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**GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE**

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**MINUTES OF THE  
13<sup>TH</sup> CONFERENCE  
OF  
CENTRAL COUNCIL  
OF HEALTH & FAMILY WELFARE**

**10<sup>TH</sup> & 11<sup>TH</sup> OCTOBER 2019,**

**At Prithvi Bhavan, Lodhi Road, New Delhi**

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**Department of Health & Family Welfare**

**Nirman Bhavan, New Delhi**

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**MINUTES OF THE 13<sup>TH</sup> CONFERENCE OF THE CENTRAL COUNCIL OF  
HEALTH & FAMILY WELFARE held on 10<sup>th</sup> and 11<sup>th</sup> October 2019, at  
Prithvi Bhavan, New Delhi.**

**Inaugural Session**

The inaugural session of 13<sup>th</sup> Central Council of Health and Family Welfare was held at Prithvi Bhawan, New Delhi.

**Address by Secretary (H) - Key features**

Secretary (Health), Ministry of Health & Family Welfare, Government of India welcomed the esteemed members of the Council and others present on the occasion. Giving a background about the Council, she mentioned that the Council for Family Welfare was in existence since 1960. There were then two Councils Viz. Council for Health and Council for Family Welfare and in 1988, both the councils were brought together to become one council- The Central Council of Health & Family Welfare (CCHFW). She remarked that presently the 13<sup>th</sup> meeting of the CCHFW was being held.

Secretary (H) mentioned that this meeting was being held after a gap of 3 years and thanked Hon'ble Union Minister of Health & Family Welfare for taking up the initiative of convening this meeting.

Welcoming the State Health Ministers and Hon'ble Members of Parliament, she stressed upon the importance of the meeting, as Health is a State subject and delivery of effective healthcare is only possible through leadership and political will of the State Ministers and Hon'ble MPs. She expressed her gratitude for their presence.

Secretary (H) recounted the recent milestones achieved in the field of public health, starting with the National Health Policy in 2017, launch of Ayushman Bharat in 2018- an initiative that aims to put together Preventive, Promotive and Wellness as the focus along with curative care.



Citing the recent speech of Hon'ble Prime Minister in UN Assembly, Secretary (H) reiterated that the four pillars of healthcare are prevention, access & affordability, infrastructure & human resources and mission mode interventions.

She explained that proceedings of the Conference would be held over seven sessions. She highlighted that the 10<sup>th</sup> October 2019 happened to be World Sight Day and World Mental Health Day. The Ministry is committed towards the cause of providing effective, affordable, accessible healthcare and also emphasized on the continued and unfinished agenda of Reproductive Maternal New-born and Child Health through the launch of the initiative SUMAN during the inaugural session.

#### **Address of Member, NITI Aayog and CCHFW – Key features**

Member, NITI Aayog greeted all Council members and mentioned about 10<sup>th</sup> October being World Sight Day and World Mental Health Day.

He highlighted that this Conference was being held at a very important juncture in the history of healthcare in India, as Ayushman Bharat is being implemented and Health is now at the heart of development agenda in the country and hence this meeting could help in assessing the progress, which would help in escalating efforts further

He underscored two specific topics pertaining to health financing and health infrastructure. Firstly, he mentioned that the National Health Policy envisages that the country will raise public health expenditure to 2.5 % of its GDP by 2025, and stressed that it is a shared responsibility of Centre and States and the Centre. He added that the States collectively have to put more resources into health as the policy envisages a target of raising States health budget to 8% of their total health budget for the States. He also gave examples of Countries like Kenya, Sri Lanka and China where health expenditure is much greater than India.

He mentioned that the Fourteenth Finance Commission increased the devolution of funds to States from 32% to 42%. However, this did not bring any significant change in States' health budgets, as the overall average allocation of State budgets has remained at 4.7 % as per RBI data, and the goal of 8% is still far away. He urged the States' Health Ministers to put extra resources and not just look at the incremental increase every year.

Secondly, he added that the National Health Policy, 2017 also envisages to reach bed to population ratio of 2 beds per thousand population by 2025. He mentioned that the current ratio is 1.2 beds per thousand population i.e. at present there are 15-16 Lakh beds and the target is to reach 26 Lakh beds by 2025 and to reach this target, 5000 hospitals having 200 beds are needed. He also emphasized on the importance of engagement with the private sector and the need to look for options to attract private equity.

**Address by, Hon'ble Union Minister of Health & Family Welfare & Chairman of the Council – key features.**

Hon'ble Union Minister of Health & Family Welfare and Chairman of the Council stated since the first CCHFW, various health milestones had been achieved through collaborative action. He highlighted that the purpose of the 13<sup>th</sup> meeting was to build consensus on the National Health Priorities. He stated that the 13<sup>th</sup> Conference of Central Council of Health and Family Welfare was an ideal platform for promoting the spirit of cooperative federalism between the Centre and States as envisioned by the Prime Minister of India, as most of the Ministers of Health and Family Welfare and Medical Education or their representatives from the States/ UTs were present.

He encouraged the States by giving an example of the challenging goal of polio eradication which was successfully completed through cooperation and support of Health Ministers from all the States/UTs. He emphasized that likewise, if all Health Ministers would come together, no task would be impossible.



Hon'ble Minister appreciated the way in which the country achieved the Millennium Development Goals for Health through synergistic action of Center and States. He remarked that a similar approach is needed to reach the Sustainable Development Goals by 2030.

He highlighted the importance of ensuring adequate financial resources for Health and mentioned that the Government of India resolves to raise Public Health Expenditure to 2.5 percent of the GDP in the coming years. He also urged the States to increase their health budget by at-least 8 % of their total expenditure so as to collectively reach the target of 2.5% set by National Health Policy, 2017.

Speaking about the Ayushman Bharat-PMJAY initiative, Hon'ble Minister mentioned that the scheme is supported by a robust system and IT support and 32 States and UTs were already implementing the scheme, 550 Million people have benefitted from the scheme and over 18000 hospitals were enrolled, and 7,500 Crore have been spent through Ayushman Bharat-PMJAY. He urged the States to gear up their efforts to reach the target of transforming 1.5 Lakh PHCs/SCs to Health and Wellness Centres (HWCs) by 2022.

He reiterated about the importance of Preventive and Promotive health and appealed to all Parliament Members, all medical professionals, and social organizations to support this initiative through participating in the social movements like Eat Right India. He stressed on the importance of physical activity in prevention of diseases and called for supporting Fit India Movement. He urged all health Ministers to take this opportunity by joining him in a cyclothon on 11<sup>th</sup> October 2019 to create a momentum towards this initiative.

He highlighted that the Government of India is committed to increase the number of medical colleges in India and to improve quality of medical education through provisions under National Medical Commission bill.



It was also mentioned that 29000 MBBS seats and about 17000 PG were created, six new AIIMS were made functional under PMSSY, and 82 district hospitals were upgraded to medical colleges. The respective States were also urged to engage and support this initiative.

Hon'ble Union Minister informed that for Elimination of Tuberculosis, a robust National Tuberculosis programme and 'TB Harega Desh Jeetega' Campaign was being implemented by providing new diagnostic facilities for screening of Tuberculosis cases, engagement of private sector for case notification and providing monetary assistance to the patient for nutritional support. He emphasized on the need to focus on elimination of malaria by taking proactive action.

It was stressed that there is a need to focus on strengthening Universal Vaccination Programme, Mission Indradhanush so that no child will be left out from getting vaccination coverage.

Hon'ble Minister, while mentioning about the World Sight Day, emphasized on the need for proper eye care to reduce preventable eye diseases and consequent blindness. He shared that the prevalence of blindness has gone down from 0.65 % to 0.36 % as per the findings of a latest survey report.

He informed that the Government is committed towards reducing maternal mortality by ending all preventable deaths and informed about the launch of Surakshit Matritva Ashwasan (SUMAN), an initiative for zero preventable maternal and new-born deaths and to provide a positive birthing experience. He informed that the programme was launched to provide assured, dignified, respectful and quality healthcare, at no cost and zero tolerance for denial of services, for every woman and new-born visiting the public health facility.

Hon'ble Union Minister mentioned that 10th of October is marked as World Mental Health Day and that this year's focus was on suicide prevention. He stressed on the need to increase efforts to help raise awareness on mental

health issues. He stated that Government of India is working towards strengthening the health system by creating centres of excellences at district level and also towards improving the psychiatric departments of medical colleges and through legal provision where suicide is no longer treated as crime. He emphasized on the need to treat the patients suffering from mental disorders with sympathy and compassion.

He informed that the Conference would host seven sessions over a span of two days, and the Council would discuss many issues related to health, after which a few Resolutions to work towards improving public health would be adopted.

#### **Launch of Website and release of booklets:**

This was followed by the launch of a Website for Surakshit Matritva Aashwasan (SUMAN) Initiative. All the present State Ministers and MPs, joined the Hon'ble Minister on the dais for the release of a booklet on SUMAN. An information leaflet on Suicide Prevention was also released. Summary Reports on National Blindness and Visual Impairment Survey (2015-19) and National Diabetes & Diabetic Retinopathy Survey (2015-16) were also released. In addition, guidelines pertaining to specific areas under National Health Mission were also released viz. Guidance document on Free Diagnostics Service Initiative, Technical Manual for Biomedical Equipment Management and Maintenance Programme, Guidelines for inclusion Peritoneal Dialysis services under the Pradhan Mantri National Dialysis Programme were also launched.

#### **Vote of Thanks.**

Director General of Health Services (DGHS) proposed the Vote of Thanks.



## PROCEEDINGS OF TECHNICAL SESSIONS:

Day:1: 10<sup>th</sup> October 2019

### SESSION I : AYUSHMAN BHARAT: HEALTH & WELLNESS CENTRES AND PMJAY

The Session was co-chaired by :

1. Hon'ble Minister, Telangana
2. Hon'ble Minister, Uttar Pradesh

#### 1. HEALTH & WELLNESS CENTRES:

A presentation on the concept of Ayushman Bharat Health & Wellness Centres was made.

The following observations/suggestions were made by the Members of the Council:

**Hon'ble Minister, Kerala** shared her experience of creating *Ayushman Bharat-Health and Wellness Centres (AB-HWCs)* in Kerala. She mentioned that out of 658 PHC-HWCs, 266 hospitals have been converted to HWCs which are termed as *Family Health Centres* in Kerala that offer patient friendly services with high technology and ensure low Out-of-pocket expenditure (OOPE). These Centres have nice gardens and reception areas to ensure overall good infrastructure. She stated that poor people's hospitals are witnessing a change. She informed that the *Family Health Centres* are playing an important role in early detection and control of NCDs. She added that out of 38 Urban PHCs, 28 UPHCs have become AB-HWCs. More help from the Centre was sought.

**Hon'ble Minister, Manipur** suggested that there should be a plan for career progression of CHOs as they form the foundation stone for AB-HWCs. He also



emphasized the need for transfer of funds directly from Centre to State Health Department, rather than through Finance Ministry.

**Hon'ble Minister, Mizoram** mentioned that poor infrastructure in NE states is a major concern apart from paucity of funds for manpower in HWCs. He sought assistance for improving the salaries.

After the discussions, the Council adopted the following three Resolutions:

- i. ***Recognizing that Comprehensive and Quality Primary Health Care is the foundation of Universal Health Coverage, the CCHFW resolves to Commit for the achievement of Comprehensive Primary Health Care (CPHC) through Ayushman Bharat Health and Wellness Centres (AB-HWCs) by converting all Sub Health Centres (that are not located in the PHC Headquarters) and rural and urban Primary Health Centres in the States/UTs by December 2022 which will have strong linkages with secondary / tertiary level care to ensure improved health outcomes and continuum of care;***
- ii. ***CCHFW resolves that Jan Swasthya Abhiyan will be created for the Prevention and Wellness utilizing, inter-alia, platform of AB-HWCs, which will prevent diseases and progression of diseases, enhance productivity and avoid Out of Pocket Expenditure (OOPE).***
- iii. ***Recognizing that medicines and diagnostics constitute the largest portion of Out of Pocket Expenditure, the CCHFW resolves to effectively implement National Free Drugs and Free Diagnostics Service Initiatives to ensure assured availability of essential medicines and diagnostics right up to Ayushman Bharat Health and Wellness Centres (AB-HWCs).***

## **2. AYUSHMAN BHARAT: PRADHAN MANTRI JAN AROGYA YOJANA(PMJAY)**

A presentation on the progress of PMJAY Scheme was made. Hon'ble HFM invited comments/ observations from the State Ministers on the subject.

The following observations/suggestions were made by the Members of the Council:

**Hon'ble Minister, Bihar** mentioned that in Bihar, as of now, 20% of the total number of entitled beneficiaries have generated their e-Card. With the same pace, it will take 5 more years to generate e-Cards for all the entitled beneficiaries. He added that it is important to explore more ways of generating e-Cards for expediting the process. As of now, only those beneficiaries who require treatment are generating their e-Cards. He also suggested that the States could make a special budgetary provision which can be given as incentive to the frontline health workers who shall be helping in generating and distributing the PM-JAY e-Cards.

**Hon'ble Minister, Gujarat** informed that Gujarat Government provides an incentive of Rs.100 to an ASHA worker who refers and brings the patient to the empanelled hospital. The Gujarat Government has converged the existing state scheme with Ayushman Bharat PM-JAY and it covers all the entitled families with a cover of Rs. 5 lakhs. He added that, to create awareness, the State Government has been organizing camps across the State. The camps help tremendously in augmenting the awareness and the State leverages the camps as one of the avenues to do mass distribution of e-Cards. Also, the State gives Rs.5 as honorary incentive to frontline health workers for e-Card distribution. Further, an incentive comprising 25% of the claim amount is provided to the staff of public hospitals.



He suggested that Transplants should be included in the list of PM-JAY packages as the transplants are life-threatening.

**Hon'ble Minister, Uttar Pradesh** mentioned that Uttar Pradesh has started a new campaign to cover all the beneficiaries below poverty line through the integrated Ayushman Bharat scheme. U.P Government covers many beneficiaries who have been left out from the Ayushman Bharat entitlement criteria. He suggested that the process of availing and generating e-Card needs to be popularized and simplified. Incentives can be given to the frontline health workers for generation and distribution of e-Cards. He added that there is a need for building a higher sense of responsibility and purpose in the health systems staff.

**Hon'ble Minister, Uttarakhand** mentioned that Govt. of Uttarakhand is leveraging all avenues (ASHA, CSCs, Call Centre number) for driving awareness. The State Government has also started a new integrated scheme, 'Ayushman Uttarakhand' which even covers the beneficiaries who have been left out from the Ayushman Bharat entitlement criteria.

**Hon'ble Minister, Madhya Pradesh** mentioned that the reimbursement process needs to be updated as the reimbursement is not happening in a timely manner. Out of all the private medical colleges in the States, only a few private medical colleges are actually providing the benefits of PMJAY. He suggested that it would be helpful if the Central Government can issue a directive to all the private medical colleges to get empanelled under Ayushman Bharat PM-JAY.

**Principal Secretary (Health), Madhya Pradesh** supplemented that in the initial few months, there was a lack of capacity at the ground level to fully comprehend the documentation process of submitting and processing the



claims and hence there was a delay in the entire claim settlement process. Later, the State had built adequate on-ground capacity and therefore it is able to submit and process the claims effectively. The time for the claims settlement process has reduced and the process has now been streamlined.

**Hon'ble Minister Kerala** informed that although Kerala implemented PM-JAY after few months of its national launch, the State has expedited the generation and distribution of e-Cards across the State. She added that through PM-JAY and other State schemes, the Govt. is covering 41 Lakh families. She mentioned that one of the issues raised by the private hospitals in the State concerns the lower package rates associated with the PM-JAY packages. With regard to the changes made in the list of AB PM-JAY packages, she mentioned that the State Govt. would soon get the feedback about the revised package rates and forward it to the Central Government. She mentioned that a prominent Government medical facility, Sree Chitra Institute for Medical Sciences and Technology has not empanelled itself with PM-JAY. She suggested that the Central Government should direct Sree Chitra Institute for Medical Sciences and Technology to get empanelled under PM-JAY so that more beneficiaries can receive quality treatment. She added that Ayushman Bharat has been a blessing for all poor citizens and the State looks forward to continuing with the scheme implementation.

**Honble Minister, Mizoram** mentioned that along with PM-JAY, Mizoram has also launched its own State scheme and aspires to be at the forefront for the scheme convergence. He added that the ceiling of the premium decided by the Central Government is a matter of concern. As insurance premiums are based on economy of scale, it becomes very difficult for smaller States such as Mizoram to get a lower premium within the ceiling. The current ceiling is Rs. 1052 per family across the country. This ceiling of the premium is not adequate for sparsely populated States. He requested the Central Government to revise the ceiling amount of premium for the second year and issue revised guidelines for the increased ceiling premium.

CEO, NHA replied that the different innovative practices adopted by the States for implementing PM-JAY were acknowledged. It was mentioned that, as a part of documenting novel practices, NHA released a booklet on best practices. The example of Jammu and Kashmir was quoted as the State provides incentives from its State budget to the frontline health workers for e-Card generation and distribution. This has led to a drastic increase in the generation of e-Cards.

All the States were urged to go through the booklet and adopt practices suitable to their plan of implementation. It was added that, for driving awareness, organizing camps have proved very effective and have led to an increase in e-Card generation. States were also requested to ensure that all the CSCs are adequately mobilized for generation of e-Cards. The Members were informed that policy guidelines have been issued recently to empower and to verify beneficiaries and issue e-Cards. For such entities, NHA would provide the necessary training and design the required accountability structures.

It was remarked that whenever a State had taken and financed novel initiatives to sensitize beneficiaries, tremendous traction in terms of generation of e-Cards and overall utilization of the scheme was seen. It was suggested that States can send requests pertaining to the support required from NHA.

Bihar and UP were urged to initiate the sensitizing of beneficiaries through organizing camps and issue more e-cards. It was added that a high level of interest within the private medical colleges to become a part of Ayushman Bharat PM-JAY was witnessed. All the States were urged to ensure that all medical colleges are empanelled within PM-JAY.

It was mentioned that in terms of performance tracking, progress at a granular level up to an empanelled hospital and district, is being done. In future, more nuanced insights would be provided to the States such that they would understand the progress in a better manner and accordingly chart out the future plan of action.



The **Chairman** remarked that in the 1<sup>st</sup> year of PM-JAY, tremendous progress has been made in terms of the e-Card generated and utilization of the scheme. He added that terms of awareness, various avenues have been adopted, including sending personalized letters from Hon. PM to all the entitled households. He remarked that there is a need to further strive and adopt more novel practices and deliver the message and sensitize beneficiaries and to increase the strength of empanelled hospitals under PM-JAY. He added that the PM-JAY IT Systems 2.0 will further help in strengthening the effort to track the progress of the scheme. He suggested that all the States may visit NHA to understand the sophisticated IT systems developed by NHA. He urged all States to actively work on the discussed areas of focus and ensure that the vision of PM-JAY is achieved.

The Council adopted the following Resolution:

***“The CCHFW resolves to ensure that all entitled beneficiaries have access to cashless quality secondary and tertiary care as envisaged under PM-JAY”.***

## **SESSION II: HEALTH SYSTEMS STRENGTHENING:**

The Session was co-chaired by:

1. Hon'ble Minister, Telangana
2. Hon'ble Minister, Uttar Pradesh.

A presentation on public health facilities, Urban health and National Health Mission (NHM)-Finance was made.

The following observations/ suggestions were made by the Members:

**Secretary, MoHFW**, reiterated the fact that States need to create a sense of pride amongst the general population in their public health facilities by



strengthening them. She mentioned that PMJAY earned funds can be utilized by public health facilities for upgradation as in Madhya Pradesh.

The **Chairman** stated that after 20 years, MBBS curriculum has been revised with special emphasis on ethics of medical care. Medical Ethics Board is created as an official body for rating of medical colleges. He assured the States that if they do a diligent task of undertaking good quality audit for their public health facilities and prepare proposals in PIPs as per the IPHS, Government of India would be glad to support them in every possible way. He also mentioned that MoHFW, Government of India undertook an extensive drive to fill the vacancies in the health institutes under Central Government. He further emphasized that States must utilize all the grants that are given to them.

**Hon'ble Minister, Sikkim** mentioned that under PMJAY, the uncovered part is out-patient services. However, most of the out of pocket expenditure (OOPE) is on medicines, diagnostics and OPD services. He requested the Central Government to support the States in strengthening their IT systems for health care and for requisite trainings.

**Dr. Shiv Kant Misra, (Eminent Individual & Member)** applauded the government on Ayushman Bharat which is the largest health care scheme in the world. He emphasized the importance of providing quality health care. He stated that the small and medium health care units are very crucial in providing health care to the majority of the population. However, they are taxed and even electricity is provided to them at commercial rates. Good hospitals are even reluctant to join the Ayushman Bharat scheme. It is thus, imperative to have proper and reasonable packages under AB-PMJAY.

**President, IMA** shared his concerns about AB-HWCs as well as PMJAY. He mentioned that 11% of the health care services are provided through Government set up of primary health care and 40% through single man clinics

and small nursing homes. The latter component needs support from the Government. Adding that steps have been taken to increase the number of MBBS seats, he suggested that for one month in a year, MBBS students should be posted and trained in a sub centre to get the community experience which would help solve the issues of lack of availability of doctors in rural areas. He stressed upon the reservation of MBBS seats for people from poor and marginalized areas with a condition that they will serve their community for at least 2 years and increasing the number of paramedical courses as per the requirement. He mentioned about the categorization of 'difficult areas' where better emoluments to the health care providers serving in these areas can be provided. He also emphasized that trust model is better than insurance model under PMJAY. There is a need to have scientific costing of packages under PMJAY

The **Chairman** mentioned about the "You quote, we pay" scheme allowed under NHM to attract the specialists and doctors in rural and difficult areas. He requested IMA to support the government in such endeavours.

**Hon'ble Minister, Telangana** and shared the experience of his State where private medical colleges and hospitals are not being utilized under PMJAY up to their fullest potential. He mentioned that out of 15000 beds in Telangana, only 3000-4000 beds are being used. He suggested that there is a need to train the ASHAs to involve them more in PMJAY. He mentioned about the successful scheme of *Basti Dawakhana*s in Hyderabad for the urban population. He requested the Central government to pool in more allocation for manpower in these *Basti Dawakhana*s along with increasing allocation for providing more manpower in PHCs and SCs. He also stressed upon the need to improve the implementation of Free Diagnostics Initiative in AB-HWCs for early detection of diseases. He also mentioned about the state-specific scheme of "Arogyashri" which includes liver transplant, kidney transplant and heart transplant since 2005.



**Dr. Rajkumar Ranjan Singh, Hon'ble Member of Parliament, Lok Sabha,** mentioned that many villages in the States don't have health centres. So, he requested the Central government for help in addressing this major issue.

**Hon'ble Minister, Madhya Pradesh** remarked that tertiary care services also need to be focused on, as NHM provides support only up to primary and secondary levels of care.

