters concerning health. We are meeting here today to take stock of the progress made in terms of our varied interventions and to draw a road map for future policy through mutual discussion. During the last five years, my frequent interactions with the States give me the feeling that we are moving in the right direction. Improvement in the health status of the population is one of the major areas in social development programme launched by our Government. Considering enormous health need and inadequacies in the public health sector, our first emphasis has been on strengthening and effecting correction in the public health infrastructure at the ground level. It was our considered view that unless this is addressed, it would not be possible to facilitate access or affordable care in the rural areas. The Health Mission launched about four years ago by our Hon’ble PM has increased access to the decentralized public health system by establishing new infrastructure in deficient areas and upgrading infrastructure in existing institutions. I am happy to see that States have been playing an active role in translating health policy into effective action. Our experiences in the flagship programme NHRM has been really creditable. The States have come with various innovation programmes to provide better health care facilities especially to the BPL population. While I very much appreciate the ground traversed, we still have a long way to go to provide universal health care. Designing of National Programmes on the disease front has very effectively helped in tackling communicable disease like Vector Borne, TB, HIV and Leprosy etc. However there has been an increase in the incidence of the so called life style diseases commonly called the non communicable diseases like diabetes, cardio vascular diseases, stroke etc. given the aging population and changes in behaviour. These diseases have come into the fore front and pose major challenges to our health care system. You must be aware that we have already launched the National Programme on prevention & control of diabetes, cardio vascular diseases and stroke
during the eleventh five year plan. It is being implemented in the pilot phase after which the whole country will be covered. Apart from the diseases we still need to address the issues of high Maternal Mortality Rate (MMR) & Infant Mortality Rate (IMR) which continue to be a concern. Structured programmes with varied interventions are being implemented to address the issues of Maternal & Child Health. I must say that with the co-operation of the States and the innovations introduced by many of them, we are going to meet our commitment in reducing IMR & MMR. Within the overall umbrella of National Rural Health Mission, this is an important plank. The Mission also has its goal meeting the requirement of the vulnerable group & bringing about an overall improvement in the manner in which health care services are delivered to promote good health. It also recognises a close interaction amongst our preventive, promotive and curative programmes.

The AYUSH systems of medicine have had age old acceptance amongst the masses in India and as such main streaming of these systems in the National Health Care delivery system is an important component of NRHM. Revitalization of the AYUSH sector needs to be taken up in the right earnest by all the States. Unfortunately many of the States do not have separate depts. for AYUSH. I would request the concerned states to take suitable action in this regard so that these systems are strengthened in their States and provided choice of treatment to the masses. I am sure today’s conference will enable the Hon’ble Health Ministers from the States to reflect on the strategies already in place & the changes which they would like to suggest based on their experience to guide us in formulating the health policy for the future. Clearly health is both a resource as well as an outcome of economic development process. The goals of sustainable development cannot & will not be achieved unless the health of the population is assured for which purpose a responsible health system & a healthy environment are inescapable. I look forward to valuable suggestions from all of you & hope the conference will be a great success.
PRESIDENTIAL ADDRESS BY 
DR. ANBUMANI RAMDOSS, 
HON’BLE UNION MINISTER OF 
HEALTH & FAMILY WELFARE

My colleagues Smt. Panabaka Lakshmi ji, my colleagues Hon’ble Ministers of Health from different States of India, Secretary Health & Family Welfare, Secretary AYUSH, Secretary Dept. of Health & Research, Secretary, National AIDS Control Organization, Director General of Health Services, Hon’ble Member of Parliament, Distinguished experts, who are members of this Central Council, officers of both Central & State Governments, Friends, Ladies & gentlemen.

I wish you all a very good morning and I would like to wish you a very happy healthy & a prosperous new year. I would also like to welcome my colleagues & their officers who have come from different states of India to attend this important 10th meeting of the Central Council of Health & Family Welfare, the highest committee in the Health Ministry. Going back to the last five years in the health sector, it has been five very productive years and during these last five years we have been able to achieve a lot of progress in India. Health, which was neglected in the past three decades, suddenly came into prominence with this Government. My Prime Minister Dr. Mamman Singh has rightly been focusing on Health, Education & Agriculture, the vital sectors of our country and it is he who has given us a lot of support in investing in Health particularly health infrastructure. There was a lot of gap in health infrastructure and health investment and now we are trying to fill the gap to our best of abilities. The gaps should not only be filled by the Central Government but also by State participation. In India, the private and public infrastructure is approximately 75% and 25% respectively and public spending on health between States and Central government is approximately about 85% and 15% respectively. There has been a lot of demand for enhancing investment suggesting that public health spending should be at least 2 to 3% of our GDP. But in the last few years, it has been hovering around 1%. Our GDP is increasing at a fast rate and through an increase in health spending is required, we have the problem of absorption capacity. When I took over as Health Minister five years ago, my health budget in my department was approximately Rs 6000 crores. Today I am proud to say that in this financial year, it has increased to Rs 16500 crores. In the Tenth Five Year Plan (2002-07), the total allocation for health was approximately about Rs. 42000 crores. I am happy to say that my Prime Minister has envisaged an allocation of approximately Rs. 1.40 lakh crores in the Eleventh Five Year Plan. Experts feel that today every rupee invested in health today is a saving of thousand rupees in the next ten years in India. So, that is such a huge vital investment which we have to do in health sector and we are trying to do. On this, I need your fullest support & participation.

The work of National Rural Health Mission has been appreciated throughout the country. It has also been appreciated globally and experts like Jeffry Sachs. Mr. Jeffry Sachs is the Ambassador on Poverty alleviation to the UN Secretary General and is one of our international
advisors. According to Mr. Jeffry Sachs, India’s National Rural Health Mission (NRHM) is the biggest and fastest expanding public health programme, in the entire world. This is such a huge programme, which has been acknowledged by almost all the UN agencies specially the WHO. DG, WHO has been very appreciative of this programme and WHO has been recommending this type of programme to other developing countries as well. Though we have recorded good progress, we have a long-long way to go. Nevertheless, never has an initiative of this dimension been initiated in India’s history of health sector. Success under this programme is credited to all of you specially the State Health Ministers who have been giving 100% support. We have had other national programmes all these years i.e. the National AIDS Control Programme, the Tuberculosis programme and many other national programmes. But I can’t say that I have got 100% support in all these national programmes. But, for the NRHM, I am very happy to say that I’ve got your hundred percent support. This reflects the thirst in your states and we are here to support you. The flexibilities of this National Rural Health Mission is its success. The programme is so flexible that it is your State specific programme, District specific programme, Village specific programme. This is the first time ever where the rural health administration has been so flexible that each village in India, they could sit together in the Village Health & Sanitation Committee and work out what the village needs, what the block needs and then we are here to sanction it for you. We are very happy about the progress on Programme Implementation plan of the NRHM. All the States are so participatory and I am happy to say that there have been 208 innovations in the National Rural Health Mission, which never has been the case in any programme in the world. These 208 innovations are your innovations, which has not been even thought of by so called experts and we are looking in all these innovations & asking them if any of the workable innovations should be implemented not only State wise, even nationally. This is a forum for you to see the success of other states and take up those successes in your states as well. We had the Common Review Mission of the NRHM in respect of 13 States to review the implementation status of NRHM work at a grass root level. It was very heartening to understand the progress made of this programme but at the same time, there were a lot of deficiencies as well, which I am sure can be easily sorted out. I have indicated in the review mission meeting that before the next review, at least 70% of those deficiencies, gaps could be addressed. These are all gaps which can easily be filled up by your participation & your commitment. I do not want to go in depth, as we have one whole session on NRHM. I’m so passionate about this programme, whichever part of the world I go I don’t fail to talk about this programme.

Bihar which has had average attendance of 40 patients in PHCs before launching of NRHM, today I am proud to say that we have an average attendance of 4000 patients because of the NRHM. Today Tamil Nadu is conducting caesarean operations in PHC attributed to the NRHM. Today, Assam has tripled the institutional deliveries under NRHM. We have a huge cadre of ASHAs in just two years; we have enlisted 80000 health personnel starting from specialists to doctors to nurses, to paramedic to ANMs. So, all of them excluding ASHAs have not been there for sixty years since independence. So this is the vibrancy of this programme and I want every one of you to give your fullest commitment to this programme.

Coming to the disease control programmes, I would like to focus on some of these programmes. TB programme, is doing really well and I like to appreciate all your efforts in this programme. In fact, the WHO has appreciated and given us an award on the success of National TB control programme. We still have a long way to go, our detection rate is 71%, our success rate which was 25% earlier, today it is 86%. The death rate was 29%, now it is about 3.5%. We have 400,000
DOTS providers and we have nearly about 16000 of them associated from private sector. I am happy to say that Indian Medical Association has been associated with this programme. We have been able to save 1.5 million lives in the last seven years, while till today, nearly ten million people were put under DOTS programme. Last year alone, there were about 1.6 million people who have been covered under this programme. I would like to say this is the biggest programme in the world.

HIV AIDS is an area, where we are doing well. We are going ahead of the virus but we need to gallop little quickly. Secretary, NACO has been instrumental in turning around the Department in last three years. We have been able to reverse the trend of increasing HIV AIDS in India and the UN AIDS has acknowledged that fact. In fact in 2004, when I took over, there were no ART centres, today, four years down the line, there are 191 ART centres supporting more than 200,000 people free of cost, nearly 12000 children have been getting these drugs, 46000 children are on line in pediatric initiative and we have nearly 48000 odd integrated counseling & testing centres (ICTC) and we are providing for HIV prevention. I want all Ministers here to play a very active role, because if left to itself, this HIV AIDS is going to be a huge problem. It’s not only a health problem but a social, developmental & economic problem. That’s why we need to go all out to thrash this issue. I am happy that while most States are participating in this programme, some of the States such as UP, Bihar, M.P, Rajasthan need to focus a little more on HIV AIDS issues.

On Malaria front, I think we still have a long way to go. In fact at my departmental level, I used to tell my officers that there are two programmes, nationally that need a lot more attention. The first one is the National Vector Borne Disease Control Programme and the second one is the Mental Health Disorder Programme. For Malaria, the good news is that ASHAs have been trained, supplied & supported with Rapid Diagnostic Kits. So in due course, within this year, almost all the ASHAs will be trained. If any person is suffering from fever in a village, ASHA will be able to test that patient for malaria with the Rapid Diagnostic Kit. If tested positive, the patient could be immediately taken to the nearest centre for treatment. As a preventive measure, we have been giving them ordinary bed nets and also long lasting impregnated bed nets. The Village Health & Sanitation Committee of the National Rural Health Mission can actively participate in the programme of clearing water bodies and supplying mosquito nets.

Leprosy control is one area, where we are really doing well. In fact India in December 2005, the country has eliminated leprosy but we have not eradicated the disease. It is going to take us another 20-25 years to eradicate. We have eliminated leprosy by bringing the level to one per thousand people population. Today, it is about 0.72‰. We still have a long way to go, especially in the Northern states like Bihar, Chhattisgarh, Uttrakhand, Jharkhand West Bengal and some other states who I think should take up this issue.

As regards Polio, India, Pakistan, Afghanistan and Nigeria are categorized on the same plank. Polio programme is the largest spending programme in the Health Ministry at the Centre level and we still have a long way to go on that. I am happy about the commitment of all the States especially U.P. & Bihar which accounts for about 95% of polio cases in the country. I want other States like West Bengal, Maharashtra, Andhra Pradesh, Haryana, Punjab, Delhi, Uttrakhand, and M.P which have experienced the incidence of polio during the last year to work more on polio front. I think, all these States should now roll up their sleeves because we’re spending about Rs. 1200 crores on this programme alone and if Polio is addressed effectively, these funds could be utilized for taking care of other programmes. We need to move in this direction.
Another issue which is tormenting us is the Bird flu. We were almost free of bird flu but due to the migration of birds especially from endemic country like Bangladesh, we have been experiencing the problem in Assam, Manipur, Sikkim and West Bengal for the last two years. In fact, all the states have to now roll up their sleeves because it is just a question of time. If we don't take action against bird flu, there is going to be human deaths. Bird deaths are happening; if a human death happens in India then India is going to be marked in black as is the case of Bangladesh, Thailand, Myanmar, Indonesia, and China. I think we need to definitely work for timely measures for tackling bird flu.

Non communicable diseases are going to be a high focus area for us. Experts say that we are moving from a phase of communicable to non-communicable diseases. I have always been passionately saying that today the big three diseases i.e. Malaria, TB and HIV/AIDS are making way for a bigger five, Diabetes, Cardiovascular diseases, Stroke, Mental Health Disorders and Cancers. In the next fifty years, India is going to be plagued with these five big diseases.

It is a fact that Life Expectancy of our population is increasing. We're going to have a lot of senior people around us on whom we need to focus our programmes.

Cancer is another dreaded disease, where lot of funds is required to fight it out. I have been taking up this matter with the Planning Commission & Finance Ministry to provide more allocation to cancer. I'm happy to say that during Tenth Five Year Plan, the total amount sanctioned for cancer control programme was Rs.280 crores but in the Eleventh Plan we have allocated Rs. 2700 crores for Cancer alone. To fight cancer, we need a lot of resources and a lot of infrastructure for early detection. Bringing awareness in the population is the main strategy of Health Ministry. In this direction massive awareness campaigns should go around because cancer is the most costly disease to treat. Now we are increasing the amount of assistance to Regional Cancer Centres (RCCs). We're in the process of seeking CCEA's approval. Once it is approved, all your proposals for cancer, especially machinery equipment, will be processed expeditiously in the next few months. We are always there to help you, to support you to initiate your RCC as quickly as possible.

Mental health disorder is an area, where we have not been able to do well. I think all the States should participate a lot in MHDP. This year, we are supporting Centres of Excellence in Mental Health. Eleven centres of Excellence across the country, each costing Rs.30 crore have been sanctioned to produce adequate man power.

As rightly pointed out by Secretary, India is facing a huge crunch of human resources in health. We have a presentation on medical education in this conference. We will have an extensive discussion on how we should start producing doctors, specialists, nurses and paramedics. Whether the State Governments should pay the doctors' salary on par with the Central Govt can be also discussed. This is one issue we need to have a resolution today in the Council. The age of retirement of doctors, some of the states have age of retirement at 55 and 58 while these doctors can work till 70. So I think we also need to have a resolution on this aspect.

Diabetes and Cardio vascular diseases are critical diseases which India is going to face in the next 40 years. If we don't take cognizance today, we are going to be the sufferers and our children are going to be the sufferers. India is a young nation, with 600 million population below the age of thirty which is a huge asset. We need to be very protective of this asset and we need to guide them in their eating, drinking habits and smoking habits. I think we need to go all out on this. The Union Health Ministry has started a war against Tobacco, Alcohol, Junk food and Drug usage. I want all my colleagues present here from the states to be very participatory in all these
programmes. For National Tobacco Control Programme, 2nd October of this year is a landmark day as we have banned smoking in public places. We are happy to acknowledge that it has been very well received by the public. State Governments are very enthusiastically participating in this ban. I would like to appreciate all of you for your wonderful and valuable support on this. I think more needs to be done on educating the people. It’s not for police or enforcement agency to go around with challans and fine them. That’s only 10% of it. The balance 90% should be the compliance, specifically voluntary compliance which is essential for success. Once this tempo is maintained for the next six months, we will be able to see the results.

I could say that alcohol is the mother of public health problems in India and we have not acknowledged the damage alcohol is doing to youths in our country. I think it is time we acknowledge this. I would be happy to initiate the resolution on Alcohol so that we should have a National Alcohol Policy and the states should adopt these policies. At one point of time, the average age at which alcohol was consumed was 28 years, it came down to 19 years and today it is 13 ½ years. Imagine all our school going children hooked on to alcohol and tobacco and by the time they are twenty five, they are out. They should be productive rather than the country providing resources for curing them of their ills after 25. 25 to 40 is the most productive part of human being. We should save the youth and definitely we should take up very stiff alcohol prevention policies covering all aspects including the timing, content, age. Article 47 of the Constitution envisages that the State Govt. has to have a prohibition policy on Alcohol. No other State in India except Gujarat, J&K, Mizoram, has a policy on alcohol. If not a policy, we could have at least partial prohibition. Karnataka has been doing a lot in that direction.

Junk food is another area, where I think we should initiate a national programme on the lines of prevention of Cardiovascular diseases, Diabetes and Stroke I think States need to take up this issue and some of the States should make a legislation bringing out issues in your Cabinet about the prohibition or banning of junk food sold to children and luring through advertisements. Today, we have childhood obesity, childhood diabetes. By the time they are twenty, they get hypertension. I know of young children, 22 year old kid dying due to heart attack which was unheard of, 20-40 years ago in India. Today it is just a common phenomenon. All these things we need to take cognizance of and of course iodization of salt which we’ve done and it is going on well. Blindness control programme is one of the best performing programmes a clear illustration of a participating programme of the state with the private sector in our country.

We are in the process of launching Central Drug Authority on quality of drugs. We have a presentation on them as well. We have changed one Act. We are about to change one more Act; Drugs & Cosmetic Act. The penalty has increased to life imprisonment for someone who is selling spurious drugs. And it’s going to be actual life imprisonment of minimum ten years and maximum entire life and ten lakh rupees fine or three times the value of confiscated goods. We have set up a Food Control Authority; slowly we are expanding it to all the states.

Population is another issue which I want to address; all my colleagues from the State Governments may please have to focus more on population. India is one sixth of humanity living on just 2.4% of the world land. We have our targets of bringing the Total Fertility Rate to below 2.1. I don’t think it will be achieved within our target time of 2010 or 2012. It will take quite some time by the standard at which our population is growing; I think by 2045 we’ll attain a stabilization phase. That is going to take us to be the most populous country in the world. I think states, especially bigger states like UP, MP, Orissa, Rajasthan, Bihar have to take cognizance of their population.
programmes. For National Tobacco Control Programme, 2nd October of this year is a landmark day as we have banned smoking in public places. We are happy to acknowledge that it has been very well received by the public. State Governments are very enthusiastically participating in this ban. I would like to appreciate all of you for your wonderful and valuable support on this. I think more needs to be done on educating the people. It’s not for police or enforcement agency to go around with challans and fine them. That’s only 10% of it. The balance 90% should be the compliance, specifically, voluntary compliance which is essential for success. Once this tempo is maintained for the next six months, we will be able to see the results.

I could say that alcohol is the mother of public health problems in India and we have not acknowledged the damage alcohol is doing to youths in our country. I think it is time we acknowledge this. I would be happy to initiate the resolution on Alcohol so that we should have a National Alcohol Policy and the states should adopt these policies. At one point of time, the average age at which alcohol was consumed was 28 years, it came down to 19 years and today it is 13 1/2 years. Imagine all our school going children hooked on to alcohol and tobacco and by the time they are twenty-five, they are out. They should be productive rather than the country providing resources for curing them of their ills after 25. 25 to 40 is the most productive part of human being. We should save the youth and definitely we should take up very stiff alcohol prevention policies covering all aspects including the timing, content, age. Article 47 of the Constitution envisages that the State Govt. has to have a prohibition policy on Alcohol. No other State in India except Gujarat, J&K, Mizoram, has a policy on alcohol. If not a policy, we could have at least partial prohibition. Karnataka has been doing a lot in that direction.

Junk food is another area, where I think we should initiate a national programme on the lines of prevention of Cardio vascular diseases, Diabetes and Stroke. I think States need to take up this issue and some of the States should make a legislation bringing out issues in your Cabinet about the prohibition or banning of junk food sold to children and luring through advertisements. Today, we have childhood obesity, childhood diabetes. By the time they are twenty, they get hypertension. I know of young children, 22 year old kid dying due to heart attack which was unheard of, 20-40 years ago in India. Today it is just a common phenomenon. All these things we need to take cognizance of and of course iodization of salt which we’ve done and it is going on well. Blindness control programme is one of the best performing programmes a clear illustration of a participating programme of the state with the private sector in our country.

We are in the process of launching Central Drug Authority on quality of drugs. We have a presentation on them as well. We have changed one Act. We are about to change one more Act; Drugs & Cosmetic Act. The penalty has increased to life imprisonment for someone who is selling spurious drugs. And it’s going to be actual life imprisonment of minimum ten years and maximum entire life and ten lakh rupees fine or three times the value of confiscated goods. We have set up a Food Control Authority; slowly we are expanding it to all the states.

Population is another issue which I want to address; all my colleagues from the State Governments may please have to focus more on population. India is one sixth of humanity living on just 2.4% of the world land. We have our targets of bringing the Total Fertility Rate to below 2.1. I don’t think it will be achieved within our target time of 2010 or 2012. It will take quite some time by the standard at which our population is growing; I think by 2045 we’ll attain a stabilization phase. That is going to take us to be the most populous country in the world. I think states, especially bigger states like UP, MP, Orissa, Rajasthan, Bihar have to take cognizance of their population.
We have launched a new Department called the Dept. of Health & Research. I want my colleagues here to utilize the services of the Department.

IDSP project is again very high on our list. We are envisaging a surveillance network with State Governments for all possible outbreaks. In fact three years ago, the only source of information through which we knew of an outbreak was through the 'media'. That is not the situation but much more needs to be done. Each State should have a structure of active surveillance mechanism. You have to pick up any small outbreak, immediately test it and then inform us, we'll send a Rapid Response Team, whatever the outbreak it may be. Orissa recently had an outbreak of Cholera and it has been effectively tackled. PMSSY scheme is one of the important schemes of this Ministry. Under this scheme, six new AIIMS like institutions are being established in different states and we are supporting about thirteen institutions for upgradation in various states.

AYUSH is a vibrant Department engaged in a lot of activities and I would like you to use its services. We have started National Medicinal Plant Mission, so you could utilize all the services. We have funding for that and this could be a participatory venture with the states. I'm happy to say that under the National Rural Heath Mission; nearly 5000 AYUSH doctors are employed in the Primary Health Centres. In all these centres, we are going to have a snake bite protocol very soon and I want the states to adopt this protocol.

On the Issue of Organ Transplantation Act, I think States have been raising various issues during the past few years. To address these problems, to make it more transparent, to increase the participation of the Public, the National Organ Transplant Act is going to be modified. We'll have regional donor centres, state donor centres and these centres will be procuring organs for transplantation and funds will be made available to these Centres.

Another programme is the Emergency Research Institute; EMRI programme or 108. You are aware that we have been having problems in the recent months on the Satyam issue. Nevertheless, I feel personally and lot of my colleagues in the state feels that it is such an important and very good programme that we are trying to address the problems which have suffered. I would like to elicit your comments on this, because of the positive response received by the States which have rolled out this programme. India should have had some sort of this programme twenty years ago to take up emergencies. I'm happy to say that 22% of the calls made are for maternity problems, 18% are for emergencies and 22% of the calls for ambulance. I think you have to be more participatory and we'll be happy to guide you.

The National Urban Health Mission is something to which we're looking forward. We're awaiting permission from the Cabinet. Once it comes, we'll be launching it. All the urban centres will be covered under that programme.

We are having a National School Health Programme and some of the states have already taken up this programme. We'll be recommending this programme for implementation in all the schools. These school children are the future of this country; they need to be tested for heath parameters, cardiac parameters, diabetes and anemia, sanitation, hygiene, environmental, HIV AIDS education. Yoga, should be made mandatory in all the schools of our country, which will enable young children to lead a healthy life.

Another Bill which is in circulation is the Public Health Act Bill which will be very important for you. You'll be there enacting this Act and so that any responses, emergencies or non emergencies based on any of these things, you could definitely take up these issues. I'll stop for now, because
we have a constraint of time for discussions. We need to go through the spectrum and we need to have resolutions adopted. This is an opportunity for all of you to share your experiences with other states. Today, we have presentations on NRHM, Procurement, Chronic Heart diseases and Medical education. I request the State Health Ministers to limit your participation on these focused issues, for otherwise, we won’t be able to finish our agenda given the time constraint. With these words, once again I would like to thank all of you for having been able to participate in this important meeting of the Central Council.
VOTE OF THANKS BY
DIRECTOR GENERAL OF HEALTH SERVICES

Hon'ble Union Health Minister Dr. A. Ramadoss ji, Madam Panabaka Lakshmi ji, Members of Parliament, Ministers of Health from States, Representatives from Union Territories, Secretary Health, Secretary AYUSH, Secretary NACO and Secretary Dept. of Medical Research.

I would like to express a very short vote of thanks because we are running behind the schedule.