AS & MD(NHM) mentioned about the need for including career progression pathways for ASHAs, like in Chhattisgarh, ASHAs are given preference in ANM selection. Further, several other States have reserved portion of ANM seats for ASHAs. He cited the minimum HR standards under IPHS. Explaining the reason for NHM's support upto district hospital level, he mentioned that ideally, 2/3rd of the investment should be made on facilities till district hospital level which is currently only 48%. He added that if tertiary sector was also included in the NHM, resources for the primary sector are likely to reduce further.

**Dr. Ashok Panagriya, (Eminent Individual - Member)** emphasized upon the need to innovate further in the National Health Mission (NHM). He mentioned about the lack of faculty in the medical colleges which have started in the district hospitals. He also stated that there is a need for strengthening the tertiary care hospitals in public sector. He emphasized on the role that PPP can play for providing better services in emergency care, trauma care, intensive care, care of high risk pregnancies, etc. in a cross-subsidy mode. He also mentioned that Community Medicine departments of the Medical Colleges should undertake Disease Surveillance Projects. He suggested that they should be the ones who collect and report information about the disease outbreaks, incidence, prevalence, etc. He added that Nutrition is another important area where we need to pay more attention. Diagnostic services need

strengthening too. He compared the increase in number of seats in medical colleges with that of increase in number of seats in engineering colleges in India. He also stated the fact that turning all MBBS doctors in to post graduate doctors will affect the availability of doctors working at primary level in rural areas.

At the end of the discussions, the following Resolutions were adopted:

#### **Implementing Indian Public Health Standards**

- i ***The CCHFW resolves to achieve Indian Public Health Standards (IPHS) in all public health facilities in a time bound manner and commit to allocate commensurate resources for it.***

#### **Strengthening Human Resources at Public Health Facilities**

- ii ***The CCHFW resolves to ensure that Human Resources are sanctioned at least as per mandatory Indian Public Health Standards in the public health facilities in their States/UTs, and to ensure that at least 85% positions are filled within one year and have robust HRMIS for monitoring so as to ensure rational deployment and efficient delivery of quality healthcare to the community.***

#### **Urban Health**

- iii ***Reorganizing gaps in implementation of National Urban Health Mission to provide comprehensive primary health care services to urban population, particularly urban poor and slum dwellers, the CCHFW resolves to accelerate the implementation of the National Urban Health Mission.***



## NHM-Finance

- iv *Recognizing that the National Health Policy 2017 envisages raising public health expenditure to 2.5 percent of the GDP by 2025 there is a need for both the States and the Centre to work towards enhancing their health budgets. The CCHFW resolves to increase State sector health spending by at least 8% of State budget by 2020 of which about 2/3<sup>rd</sup> will be earmarked for Primary Health Care and to increase in State Health Budget by at least 10% every year. Further the CCHFW resolves to ensure timely release of matching State share and timely transfer of Central Grants from State Treasury to State Health Society.*

## **SESSION III : COMMUNICABLE DISEASES AND NATIONAL AIDS CONTROL PROGRAMME:**

The Session was co-chaired by:

1. Hon'ble Minister, Kerala
2. Hon'ble Minister, Gujarat

### **1. REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP),**

A presentation on the initiatives and status of RNTCP was made.

The **Chairman** suggested that all States should make a public commitment to end TB by 2025 and launch their action plan by end of calendar year 2019.

The following observations/suggestions were made by the Members:

**Hon'ble Minister, Bihar** informed that the Government of Bihar had already made a public commitment to end TB by 2025, and is now engaging with private sector, closely monitoring CBNAAT utilization, and Nikshay Poshan. He

informed that Drug inspectors are being engaged in monitoring Schedule H1 sale of drugs in private sector.

Concerns were expressed over the relatively high prevalence of TB among mining workers. It was explained that an Employer led Model has been adopted by the MoHFW, which would be implemented to address occupational risk of TB. It was expressed that, given the higher risk of exposure to TB among mine workers, more focus should be put on implementation of the workplace policy in the mining industries. It was decided that the Ministry would consult various stakeholders and experts for framing the guidelines for TB screening among mine workers.

**Principal Secretary, Kerala** explained about the Kerala model for Ending TB in Kerala by 2020, its approach to address TB among vulnerable population like vulnerability- mapping for Active Case Finding, special diagnostic camps in concurrence with Labour Ministry, nutritional support through NREGA, afternoon speciality clinics at Family Health Centres, etc.

On a suggestion that RNTCP should make private sector providers more aware about various facilities and services available under the Programme such as free drugs and diagnostics for patients availing services from the private sector providers, MoHFW informed that it had already engaged with IMA and Indian Association of Paediatricians for not only creating more awareness, but also for addressing the gaps in diagnostics capacities for Extra Pulmonary TB.

Principal Secretary, Madhya Pradesh highlighted the efforts made by the State for implementation of Schedule H1 by developing a reporting mechanism through a mobile application for capturing real-time private sales of Anti TB drugs in the State. It was also highlighted that the State is upgrading four TB Hospitals in Medical Colleges as Pulmonary Speciality Hospitals. A new financing mechanism for leveraging CSR fund is also being implemented on a pilot basis.



**IMA President (Member)** and **Dr. Ajay Kumar (Eminent Individual - member)** opined that migration is a critical issue and stressed on the aggressive involvement of CSR in TB patients' management. It was clarified that migration is being addressed through patient tracking mechanism on Nikshay portal.

The house adopted the following Resolution:

***Recognizing that Tuberculosis is the biggest killer among communicable diseases in India, CCHFW resolves to End TB in the country by 2025. The CCHFW also resolves to provide adequate resources for implementation of the RNTCP and to ensure that every TB patient is identified, initiated on appropriate treatment, successfully completes treatment, is provided the necessary support and is empowered.***

## **2. NATIONAL VECTOR BORNE DISEASES CONTROL PROGRAMME (NVBDGP):**

A presentation giving a brief overview of the situation of the major six Vector Borne Diseases (VBDs) in India, targets of elimination, progress made and the key issues was made.

The following observations were made by the Members:

**Hon'ble Minister, Bihar** raised the issue on the supply chain system of JE vaccine in the state. He mentioned that apart from 24 JE endemic districts, 11 new districts have been added to JE endemic districts last year. He added that there is no adequate supply of JE vaccine. He also mentioned that some non-endemic districts are also reporting JE cases.

A similar issue of JE vaccine also raised by the Health Secretary(Assam). He stated that there is an increase in JE cases, and that the state has requested

for adult JE vaccination. Due to irregular supply chain management, the state is not in a position to give JE vaccine.

The **Chairman** responded by asking States to send the detailed observations and updated information of new cases of JE/AES to the MoHFW, in order to have their requests for grant processed.

AS & MD, MoHFW mentioned that inadequate supply of JE vaccines is due to the default from the supplier's side. He informed that the number of districts needing vaccination has increased but the supplier has not been able to supply as per the increased requirement.

**Dr Ajay Kumar (Eminent Individual - Member)** suggested that there could be holistic approach instead of a disease – wise approach. He observed that there should be a single mosquito control program, rather than dealing with each disease separately. The house was informed that a Draft document on Integrated Vector Management has been prepared and NVBDCP is working on finalizing it. The idea of this document is not to look at diseases separately, but to look at responsible vectors. It was informed that most of the source reduction and vector control strategies are common to all, and the NVBDCP is working out a holistic methodology.

The **Chairman** emphasized the need of involvement of all the Ministries to make Vector Control a social movement, in order to make it possible for the country to eradicate the diseases.

Recognizing that time bound action needs to be taken in respect of Vector Borne Diseases, the CCHFW adopted the following Resolutions:



- i **Malaria elimination:** *"Zero Indigenous Transmission" in 15 low endemic states by 2020.*
- ii **Kala Azar:** *Expediting of construction of Pucca houses in Kala Azar affected villages under Pradhan Mantri Awaas Yojna- Gramin, and strengthening of active case detection activities to achieve elimination by 2020.*
- iii **Lymphatic Filariasis:** *Expanding Triple Drug Regimen (IDA) for Mass Drug Administration in order to achieve elimination target by 2021.*
- iv **Dengue, Chikungunya and Japanese Encephalitis:** *Strengthening Prevention and control of the disease by following the National Guidelines*

### **3. NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP) :**

A presentation on status of Leprosy control programme was made.

The **Chairman** made an appeal to the Hon'ble State Health Ministers and other representatives of the States/UTs to focus on all communicable diseases including leprosy.

The following Resolution was adopted by the Council:

***Recognizing that Leprosy is a serious public health problem, the CCHFW resolves to commit to reduce Grade II Disability (G2D)/million population to 1 by 2020.***

### **4. VIRAL HEPATITIS CONTROL PROGRAMME:**

A presentation on Viral Hepatitis Control Programme was made.

The following Resolution was adopted by the Council:

***The CCHFW resolves to implement the National Viral Hepatitis Control Programme and to start free of cost diagnostics and treatment services for Hepatitis B & C infected patients up to the district level initially by 2020 and subsequently up to the sub-district level.***

## **5. NATIONAL AIDS CONTROL PROGRAMME**

A presentation on the National AIDS Control Programme (NACP) was made.

The following observations/suggestions were made by the Members:

**Hon'ble Minister, Manipur** drew attention to a criticality in availability of Antiretroviral medicines in the State of Manipur. It was clarified that the stocks of all essential ARV medicines are procured and are available in adequate quantities. It was indicated that only for third line ARV, where the numbers of patients are very few and distributed widely across the country, State AIDS Control Societies have been provided budget for procurement. He also reiterated that the second tranche of funds to SACS has been released and the third and final tranche will be due in November 2019.

The chair was also informed that the issue pertaining to Manipur would be accorded priority attention through personal discussion with the Manipur team on the side-lines.

The following Resolutions were adopted by the Council:

- i ***Elimination of Mother to Child Transmission (EMTCT) of HIV is critical to achieving end of AIDS. The CCHFW recognizes that it is important that no baby is born with HIV in India and resolves to undertake universal HIV testing of all pregnant women so as to***



*ensure early identification of HIV positive pregnant women and their early initiation on Anti-retroviral therapy.*

- ii *Voluntary Blood donation is the cornerstone of ensuring availability and access to safe and high-quality blood and blood components to all those who require transfusions. The CCHFW recognizes the invaluable contribution of voluntary blood donation and resolves that the institutional arrangement of State Blood Transfusion Council will be revived and strengthened for the coordinated functioning of blood transfusion services aiming towards 100% voluntary blood donation.*

#### **SESSION IV: REPRODUCTIVE AND CHILD HEALTH:**

The Session was Co-Chaired by:

1. Hon'ble Minister, Kerala
2. Hon'ble Minister, Gujarat

A presentation on the Reproductive and Child Health activities and initiatives in the country, the Family Planning strategy, Maternal health, Immunization, Adolescent Health, and School health Programme to be rolled out shortly, was made.

The following observations/ suggestions were made by the Members:

**Hon'ble Minister, Sikkim** stated that though the target for TFR is 2.1 (replacement level) for the country, state of Sikkim is struggling with low TFR of 1.2 which is a serious concern and state needs steps to increase the TFR. He further raised the concern that linking conditionalities of providing 20% additional funds for achieving 90% of immunization target is not appropriate since the available number of children in the state is 7000 as against the target of 10000 provided by the Centre.

**Hon'ble Minister, Mizoram** shared the achievements of the state in reducing IMR from '37' in 2010 to '15' in 2017 as per SRS (highest drop of 22 points) and improving full immunization coverage to 97.26%. However, he raised concern regarding high burden of HIV in the state and sought help from NACO in treatment, vigilance and providing vehicles for special monitoring in hard to reach areas.

Additional DHS, (FW) Kerala shared the achievements of the state and strategies used to improve the MCH indicators. He mentioned that for reducing MMR, understanding and addressing the reasons for maternal deaths were to be focused on. He added that the state had partnered with private sector and professional associations for conducting monthly meetings on 3<sup>rd</sup> Wednesday of every month, for verbal autopsies and for listing common reasons for deaths. He added that Kerala is also extending a range of services to migrant population which is being addressed by volunteers and peer educators. He shared that reaching out to urban population (where level of awareness is good) regarding causes of maternal deaths is a big issue. He added that the state had an ambitious target of reducing IMR from '8' to '6' per 1000 live births for which it is involving private sector under 'Vidya' program for combating congenital anomalies. He suggested that a grading system should be developed at the national level where good performing states should be incentivized on an incremental basis.

**President, IMA& Member** suggested few strategies to improve maternal and child health outcomes like intensified efforts to promote hospital based deliveries, increased incentives for ASHA, addressing religious objections to immunization, modification of existing education material for immunization to answer related misinformation and misconceptions, development and use of digital apps (and social media) for answering relevant questions and bridge courses etc.

**Dr. Kamal Buckshee, Member (Eminent Individual)** highlighted that addressing anaemia (including sickle cell anaemia and thalassemia) is central



to improving maternal health and that importance of diet, nutrition and exercises must be recognized. She stated that learnings from countries like Bhutan (in institutional deliveries and training of midwives) may prove useful for improving maternal health in India also. For improving family planning, she stated that awareness of issues like pollution, education, resources etc. with respect to population would prove beneficial. She further suggested that reducing school drop outs and emphasizing on Vitamin D deficiencies, exercises and health education may improve adolescent health indicators. She also raised a concern on non-responsiveness of call centres and poor accessibility that hampers women to avail services.

**Hon'ble Minister, Telangana** mentioned that in Telangana, in each Anganwadi centre, 30 eggs per pregnant woman are provided per month in addition to 200 ml milk/day/ pregnant woman. Also, Rs.4000 are provided to the women at 4 months of pregnancy for nutrition and diet. He added that the state runs 'Shaadi Mubarak' scheme under which Rs.1 lakh is given to a girl if she marries after attaining the legal age of 18 years. He also claimed that due to state efforts, MMR has reduced from '85' to around '62' per 1 lakh live births and IMR has reduced to '29' per 1000 live births.

**Shri Arvind Sharma (Hon'ble Member of Parliament)** highlighted the importance of nutrition and diet in poor population. He reiterated that for all the programs to run and work optimally, qualified Human resource (HR) is needed in public sector. HE suggested that vacancies must be filled at the earliest and separate commission for health department (like UPSC and State commissions) must be created in all the states. He added that a provision for waiting list must be made so that HR attritions do not impact the services.

Replying to the observations, the **Chairman** remarked that since 2018, all the programs are being revisited and definitions are changing accordingly. He also agreed that preventable maternal and child deaths must be averted at any cost. Talking about School Health Program, he cited an example from state of Delhi 25 years back wherein a model was developed in 100 schools with health

monitors, counsellors and volunteers and 4000 teachers who had passion for health programs. He added that these monitors and teachers underwent 3 days training on health promotion and disease prevention at Maulana Azad Medical College and became Health Messengers after training. He added that this model was greatly appreciated by WHO at various platforms, and remarked that all the health programs must be institutionalized properly.

The **Chairman** observed that nutrition has come up in a big way and realizing its importance, dedicated Nutrition Mission has been launched. He remarked that Anaemia Mukht Bharat initiative is robust for all categories (whether women, child or adolescents). He emphasized that RMNCH+A program is important for everyone because pregnancy is a blessing and should not become a curse for any woman.

He closed the session by urging the states to work passionately towards common goal of improving maternal and child health.

The following Resolutions were adopted by the Council:

- i **Reproductive Health:** *The CCHFW resolves to embed family planning as a core component of maternal and child health program, by driving access, choice and quality of family planning services to all eligible couples, thereby ensuring universal access to contraceptives and reducing the unmet need.*
- ii **Maternal Health:** *The CCHFW resolves to provide free, comprehensive, quality and respectful services to every pregnant woman and new-born and work towards the goal of zero preventable maternal and new-born deaths.*
- iii **Child Health:** *The CCHFW resolves to undertake all measures including the proactive steps to implement newer initiatives like*



**Anaemia Mukht Bharat (AMB), Home Based Care for Young Child (HBYC) for improving the Health & Nutrition of every child in our State.**

- iv **Immunization:** *The CCHFW resolves to make every effort to reach each and every eligible child repeatedly to give all vaccines and ensure that no child dies of vaccine preventable diseases.*
- v **Adolescent Health:** *The CCHFW resolves to take adequate measures to promote health and well-being of all adolescents with special focus on Menstrual Hygiene Scheme and School Health program.*

## **SESSION V: NON- COMMUNICABLE DISEASES**

The Session was co-chaired by:

- 1.Hon'ble Minister, Bihar
- 2.Hon'ble Minister, Sikkim

### **1. NPCDCS, NPCB&VI, NPHCE & NMPH**

A presentation on the National Programmes for (i) Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Strokes (NPCDCS) (ii) Control of Blindness and Visual Impairment (NPCB&VI) (iii) Health Care of Elderly (NPHCE) and (iv) Mental Health (NPMH) was made.

The following observations/suggestions were made by the Members:

**Hon'ble Minister, Mizoram,** opined that decision of the Central Government for release of further financial assistance under tertiary care programmes on reimbursement basis will hamper progress as it will not be possible for the State to incur prior expenditure on the programme from the State budget. He suggested restoring the earlier pattern of funding. He requested for construction of a Mental Hospital in the State. He suggested that 10% of the budget of all the Central Ministries be placed at the disposal of the Ministry of

DONER for development of the North Eastern States. He also suggested that Diabetes, obesity and COPD are increasing and problem of obesity needs to be addressed immediately.

**Hon'ble Minister, Kerala** stated that Chronic Kidney Disease is increasing and informed that there are 90 Dialysis Centres in the State. She also drew attention to the growing elderly population and need to address their health issues. She suggested that Cancer may be made a notifiable disease.

**Hon'ble Minister, Telangana** stressed on the need for better coordination with other Ministries i.e. Social Welfare, Urban Development, Education, Rural Development etc., for seamless delivery of services for the elderly. He explained about the State's initiative for universal eye health screening named as 'Kanti Velugu', and explained that the State had screened a large number of school children and distributed free spectacles for control of refractive errors. He requested for more Central assistance for specific NCDs.

**President, IMA, Member**, mentioned about the problems of elderly people and emphasized on the need for old age homes.

**Dr. Arvind Kumar Sharma, Member of Parliament**, remarked that suicide cases in the country are increasing and it is a matter of serious concern.

Clarifying on the above issues it was mentioned that decision to release funds under the tertiary care programmes on reimbursement basis has been taken to ensure proper utilization of available resources and to avoid instances of funds lying unutilized for a considerably long period of time. Regarding the budget provision for NE region, it was clarified that 10% of the budget provision of the Ministry of Health & FW is spent for the Ministry's Schemes/Programmes in the NE region and other Ministries should also be



using the same for implementation of their respective Schemes and Programmes in the region. Therefore, the placing the entire 10% of the budget of all Ministries with DONER Ministry may not be possible.

It was further clarified that the funding pattern under NHM is very flexible and States/UTs are at liberty to submit their PIPs as per their priorities and requirements.

The Members were informed that the support being extended to States/UTs under NPCDCS includes support for activities aimed at prevention and management of common NCDs including diabetes and COPD. They were informed that Food Safety and Standards Authority of India (FSSAI) has taken initiatives to promote healthy eating. It was informed that the State Governments are also being supported for providing dialysis services free of cost to the BPL families under the Pradhan Mantri National Dialysis Programme.

The house was informed that the National Programme for Health Care of Elderly is being implemented under NHM to provide dedicated health care facilities to senior citizens. 10 bedded IPD facilities are being created under the programme at the District level, besides such facilities under the tertiary component through Regional Geriatric Centres.

The Members were informed that though there is no provision under the National Mental Health Programme for establishment of new mental health hospitals in the States, under the District Mental Health Programme, support is provided to States/UTs for making provision of basis mental health services for early detection and treatment of mental illnesses at the District hospital level and below. It was informed that in addition to the above, manpower development scheme is also being implemented to augment the availability of mental health specialist through creation of PG seats in mental health

specialities. The house was informed that Suicide prevention activities are important components of the District Mental Health Programme under which school/college counselling, workplace stress management etc. are regularly undertaken. Such facilities are also available in all the Central and State Mental Health Institutes and in the Departments of Mental Health specialties in Medical colleges. Extensive IEC activities are also part of the National Mental Health Programme with focus on counselling for suicides etc.

The Council adopted the following Resolutions:

- i ***In view of the increasing burden of NCDs, there is a need to strengthen the service delivery for NCDs. Towards this end, the CCHFW resolves that all the facilities approved up to 2018-19, under the National Programme for Prevention and Control of Diabetes, Cancer, Cardiovascular Diseases and Stroke (NPCDCS), National Programme for Health Care of Elderly (NPHCE) and National Programme for Control of Blindness and Visual Impairment (NPCB&VI) will be made fully functional at the earliest. Efforts will be made to complete the approved tertiary care facilities under the above mentioned programmes by March, 2020.***
- ii ***The CCHFW also resolves to scale up the Population Based screening for common NCDs to all the Districts and universalize use of NCD app for effective monitoring of screening and ensuring continuum of care.***
- iii ***Recognizing the growing challenge of Mental Health and requirement under the Law, the CCHFW resolves to implement all the provisions of the Mental Healthcare Act, 2017 and take***



*immediate steps to constitute State Mental Health Authorities, create State Mental Health Authority Fund, constitute State Mental Health Boards at District Level and frame required Rules and Regulations under the Act. . The CCHFW also resolves to implement the District Mental Health Programme (DMHP) in all the Districts and to make functional all the approved outdoor and indoor patient facilities in the Districts.*

*On the occasion of World Mental Health Day, 2019, CCHFW also resolves that:*

- a. Strengthen our governance and institutional capacities to effectively implement comprehensive suicide preventive plans;*
- b. Ensure effective coordination among multiple stakeholders for delivering a range of suicide prevention interventions;*
- c. Enhance the capacity of health services and gate keepers to provide suicide prevention services; and*
- d. Develop community resilience and societal support for suicide prevention and reduce stigma associated with suicidal behaviours.*

## **2. NATIONAL TOBACCO CONTROL PROGRAMME:**

A presentation on the National Tobacco Control Programme was made.

The following observations/suggestions were made by the Members:

**Hon'ble Minister, Bihar** highlighted that 15 brands of pan masala have been prohibited and are fit for prosecution in the State of Bihar as they contain magnesium carbonate and 7 brands have been found containing nicotine.

**Dr Shiv Kant Mishra, Eminent Member** of the Council opined that there should be the blanket ban on usage of tobacco products in educational institutions, and as such, efforts should be made to make all educational institutions tobacco-free.

**Hon'ble Minister, Kerala** said that Kerala had already prohibited e-cigarettes and with the Ordinance on prohibition of e-cigarettes and like devices, effective measures will be taken for its enforcement. She also said that the matter relating to pan masala also needs to be looked into as the habit of chewing pan masala is becoming rampant in the State of Kerala also.

In reply to the concerns raised by the Hon'ble State Ministers, the **Chairman** clarified that smoking is already banned in premises of educational institutions under CoTPA, 2003. He added that MoHFW had also released revised Guidelines for Tobacco Free Educational Institutions (ToFEI). States are also requested to go in for speedy and effective implementation of the Guidelines. Summing up the discussion, the Chairman said that the Centre would support the States/UTs in their efforts and provide all technical support for implementation of Guidelines for Tobacco Free Educational Institutions. He added that for ensuring implementation of CoTPA, the States should expeditiously take necessary steps to enforce the Prohibition of Electronic Cigarettes (production, manufacture, import, export, transport, sale, distribution, storage and advertisement) Ordinance, 2019.

The Council then adopted the following Resolution:

***"The CCHFW resolves to effectively implement the ban on e cigarettes and other tobacco control laws to promote well - being of people, especially of our younger generation".***

**Discussion Point** – Establishment of All Indian Medical Services- Views of all Members were solicited



**DAY 2: 11<sup>TH</sup> OCTOBER 2019 :**

**SESSION VI: REGULATION, PUBLIC HEALTH CADRE & PMSSY :**

The session was co-chaired by :

1. Hon'ble Minister, Chhattisgarh
2. Hon'ble Minister (Medical Education), Madhya Pradesh

**1. MEDICAL EDUCATION REGULATION & DISTRICT RESIDENCY PROGRAMME:**

A presentation on Medical Education Regulation in the country was made.

There was also a presentation on District Residency Programme under which the PG students would have to do 3 months rotational posting in a district hospital. Member, NITI Aayog & Chairman BoG-MCI informed that an amendment notification would be brought out soon.

The following observations were made by the Members:

**Hon'ble Minister, Sikkim** wanted to know more about CPS. It was conveyed that CPS would be instructed to contact the State authorities. He also raised the issue of late allotment of seats under Central Pool and the uncertainty for the candidates. It was conveyed that Central pool is a voluntary pool and allocation to beneficiaries is done only after the contribution of seats from donor States is confirmed.

**Hon'ble Minister, Uttar Pradesh** was desirous of knowing the status of 11 DPRs submitted by the State under Phase III. It was informed that the Technical Evaluation Committee has considered the DPRs in its meeting on 10.10.2019 and would be making its recommendations shortly.

**Hon'ble Minister, Telangana** raised the issue of the problems associated with increase in MBBS class size in medical colleges. He suggested that more

Sections in the classes may be allowed and more attention to pre-clinical teaching so as not to dilute the training.

Another member raised the point that State Governments are not serious about taking action against quacks. He also stated that NEET paper should have descriptive section also besides the multiple choice questions. He urged to exercise caution in increasing medical seats, lest the quality of training be diluted

**President, IMA** (Member) expressed certain reservations about the CPS courses.

**Secretary(HFW)** responded that the governing structure of CPS has been amended with the inclusion of Ministry, DGHS and Maharashtra Government representative in the Governing Body. The CPS courses have also been modified to bring in alignment with MCI curriculum. She added that the Ministry would endeavor to increase the availability of sub-specialists at primary level while maintaining standards.

**President, NBE** made a request to the States to start Family Medicine course in District Hospitals where the basic departments are available. The candidates would do 9 months of training in PHC/CHC in the course.

**Member, NITI Aayog & Chairman, BoG-MCI** requested the States to share the fee details of medical colleges in their States so as to help BoG make preliminary report which may be considered by NMC upon its constitution.

The Council adopted the following Resolutions:

- i. ***Considering the importance of medical education, the CCHFW resolves to take steps to increase the availability of doctors and specialists in the country to improve access to quality and affordable health care.***



- ii. *The CCHFW further resolves for adoption and smooth implementation of District Residency Programme as may be provided for by MCI through regulations.*
- iii. *Additional: Looking at the need for rapid expansion of medical education infrastructure and the consequent need for faculty at higher levels, it was resolved to adopt the system of floating designations for faculty members in Government Medical Colleges in conformity with teachers' eligibility guidelines of MCI*

## **2. PUBLIC HEALTH MANAGEMENT CADRE**

A presentation on creating a Public Health Management Cadre was made. The following observations/suggestions were made by the Members:

**Dr. Ajay Kumar, (Eminent Individual – Member)** opined that the starting a Public Health Management cadre is an innovative idea to bring about positive health outcomes. He however felt that enough efforts need to be made to integrate this with the existing cadres, otherwise, creating a new cadre would altogether become a superfluous exercise.

**Member, NITI Ayog** informed that contours would be made available through Model Public Health Management cadre guidelines. He opined that having one more round of expert consultations would be a model path to move forward with. He stated that in the current situation, the need is to have multi-disciplinary teams for achieving better health outcomes in public health sector. He also mentioned that there is a need to create a cadre of hospital managers and administrators

**Director General of Health Service (Member)** shared his views about the large pool of DGHS employees and MD community medicine doctors that may be considered for this cadre.

**Hon'ble Minister, Telangana** also mentioned that professional superintendents and specialists should be different as in Government hospitals.

The **Chairman** stressed upon the need to have the Public Health Management Cadre in place within one year since there has been talk about it for many years now. **Secretary, MoHFW** also seconded the decision by saying that this would change the scenario of health care delivery system in India.

**Dr. Shiv Kant Misra, Eminent Member** spoke on the dangerous implication of introducing CPS courses/ diplomas such as diploma in surgery and diploma in urology which may lead to quality concerns in providing such specialist services. He also reiterated that one should not be in a haste to increase the number of MBBS seats and PG seats as there is a need to deploy resources in parallel for creating adequate infrastructure and HR for providing good quality medical education.

**Dr. Arvind Kumar Sharma, Member of Parliament, Lok Sabha** informed that the 3 years Family Medicine course has 1000 seats as on date since January, 2019. IMA representative also shared his objections to diploma courses like CPS.

**Hon'ble Minister, Uttar Pradesh** also gave his views about deciding professional qualifications for the public health management cadre along with adequate addressing of ethical and empathy issues in staff in public health facilities. He stressed upon having a one year course with focus on empathy and ethics for all health care providers including management staff.

The following Resolution was adopted by the Council:



***“CCHFW resolves to commit to constitute Public Health Management Cadre in their States by March 2022 to achieve the goal of Health for All.”***

### **3. DRUG REGULATION:**

A presentation was made on drug regulation in the country. The Council adopted the following Resolution concerning Drug Regulation:

***“Recognizing that strengthening of drug regulatory systems is crucial to ensuring the safety, quality and efficacy of drugs thereby impacting the health of the patients, resolved that States/UTs which have not signed the MoU with GOI will do so at the earliest; and that all States/UTs will utilise the funds and send the detailed progress of the projects along with utilization certificates and projected further requirement.***

***Resolved further that States/ UTs will ensure uploading of manufacture and product data on SUGAM portal, take adequate and swift action in NSQ cases, ensure adequate sampling and inspection, and strive to set up monitoring cells an urgent basis”.***

### **4. FOOD REGULATION**

The Members of the Council were informed about the launching of the campaign “Eat Right India” which envisions transforming India’s food ecosystem and ensures access to safe and healthy food to 1.3 billion Indians.

After discussions on Registrations and Licenses, Inspections, Accredited food & mobile labs, Capacity Building, Clean street food hubs, consumer empowerment, etc. the Council adopted the following Resolution:

***“Recognizing the need for safe food and healthy India, the CCHFW resolves that the States/UTs shall strive towards Registrations and Licensing of all the Food Business Operators, undertake regular***

*inspections, review the laboratory infrastructure, participate in Central Scheme for strengthening the Food Eco system, train manpower and identify and adopt Clean Street Food Hubs at the earliest and participate effectively in the Eat Right India Movement”*

#### **5. CLINICAL ESTABLISHMENTS ACT: -**

A brief presentation was made on Clinical Establishments Act.

The following Resolution was adopted:

*“Recognizing the need for regulating Clinical Establishments (CE) in the interest of the patient care, the CCHFW resolves that the respective States/UTs shall take steps for ensuring effective implementation of the CE Act/ have stringent Act in place/ adopt the CE Act if none exists as on date at the earliest”.*

#### **6. NATIONAL ORGAN TRANSPLANT PROGRAMME**

A brief presentation on the National Organ Transplant Programme was made.

The following Resolution was adopted:

*Considering the need to address the huge requirement of deceased organ donation in the country, the CCHFW resolves that the States/UTs shall make efforts for adopting The Transplantation of Human Organs (Amendment) Act, 2011, setting up SOTTOs, strengthening institutions for organs retrieval & transplant, and mandating sharing of information by the hospitals on NOTTO online platform, at the earliest.*

#### **7. PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)**

A presentation on the scheme and issues related to the PMSSY was made.



The following observations/suggestions were made by the Members:

**Hon'ble Minister, Madhya Pradesh** highlighted issues being faced by the State during project execution. She requested the Centre to create systems to enable larger role and better control of the State Government in the execution of GMC upgradation projects under the scheme so that the Executing agencies become more accountable to the States. She suggested that the GMC upgradation project should be considered as centrally sponsored schemes instead of central sector scheme so that the project execution could be done at the State level to avoid the delay in project execution and ensure the quality of construction work. She also requested to consider the State's requests for upgradation of more GMCs in M.P.

**Hon'ble Minister, Bihar** raised the matter about delay in construction of SSB at Government Medical College, Muzaffarpur and urged for early completion of the project.

Replying to the observations of the Members, the following clarifications were provided:

Regarding the suggestion of the State that the execution of the projects may be given to the States through their Executing agencies, as is the case with the Centrally Sponsored schemes, it was decided that in future projects, if approved by the Finance Commission, this model will be considered positively.

The States were requested to hold State level Project Monitoring Committee meetings, under the chairmanship of Chief Secretary/Principal Secretary (ME), on regular basis to monitor and review the progress of the AIIMS as well as the GMC upgradation projects. The senior officials of Executive Agency and the PSA (M/s HITES) have been advised to attend these meetings.

Regarding upgradation project at Muzaffarpur, it was clarified that due to poor performance of the construction contractor at site the work has got delayed.

The Executing Agency had to terminate the contract due to their poor performance. All efforts will be made to complete the remaining construction work by May, 2020.

The following Resolution was adopted:

***“The CCHFW resolves to make efforts to ensure that all bottlenecks relating to projects of PMSSY are removed and that States would endeavor to ensure timely release of funds for early completion of projects.”***

## **SESSION VII: E-HEALTH**

The Session was Co- Chaired by :

1. Hon'ble Minister, Chattisgarh
2. Hon'ble Minister, (Medical Education), Madhya Pradesh

A presentation on e- Health initiatives was made.

Regarding rolling out of Tele-Medicine services in Health & Wellness Centres (HWCs), **Secretary (Health)** added that MoHFW has shortlisted 50 Government Medical Colleges in the country under National Medical College Network (NMCN) scheme which may be adopted by States to create Hubs for providing telemedicine services to HWCs (spokes). She requested Honourable Ministers from States/UTs to expedite the roll out of telemedicine services in HWCs.

**Hon'ble MoS & Vice-Chairman** of the Council cited the example of eUPHC project being operational in Andhra Pradesh which was demonstrated to him during his recent visit to the State. He sensitized everyone on the benefits that Telemedicine services can provide to masses in remote areas and requested all to prioritize Tele-medicine roll out at the earliest.



The **Chairman** desired that the National Medical College Network (NMCN) may be leveraged by States/UTs to provide Tele-education, CME and live-surgery services to students and doctors stationed in field. He desired that States should propose State medical colleges to extend telemedicine services from 50 more Medical colleges (except NMCN) to Health & Wellness Centres (HWCs) under Ayushman Bharat Scheme. He desired to augment Medical Colleges under NMCN and State opted Medical Colleges to create a common grid of Hubs providing Telemedicine services to entire nation.

The following Resolution was adopted by the Council on Digital Health:

***“The CCHFW recognizes the immense potential of Digital Health and resolves to use Information Technologies towards improvement of Healthcare service delivery and to ensure improved health outcomes and continuum of care. Digital Technologies are also recognized as the key contributor for achieving Universal Health Coverage (UHC)”***

#### **Concluding Session:**

Summing up the proceedings of the Conference, Secretary (H) concluded that 33 resolutions were put up before the Members of 13<sup>th</sup>CCHFW over the course of two days and another one was added on behest of Hon’ble Minister from Madhya Pradesh.

Hence, a total of 34 resolutions were passed by the Council on issues pertaining to Health and Wellness Centers, PMJAY, Health Systems Strengthening, Tuberculosis, Vector Borne Diseases, Leprosy, Viral Hepatitis, National AIDS Control Programme, Reproductive, Maternal, Child and Adolescent health, Non Communicable Diseases, Medical Education, Drugs & Food Regulation, PMSSY and E-Health interventions.

The Vice-Chairman congratulated the Council for passing 34 resolutions. He spoke about the importance of operationalizing Cancer tissue collection centres in State Cancer Institute's to enable development of database that can be utilized further for research and development for treatment of Cancer.

The Chairman emphasized on the need to prioritize operationalisation of digital health records, Elimination of Tuberculosis through 'Desh Jeetega TB Harega' Campaign, strengthening Universal Full Immunization programme and elimination of diarrheal deaths through roll out of Rotavirus vaccination, and implementation of SUMAN Initiative. He also informed that there will be a launch of new campaign on renewing the pledge to reach every child during silver jubilee year of Pulse Polio campaign on 31<sup>st</sup> October 2019.

He also urged the States to effectively implement ban on e-cigarettes and provisions under COTPA Regulation.

He suggested that Ayushman Bharat - Health and Wellness Centres can be strengthened further by institutionalizing them with medical colleges in the States/ UTs. He also urged that the States need to evaluate their health facility and prepare proposals for up gradation, if required under for funding through National Health Mission.

He advocated the need for State Health Ministers to lead the initiatives for creating social movement like Eat right campaign in all States and UTs for promoting Preventive and Promotive health. He assured that the Government of India working towards strengthening infrastructure of medical hospitals and colleges, and improving quality of medical education. Health Minister, Uttar Pradesh talked about the importance of inculcating ethics into the curriculum of Medical Professionals.



## **RESOLUTIONS ADOPTED AT 13<sup>TH</sup> CCHFW CONFERENCE**

The Central Council of Health & Family Welfare, during its 13<sup>th</sup> meeting, made and adopted the following Resolutions:

### **I. Ayushman Bharat : PM-JAY :**

1. The CCHFW resolves to ensure that all entitled beneficiaries have access to cashless quality secondary and tertiary care as envisaged under PM-JAY.

### **II. Ayushman Bharat : Health & Wellness Centres :**

2. Recognizing that Comprehensive and Quality Primary Health Care is the foundation of Universal Health Coverage, the CCHFW resolves to commit for the achievement of Comprehensive Primary Health Care (CPHC) through Ayushman Bharat Health and Wellness Centers (AB-HWCs) by converting all Sub Health Centers (that are not located in the PHC Headquarters) and rural and urban Primary Health Centers in the States/UTs by December 2022 which will have strong linkages with secondary / tertiary level care to ensure improved health outcomes and continuum of care;
3. CCHFW resolves that Jan Swasthya Abhiyan will be created for the Prevention and Wellness utilizing inter-alia platform of AB-HWCs, which will prevent diseases and progression of diseases, enhance productivity and avoid Out of Pocket Expenditure (OOPE).
4. Recognizing that medicines and diagnostics constitute the largest portion of Out of Pocket Expenditure, the CCHFW resolves to effectively implement National Free Drugs and Free Diagnostics Service Initiatives to ensure assured availability of essential medicines and diagnostics right up to Ayushman Bharat Health and Wellness Centers (AB-HWCs).

### **III. National Health Mission:**

#### **A. Implementing Indian Public Health Standards**

5. The CCHFW resolves to achieve Indian Public Health Standards (IPHS) in all public health facilities in a time bound manner and commit to allocate commensurate resources for it.

#### **B. Strengthening Human Resources at Public Health Facilities**

6. The CCHFW resolves to ensure that Human Resources are sanctioned at least as per mandatory Indian Public Health Standards in the public health facilities in their States/UTs, and to ensure that at least 85% positions are filled within one year and have robust HRMIS for monitoring so as to ensure rational deployment and efficient delivery of quality healthcare to the community.

#### **C. Urban Health**

7. Reorganizing gaps in implementation of National Urban Health Mission to provide comprehensive primary health care services to urban population, including urban poor and slum dwellers, the CCHFW resolves to accelerate the implementation of the National Urban Health Mission.

#### **D. NHM-Finance**

8. Recognizing that the National Health Policy 2017 envisages raising public health expenditure to 2.5 percent of the GDP by 2025 there is a need for both the states and the center to work towards enhancing their health budgets. The CCHFW resolves to increase State sector health spending by at least 8% of State budget by 2020 of which about 2/3rd will be earmarked for Primary Health Care and to increase in State Health Budget by at least 10% every year. Further the CCHFW resolves to ensure timely release of



matching State share and timely transfer of Central Grants from State Treasury to State Health Society.

#### **IV. Communicable Diseases and National AIDS Control Programme:**

##### **A. TB Control:**

9. Recognizing that Tuberculosis is the biggest killer among communicable diseases in India, CCHFW resolves to End TB in the country by 2025. The CCHFW also resolves to provide adequate resources for implementation of the RNTCP and to ensure that every TB patient is identified, initiated on appropriate treatment, successfully completes treatment, is provided the necessary support and is empowered.

##### **B. Vector borne diseases control:**

The CCHFW recognizes that time bound action needs to be taken in respect of Vector Borne Diseases, and, therefore, we commit to the following: -:

10. **Malaria** elimination i.e. "Zero Indigenous Transmission" in 15 low endemic states by 2020.
11. **Kala Azar:** Expediting of construction of Pucca houses in Kala Azar affected villages under Pradhan Mantri Awaas Yojna- Gramin, and strengthening of active case detection activities to achieve elimination by 2020.
12. **Lymphatic Filariasis:** Expanding Triple Drug Regimen (IDA) for Mass Drug Administration in order to achieve elimination target by 2021.
13. **Dengue, Chikungunya and Japanese Encephalitis:** Strengthening Prevention and control of the disease by following the National Guidelines.

#### **14. Leprosy Control**

Recognizing that Leprosy is a serious public health problem, the CCHFW resolves to commit to reduce Grade II Disability (G2D)/ million population to 1 by 2020.

#### **15. Viral Hepatitis control**

The CCHFW resolves to implement the National Viral Hepatitis Control Programme and to start free of cost diagnostics and treatment services for Hepatitis B&C infected patients upto the district level initially by 2020 and subsequently upto the sub-district level.

#### **C. National AIDS Control Programme:**

- 16.** Elimination of Mother to Child Transmission (EMTCT) of HIV is critical to achieving end of AIDS. The CCHFW recognizes that it is important that no baby is born with HIV in India and resolves to undertake universal HIV testing of all pregnant women so as to ensure early identification of HIV positive pregnant women and their early initiation on Anti-retroviral therapy.

Voluntary Blood donation is the cornerstone of ensuring availability and access to safe and high-quality blood and blood components to all those who require transfusions. The CCHFW recognizes the invaluable contribution of voluntary blood donation and resolves that the institutional arrangement of State Blood Transfusion Council will be revived and strengthened for the coordinated functioning of blood transfusion services aiming towards 100% voluntary blood donation.

#### **V. Reproductive health, Maternal Health, Child Health, Adolescent Health, and Immunization(RMNCAH):**

- 17. Reproductive Health:** The CCHFW resolves to embed family planning as a core component of maternal and child health program, by driving access,



choice and quality of family planning services to all eligible couples, thereby ensuring universal access to contraceptives and reducing the unmet need.

18. Maternal Health: The CCHFW resolves to provide free, comprehensive, quality and respectful services to every pregnant woman and new-born and work towards the goal of zero preventable maternal and new-born deaths.
19. Child Health: The CCHFW resolves to undertake all measures including the proactive steps to implement newer initiatives like Anemia Mukh Bharat (AMB), Home Based Care for Young Child (HBYC) for improving the Health & Nutrition of every child in our State.
20. Immunization: The CCHFW resolves to make every effort to reach each and every eligible child repeatedly to give all vaccines and ensure that no child dies of vaccine preventable diseases.
21. Adolescent Health: The CCHFW resolves to take adequate measures to promote health and well-being of all adolescents with special focus on menstrual hygiene scheme and school health program.

## **VI. Non-Communicable Diseases:**

### **A. National Mental Health Programme(NMHP)**

22. Recognizing the growing challenge of Mental Health and requirement under the Law, the CCHFW resolves to implement all the provisions of the Mental Healthcare Act, 2017 and take immediate steps to constitute State Mental Health Authorities, create State Mental Health Authority Fund, constitute State Mental Health Boards at District Level and frame required Rules and Regulations under the Act. The CCHFW also resolves to implement the District Mental Health Programme (DMHP) in all the Districts and to make functional all the approved outdoor and indoor patient facilities in the Districts.

On the occasion of World Mental Health Day, 2019, CCHFW also resolves that:

- i. Strengthen our governance and institutional capacities to effectively implement comprehensive suicide preventive plans;
- ii. Ensure effective coordination among multiple stakeholders for delivering a range of suicide prevention interventions;
- iii. Enhance the capacity of health services and gate keepers to provide suicide prevention services; and
- iv. Develop community resilience and societal support for suicide prevention and reduce stigma associated with suicidal behaviours.

**B. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke(NPCDCS), National Programme for Health care for the Elderly, and National Programme for Control of Blindness and Visual Impairment:**

23. In view of the increasing burden of NCDs, there is a need to strengthen the service delivery for NCDs. Towards this end, the CCHFW resolves that all the facilities approved up to 2018-19, under the National Programme for Prevention and Control of Diabetes, Cancer, Cardiovascular Diseases and Stroke (NPCDCS), National Programme for Health Care of Elderly (NPHCE) and National Programme for Control of Blindness and Visual Impairment (NPCB&VI) will be made fully functional at the earliest. Efforts will be made to complete the approved tertiary care facilities under the above mentioned programmes by March, 2020.

The CCHFW also resolves to scale up the Population Based screening for common NCDs to all the Districts and universalize use of NCD app for effective monitoring of screening and ensuring continuum of care.



### **C. National Tobacco Control Programme(NTCP)**

24. The CCHFW resolves to effectively implement the ban on e-cigarettes and other tobacco control laws to promote well-being of people, especially of our younger generation.

### **VII Regulation:**

#### **A. Medical Education Regulation:**

25. Considering the importance of medical education, the CCHFW resolves to take steps to increase the availability of doctors and specialists in the country to improve access to quality and affordable health care.
26. Additional: Looking at the need for rapid expansion of medical education infrastructure and the consequent need for faculty at higher levels, it was resolved to adopt the system of floating designations for faculty members in Government Medical Colleges in conformity with teachers' eligibility guidelines of MCI.

#### **B. Food Regulation**

27. Recognizing the need for safe food and healthy India, the CCHFW resolves that the States/UTs shall strive towards Registrations and Licensing of all the Food Business Operators, undertake regular inspections, review the laboratory infrastructure, participate in Central Scheme for strengthening the Food Eco system, train manpower and identify and adopt Clean Street Food Hubs at the earliest and participate effectively in the Eat Right India Movement.