On behalf of Ministry of Health, I would like to express my thanks for the leadership provided by Hon'ble Minister of Health and Family Welfare, Hon'ble Minister of State for Health and Family Welfare and all the officers who are involved in organizing this meeting. I would also like to put it on record that the Central Council of Health and Family Welfare meeting is probably one of the largest meetings which we are organizing today.

I would also like to express my thanks to Members of Parliament, State Ministers of Health, State Ministers for Health Education and other dignitaries who are accompanying them for making this particular meeting a very successful one. My special thanks also to all the Secretaries who are participating in the conference.

I would also like to offer my thanks to the Hon'ble Minister of Health and Family Welfare, for releasing the Guideline on the Nutritional Therapy. I am sure that these guidelines will be very useful to you all. Thank you very much.
PROCEEDINGS
PROCEEDINGS

Presentations were made highlighting the achievements of National Rural Health Mission, Non-communicable Diseases, Procurement and Supply Chain Management and Medical Education. The presentations are given in Annexure – I. After the presentations, initiating the discussions, the Union Minister for Health and Family Welfare invited comments from the Members of the Council.

RAJASTHAN

Written Speech of Minister of Medical & Health, F.W., Ayurveda & Medical Education
Rajasthan State :

Hon’ble Union Minister for Health & Family Welfare, Minister of State in the Ministry of Health and Family Welfare, State Health Ministers, representatives from UTs and friends.

It gives me immense pleasure to participate in this 10th Conference of Central Council to review the implementation of the policies and the programs of government relating to medical & health sectors and to recommend ways and means for better implementation of these policies & programs.

The flagship programme of the Union Govt. in the health sector is the National Rural Health Mission. A lot has been achieved in the rural health sector since the launch of the NRHM. That said, the challenges of improvement in rural health sector are enormous and what necessitates substantial absorption & spending capacities by States. As a high focus State allocation for Rajasthan under the 11th five year plan has been projected at Rs 6200 crores. At the end of March 2009, the State would have utilized Rs. 1400 crores of the 11th plan outlay. We have successfully scaled up utilization in the current year to Rs. 980 crores by end of March 2009, from Rs. 335 crores in 2007-08, an increase of nearly 300%. Despite this fiscal expansion, there is an urgent need to further scale up absorption and spending capacities so that the 11th plan allocations are fully utilized. In pursuance of this objective, Rajasthan has formulated an NRHM Programme implementation plan for 2009-10 amounting to Rs. 1280 crores.

However a burgeoning size of NRHM PIP in the coming years imposes tremendous strain on State resources. Given that States have to contribute 15% matching share, the state share for NRHM has increased in the past three years from Rs. 45 crores in 2007-08 to Rs. 126 crores in 2009-10. By 2011-12, the size of the NRHM PIP would be Rs. 2100 crores and this would necessitate a state share of Rs. 210 crores imposing substantial burden on an already crowded State plan. It is therefore imperative to introduce a lesser resource burden on the States in the coming years particularly if NRHM is likely to continue in the 12th Five year plan period.

Besides NRHM, allocations come with considerable rigidity of guidelines which are in the nature of structured conditionality. Health Dept., Rajasthan has been grappling with the issue of creation of additional ANM’s in the Sub Centres. According to Union health ministry guidelines, unless the second ANM is created under the State plan resources, central Govt. will not be financing creation of a third post of ANM to be deployed at Sub Centre level. Despite a multitude of meetings with our finance dept., we have not succeeded in getting a sanction for putting in place 10000 second ANMs and as a result could not put in place third ANMs. This has affected our
routine immunization programmes substantially. The State PIP has a provision for creation of 5800 third ANMs in 2008-09 but we would be reappraising the entire allocation due to our inability to find resources for creation of the second ANM position and inter alia no third ANM is being created.

May I request you Sir to relax this rigid conditionality and allow creation of an additional ANM from Union Ministry’s resources in our state so that health indicators under Routine immunization and home deliveries through skill birth attendants can improve? This will provide an immediate break through in High focus states like Rajasthan.

The strength of NRHM is in creation of Accredited Social Health Workers at Village Level to provide household visits to motivate and counsel every pregnant mother to come to the nearest Health Institution for delivery. DLHS-3 has pointed out that ASHA performance has considerable scope for improvement. As per DLHS-3 in most of the high focus states, ASHA involvement with institutional deliveries, ANC and sterilization cases remain less than 5%. An architectural correction is urgently needed for enhanced monitoring and phasing out of non-functional ASHAs. A national evaluation of ASHA performance is needed so that this large mass of health workers is effectively mainstreamed to adopt Union Health Ministry’s agenda. I would congratulate you sir, for decision to provide ASHAs with a fixed remuneration of Rs 500 per month taken in the NRHM Meeting held on Jan 29 2009. It will help improve ASHA performance on specific indicators that could be firmly up in the evaluation study that I am proposing.

Effective implementation of the Janani Suraksha Yojna has resulted in substantial increase in work load at District Hospitals and CHCs. It is important to recognize that Public health institutions at District hospital and CHC level in Rajasthan are among the most stressed Public Health Institutions in the country. Average OPD at district hospital with 300 beds is 25000 cases per month, at District Hospitals with 150 beds is 20,000 cases per month, at District Hospitals with 100 beds is 12000 cases per month, at CHCs with 50 beds is 8000 cases per month & CHCs with 30 beds is 5000 cases per month. With institutional deliveries increasing from 28% in 2005-06 to 70% in 2008-09, Rajasthan is grappling with a need to rapidly scale up infrastructure and man power resources to cope up with these enhanced work loads. May I request you, Sir, to increase the allocations for the Construction Programme from the current 33% of additionalities to 40% of additionalities, so that institutional infrastructure can be adequately created.

Amongst the most successful models of Ambulance care developed under NRHM is the collaboration with EMRI. However, such collaboration while being efficient & patient friendly comes at a huge financial cost to the NRHM Programme. Ways must be designed to make the EMRI model of ambulance care more cost effective and I would seek your guidance in this regard. An amount of Rs. 2000 crore as Corpus fund for operational cost in the long term could be considered.

Let me also highlight, Sir, some of important achievements of the NRHM Programme in Rajasthan in the year 2008-09. As a high focus State, Rajasthan has witnessed an increase in institutional deliveries from 55% in 2007-08 to 70% in 2008-09. The period of stay has improved significantly the substantial institutional quality improvement measures of BCC training and Sulabh International deployment for clean toilets being introduced. To focus on child health indicator, Rajasthan has operationalised 33 facilities based new natal care units and malnutrition treatment corners in 2008-09, 43 urban RCH centres have been operationised in collaboration with NGOs.
The state is fully geared up to launch the National Urban Health Mission in five cities, as soon as it is announced by the Union Govt. 53 mobile medical units have been operationalised. Diagnostic vans have been procured for taking high quality health care to “C” category villages. 100 CHC based ambulances have been procured for institutional emergencies, “102” services are being strengthened.

Human Resources have been the major thrust of the NRHM Programme. All positions of SPMU/33 DPMU’s have been filled. Recruitment of 237 BPMs has been completed, 184 accounts have been recruited, as also 27 specialists and 3704 GNMs. Hard duty allowances have been sanctioned to 557 PHCs. Recruitment of pharmacists, lab technicians & AYUSH doctors is in progress. Recruitment of 12000 ASHAs has been completed. Against 46000 ASHA, Rajasthan has deployed 42000 ASHAs; 28000 ASHAs have been equipped with drug kits. The ASHA incentives structure has been stream lined to ensure timely incentive payment.

All building less CHCs/PHCs/Sub-centres have been taken up for renovation/construction. Rs.150 Crores has been sanctioned for construction programme in 2008-09 keeping in view the larger vision of the dept. to have a 500 bedded District Hospital, and 100 bedded CHCs by the end of the 11th FYP, 30 bedded maternity wards have been sanctioned in all District Hospitals and CHCs with more than 200 deliveries per month. I would also propose additional infrastructure build up at medical colleges, keeping in view the vast in patient care that JSY is bringing to the institution.

Rajasthan has fully integrated Village Health Planning process into the institutional framework and 41000 Village Health Committees have been constituted. They have been fully empowered and funds have been transferred to all Committees. The Village Health Plan is a physical plan. An integration of the financial plans in health sector is only upto the block level. Health Ministry may like to take a fresh look if a health plan is needed up to the village level as a physical plan or whether we can operate a financial plan up to the block level. I would propose that we formulate Gram Panchayat wise plans, so that institutional integration with Panchayat Raj institutions can be maintained.

Mainstreaming AYUSH remains an important issue where further attention is needed. NRHM envisages convergence with AYUSH to provide different health systems under one roof. However, such convergence in a PHC & CHC has proved difficult as AYUSH doctors are attending to a very small number of Out Patients. In several PHCs, only AYUSH doctors are available. With acute shortages of manpower in allopathic doctors, NRHM would have to build adequate training modules & integrate AYUSH into other activities like Alternate Vaccine Delivery, supervision of MCHN sessions etc. so that this manpower is fully utilized.

Chronic shortages of specialists have been felt in many Public health institutions in the State. Despite numerous efforts to recruit personnel, specialists have shown little interest in working in harsh rural conditions. The Rajasthan Rural Health service constituted as a Panacea for the chronic shortage of doctors in rural areas has helped this situation considerably. However we need to identify more anesthetists, Gynaecologists surgeons and pediatricians to ensure that all CHCs function as FRUs and all 24x7 PHCs are providing basic emergency obstetric care. For this purpose, post graduation seats need to be increased in Medical colleges and the amendments that this council is going to deliberate today under Medical education will be a good step in this direction.

Health insurance has been tried out in Rajasthan in various forms. We have implemented the Rashtriya Swasthya Beema Yojna through the Labour Ministry; the Rajasthan Swasthya Beema
Yojna through the NRHM and Swasthya Bema Yojna through state plan funds. Our experience has been that in the absence of adequate private accredited institutions, health insurance through a private insurance is likely to result in very poor numbers of claims against the premium transferred. We have now reconstituted the scheme as ‘Mukhya Mantri Jeevan Raksha Kosh’ with direct funding to Medicare, relief societies of Public health institutions.

I would like to turn to the issues of financial management of the NRHM Programme. Rajasthan, for the first time in three years, is in a position to fully absorb & spent the PIP 2008-09 allocations of Rs. 980 crores. This is a significant achievement & a significant transformation in many public health institutions could be achieved. Given the large flows of money liquidity, Management has posed considerable problem with nearly 80% of the RCH to PIP being spent at the institution level. Better banking system to ensure timely electronic transfers up to block/ institution level is necessary. The financial management group could be advised to work on putting in place better liquidity management practices that will reduce the age of advances and the amount of advances at the institutional level, besides it is very difficult to collect utilization certificates from village level institutions where considerable moneys are flowing and all such advances can be treated as booked expenditures once amounts are transferred to village institution.

The National Health Bill 2008 represents progressive social legislation empowering citizen with Right to Health. However, it could be premature legislation as considerable strengthening of health institutions is required before the law is enacted to make it justifiable. The following issues need further consideration:

a) Availability of funds to maintain IPHS standards would these resources flow from the Union Govt.,

b) Share of Union & State Govt. in the health repatriation funds?

c) Can Sub-centres be excluded from Govt. Health Care establishments?

d) Status of medico legal cases should be very clear in case of Medical negligence,

e) What will be the position of the state Governments in case of insufficient manpower?

f) Liability of other concerned depts. such as Sanitation, safe drinking water etc.

g) In the duties of users, it is proposed to add clean user friendly institution.

h) A district level monitoring is also recommended.

Rajasthan is short by at least 1.5 medical colleges. In this regard, I welcome the proposed central scheme for strengthening & up-gradation of govt. Medical Colleges in the States. We look forward to early launch of the scheme, the amendments to the MCI regulation and condition for land requirement for a medical college are welcome and it is expected that these measures will enable establishment of additional medical colleges in the State.

WEST BENGAL

Minister of Health & F.W. of West Bengal expressed his satisfaction over the overall performance of the National Rural Health Mission and supported the views of the Chairman with regard to increased fund allocation for Health Sector by the States. The Minister also raised certain specific issues and made suggestions which included the following:
• The web-site of the Ministry should be updated regularly.
• Number of sub-centres may be increased and the criteria for establishing a sub-centre should be based on a realistic base year but should not be on the basis of 1991 population as is being followed at present.
• Issuance of guidelines to employ doctors on contract basis under NRHM.
• Non-availability of certain essential drugs & vaccines.

ORISSA

Minister of State for Health and Family Welfare of Orissa in his speech briefly narrated the achievements made by the State in the Health sector, especially with regard to achievement of 60% institutional delivery and formation of 1188 Rogi Kalyan Samitis under NRHM. He also brought to the notice of the Chairman that a month long campaign has been started from 26th Jan, 2009 where in Swasthya Rath will be moving from village to village in the State to create awareness and supportive environment for various health related programmes being undertaken by the State Govt. The other important achievements, as mentioned by the Minister include a) creation of Drug management Units by following TN pattern b) a proposal to create a Corporation for drug procurement.

The issues raised by the Health Minister include:

• Timely release of funds under Central Schemes and Centrally Sponsored Schemes.
• Timely and adequate supply of medicated mosquito nets and life saving drugs such as anti Malaria drugs, vaccines etc.
• Expedite the construction & related activities of AIIMS like institutions at Bhubaneswar to make it functional within a short period of time.
• Need for detailed information regarding AYUSH in the Economic Survey.

ASSAM

Minister of Health & Family Welfare of Assam thanked the Chairman for the support extended to his state in implementation of various Health Schemes. He also complemented the Union Minister of Health for bringing about revolutionary changes in the Health scenario of the State through the NRHM. In his speech, the Health Minister of Assam informed the Chairman that the State Government is committed to introduce the State Public Health Bill in the Assembly during March, 2009.

The Minister also suggested / raised the following issues:

• A representative of the Central Govt. may be nominated on the Board of EMRI to maintain transparency of its functioning.
• One medical institute in the State may be taken up for development under PMSSY as there is no allocation of seats in MBBS course at NEIGRIMS.
• Release of Rs. 100 crore announced by the Prime Minister for Guwahati Medical College.
KERALA

Written Speech of Minister of Health & Social Welfare, Kerala

Respected Union Minister for Health Dr. A Ramadoss, Minister of State for Health and Family Welfare, Ministers of Health from other States, Secretary, Health & Family Welfare Govt. of India, Secretary, AYUSH, Govt. of India, Director General of Health Services, Additional Secretary & Mission Director NRHM, Joint Secretary Govt. of India, State Principal Secretaries & other dignitaries.

I wish you all a very warm morning. I am very happy to be here on the occasion of the 10th Conference of Central Council of Health and Family Welfare.

I take pride that the State of Kerala leads the rest of the nation as far as important health indicators are concerned. Mortality indicators show that health status of Kerala is far advanced and higher than the all India average and is even comparable with developed countries. In spite of Kerala's better health care indicators, we are facing the challenge of high morbidity both from re-emergence of communicable diseases and the second generation problems like the ageing population and rise in the non communicable, life style diseases.

In this context, I would like to mention that NRHM has worked as a catalyst to revive the Public Health system in the country and perhaps this is the best chance offered ever in independent India to restore the credibility and peoples' confidence in the health system.

At this juncture, I would like to recall the speech made by Hon’ble Health Minister Dr. Anbumani Ramadoss, wherein he lauded the State of Kerala for making using of Health Sanitation Committee funds for effective control of vector borne diseases. To reaffirm this I would like to tell you, Sir, that Ward Health Sanitation Committees, under NRHM, have been formed in all the wards of the State and we have been receiving encouraging reports regarding the utilization of funds at the grassroots for Vector control and other health promotion measures. Towards tackling the emerging threat of communicable diseases, a State Level Disease Control & Monitoring Cell (SDCMC) has been constituted to act as the core response team to take care of emergencies & to co-ordinate various interventions in disease control & management. SDCMC is synchronized with the IDSP and hence complements the task of IDSP.

Bridging the critical shortage of manpower has already been a matter of concern. The Government has taken bold steps to implement compulsory rural service for doctors and bonded services and internship for Nurses and contract appointment of Specialists. Further, steps are afoot to provide quality education to personnel manning health care by way of strengthening nursing education and in-service training.

Around, 20000 ASHA volunteers have been selected so far of which nearly 15000 have been deployed in the State after the induction training. Drug kits have been procured and are being distributed to all the ASHA workers. Debit card system has also been implemented in one of the districts to avoid delay in payment of incentives.

115 CHCs and number of other selected institutions are being upgraded to IPHS standards under NRHM. 63 CHCs have already been upgraded and the work of remaining 62 is going in full swing. The process of standardizing institutions to bring in a uniform pattern and the minimum required standards is being done in consonance with the fundamental principles of Public Health Planning and the Indian Public Health Standards (IPHS).
Up-gradation and standardization of services through National Accreditation Board of Hospitals (NABH): 19 Hospitals will be taken up in the first phase of accreditation-and improving quality of service in 358 government medical laboratories by getting accreditation of National Accreditation Board for Laboratories through QCI have been taken up.

Untied funds, Annual maintenance grants and Hospital Management Committee (RKS) funds released through NRHM are a boon to many of the institutions. The institutions that were in a bad shape are getting a facelift because of NRHM funds. Innovative and patient friendly services are initiated like Token systems, better seating arrangements for patients and service providers, drinking water for patients and bystanders, modified buildings etc.

Of the many strides that Kerala has been able to make in the last 3 years, setting up of Kerala Medical Services Corporation Ltd. (KMSCL) as a fully Government owned company is worth mentioning. Now, we are in a position to procure and provide quality medicines, equipments and diagnostic services to the poorest of poor in the shortest time.

Kerala is in the process of implementing the web based ‘Health Management Information System’ project, which links approximately 1215 health facilities in the State.

Implementation of Janani Suraksha Yojana, one of the flagship schemes of Government of India has shown phenomenal progress in the last two years in the State, with the number of women benefiting out of it increasing considerably over the years. The State Government has entrusted the respective hospital superintendents to make all payments in one installment to the women before discharging them after delivery.

Kerala is one of the few States to adopt a Pain and Palliative care Policy. In line with this policy, one of pioneering schemes initiated in 2008 by NRHM in the State is the Pain and Palliative Programme that aims at the development of community based care services for the bed ridden, elderly, chronically and incurably ill people in the State. Kerala has high proportion of elderly people and a Geriatric care programme is also on the anvil.

A special pilot programme on managing non-communicable diseases has been launched in two districts of the state where ASHA workers will be thoroughly trained and equipped with necessary instruments, to manage NCDs at the community level. We have established a State Institute of Non-Communicable Diseases in Thiruvananthapuram and I request the Hon’ble Union Minister to help us to scale this to a national level institute.

A comprehensive decentralized Cancer care programme is also in the pipeline, whereby, a community based cancer registry will be formed by involving Panchayati Raj institutions and with the help of ASHA. A network of community volunteers and NGOs engaged in awareness creation, early detection, follow up and palliative care activities will be also set up.

Management of Emergencies is another priority concern to the state of Kerala, with high incidence of road accidents. A pilot Project KEMS (Kerala Emergency Medical Services Project) will be started soon, with a fleet of 25 ambulances, in the district of Thiruvananthapuram and neighboring areas.

National Rural Health Mission under the Health Department has joined hands with the Education Department in chalkling out a School Health Programme. The programme is of utmost significance as almost all the children in the state attend school regularly till 10th standard. Apart from many other activities, the School Health cum Transfer Certificate Record to be issued to each child is one of the highlights of the scheme.
A comprehensive Health Insurance Scheme has been launched in all the 14 districts covering 21.79 lakhs BPL families that include the 10 lakh 'absolute poor' categories who are covered under RSBY. As per this scheme, selected hospitals are being upgraded in the shortest time, with regard to infrastructure, equipments, diagnostic and other facilities, through empanelled agencies. We have signed a MoU with Quality Council of India (QCI) for NABH accreditation for 19 hospitals and 358 laboratories. We are also planning to take ISO certification with National Health Resource Centre (NHRC) for CHCs. The State Government has also tied up with Hindustan Latex Limited to set up MRI scan units in the three rural medical colleges in the state.

We are in the process of updating and finalizing a Public Health Act for the state. A draft Public Health Act has been prepared and is now put in the public domain for views and comments.

The Medical and Nursing education sectors in the State are also getting revitalized with large scale investment of infrastructure development; the PMSSY project in Thiruvananthapuram Medical College being the foremost among them.

Development of Ayurveda and Homeopathic institutions, which constitute more than half of the total public health institutions in the state also have received a tremendous boost in the state. A state of the art Panchakarma hospital is being set up in Thiruvananthapuram. 100 Ayurveda and 100 Homeo dispensaries will be additionally opened this year.

I would like to place on record that many schemes outlined above could be launched only because of the personal interest shown by the Hon'ble Union Minister of Health Dr. Anbumani Ramadoss. The openness he has shown in knowing and understanding the special needs of the State during all the discussions we had with him is praiseworthy. To mention a few – the approval of Centre of Excellence scheme for Institute of Maternal and Child Health in Kozhikode and the scaling up of the ASHA scheme in the State and the starting of Field Station of NIV in Alappuzha. I gratefully acknowledge the support and guidance the Union Health Ministry under the dynamic leadership of Dr. Anbumani Ramadoss has given us whenever required; especially during the last three years since I took charge as the Minister for Health and Social Welfare.

I am confident that this year is going to be A YEAR OF CHANGE as far as implementation of health care schemes in the State is concerned. Many of the promising initiatives like Accreditation and quality improvement of hospitals and laboratories, Comprehensive Health Insurance scheme, standardization of health institutions as per IPHS and Health information systems project that we have taken up with your support and guidance are going to get completed and will have a great impact in providing better well being for the people of the State.

Participating in the discussion, Health Minister of Kerala supported the suggestion of introducing one year mandatory rural service as a condition for PG admission and favored adoption of Cuban model to counter the shortage of manpower. Without sacrificing the quality of medical education, She suggested to convert all major govt. hospitals with a bed capacity of 300 beds and above into mini Medical Colleges of 50 seats each.

Special package should be announced for setting up medical colleges in rural areas or under served areas, to prevent clustering of colleges in bigger town and cities. It should be similar to promotion of industries in backward areas since private medical colleges are primarily set up for commercial objectives only.

Tenth Conference of Central Council of Health and Family Welfare
Reacting to the suggestions made by the Minister, the Chairman expressed his desire to visit Cuba and study the model. However, adoption of the model in India's context is very difficult considering the disproportionate huge population and doctor-patient ratio prevailing in the two countries.

HIMACHAL PRADESH

Minister of Health & F.W, Ayurveda of Himachal Pradesh complemented the Union Minister for the Health and Family Welfare for effective implementation of Health Schemes in the country and narrated achievements made by his state. He also informed the Chairman that the State had launched a scheme “Anemia free Himachal” on 2nd October on pilot basis in two districts to tackle the problem of widespread anemia and the scheme is to be extended to the entire State during next year. The Health Minister in his speech focused on the following:

- Shortage of manpower especially specialist doctors for effective implementation of NRHM.
- Permission to start diploma courses particularly in the clinical subjects like radiology, anesthesia, gynecology etc. in the District Hospitals to cope up with shortage of specialists.
- Flexibility in the payment plan to ASHA depending upon the location of the village and population.
- Extension of training period of ASHA.
- A Panchayat Swasthya Mahila Karyakarta (PSMKK) may be appointed in rural areas. The PSMKK should be qualified as in the case of ANM with a minimum remuneration of Rs. 2000-3000.
- Difficulties in implementation of EMRI programme.
- AYUSH doctors should be given parity with other doctors in scales and remunerations. Parity should also be maintained in the case of stipend to PG students.
- Liberal funding should be made available to develop Himachal Pradesh as a Herbal state.

Participating in the discussion, the Health Minister of Himachal Pradesh brought the following to the notice of the Chairman:

- One year compulsory rural service to Medical graduates after completing MBBS to pursue specialization courses at Post Graduate level may not be introduced as it will probably affect State Health care system, which is already facing shortage of specialists.
- Introduction of a Bill for regulating fee and admission in Private Govt. Medical Colleges may not be required since the State Govt. has already passed legislation for this purpose.
- Financial support extended for increasing PG seats in Medical Colleges and funds provided for setting up Nursing Colleges should be kept under flexi-pool enabling the State Govts. for effective implementation of the scheme.
Provision of fee concession to poor girls in nursing colleges to attract them to this noble profession.

Giving clarifications to the issues raised by the Health Minister, the Chairman expressed agreement in principle in allowing the State Govts. to utilize the funds provided for increasing the PG seats in Medical Colleges and funds provided for setting up Nursing Colleges to be kept under flexi-pool, after careful examination.

Referring to introduction of a Bill for regulating fee and admission in Private Govt., the Chairman informed the Minister that this is as per the direction of the Supreme Court to bring uniformity in all private medical colleges in the country, and this requires to be complied with.

The issue of not making one year compulsory rural service to pursue specialization courses at Post Graduate level after completing MBBS will be considered, keeping in view of the State's requirement.

**PUNJAB**

Smt. Lakshmi Kanta Chawala, Hon'ble Minister of Health & Family Welfare Govt. of Punjab

आदरणीय केंद्रीय स्वास्थ्य मंत्री जी और यहाँ जितने भी स्वास्थ्य विभाग के सभी प्रांतों के मंत्री और अधिकारी आए हैं, सबको बताना कर के मैं यहाँ अपनी बात शुरू करती हूँ। इसमें कोई संदेह नहीं कि आपके साथ काम करने में बहुत अच्छा लगा और आप निस्संदेह तो आपने भारतीय और माता की समस्याओं को भी सुना। मुझे लगा आप पूरे देश को जानते हैं और बहुत अच्छा लगा आपके साथ काम करना। जिस तरह राष्ट्रीय ग्रामीण स्वास्थ्य मिशन ने कार्यन की है, मैं योजना बनाने वालों को काम कराये।

मैं सब जानता हूँ कि जो हमारा Rural Health Mission है और मौं और बच्चे की सुरक्षा है IMR कम करना है। MMR कम करना है। इसके लिए रीढ़ की हड्डी हमारे ANM हैं और मुझे एक बात कहनी है कि जो पंजाब में है होंगे पूरे देश में है कि ANM को ही आप वेतन दें। तीन महीने का इकट्ठा वेतन आप भेजते हो और उसको आमे में पॉब्ल महीने लग जाते हैं। तो जिससे हर महीने वेतन नहीं मिलता उसकी मानकिक स्थिति रीढ़ की हड्डी बनने वाली नहीं रह जाती। वो अपनी demand रखने में ज्यादा लगती है और अभी जो rural health mission में ANM महीने किए है या staff nurses नतीजा है उनका वेतन इतनांत कम रहा है। रीढ़ हेजार जो ANM लेती हैं वो उससे ज्यादा काम करते हैं जिनका regular वेतन लेने वाली regular कर्मचारी काम करती है। और जो staff nurses हमने rural health mission में रखी हैं उनकी भी 5000 या 6000 देते हैं। यह RHM का जो paramedical staff है, on contract टेकर उनकी हालत बिना है जो एक police के head constable की और SPO, home guard की होती है। काम SPO home guard ज्यादा करता है और रीढ़ ज्यादा regular वालों का करता है।

काम के बदले पूरे दाम दीजिए। वो contract पर हैं तो हैं। उनका वेतन पूरा मिलना चाहिए और regular ANM को दूसरे वेतन हर महीने में जा जाना चाहिए। आप states पर भरोसा करिए। उनका बाह्र महीने का वेतन इकट्ठा में जाने। मुझे खुशी है कि पंजाब की एक भी ANM ऐसी नहीं जिससे हम सभी जाकर नहीं मिली।

इसलिए उन सब की एक ही कठिनाई है। जो आपने नई भर्ती की है वो contract पर तो रहें लेकिन उनका वेतन पूरा होना चाहिए। आपे पेट से कोई काम नहीं कर सकता। दूसरी बात, जिस बात के लिए मैं RHM की ज्यादा प्रशंसा करती थी कि आप कोई Asha worker काम करेगी। तो पैसा लेगी। स्वास्थ्य मंत्री जी इस देश के राजनीतिक ढाँचे को जानते हैं, चुरुबुद्दी जी बाद में आपको हिँदी का अनुवाद कर देंगे। मुझे...
पता है आप काफी समझते भी हैं दिनदहाड़ी को। रोगियों नहीं अलग बात है। आप एक बात देखिए, इस डेस का जो राजनीतिक धरोहर है, 200 लाख का बुरापा pension लगाने के लिए या बिवाह pension लेने के लिए नकली certificate बनाते हैं। जब आपने Asha worker का नियोजित honorarium तय कर दिया तो फिर काम करा जाएगा और लोग यह कहेगे कि इसका नाम तो लिख लो। बाद में देखा जाएगा, राजनीतिक झांकी लगा रहे। आग progs. के पैसे दस गुणा कर दीजिए लेकिन जो काम कर वही पैसे ले, नहीं तो किसी की नहीं, किसी की बूढ़ी, किसी की पत्नी नाम लिखना कर गयौं में बौढ़गिरी और राजनीतिक झांकी दुरु कर जाएगा।

एक पारी जाएगा तो दूसरी पारी की आगे आएगी, दूसरी जाएगी तो तीसरी की आएगी, कृपया इस पर ध्यान दीजिए। काम नहीं होगा। आग progs. के केवल बेटन पर आएगी और कल की एक squad बढ़ा हो जाएगा। क्योंकि हम लोग सधारण हैं, हमको पक्का करने तो हमारी सरकार ग्रामीण स्वास्थ्य मिशन अगले दो सालों में ये रोटेट करने वाले और नवोदय स्वास्थ्य सेवा लगभग आएगा। यह मैं कहूँ कि मिशन का देखना है उसका आदेश रहा। आपको बता रही हूँ। MMU आपने दी, मुझे खुशी है। पंजाब में ही हमे MMU plus मार्च जिलों के लिए हमने तय कर दिया, काम में लगा दिया। उसका result बहुत अच्छा है और मुझे यह भी खुशी है कि पंजाब ने एक target लिया है और वह भी मुझसे भी पहले मार्च में लगा है कहा, हमारी 42 बच्चे (एक साल में एक हजार के पीछे) में जाएगा है। हमने इसके IMR और MMR को Rural Health Mission की मदद से एक challenge के रूप में लिया है। Narendra Modi ji से जुड़कर से मुझे सीधा कर आई थी। तो हमने गर्भाशायी मिशन और स्वास्थ्य मिशन भी उपलब्धशील विश्व स्वास्थ्य दिवस के साथ-साथ (2 दिन मनाया है।) राज्य के सारे अधिकारी जिनमें से रहते हैं और हम देश को बताते हुए प्रस्तावित है कि 24-25-26 जनवरी हमने मार्च में बच्चों की समस्या को। एक लाख सेतिस हजार pregnant mothers का registration किया गया है। हमारी institutional delivery देखी। MMR कम होना है। IMR कम होना है। यह Asha ANM की मदद से होगा क्योंकि NRHM ने यह हमारा दिया। हमने PHC 104 promote कर दिया। पुरी delivery के लिए, 66 CHC कर दिया। जैसा Himachal पर नहीं हमारी कठिनाई है referral unit में अगर anaeesthesia व Radiologist नहीं है तो वो preliminary हो जाएगा। वहाँ से फिर आगे civil अस्पतालों में refer होगा। इसको कृपया ध्यान दीजिए। बाकी बात भी हमके साथ ही जोड़ दूं। आपके मानने जाने आयुर्वेद के 121 डॉक्टरों को मिला तो लेकिन आपने जो per आयुर्वेद के Dispensary के लिए दस लाख रुपया देना था उसके लिए हमने अवकाश का case बना के भेजा हुआ है, वो आपने हमें आगे लाए नहीं दिये हैं। क्रृपया जल्दी भेज दीजिए और अगली PIP में डॉक्टरों के लाभ pharmocist भी और एक महिला nurse भी दीजिए। वह हमारे आयुर्वेद के और होम्योपैथी के Doctors को चाहिए। उसके लिए कृपया हमें सहायता दीजिए और जो स्वास्थ्य बीमा योजना है, काम तो हमने कराया है। काम हम कर रहा है। similarly de-addiction का काम हमें हमने करना है लेकिन जो भी उसके लिए एक राहि आने है वो आती है सामाजिक सुखद विवाह से। तो उसका तो हमारे बांधे कठिनाई आती है। वो पंजाब अपनी प्रीतिका कर रहा है। आपने दिसंबर में आया था, आप आए नहीं और आपने बुधवार control करना था। वो अभी ही नहीं पाएंगे। कृपया शराब के लिए भी काम कराये और जो बदले के high court में cinema में हुम्बना विफल नहीं हैं, इसके विरुद्ध लड़ाई हम लड़नी हैं। केंद्र सरकार उसको लड़नी गी। आपको पता है कि लोगों ने कहा कि हमे पहले हो, लोगों ने बांधे को design करना है, tooth paste को बना सा प्रयाग करता है। यह cinema और TV तय करता है। अगर cinema वाले बुधवार से दिखाये गए तो फिर सड़कों पर नहीं हो जा पाएगा। और एक बात जो में परिपक्व रूप से कहना चाहिए कि दूसरे डॉक्टर को बांधे आयुर्वेद के हैं या होम्योपैथी के हैं, उनको एक जेंसा बनाया दीजिए। इस तरह हमने कहा कि हम आयुर्वेद लगता है कि जैसे-जैसे जमा के डॉक्टर हैं। इसका वेतन एक जेंसा दीजिए। इसके
The representative of the Minister of Medical Education, Govt. of Punjab raised suggested the following:

- The distance between the two pieces of land for establishing new Medical College and Hospital should not be more than 5 Kms.
- The criteria for fixing the number of seats in a medical college and bed strength in teaching hospitals should not be relaxed.
- Relaxation of age of retirement of specialists to 70 years may be allowed after proper assessment of physical & mental fitness and the appointment should be renewed on yearly basis.
- Admission to MBBS course should be based on the performance in the Medical Entrance Examination.
- It should be made mandatory for existing and new medical colleges to have Dept. of anesthesia, blood banks, component separation unit and community medicine and transfusion medicine.
- Student- teacher ratio for PG courses should be 1:1 for Clinical subjects and 1:2 for pre and Para clinical subjects.
- IMA's viewpoint may be considered for admission to PG course instead of making one year rural posting as mandatory.

UTTAR PRADESH

The Health and Family Welfare Minister of Uttar Pradesh appreciated the Union Ministry of Health & Family Welfare for initiating several Health programmes which have brought about fundamental change in the Governmental approach towards health care and requested the Chairman to extend support to the new initiatives taken up under NRHM by the State. The Health Minister sought support of the Union Government for the following:
• To implement the EMRI scheme in the State speedily.
• To extend MMV project in all the 71 districts.
• To effectively implement the ongoing two schemes involving regular check up for the students in rural areas, “Saloni Scheme” for the girls and “Aashirwad Scheme” for boys in the rural areas.
• To Strengthen the Virology Institute
• To tackle Japanese encephalitis in the State by way of granting permission to import vaccine in sufficient quantity.
• To strengthen the cold chain system for effective implementation of Janani Suraksha Yojna.
• To grant additional funds to develop Hospital infrastructure.
• To increase the cash incentive given under Janani Suraksha Yojana to achieve higher targets of institutional deliveries.
• To give permission to commence B.Sc. Nursing degrees at “King George Medical College” Lucknow.
• To provide financial assistance for implementation of the HMIS
• To set up Sulabh type of toilets and waste disposal system under NRHM in the district hospitals.

The Chairman, intervening in the discussion stated that if India needs to succeed, U.P. needs to succeed because U.P. is the largest state in India. The population of the State equals to the population of a country like Brazil and it would have been the sixth largest country in the world.

UTTARAKHAND

Dr. Ramesh Pokhriyal ‘Nishank’, Hon’ble Minister of Health & Family Welfare, Govt. of Uttarakhand

माननीय मंत्री जी, आदरणीय राज्य मंत्री जी नरेश दयाल जी और मंत्र पर उपरिित सभी अधिकारीय, सभी प्रदेशों के मंत्रीगण और अधिकारीगण। माननीय मंत्री जी हम आपको बहुत आभारी हैं। पिछली बार हम ने उत्तराखंड की कुछ समस्याओं को आपके सामने रखा था और समाधान की दिशा में आपने हमारा प्रोत्साहन काफी बढाया है। मैं यह कहना चाहता हूँ कि उत्तराखंड भले ही छोटा राज्य है लेकिन देश की संस्कृति का प्राण, धरती का स्वर्ग है और इसने देश को ऐसे बलिदानी नीजवान दिए हैं जिन्होंने देश की रक्षा में समय—समय पर अपने प्राणों की आह्वान दी है। इसलिए दो—दो विदेशी सीमाओं से चिर हुआ उत्तराखंड देश के लिए कई प्रकार से बहुत अहम हो जाता है। इसलिए हम आपके आभारी हैं कि आपने इस दिशा में हमारा काफी ध्यान रखा है। मैं सोचता हूँ कि NRHM के माध्यम से जो कुछ बिन्दु सामने आए हैं भेस युद्ध यह है कि जोसे जननी सुक्ष्मा योजना, यह बहुत ही अहम योजना है और बहुत ही सफलता के मिलकर पहुँची है लेकिन जहाँ हम संबंधित प्रसव पर तारी है ये वहाँ उदाहरण ये आ रहे हैं कि यदि कोई महिला चिकित्सालय सी बैंड का है तो उसमें 200 से भी अधिक प्रसव हो रहे हैं।
ऐसी स्थिति में जो जवाब थे, चिकित्सकों की सरकार कितनी है, यदि इस पर ध्यान नहीं दिया गया तो इसके विपरीत असर भी पड़े शुद्ध होंगे। उत्तराखंड में 51% सरकारी प्रवर्तन होते हैं और शेष जो 49% है वो ग्रामीण क्षेत्र में home delivery से होते हैं। ग्रामीण क्षेत्र में जो ‘आशा’ और जो वहाँ दायें हैं, उन दायें को भी हम आपने अदालत नहीं कर सकते इसलिए उत्तराखंड शासन ने दायें के प्रशिक्षण का अलग से अभियान शुरू किया है ग्रामीण क्षेत्र में। हम आपके आराम के लिए हैं कि पिछली बार अपने लाभग 450 satellite उपकरण जो इसके लिए दे ये हमें ग्रामीण क्षेत्र में दूर स्थानों पर स्थापित किए हैं लेकिन जो चिकित्सालय NRHM के तहत हैं, उनमें आपूर्ति विंग की स्थापना की है, यह बहुत ही महत्वपूर्ण योजना है लाभग 262 डाकोता 262 Pharmacist और 262 अन्य पदों के कमी पिछली बार संभाले दे रखने के लिए आपने हमको दिये हैं और इस वर्ष भी आप उतना ही देना चाहते हैं बहुत ही लोकप्रिय योजना है, लेकिन तीन तीन रुपए प्रमाणित स्वास्थ्य केंद्र के में एक कक्ष के निर्माण के लिए और सात लाख रुपए सामान्य स्वास्थ्य केंद्र निर्माण हेतु योजना है। इससे चिकित्सालय में कोई स्थान उपलब्ध न होने के कारण इस योजना में अधिकतम है। इसलिए में अनुरोध के लिए हम इसे बढ़ा म्याकिना को लेकर बच रहे हैं।

उत्तराखंड में 5 ANM हर जिता रातर एक ANM प्रशिक्षण केंद्र स्थापित कर रहे हैं। में अपने अनुरोध है कि उसमें अलग से कुछ Budgeting किया जाए। 108 पंडित दीन दयाल उपाध्याय आचार्यकालीन सेवा ने उत्तराखंड में बहुत समकालीन परिवर्तन किया है। केंद्र 8 महीने के अंतर 7000 प्रवर्तन केंद्र 108 में हुए और शांत देश के अंदर भी नहीं दुनिया के अंदर यह पहला उदाहरण होगा कि 282 वचन ने केंद्र सात महीने के अंदर केंद्र बनाया हुआ रहते हैं। इस से बन्दर है कि पर्यावरण क्षेत्र में जिसके भारतीय एम्युलसन और मा। कृषि उत्पादन दर में बहुत परिवर्तन हुआ है इस योजना में सात महीने में 44000 आपूर्तिकाल के में बना है जिसमें 7500 प्रवर्तक कार्यरत है। उन ऐसे आकार है कि शांत देश के अंदर भी ही हुआ होगा। आंशिक धरण में तब हमारे एम्युलसन उस स्थान पर पहुँचती है। हर विकास क्षेत्र तक इसको पहुँचाना की योजना है। हर तरह से चाहिए है कि मूलतः एक शिक्षा और मानवीय दर में कोई भी शिक्षा और मानवीय दर में कोई नहीं हो तो एक क्षेत्र यथा एम्युलसन वीनी चाहिए। इससे आपकी कुछ डॉक्टर्स का अभाव भी नहीं है। इसके इन वैद्य और ऐसे स्थिति में हमे अधिक से अधिक स्थान प्रदान भी कर सकते हैं।

इसके विवेक के द्वितीय क्षेत्र के अंतर की ज़रूरत है कि यदि एम्युलसन, हॉम्युलसन, आयुर्वेद इनके किसी भी कर्मी में जो अलग वेतनान्वयन या सुविधाओं को अलग-2 नहीं करें तो उससे इसको ताकत मिलेगी। तीसरी है कि 550 आयुर्वेदिक चिकित्सालय उत्तराखंड में है लेकिन इस योजना के तहत हमें भी यथानुशासन के निर्माण की कोई बात नहीं है।

इसलिए में यह भी अनुरोध है कि हम NRHM के माध्यम से उन चिकित्सालयों को भी सुधार किया।
रोगी कल्याण समितियों का हम लोग गठन कर रहे हैं और अभी जो "आर्याध" का अपने पौधा सो रखना सुनिश्चित किया है हम आपके बहुत आभारी हैं यह आपका बहुत महत्वपूर्ण निर्णय है मेरे यहाँ ने हजार "आर्याध" है और श्रेय सभी प्रदेशों में होगी यदि जिस दिन यह पौधा सो रखे प्रति माह मिलना हो जाएगा। उनकी union वनेंगी और धीरे-2 करके यह कहने, हमके अब पकड़ करिए। इसलिए मेरे सुझाव है यदि आपको उत्तम लगे कि रूपये 500 प्रति माह, वर्ष महीने में होंगे 6000/-- यदि यह जो 14000 रूपये हम इनको देते हैं यदि इसको बढ़े करके हम 400 रूपये और कर देंगे 18000 रूपये प्रति केंद्र देंगे तो शायद सहृदयता होगी। इस पर भी विचार करना क्योंकि भविष्य में शायद यह बीतानिय का विषय भी बन सकता है। यह जो EMRI के बारे में विशेषकर गर्दा अनुरोध है कि हम लोगों को ऐसी उपलब्धियों में आप मदद कर देंगे तो इस आभारों को और अछे तरीकों से आपेक्षाकर बढ़ा सकेंगे। स्वास्थ्य कार्यक्रमों की रिश्ता में दाँड़ी के प्रशिक्षण के लिए हमने आपसे अनुरोध किया है। आर्याध, हमें आपसी का यह जो आयुष्मान विकास है, यहां-जबस पंच-कर्म का कंट्या है। इसके लिए भी आयुष्मान विश्वविद्यालय का अलग से मनुष्य बनाने की जरूरत है क्योंकि मानसिक लब्धि जी जी अछूते के देहरादून में तो देहरादून में पूरे देश का आयुष्मान का सबसे बड़ा मेला लगा था। आपने आयुष्मान प्रदेश घोषित किया क्योंकि हम मध्य-वृत्ती एवं सहज विश्व देश के लोग हैं। हमारी जी विश्वविद्यालय में है जिससे आप पूरी दुनिया को अच्छा कर सकते हैं। इसलिए हम आभार है कि हम रहें हैं और आपका माना देश हम भी चाहते हैं। देश भी चाहते हैं कि उसको हरथल ग्रेटर मिनिस्टर करिए क्योंकि लोगों का आयुष्मान के प्रति जिस तेजी से लगाया है यदि जहीरा उसके उद्याधिकार उस तेजी से नहीं होगा तो इसकी गुणवत्ता पर असर पड़ेगा। इसलिए उल्लसाह को देश भर का एक शिक्षण हम बनाया जाए।

Participating in the discussion the Hon'ble Minister has further stated:

मात्रवर हमारे प्रदेश में तीन गेट-सरकारी और एक सरकारी, चार महिलावाद के लेखक हैं और हमें 400 नीट है। आयुष्मान के दो कॉलेज सरकारी है और दो निजी क्षेत्र में है। ग्रामीण क्षेत्रों में भी अधिक डॉक्टरों के पद शिक्षित है और लगभग सात से भी अधिक विशेषज्ञों के पद शिक्षित है। इस तथ्यावधि से उल्लसाह जुड़े रहा है और इसके बहुत विश्वसनीय हमारे सामने है। इसलिए श्रीमती का जो राजकीय महिलावाद के लेखक है उसमें हमने कैद 15000 रूपये प्रतिवर्ष MBBS शुल्क लेकर, उस कॉलेज को बनाना शुरू किया है और हमने भारत सरकार से जुड़ा है। यदि वे हमारे पौधा वर्ष प्रामाण्य क्षेत्र में हमको सेवा देंगे। इसलिए मेरे सुझाव है कि हमारे प्रदेश का प्रामाण्य क्षेत्र में हमने किया जाए। इसलिए हमारे प्रवेश प्रामाण्य क्षेत्र में होगा आपकी वर्तमान देश के अंदर राजकीय महिलावादी में मुद्दा लगाता है क्योंकि नया एक अप्लास्टिस्त है। इसलिए हमारा अनुच्छेद है कि हमारे में तीन सो भी अधिक बैड हो। यदि हमारे में महिलावाद के लेखक की आनुमति मिल जाती तो हम सहज तरीकों से पूरे नीट हम बनाना चाहते हैं। इससे PG courses भी हम भर सकेंगे। में वापसी जी की वात से सहमत हूँ, उस पर में वल देखा चाहता है। अचार MCI ने या CCIM ने कहीं बैड करके कोई तो नाम करवाई होगी। बैड के पदोंसे, एकड़ मूल्य, उस पर होने वाले लाखों वर्ष में भवनों का निर्माण और सभी उपकरणों पर, 150 से 200 करोड़ एक व्यक्ति होने पर एक महिलावाद कॉलेज बनता है। जो सुप्रीम कोर्ट के निर्देश के अनुसार फौस का पैतंजलि निर्माण हुआ है, कोई भी महिलावाद कॉलेज यदि उस
आधार पर चलता है तो पवास वर्ष में भी वो अपने पौंड पर नहीं खड़ा हो सकता। तो यह बताएँ कि क्या जिसके पास समय दो का पैसा है वो ही मैदिकल कोठीज खोल सकता है। यह तो नितांत अवहानिक है इस पर एक बार बैठा जाना चाहिए और इस पर एक बार किर अध्ययन करना चाहिए। इस दिशा में राज बहुत बिना अनुरोध है। जहाँ तक पर्यावरण का क्षेत्र है, योग्य पंडित-पंडित एक भी एक घर पर रहने का कोई मतलब ही नहीं है और इसलिए पर्यावरण क्षेत्र में तो इस पर और अधिक छोटे होने की आवश्यकता है।

अभी जहाँ हमारे पास doctors की कमी है, वहीं हमारे पास चिकित्सा अधिकारों की भी कमी है। सी साल पुराना मालिकी जी द्वारा स्थापित गुरुकुल में अधिकारों की कमी को देख कर CCIM ने बजट उसकी ओर और विकास के लिए 2007-08 में उसमें प्रवेश पर प्रतिक्रिया लगायी थी। इसकी पुरानी संख्या में और ऐसे संकट के समय में CCIM और MCI इन दोनों संस्थाओं को उनको रोकने के बजाए उनको ताकत देना चाहिए था। हम लोग आयुष्मान प्रदेश के लोग हैं। अभी तक वहाँ पर कोई भी आयुर्विज्ञानिक विषयविद्यालय नहीं है। आयुर्विज्ञानिक विषयविद्यालय बनाने की दिशा में जहाँ हमारी Herbal state उसको ध्यानित किया है, वहीं आयुष्मान प्रदेश उसको ध्यानित करके जहाँ दूरी धारा संस्थान औपचारिक बोड़, इन दोनों ही हम सशक्तीकरण कर रहे हैं। यह न केवल उत्तराखंड के लिए, वर्तमान पूरे देश और दुनिया के लिए महत्वपूर्ण होगा। इसलिए आयुर्विज्ञानिक विषयविद्यालय बनाने के लिए हमारी आपसी विनम्र अनुरोध है। इससे लागू कर लेंगे तो यह आपके आगामी संस्थाओं के स्वरूप में देंगे तो हम आपके आगामी संस्थाओं की विशेषतें हैं। फिर यह बार यह कहा गया था कि act में आयुर्विज्ञानिक विषयविद्यालय बनाने के लिए हमारी आपसी विनम्र अनुरोध है।

Supreme Court ने जिस act की चर्चा की है उसको अनुसार allopath side में BAMS के लोग practice नहीं कर सकते हैं। उस act पर किर जाने का राजा क्योंकि BAMS के पर्यावरण डॉक्टर हैं उनको अधिकारकृत कर देने की जरूरत है। वैसे तो अधिकारकृत राज्य चिकित्सा भी वो करते हैं। अतः उस act में आयु अधिकारी करार दीजिए। मैं सोचता हूँ कि ऐसा करने से डॉक्टरों की बहुत बड़ी कमी दूर हो जाएगी। मैं आपका आभारी हूँ कि हमारे क्षेत्र में पौंड ANM स्कूल और पौंड B.Sc. Nursing school खोले जा रहे हैं। यह भी हमारा अनुरोध है कि हमारा राज्य नवीनतादीन राज्य है। वहीं जो BAMS के लोग हैं, जो doctors हैं, जो शिक्षा है उनको एलोचर और आयुष्मान मान्यता मिल जाने से इतनी बड़ी समस्या का समाधान होगा। बहुत धन्यवाद।

The Chairman thanked the Health Minister and assured to consider implementation of suggestions wherever possible. The Chairman also requested the State Government to go ahead with establishing of Medical College in Dehradun, as clinical facilities to serve the medical college are already available.