#### **C. Drug Regulation**

28. Recognizing that strengthening of drug regulatory systems is crucial to ensuring the safety, quality and efficacy of drugs thereby impacting the health of the patients, the CCHFW resolved that States/UTs which have

not signed the MoU with GoI will do so at the earliest; and that all States/UTs will utilize the funds and send the detailed progress of the projects along with utilization certificates and projected further requirement.

CCHFW resolved further that States/UTs will ensure uploading of manufacturer and product data on SUGAM portal, take adequate and swift action in NSQ cases, ensure adequate sampling and inspection, and strive to set up monitoring cells on an urgent basis.

#### **D. Clinical Establishments (Registration and Regulation) Act**

29. Recognizing the need for regulating Clinical Establishments (CE) in the interest of the patient care, the CCHFW resolves that the respective States/UTs shall take steps for ensuring effective implementation of the CE Act /have stringent Act in place/adopt the CE Act if none exists as on date, at the earliest.

#### **E. National Organ Transplant Programme:**

30. Considering the need to address the huge requirement of deceased organ donation in the country, the CCHFW resolves that the States/UTs shall make efforts for adopting The Transplantation of Human Organs (Amendment) Act, 2011, setting up SOTTOs, strengthening institutions for organs retrieval & transplant, and mandating sharing of information by the hospitals on NOTTO online platform, at the earliest.

#### **F. District Residency Programme:**

31. The CCHFW resolves for adoption and smooth implementation of District Residency Programme as may be provided for by MCI through regulations.



### **VIII. Model Public Health Management Cadre:**

- 32.** CCHFW resolves to commit to constitute Public Health Management Cadre in their States by March 2022 to achieve the goal of Health for All.

### **IX. PMSSY**

- 33.** The CCHFW resolves to make efforts to ensure that all bottlenecks relating to projects of PMSSY are removed and that States would endeavor to ensure timely release of funds for early completion of projects.

### **X. e-Health**

- 34** The CCHFW recognizes the immense potential of Digital Health to transform healthcare and resolves to use Information Technologies towards improvement of Healthcare service delivery and to ensure improved health outcomes and continuum of care. Digital Technologies are also recognized as the key contributor for achieving Universal Health Coverage (UHC).

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**List of Participants****Annexure II**

**Members present in the 13<sup>th</sup> Conference of Central Council of Health &  
Family Welfare (CCHFW) held on 10<sup>th</sup>& 11<sup>th</sup> October, 2019 at Prithvi  
Bhawan, , New Delhi**

**Dr. Harsh Vardhan**

Union Minister for Health and Family Welfare

**Chairman****Shri Ashwini Kumar Choubey**

Union Minister of State for Health and Family Welfare

**Vice Chairman****Dr. V.K. Paul**

Member, NITI Aayog

**Member**

**Minister(s)-in-charge of the Ministries of the Health and Family Welfare,  
Medical Education in the States / UTs**

1.	Shri Alo Libang Minister of Health & Family Welfare Arunachal Pradesh	Member
2.	Shri Pijush Hazarika Minister of Health, Assam	Member
3.	Shri Mangal Pandey Minister of Health & Family Welfare, Bihar	Member
4.	Shri Nitinbhai R Patel Deputy Chief Minister & Minister, Health& Family Welfare Gujarat	Member
5.	Smt. K. K. Shylaja Teacher, Minister of Health & Social Justice Kerala	Member
6.	Shri Tulsiram Silawat Minister of Health and Family Welfare Madhya Pradesh	Member
7.	Dr. Vijay Laxmi Sadho Minister for Medical Education, Culture and AYUSH Madhya Pradesh	Member
8.	Shri L Jayanta Kumar Singh Minister of Health & Family Welfare	Member



	Manipur	
9.	Shri Satyendar Jain, Minister of Health, Delhi	Member
10.	Dr R. Lalthangliana Minister of Health & Family Welfare, Mizoram	Member
11.	Dr. Mani Kumar Sharma Minister of Health & FW East Sikkim	Member
12.	Shri Etala Rajendar Minister of Medical & Health & Family Welfare Telangana	Member
13.	Shri Suresh Kumar Khanna Minister of Medical Education, Uttar Pradesh	Member
14.	Shri Madan Kaushik Minister Urban Development & Housing Uttarakhand	Member
15.	Shri T.S. Singh Deo Minister of Health & Family Welfare, Chattisgarh	Member

### Members of Parliament

1.	Dr. Arvind Kumar Sharma Member of Parliament (Lok Sabha)	Member
2.	Dr. Raj Kumar Ranjan Singh Member of Parliament (Lok Sabha),	Member
3.	Dr. C. P. Thakur Member of Parliament (Rajya Sabha)	Member
4.	Smt. Kanta Kardam Member of Parliament (Rajya Sabha)	Member

### Non – Official Members

1.	Dr. Santanu Sen, President Indian Medical Association,	Member
2.	Mr. Umesh Aradhya,	Member

	President, Family Planning Association of India	
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### Official Members

1.	Ms. Preeti Sudan, Secretary (HFW)	Member
2.	Dr. Sanjay Tyagi, Director General of Health Services	Member
3.	Ms. Preeti Nath, Economic Adviser, MoHFW	Member-Secretary

### Eminent Individuals (Members)

1.	Dr. Ashok Panagariya, Professor Emeritus, Sawai Man Singh Medical College, Jaipur, Rajasthan	Eminent Individual
2.	Prof. Ashok Puri, Distinguished Professor, Jaipuria Institute of Management, Noida, Uttar Pradesh	Eminent Individual
3.	Dr. T.K. Joshi, Advisor Environmental Health, Ministry of Environment Forest & Climate Change,	Eminent Individual
4.	Dr. Harish Gupta, Senior Consultant Surgeon, Dr. R B Gupta Medical Center, Delhi. Elected Member of Delhi Medical Council,	Eminent Individual
5.	Dr. Ajay Kumar, Chairman & HOD, BLK Institute of Digestive and Liver Diseases, New Delhi, President, Indian Society of Gastroenterology. Former Chairman, Fortis Escorts Liver and Digestive Diseases Institute. Ex. President, Society of GI Endoscopy of India.	Eminent Individual
6.	Dr. Shiva Kant Misra, President, South East Asia Regional Co-operation of Surgical Care Society (SEARC). Director & CEO, Shivani Hospital and IVF, Kanpur, Ex- President of Association of Surgeons of India	Eminent Individual
7.	Dr. Vijayendra Kumar, President, National Medicos Organization, Prof. And Head, Deptt. of Paediatric Surgery, IGIMS, Patna, Bihar	Eminent Individual



8.	Dr. Kamal Buckshee, Senior Consultant, Indraprastha Apollo Hospital, Sarita Vihar, Senior Consultant, Fortis La Femme, Greater Kailash II, Delhi	Eminent Individual
9.	Dr. D. S. Rana, Chairman, Deptt. of Nephrology, Sir Ganga Ram Hospital, New Delhi, Chairman, Board of Management, Sir Ganga Ram Hospital, New Delhi	Eminent Individual
10.	Dr. Rajiv Kumar Gupta, Professor and Head, Dayanand Medical College and Hospital, Ludhiana, Punjab	Eminent Individual

### **Non-Members**

#### **Official Participants from Central Ministries / State Governments / UTs**

<b>S. No</b>	<b>State</b>	<b>Name &amp; Designation</b>
1.	Shri K. Moses Chalai	Additional Secretary, Ministry of Women and Child Development, New Delhi
2.	Government of Andhra Pradesh	Shri Vijay Rama Raju MD, APMSIDC
3.	Government of Assam	Shri Anurag Goel Commissioner Health and Family Welfare
4.	Government of Bihar	Shri Lokesh Kumar Singh Secretary, Deptt. of Health
5.	Government of Chhattisgarh	Shri Bhuvanesh Yadav Special Secretary ( H)
6.	Government of Goa	Mrs. Nila Mohanan Secretary (H&FW), Department of Health & Family Welfare, Goa
7.		Dr. Jose D 'Sa DHS Goa
8.		Dr. Vikas Kuvelkar, Medical Supdt, Goa
9.		Dr. Vandana Dhume, CMO, DHS, Goa
10.	Government of Gujarat	Dr. Jayanti S. Ravi

		Principal Secretary (Public H&FW) Department of Health & Family Welfare, Gujarat
11.	Government of Haryana	Shri Amit Jha, IAS Add. Chief Secretary Medical Education & Research
12.		Shri Amneet P Kumar Secretary Health
13.		Dr. Daya Nand Bagri DHS
14.		Shri D.K Sharma JC (Food)
15.		Dr. Malti Dy. Director, Department of Medical Education & Research
16.		Shri N.K Ahooja SDC
17.		Dr Raman Bhardwaj Consultant PNDT, Office of DGHS
18.		Dr. Jyoti DD, DMER, Haryana
19.	Government of Himachal Pradesh	Dr. Gopal Beri Dy. Dir. Health Services
20.	Government of Jammu & Kashmir	Sh. Atal Dulloo Secretary (Medical HFW) Department of Health & Family Welfare
21.	Government of Karnāṭaka	Ms. P. Hemalatha, Secretary, Medical Education
22.		Shri Pankaj Kumar Pandey Commissioner Health
23.	Government of Kerala	Dr Rajan N Khobragade Principal Secretary (H&FW) Department of Health & Family Welfare
24.		Shri Haridash K. C. Assist. Information Officer
25.	Government of Madhya Pradesh	Dr. Pallavi Jain Govil Principal Secretary (H&FW), Department of Health & Family welfare
26.		Shri Sheo Shekhar Shukla Principal Secretary Medical Education
27.		Shri Nishant Warwade



		Commissioner, Medical Education, Madhya Pradesh
28.		Smt. Usha Parmar, AMD, NHM, Madhya Pradesh
29.		Shri R.K. Pawar PS to Minister
30.		Shri Deepak Jain PA
31.	Government of Maharashtra	Dr. Jai Prakash Rathod (OSD) DMER, Mumbai
32.	Government of Manipur	Shri R. Rang Peter Jt. Secretary, H&FW
33.		Dr. K Rajo Dir. HFW
34.		Dr. Abhiram M. Joint Director, DHFW
35.		Dr. A. Guneshwor Sharma State Licensing Authority
36.		Shri N. Rimot Kumar Meetei Addl. State Drug Controller
37.		Shri Tombi Seram PA to MP
38.	Government of Meghalaya	Dr. Aman Warr DHS
39.	Government of Mizoram	Shri H. Lalengmawia Secretary, HFW
40.		Dr. T. Lalhmangahi Director Hospital & Medical Education
41.		Dr. Eric Zomawia MD, NHM
42.		Shri Vanlaltlanazote, PS to Minister
43.	Government of Punjab	Shri D. K. Tiwari, IAS Principal Secretary Medical Education
44.		Shri Kumar Rahul, IAS Secretary(H), NHM
45.		Dr. Rajiv Kumar Gupta Prof. Head CTVC, DMC&H Ludhiana
46.		Dr. Parvinder Pal Singh Sidhu Dir. NHM
47.	Government of Rajasthan	Dr. S Bhatnagar OSD Medical Education

48.		Dr. Ravi Sharma Addl. Dir
49.		Dr. R S Chhipi Dir.(RCH)
50.		Dr. Jalaj Vijay Dy. Director & SPM
51.	Government of Sikkim	Dr. P.M. Pradhan MD, NHM Department of H & FW
52.	Government of Tamil Nadu	Dr. Beela Rajesh, IAS Secretary (H&FW) Department of Health & Family Welfare
53.		Dr. Senthil Raj MD, NHM
54.	Government of Uttarakhand	Shri Yugal Kishore Pant MD, NHM/AS(Health)
55.		Dr. Abhai, Director
56.		Shri S K Gupta PR, NHM
57.	Government of Uttar Pradesh	Shri Pankaj Kumar MD, NHM Department of Health & Family Welfare
58.	Government of West Bengal	Ms. Sanghamitra Ghosh Secretary (H&FW), Department of Health & FW
59.		Md. Ghulam Ali Andari MD NHM & Secy, HFW
60.	A&N Island	Shri K.R .Meena Principal Secretary (H&FW), Department of Health & Family Welfare
61.		Dr. S.P. Burma DHS
62.	D & N Haveli	Dr A. Muthamma Secretary (H&FW)
63.	Daman & Diu	Department of Health & FW

**Others Organizations:**

1.	Shri R K Vats	Secretary General, MCI / BoG
2.	Dr. Indu Bhushan	CEO, National Health Authority



3.	Shri Pawan Agarwal	CEO, FSSAI
4.	Dr. Abhijat Sheth	President NBE
5.	Dr. Rashmi Kant Dave	Vice President & Honorary Executive Director, NBE
6.	Dr. N.S. Malik	Dy. CEA, NHA
7.	Dr. S. Venkatesh	Principal Advisor to BoG(MCI)
8.	Ms. Inoshi Sharma	Dir. (FSSAI)
9.	Ms. Malika Taneja	Asstt. Dir (FSSAI)
10.	Ms. Henna Dhawan	OSD to CEO, NHA

### Participants from MoHFW

S.No.	Name of the Officer	Designation
1.	Shri B. N. Tiwari	DG (Stats)
2.	Shri Arun Singhal	Addl. Secretary, MoHFW
3.	Shri Manoj Jhalani	AS&MD, MoHFW
4.	Ms. Vandana Gurnani	Jt. Secretary, MoHFW
5.	Shri Sudhansh Pant	Jt. Secretary, MoHFW
6.	Dr. Manohar Agnani	Jt. Secretary, MoHFW
7.	Shri Lav Agrawal	Jt. Secretary, MoHFW
8.	Shri Vikas Sheel	Jt. Secretary, MoHFW
9.	Shri Alok Saxena	Jt. Secretary, MoHFW
10.	Dr. MK Bhandari	Jt. Secretary, MoHFW
11.	Ms. Rekha Shukla	Jt Secretary, MoHFW
12.	Shri Sudhir Kumar	Jt. Secretary, MoHFW
13.	Ms. Gayatri Mishra	Jt. Secretary, MoHFW
14.	Shri Sunil Sharma	Jt. Secretary, MoHFW
15.	Ms. Preeti Pant	Jt. Secretary, MoHFW
16.	Shri D. K. Ojha	Dy. Director General(Stats), MoHFW
17.	Ms. Kavita Singh	Dir. Finance
18.	Shri Jitendra Arora	Dir (PMSSY) MoHFW
19.	Shri Devesh Deval	Dir. MoHFW
20.	Shri Ashish V Gawai	DS (RTI /Legal/ FR)
21.	Dr. Sandhya Bhullar	Director
22.	Shri Pankaj Mishra	Media Adviser to MoS(Health)
23.	<b>Office of DGHS</b> Dr. V. G. Somani,	Drug Controller General of India, CDSCO, DGHS
24.	Dr. Anil Kumar	DDG, DGHS
25.	Dr. Jyoti	JC, NUHM
26.	Dr. Sudhir Gupta	Addl DDG, DGHS

27.	Dr. Alok Mathur	Addl DDG, DGHS
28.	Dr. Vasanthi Ramesh	Director, NOTTO, DGHS
29.	Dr. Megha Khobragade	ADG, NLEP, DGHS
30.	Dr. Gowri N Sengupta	ADG, DGHS
31.	Dr. Manas P. Roy	DADG(MPR/NCD), DGHS
32.	Dr. Raghuram Rao	DADG, DGHS
33.	<b>MoHFW :</b> Shri R.G. Singh	US(DR) MoHFW
34.	Shri Rajeev Attri	US(MS), MoHFW
35.	Dr. Sriramappa V.	DD, BOP, MoHFW
36.	Shri Kuldip Narayan	PS to MoS
37.	Dr. K R Rajeshwari	AD, BOP, MoHFW
38.	Smt. Archana Verma	SSO, BOP, MoHFW
39.	Shri Dhruva Raj Yadav	SSO, BOP, MoHFW
40.	Shri Valsraj	Consultant, Protocol, MoHFW
41.	Ms. Akanksha Aggarwal	ASO, PMSSY, MoHFW
42.	Shri Amit Kumar	ASO, Protocol, MoHFW
43.	Shri Ajay Tiwari	Protocol, MoHFW
44.	Shri Vivek Kumar	JSO, BOP, MoHFW
45.	Shri Rahul Kumar	1 <sup>st</sup> PA to MoS
46.	Shri Naveen	Office of MoS (Health)
47.	Shri Raleep	Office of MoS
48.	Shri Suresh Rana	Office of Mos
49.	Shri Dharam Singh	Office of MoS
50.	Shri Sat Pal	Consultant, O/o HFM
51.	Shri Jayanta Kumar Mandal	Sr. Finance Controller, NHM- Fin, MoHFW
52.	Shri Rakesh Kumar	Sr PPS, MoHFW
53.	Dr. Narender Goswami	Sr. Consultant, MoHFW
54.	Dr. Rajni	Sr. Consultant, NUHM
55.	Dr. Salima Bhatia	Sr. Consultant, RCH
56.	Dr. Rakshita	Consultant, NHM, MoHFW
57.	Dr. Indu	Consultant, eHealth, MoHFW
58.	Dr. Gurcharan	Consultant, eHealth, MoHFW
59.	Shri Sumanta Kumar	Consultant, MoHFW
60.	Dr. Priyanka Bharti	Consultant (BoP), MoHFW
61.	Dr. Pankaj Agrawal	Consultant, MoHFW
62.	Dr. Honey Arora	Consultant, NHM, MoHFW
63.	Ms. Anita Ahuja	Consultant, NPHCE, MoHFW
64.	Dr. Pradeep Kumar	PO, NACO, MoHFW



65.	Dr. Raman Bhardwaj	Consultant, PNDT, MoHFW
66.	Shri Vardharajan	Consultant.
67.	Shri Ajai Basil	Consultant, NHSRC
68.	Dr. Kalpana Pawalia	Consultant, NHSRC
69.	Dr. H.Bhushan	Advisor NHSRC
70.	Ms. Anjaney	Consultant, NHSRC

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## Session I

### 1. Ayushman Bharat – Health & Wellness Centres for Comprehensive Primary Health Care

1

#### Ayushman Bharat – Health and Wellness Centres

a Platform to integrate service delivery – provide comprehensive care



RMNCHA+N



Communicable Diseases



Non Communicable Diseases



Preventive and Promotive



**Comprehensive  
Primary Health Care**

— Oral, Mental, Geriatric etc.



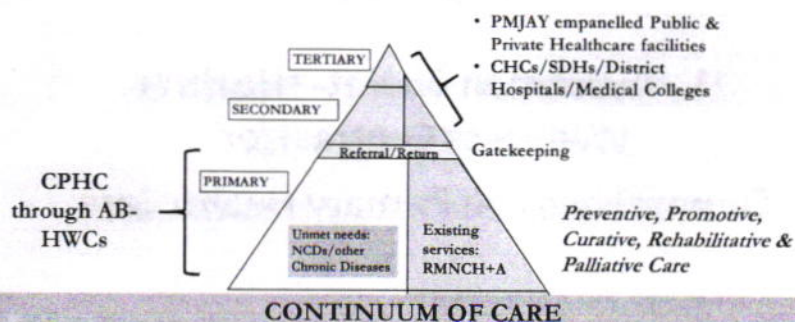
Moving towards  
Universal Health  
Coverage  
through Primary  
Health Care



2



## Universal Health Coverage



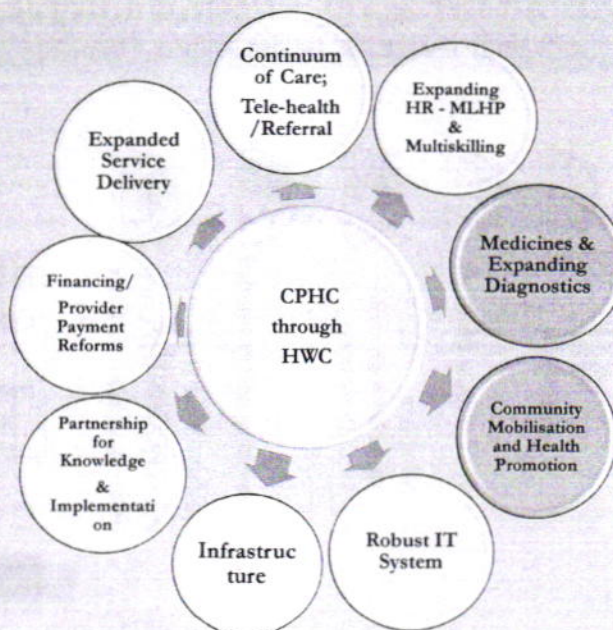
➤ 64.2 % is OOPe as a % of Total Health Expenditure (NHA 2015-16).

➤ 11.5% households in rural and 4% in urban areas sought OPD care at or below the level of CHC (except childbirth)\*

\*NSSO 71<sup>st</sup> round 2014-15

3

## Key Elements to Roll out CPHC



4

### AB-HWCs- Status

1. Andhra Pradesh, Maharashtra, Punjab, Dadra & Nagar Haveli, Pudducherry, Chandigarh and Daman and Diu. (States / UTs which have made 25% facilities functional as AB-HWCs )
2. Arunachal Pradesh, Andaman & Nicobar Islands, Manipur, Assam, Haryana, Chhattisgarh, Goa, Odisha, Sikkim, Tamil Nadu, Telangana, Nagaland, Gujarat, Karnataka have achieved > than 50% their targets for FY 2019-2020.
3. States / UTs which are required to improve their performance are Bihar, HP, J&K, Jharkhand, Kerala, Lakshwadeep, Meghalaya, Tripura, West Bengal, Mizoram, Uttarakhand, Madhya Pradesh, Rajasthan and Uttar Pradesh.

### Comprehensive Primary Health Care through AB-HWCs

#### Action requested from States

1. Vision Document on operationalising AB-HWCs involving all aspects of comprehensive primary healthcare and financial planning (December 2019)
  - Assigning population to the AB-HWCs – Rural and Urban
  - Mapping for Bidirectional referral and return - Continuum of Care
  - Human Resources as per IPHS
  - Infrastructure strengthening
    - Convergence with ULBs – space, wellness, cleanliness activities etc. addressing social determinants of health.
  - Ensuring availability of Free Essential Drugs and Diagnostic services
  - Plan for Wellness activities (Flexible annual Health Calendar)
  - Expanded package of services



## Comprehensive Primary Health Care through AB-HWCs

### Action requested from States (contd.)

2. Urban Areas need special focus and attention
  - ✓ Rapidly increasing population, migration, slum and vulnerable habitations
  - ✓ Health indicators for the Urban Poor are worse than rural health indicators
3. Facilitate Public movement for Healthy India – Eat Right, Fit India campaign (Jan Swasthya Abhiyan)
4. To establish Mechanism for facility based & community based monitoring involving PRI members, VHSNCs, MAS/SHGs, etc.
5. Financial planning – NHP 2017 (2/3rd allocation to Primary Care)

## Free Essential Drugs Services Initiative

- India is one of the largest manufacturers & suppliers of generic medicines to the world ; is considered 'Pharmacy of the Global South'
- As per NSSO (71st Round 2014-15), 70% of OOPE is on Medicines and around 10% is on Diagnostics.
- Road map is already known :
  - Setting up of robust systems for drug procurement
  - IT based supply chain and logistics management system
  - Quality assurance
  - Prescription audit mechanisms
  - Orientation for behaviour change, Training and IEC
  - Grievance redressal & monitoring

## Free Essential Drugs Services Initiative

- 32 States/UTs have centralized procurement:
  - Andaman & Nicobar, Chandigarh, Dada & Nagar Haveli & Lakshadweep yet to implement.
- 29 States/UTs have operationalized IT enabled logistics & supply chain system/DVDMS:
  - Mizoram, Nagaland, Sikkim, A&N Island, Chandigarh, Lakshadweep & Puducherry yet to implement.
- 28 States/UTs have NABL accredited labs to ensure quality of drugs provided.
  - Uttar Pradesh, Himachal Pradesh, Manipur, Meghalaya, Goa, A&N Islands, Chandigarh & Daman & Diu yet to implement.