NAGALAND

The Health & Family Welfare Minister of Nagaland thanked the Chairman for his thought provoking speech and congratulated the Government of India for providing all types of assistance to the people of the State under NRHM to improve the health parameters. He explained some of the achievements made under NRHM such as remarkable increase in institutional delivery, inpatients, outpatients at health institutions and the services provided by Mobile Units which are distributed to all the District Hospitals.

The Chairman also requested the Health Minister for his suggestions wherever possible. The Chairman also requested the State Government to go ahead with establishing of Medical College in Dehradun, as clinical facilities to serve the medical college are already available.

The Health Minister in his speech focused on the following issues.

- Shortage doctors for effective implementation of NRHM.
- Release of funds to State under NRHM as projected in the State PIP for year 2008-2009.
PUDUCHERRY

Health and Family Welfare Minister of Puducherry appreciated the Chairman for launching a unique health programme i.e. National Rural Health Mission in the country and briefly highlighted health scenario of the State especially with regard to achievement of 99.9% institutional deliveries, sex ratio of 0 to 5 years 1001 to 1000, reduction of anaemia in adolescent girls from 99% to 75%, coverage of 100% children in IPPI, zero death rate due to vaccine administration in the last 3 years, starting of adolescent clinics for girls, supply sanitary napkins to all the school going adolescent girls in the rural areas. The other important achievements of the State, include:

• Constitution of adolescent health teams consisting of medical officer, staff nurse, councilors, lab assistant to conduct health checkups for school children (adolescent boys & girls) and college students
• Administration of rubella vaccination to adolescent girls
• Operationalization of Mobile Medical Units for Pondicherry & Kanyakar districts.
• Provision of dental services in the PHCs.

The Minister also focused on the following:

• Approval for release of funds towards human resource component under NRHM as projected in the PIP of 2009-10.
• Support for infrastructure development and research grant to implement schemes under AYUSH.
• Release of procurement funds at the beginning of the financial year.
• Supply of Kits well in advance if they are to be supplied by Govt. of India.

MANIPUR

The Health and Emily Welfare Minister of Manipur, while giving a vivid description of the terrain of land, existing law and order situation and prevailing weak communication system in the state requested the Chairman to provide special assistance / support in respect of the following:

• To tackle the problem of shortage of manpower.
• To construct quarters to health personnel posted in the institutions in hilly regions, under NRHM
• To establish PHCs under NRHM.
• To control Malaria as it is a malaria prone state.
• To release funds under TB Control Programme regularly.
• To control HIV AIDS in the State
• To establish a full fledged AYUSH college in the state.
• To strengthen the overall Medical education in the state.

The Health Minister of Manipur also participated in the discussion and requested the Union Health Minister to provide financial assistance to start PG courses and B.Sc. Nursing course simultaneously.
The Chairman assured the Minister to do the needful to start PG courses and B.Sc. Nursing courses, after going through the due process. The Chairman also requested the State Health Minister to submit the Utilization Certificates in respect of the funds already released to consider release of remaining installments.

MEGHALAYA

Health and Family Welfare of Minister of Meghalaya in his speech briefly highlighted the achievements which include appointment of 6000 ASHAs and providing training to more than 5000 of them and formation of Village Health Sanitary Committees in the state under NRHM. He also thanked the Chairman for approving the PPP model for running PHCs and CHCs in the state. In his speech, the Health Minister narrated the following health problems and sought special support:

- To tackle the problem of trained Manpower shortage
- To set up more Sub-centres.
- To implement EMRI by way of providing more Ambulances
- To tackle the problem of wide spread meningococcal mining disease.
- To strengthen IDSP
- To strengthen MIS in the state.

MIZORAM

Health and Family Welfare Minister of Mizoram in his speech gave a brief account of community friendly and innovative health programmes being pursued under NRHM in the State. He suggested that the criteria for establishing Health Centers needs to be reviewed and suggested that it should be based on specific local needs rather than on population norms alone, as Mizoram is a hilly state and accessibility to these Health Centres is very difficult. The Health Minister sought support of the Central Government for the following:

- To establish a Medical College in the State.
- To control Malaria as it continues to be a major health hazard in terms of morbidity & mortality.
- To tackle the problem of HIV AIDS
- To control cancer.

Participating in the discussion the Health Minister congratulated the Chairman for launching a National Programme on Prevention & Control of Diabetes, Cardiovascular Disease & Stroke, as it is going to benefit the North Eastern States in general and Meghalaya in particular where throat cancer is rampant. He also suggested that the country should have strong legislation to restrict the consumption of alcohol, junk food. During the course of deliberations the Health Minister of the State also informed the Chairman about launching of anti-tobacco anti-smoking campaign in the state.
श्री ल. क. चतुर्वेदी, म. प. (रै)

माननीय मंत्री महोदय, राज्य मंत्री महोदय, सम्मानित मंत्री, देश के सभी प्रदेशों से आए हुए स्वास्थ्य मंत्री बुधनों, अभिव्यक्ति भाषाओं और वचनों तथा अधिकारियों! मैं माननीय मंत्री महोदय को धन्यवाद देना चाहता हूँ जिन्होंने इस बैठक का आयोजन करने के देश के प्रतिमातंत्र में चिकित्सा क्षेत्र में आने वाली समस्याओं और उनके समाधान को प्रस्तुत करने का प्रयास किया है। सबसे पहले तो मैं सबको नववर्ष की शुभकामनाएं देना चाहता हूँ, जो procedure से संबंधित है। पहला सुकाव यह है कि वर्ष में इस परिषद की कम से कम एक बैठक करने का प्रयास है और 13 नवंबर, 2007 के बाद हम मिल रहे हैं। कम से कम एक बैठक का मतलब यह नहीं है कि एक ही बैठक हो। आपने देखा होगा कि agenda आया है उसके संबंध में एक बैठक में आयोजित एक ही बैठक में प्रवास-पिंमरण करना संभव नहीं है। ऐसा मेरा सोचना है। इसलिए मेरा सुझाव है कि वर्ष में कम से कम जनवरी और जुलाई में दो बार बैठकें आयोजित की जाए ताकि विस्तार से विचार-पिंमरण हो सके। शायद मुझे यह जानकारी इसलिए है क्योंकि मुझे भी नीचे साल तक स्वास्थ्य मंत्री बने रहने की माूँग मिलता है। पहले जो बैठक आयोजित की जाती थी, वह दो दिनों के लिए की जाती थी। किन्तु जब देश भर में चिकित्सा क्षेत्र की जानी-मानी हस्तियों यादों इकट्ठा होती है और देश की योजना पर विचार किया जाता है तब एक दिन की बैठक में हम क्या कर पाएंगे। सबको short करना पड़ता है। इसलिए मेरा दूसरा सुझाव यह है कि दो दिनों के लिए बैठक आयोजित करने के विचार को संस्थान से अलग रखने का प्रयास किया जाए। तीसरा, मेरा सुझाव यह है कि मैं मिच्छली बैठक होती है उसमें मैं agenda आया हूँ, समस्याओं में जो निर्णय लिए जाते हैं, जो संकुच किये जाते हैं, जो प्रस्ताव रखे जाते हैं, उस एक दिन में या आड़ूँ। मैंने बताया है कि जो Action Report के साथ-2 जैसे आपने कहा मुझे पढ़ने का अवसर नहीं मिला। कोई ती स्थिताएं रही है, कोई ती कमियाँ रही है, कोई से अवसर आए हैं, कोई सी कठिनाइयों से उपस्थित हुई है उन प्रस्तावों का क्रियान्वयन में इसकी प्रगति हुई है, इसकी सुधारा भी परिषद के सभी लोगों की मिलनी चाहिए। Action Token Report हो सकती है। मिच्छली बार अभी हम मिले थे, और मैं इसलिए यह कहना है कि उस Action Report के साथ-2 जैसे आपने कहा मुझे पढ़ने का अवसर नहीं मिला। कोई ती स्थिताएं रही है, कोई ती कमियाँ रही है, कोई से अवसर आए हैं, कोई सी कठिनाइयों से उपस्थित हुई है उन प्रस्तावों का क्रियान्वयन में इसके लिए भी शायद घटे-दो घटें का समय रखना आवश्यक है। इसके पश्चात मैं procedure के अनुरूप लगाता हूँ। आप देखने की कोशिश करेंगे। मिच्छली बार हम निकले थे। एक बार के लिए मैं आपको बहुत बादौ देना चाहता हूँ और उसके माध्यम से में सभी स्वास्थ्य मंत्रीयों के निवेदन भी करना चाहता हूँ। मैंने consultative committee में भी इस बात की चर्चा की थी। जो Rural Mission के लिए मैं आपको बहुत बार निकलने का अनुरोध लगाता हूँ। आपको बहुत बार निकलने का अनुरोध लगाता हूँ। जो Rural Mission के लिए मैं आपको बहुत बार निकलने का अनुरोध लगाता हूँ।

Tenth Conference of Central Council of Health and Family Welfare
जाए और बनाना आवश्यक है, तीक भी है, मेरा यह निवेदन है कि सरकारों तो बदलती हैँ, राज्य भी बदलते हैं। और भी वाले हैं और उसको में इसका नहीं चाहता कि पिछली बार कौन-2 सी scheme बदल कर क्या-2 फायदे और क्या-2 नुकसान हुए है इसलिए इस परिषद में हम इस बात को निश्चित रूप से सबके सामने रखना चाहता हूँ। इसी अक्षर चलने वाली scheme गॉंग और गरीब दो फायदा पहुँचाने वाली गिजातका के क्षेत्र की scheme लगातार लागू रहें, कुछ इससे बदलाव हो जाता है, तो इसको भी किया जाना चाहिए, ऐसी मेरी विचार प्रारंभ है। मैं निवेदन करना चाहता हूँ कि पिछली बार की बैठक में हमने निर्णय किया था। Micronutrient deficiency disorders के बारे में एक प्रस्ताव लिया था। Iron, folic acid गोलियाँ और Vitamin A syrup वितरण को सुनिश्चित किया था। यह कार्य राष्ट्रीय ग्रामीण स्वास्थ्य मिशन और एकजुट बात विकास स्थापना के अन्तर्गत किया जाना था। हम जानते हैं कि विश्व स्वास्थ्य संगठन ने आकर्षण करने का, कि 47% से अधिक लोग बाल जनसंख्या भारत में भाग कर कृपयाः से पीड़ित है। हमने पिछली बार प्रस्ताव भी लिया है। हम ग्रामीण बोजन आंदोलन के लिए। उनके माध्यम से इसको दूर करने की कोशिश का जा रहा है। किन्तु मुझे यह कहना है कि, इस परिषद के केंद्रीय सरकार के समक्ष अपने स्लॉट रिस्पार्शी करनी चाहिए कि यह जो काम हमने पिछली बार किया था, उसका निर्णय निर्णय किया था, उसमें गरीबी उन्नयन, महत्वपूर्ण समाजकर्मी, परिवार, वित्त, जन विभ, या नहीं देने का निर्णय, यह एक साथ किया जाना चाहिए। यह multidisciplinary action है, activity है। अभी स्वास्थ्य और परिवार कथाना में इसका कर रहा है। किन्तु आगर यह multidisciplinary activity है, इसके राखे तो गिज्जा इसमें involved होते हैं तो मेरी आपसे भी प्रारंभ है और मैं सममें से भी प्रारंभ करना चाहता हूँ कि कुछ और प्रताप उनमें लेने वाले हैं। हमको clear indication, direction दिया जाए और इस बात को भी स्निस्कित रूप में किया जाे। कि multidisciplinary activity होने के कारण जो–2 इसके साथ stakeholders है, उनको सबको में शामिल किया जाए तथा कि कार्य के लिए हम कार्यक्रम चलारहे हैं, स्वयं-सतता संस्थाएँ, गॉंग के दिशित लोक, प्रेमकुश नागरिकों को इसमें कैसे जोड़ा जा सकता है। पवित्र जनता का कार्यक्रम बनाना चाहिए। मैंने यह बात इसलिए कही कि पिछली बार प्रताप भी नहीं लिया गया और निर्णय नहीं लें लिया गया। थोड़ा सा गृहु है जो में Action Report नहीं पढ़ सका किन्तु मुझे लगता है और अभी तक यहाँ तक कि आज यह नहीं हुआ है। इस पर विचार करना निष्ठित रूप से मेरे लिए आवश्यक है राष्ट्रीय ग्रामीण स्वास्थ्य समिति की स्थापना को लेकर भी हमने पिछली बार निर्णय किया था। अंशद फिक्स के वितारण, की व्यवस्था, आशा स्वास्थ्य में इनमें, कहा गया था कि रोगी सम्मान समस्याओं बनने की, भी है। description आया किया जिससे आप और हम दौरा करने के लिए गए थे consultants committee Goo में। उनको तो पता ही नहीं है अभी कि स्थान का आधार पर National Rural Health scheme को गॉंग–2 गरीब–2 तक पहुँचाना है अगर यह कमजोरी नहीं बनी। Active नहीं विभी इसका persuasion नहीं हुआ इसका monitoring नहीं हुआ तो क्या गोरा। इसलिए मेरी प्रार्थना है कि इस दृष्टि से भी विचार करने की आवश्यकता है। एक अन्य विषय जो आयुष्मन के बारे में है जिसमें बहुत अधिक चर्चा हुई है। सबने यह कहा है कि यह एक ऐसी व्यवस्था है कि जिस सारे राजार के निश्चित रूप से सभी को गंभीर रूप से विचार करना चाहिए और हमारे यहाँ बड़ी prominent भी है आप कृपयाः करेंगे और आप मानद्वितिया देखिए, देश की मनोभावित देखिए।

चार parliamen के सदस्यों में एक में है। इसलिए थोड़ा सा खत्म करता हूँ। मेरा इसलिए निवेदन है, इसलिए कहना चाहता हूँ, कि आयुष्मन को अप medical colleges में भी कोई न कोई शिक्षण–प्रशिक्षण दिया जाना चाहिए और उसी प्रकार आयुर्वेदिक कालेज में भी, दिया जाना चाहिए ताकि एक दिल–दिमाग उस प्रकार का बन सके। मानवता मजी जी, मैं यह आज कहना चाहता हूँ कुछ तो विषय ऐसे हैं जिसके बारे में विचार अभी नहीं हुआ है। आगे गोरा । जो संशोधन लेकर आयेंगे 25 एकड़, 24 एकड़
करना और बीस लाख की आवागी में उनके बारे में कहना चाहता हूँ कि जिन्हें Rural schemes के बारे में मेरा यह कहना है कि आज सबसे अधिक आवश्यकता है Doctors की Paramedical staff की। इस आवश्यकता की कंप्यूटर पूरी हो। विश्व देश में समयबाद कार्यक्रम नहीं बनाया जाना चाहिए। मैं राजस्थान से आता हूँ। आधी मैंडिकल कॉलेज हैं। माननीय मंत्री महादेव ने भी ठीक कहा है कि हमारे 15 मैंडिकल कॉलेज और होने चाहिए और देश के, विदेश के विद्वान इसका विचार करने तो सचमुच देखने को मिलेगा कि कितने मैंडिकल कॉलेज की आवश्यकता है।

मेरे इसलिए पुछा था कि time is so short किसे difficult to give इसलिए मैं केवल इतना कहना चाहता हूँ कि यह doctors का और Paramedical staff-इसके लिए एक time bound prog. सारे देश में लिए जाने की आवश्यकता है। college खोलने चाहिए दोनों पक्ष दो के। लाल फोला शायद जो बीच में आती है क्योंकि यह मंत्री महादेव अब विराजमान हैं कम involved होता है। इन कामों में देरी होती है। केंद्र की ओर से ऐसा monitoring process होना चाहिए कि जिसके कारण समयबाद तरीके से हम जो नवर ऑफ colleges चाहते हैं वो खोले जा सकें। no. of training colleges जो paramedical staff के लिए खोले जा सकें वो नहीं होंगे। को संयुक्त आर्थिक में देखा गया जब प्रमेय कर पाएंगे। को संयुक्त आर्थिक कर पाएंगे। PSC और CSC के बारे में जो मूल रूप से ग्रामीण क्षेत्र में चिकित्सा सुविधा पहुँची है। No. of doctors शायद ठीक है। CSC में वार doctors हैं। Anaesthesia नहीं हुआ तो कैसे कोई minor operation भी होगा वह। round the clock हम कार्यक्रम को चलाना चाहते हैं। मरीजों की सहायता करना चाहते हैं। यह व्यवसाय हमारे मन की है। सार doctors कम से कम एक CSC में होने चाहिए। पांच डॉक्टर PSC में होने चाहिए और उसी अनुसार paramedical staff के होने की आवश्यकता है। ऐसा मुझे लगता है। मैं यह बात इसलिए कह रहा हूँ। अतः मैं एक बार में कहना चाहता हूँ जिसकी चर्चा में करना रहा है। यह गाँव और गरीब को चिकित्सा देने की बात करते हैं और दे रहे हैं। मैं उनसे पहले भी चर्चा की थी। मैं तो राजस्थान को ध्यानबद्ध देना चाहता हूँ कि जहाँ कभी किसी गरीब व्यक्ति को, और भी प्रदेशों में सुग्ह है मुझे पता है कि जहाँ किसी गरीब व्यक्ति का गंभीर बीमारी हो गई वह BPL है चाहे APL है। जो income जब से देना अगर एक valve खोला हो गया तो 1,30,000 रुपये चाहिए। Angioplasty needs 80,000 भरना ही है। उस तरक कम से कम केंद्र सरकार और राज्य सरकार को joint responsibility लेना चाहिए कि जो income tax paye नहीं है उनको यदि अगर गंभीर बीमारी हो गई, तो उनका बिचार अपने ऊपर लेकर उनका इलाज करने की आवश्यकता है। ऐसा मेरा कहना है। मैं अपना ध्यान जो है on record आपको दूर गाए क्योंकि समय की न्यूनता इसके से मुझे नहीं लगता कि और तीसरे session में क्योंकि अभी तो दो presentations हुए है तीन होना अभी बाकी है। शायद उसमें भी और लोगों का समय मिलेगा कि नहीं मिलेगा। आपने मुझ समय दिया। उसके लिए आपको ध्यानबद्ध देता हूँ मेरी बात को में समाप्त करता हूँ।

यह जो भारतीय चिकित्सा परिषद के regulations में संशोधन की बात है, जैसा कि अभी आसम से आने वाले माननीय सदस्य ने कहा था। उन्होंने कहा था कि केंद्र में संशोधन हो रहा है, पता नहीं हो रहा है कि नहीं। किन्तु कभी कोई court में चला गया तो क्या होगा और इसलिए निश्चित रूप से regulations में संशोधन करना आवश्यक है। नया दो, यह जो स्वास्थ्य मिशन चलाने वाले राज्य हैं और उत्तर पूर्वी राज्य हैं, पहाड़ी राज्य हैं, पहाड़ी जिले हैं, बीस लाख से कम जन संख्या वाले शहर हैं इनमें इस मिशन के लिए 25 एक्स 20 एक्सट्रम उत्साहित किया है। मेरा सुझाव है आजकल जमीन मिलना बहुत मुश्किल है। इसलिए अन्य राज्यों के लिए 25 से 20 एक्सट्रम किया जा एक्सट्रम किया जा एक्सट्रम किया जा एक्सट्रम किया जा एक्सट्रम किया जा एक्सट्रम किया जा एक्सट्रम किया जा एक्सट्रम किया जा। जमीन को कभी के कारण आजकल horizontal विस्तार के बदले vertical विस्तार अधिक होता है। medical college में पांच-छः मिले होते हैं, जिन्हें सात-आठ किया जा आ। चिकित्सालय में तीन होती है, उन्हें पांच बिक्री किया जाये और experts बेकार कितना built up area
Prof. (Dr.) Ranjit Roy, Chaudhury, Eminent Individual

Prof. (Dr.) Ranjit Roy, Chaudhury, Member of the Council, in his speech, congratulated the Chairman for effective implementation of NRHM. He strongly supported establishment of the Pharmaceutical Corporations which will improve the distribution of medicines. He felt that the programme of procurement, use of medicines and prescription of medicines must go together in order to increase access to medicines without extra expenditure.

The Chairman thanked the Member for his useful comments and stated that not only medicine, blood, rational use of blood plus medicines must go together. The Indian Medical Association and like minded organizations, professional bodies should evolve specific guidelines in this regard. The professionals who are prescribing the medicines need to be kept informed about the misuse.

Dr. Anjali Gopalan, Eminent Individual

Dr. (Mrs.) Anjali Gopalan, Member of the Council congratulated the Chairman for the courageous stand taken by him on the issues of homosexuality. The other issues raised by the Member include:

- Integrating and dovetailing HIV-AIDS programme with other National Health Programmes.
- Sex education to school children

The Chairman thanked the Member for the suggestion and informed Council Members that the Ministry of Health and Family Welfare is in the process of integrating HIV-AIDS with NRHM.
and population issues, environmental issues, hygiene, sanitation, yoga, life style issues, alcohol, tobacco and drugs are going to be a part of National School Health Programme and Health Education.

**SHRI L.K. CHATURVEDI., M.P. (RS)**

धुम्रपान निषेध के विषय में जो निर्णय दिए गए थे, legislation आया। साथ आपको जानकारी होगी कि दो बातें कि साव्यसिक स्थानों पर धुम्रपान निषेध और दूसरा फिल्मों और धारावाहिकों में धुम्रपान नहीं दिखाने के आदेश। अभी कुछ दिन पहले एक न्यायालय ने इस आदेश को अमान्य कर दिया कि इससे फिल्मों पर प्रतिकूल प्रभाव पड़ता है। एक दूसरे न्यायालय ने यह निर्णय कर दिया कि समाचार पत्र में तौलकू सबकी विज्ञापन पर रोक लगाने से उसकी बिक्री कम होने के कारण नुकसान होता है। इसलिए विज्ञापन पर प्रतिकूल नहीं लगाना चाहिए। मैं आपसे यह निंदन करना चाहता हूँ कि इस पर गौर किया जाए और न्यायालय ने जो निर्णय किए हैं इनको कैसे counteraction किया जाए इस पर विचार करने की आवश्यकता है।

**HFM’S REMARKS**

The Chairman thanked the Member for highlighting issue of banning the smoking in public places and prohibiting smoking scenes in the movies. The Chairman informed the Member that the Ministry had taken the decision keeping in view of the public health issues and statistics showing positive direct linkages between smoking scenes in movies & youngsters taking up smoking. According to a survey, 52% of the children who start smoking are directly attributed to the movies. But the Hon. High Court set aside the Ministry’s decision to prohibit smoking scenes in movies. The Government is planning to move the Hon.Supreme Court against the judgment of the High Court.

**PROF. GOURI PADA DUTTA, EMINENT INDIVIDUAL**

Prof. G.P. Dutta, Member of the Council in his speech suggested that NRHM should make an attempt to collect information on the morbidity profile of the country. He suggested implementation of Decentralized health awareness programmes involving Nagarpanchayatas, Equal status to AYUSH at par with modern Allopathic system in providing treatment to patients.