## Free Essential Diagnostics Services Initiative

- Provision of services in-house or under PPP mode
- High volume low cost (in-house) and Low volume high cost (out source)
- Expanded list of POC Diagnostics : 14 tests at AB-HWC-SHC and 63 tests at AB-HWC-PHC/UPHC.
- 31 States/UTs have facility wise EDL:
  - Manipur, Sikkim, A&N Island, Chandigarh & Lakshadweep do not have facility wise EDL.
- 20 States/UTs have established call centre based grievance redressal mechanism with dedicated toll-free number:
  - Andhra Pradesh, Assam, Bihar, Chhattisgarh, D&N Haveli, Daman & Diu, Delhi, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Lakshadweep, Madhya Pradesh, Maharashtra, Punjab, Rajasthan, Tamil Nadu, Telangana, Tripura (under process), Uttarakhand



## Comprehensive Primary Health Care through AB-HWCs

- Draft Resolution

"Recognizing that Comprehensive and Quality Primary Health Care is the foundation of Universal Health Coverage, the CCHFW resolves to Commit for the achievement of Comprehensive Primary Health Care (CPHC) through Ayushman Bharat Health and Wellness Centers (AB-HWCs) by converting all Sub Health Centers (that are not located in the PHC Headquarters) and rural and urban Primary Health Centers in the States/UTs by December 2022 which will have strong linkages with secondary / tertiary level care to ensure improved health outcomes and continuum of care;

CCHFW further resolves that Jan Swasthya Abhiyan will be created for the Prevention and Wellness utilizing inter-alia platform of AB-HWCs, which will prevent diseases and progression of diseases, enhance productivity and avoid Out of Pocket Expenditure (OOPE).

Recognizing that medicines and diagnostics constitute the largest portion of Out of Pocket Expenditure, the CCHFW resolves to effectively implement National Free Drugs and Free Diagnostics Service Initiatives to ensure assured availability of essential medicines and diagnostics right up to Ayushman Bharat Health and Wellness Centers (AB-HWCs)."



## Session II

### Health System Strengthening

1. Indian Public Health Standards,
2. HRMIS,
3. Urban Health (NUHM),
4. NHM Finance

1

### 1. Implementing Indian Public Health Standards

- Ensuring assured set of Quality services.
- Norms for human resource, infrastructure, equipment, laboratory, blood storage facilities, and drugs have been formulated.
- Basic standards / Inputs required to improve the quality of health care delivery at SHC,PHC,CHC, SDH and DH
- Revision of IPHS 2012 underway : will include the norms for Ayushman Bharat – Health and Wellness Centres and UPHCs aswell.

2



## Implementing Indian Public Health Standards

### ❑ Action requested from States

- Systematic planning for gaps identification, effective implementation of IPHS, continuous monitoring and allocation of required resources is required for achieving IPHS in the public health facilities in a time-bound manner

3

## 2. Strengthening Human Resources at Public Health Facilities

- HR is the most critical input for Health Systems Performance.
- High Vacancy reported in many States (Source: PIP 2019-20)
- Improper skill mix
  - Number of sanctioned regular position of Staff Nurse is much less than the requirement as per IPHS in most of the states:
    - Jharkhand (13%), Assam (19%), Uttar Pradesh (20%), Nagaland (24%), Karnataka (30%), Uttarakhand (34%), MP (40%), Mah. (48%)

Vacancy	Specialists	MO-MBBS	Staff Nurse	Lab Technician
<b>Regular</b>	<ul style="list-style-type: none"> <li>• Chhattisgarh (91%)</li> <li>• Jharkhand (80%)</li> <li>• Bihar (71%)</li> <li>• MP (68%)</li> <li>• Gujarat (64%)</li> </ul>	<ul style="list-style-type: none"> <li>• Sikkim (74%)</li> <li>• Gujarat (47%)</li> <li>• Manipur (45%)</li> <li>• Chhattisgarh (44%)</li> </ul>	<ul style="list-style-type: none"> <li>• Sikkim (80%)</li> <li>• Gujarat (70%)</li> <li>• Odisha (63%)</li> <li>• Jharkhand (55%)</li> </ul>	<ul style="list-style-type: none"> <li>• Bihar (81%)</li> <li>• HP (67%)</li> <li>• Jharkhand (62%)</li> <li>• Haryana (50%)</li> </ul>
<b>Contractual</b>	<ul style="list-style-type: none"> <li>• Rajasthan (90%)</li> <li>• Meghalaya (85%)</li> <li>• MP (81%)</li> <li>• J&amp;K (77%)</li> <li>• Ar. Pradesh (77%)</li> </ul>	<ul style="list-style-type: none"> <li>• HP (97%)</li> <li>• Rajasthan (78%)</li> <li>• Odisha (77%)</li> <li>• Bihar (74%)</li> <li>• Maharashtra (63%)</li> </ul>	<ul style="list-style-type: none"> <li>• Rajasthan (81%)</li> <li>• HP (74%)</li> <li>• Bihar (77%)</li> <li>• Jharkhand (70%)</li> <li>• Maharashtra (61%)</li> </ul>	<ul style="list-style-type: none"> <li>• Ar.Pradesh (76%)</li> <li>• Rajasthan (69%)</li> <li>• Jharkhand (63%)</li> </ul>

## **Strengthening Human Resources at Public Health Facilities**

- **No Specialist Cadre:** UP, MP, Chhattisgarh, HP, Rajasthan, Uttarakhand, Punjab, Haryana, Assam, Nagaland, Meghalaya, Mizoram, Tripura
- **Poor accountability and monitoring of HR Performance**
- **Irrational deployment : Human Resource Management Information System (HRMIS):**
  - Implemented in Chhattisgarh, Kerala, Punjab, Haryana and Assam
  - Partial in Tripura, UP, AP and Odisha
  - **Not yet functional in other states**

5

## **Strengthening Human Resources at Public Health Facilities**

### **❑ Action requested from States**

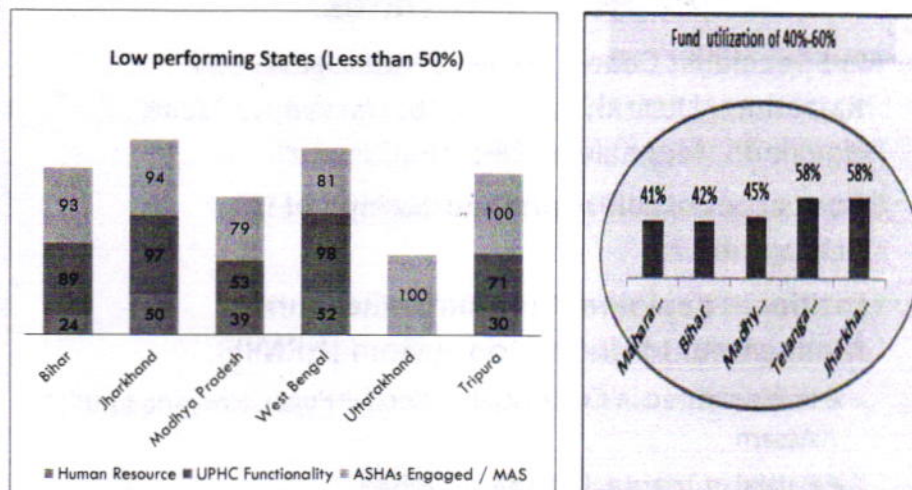
- To create Regular Specialist cadre in Public Health Departments
- To sanction requisite number of posts for different cadres at public health facilities as per IPHS and fill them.
- To set-up and implement integrated HRMIS system for real time monitoring of HR completely.

6



### 3. NUHM :State wise Performance

(In respect of Physical Progress and fund utilization)



Source: QPR Report ending March, 2019

7

## NUHM

### □ Action requested from States

- Planning and operationalizing the Urban Primary Health Centres (UPHCs) as per population norms.
- Referral Pathways - Continuum of care Linkages to be ensured with secondary and tertiary care.
- Initiating / Focusing screening for NCDs in urban areas including Training / Capacity Building of all personnel.
- Ensure adequate utilization of funds earmarked under NUHM.

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#### 4. NHM Finance

- ☐ Delay in Transfer of Central Grants from State Treasury to State Health Society (SHS) account, varies with a **minimum delay of 18 days to maximum delay of 313 days** against the stipulated 15 days.
- ☐ States Expenditure on Health ranging from **4.4% to 7.5%\*** of State budget.
- ☐ Delays in transfer of State share.
- ☐ The Result Based Financing in Health Sector to promote good performing States by incentivising **up to 20% of allocation** under flexible pools of NHM.

\*Source: State Expenditure on Health: NHA, 2015-16

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#### NHM Finance

- ☐ **Action requested from States**
  - Need to increase State health sector spending to atleast 8% of the total State budget by 2020.(NHP 2017)
  - Need to provide the matching State share on time under NHM.
  - Need to transfer funds to State Health Society within 15 days of receipt of Central grants in State Treasury.
  - Provide more financial allocations to High Priority Districts and weaker sections (SC and STs) and also report utilization accordingly.

10



### Draft Resolution by CCHFW

"The CCHFW resolves to achieve Indian Public Health Standards (IPHS) in all public health facilities in a time bound manner and commit to allocate commensurate resources for it."

"The CCHFW resolves to ensure that Human Resources are sanctioned at least as per mandatory Indian Public Health Standards in the public health facilities in their States/UTs, and to ensure that at least 85% positions are filled within one year and have robust HRMIS for monitoring so as to ensure rational deployment and efficient delivery of quality healthcare to the community."



### Draft Resolution by CCHFW

"Reorganizing gaps in implementation of National Urban Health Mission to provide comprehensive primary health care services to urban population, including urban poor and slum dwellers, the CCHFW resolves to accelerate the implementation of the National Urban Health Mission".

"Recognizing that the National Health Policy 2017 envisages raising public health expenditure to 2.5 percent of the GDP by 2025 there is a need for both the states and the center to work towards enhancing their health budgets. The CCHFW resolves to increase State sector health spending by at least 8% of State budget by 2020 of which 2/3<sup>rd</sup> will be earmarked for Primary Health Care and to increase in State Health Budget by at least 10% every year. Further the CCHFW resolves to ensure timely release of matching State share and timely transfer of Central Grants from State Treasury to State Health Society."



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## Session III

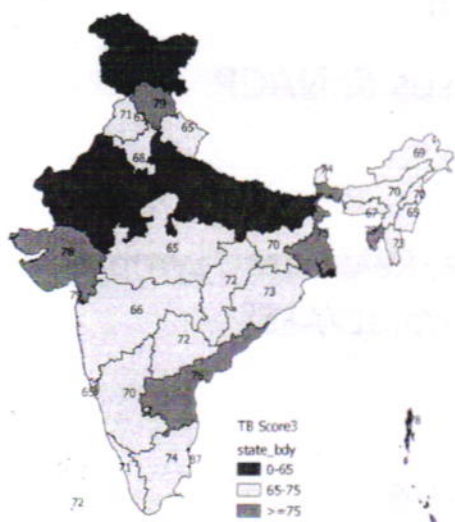
### Communicable Diseases & NACP

1. TB
2. Vector Borne Diseases: Malaria, Kala-azar, Lymphatic Filariasis, Dengue & Chikungunya, JE/AES
3. Leprosy
4. Viral Hepatitis
5. National AIDS Control Programme

1. Revised National Tuberculosis Control programme (RNTCP)



## State TB Index Score



## Key Suggested Actions

### TB Harega Desh Jeetega Campaign

1. Community Engagement
2. Advocacy and Communication
3. Health & Wellness centres and TB
4. Inter-Ministerial collaboration
5. Private health sector engagement
6. Corporate sector engagement
7. Latent TB Infection Management

## TB Harega Desh Jeetega

### Public Commitment for TB Free State

**6** States

Kerala, Lakshadweep  
Tamil Nadu, Himachal Pradesh,  
Chhattisgarh, Sikkim

### Public Commitment for TB Free State

**All** States

**By December 2019**

Key Issues	Actions Suggested
➤ <b>Missing TB patients</b>	<ul style="list-style-type: none"> <li>✓ TB Harega Desh Jeetga Community Mobilization Campaign</li> <li>✓ Private Sector Engagement</li> <li>✓ Inter-Ministerial Collaboration</li> </ul>
➤ <b>Drug Resistant TB</b>	<ul style="list-style-type: none"> <li>✓ Expansion of newer diagnostics and drug</li> </ul>
➤ <b>Prevention of TB</b>	<ul style="list-style-type: none"> <li>✓ Management of Latent TB Infection</li> <li>✓ Air Borne Infection Control</li> </ul>
➤ <b>Out-of-pocket expenditure on TB</b>	<ul style="list-style-type: none"> <li>✓ NIKSHAY Poshan Yojana Coverage</li> <li>✓ Free Diagnosis and Treatment in Private Sector</li> <li>✓ Sensitization of Local Self Government / Elected Representative</li> <li>✓ Corporate Sector Engagement</li> </ul>

## TB Harega Desh Jeetega

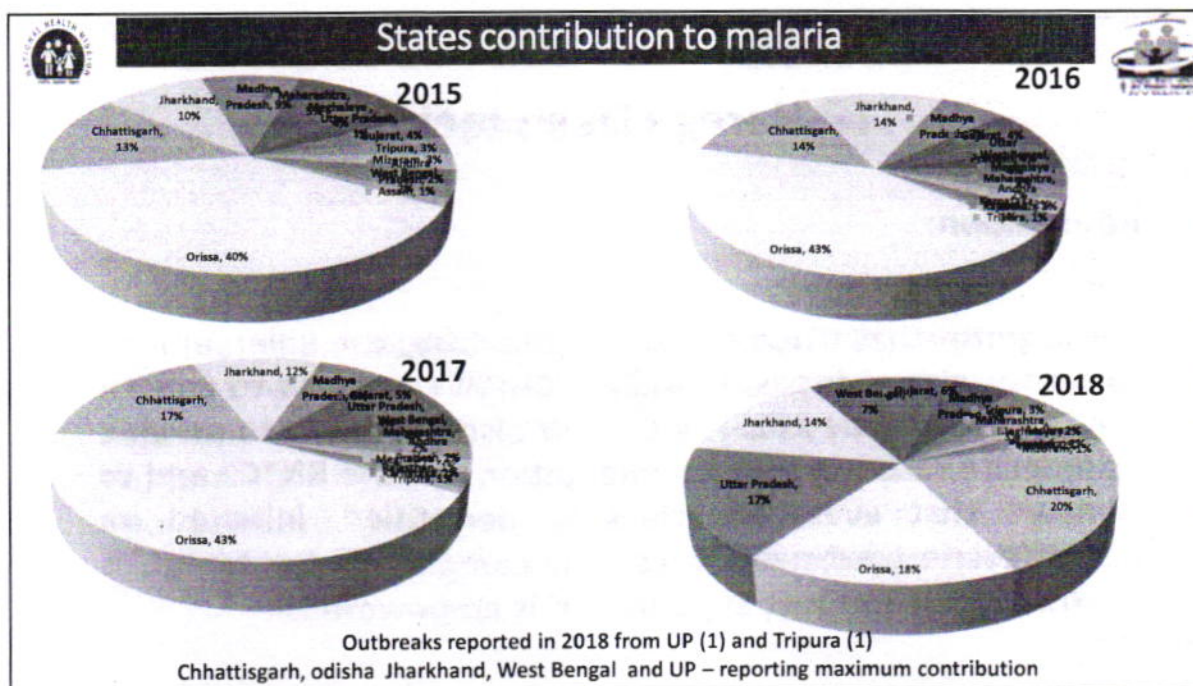
### Resolution:

Recognizing that Tuberculosis is the biggest killer among communicable diseases in India, CCHFW resolves to End TB in the country by 2025. The CCHFW also resolves to provide adequate resources for implementation of the RNTCP and to ensure that every TB patient is identified, initiated on appropriate treatment, successfully completes treatment, is provided the necessary support and is empowered.





## 2a . MALARIA



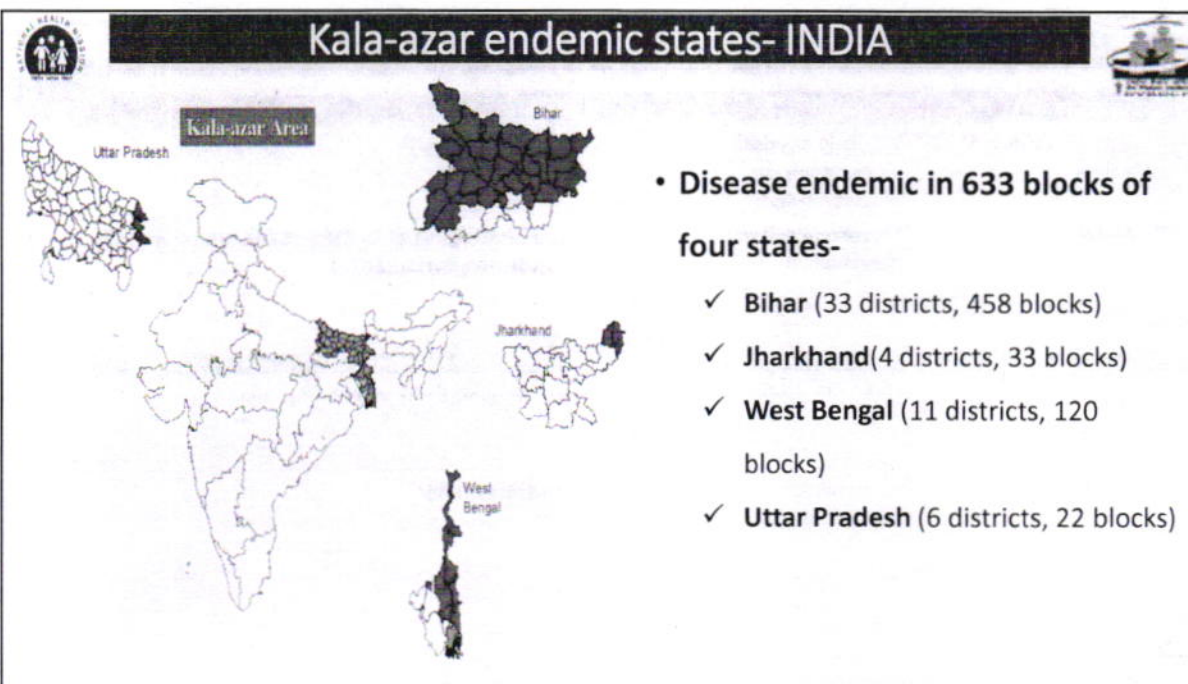
Key Issues		
Key issues	Action	States/ UTs
Malaria Elimination by 2020 (Category I)	No indigenous transmission	Delhi, HP, J & K, Chandigarh, Haryana, Punjab, Rajasthan, Uttarakhand, Goa, Puducherry, Daman & Diu, Lakshwadeep, Kerala, Sikkim, Manipur
Malaria Elimination by 2022 (Category II)	No indigenous transmission	Bihar, West Bengal, Nagaland, Assam, Gujarat, Maharashtra, Uttar Pradesh, Andhra Pradesh, Tamil Nadu, Telangana, Karnataka
Malaria Elimination by 2024 (Category III)	No indigenous transmission	A & N Islands, DNH, MP, Chhattisgarh, Jharkhand, Odisha, Meghalaya, Tripura, Mizoram, Arunachal Pradesh
Notifiable disease	Make malaria notifiable	Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Uttar Pradesh, West Bengal, Delhi, Jammu & Kashmir, Telangana, Meghalaya, Sikkim, Arunachal Pradesh, Maharashtra, Rajasthan, A&N Islands
Rapid diagnostic tests	RDT kits availability	All States/ UTs

Key Issues		
Key issues	Action	States/ UTs
Large no. of vacant positions	Fill up all positions especially zonal entomologists	All States/ UTs
Mortality	Prevent delayed detection	Chhattisgarh (14), Odisha (4), Jharkhand (2) Assam (3), and Rajasthan (1)
Increase in Malaria cases	Fill gaps in vector control strategies	Tripura (31%),Uttar Pradesh(258%), Mizoram(86%) and Punjab(86%) and Bihar (57%)
Enhanced surveillance	Formation of rapid response teams	All States/ UTs







## 2b. Kala-Azar Elimination



Key Issues		
Key issues	Action	States/ UTs
Active case detection and treatment	Ensure six rounds	Bihar, Jharkhand, West Bengal, Uttar Pradesh
Default in treatment	Ensure strong follow up, filling up of patient cards	Bihar, Jharkhand, West Bengal, Uttar Pradesh
Rationalisation of manpower	Relocate KTS and VBD consultants from low endemic to high endemic areas	-do-
Large no. of vacancies	Fill up KTS posts	Bihar (38/186), West Bengal (45/66)
Sand fly breeding	Ensure pucca houses under PMAY-G	Bihar, Jharkhand, West Bengal, Uttar Pradesh
Supervision and surveillance	Extensive field visits by Senior officers, SPOs	Bihar, Jharkhand, West Bengal, Uttar Pradesh


**19% increase in UP upto Aug. 2019, state failed to sustain elimination at block level**

## 2c. Lymphatic Filariasis

*45% of Gobar burden with 10.63 lac cases*

**Target : DECREASE Mf RATE TO < 1 PERCENT by 2021**







## Key Issues

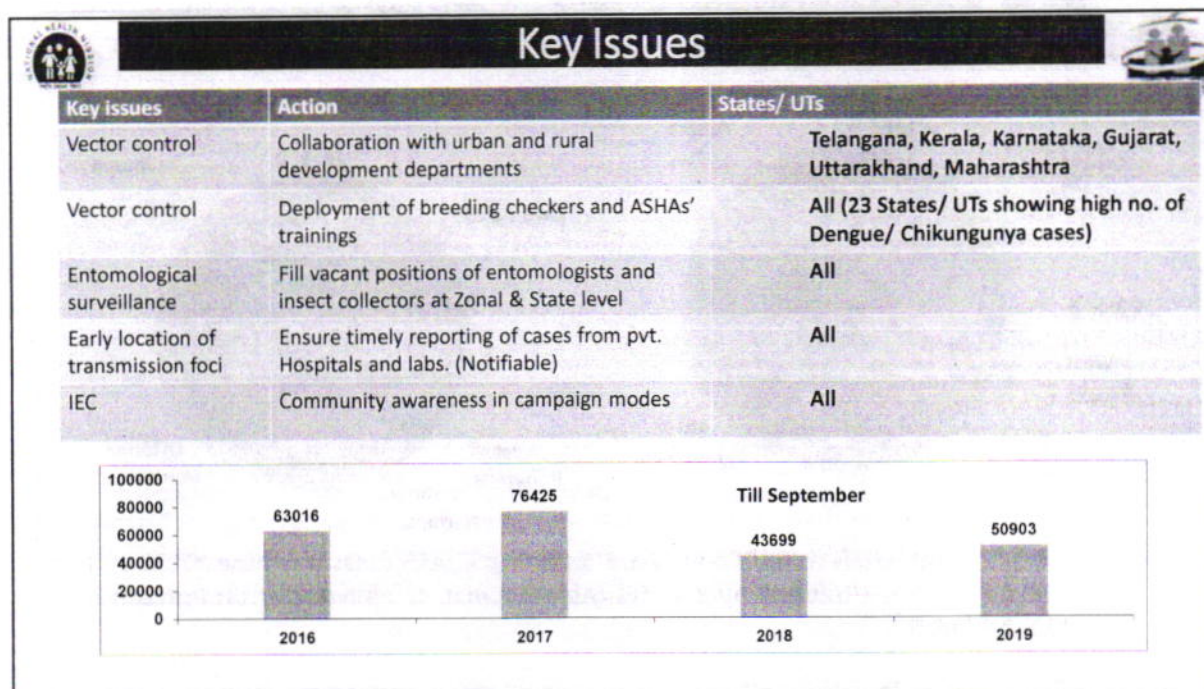
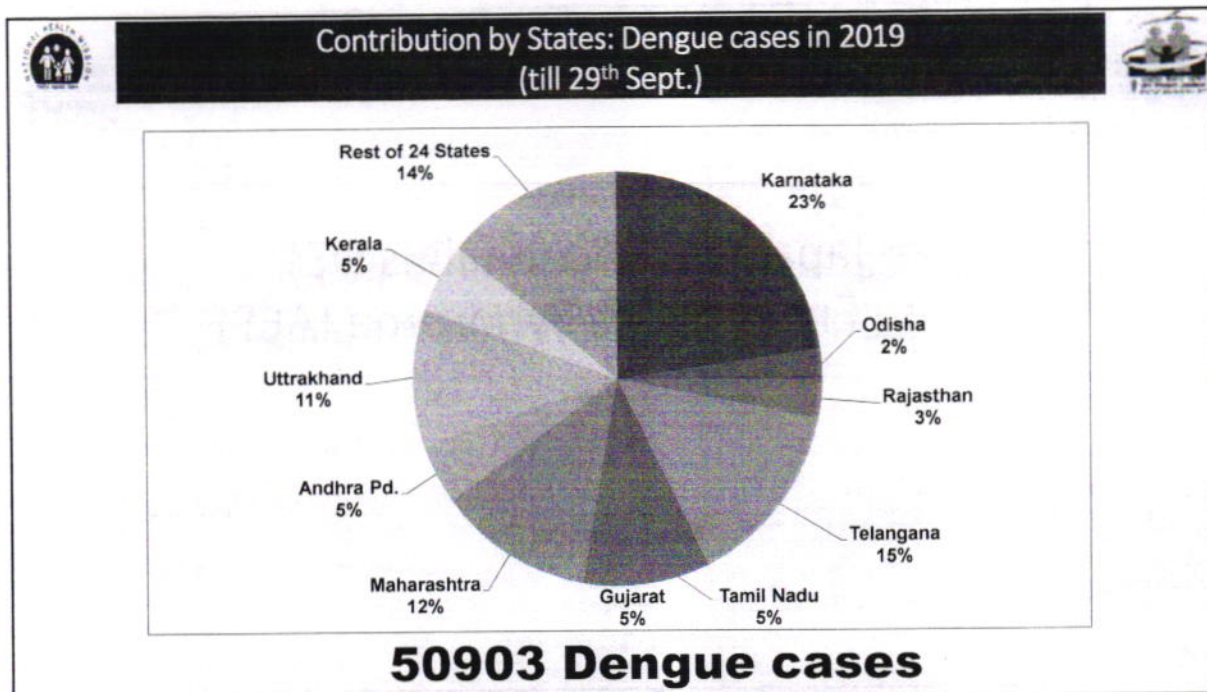


Key Issues	Action	States/ UTs
Drug compliance	Promote supervised drug administration under MDA	Bihar, Jharkhand, UP, MP, Chhattisgarh, Odisha, West Bengal, Maharashtra, Karnataka
Early elimination	Triple drug therapy	Bihar (Arwal), Jharkhand (Simdega), UP (Varanasi & 11 other districts), Maharashtra (Nagpur), Karnataka (Yadgir)
Successful MDA campaigns	Preparation of microplans, engagement of DCs, Strong IEC, Post MDA assessment	All 21 States/ UTs
Night blood survey	Make trained manpower available	All 21 States/ UTs
Morbidity management and disability prevention	Linelist cases for hydrocelectomy & lymphedema management	All 21 States/ UTs



## 2d. Dengue and Chikungunya





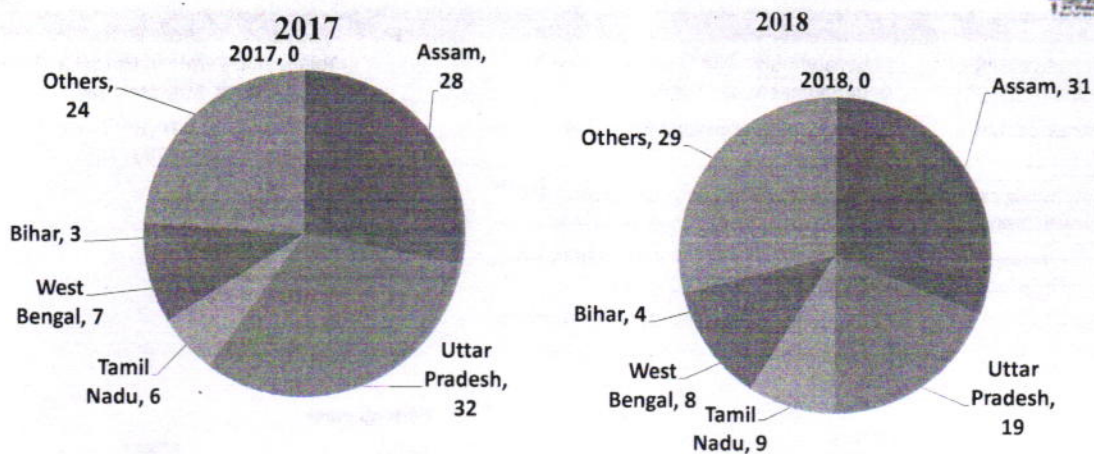




## 2e. Japanese Encephalitis (JE)/ Acute Encephalitis Syndrome (AES)



### State-wise Proportion JE cases – 2017 & 2018 (up to Dec)



- 22 out of 36 States/UTs in the Country are reporting JE/AES cases of these ~70% of disease burden is contributed by 5 States (Assam, Bihar, Tamil Nadu, Uttar Pradesh and West Bengal).

Key Issues		
Key issues	Action	States/ UTs
Poor JE vaccination coverage	Enhanced coverage to atleast 80% under RI	22 States/ UTs (Especially Assam, Odisha, Meghalaya)
Cover leftover children for vaccination	Identify block wise left over children and special drives at block level	-do-
Early referral of AES cases	Strengthen ASHAs through trainings	-do-
Intensive care	PICUs to be made fully functional	Assam, Bihar, Uttar Pradesh
Physical and medical rehabilitation for JE disabled patients	PMR department to be made functional	Assam, Bihar, Uttar Pradesh, West Bengal

Resolutions: Malaria, Kala-azar, Filariasis , Dengue & Chikungunya	
<p>"The CCHFW recognizes that time bound action needs to be taken in respect of Vector Borne Diseases, and, therefore, we commit to the following:-</p> <ul style="list-style-type: none"> <li>• Malaria elimination i.e. "Zero Indigenous Transmission" in 15 low endemic states by 2020.</li> <li>• Kala Azar : Expediting construction of Pucca houses in Kala Azar affected villages under Pradhan Mantri Awaas Yojna- Gramin, and strengthening of active case detection activities to achieve elimination by 2020.</li> <li>• Lymphatic Filariasis : Expanding Triple Drug Regimen (IDA) for Mass Drug Administration in order to achieve elimination target by 2021.</li> <li>• Dengue, Chikungunya and Japanese Encephalitis: Strengthening Prevention and control of the disease by following the National Guidelines.</li> </ul>	



### 3. Leprosy



#### Why NLEP is important



- Leprosy, if not detected in time and treated, is a dreadful disease; Causes Grade II disability

Key issues		
Issue	Action	States/UT
Least priority area - absence of sufficient manpower, trainings & reviews	<ul style="list-style-type: none"> <li>Provision of full time SLOs/DLOs and other level of functionaries with no additional charges</li> <li>Conduct of trainings</li> <li>Regular Review by Health Secretaries/ Health Ministers</li> </ul>	<ul style="list-style-type: none"> <li>All States/UTs</li> </ul>
Elimination target not achieved/ reverted	To bring Prevalence Rate (PR) < 1/ 10,000 population	Chhattisgarh, Odisha, DNH, Chandigarh
High Grade II Disability (G2D)/ million population & High G2D % among new cases	<ul style="list-style-type: none"> <li>To bring G2D to &lt;1 case/ million population</li> <li>Early Detection and treatment &amp; PEP</li> </ul>	All States/ UTs <ul style="list-style-type: none"> <li>Tripura, Meghalaya, Manipur, A&amp;N Islands, Puducherry, Nagaland, Arunachal Pradesh, Delhi</li> <li>Assam, HP, Kerala, Punjab</li> </ul>
High Child cases & Child Disability	Early Detection and treatment & PEP Reconstructive surgeries and rehabilitation	<ul style="list-style-type: none"> <li>Bihar, Maharashtra, Tamilnadu, UP, WB, Jharkhand, Chhattisgarh, Gujarat, AP, Assam, MP, Odisha, Telangana, Delhi, Karnataka, Haryana</li> </ul>

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Key issues		
Issue	Action	States/UT
Strengthening of ABSULS	Training of ASHAs for regular screening and suspect identification	<ul style="list-style-type: none"> <li>All States/UTs</li> </ul>
Convergence of leprosy with other health programmes	Screening for leprosy under RBSK, Comprehensive primary healthcare under NHM	<ul style="list-style-type: none"> <li>All States/UTs</li> </ul>
Hard To Reach Areas not covered	Special strategies to access needed	<ul style="list-style-type: none"> <li>Chhattisgarh, Jharkhand, MP, all Northeast States, HP, UK, DNH, A&amp;N Islands, UP, AP, WB, J&amp;K, Odisha, Gujarat, TN, Goa, Rajasthan, Kerala, Karnataka, Telangana</li> </ul>
Discriminatory Laws	Repeal such laws	<ul style="list-style-type: none"> <li>All States/ UTs (Except Chandigarh, Jharkhand, Lakshadweep, A&amp;N, D&amp;NH, HP, Manipur, Mizoram, Nagaland, Tripura, UK)</li> </ul>

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## Resolution



"The CCHFW recognizes that Leprosy is a serious public health problem. Therefore, we commit to reduce Grade II Disability (G2D)/ million population to 1.7 by 2020 & to <1 by 2022, in order to make India Leprosy Free by 2030."

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## 4. National Viral Hepatitis Control Programme

## National Viral Hepatitis Control Program

Issue	Action required
Establishment of State Viral Hepatitis Management Unit	Established : 31 States/UTs
State Steering Committee	Pending in – MP, A&N Islands, Chandigarh, D&NH and Daman & Diu Established : 25 States/UTs
Model Treatment Centre/Treatment Centre	Pending in – Goa, MP, Mizoram, Uttarakhand & all UTs MTCs Established in 22 States/UTs – 24 functional  Pending in: Andhra Pradesh, Chhattisgarh, Karnataka, Kerala, MP, Meghalaya, Mizoram, Odisha, Puducherry, UP, Uttarakhand, A&N, Chandigarh, Assam  TCs functional in 95 districts – (Completed in Punjab, Haryana, J&K, Gujarat)

## National Viral Hepatitis Control Program

Activities		Status
Training Progress	Medical Officers	Training Completed: 18 States
	Lab Tech	Training Completed: 15 states
	M& E Portal	Training Completed: 10 states Bihar, Goa & Sikkim have done only for M&E
Immunization of Health Workers		Completed in Himachal & Maharashtra Started in Gujarat, Mizoram, Tamil Nadu & Telangana, Haryana



**Resolution:**

The CCHFW resolves to implement the National Viral Hepatitis Control Programme and to start free of cost diagnostics and treatment services for Hepatitis B & C infected patients up to the district level initially by 2020 and subsequently up to the sub-district level.

## 5. National AIDS Control Programme

National AIDS Control Programme: Issue and Action Required		
S No	Issue	Action Required
1	State rules for HIV and AIDS (Prevention & Control) Act, 2017 are not yet notified	All States and UTs (except Chhattisgarh, Jharkhand, Karnataka and Punjab) have to draft State specific rules based on their HIV prevalence, geography, administration and positive population. Central Govt rules may be referred while formulating the State rules
2	Universal HIV testing of pregnant women for early detection of HIV positive pregnant women to prevent parent to child transmission not happening	<ul style="list-style-type: none"> <li>• Saturation of Health facilities in term of HIV screening/testing in Sub-health Centre, Primary Health Centre, Community Health Centre, Sub Divisional Hospital and District Hospitals. (Saturation defined as the facility having the HIV Screening or Confirmation Facility).</li> <li>• Inclusion of HIV screening at all VHSND session conducted in States/UTs for Pregnant Women to be screened for HIV in their first trimester.</li> <li>• Registration of all diagnosed HIV positive pregnant women at Anti-retroviral therapy (ART) centre.</li> <li>• Timely screening and initiation of HIV exposed babies on ART treatment as per the guidelines</li> </ul>
3	The 100% voluntary blood donation to ensure safe and high quality blood transfusion services is not being implemented	<ul style="list-style-type: none"> <li>• State Blood Transfusion Council under chairpersonship of Principal Secretary (H) must be revived and strengthened</li> <li>• Funds should be allocated by State governments for conduction of blood donation camps and retention of voluntary blood donors</li> <li>• Multi-sectoral approach through engagement with voluntary organizations, professional associations, corporate and educational institution is required for engaging with the healthy individuals to donate blood regularly.</li> <li>• Communication and advocacy is required with all stakeholders to sustain voluntary blood donation.</li> </ul>

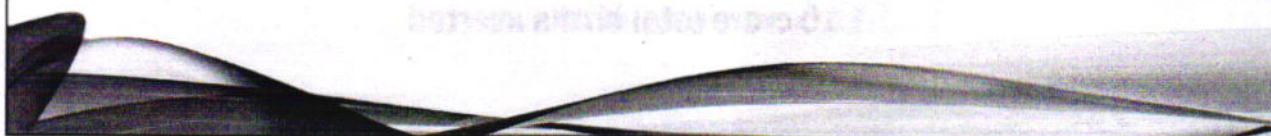
National AIDS Control Programme: Resolution
<ul style="list-style-type: none"> <li>• Elimination of Mother to Child Transmission of HIV</li> </ul> <p>Elimination of Mother to Child Transmisison (EMTCT) of HIV is critical to achieving end of AIDS. The CCHFW recognizes that it is important that no baby is born with HIV in India and resolves to undertake universal HIV testing of all pregnant women so as to ensure early identification of HIV positive pregnant women and their early initiation on Anti-retroviral therapy.</p> <ul style="list-style-type: none"> <li>• Provision of safe and high-quality blood</li> </ul> <p>Voluntary Blood donation is the cornerstone of ensuring availability and access to safe and high-quality blood and blood components to all those who require transfusions. The CCHFW recognizes the invaluable contribution of voluntary blood donation and resolves that the institutional arrangement of State Blood Transfusion Council will be revived and strengthened for the coordinated functioning of blood transfusion services aiming towards 100% voluntary blood donation.</p>



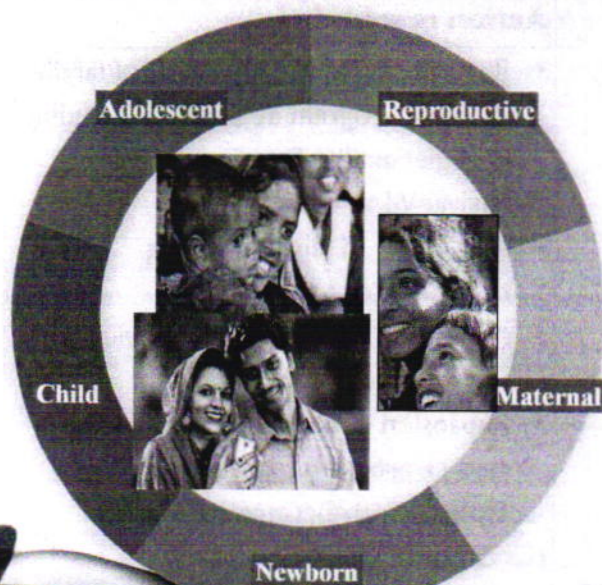


## SESSION IV

# Reproductive and Child Health



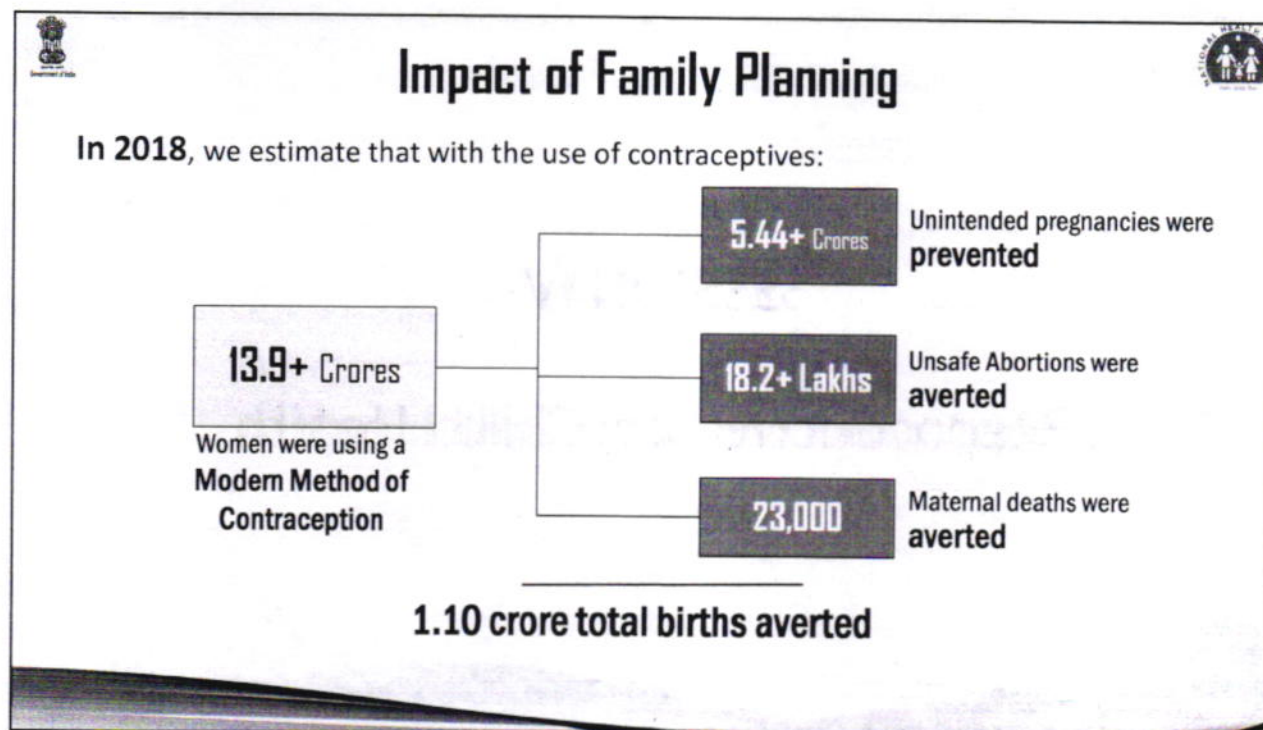
## The RMNCAH STRATEGY



•This is a comprehensive strategy for improving the maternal and child health outcomes

•Links maternal and child survival to other components (family planning, adolescent health, gender & PC & PNDT)

•This is built upon the continuum of care' concept and focuses on the strategic 'life cycle approach'.



<b>FAMILY PLANNING: Core of MCH</b>		
<b>S. No.</b>	<b>Issues</b>	<b>Action required</b>
1.	<ul style="list-style-type: none"> <li>• <b>High unmet need</b> continues</li> <li>• <b>Birth Spacing of less than 3 years</b> in nearly half the births</li> </ul>	<ul style="list-style-type: none"> <li>• Regular performance review of family planning program at all levels including in High Fertility Districts (Mission Parivar Vikas districts).</li> <li>• Availability of family planning commodities to the last mile</li> <li>• A commitment to quality service provisioning.</li> <li>• Expansion of basket of choice viz. Antara program (Injectable Contraceptive), Centchroman pill (Chhaya), PPIUCD</li> </ul>
2.	States of BH, UP, MP, RJ, JH, NG, MN and MG are not likely to reach the National Health Policy target of achieving <b>replacement level of fertility</b> of 2.1 by 2025.	



Maternal Health: Ending all preventable Maternal Deaths	
SN.	Importance
1. <b>Surakshit Matritva Aashwasan (SUMAN)</b>	-In spite of so many initiatives, people accessing the public health facilities (PHFs) still find challenges in getting absolute free and comprehensive care during pregnancy and childbirth with respect to autonomy, dignity, choices and preference .
2. <b>LaQshya</b>	-Approximately 46% maternal deaths, over 40% stillbirths and 25% of under-5 deaths take place on the day of the delivery. -Half of the maternal deaths each year can be prevented if we provide higher quality health care. LaQshya ensures quality service delivery around birth.
3. <b>Midwifery</b>	Recent evidence indicates that when midwives are educated to international standards, it could avert more than 80% of all maternal deaths, still births and neonatal deaths
4. <b>FRU</b>	-Out of total pregnancies, nearly 15% end up in complication and require specialized EmOC care through FRU.