The Chairman thanked the Member for the suggestions given to the Council and informed the Members that the Health ministry is trying to focus more on preventive measures rather than having a curative pattern for various diseases and trying to mainstream AYUSH with the modern system of medicine, integrate it at the curriculum wise also.

**CLARIFICATIONS:**

Shri G.C. Chaturvedi, Additional Secretary and Mission Director NRHM, Ministry of Health and Family Welfare, Govt. of India, clarified to the Members of the Council on the issues raised by them as per the details given below:

- **Multipurpose Worker (Male):** In case Multipurpose Worker (Male) is not available, the State Govts. may employ a ANM in place of MPW (Male) with their funds and the 3rd ANM could be employed with NRHM funds.
• **Increasing the limit of Civil Works to 40%**: Ministry of Health and Family Welfare has been allowing 33% of the assistance for civil works in high focus states and 25% in non high focus states. The demand of the members for increase in the percentage of assistance towards civil works is not justified as gestation period is long in the case of civil works. Moreover, sufficient funds are also required to meet other recurring expenses. The present status will continue and there is no need for enhancing this limit to 40%.

• **Preparation of Plans**: As regards financial and physical plan, the physical plan should be prepared at the village level and financial plan from block level onwards.

• **Updating Website**: Ministry’s Website is regularly updated. However, updation is linked to flow of information/data from the States.

• **Implementation of EMRI**: Evaluation of EMRI scheme is being done by NHRC in the States where the scheme is in operation and the report is expected shortly. The Report would be circulated to all states enabling them to take a decision with regard to implementing the scheme in respective states, on the basis of the findings.

• **Base year for arriving at the No. of Sub Centres / PHCs**: This Ministry had been advocating to arrive at the number of Sub-centres / PHCs in a State on the basis of 2001 census not on the basis of 1991 Census.

• **Support for Construction of Staff quarters**: The Ministry of Health and Family Welfare has been supporting for construction of staff quarters under NRHM, and there is no change in the policy of the Ministry in this regard.

• **Delay in release of Funds to States**: ANM salary is disbursed to the States through treasury route and hence there is no delay from the Ministry’ side; States are required to take prompt action for timely payment of ANM salaries.

As regards of release of funds under various components, Ministry requires two documents every year, at least by 30th September; the first one is Audited account certificate for the previous year and the second one is Utilization Certificate. The States that are not able to provide these two documents face problem in release of funds. Initially, the Ministry releases up to 75% of the funds without getting these two documents but for 100% releases, the States are required to fulfill the formalities.

• **Posting of AYUSH Doctors**: The Ministry has been trying to co-locate AYUSH doctors into the health facilities under NRHM. Funds required for engaging doctors is being financed through NRHM flexi pool. Almost 5000 AYUSH doctors are employed on contract basis utilizing NRHM funds. Other measures like medicine etc. are being provided by Dept. of AYUSH. Ministry would definitely like to have more pro-active role of the States in scaling it up AYUSH activities.

• **Support for construction of Building for AYUSH**: The Ministry of Health and Family Welfare shall also support the States, if they want to construct a small building near the existing health facility like PHC, CHC, to provide health care facilities under AYUSH, but duplicating pharmacist nurse at the same facility specifically for AYUSH is a matter to be considered by the State.
Secretary, AYUSH, Govt. of India, briefed the Members about the facilities available under AYUSH as per the details given below:

- **Mainstreaming of AYUSH**: Ministry of Health and Family Welfare has been giving utmost priority to mainstream AYUSH under NRHM and revitalization of the AYUSH sector. The major objective of mainstreaming AYUSH under the NRHM would be in the form of co-locating AYUSH facilities with the PHCs by providing a doctor and also a pharmacist, a compounder, an attendant along with it. The AYUSH Dept. will supply the medicines and provide the space for it.

- State Governments should complete the process of co-location as quickly as possible. Co-location should not be only at the PHC level, but at the secondary level and the tertiary level also. States are requested to do the co-location depending upon the kind of medicines used by people; keeping in view of the popularity of a particular system of medicine; Homeopathy or Ayurveda / other systems of medicine. There is a Provision to support 30,000 AYUSH dispensaries, spread all over the country under the NRHM.

- **Plan Allocation**: Under the 11th Plan allocation, Rs. 4000 crores is earmarked for AYUSH; States should improve their absorption capacity by restructuring AYUSH set up in the States. Under the restructuring plan, the Ministry, as in the case of NRHM, will provide managerial staff such as Manager, Computer Manager, MBA, and Finance Manager. The states are required to form Rogi Kalyan Samitis.

- **Interdepartmental Co-ordination**: For proper interdepartmental co-ordination, AYUSH doctors are getting trained in allopathic system similarly the allopathic doctors should also get some kind of training in AYUSH matters.

- **Medical Education**: State Governments should fill up all the posts which are lying vacant and ensure quality of education. For nursing education in AYUSH, state Governments are requested to explore affiliation with Universities in the State.

- Medicinal Plant Programme: Rs. 1000 crores are earmarked for this scheme. State Governments may submit plans under medicinal plant programme. Medicinal plant cultivation should be given priority. States may plan for a good set up and make use of this scheme.

Union Government is going to provide a cluster centre in Assam very shortly to facilitate collection of medicines manufactured in the North Eastern Region. State Governments should try to set up such Collection centres, with the assistance from AYUSH Department.

- **Compulsory Yoga Education**: Yoga should be made compulsory in schools and colleges.

- **Facilities to Train AYUSH Doctors**: Facilities should be created to train AYUSH doctors at all levels in the State. Funds would be made available under AYUSH / NRHM budget.
Secretary, Dept. of Health Research and Director General of ICMR, Govt. of India participating in the discussion stressed the need for modernizing the health care facilities in terms of creating an infrastructure for research. He informed the members that modalities are being worked out

- for providing special assistance to the mid career scientists, in the form of fellowships, so that the atmosphere in the medical colleges is totally galvanized
- to provide assistance for establishing Model Rural health research units in the States to provide training to doctors, and health care workers.

Concluding the discussions, the Chairman thanked all the Members of the Council for giving valuable suggestions to improve the health delivery system in the country and requested the State Governments to make use of the facilities available under NRHM and AYUSH to improve their absorption capabilities.
RESOLUTIONS /
DECISIONS TAKEN
RESOLUTIONS /DECISIONS TAKEN

1. NATIONAL AIDS CONTROL PROGRAMME
   i. It is resolved that the States will make efforts to fill up all sanctioned posts and post a qualified Project Director for a minimum of 3 years to maintain continuity in implementation of NACP-III.
   ii. It is resolved that as per directives of the Supreme Court, a comprehensive Care, Support and Treatment programme for persons living with HIV/AIDS will be implemented and extend all concessions that are envisaged in the directives of the Supreme Court.
   iii. The States should take initiatives to alleviate stigma and discrimination towards persons living with HIV/AIDS and establish a grievance mechanism to resolve any related issues.
   iv. It is resolved that activities under NACP-III will be mainstreamed with the NRHM, particularly with programmes relating to tuberculosis, reproductive and child health, blood safety and sexually transmitted diseases.

2. TUBERCULOSIS
   i. 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.
   ii. 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.

3. NATIONAL RURAL HEALTH MISSION
   i. The CCH&FW takes note of the very successful implementation of the National Rural Health Mission and resolves that the Government of India must ensure adequate financial provision for NRHM, in line with its approved Framework and XI Plan allocation. CCH&FW also requests all states to enhance their financial allocation for the health sector, to enable achievement of 2-3% GDP public expenditure on health by 2012.
ii. Standardizing nomenclature of Public Sector health facilities (like Health Sub Centers, PHCs, CHCs). The CCHFW resolves that States/UTs will strive to standardize nomenclature of public sector health facilities taking note of the service guarantees at each level, their link in the referral chain, and the human resource that would be needed.

iii. In view of the necessity to ensure injection safety and prevalence of unsafe use of syringe, the Central Government has already introduced auto-destruct syringes in the Universal Immunisation Programme and all Central Government hospitals. It is resolved that all States should also strive to introduce auto-destruct syringes in all State Government hospitals over the next six months and eventually over the next two years in all medical establishments whether public or private.

iv. School Health Programme: State governments will carry out school health programmes. Under this there will be provision for essential screening and health services to school children. There will also be health promoting schools wherein health education will be provided including counseling, yoga, life skills education. Need based intervention will be undertaken to involve not only health personnel but also teachers to ensure better convergence and sustainability. Government of India will provide necessary technical assistance for this.

v. Polio: Government of India and state governments to commit to give highest priority to eradication of polio in the country in a time bound manner. State Governments to carry out polio SIAs, mopups, strengthened RI and any other activities required as per Government of India policy. States Governments to monitor polio eradication activities regularly at the highest level. Govt. of India will continue to provide essential support for this programme.

vi. Institutional Delivery Services: NRHM has the goal of reduction of MMR. In view of the phenomenal increase in institutional deliveries due to the Janani Suraksha Yojana, State Governments commit to improve services so that women and their newborns can get quality services. For this purpose, State Governments will improve physical infrastructure, provide essential manpower and support on priority for these facilities. Govt. of India will continue to provide essential support for this.

vii. MIS: All States/UTs will ensure that the required information is collected in the rationalized HMIS formats and uploaded on the HMIS portal (nrhm-mis.nic.in).

4. MEDICAL EDUCATION

i. To endorse the Ministry’s proposal for removing the requirement of unitary piece of land and allowing not more than two pieces of land separated by a distance of 15 kms to set up the medical colleges; and further relaxation be given to NRHM States, North Eastern States, hill States, hill districts in other States and in respect of urban areas having population of less than 20 lakhs to the extent that the land requirement be 20 acres instead of 25 acres.

ii. To endorse the proposal of MoHFW to amend the MCI Regulations relating to Minimum Standards to set up medical colleges in the country especially for providing relaxation in respect of high focus NRHM States, North Eastern States, hill States.
and hill districts in other States so as to enable them to go in for Public Private Partnership model of medical colleges. This will allow the private partner to utilize district hospital/Govt. owned hospital as teaching hospital.

iii. To endorse the move of the MoHFW in making rural service of one year mandatory for MBBS graduates to become eligible to pursue post graduate medical courses in the country. In order to implement this proposal, State Govt. would make necessary budgetary and administrative provisions.

iv. To endorse the scheme of funding State Government medical colleges to increase more number of post graduate medical seats in needy disciplines and agree to the financial contribution by the State Govt. to the extent of 25% of the total budget.

v. To support Ministry’s proposal to have a central legislation to regulate process of admission and fee structure in the private medical colleges in the country, rationalized HMIS

5. RESOLUTION ON COMPENSATION AND RETIREMENT AGE OF HEALTH FUNCTIONARIES

i. The CCHFW resolves that the compensation and retirement age of health functionaries in State Governments/UT Governments should be at par with the Central Government and appropriate incentives should be developed for difficult and hard to reach areas.

ii. CCHFW resolves that there is urgent need to invest public health funds for mass production of supportive paramedical & nursing professional both for faculty & service needs, under NRHM, so that these health professionals are available in appropriate number to match the increased demands generated by NRHM.

6. RESOLUTION ON PROCUREMENT

CCHFW resolved that an efficient Procurement Agency, autonomous in nature, to be supported by an Integrated Management Information System, shall be established at the Centre. The Agency will have an array of networked warehouses up to the State level. The States will establish similar agency at their level which will have warehouses at the district level.

7. NATIONAL PROGRAMME FOR THE PREVENTION AND CONTROL OF DIABETES, CARDIO-VASCULAR DISEASE AND STROKE

i. Recognizing that India is facing a large and rapidly rising disease burden of chronic non-communicable diseases (NCDs) such as Diabetes, Cardio-Vascular Disease, chronic lung diseases and Stroke.

ii. Recognizing that the causes of NCDs are Tobacco, Alcohol, unhealthy diet and physical inactivity.

iii. Aware that NCDs are preventable through integrated and comprehensive interventions such as health promotion and health education advocacy in communities, work places and schools and through disease prevention of high risk groups.
iv. Acknowledging that the existing health care delivery system is mainly focused on Communicable diseases and that there is an additional need to re-orient the existing public health delivery system by strengthening it all levels to address NCDs through effective screening and risk detection.

v. Acknowledging that the MoHFW has launched a Pilot Project of the National Programme for the Prevention and Control of Diabetes, Cardio-Vascular Disease and Stroke in 10 districts of the country and is in the final stages of launching the programme in the whole country include the District NCD Programme, setting up dedicated units at medical colleges and NCD Cells in States and UTs along with IEC, research and training activities.

Draft design of the national programme to be shared with all States before finalization.

vi. Resolved that all States may strongly support and participate in the implementation of the National Programme for the Prevention and Control of Diabetes, Cardio-Vascular Disease and Stroke

vii. A morbidity profile of the community should be obtained through participatory neighbourhood survey, to ensure proper planning and balanced priority of National Programmes.

8. CONTROL OF TOBACCO

Recognizing that tobacco and tobacco products inflict irreparable damage on the health of citizens of the country and taking note that younger generation are more vulnerable to the ill-effects of tobacco, the CCH&FW resolves to urge States to take all possible steps to build awareness about harmful effects of tobacco and take pro-active and affirmative administrative and legislative measures towards creating a tobacco free society.

9. NATIONAL ALCOHOL CONTROL POLICY

Resolved that a national policy be framed to control the consumption of alcohol in order to contain the harmful physiological, social and economic effects on society in general and youth in particular. Further resolved that though alcohol happens to be on the State list (List-II) of the Seventh Schedule of the Constitution of India, the Ministry Health and Family Welfare be entrusted with the task to develop such a national policy and to implement the same in consultation with the State Governments in the interest of public health of the nation.

10. JUNK FOOD

i. Expressing concern about the increasing consumption of junk foods, especially among school and college students, aware that junk foods provide empty calorie deficient in essential nutrients leading to overweight, obesity and diet related chronic diseases.

ii. The CCH&FW resolves to urge States to take appropriate steps to discourage promotion, availability and consumption of junk foods, particularly in education institutions and undertake active awareness campaign to promote a health diet and life-style.
11. CLINICAL ESTABLISHMENT BILL

i. The Ministry of Health & Family Welfare has introduced a Bill namely Clinical Establishments (Registration and Regulation) Bill 2007 in Parliament on 30th August, 2007. The Bill is aimed to provide for registration and regulation of clinical establishments in the country with a view to prescribe minimum standards of facilities and services.

ii. A National Council for clinical establishments shall determine the standards for clinical establishments, classify the clinical establishment into different categories, develop the minimum standards and their periodic review, compile, maintain and update a national register of clinical establishments, perform any other function determined by the Central Government, from time to time.

iii. The proposed legislation provides for maintenance of register of clinical establishments at the district level, State level and the National level.

iv. Any person who contravenes any provision of the proposed legislation or any rules made there under shall be liable to be punished with fine.

v. The Bill was referred to the Parliamentary Standing Committee for Ministry of Health and Family Welfare. The report of this Committee has been received and is under examination.

12. TRANSPLANTATION OF HUMAN ORGANS ACT

i. Recognizing that the Transplantation of Human Organs Act, (THOA)1994 promulgated by the Parliament to provide for the removal, storage and transplantation of Human organs for therapeutic purposes and for the prevention of commercial dealings in human organs.

ii. Aware that there have been reports in the print and electronic media about illegal transaction in human organs in the country and the consequential commercial exploitation of weaker sections of the society.

iii. Recognizing the need to restructure the law pertaining to transplantation of human organs in India in a manner to facilitate genuine cases and at the same time to effectively curb commercial transactions in human organs.

iv. Acknowledging that the draft bill to amend various provisions of THOA, 1994 has been finalized by MoHFW in consultation with State Governments and civil society at large.

v. Acknowledging the amendment to THOA, 1994 can be passed by the Parliament only after appropriate resolutions are passed by the Legislative Assembly of two or more States authorizing the Parliament to amend the Act.

vi. Resolved that all States may in their respective Assemblies pass resolutions authorizing Parliament to amend the Transplantation of Human Organs Act, 1994 in exercise of powers under Article 252 (2) of the Constitution of India.

13. NATIONAL PROGRAMME FOR THE HEALTH CARE OF THE ELDERLY

i. Recognizing that the world’s population has continued on its transition path from a state of high birth and death rates to one characterized by low birth and death...
rates and that at the heart of that transition has been the growth in the number and proportion of older persons.

ii. Recognizing that India is poised to become home to the second largest number of older persons in the world and that projection studies indicate that the number of 60+ in India will increase to 100 million in 2013 and to 198 million in 2030.

iii. Acknowledging that the special features of the elderly population in India are: (a) a majority (80%) of them are in the rural areas, thus making service delivery a challenge, (b) gender challenge of the elderly population (51% of the elderly population would be women by the year 2016), (c) increase in the number of the older-old persons (above 80 years) and (d) a large percentage (30%) of the elderly are below poverty line.

iv. Aware that policy interventions that include social and human, as well as economic investments are the need of the hour to prevent unnecessary dependencies from arising, whether in life for individuals, or downstream in ageing societies and that when judicious investments are made in advance, ageing can be changed from a drain on resources to build up of a humane social, economic and environmental capital.

v. Acknowledging that the MoHFW is preparing The National Programme for Health Care for the Elderly to address this issue by way of introducing a comprehensive healthcare set up completely dedicated and tuned to the needs of the elderly with interventions designed to capture the Preventive, Curative and rehabilitative aspects in the geriatric through various interventions at all verticals of the present public health system viz. tertiary level (through 25 identified Government Medical Colleges), Secondary level (through 100 identified District Hospitals/CHCs/Sub-divisional hospitals) and also at the Primary level (through community outreach activities and PHCs). Resolved that all States may strongly support and participate in the implementation of The National Programme for Health Care for the Elderly upon its final launch.

14. AYUSH

i. It is resolved that the Central and State Governments would endeavour to increase their AYUSH budget progressively up to 10% of the Health Budget by the end of the Eleventh Five Year Plan.

ii. Re-organizing the importance of traditional systems of medicines in the prevention and treatment of diseases, it is resolved that highest priority will be accorded to the following National Campaigns announced by the Central Government:-

a. Yoga & natural Health

b. Unani in treatment of skin disorders

c. Ayurveda for treatment of maternal Anaemia (in phases) and further to commit necessary human and financial resources to achieve the campaign objectives
ANNEXURES
LIST OF POWER POINT PRESENTATIONS

1. National Rural Health Mission
2. Non-communicable Diseases
3. Procurement and Supply Chain Management
4. Medical Education
**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
- Dengue Mortality reduced by 50% by 2012

(Year of 2006)

- TB DOTS maintain over 70% case detection & 85% cure rate
- 46 lakhs cataract operations annually by 2012

Upgrading all health facilities to PHPS.
Increase utilization of FRUs from 20% bed occupancy to 75%.

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**NRHM – The Context**

- Health is a State subject – NRHM respects the leadership and priorities of States based on felt needs – States decide within resource envelope.
- NRHM respects the framework for decentralized management of health, flexibility, accountability and community ownership at all levels – PRI, Panchayat, State and District Health Mission, PHS, VH&SCs.
- NRHM a Centre – State partnership to push reforms with resources in human resources, financing, community ownership, procurement and logistics, to ensure quality health services guarantees to all households in remote areas, at all levels.
NRHM – Achievements 2005-08

- Decentralization
  States/Districts determine priority from Resource Envelope
- Human Resource Thrust
  ASHAs, ANMs, Nurses, Para-Medics, GDMOs, Specialists, AYUSH
- Flexibility – Unbundled Resources
  To every health facility of the country up to the District level
- Institutions and activities
  PRIs, VHSCs, RKSs, BHMIs, DMMIs, BHMIs VHND
- Stronger management
  Skills - MBAs, Accountants, Data Managers, etc.

NRHM – The gains made so far

<table>
<thead>
<tr>
<th>Nutrition initiatives</th>
<th>AP, WB, Bihar, MP, Orissa, Gujarat</th>
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<td>PPPs</td>
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<tr>
<td>EMRI Operational</td>
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<tr>
<td>ISO /NABH accreditation in process</td>
<td>Bihar, Chhattisgarh, Jharkhand, Uttarakhand, Gujarat, MP, UP, Rajasthan, Orissa</td>
</tr>
<tr>
<td>TNMSC like systems</td>
<td>Kerala has set up corporation. In process in WB and many more</td>
</tr>
<tr>
<td>Functional public systems, better maintained</td>
<td>Nearly all the States/UTs.</td>
</tr>
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</table>

Major Improvements
Key Learnings from 2nd CRM

- NRHM: a revolution in utilization of public health services
- Major upgradation of Infrastructure
- Substantial increase in number of service providers
- Improved availability of diagnostic services:
  - Improved drugs & supplies
- Massive increase in institutional deliveries
- Family Planning services gearing up
- Unified funds a boon in improving preparedness.

Major Improvements
Key Learnings from 2nd CRM

- PRIs involved in all states
- Community Monitoring: Good start
- Vibrant ASHA presence in villages.
- Increase in absorptive capacity of States
- New Accountants and Accounts Managers
- Electronic transfer of funds monthly “concurrent audit”
- Leap forward in central data receipts

Upgrading of Sub Centres / VHSCs

Joint Account at SC & VHSC

- States reporting excellent progress
  Orissa, Himachal Pradesh, Uttarakhand, Arunachal Pradesh, Sikkim, Kerala, Chandigarh, Maharashtra, Chhattisgarh, Karnataka & Uttar Pradesh.

- States reporting good progress
  Assam, Haryana, M P, Goa, Mizoram, Andhra Pradesh, Tamil Nadu, Manipur & Tripura.

- States needing concerted efforts
  Nagaland, Rajasthan, Meghalaya, Gujarat, Jharkhand, WB, J & K, Punjab, Bihar

Tenth Conference of Central Council of Health and Family Welfare
Second ANM at Subcentre

*States reporting excellent progress*
Jharkhand, Manipur, Haryana & A & N Island

*States reporting good progress*
Assam, Bihar, Maharashtra, D & N Haveli, Mizoram & Andhra Pradesh

*States needing Concerted efforts*
Nagaland, Rajasthan, Tripura, Sikkim, J&K, Orissa, M.P, Meghalaya, Uttarakhand, Arunachal Pradesh, Chhattisgarh, Karnataka, Himachal Pradesh, Uttar Pradesh, Gujarat, Kerala, Tamil Nadu, Punjab, West Bengal, Goa.

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Community Health Worker - ASHA

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Village Health & Sanitation Committee

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Tenth Conference of Central Council of Health and Family Welfare
Village Health & Sanitation Committee

*States reporting excellent progress*
Kerala, Sikkim, Manipur, Daman & Diu, Tripura, J & K, Assam, Mizoram, Puducherry, Goa, Tamil Nadu, Jharkhand, Punjab, Chhattisgarh, Meghalaya, Gujarat, & Maharashtra.

*States reporting good progress*
Andhra Pradesh, Haryana, Karnataka, & Arunachal Pradesh.

*States needing Concerted efforts*
Uttar Pradesh, Madhya Pradesh, West Bengal, Nagaland, Orissa, Rajasthan, Bihar, Himachal Pradesh, Uttarakhand.

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**Village Health & Nutrition Days (in lakh)**

<table>
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<tr>
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**Janani Suraksha Yojana**

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**State wise Status of JSY (in lakh)**

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<th>07-08</th>
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Tenth Conference of Central Council of Health and Family Welfare
Family Planning Procedures (in lakh)

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Total 7212

24 x 7 Facility below District level

*States reporting excellent progress*

*States reporting good progress*
- Arunachal Pradesh, Mizoram, Karnataka, Andhra Pradesh, Puducherry, Assam, & Nagaland.

*States needing Concerted efforts*
- West Bengal, Jharkhand, Haryana, Manipur, Rajasthan, Madhya Pradesh, Maharashtra, Himachal Pradesh, Bihar, Kerala, Uttarakhand, J & K, Punjab, Uttar Pradesh, Gujarat, Orissa, & Meghalaya.

Family Planning Procedures

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Three Staff Nurse at PHCs

*States reporting excellent progress*
- Rajasthan, Lakshadweep, Delhi, A & N Island, Mizoram, Tamil Nadu, D & N Haveli, Goa, Puducherry, & Meghalaya.

*States reporting good progress*
- Andhra Pradesh, Karnataka, Nagaland, & Assam.

*States needing Concerted efforts*
- Punjab, Maharashtra, West Bengal, Manipur, Kerala, Uttar Pradesh, Orissa, Gujarat, Bihar, Meghalaya, Uttarakhand, Haryana, Arunachal Pradesh, J & K, Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh, Sikkim.