## Maternal Health: Ending all preventable Maternal Deaths- cont.

SN.	Issues	Action required
1.	<b>Surakshit Matritva Aashwasan (SUMAN):</b> Lack of Service Guarantee in Public Health Facilities.	<ul style="list-style-type: none"><li>■ Implementation for<ul style="list-style-type: none"><li>➤ Free and assured package of services for pregnant women</li><li>➤ Responsive call center for grievance redressal</li><li>➤ Robust client feedback mechanism</li><li>➤ Community involvement and awards to safe motherhood champions</li></ul></li></ul>
2.	<b>LaQshya:</b> Need to accelerate State & National LaQshya Certification.	<ul style="list-style-type: none"><li>■ All State Certified facilities should apply for National certification within three months..</li><li>■ Rest of LaQshya identified facilities should prepare action plan for gap closure based on issues identified during baseline assessment.</li></ul>

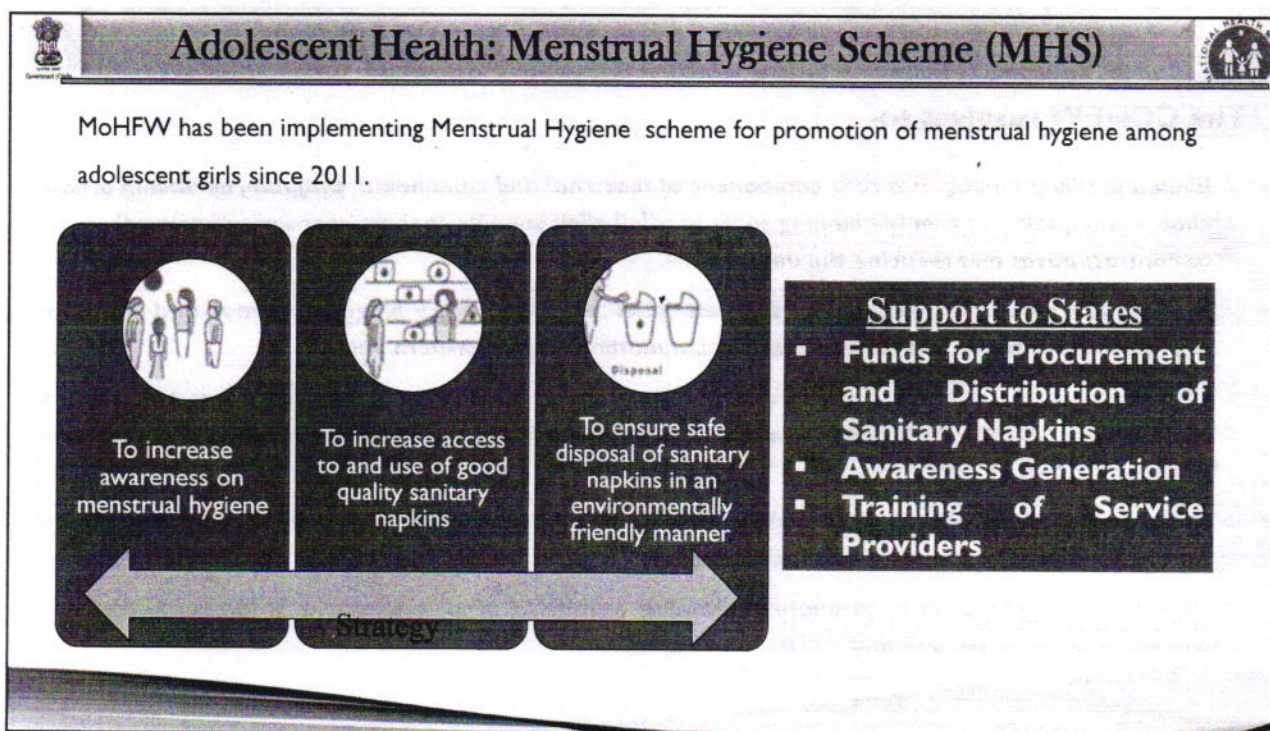
SN.	Issues	Action required
3.	<b>Midwifery:</b> Need to improve Quality of Care and ensure care with respect in dignity	<ul style="list-style-type: none"> <li>▪ Roll out of Midwifery initiative</li> </ul>
4.	<b>FRU:</b> Lack of CEmOC/EmOC services	<ul style="list-style-type: none"> <li>▪ Ensuring full-fledged CEmOC/EmOC service delivery at all identified FRUs.</li> <li>▪ Rational deployment of Human Resource (Use NHM flexibility)</li> </ul>

	Importance of Immunization
	<ul style="list-style-type: none"> <li>• One of the most cost effective public health interventions and largely responsible for reduction of under-5 mortality due to Vaccine Preventable Diseases (VPDs).</li> <li>• Vaccines not only provide protection against specific VPDs but also positively impact health, cognitive development and productivity.</li> <li>• As per WHO estimates, worldwide 2 to 3 million deaths are prevented every year through immunization against diphtheria, tetanus, whooping cough, and measles,.</li> <li>• A study conducted by Johns Hopkins University found that for every dollar invested in vaccination in the world's 94 lowest-income countries, US\$ 16 are expected to be saved in healthcare costs, lost wages and lost productivity due to illness and death.</li> </ul>





SN.	Issues	Action required
1.	<b>Full immunization coverage (FIC)</b> of many states <90%	Regular review of the program for RI strengthening
2.	<b>Measles Elimination targeted by 2023: MRCV-1 &amp; MRCV-2</b> • coverage under RI < 85% • > 30% drop out from MRCV-1 to MRCV-2	<ul style="list-style-type: none"> <li>State specific communication strategy</li> <li>Impactful implementation of supplementary immunization activities like Mission Indradhanush &amp; Intensified MI</li> <li>Lessons learnt during MI &amp; IMI to be integrated into RI.</li> </ul>

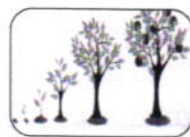
MRCV: Measles Rubella containing vaccine, RI: Routine Immunization






**SCHOOL HEALTH PROGRAMME TO BE ROLLED OUT SHORTLY**








**Growing Up Healthy**




**Emotional Well-being and Mental Health**




**Interpersonal Relationships**




**Values and Responsible Citizenship**




**Gender Equality**



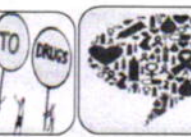
**Nutrition, Health and Sanitation**




**Promotion of Healthy Life Style**




**Prevention and Management of Substance Misuse**



**Reproductive Health and HIV Prevention**





**Safety and Security Against Violence and Injuries**



**Promotion of Safe Use of Internet and Social Media Behaviors**

- Two teachers in every school designated as "Health & Wellness Ambassadors" will be trained in a 24-hour curriculum (24 sessions – 1 hr/ session) to transact age appropriate, culturally sensitive activity based weekly sessions
- Existing infrastructure of School Education Department will be used for capacity building of Health and Wellness Ambassadors

**Resolution for Adoption in Conference**

**The CCHFW resolves to-**

- Embed family planning as a core component of maternal and child health program, by driving access, choice and quality of family planning services to all eligible couples, thereby ensuring universal access to contraceptives and reducing the unmet need.
- Provide free, comprehensive, quality and respectful services to every pregnant woman and new-born and work towards the goal of zero preventable maternal and new-born deaths.
- Undertake all measures including the proactive steps to implement newer initiatives like Anemia Mukh Bharat (AMB), Home Based Care for Young Child (HBYC) for improving the Health & Nutrition of every child in our State.
- Make every effort to reach each and every eligible child repeatedly to give all vaccines and ensure that no child dies of vaccine preventable diseases.
- Take adequate measures to promote health and well-being of all adolescents with special focus on Menstrual hygiene scheme and school health program.





***“Health of mothers will determine the health of our children. Health of children will determine the health of our tomorrow”***

***- Shri Narendra Modi  
during Partners' Forum 2018***

## Session V

### NON COMMUNICABLE DISEASES:

- NPCDCS
- NMHP
- NPHCE
- NPCB&VI
- NTCP

### PRESENTATION ON NATIONAL PROGRAMMES FOR

- Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke
- Health Care for Elderly
- Mental Health & implementation the Mental Healthcare Act
- Control of Blindness and Visual Impairment



## CONTEXT : RISING BURDEN OF NCDs

- Contribution of major disease groups to deaths

Disease Group	Percent of deaths to total deaths	
	1990	2016
Communicable, maternal, neonatal and nutritional diseases	53.6	27.5
Non communicable diseases	37.9	61.8
Injuries	8.5	10.7

- Major NCDs by their contribution to death (2016) – CVDs (28.1%), Chronic Respiratory Disease (10.9%), Cancers (8.3%)

## NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE (NPCDCS)

### Being implemented under NHM with focus on :

- strengthening infrastructure
- human resource development
- early diagnosis
- management and referral.

### Setting up of Tertiary Cancer Care facilities – State Cancer Institutes and Tertiary Care Cancer Centres

(15 SCIs and 20 TCCCs approved upto March, 2018 and 2 more SCIs at Jammu and Jabalpur approved in 2019-20)

### PROGRESS UNDER NPCDCS

Sl. No.	Type of facility	Approved	Functional
1	State NCD Cell	36	36
2	District NCD Cells	688	543
3	District NCD Clinics	706	585
4	Cardiac Care Units (CCU)	251	168
5	District Day Care Centres	276	168
6	CHC NCD Clinics	5351	3084

### POPULATION-BASED PREVENTION INITIATIVE FOR PREVENTION, SCREENING AND CONTROL OF COMMON NCDs

- Population Level initiative for prevention, control & screening for common NCDs being implemented as a part of comprehensive primary health care.
- Persons more than 30 years of age are targeted for screening for common NCDs. Screening services are being provided through trained frontline workers
- Referral support and continuity of care are through PHC, CHC, District Hospitals and other tertiary care institutions.
- Currently PBS has been approved in 219 districts – need to be expanded to remaining Districts.
- 1,55,084 ASHAs, 37,584 ANM/MPWs, 10,135 Staff nurses and 11,024 Medical officers have been trained on screening of common NCDs.



## COMPREHENSIVE PRIMARY HEALTH CARE - NCD APPLICATION

- An IT platform to monitor and supervise PBS and to ensure continuum of care
- Pre-requisites for successful roll-out of the application :
  - Procurement/availability of tablets for ANMs
  - IT infrastructure at different levels of health facilities upto District level
  - Training of health professionals in use of the application
- States being assisted financially for procurement of tablets and other IT infrastructure
- Deployment support, including training of health personnel, being provided by Tata Trusts

## COMPREHENSIVE PRIMARY HEALTH CARE - NCD APPLICATION

### Status of use of NCD application

- So far 1,19,817 tablets have been procured.
- In 5 States/UTs, (Delhi, West Bengal, Lakshadweep, Uttarakhand, and Rajasthan) procurement process has not progressed at all.
- In many States/UTs the tablets procured is too less in comparison to the requirement.
- 19736 Health Professionals trained on NCD Application till 17/09/2019 across Pan India.
- 6 states namely Andhra Pradesh, Gujarat, Himachal Pradesh, Kerala, Tamil Nadu, Dadra & Nagar Haveli using their own NCD software application. One time data from these states successfully migrated in GOI NCD Application, prospective data is not getting updated on real-time basis.
- Till the first week of 17<sup>th</sup> September, 2019, total enrolment through NCD application is 8.36 crore and 1.30 crore were screened.

## ISSUES

- 26 states have procured tablets, of which few of them have procured tablet much lesser than required (Odisha, Chhattisgarh, Jharkhand, Telangana, Kerala, TN UP, Gujarat, MP, Maharashtra, and AP).
- Five States/UTs have not procured tablets (Delhi, West Bengal, Lakshadweep, Uttarakhand, and Rajasthan).
- While Total number of Tablets procured stands at 1.19 lakhs, the number of ANMs using tablet regularly is only about 14300 (about 12%).
- Usage of Application by the Medical Officers has not taken off. Less than 2,000 MOs are found using the NCD Application.
- States need to come forward for any requirement for conducting training of field functionaries.
- Need for regularly review of status of usage of NCD application by States/UTs.

## HEALTH CARE OF ELDERLY

- Elderly population (60+years) constituted 8.6% of the total population in 2011
- In 2011, the old-age-dependency ratio was 14.9% and 13.6% for males and females respectively
- the proportion of population above 60 years will be almost 20 % by 2050.
- Objective of NPHCE is to provide accessible, good quality, affordable and dedicated health care services to the Ageing population



## NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY (NPHCE)

### COMPONENTS:

- NHM – Primary and secondary care service delivery through District Hospitals, CHCs, PHCs and sub-centres –
  - Geriatric clinics at PHC and CHC
  - OPD services and 10 bedded geriatric ward at District Hospitals
- Tertiary component: through Regional Geriatric Centres located in 19 medical colleges in 18 States and two National Centres of Ageing – AIIMS, New Delhi and Madras Medical College, Chennai and

## NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

### Burden of Mental Disorders

- Common mental disorders (CMDs), including depression, anxiety disorders and substance use disorders affect nearly 10.6% of the population
- 150 million people in India are in need of intervention for mental disorders.
- 1 in 20 person in the country currently suffers from depression out of which 39% suffer from Severe Depression
- 0.9 % of the population at high risk of suicide
- 3 out of 4 persons with mental disorders had disabilities affecting their work, family, education and other aspects of life.

Source : Key findings of the National Mental Health Survey conducted by Ministry of Health and Family Welfare through NIMHANS, Bengaluru in 12 States (2016).

## COMPONENTS OF NMHP

- **District Mental Health Program (DMHP) under NHM**
  - Support provided to States/UTs for making provision of basic mental health services for early detection & treatment of mental illness at the District Hospital - support for human resource, training, community awareness
  - Till date a total of 655 districts have been covered under the District Mental Health Programme.
- **Tertiary Care Component**
  - Manpower Development Scheme – Creation of specialist manpower by setting up of Centres of Excellence and Strengthening/ Establishment of Post Graduate Departments in mental health specialties

## MENTAL HEALTHCARE ACT, 2017

- Mental Healthcare Act, 2017 came into force w.e.f. 29/05/2018
- In pursuance of the provisions of the Mental Healthcare Act, 2017, Rules under the Act were also framed by the Central Government
- Provisions of the Act are however to be implemented primarily by the State Governments.
- Priority actions required from the State Governments on:
  - establishment of State Mental Health Authorities
  - creation of State Mental Health Authorities Funds
  - establishment of Mental Health Review Boards
  - framing of Rules and Regulations



## MENTAL HEALTHCARE ACT, 2017 - ISSUES

- State Mental Health Authorities yet to be established in the 17 States/UTs. (A&N Islands, Arunachal Pradesh, Bihar, Chandigarh, Chhattisgarh, Dadra & Nagar Haveli, Daman & Diu, Delhi, Goa, Haryana, J & K, Lakshadweep, Madhya Pradesh, Meghalaya, Puducherry, Rajasthan, West Bengal)
- States/UTs should inform about the action taken on implementation of other provisions of the Mental Healthcare Act, 2017, namely:
  - Establishment of State Mental Health Authorities
  - Establishment of Mental Health Review Boards
  - Creation of State Mental Health Authority Fund
  - Adoption of the Rules framed by the Central Government/framing of rules by the States/UTs.
  - Framing of Regulations by the State Mental Health Authorities.

## BLINDNESS AND VISUAL IMPAIRMENT

- Prevalence of Blindness - 1.1% (2001-02), 0.68% (2006-07), 0.36% (2015-19 survey)
- WHO Goal – reduction of prevalence of avoidable blindness to 0.3% by 2020.
- Major Causes of Blindness
  - Cataract (66.2%)
  - Corneal opacity (7.4%)
  - Surgical Complication (7.2%)
  - Posterior segment disorder (5.90%)
  - Glaucoma (5.50%)
  - Others (4.19%)

## NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT

### ○ Major Activities under NHM Component

- Free cataract surgery
- Eye Screening and Distribution of Free spectacles to School children and elderly
- Collection of Donated Eyes through network of eye banks and eye donation centres
- Diagnosis and Treatment of other eye diseases (glaucoma, childhood blindness, squint etc.)

### ○ Major activities under tertiary care component

- Provision of super specialty and referral eye care services for diabetic retinopathy, Glaucoma, childhood blindness, retinopathy of prematurity and Keratoplasty (corneal transplantation) etc. at Regional Institutes of Ophthalmology and Medical Colleges.
- Construction of modular Eye OTs at RIOs for providing modern and tertiary level eye care services

## NATIONAL PROGRAMMES -ISSUES FOR DISCUSSION

### ○ Common issues

- Low utilisation of resources allocated under NHM
- Delay in making approved facilities functional
- Non-availability of required manpower at approved facilities, impacting delivery of services
- Non-submission of Utilisation Certificates

### ○ Programme specific issues

- Population based screening and use of NCD app to be expanded to all the Districts
- District Mental Health Programme to be expanded to cover all the Districts
- Sporadic episodes of cluster enophthalmitis, need to strictly adhere to prescribed eye surgery guidelines.



### UTILIZATION OF RESOURCES ALLOCATED UNDER NHM

S.No	Programme	States with less than 50% utilization
1	<b>NPCDCS</b>	Bihar, Delhi, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Meghalaya, Nagaland, Odisha, Puducherry, Telangana, Tamil Nadu, Tripura, Arunachal Pradesh, Andaman & Nicobar Island, Chandigarh, Daman & Diu, Uttarakhand, Karnataka, Assam, Madhya Pradesh, Haryana, Maharashtra, Punjab (23 States/UTs)
2	<b>NPHCE</b>	Andhra Pradesh, Bihar, Goa, Haryana, J&K, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Uttar Pradesh, Uttarakhand, Telangana, Assam, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, A&N Islands, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, Delhi & Puducherry (27 States/UTs)
3	<b>NMHP</b>	A&N Island, Andhra Pradesh, Arunachal Pradesh, Assam, Bihar, Chandigarh, Chhattisgarh, Daman & Diu, Delhi, Goa, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Lakshadweep, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Punjab, Puducherry, Rajasthan, Sikkim, Tamilnadu, Telangana, Tripura, Uttar Pradesh, Uttarakhand, West Bengal (34 States/UTs)
4	<b>NPCBVI</b>	Bihar, Chhattisgarh, Goa, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Uttar Pradesh, Uttarakhand, West Bengal, Andaman & Nicobar Island, Chandigarh, Dadra & Nagar Haveli, Arunachal Pradesh, Assam, Mizoram, Nagaland, Sikkim, Tripura, Delhi, Puducherry. (29 States/UTs)

### NPCDCS - LESS THAN 50% APPROVED FACILITIES FUNCTIONAL

Infrastructure	Name of States
District NCD clinics	Telangana, Lakshadweep, Delhi, Andaman & Nicobar Island, Daman & Diu (5 States/UTs)
CHC NCD Clinics	Bihar, Goa, Jammu & Kashmir, Kerala, Odisha, Telangana, Tripura, West Bengal, Dadra Nagar & Haveli, Delhi, Assam, Haryana, Manipur, Rajasthan, Uttar Pradesh, Uttarakhand, Andaman & Nicobar Island, Daman & Diu (18 States/UTs)
CCUs	Chhattisgarh, Jammu & Kashmir, Bihar, Goa, Jharkhand, Kerala, Odisha, Tripura, Lakshadweep, Arunachal Pradesh, Assam, Gujarat, Haryana, Uttar Pradesh, Uttarakhand, Andaman & Nicobar Island (16 States/UTs)
Day Care Centres	Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Tamil Nadu, Telangana, Tripura, West Bengal, Lakshadweep, Puducherry, Arunachal Pradesh, Gujarat, Maharashtra, Manipur, Punjab, Uttar Pradesh, Uttarakhand (17 States/UTs)



### NPHCE - LESS THAN 50% APPROVED FACILITIES FUNCTIONAL

Infrastructure	Name of States
District level	J&K, Jharkhand, Rajasthan, Telangana, Manipur, A & N Islands, Lakshadweep - 7 States/UTs
CHC level	Himachal Pradesh, UP, Bihar, Jharkhand, Orissa, Gujarat, MP, Rajasthan, Tamil Nadu, Telangana, Arunachal Pradesh, Assam, Manipur, Mizoram, Nagaland, A & N Islands, Lakshadweep - 17 States/UTs
PHC level	Himachal Pradesh, J&K, Punjab, UP, Bihar, Jharkhand, Orissa, West Bengal, Gujarat, MP, Rajasthan, Karnataka, Kerala, Tamil Nadu, Telangana, Arunachal Pradesh, Assam, Manipur, Mizoram, Nagaland, Sikkim, A & N Islands, Lakshadweep - 23 States /UTs

### NPCBVI - PHYSICAL PERFORMANCE OF STATE/UTs

Three Signature Activities under NPCBVI	Name of States / UTs (Performance less than 50% of the target)
Cataract Operations	Jammu & Kashmir, Meghalaya, Lakshadweep, Sikkim, Nagaland, A&N Nicobar, Assam, Arunachal Pradesh, Daman & Diu, Manipur
Free Spectacles to School Children	Bihar, Haryana, Himachal Pradesh, Kerala, Maharashtra, Rajasthan, Telangana, Arunachal Pradesh, Manipur, Sikkim, Chandigarh, Daman & Diu
Cornea Collection	Bihar, Goa, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Uttarakhand, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Sikkim, Tripura, A & N Nicobar, D&N Haveli, Daman & Diu, Lakshadweep



## ACTION REQUIRED FROM STATE GOVERNMENTS

- Improve utilisation of allocated resources under NHM
- Approved facilities under different programmes to be made functional at the earliest
- Population based screening and use of NCD app for effective monitoring and continuum of care to be expanded to all the Districts
- Cover all the District under the Mental Health Programme
- All the provisions of the Mental Healthcare Act to be implemented in time-bound manner
- Projects under the Tertiary care components should be completed by March, 2020 – further release of Central assistance will be on reimbursement basis.

## RESOLUTION ON NON-COMMUNICABLE DISEASE CONTROL PROGRAMME - NPCDCS, NPCB&VI and NPHCE.

*"In view of the increasing burden of NCDs, there is a need to strengthen the service delivery for NCDs. Towards this end, the CCHFW resolves that all the facilities approved up to 2018-19, under the National Programme for Prevention and Control of Diabetes, Cancer, Cardiovascular Diseases and Stroke (NPCDCS), National Programme for Health Care of Elderly (NPHCE) and National Programme for Control of Blindness and Visual Impairment (NPCB&VI) will be made fully functional at the earliest. Efforts will be made to complete the approved tertiary care facilities under the above mentioned programmes by March, 2020.*

*The CCHFW also resolves to scale up the Population Based screening for common NCDs to all the Districts and universalize use of NCD app for effective monitoring of screening and ensuring continuum of care."*

## RESOLUTION ON MENTAL HEALTH

*"Recognizing the growing challenge of Mental Health and requirement under the Law, the CCHFW resolves to implement all provisions of the Mental Healthcare Act, 2017 and take immediate steps to constitute State Mental Health Authorities, create State Mental Health Authority Fund, constitute State Mental Health Boards at District Level and frame required Rules and Regulations under the Act.*

*The CCHFW also resolves to implement the District Mental Health Programme (DMHP) in all the Districts and to make functional all the approved outdoor and indoor patient facilities in the Districts.*

*On the occasion of World Mental Health Day, 2019, CCHFW also resolves to:*

- i. strengthen our governance and institutional capacities to effectively implement comprehensive suicide prevention plans;*
- ii. ensure effective coordination among multiple stakeholders for delivering a range of suicide prevention interventions;*
- iii. enhance the capacity of health services and gate keepers to provide suicide prevention services; and*
- iv. develop community resilience and societal support for suicide prevention and reduce stigma associated with suicidal behaviours"*



## National Tobacco Control Programme (NTCP)

### National Tobacco Control Programme (NTCP)

Issue	Action required by the State
Enforcement of Ordinance on Prohibition of Electronic Cigarettes	Necessary directions may be issued for strict enforcement of the provisions of the Ordinance.
	Necessary measures may be taken for creating awareness about the harmful effects of e-cigarettes via social media/TV/Radio.
	Vigilance against use of e-cigarettes in the premises of schools and colleges, specially among the students.