24 x 7

Tenth Conference of Central Council of Health and Family Welfare
24 x 7 Facility below District level

*States reporting excellent progress*

*States reporting good progress*
- Arunachal Pradesh, Mizoram, Karnataka, Andhra Pradesh, Puducherry, Assam, & Nagaland.

*States needing Concerted efforts*
- West Bengal, Jharkhand, Haryana, Manipur, Rajasthan, Madhya Pradesh, Maharashtra, Himachal Pradesh, Bihar, Kerala, Uttar Pradesh, Jammu & Kashmir, Punjab, Uttar Pradesh, Gujarat, Orissa & Meghalaya.

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### Functional Referral Chains

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### Facility Survey of CHCs

*States reporting excellent progress*
- Himachal Pradesh, Rajasthan, Andhra Pradesh, Uttar Pradesh, Odisha, Sikkim, Mizoram, Nagaland, Manipur, Meghalaya, Gujarat, Kerala, Karnataka, Punjab, West Bengal, Chandigarh, Daman & Diu, D & N Haveli, & Lakshadweep.

*States reporting good progress*

*States needing Concerted efforts*
- Haryana, Tamil Nadu, Goa, & Delhi.

### Upgradation of District Hospitals

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Tenth Conference of Central Council of Health and Family Welfare
### Contractual Appointments of HR

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### Contractual Appointment of AYUSH Doctors

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### Rogi Kalyan Samitis

- **States reporting excellent progress**

- **States reporting good progress**
  - M P, Orissa, Jharkhand, Himachal Pradesh, & Goa.

- **States needing Concerted efforts**
  - Uttar Pradesh, Uttarakhand, Punjab, Bihar, D & N Haveli & Delhi.

### Integrated District Action Plan

- **States reporting excellent progress**
  - Chhattisgarh, J & K, Madhya Pradesh, Orissa, Uttarakhand, Uttar Pradesh, Assam, Sikkim, Mizoram, Nagaland, Manipur, Arunachal Pradesh, Tripura, Meghalaya, Andhra Pradesh, Gujrat, Kerala, Karnataka, Punjab, Chandigarh, Daman & Diu, Puducherry, Delhi, Tamil Nadu, West Bengal, Himachal Pradesh & Jharkhand.

- **States reporting good progress**
  - Maharashtra & Rajasthan.

- **States needing Concerted efforts**
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<td>Tirupur</td>
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<td>Nagpur</td>
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</tbody>
</table>

**Total** 634 565

---

**Andhra Pradesh**

**Toopram PHC**

**Gujarat**

**Infrastructure Upgradation under NRHM**

---

**Assam**

**BARBARUAI FRU**

**NURSES QUARTER (LENGERI MINI PHC)**

**LABOUR ROOM (MODHUPUR 3D)**

---

**Tenth Conference of Central Council of Health and Family Welfare**
Gardens for all the PHCs with RKS funds and sponsors, clean surroundings

Patient waiting hall with Reverse osmosis water equipment (PHC)

Nellore PHC, Kancheepuram District

Kapadvil PHC, Kancheepuram District

Muruppur PHC, Dharmapuri District

Assam
BLOCK POOING COMPLEX (MORAN SD)

Assam
LABOUR ROOM (MORAN SD)

Assam
DOCTORS QUARTER OF NAHARANI CHC

IMPROVING DELIVERIES IN THE PHCs-TN
PHCs provide with Gas stoves

Screens provided for Privacy of mothers

Sub Centre - Maharashtra

Sub Centre - Maharashtra

WORKS UNDERTAKEN THROUGH
PATIENT WELFARE SOCIETY

Maternity Picnic in the PHC

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Phone Nos. details distributed to AN mothers

Free food for pregnant mothers attending ANC

Neonatal Corner - Haryana

SPECIAL CARE NEW BORN UNIT

Assam
Special Care New born Unit at AMCH, Dibrugarh

NGOs making difference for Severely malnourished children in MP (Guna dist)

Prahled August 2005,
Gartagird village, Guna

Prahled March 2006

NGO Interactions - Assam

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Major Achievements - MP

Target-surpassing – Institutional Deliveries in MP

- Institutional Deliveries gone up from 51% in year 2006 to 67% by estimated No. of Deliveries in 2007-08

Our March Towards Progress

No. of Patients Visiting (cont. Hospital per Month)

Gujarat Institutional deliveries

Trend in deliveries

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Financial Matters

Allocations and Utilization
Mission Flexible Pool

The unification process flow

1. Electronic Fund Flow:

- Funds to all States and UTs being sent electronically.
- Time taken in fund transfer brought down from 1-3 months to 1-2 days.
- Sanction letters uploaded on website along with e-transfer
Monitoring & Mentoring

- Regular review meetings
- State visits – evaluation teams, SFTs, RDS
- SRS of RGI Census, DLHS II, III, NSSO, NFHS Integrated MIS (web based)
- Periodic public reports – JSA, VHAI, etc.
- State Health Mission under CM and District Health Mission under Zila Parishad Adhyaksha.
- Performance audit by CAG
- External Surveys
  - Immunisation - UNICEF
  - ASHA & JSY - UNICEF, UNFPA, GTZ
  - Financial protocols - Institute of Public Auditors
  - Concurrent External Evaluations

Monitoring & Mentoring

- Concurrent Financial Audit at District level by external CAs
- Financial Audit of SHS/DHS by CAG CAs
- Community monitoring – AGCA/PFI
- ASHA Mentoring Group
- JRM & Common Review Mission JRM/Missions of programmes – RCH-II, Malaria, RNTCP, Kala Azar, etc.
- Procurement & civil works audit.
- Annual State and District Public Reports on Health
- Assessment by Parliamentary Committees.
- Review under District Vigilance and Monitoring Committee of Ministry of Rural development.

Policy Issues for Consideration of States

COMMUNITIZATION

- While Institutions for community ownership have been established, large scale development of capacity is needed for effective communitization of Public Health services

- Transparency and accountability built into institutional arrangements — need for full public disclosure of all programme interventions

MEDICAL EDUCATION

- A few District Hospitals in high focus States must have a need to expand Medical Colleges — reforms in MCI needed to facilitate such a process without compromising excellence

- New courses aimed exclusively at in -service public sector needs. One year Public Health Management Diploma through PHFI, 2 year District Family Medicine Programme through CMC, Vellore, more DNB in Family Medicine in District Hospitals etc. proposed

- Need for accelerating multi -skilling as a general policy but immediately for gynaecologists and anaesthetists and at looking at

- Follow outcomes of state experiments in three year programme of Rural Medical Assistants and Rural Health Practitioners in Orissa and Assam

NURSING EDUCATION

- Priority attention to improve and enhance in -take in all existing Government Nursing Institutions

- New Nursing Schools and Colleges in deficient States with partnerships in faculty from surplus States

- Partnerships with non -governmental sector for Nursing courses

- Reservation of seats for ASHAs and Aanganwadi workers based on local criteria in ANM/Nursing Schools

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PROCUREMENT AND LOGISTICS

- Effective and efficient public system of health care needs transparent, timely and quality procurement and logistic systems
- TNMSSC – an exemplar
- Jan Aushadhi programme for promotion of generic drugs and for essential drug lists
- Need for corporations in States to manage infrastructure, drugs and equipment
- Need for a transparency act like in Tamilnadu.

HUMAN RESOURCE REFORMS

- New cadre rules that allow Specialists for Block Hospitals
- Incentives for difficult areas and performance linked incentives
- Continuing Medical and Nursing Education targeted at all cutting edge health functionaries
- Restructuring Directorates to lead more effectively towards delivery of quality services

GOVERNANCE REFORMS

- Even greater thrust on transparency, accountability and full public disclosure
- Reforms in cadre management, transfer and posting policies, and in higher compensation for difficult areas
- Shift in focus from employment guarantee to service guarantee

Sharing of Information

Together we have started on our journey and have miles to go . . . . .

thank you

email: healthmission@nic.in
web: www.mohfw.nic.in

60

Tenth Conference of Central Council of Health and Family Welfare
Non Communicable Diseases in India: The New Public Health Challenge

Prof. K.Srinath Reddy
President
Public Health Foundation of India

Deaths in India (2005)

ACTUAL AND PROJECTED NUMBERS OF DEATHS IN INDIA BY CAUSE 1990 AND 2020

Andhra Pradesh Rural Cause Of Death Study (2004)

Rising Chronic Disease Burdens

Tenth Conference of Central Council of Health and Family Welfare
Cancers and COPD

- Incidence of cancer in India: ~800,000/year
- Estimated burden of cancer: ~24,000,000 cases

COPD in India

- Prevalence
  - Men: 5.0%
  - Women: 2.7%
- Estimated cases in 2006: 17.01 million
- Projections for 2015: 22.21 million

YEARS OF LIFE LOST DUE TO CVD IN POPULATIONS
Aged 35-64 Years

Neglected Chronic Diseases Carry Economic Costs

- In 2005, it is estimated that India lost 9 billion USD in national income from premature deaths due to heart disease, stroke and diabetes.
- These losses are expected to cumulatively lead to 237 billion USD over the next 10 years.

INTERHEART Study

About 50% of CHD Risk (PAR') in South Asia can be explained by 9 Risk Factors

- Smoking (37.4)
- Dyslipidemia (50.0 ± Aged B Risk) (68.7)
- High BP (19.5)
- Diabetes (11.8)
- Abdominal Obesity (67.7)
- Psychosocial Factors (40.0)
- Fruits & Vegetables (18.9)
- Exercise (27.1)
- Alcohol (25.6)

Rising Consumption of Edible Oils in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Consumption (in tonnes)</th>
<th>Consumption (kg/capita)</th>
<th>Consumption (kg/capita/day)</th>
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<tbody>
<tr>
<td>1983</td>
<td>3.9</td>
<td>5</td>
<td>128</td>
</tr>
<tr>
<td>1993</td>
<td>5.8</td>
<td>6</td>
<td>155</td>
</tr>
<tr>
<td>2003</td>
<td>10.5</td>
<td>9</td>
<td>240</td>
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</table>


Nutrition Transition is Underway in India

- Analysis also indicates that overweight (obesity) is a major problem within the urban environment, with a majority of individuals with BMI ≥ 25% between 10-60% and 30% among the adults and >60% of the obese also an emerging problem in urban India.
- It is also noted that the relationship between levels of urbanization and percentage of individuals with BMI ≥ 25.0% rural: 22.4%, town: 34.1%, small city: 40.9% large city, p<0.0001

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Prevalence of overweight and obesity in India
School children in Gown:
- 22% PSE group
- 70% non-PSE group
- 8% non-PSE group
Higher risk of childhood obesity

All age group results:
- 21% overweight
- 79% obese
- 2% overweight

CASE-CONTROL STUDY OF AMI
(DELHI - BANGALORE, 1999)*

Variable          Age & Sex Adjusted RR Multivariate RR
Education
- same vs. highest level  2.0  2.2
- Household income
- <$200 vs. > $2000  1.6  1.5


Worksite Wellness Programme

Age adjusted prevalence of risk factors 2000-2003

Risk factors

CVD Risk Factor Survey in 10 Industries
Risk Factors by Educational Status in Men

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WE NEED
AN EFFECTIVE PUBLIC HEALTH RESPONSE
THAT CAN TELESCOPE THE HEALTH TRANSITION
AND AVOID THE HUGE BURDENS
OF MID-LIFE DISEASE, DISABILITY & DEATH
IN LOW AND MIDDLE INCOME COUNTRIES
SPECIALLY IN SOCIO-ECONOMICALLY
DISADVANTAGED GROUPS

“High” Blood Pressure Or
“Hypertension”?
- Changing Definitions of “Normal”, “Abnormal”, “Optimal”
  (Systolic Blood Pressure: 160 140 130 120 115)
- Observational studies
  Clinical Trials
  (Prevention Norms Clinical Norms)
- High Risk AND population approach
- Risk Factor Social cause
- Clinical Medicine Public Health

RESPONSE TO HEALTH TRANSITION

PUBLIC HEALTH INTERVENTIONS

Policy Interventions Educational Interventions

Enabling Environment (Financial, Social, Physical)
Health Beliefs and Behaviours (Community; Individual)

Desired Change

POWER OF POLICY
FOR CHRONIC DISEASE PREVENTION

TOBACCO
Evidence is available from many countries
(including LMIC) that
- Taxation
- Ads Bans
- Smoke Free Policies
- Health Warnings

ARE EFFECTIVE

Tenth Conference of Central Council of Health and Family Welfare
Diet

For Heart Disease Prevention
- ↓ Unhealthy Fats (SFA; Trans-Fats)
- Substitute with Healthy Fats (PUFA; MUFA)
- ↓ Salt intake
- ↑ Fruit and vegetable intake
- ↓ Consumption of simple sugars

Power Of Policy
For Chronic Disease Prevention
DIET

Evidence of preventive potential of policy interventions available from:
- H. Mauritius (Price of Edible Oils)
- H. France (Import of F&V and Healthy Fats)
- H. Finland (Farming; Marketing; Community Education)

New Initiatives:
- Food Labelling
- Reduced Salt in Processed Foods
- Ban on Trans-Fats
- Advertising Restrictions

Salt Reduction Strategy

Tobacco Reduction Strategy

- 8.5 Million Deaths
- 12.5 Million Deaths
Policy Implications

- Ensuring availability of healthier ready-to-eat (rte) for children
- Reducing salt, sugar and saturated fats in processed foods
- Eliminating trans fats from processed foods and cooking
- Promoting portable hand sanitizers
- Promoting physical activity
- Promoting nutritious foods
- Encouraging physical activity
- Encouraging healthy eating and lifestyle

Programme Implications

- Strengthening nutrition as an essential component of NRHM & NUHM
- Partnership with industry for Worksite programmes in organized sector
- School based programmes for improving nutrition knowledge & practices
- Community based programmes for promoting healthy diets
- Mass media approaches for community awareness

Worksite Wellness Programme
Intermediate changes (2004-2006)

Behaviors % changes

Physical activity levels 17.1%
Fruits and vegetables consumption 36.3%
Conscious effort to decrease oil/heavy butter consumption 31.3%

Age adjusted prevalence of risk factors in females
(before and after intervention)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
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<tbody>
<tr>
<td>Overweight</td>
<td>0.1</td>
<td>0.0</td>
<td>-0.1</td>
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<tr>
<td>Underweight</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.1</td>
<td>0.0</td>
<td>-0.1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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</tbody>
</table>

Trends in mean levels of variables in Men
(six centre data)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Baseline 2002</th>
<th>First Annual Surveillance 2004</th>
<th>Final Survey 2008</th>
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<tbody>
<tr>
<td>SBP</td>
<td>120 (16.7)</td>
<td>122 (15.4)</td>
<td>123 (12.7)</td>
</tr>
<tr>
<td>DBP</td>
<td>70 (10.8)</td>
<td>70 (10.5)</td>
<td>74 (10.5)</td>
</tr>
<tr>
<td>Weight</td>
<td>62 (12.8)</td>
<td>61 (12.3)</td>
<td>60 (11.9)</td>
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<tr>
<td>WC</td>
<td>84 (10.1)</td>
<td>81 (10.1)</td>
<td>80 (10.4)</td>
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<tr>
<td>PG</td>
<td>92 (29.9)</td>
<td>90.1 (30.1)</td>
<td>85 (31.8)</td>
</tr>
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<td>TC</td>
<td>175 (45.9)</td>
<td>175.1 (45.9)</td>
<td>160 (43.8)</td>
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<tr>
<td>TG</td>
<td>132 (76.1)</td>
<td>132.0 (80.1)</td>
<td>130 (80.9)</td>
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<tr>
<td>HDL</td>
<td>43.2 (11.6)</td>
<td>43.8 (11.7)</td>
<td>43.8 (10.9)</td>
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</table>
PREVENTION & CONTROL OF CVD & DIABETES
HEALTH PROMOTION
Health Education + Enabling Policy Measures
EARLY DETECTION OF VETERAN
Opportunities + Target-Related measures
Non-Fasting Blood Chemistry
EFFECTIVE TREATMENT

PRIMARY PREVENTION OF CVD
Risk Detection + Risk Reduction in Individuals

EDUCATION

GUIDELINES

HEALTH SYSTEMS STRENGTHENING
- Equip the health system with the structural tools needed to incorporate:
  - appropriate health promotion and education activities in health care facilities and
  - prevention and proactive care into the routine practice of physicians and other health care personnel
- Re-orientation of primary health care to provide culturally and contextually appropriate and evidence-based chronic care
- Strengthening and updating of referral mechanisms

Tenth Conference of Central Council of Health and Family Welfare
WHAT CAN BE DONE AT PHC LEVEL:

- Health Education
- High Blood Pressure Detection and Management
- Diabetes Detection and Management
- Detection of tobacco health risks

Integrate with National Rural Health Mission

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DIABETES, CARDIOVASCULAR DISEASES & STROKE

Pilot: 2008 (10 Districts)
National Upscaling: 2009

Key Components

- District Health Promotion Services (608)
- Strengthening of Medical Colleges (140)
- Integrated NCD Clinics in Medical Colleges and District Hospitals
- School Based Programs
- Worksite Wellness Programs
- IEC Activities for Mass Education
- NGO Partnership
Tamil Nadu Model - Tamil Nadu Medical Services Corporation Ltd. (TNMSC)

- Efficient quality control systems to eliminate sub-standard items
- Overall stock control through online network
- An accurate online Management Information System (MIS) for monitoring and decision support
- Cashless transactions through a Passbook system for drawer of supplies by service providers
- A lean and efficient organisation

Recommendation for States

An autonomous organization with full powers and control over procurement and logistics like the TNMSC

Set up an autonomous organisation - a Central Procurement Agency (CPA)

- An autonomous organisation (CPA), either society or company, with administrative and financial autonomy
- Service rather than profit should be its goal
- Health secretary as Chairman with a full time CEO
- Full powers to settle tenders
- Two bid system fixing unit price
- Available funds to be transferred quarterly
- 5% service charges on turnover - CPA’s running expenditure to be within this

Drug price comparison

<table>
<thead>
<tr>
<th>Commodity</th>
<th>Pre-TMSC (Rs)</th>
<th>Post-TMSC (Rs)</th>
<th>Savings (Rs)</th>
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<tbody>
<tr>
<td>Tramadol</td>
<td>135</td>
<td>110</td>
<td>25</td>
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<tr>
<td>Diclofenac</td>
<td>223</td>
<td>173</td>
<td>50</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>120</td>
<td>90</td>
<td>30</td>
</tr>
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</table>

Defining the goals – the first step

States should define the goals:

- Supply high quality essential drugs to the public
- Timely availability
- No shortage, any time - budget not to be a constraint
- Availability at or near the point of use - warehouses in districts
- Superior and convenient packaging
- Transparent procurement to get the best prices
- Standard treatment guidelines and rational drug use

Drug List

- Prepare an Essential Drug List
- Order use of only generic drugs/standard treatment guidelines to be issued
- About 100 drugs could cater to the needs of 90%
- For super-specialty wings of major hospitals, give 10% of drug budget
- No loose drugs, either blister or strip, and packed in convenient sizes
Supply chain management

- Set up warehouses (initially by hiring) at districts, with one larger one at State headquarters
- Capacity based on needs and should include the requirement of GOI supplies
- Suppliers will supply to district warehouses
- Service providers to receive stock from district warehouses
- Quality testing from samples taken after supply plus random checks by Head office
- Warehouses interconnected for proper MIS

Supply to service providers

- CPA responsible for delivery to the service providers
- Issues once a month on a calendar
- Supplies based on passbook
- Supplies based on needs based on patient strength
- Allocation to be flexible to meet full needs – to fulfill the objective of no unmet need

Action Plan

- Setting up a CPA
- Announcement of a procurement policy
- Posting of a full time CEO
- Recruitment of core staff
- Hiring of warehouses
- Finalising EDL and calling for tenders
- Use IT to interconnect warehouses and get MIS for decision support and inventory control
- Doable in about six months

Benefits of the Reform

- Steady availability of drugs and sutures to the public
- Shortage will be eliminated
- Better quality control is possible
- Wastage will be eliminated
- Effectiveness of health delivery will go up
- Savings on account of efficient procurement

Outline of the presentation

- Current procurement systems in States
- Procurement-related issues
- Elements of an ideal procurement system
- TNMSC Model and its causes for success
- Setting a goal on drug supply
- Recommended steps for fulfilling the goal
- Procurement policy
- Action plan

Thank You
Current Situation in States

- A departmental tender to decide unit prices of drugs (Rate Contract)
- Orders placed by service providers (hospitals and district officers) with suppliers based on available budget
- Direct supplies from suppliers to service providers
- Indents left to lower staff
- Payment settled centrally/locally

Causes for success of TNMSC

- Excellent systems that survive:
  - Full autonomy - all decisions taken by the board, no reference to government
  - A system designed with user in view with the objective that user should have all goods at all times - goal is no stock out
  - Procurement based on a calendar; it is over before February and tender process does not take more than a month; Standard documents

Causes for success of TNMSC

- An excellent online MIS to monitor stock inventory, quality control, prompt payment
- An excellent distribution system - district warehouses and arrangement to move to users
- Forecasting eliminated by ordering goods that move
- Passbook-based cashless transactions

States to announce a Procurement Policy

Main elements of the Policy could be:

- Two-bid tender
- No reservation for anyone
- Only manufacturers with GMP and three-year market standing
- Fixing unit rate and monthly orders based on needs
- More than one supplier for main drugs
- Tender based on a calendar
- CPA to procure with transparency and flexibility and full autonomy

Financial implication

- Equity Rs 10 Crores; 15 employees in head office and three per warehouse
- Lean organisation, technology savvy and paperless
- Competent and trained manpower with some commitment
- CPA to get 5% of the value of procurement to meet all its cost including warehouse rents
- Government's commitment only Rs 10 Crores
- Savings to Government at least 20% of the drug budget (the savings of TNMSC 32%) in addition to immense benefits to the user

Achievements of TNMSC

- Shortages totally eliminated
- Savings in the first year was 32% despite superior packing
- All stakeholders immensely happy with continuous availability of drugs at the point of use
- Passbook system gave flexibility to get drugs based on needs
- Better quality assurance, packaging enhanced credibility
- Loss due to time expired drugs eliminated
Presentation on Medical Education & Human Resources in Health Sector

Debasish Panda
Joint Secretary
Ministry of Health & FW
Government of India

Number of medical colleges in the Country

<table>
<thead>
<tr>
<th>No.</th>
<th>Medical colleges in the Govt. Sector</th>
<th>Medical colleges in the Pvt. Sector</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>142</td>
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<td>148</td>
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</table>

Shortage of Medical Colleges in the Country

- There is acute shortage of medical professional in the country. There is also regional imbalance in the growth of medical colleges among the States.
- About 51% of the medical colleges are concentrated in 4 States, namely, Maharashtra, Karnataka, Andhra Pradesh and Tamil Nadu.
- There is shortage of medical colleges in States like Uttar Pradesh, Rajasthan, Madhya Pradesh, Orissa, Chhattisgarh and North Eastern States. The number of medical colleges in the country including annual intake are given in the following tables:

Number of seats in MBBS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of the State</th>
<th>Government Colleges Total</th>
<th>Government Seats</th>
<th>Private</th>
<th>Private</th>
<th>Total</th>
<th>Total Seats</th>
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</thead>
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<td>175</td>
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<td>265</td>
<td>423</td>
</tr>
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<td>Assam</td>
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<td>428</td>
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</tr>
<tr>
<td>3</td>
<td>Bihar</td>
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<td>5</td>
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<td>Delhi</td>
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<td>6</td>
<td>560</td>
<td>100</td>
<td>660</td>
<td>670</td>
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<td>Gujarat</td>
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<td>5</td>
<td>120</td>
<td>550</td>
<td>370</td>
<td>720</td>
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<td>9</td>
<td>Himachal Pradesh</td>
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<td>156</td>
<td>200</td>
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Tenth Conference of Central Council of Health and Family Welfare
### Number of Seats in MBBS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of the State</th>
<th>Number of Medical Colleges Govt.</th>
<th>Private</th>
<th>Total</th>
<th>Total number of seats Govt.</th>
<th>Private</th>
<th>Total</th>
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<tr>
<td>20</td>
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<td>270</td>
<td>780</td>
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<tr>
<td>21</td>
<td>Rajasthan</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>610</td>
<td>500</td>
<td>1110</td>
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<tr>
<td>22</td>
<td>Sikkim</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>50</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>23</td>
<td>Tamil Nadu</td>
<td>16</td>
<td>14</td>
<td>30</td>
<td>1745</td>
<td>3020</td>
<td>4765</td>
</tr>
<tr>
<td>24</td>
<td>Tripura</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>200</td>
<td>200</td>
<td>400</td>
</tr>
<tr>
<td>25</td>
<td>Uttar Pradesh</td>
<td>10</td>
<td>9</td>
<td>19</td>
<td>1112</td>
<td>900</td>
<td>2012</td>
</tr>
<tr>
<td>26</td>
<td>Uttarakhand</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>200</td>
<td>200</td>
<td>400</td>
</tr>
<tr>
<td>27</td>
<td>West Bengal</td>
<td>9</td>
<td>1</td>
<td>10</td>
<td>1050</td>
<td>150</td>
<td>1200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>142</strong></td>
<td><strong>140</strong></td>
<td><strong>282</strong></td>
<td><strong>16537</strong></td>
<td><strong>17125</strong></td>
<td><strong>33662</strong></td>
</tr>
</tbody>
</table>

### Amendments to Minimum Standards required for starting New Medical Colleges Regulations:

- **Land Requirement**
  - Area 25 acres
  - Not more than two pieces of land separated by a distance of 15 Kms.
  - Land separated by a road or canal connected with a bridge shall be treated as one piece of land for opening of medical colleges.
  - Further Relaxation for NRHM States, NE states, Hill States, Hill Dist. in other states and in respect of urban areas/cities having population less than 20 lakhs (as per 2001 Census) – Land requirement 20 acres

### Minimum Standards required for starting New Medical Colleges Regulations:

- In the NRHM focused States, North Eastern, Hill States and Hill District in other states, public private partnership shall be allowed to utilize Civil Hospital/District Hospital/Hospital run by Central/State Govt., IHSUs, hospitals run by local bodies, state societies, state owned cooperatives, corporations as teaching hospital to the medical college.
- Concerned Government/public sector undertakings shall enter into legal agreement with the private partner for a period of not less than 15 years for this purpose.
- Company registered under Company Act are allowed to open medical colleges.

### Multipronged strategy for increase/expansion of medical colleges

- MCI Regulations are being amended to rationalize the existing norms:
  - Requirement of land being rationalized.
  - Encouraging Public Private Partnership (PPP) in high focused NRHM States, North East and Hill States.
  - Corporate sector being allowed to set up medical colleges.
  - For NE states, hill states and hilly states: bed strength and bed occupancy being relaxed.
  - Strengthening and upgradation of state Government medical colleges through central assistance of Rs. 1350 crores during 11th Plan for starting/increasing PG courses.
  - Recognition of foreign PG degrees.
  - Relaxation in age limit of medical teachers from 65 to 70 years.

### Functional teaching hospital with 300 beds and at least 80 % average bed occupancy, prior to the date of application for establishment of medical college.

- However, in the case of North Eastern, hilly and tribal States, the minimum bed strength shall be 250 and bed occupancy 60%.

### Post Graduate Medical Education Regulations:

- 50% of PG Diploma seats to be reserved for in service doctors who have served in rural areas for 3 years.
- The ratio of teacher to the number of students to be admitted in any department is proposed to be revised from 1:1 to 1:2 in general speciality and super speciality and 1:3 in pre clinical and para clinical process.
- One year rural posting shall be mandatory for admission to PG courses. (Except for pre clinical and para clinical)
- Teaching experience gained by Indian citizens holding foreign Post graduation degree, in recognized foreign medical institution shall be counted towards teaching experience for appointment as teachers in medical colleges.
Minimum qualification for Teachers Regulations:

- To allow recruitment up to 50% non medical teachers in pre and para clinical departments to meet the shortage of medical teachers,

- Teaching experience in permitted medical colleges will also be counted for appointment as medical teacher,

- Increase in maximum age limit for appointment of teachers from 65 years to 70 years.

Scheme for strengthening and up-gradation of State Governments' medical colleges

- During 11th Five Year Plan - A Centrally Sponsored Scheme.
- Total Central Funding - Rs. 1350 crores
- Funding Pattern: 75% Central Government, 25% State Government.
- Objective of the Scheme:
  - To remove regional imbalance in distribution of medical colleges
  - To upgrade the teaching facilities of the medical colleges to increase teaching and non teaching specialists.

Scheme for strengthening and up-gradation of State Governments' medical colleges (contd.)

- Financial Assistance to:
  - Increase number of PG Courses or PG seats in the college
  - Upgrade infrastructure, purchase and replacement of old equipment, meet the cost of manpower
  - Directly to each medical college as per actual requirement after assessment by an Empowered Committee headed by Secretary (Health)

- States are requested to submit their proposals in the prescribed proforma.

Expansion of Nursing Institutions Norms relaxed

- Student patient ratio relaxed from 1:5 to 1:3
- Distance between nursing institution and hospital increased from 15 to 30 kms
- Admission criteria relaxed to have more nursing students i.e.
  - 10th Pass to ANM
  - 10+2 pass with 40% to GNM
  - 10+2 pass with 45% (PCBE) to B.Sc(N)

Expansion of Nursing Institutions Norms relaxed (contd.)

- Super speciality hospitals can start M.Sc(N) programme without having undergraduate programme
- Government order exempted for M.Sc(N), P.B.B.Sc(N) programme if the B.Sc(N) programme is recognised by INC and one batch has qualified from the respective institution

Expansion of Nursing Institutions Norms relaxed (contd.)

- Government order exempted for post basic diploma programmes (nurse speciality course) if any of the nursing programme is recognised by INC
- Maximum of 100 seats will be given to those parent hospital with 300 beds without insisting Medical College

Tenth Conference of Central Council of Health and Family Welfare
Expansion of Nursing Institutions
Norms relaxed

- Relaxed norms for teaching faculty to start B.Sc. (N) Programme.
  - At least 2 M.Sc. (N) faculty to be available
  - Qualification and Experience of the Nursing Teachers has been relaxed up to 2012.
  - Sharing of teaching faculty for both Diploma and Graduate Programme.
- Relaxation of student teacher ratio for M.Sc (N) programme has been relaxed from 1:5 to 1:10

Additional Number of Nursing educational Institution likely to be established in XI year plan

<table>
<thead>
<tr>
<th>Opening of new GNM Schools</th>
<th>137 (intake of 100 per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening of new ANM Schools</td>
<td>132 (intake of 50 per year)</td>
</tr>
<tr>
<td>Opening of College of Nursing</td>
<td>7 (intake of 100 per year)</td>
</tr>
<tr>
<td>Establishment of Center of Excellence</td>
<td>24 (with B.Sc (N) of 100 per year)</td>
</tr>
<tr>
<td>Establishment of Regional Institute of Nursing</td>
<td>4 (with B.Sc (N) of 100 per year)</td>
</tr>
<tr>
<td>Outcome of training capacity by new Scheme</td>
<td>23,800 per year</td>
</tr>
</tbody>
</table>

Human Resources Development (Nurses)

New Scheme

- A sum of Rs. 2900.00 crores has been allocated for XIth Plan period.
  - Establishment of 24 Center of excellence in States @ Rs. 20.00 crore per institute.
  - 24 X 20.00 = Rs. 480 crores
  - The Centre of Excellence will have courses in B.Sc. (N), M.Sc (N), PhD (N), Nurse Practitioner Course, Speciality Courses and Continuing Education Programmes, teleconferencing facility and maintain continuing education roster.

New Scheme contd...

- Establishment of 4 Regional Institutes of Nursing @ Rs. 50.00 crores per Institute.
- 4 X 50.00 = Rs. 200.00 crores
- This will under Central Government Administration.
- Will provide technical assistance in monitoring and evaluation planning, in areas of nursing education, service and administration.
- Will also facilitate research activity

Tenth Conference of Central Council of Health and Family Welfare
New Scheme contd...

- Opening of 132 ANM Schools @ Rs. 5.00 crores per institution (Difficult States to address Regional imbalances).
  \[132 \times 5.00 = Rs. 660.00\] crores

- Opening of 137 GNM Schools @ Rs. 10.00 crores per institution (Difficult States to address Regional imbalances).
  \[137 \times 10.00 = Rs. 1370.00\] crores

New Scheme contd...

- Strengthening of 20 State Nursing Councils @ Rs. 1.00 crore per Nursing Council.
  \[20 \times 1.00 = Rs. 20.00\] crores

- Strengthening of 20 Nursing Cells (Directorate of Health Services) at the State level @ Rs. 1.00 crores per State/UT.
  \[20 \times 1.00 = Rs. 20.00\] crores

Draft Private Medical/Dental Educational Institutions (Regulations of Admission and Fee) Bill

- In the absence of Central Legislation currently admissions and fees in medical/dental institutions are guided by the Judgement of the Supreme Court.
- As per judgement dated 14.8.2003 in Islamic Academy of Education Vs State of Karnataka, State Govt. are required to constitute two committees - one to regulate fees and other for admissions - under the chairmanship of a retired High Court Judge.
- Central Government is considering to introduce a bill on this issue.

Allocation of Seats

1. Admissions

   Allocation of Seats

- At least 75% seats will be filled up on the basis of merit in Common Entrance Test to be conducted by the State Governments or qualifying examination, as decided by the concerned State/UT.
- Reservation will be provided to students belonging to SC/ST, OBC students residing in the State / Union Territory by taking into account total number of seats in private medical colleges or Dental Colleges in the state/UT.

Allocation of seats (contd).

UNAIDED INSTITUTIONS

In minority Institutions - at least 50% and in Non minority institutions - at least 60% seats shall be filled up as Government Quota seats.

Allocation of Seats - contd

- Admission in Minority Institutions
  - In an unaided institution, at least 50% seats may be filled up by the minority community students by the management of the institute.
  - In an aided institution, up to 50% seats may be filled up by the minority community students.
  - Reservation will be provided to SC/ST/OBC students in the government quota seats.
**Allocation of Seats – contd**

- In an *aided non-minority* institution, the seats shall be filled up in the same manner as in a Govt. institution under concerned State/UT Govt.

- In an institution, Management may fill up upto 15% of total intake capacity by Non-Resident Indian students, Persons of Indian Origin or foreign students under their quota.

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**Admission – contd**

- State Government/UT Administration may decide the number of seats to be filled up by students who are not domicile of that State or Union Territory or by the students sponsored by other states/UTs.

- To facilitate filling up the seats in an unaided minority institution reserved for minority students, the *authorized agency* shall allot students belonging to the concerned minority community.

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**2. Admission and Fee Regulatory Committee**

- To regulate admission and fee, the State Government/UT Administration shall constitute the *Admission and Fee Regulatory Committee*.

- **Composition of the Committee**:
  - *Chairman*: Vice Chancellor of a Central University/State Govt. University or any eminent person who has been member of medical faculty of any university for at least 20 years
  - *Three members*: having experience in matters of finance or administration/Law; State Health Secretary/Principal Health Secretary.

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**Admission and Fee Regulatory Committee (contd.)**

- Institution located within the State or the Union Territory shall furnish information asked by the Committee for determination of fee to be charged by the institution failing which fee fixed by the Committee shall become applicable in respect of that institution.

- The Committee, on violation of any provisions of this Act by the institution, may recommend to the appropriate statutory authority under the Central Government or State Government or the university for withdrawal of the recognition or affiliation of such institution.

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**3. Fixation of Fee**

- **Factors**

  - The Committee shall determine the fee chargeable in each institution / University / Deemed to be University, located in the State or the Union Territory for each course keeping in view certain factors such as:
    - Location of the institution.
    - The nature of the medical course.
    - Cost of available infrastructure and expenditure.
    - Govt. assistance received.
    - Revenues earned from patient care etc.

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**Fixation of Fee (Contd.)**

- The fee fixed in any institution by the Committee shall not exceed the maximum fee determined by the by the Admission and Fee Regulatory Authority.

- The fee determined by the Committee shall remain valid for at least three years and any increase in fee due to revision shall be only applicable to the new entrants.
4. Admission and Fee Regulatory Authority

- The Central Government shall appoint an Admission and Fee Regulatory Authority to regulate admission and fee in the institutions under Central University.

- Composition of the Authority: The Chairman and Members from Union Ministry of Health and Family Welfare, Directorate General of Health Services, Union Ministry of Higher Education, Financial Adviser in the Union Ministry of Health and Family Welfare, President, Medical Council of India, the President, Dental Council of India, Secretary, Department of Health & Medical Education of two States by rotation.

Admission and Fee Regulatory Authority (Contd.)

- The Authority may ask an institution affiliated to Central University to furnish information for determining fee for that institution failing which fee fixed by Authority shall be applicable.

- The Authority shall make appropriate recommendations to the Central Government for improvement in the system of making admissions, charging of fee, redressal of grievances, etc. to facilitate smooth running of the system.

- The Authority shall act as Appellate Authority in respect of fee and admission related matter pertaining to private medical/Dental colleges.

- The Authority shall determine the maximum fee for any medical courses by the institutions across the country.

- In case of violation of provision of the Act by the institution affiliated to the Central University, the Authority may recommend to the Central Government/ university for withdrawal of recognition or affiliation of such institution.

Thank You
नई दिल्ली, 9 जनवरी, 2009
केंद्रीय स्वास्थ्य एवं परिवार कल्याण परिषद का गठन

का. आ. 106(अ). - राष्ट्रपति, संविधान के अनुसार 263 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए और भारत के राजपत्र असाधारण भाग-2, खंड-3, उपखंड (ii), तारीख 16 नवम्बर, 2005 और 01 अगस्त, 2006 को प्रकाशित इस मंत्रालय की अधिसूचना संख्या जेड 16011/3/2004 जी.पी., तारीख 16 नवम्बर, 2005 और 1 अगस्त, 2006 को अधिकार करते हुए, केंद्रीय स्वास्थ्य और परिवार कल्याण परिषद 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) परिषद का गठन

(i) परिषद निम्नलिखित से मिलकर बनेगी:-

(क) केंद्रीय स्वास्थ्य एवं परिवार कल्याण मंत्री

(ख) स्वास्थ्य और परिवार कल्याण मंत्रालय में केंद्रीय राज्यमंत्री

(ग) सदस्य (स्वास्थ्य), योजना आयोग

(घ) विभागाधिकारियों वाले राज्यों/संघ राज्य क्षेत्रों में स्वास्थ्य और परिवार कल्याण, चिकित्सा पिय्या और लोक स्वास्थ्य मंत्रालयों के प्रभारी मंत्री

(ड) दादर व नागर, चंदीगढ़, अंडमान और निकोबार द्वीप समूह, दमों व दीव और लक्ष्यदीप के एक एक प्रतिनिधि
(च) संसद-सदस्य
1. डॉ. बलूबाई कलीरिया  
2. डॉ. अरविंद शर्मा  
3. सुश्री सुशीला तिरिया  
4. श्री ललित किशोर चटुबेंडी  

(छ) गैर सरकारी
1. स्वास्थ्य और परिवार कल्याण क्षेत्र के प्रतिनिधि  
   1. अध्यक्ष, भारतीय आयुर्विज्ञान संघ (पदेन)  
   2. अध्यक्ष, भारतीय परिवार नियोजन संघ, मुंबई (पदेन)  
   3. अध्यक्ष, भारतीय सिस्टर्स कल्याण परिषद्, नई दिल्ली (पदेन)  
   4. अध्यक्ष, केंद्रीय समाज कल्याण बोर्ड, नई दिल्ली (पदेन)  
   5. अध्यक्ष, अंडरलेवन ऑफ इंडियन चैंबर ऑफ कामर्स एंड इंडस्ट्री, नई दिल्ली (पदेन)  
   6. अध्यक्ष, अंतर्राष्ट्रीय नियोजक संघ, नई दिल्ली (पदेन)  

(ह) विश्वासद व्यक्ति—
1. प्रो. रंजीत रांज चोधरी, इमर्सन वैज्ञानिक, राष्ट्रीय प्रतिष्ठान संस्थान, हर्षाळा आयुर्विज्ञान अभ्यासकार, नई दिल्ली - 110067  
2. डॉ. प्रभाप्रेम चंद रैड्डी, अध्यक्ष इंद्रप्रस्थ अग्रोली अस्पताल, मथुरा रोड, सरिता विहार, नई दिल्ली-110003  
3. प्रो. पौरी पांडा दर्शनी, योजना आयोग संसद, पश्चिमी बंगाल सरकार, पौरी भवन, सॉल्ट लेक, कोलकाता - 700106  
4. डॉ. अण्डरली गोयाल, नाज फाउंडेशन, नई दिल्ली  
5. श्री ए.के. शिव कुमार, गृहसेवक संसद, 73, लोक्य एस्टेट, नई दिल्ली-110003  
6. श्री टी.बी. एंडरली, मूलपूर्व मृदु चिन्ह विभाग, तमिलनाडू सरकार, न. 6 (पुराना 85),वॉशी मंडल रोड, गांधी नगर, अड्डायर चेतलई -600029  
7. डॉ. के. एस, जैकब, मनोविज्ञान प्रोफेसर, किर्णन मेडिकल कॉलेज, बेल्लौर 632002  
8. प्रो. गीता सेन, भारतीय प्रभाव संस्थान बैंगलोर  

82  

Tenth Conference of Central Council of Health and Family Welfare
9. डॉ. देबी प्रसाद शहीद, अध्यक्ष एवं चर्च अध्यक्ष परामशायताकार अ्योगी सर्जन, नागपुर
हदवाल, न.258/ए, बोम्बेयनाथारा, अध्यापिका क्षेत्र, अनेकल तालुक, बेगलूर-560099
10. डॉ. चर. आर. मुरलीदर, मानविकी एवं सामाजिक विज्ञान प्रोफेसर, कर्मसंगता संस्थानों, बी.एच.एस.बी. 340,
भारतीय तकनीकी संस्थान, आई.आई.टी. पोस्ट ऑफिस, चेन्नई - 600036
11. डॉ.आर.के. श्रीनाथ रेड्डी, अध्यक्ष, भारतीय जन स्वास्थ्य फाउंडेशन, पी.एच.डी. हास्य, दूरसंचार वत., नर्सरी फार्मेसी इंस्टीट्यूट एचार, अमरस्त्र कृति मार्ग, नई दिल्ली-110016
12. डॉ.एस.के. नूरबीन, भूतपूर्व निर्देशक (कृपया), कार्यक्रम डी.एच.ओ.एच. अध्यक्ष कृपया उन्मूलन
अन्वयांस, 1-ए, ज़ो.बैलेन्स, 57,फार्म, मेन रोड, गांधी नगर, चेन्नई - 600020

(अ) सरकारी
1. सचिव, स्वास्थ्य एवं विकास कल्याण विभागा
2. सचिव, आयुक्त, योगे एवं प्राकृतिक चिकित्सा, यूनानी, सिस्का और होम्योपेथी (आयु)
3. सचिव, स्वास्थ्य अनुसंधान विभाग एवं महानिदेशक (आई.एम.ए)
4. विशेष सचिव एवं महानिदेशक, एड्स नियंत्रण विभाग
5. सचिव, शिक्षा विभाग, मानव संसाधन विकास मंत्रालय
6. सचिव, महिला एवं बाल विकास विभागा
7. स्वास्थ्य सेवा महानिदेशका
8. आर्थिक सरकारी सहकारा (सदस्य-सचिव)

(पी) पृष्ठ 3(iii) में 1 से 12 तक विचार व्यक्ति साधारणतया दो चरण की अवधि के लिए परिषद के सदस्य होंगे।
लोकसभा के सदस्य तब तक परिषद के सदस्य होंगे जब तक वे या तो लोकसभा के सदस्य हैं या दो चरण के
लिए, जो भी पहले होंगे।

(पी) राज्यसभा के सदस्य तब तक परिषद के सदस्य होंगे जब तक वे राज्यसभा के सदस्य हैं। अथवा 08 जानवरी,
2011 तक, जो भी पहले होंगे।

(पी) परिषद की बैठकों में भाग लेने वाले गैर सरकारी सदस्यों के यात्रा भाग, दैनिक भाग, एच.एस.आर. 190 के उपरोधों
तथा भारत सरकार द्वारा उनके अधिकार समय-समय पर जारी किए आदेशों के अनुसार निर्देशित किए जायेंगे।

(पी) उस पर होने वाली व्यवस्था की पूर्ति इस प्रयोजन के लिए स्वीकृत व्यापक अनुमोदन में से की जाएगी।

(पी) केंद्रीय सरकार और राज्य सरकारों के विविध क्षेत्र तथा तकनीकी सलाहकार, परिषद के सदस्य नहीं होंगे और
परिषद द्वारा नियुक्त हो जाते समय उन्हें तत्कालीन अधिकार किए जाते हैं। किंतु यदि परिषद द्वारा अपेक्षित हो
तो वे परिषद बैठक में हाजिर होंगे।

(पी) परिषद का सचिवालय कर्मचारीकृत होगी जिसमें एक सचिव होगा तथा उसे अधिकारी और पदधारी होगे जिन्हें
अध्यक्ष, केंद्रीय सरकार के अनुमोदन से नियुक्त करना उचित समझें।

Tenth Conference of Central Council of Health and Family Welfare
2. इस परिषद् द्वारा किए जाने वाले कार्यों की प्रकृति-

परिषद् एक सलाहकार निकाय होगी और उस हैसियत से यह निम्नलिखित कार्य करेगी,अर्थातः

(क) स्वास्थ्य एवं परिवार कल्याण के मामले में संबंधित सभी पहलुओं पर नीति की मोटी-मोटी रूपरेखा पर विचार-विचार्य तथा सिफारिश करना जैसे- उपचारी-स्वास्थ्यवर्धक और रोग रोधी उपचार का प्रबंध करना, पर्यावरणिक सफाई, पोषण, स्वास्थ्य शिक्षा एवं अनुसंधान के लिए सुविधाओं का बढ़ावा देना।

(ख) विकल्प में लोक स्वास्थ्य तथा परिवार कल्याण के मामलों से संबंधित क्रियाकलाप के क्षेत्रों में विभाग के लिए प्रस्ताव तैयार करना और समस्त देश के विकास के लिए प्रतिमान अभिकल्पन करना।

(ग) त्योहारों के अवसर पर अंतर-राज्यक संगठन, महामारियों के फैलने और विपत्ति के स्थिति में जैसे भूकंप तथा सूखे के स्थिति में व्यापक आधार पर यथासभ्य सहयोग की संभावना का पता लगाना और सामान्य कार्यक्रम तैयार करना।

(घ) स्वास्थ्य और परिवार कल्याण प्रयोजनों के लिए उपलब्ध सहयोग अनुदानों को राज्यों में वितरित करने के संबंध में केंद्रीय सरकार की सिफारिश लेना और इन सहयोग अनुदानों के उपयोग द्वारा विभिन्न क्षेत्रों में हुए कार्य की आवश्यक समीक्षा करना।

(ङ) केंद्र और राज्यों के स्वास्थ्य और परिवार कल्याण प्राधिकृतों के बीच सहयोग और उसको बढ़ावा देने के लिए ऐसे समावेश अथवा संगठनों की स्थापना करना जिन्हें उपयुक्त कार्य सीखे जाए।

3. परिषद् की प्रक्रिया

परिषद् अपने काम काज के संचालन के लिए निम्नलिखित प्रक्रिया अपनाएगी, नामातः

(क) परिषद् हर वर्ष एक वर्ष का अधिकार बार अपनी बैठक करेगी।

(ख) इस परिषद् की बैठक उस समय और उस स्थान पर होगी जो अध्यक्ष द्वारा निम्नलिखित नियम नियाम की जाएगी।

(ग) इस परिषद् की बैठक के लिए पाँच सदस्यों (अध्यक्ष सहित) का कोर्ट होगा।

(घ) अध्यक्ष और उनकी अनुपस्थिति में उपाध्यक्ष या कोई ऐसा सदस्य जिसे पैसे-1 उप पैसे-(ी) के खर्च (घ) में विविधता सदस्यों में अध्यक्ष सदस्यों में अध्यक्ष द्वारा इस निमित्त अभिवृद्धि किया जाए, बैठक की अवधि का निर्धारण करेगा।

(ङ) इस परिषद् की बैठकों में उड़ाए जाने वाले सभी प्रस्तावों का विनिर्देश बैठक में उपस्थित सदस्यों (अध्यक्ष सहित) के भाग में से किया जाएगा।

(च) मतों के बराबर होने की दशा में अध्यक्षता करने वाले व्यक्ति का दूसरा अध्यक्ष निर्यातक मत होगा।

(छ) परिषद् अपने कामकाज के लिए ऐसी अन्य प्रक्रिया का पालन करेगी जो वह केंद्रीय सरकार के अनुमोदन से सम्मान-सम्मान पर अधिकृत करे।

[स. जैड़-16011/1/2008-बी.पी.]

नरेंद्र द्याल, सचिव

Tenth Conference of Central Council of Health and Family Welfare
MINISTRY OF HEALTH FAMILY WELFARE

NOTIFICATION

New Delhi, the 9th January, 2009

Constitution of Central Council of Health and Family Welfare

S.O. 106(E).-- In exercise of the powers conferred by the Article 263 of the Constitution and in suppression of this Ministry's notification No. Z-16011/3/2004-BP dated 16th November 2005 and Z-16011/3/04-BP dated 1st August 2006 published in the Gazette of India: Extraordinary Part-II Section 3 Sub-Section (ii) dated 13th-16th November 2005 and 17th August 2006, 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 organization 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 Chairperson

(c) Member (Health), Planning Commission  : Member

(d) Minister in charge of the Ministries of the Health and Family Welfare, Medical Education and Public Health in the States/Union Territories with Legislatures  : Member

(e) A representative each of the Dadar Nagar Haveli, Chandigarh, Andaman and Nicobar Islands, Daman and Diu and Lakshadweep  : Member(s)

(f) Members of Parliament
   1. Dr. Vallabhbhai Kathiria  : Lok Sabha
   2. Dr. Arvind Sharma  : Lok Sabha
   3. Ms. Sushila Tiria  : Rajya Sabha
   4. Sh. Lalit Kishore Chaturvedi  : Rajya Sabha

(g) Non-Officials
   (i) Representatives from Health and Family Welfare Sector
       1. President, Indian Medical Association (ex-officio)  : Members
       2. President, Family Planning Association of India, Mumbai (ex-officio)  : Members

Tenth Conference of Central Council of Health and Family Welfare
5. The President, Federation of Indian Chambers of Commerce and Industry, New Delhi (ex-officio)
6. The President, All India Organisation of Employers, New Delhi (ex-officio)

(ii) Eminent Individuals

1. Prof. Ranjit Roy Choudhury, Emeritus Scientist, National Institute of Immunology Aruna Asaf Ali Marg, New Delhi-110 067
2. Dr. Pratap Chandra Reddy, Chairman, Indraprastha Apollo Hospital, Mathura Road, Sarita Vihar, New Delhi- 110 076
3. Prof. Gouri Pada Dutta, Member, Planning Commission, Government of West Bengal, Poura Bhawan, Salt Lake, Kolkata-700 106
4. Dr. Anjali Gopalan, Naz Foundation, New Delhi
5. Mr. A.K. Shiva Kumar, Member UNICEF, 73, Lodhi Estate, New Delhi- 110 003
6. Shri T.V. Antony, Former Chief Secretary, Government of Tamil Nadu, No. 6 (Old 85) 4th Main Road, Gandhi Nagar, Adyar, Chennai-600 020
7. Dr. K.S. Jacob, Prof. of Psychiatry, Christian Medical College, Vellore- 632 002
8. Prof. Geeta Sen, Indian Institute of Management, Bangalore
9. Dr. Devi Prasad Shetty, Chairman & Senior Consultant, Cardiac Surgeon, Narayan Hrudayalaya, No. 258/a, Bommansandra, Industrial Area, Anekal Taluk, Bangalore- 560 099
10. Dr. V.R. Muraleedharan, Professor of Humanities & Social Sciences, Room No. HSB 340, Indian Institute of Technology, I.I.T. Post Office, Chennai- 600 036
11. Dr. K. Srinath Reddy, President, Public Health Foundation of India, PHD House, Second Floor, 4/2, Sirifort Institutional Area, August Kranti Marg, New Delhi- 110 016
12. Dr. S.K. Noordeen, Former Director Leprosy,
Programme DHO & Chairman,
Leprosy Elimination Alliance,
1-A, K.G. Valencia, 57, 1” Main Road,
Gandhi Nagar, Chennai- 600 020

(h) Officials:
1. Secretary, Department of Health and
   Family Welfare : Member
2. Secretary, Department of Ayurveda,
   Yoga and Naturopathy, Unani,
   Siddha and Homoeopathy (AYUSH) : Member
3. Secretary, Department of Health Research
   and Director General (ICMR) : Member
4. Special Secretary & Director General
   Department of AIDS Control : Member
5. Secretary, Department of Education,
   Ministry of Human Resource Development : Member
6. Secretary, Department of Women and Child
   Development : Member
7. Director General of Health Services : Member
8. Economic Advisor : 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 8th January 2011, whichever is earlier.

(iv) The traveling and daily allowances of the non-official members for attending the meeting 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 issued 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.

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

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

Tenth Conference of Central Council of Health and Family Welfare
(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 time 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 State and to review periodically the work accomplished in different areas through the utilization of these grants-in-aid; and

(e) to establish any organization or organizations 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 1 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.
MEMBERS PRESENT AT THE CONFERENCE OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE

Dr. Anbumani Ramadoss
Union Minister for Health & Family Welfare Chairman

Smt. Panabaka Lakshmi
Minister of State for Health & Family Welfare Vice-Chairperson

Minister In-Charge of Ministries of Health & Family Welfare, Medical Education in the State/UTs

Dr. Himanta Biswa Sarma,
Minister of Health & F.W.
Government of Assam Member

Dr. Rajiv Binal, 
Minister of Health & F.W., Ayurveda
Government of Himachal Pradesh Member

Smt. P.K. Srivastha Teacher
Minister of Health & Social Welfare
Government of Kerala Member

Sh. Ramachandra Gowda
Minister of Medical Education,
Government of Karnataka, Member

Mr. P. H. Parijat Singh,
Minister of Health & F.W.
Government of Manipur Member

Dr. A. Pariong
Minister of Health & F.W.
Government of Meghalaya, Member

Mr. Kuzholuoz Nienu,
Minister, Health & Family Welfare
Government of Nagaland, Member

Sh. Sanatan Bisi,
Minister of State for Health and Family Welfare
Government of Orissa, Member

Tenth Conference of Central Council of Health and Family Welfare
Prof. Laxmikanta Chawla
Minister of Health & F.W.
Government of Punjab,

Member

Shri Tikshan Sood
Minister of Health Education & Reasearch
Govt. of Punjab
Civil Sectt. Chandigarh

Member

Thiru E. Valsaraj
Minister of Health & F.W.
Government of Puducherry
Puducherry-605 001

Member

Sh. Aimaduddin Ahmad 'Duru Miyan'
Minister for Medical and Health and F.W, Ayurveda,
Govt. of Rajasthan

Member

Sh. Anant Kumar Misha
Minister of Health and Family Welfare,
Government of Uttar Pradesh

Member

Sh. Ramesh Pokhriyal 'Nishank',
Minister of Medical, Health and Family Welfare,AYUSH
Govt. of Utrrakhand,

Member

Dr. Surjiya Kanta Mishra
Minister of Health & F.W.
Government of West Bengal

Member

Prof. Kiran Walia,
Minister for Health and F.W.
Government of NCT Delhi

Member

Members of Parliament

Shri Lalit Kishore Chaturvedi,
Member of Parliament (Rajya Sabha)

Member

Eminent Individuals

Prof. Ranjit Roy Chaudhury, Emeritus Scientist,
National Institute of Immunology
Aruna Asaf Ali Marg, New Delhi-110 067

Member

Prof. Gouri Pada Dutta, Member, Planning Commission,
Government of West Bengal, Poura Bhawan, Salt Lake,
Kolkata- 700 106

Member

Tenth Conference of Central Council of Health and Family Welfare
Dr. Anjali Gopalan,  
Naz Foundation, New Delhi  

Mr. A.K. Shiva Kumar, Member UNICEF,  
73, Lodhi Estate, New Delhi- 110 003  

Dr. V.R. Muraleedharan,  
Professor of Humanities & Social Sciences,  
Room No. HSB 340, Indian Institute of Technology,  
I.I.T. Post Office, Chennai- 600 036  

Dr. K. Srinath Reddy, President,  
Public Health Foundation of India,  
PHD House, Second Floor,  
4/2, Sirifort Institutional Area,  
August Kranti Marg, New Delhi- 110 016  

Dr. S.K. Noordeen, Former Director Leprosy,  
Programme DHO & Chairman,  
Leprosy Elimination Alliance,  
1-A, K.G. Valencia, 57, 1st Main Road,  
Gandhi Nagar, Chennai-600 020  

Non Official Members  

Dr. Ashok Adhao  
President,  
Indian Medical Association,  
Indraprastha Bhawan,  
New Delhi-110 002  

Dr. (Mrs.) Mandakini Purandare  
Vice President,  
Family Planning Association  
Bajaj Bhawan, nariman Point,  
Mumbai, 400 021  

Official Members  

Sh. Naresh Dayal  
Secretary (H & FW)  
Ministry of Health & Family Welfare,  
Government of India  

Smt. S. Jalaja  
Secretary, (AYUSH)  
Ministry of Health & Family Welfare,  
Government of India  

Tenth Conference of Central Council of Health and Family Welfare
Dr. V.M. Katoch,
Secretary (HR)
Ministry of Health & Family Welfare,
Government of India

Ms. K. Sujatha Rao
Spl. Secretary & DG (AIDS Control)
Ministry of Health & Family Welfare
Government of India

Dr. R.K. Srivastva
Director General of Health Services
Nirman Bhawan, New Delhi

Mrs. Ganga Murthy
Economic Adviser
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi

Participants from Department of AYUSH

Sh. B. Anand,
Joint Secretary, AYUSH,
Ministry of Health & Family Welfare,
Government of India

Dr. S.K. Shau
Adviser AYUSH
Ministry of Health & Family Welfare,
Government of India

Sh. D.D. Sharma,
Director, AYUSH
Ministry of Health & Family Welfare,
Government of India

Smt. Meenakshi Negi,
Director, AYUSH
Ministry of Health & Family Welfare,
Government of India

Dr. S.K. Sharma,
Adviser, AYUSH (Ayurveda)
Ministry of Health & Family Welfare,
Government of India

Tenth Conference of Central Council of Health and Family Welfare
Dr. M. Jalli  
Assistant Adviser, AYUSH (Unani)  
Ministry of Health & Family Welfare,  
Government of India

Sh. P.K. Jha  
Deputy Secretary, AYUSH  
Ministry of Health & Family Welfare,  
Government of India

Dr. M.A. Kumar,  
Deputy Adviser, AYUSH,  
Ministry of Health & Family Welfare,  
Govt. of India

Participants from The Directorate General of Health Services

Dr. Shiv Lal,  
Special Director General,  
D.G.H.S,  
Ministry of Health & Family Welfare,  
Govt. of India

Dr. R.N. Salhan,  
Additional Director General,  
D.G.H.S,  
Ministry of Health & Family Welfare,  
Govt. of India

Dr. H.C. Goyal,  
Additional Director General,  
D.G.H.S,  
Ministry of Health & Family Welfare,  
Govt. of India

Dr. (Mrs.) R. Jose  
Additional Director General,  
D.G.H.S,  
Ministry of Health & Family Welfare,  
Govt. of India

Dr. K P S Malik  
Additional Director General,  
D.G.H.S,  
Ministry of Health & Family Welfare,  
Govt. of India

Tenth Conference of Central Council of Health and Family Welfare
Dr. N.K. Mohanty,
Additional Director General,
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Arun Kumar Aggrawal,
Additional Director General,
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. D. Kanungo,
Additional Director General(Stores)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. N.S. Dhramshaktu,
Deputy Director General (NSD)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. L. Sonar,
Deputy Director General (P)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. L. S. Chauhan,
Deputy Director General (T.B.)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. A.K. Mandal
DDG (M)
Dte. GHS
Govt. of India

Dr. D.C. Jain,
DDG (LME)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Tenth Conference of Central Council of Health and Family Welfare
Dr. G.P.S. Dhillon,
Director (NVBCDP)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Smt. Anjana Chattopadhyay,
Director NML,
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. A.K. Harit,
Chief Medical Officer (AKH)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Arvind Thergaonkar,
DDG,
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Sudhir Gupta,
Chief Medical Officer (NCD),
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. B.K. Tiwari,
Adviser (Nutrition),
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Mangala Kohli,
ADG (ME)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. S.R. Aggarwal,
CMO (SRA)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India
Dr. Rita Nagpal
Officiating Director (CHEB)/CMO
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Jaskiran Singh,
Officiating Director (CHEB)/CMO
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Pradeep Haldar,
Director, CGHS (OSD)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Mr. Sanjay Prasad,
Director, RCHDC
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Prema Sundara Rajan,
C.H. Division,
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Mr. C.A. Narayan,
Private Secretary to Secretary NACO
Ministry of Health & Family Welfare
Government of India

Dr. P.K. Srivastava,
Joint Director, NVBDCP
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Bina R Sawhney,
CMO (NFSG)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India
Dr. Yatish Agarwal,
Associate Professor, SJH
New Delhi

Sh. T. Dileep Kumar
Adviser (Nursing)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Vinay Hans
CMO (NFSG)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. W.D. Bhutia,
CMO (NFSG)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. D. Bhatnagar,
Additional Director General,
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. Anil Kumar,
CMO (NFSG)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. D.M. Thorat,
DADG (Leprosy)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India

Dr. A.K. Puri,
DADG (Leprosy)
D.G.H.S,
Ministry of Health & Family Welfare,
Govt. of India
Participants from the Ministry of Health & Family Welfare

Shri V. Santosh Kumar,
PS to the Minister of State for H& FW
Govt. of India

Shri A.K. Singh
APS to the Minister of State for H& FW
Govt. of India

Shri G.C. Chaturvedi,
Addl. Secretary,
Ministry of Health & Family Welfare,
Government of India

Shri. V.K. Malhotra,
Addl. DG (Stat.)
Ministry of Health & Family Welfare,
Government of India

Shri B.K. Prasad
Joint Secretary
Ministry of Health & Family Welfare,
Government of India

Ms. Shakuntala D. Gamlin,
Joint Secretary,
Ministry of Health & Family Welfare,
Government of India

Dr. Rattan Chand,
CD (Stat)/CD (M&E)
Ministry of Health & Family Welfare,
Government of India

Dr. Sunil D. Khaparde,
DC (ID&I),
Ministry of Health & Family Welfare,
Government of India

Dr. Tarun Seem,
Director,
Ministry of Health & Family Welfare,
Government of India
Shri Arun Baroka,
Director,
Ministry of Health & Family Welfare,
Government of India

Shri Avinash Mishra,
Director (SSM/UIP)
Ministry of Health & Family Welfare,
Government of India

Dr. Sharat Chauhan,
Director (IH & IC)
Ministry of Health & Family Welfare,
Government of India

Dr. G.P. Kumar,
Additional Economic Adviser,
Ministry of Health & Family Welfare,
Government of India

Shri Deep Shekhar,
Director,
Ministry of Health & Family Welfare,
Government of India

Dr. H. Bhushan,
AC (M-II)
Ministry of Health & Family Welfare,
Government of India

Shri Kal Singh,
Director (PNDT)
Ministry of Health & Family Welfare,
Government of India

Shri Sanjay Prasad,
Director (DC/IEC)
Ministry of Health & Family Welfare,
Government of India

Dr. Sangeeta Gopal Saxena,
AC(CH-II),
Ministry of Health & Family Welfare,
Government of India

Dr. B. Kishore,
AC (CH-I)
Ministry of Health & Family Welfare,
Government of India

Tenth Conference of Central Council of Health and Family Welfare
Dr. Anil Kumar,
AC (IMM),
Ministry of Health & Family Welfare,
Government of India

Dr. Naresh Goel,
AC (UIP)
Ministry of Health & Family Welfare,
Government of India

Dr. S.K. Sikdar,
AC (FP-I)
Ministry of Health & Family Welfare,
Government of India

Dr. Keerti Malaviya,
AC (FP-II)
Ministry of Health & Family Welfare,
Government of India

Ms. Sujaya Krishnan,
Director (EPW)
Ministry of Health & Family Welfare,
Government of India

Sh. Hari Ram Joshi,
DS,
Ministry of Health & Family Welfare,
Government of India

Shri Robert L. Chongthu,
DS (NCD)
Ministry of Health & Family Welfare,
Government of India

Shri K.S. Palachandran,
DS (CHS)
Ministry of Health & Family Welfare,
Government of India

Shri. R. Ravi,
DS (MS)
Ministry of Health & Family Welfare,
Government of India

Shri K.V.S. Rao
DS (ME)
Ministry of Health & Family Welfare,
Government of India

Tenth Conference of Central Council of Health and Family Welfare
Shri R. Rajagopal,
DS (SSM)
Ministry of Health & Family Welfare,
Government of India

Shri Rajesh Bhatia,
JD (Stats.)
Ministry of Health & Family Welfare,
Government of India

Ms. Ratna Chaudhuri,
JD (EPW),
Ministry of Health & Family Welfare,
Government of India

Shri P.K. Abdul Kareem
Deputy Economic Adviser,
Ministry of Health & Family Welfare,
Government of India

Shri Rakesh Kumar Maurya
Deputy Director
Ministry of Health & Family Welfare,
Government of India

Ms. Shruti Pandey,
Sr. Consultant, NHSRC,
Ministry of Health & Family Welfare,
Government of India

Dr. P. Priswal
Consultant
Ministry of Health & Family Welfare,
Government of India

Dr. C.N. Bhargavi,
DADG (Nursing)
Ministry of Health & Family Welfare

Shri. Yojesh Sharma,
Ministry of Health & Family Welfare,
Govt. of India

Shri Dhiraj Singh,
JD
Ministry of Health & Family Welfare,
Government of India

Tenth Conference of Central Council of Health and Family Welfare
Shri A.K Mehta  
Ministry of Health & Family Welfare,  
Government of India

Shri N C Dhawan,  
Deputy Director,  
Ministry of Health & Family Welfare,  
Government of India

Shri M.M.Lal,  
DS (HR)  
Ministry of Health & Family Welfare,  
Government of India

Mrs. Ravinder Narang,  
Director (O.L)  
Ministry of Health & Family Welfare,  
Government of India

Participants from Department of AIDS Control

Dr. S. Venkatesh,  
Addl. Project Director (NACO)  
Ministry of Health & Family Welfare,  
Government of India

PARTICIPANTS FROM DIFFERENT STATES

Andhra Pradesh  

Anil Punetha,  
Principal Secretary,  
Health & Family Welfare,  
Hyderabad  
Andhra Pradesh

Assam  

Sh. V. S. Bhaskar  
Commissioner & Secretary (Health & FW)  
IT & Sports and Youth Welfare department,  
Govt. of Assam

Partha Gogoi,  
Regional Director  
Health, Govt. of India

Dr. Manuj Kr Choudhury,  
Jt. DME Assam

Tenth Conference of Central Council of Health and Family Welfare
<table>
<thead>
<tr>
<th>State</th>
<th>Name</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andaman &amp; Nicobar</td>
<td>Shri Kuldeep Singh Thakur</td>
<td>Deputy Resident Commissioner, A&amp;N Administration</td>
</tr>
<tr>
<td>Chattishgarh</td>
<td>Shri Ajay Pandey,</td>
<td>Special Secretary, Health &amp; Family Welfare, Govt. of Chattishgarh</td>
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<tr>
<td></td>
<td>Dr. Manjeet Singh Bains,</td>
<td>Director Health &amp; F.W.</td>
</tr>
<tr>
<td>Gujarat</td>
<td>Sh. Jaynarayan Narmadasankar Vyas,</td>
<td>Ministry of Health &amp; Family Welfare, Government of Gujarat, Block-5, Dr. Jivan Mehta Building, Gandhi Nagar-10, Gujarath</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>Dr. Rakesh Pandit,</td>
<td>OSD, Department of Ayurveda, Government of Himachal Pradesh</td>
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<tr>
<td>Jammu &amp; Kashmir</td>
<td>Shri Shyam Pal Sharma,</td>
<td>Ministry of Health &amp; Family Welfare, Govt. of J &amp; K</td>
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<td></td>
<td>Dr. Yogesh Gupta,</td>
<td>Representative of The Commissioner, Health, Govt. of J &amp; K</td>
</tr>
<tr>
<td>Kerala</td>
<td>Dr. Vishwas Mehta,</td>
<td>Secretary (Health &amp; Family Welfare), Department of Health &amp; Family Welfare, Government of Kerala,</td>
</tr>
<tr>
<td>Karnataka</td>
<td>Mr. Madan Gopal,</td>
<td>Secretary (Health &amp; FW), Health and FW Department, Govt. of Karnataka,</td>
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<td></td>
<td>Sh. K.V.N. Gowda,</td>
<td>PS to Minister for Medical Education, Govt. of Karnataka,</td>
</tr>
</tbody>
</table>

Tenth Conference of Central Council of Health and Family Welfare
Sh. Virupaksha,
PA to Minister for Medical Education,
Govt. of Karnataka

Madhya Pradesh

Dev Raj Birdi, IAS
Principal Secretary (Health & FW),
Public Health & Family Welfare,
Government of Madhya Pradesh,

Shri S.K. Shrivastava,
JDHS
Directorate Health, Bhopal

Maharashtra

Mrs. Vandana Krishana
Secretary & Commissioner H&FW

Dr. Jakkal Pr.
Principal Director,
Health Services

Manipur

Shri L.P. Gonmei,
Commissioner & Secretary
(Health & Family Welfare),
Manipur Secretariat,
Government of Manipur

Meghalaya

Dr. A. Pariong
Minister of Health & F.W.,
Government of Meghalaya,
Shillong-793001

Mizoram

Sh. J. C. Ramthanga,
Pr. Secretary (Health &FW),
SAD Social Welfare & Health Department,
Government of Mizoram,

Dr. D. Baruah,
Director Hosp & Medical Education
Dr. Jane R Ralte,
Officer on Special Duty,
Health & Family Welfare Department
Government of Mizoram

Nagaland

Dr. Vizolie Suokhrie,
Joint Director,
Govt. of Nagaland

Tenth Conference of Central Council of Health and Family Welfare
Shri Menukhel John,
Commissioner & Secretary (Family Welfare),
Department of Health & Family Welfare,
Government of Nagaland,
Secretariat, KOHIMA-797001,
Nagaland

Orissa

Ms. Anu Garg,
Commissioner cum Secretary (Health & FW),
Department of Health & Family Welfare,
Government of Orissa,
Punjab

Shri A. R. Talwar,
Principal Secretary,
Health & Family Welfare,
Govt. of Punjab

Dr. S.P Sohal,
Director, Health & Family Welfare,
Govt. of Punjab

Puducherry

Sh. T.M. Balakrishnan,
Secretary (Health & FW)
Department of Health & Family Welfare
Govt of Puducherry

Rajasthan

Shri V. Srinivas,
Secretary FW
Govt of Rajasthan

Shri G.N. Bhatt.
Joint Director,
Govt of Rajasthan

Sh. R. K. Meena,
Principal Secretary (Health & FW),
Department of Health & Family Welfare,
Government of Rajasthan,
Room No. 260, Govt. Secretariat,

Sikkim

Shri V.B. Pattak
Commissioner cum Secretary,
Govt of Sikkim

Tamil Nadu

Shri V.K. Subburaj, IAS
Principal Secretary, Health & FW
Govt of Tamil Nadu

Tenth Conference of Central Council of Health and Family Welfare
Uttar Pradesh

Dr. S. Elango,
DPH & FW
Govt of Tamil Nadu

Shri Pradeep Shukla,
Principal Secretary (Health)
Govt of Uttar Pradesh

Shri Alok Krishan Dhawan,
CMO,
Gaziabad,
Govt. of Uttar Pradesh

Mr. R.R. Bharti,
Director Health,
Govt. of Uttar Pradesh

Uttarakhand

Mr. Keshav Desi Raju,
Pr. Secretary (Health & FW),
Government of Uttarakhand,

West Bengal

Sh. Samar Ghosh, IAS,
Secretary (Health & Family Welfare),
Department of Health & Family Welfare
Government of West Bengal,

Delhi

Shri Manoj R
I.O to Minister of Health & FW NCT Delhi

Daman & Diu

Dr. H.K. Haidya, CMO

OTHER THAN COUNCIL MEMBERS & MINISTRY OF HEALTH & FAMILY WELFARE

Ms. Anita Bhatnagarjan, IAS,
Joint Secretary,
Department of Higher Education,
Govt. of India

Shri K. Srinath Reddy,
President PHFI

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