National Tobacco Control Programme (NTCP)	
Issue	Action required by the State
Enforcement of Cigarettes and Other Tobacco Products Act (COTPA), 2003	Quarterly review of enforcement efforts at state level.
	<b>QR's not submitted:</b> Andaman & Nicobar Islands; Chandigarh, Dadra & Nagar Haveli; Daman & Diu; Goa, Himachal Pradesh; Kerala; Madhya Pradesh; Manipur; Meghalaya; Nagaland; Sikkim; Telangana; West Bengal.
	<b>QR's submitted on intermittent basis:</b> Bihar; Haryana; Maharashtra; Tripura.
	Strict action against the violations of COTPA, 2003 through regular raids and surprise visits to the shops selling tobacco products .

National Tobacco Control Programme (NTCP)	
Issue	Action required by the State
Implementation of Guidelines for Tobacco Free Educational Institutions (ToFEI)	To ensuring the effective implementation of Guidelines for ToFEI in all educational institutions.
	Target to <b>declare the government schools, colleges. Universities 'Tobacco Free' by March 2020.</b>
Action against Pan Masala containing nicotine/ Magnesium Carbonate	Action has been initiated in Maharashtra, Bihar & Rajasthan.  NTTLs have been notified. Samples may be sent for testing for further action.



## **National Tobacco Control Programme (NTCP)**

### **Resolution:**

The CCHFW resolves to effectively implement the ban on e cigarettes and other tobacco control laws to promote well-being of people, especially of our younger generation.

## Session VI

### Regulation and PMSSY

1. Regulation : Medical Education
2. District Residency Programme
3. Public Health Management Cadre
4. Drug Regulation
5. Food Regulation
6. Clinical Establishments Act
7. National Organ Transplantation Programme
8. PMSSY

### Medical Education

<u>Issues</u>	<u>Action required by States/UTs</u>
Constitution of the National Medical Commission	Nominations from State Governments and State Medical Councils
Centrally Sponsored Scheme for New Medical Colleges – Phase-III	Proposals for establishment of new Medical Colleges under Phase-III from States/UTs
Centrally Sponsored Scheme for New Medical Colleges – Phase-I	States/UTs are requested to apply to MCI for permission to start from the academic session 20-21 and complete remaining construction works.
Centrally Sponsored Scheme for New Medical Colleges – Phase-II	DPR for Siwan, Bihar is awaited. Land document for Uluberia, West Bengal is awaited. Construction works to be expedited at all locations.
Centrally Sponsored Scheme for increase of UG & PG seats.	Proposals from States/UTs expected.
Expansion of CPS courses	States/UTs are requested to run CPS courses in District Hospitals



**Contd...**

<u>Issues</u>	<u>Action required by States/UTs</u>
Expansion of DNB courses	States/UTs are requested to run DNB courses in District Hospitals
Reservation of MBBS and PG seats under EWS	States/UTs may apply for increase of UG and PG seats both for normal increase and under EWS quota.
Problem of Quacks	Action taken report from States/UTs against quacks awaited.
Utilisation Certificate	States are requested to send all pending Utilization Certificates under the three schemes.
Dash Board	States/UTs are requested to update dashboard regularly, upload photographs and to expedite progress on ongoing works.
District Residency Programme	MCI is expected to come up with regulations for district residency programme.

## District Residency Program

- ▶ BoG MCI has mandated that all **PG Medical Students of Broad Specialities** to undertake a 3 months Rotation in designated District Hospitals
  - To learn &
  - To serve
- ▶ In 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> semester; part of curriculum; essential for examination
- ▶ To work in respective specialities under the overall directions of the District Hospital head and specialists
- ▶ This will lead to placement of 4-6 house surgeon level specialty doctors in each district hospital

### **'District Residency Program**

- ▶ District Hospital: A functional public sector / government-funded hospital of about 200 beds or more, with specialty facilities/ staff
- ▶ The clinical responsibilities to include outpatient, inpatient, casualty and other areas, and night duties.
- ▶ Quality of training will be ensured by log books, supervision and assessment of work performance
- ▶ The District Hospital Head will issue Certificate of Completion of the Rotation
- ▶ The Residents will continue to draw full stipend/salary from their respective medical colleges for the duration the rotation.

### **Implementation**

- ▶ The State Governments will implement the Scheme in respective states
  - Coordinated jointly by the Department of Medical Education and the Department of Health Services.
- ▶ A rapid landscaping exercise will be carried out to identify hospitals suitable for such rotation
- ▶ The Department of Medical Education will develop a placement schedule at least 6 months in advance



## State Governments

- › Provide appropriate amenities to the Residents.
  - Suitable accommodation (official/rented), transportation to workplace (if living quarters are away), security
- › Reimburse travel costs to and from the place of posting (or make arrangements thereof)
- › Provision for Health insurance/cover during this phase
- › State may consider additional honorarium to the Residents
- › Monitoring training through e-log books and traditional processes.
- › Creating a feedback mechanism for students and colleges.
- › Addressing Residents' grievances / problems, provide helpline.

## Steering / Oversight

- › National Steering Committee at the MoHFW (with members from BoG/MCI, DGHS and states); and a Core Group for coordination
- › State Steering Committees to be headed by Additional Chief Secretary with Principal Secretary (Health), Principal Secretary Medical Education, DHS, DME, Registrar Medical/ Health Sciences University, Deans of Medical Colleges etc. as members.
- › Nodal officers at MoHFW/DGHS, BoG-MCI/NMC and each State

## Draft resolution

- Considering the importance of medical education, the CCHFW members resolve to take steps to increase the availability of doctors and specialists in the country to improve access to quality and affordable healthcare.
- The CCHFW members further resolve for adoption and smooth implementation of District Residency Programme as may be provided for by MCI through regulations.



### 3. Public Health Management Cadre

#### Public Health Management Cadre

- The **National Health Policy** 2017 proposes creation of Public Health Management Cadre in all States.
- It advocates an appropriate **career structure** and **recruitment policy** to attract young and talented **multidisciplinary professionals** from **sociology, economics, anthropology, nursing, hospital management, biomedical engineers, communications, etc.** who have since undergone public health management training.
- States could have Public Health Management Cadre as per their specific requirements.

## A Public Health Management Cadre

- Likely to help **epidemics forecast**, early identification, **warning** and prompt management of public health crisis
- **Comprehensive** planning of preventive, promotive, curative and rehabilitative services - towards an integrated and systemic change.
- **Plan** to prevent and aid in effective disaster management strategies.
- Address the **zoonotic diseases** of public health importance – Rabies, Zika, Ebola, Nipah etc. – recent threats world-wide.

## A Public Health Management Cadre – Tamil Nadu

- Adopts an annual cycle of **anticipatory planning** for responding to potential natural disasters such as floods and cyclones.
- Ensures that the state **capacities** are built with an internal resilience and response to deal with these adverse events.
- A separate **public health directorate** for independent and co-dependent, effectiveness and efficiency to deliver primary health care.
- A **definite career progression** pathway.
- **State Public Health Act** - regulatory authority and powers to enforce public health legislation



### 3. Public Health Management Cadre

#### ☐ Action requested from the States

- To adopt/implement Public Health Management Cadre taking into account comprehensive requirements of the entire health system of the State and its organizational set-up
- To create opportunity for career progression for every health official.

#### **Draft Resolution by CCHFW**

- **“CCHFW Members commit to constitute Public Health Management Cadre in their States by March 2022 to achieve the goal of health for all”**

## 4. Drug Regulations

Issues	Action Required to be taken by States
Signing of MoU	Nine States/UTs requested to sign MoU with GoI
Submission of UCs	States/UTs required to submit UCs along with progress on the projects.
Uploading of data on Sugam Portal	Uploading of manufacturers and products data on Sugam portal (Notification dated 10.01.2019)
Action on Not of Standard Quality (NSQs)	States need to take adequate and swift action on NSQs.
Sampling and Inspection	States are required to ensure adequate sampling and inspection and take actions proportionate to failures and deficiencies.
Setting up of Monitoring Cells	All states are requested to set up monitoring cells on an urgent basis.

## 5. Food Regulations

Issues	Action Required
Registrations and Licenses	<ul style="list-style-type: none"> <li>• Special drives to identify unregistered/ unlicensed FBOs.</li> <li>• Licenses/registrations to be issued promptly.</li> <li>• Activate State Web Portal, helpdesk or helpline.</li> </ul>
Inspections	<ul style="list-style-type: none"> <li>• Adopt IT system for faster processing and transparency, online fee payment.</li> <li>• Food Safety Compliance through Regular Inspections- FoSCoRIS.</li> </ul>
Accredited food/mobile labs	<ul style="list-style-type: none"> <li>• Review food testing laboratories/ NABL accreditation.</li> <li>• FSSAI's Central scheme for strengthening of laboratories.</li> <li>• Participate in INFOLNET (Indian Food Laboratories network).</li> </ul>
Capacity building (training of food personnel)	<ul style="list-style-type: none"> <li>• Participate in Food Safety Training and Certification programme (FoSTaC) of FSSAI.</li> <li>• Appoint senior officers as nodal points.</li> </ul>
Clean street food hubs/ markets	<ul style="list-style-type: none"> <li>• Identify and adopt clusters.</li> </ul>



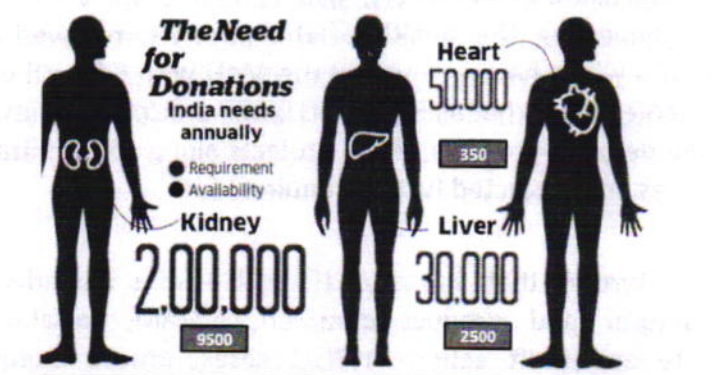
### Eat Right India- Sahi Bhojan Behtar Jeevan

- 'Eat Right India', built on two broad pillars of 'Eat Healthy' and 'Eat Safe'.
- Robust standards & code of practices, credible food testing & effective surveillance, strengthened compliance, strong culture of self-compliance, promoting healthy diets & sustainability and empowered consumers.
- **Key Performance Indicators:** Ease of Living through safe food and healthy diets, Ease of Doing business and trade, creation of Jobs, Skilling on food safety and hygiene, Reduction in foodborne illnesses and NCDs, Food fortification, Food loss and wastage.
- Eat Right Toolkit to be used in all 1.5 lakh Health and Wellness Centres.
- States/UTs to budget for IEC funds.

### 6. Clinical Establishments (Registration and Regulation) Act, 2010

Issues	Action required by the States
States/ UTs which have adopted CE Act, 2010	To ensure effective implementation of the Act and registration of all clinical establishments.
States/ UTs which have their own State specific legislation.	States/ UTs that have their own State specific legislation need to relook their Act to ensure that the provisions are as stringent as C.E. Act, 2010.
State that has neither adopted CE Act, 2010 nor have their own Act	Need to adopt the said Act or create its own.

## 6. National Organ Transplant Programme (NOTP) Why Organ Donation?



## National Organ Transplant Programme (NOTP)

Issues	Action required by the States
Adoption of The Transplantation of Human Organs (Amendment) Act, 2011.	Only 13 States/UTs have so far adopted the Amendment Act.
Establishment SOTTO in each State/UT.	Identify the GMC/ hospitals and send proposal.
Sharing of organ transplant data with NOTTO.	Direction to all concerned hospitals for sharing of data with NOTTO.
Retrieval and organ transplant centres	Identify and deploy organ transplant coordinators.



### **Resolution**

"Recognizing that strengthening of drug regulatory systems is crucial to ensuring the safety, quality and efficacy of drugs thereby impacting the health of the patients, resolved that States/ UTs which have not signed the MoU with GOI will do so at the earliest; and that all States / UTs will utilise the funds and send the detailed progress of the projects along with utilization certificates and projected further requirement.

Resolved further that States / UTs will ensure uploading of manufacturer and product data on SUGAM portal, take adequate and swift action in NSQ cases, ensure adequate sampling and inspection, and strive to set up monitoring cells on an urgent basis."

### **Resolution**

"Recognizing the need for safe food and healthy India, resolved that the States/UTs shall strive towards Registrations and Licensing of all the Food Business Operators, undertake regular Inspections, review the laboratory infrastructure, participate in Central scheme for strengthening the Food Eco system, train manpower and identify and adopt Clean Street Food Hubs at the earliest and participate effectively in the Eat Right India Movement."

### **Resolution**

"Recognizing the need for regulating Clinical Establishments (CE) in the interest of the patient care, resolved that the respective States/UTs shall take steps for ensuring effective implementation of the CE Act/ have stringent Act in place/ adopt the CE Act if none exists as on date at the earliest".

### **Resolution**

"Considering the need to address the huge requirement of deceased organ donation in the country, the states/ UTs shall make efforts for adopting The Transplantation of Human Organs (Amendment) Act, 2011, setting up SOTTOs, strengthening institutions for organs retrieval & transplant, and mandating sharing of information by the hospitals on NOTTO online platform, at the earliest".



## 8. Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)

### PMSSY- brief introduction

- Launched in 2003
- Scheme components:

• *New AIIMS- 21 approved.*

• *GMC Up-gradation Projects- 75 projects in 24 States.*

PMSSY- new AIIMS		
	Issues	Action Required By States
1	Site for 2 <sup>nd</sup> AIIMS in Bihar	Government of Bihar to expedite identification of alternate sites.
2.	Statutory approvals	Govt. of Haryana to expedite FCA clearance for the AIIMS site at Manethi.
3.	Water (1.5 MLD) and Electricity (15 MVA) connection	<ul style="list-style-type: none"> <li>State Governments to arrange supply up to the campus.</li> <li>Supply required on high priority for OPD and MBBS classes</li> <li>✓ Mangalagiri (AP), Nagpur (Maharashtra), Kalyani (WB), Bathinda (Punjab), Bilaspur (HP).</li> </ul>
4.	Encumbrance free Sites for AIIMS	<p><b>AIIMS Bilaspur:</b> Vacation of site by Animal husbandry Department- cattle, old buildings.</p> <p><b>AIIMS Kashmir :</b> 15 acres of private land remaining be handed over- Early finalization of Court case.</p> <p><b>AIIMS Rae Bareli:</b> Availability of 50 acre additional land is pending out of committed 150 acre.</p>

PMSSY- GMC Upgradation Projects		
	Issues	Action Required By States
1	Release of pending State share for PMSSY Phase-III Projects- serious fund crunch being faced	<ul style="list-style-type: none"> <li>Urgent release of State share               <ul style="list-style-type: none"> <li>➤ KERALA : Rs. 40 Cr each for 2 GMCs</li> <li>➤ TELENGANA : Rs. 30 Cr each for 2 GMCs</li> <li>➤ ANDHRA PRADESH : Rs. 30 Cr each for 2 GMCs</li> <li>➤ ASSAM : Rs. 30 Cr for 1 GMC</li> <li>➤ HIMACHAL PRADESH : Rs. 23.43 Cr for 1 GMC</li> </ul> </li> </ul>
2	Release of pending State share for PMSSY Phase-IV Projects	<ul style="list-style-type: none"> <li>States to release State share on priority               <ul style="list-style-type: none"> <li>➤ BIHAR : Rs 47 Cr each for 3 GMCs</li> <li>➤ CHHATTISGARH : Rs 47 Cr each for 2 GMCs</li> <li>➤ GUJARAT: Rs 47 Cr for 1 GMC</li> <li>➤ MADHYA PRADESH: Rs 23 Cr for 1 GMC</li> <li>➤ ODISHA : Rs 47 Cr. for 1 GMC</li> <li>➤ RAJASTHAN : Rs 32 Cr. for 1 GMC</li> <li>➤ UTTAR PRADESH : Rs 42 Cr. for 1 GMC</li> </ul> </li> </ul>
3	Human Resource for running the new facilities	States to recruit Super-specialists and Paramedics to run the facilities
4	Creation of additional PG seats against new Super Specialty Departments	States to initiate and pursue proposals with MCI/NMC for creation of additional PG seats.



**Resolution for adoption in the Conference**

The CCHFW resolves to make efforts to ensure that all bottlenecks relating to projects of PMSSY are removed and that States would endeavor to ensure timely release of funds for early completion of projects.

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## Session VII

### E Health

#### E Health – Issues in Focus

S. No.	Issues	Action required by the States
1	Clinical data not getting captured in Hospital Information System (HIS)	States to ensure that clinical data is getting captured in Hospital Information Systems (HIS)
2	Limited hospitals using Online Registration System (ORS) and Mera Asptaal application	States to propose all Health facilities to use ORS & Mera Asptaal application
3	Delay in finalization of HUB and Spokes for Tele-Medicine services under Ayushman Bharat – Health & Wellness Programme	<ul style="list-style-type: none"> <li>i. States to propose budgetary requirements in PIP</li> <li>ii. States to finalize HUBs and Spokes for Telemedicine services on priority</li> <li>iii. States to nominate Nodal officers as per guidelines</li> </ul>
4	Limited utilization under National Medical College Network Scheme (NMCN) project	States, Medical Education department to ensure maximum utilization of NMCN infrastructure
5	Non-standardized and limited interoperability amongst IT application operational in States	MoHFW has created a resource centre at CDAC-Pune EHR implementation. States to propose applications for compliance to standards in consultation with CDAC-Pune
6	Data on Digital Payment not getting uploaded on MoHFW portal	States have already been issued with login credentials, States to ensure data being uploaded on monthly basis
7	Regular review of ongoing IT applications	Key IT applications RCH portal, CPHC application, HWC portal, HMIS, E-Nikshay are not being utilised or updated regularly.



## **E Health – Resolution**

The CCHFW recognises the immense potential of Digital Health and resolves to use Information Technologies towards improvement of Healthcare service delivery and to ensure improved health outcomes and continuum of care.

Digital Technologies are also recognised as the key contributor for achieving Universal Health Coverage (UHC)



# भारत का राजपत्र The Gazette of India

असाधारण

EXTRAORDINARY

भाग II—खण्ड 3—उप-खण्ड (ii)

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स्वास्थ्य और परिवार कल्याण मंत्रालय

अधिसूचना

नई दिल्ली, 26 सितम्बर, 2019

केन्द्रीय स्वास्थ्य और परिवार कल्याण परिषद् का गठन

**का.आ. 3497(अ).—**राष्ट्रपति संविधान के अनुच्छेद 263 के द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए केन्द्रीय स्वास्थ्य एवं परिवार कल्याण परिषद् का पुनर्गठन करते हैं और इसके द्वारा किए जाने वाले कार्यों की प्रकृति तथा उसके संगठन और क्रियाविधि को निम्नलिखित रूप में परिभाषित करते हैं अर्थात्-

## 1. परिषद् का संगठन:

(i) परिषद् में निम्नलिखित शामिल होंगे: -

- |                                                                                                                                                 |   |           |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---|-----------|
| (क) केन्द्रीय स्वास्थ्य एवं परिवार कल्याण मंत्री                                                                                                | : | अध्यक्ष   |
| (ख) स्वास्थ्य और परिवार कल्याण मंत्रालय में केन्द्रीय राज्य मंत्री                                                                              | : | उपाध्यक्ष |
| (ग) सदस्य (पूर्णकालीन), नीति आयोग                                                                                                               | : | सदस्य     |
| (घ) विधानमंडलों वाले राज्यों/संघ राज्य क्षेत्रों में स्वास्थ्य एवं परिवार कल्याण, चिकित्सा शिक्षा और लोक स्वास्थ्य मंत्रालयों के प्रभारी मंत्री | : | सदस्य     |
| (ङ.) दादरा व नागर हवेली, चंडीगढ़, अंडमान और निकोबार द्वीप समूह, दमन और दीव तथा लक्षद्वीप संघ राज्य क्षेत्रों का एक-एक प्रतिनिधि                 | : | सदस्य     |

## (च) संसद सदस्य

- |                            |   |           |
|----------------------------|---|-----------|
| 1. डॉ. अरविन्द कुमार शर्मा | : | सदस्य     |
| 2. डॉ. राजकुमार रंजन सिंह  | : | लोकसभा    |
| 3. डॉ. सी.पी. ठाकुर        | : | लोकसभा    |
|                            | : | राज्य सभा |



4. श्रीमती कान्ता कर्दम : राज्य सभा

**(छ) गैर-सरकारी सदस्य:**

स्वास्थ्य और परिवार कल्याण क्षेत्र के प्रतिनिधि

1. अध्यक्ष, भारतीय चिकित्सा संघ (पदेन) : सदस्य
2. अध्यक्ष, भारतीय परिवार नियोजन संघ, मुंबई (पदेन) : सदस्य
3. अध्यक्ष, भारतीय बाल कल्याण परिषद्, नई दिल्ली (पदेन) : सदस्य
4. अध्यक्ष, केन्द्रीय समाज कल्याण बोर्ड, नई दिल्ली (पदेन) : सदस्य
5. अध्यक्ष, फेडरेशन ऑफ इंडियन चैंबर्स ऑफ कामर्स एंड इंडस्ट्री, नई दिल्ली (पदेन) : सदस्य
6. अध्यक्ष, अखिल भारतीय नियोक्ता संघ, नई दिल्ली (पदेन) : सदस्य

**(ii) प्रख्यात व्यक्ति**

1. डॉ. अशोक पनगडिया  
प्रोफेसर इमेरिटस,  
सवाई मान सिंह मेडिकल कॉलेज, जयपुर,  
पूर्व-कुलपति, राजस्थान यूनिवर्सिटी ऑफ हेल्थ साइंस,  
पूर्व प्रधान निदेशक, सवाई मान सिंह मेडिकल कॉलेज, जयपुर,
2. प्रो. अशोक पुरी  
प्रतिष्ठित प्रोफेसर,  
जयपुरिया इंस्टीट्यूट ऑफ मैनेजमेंट, नोएडा  
पूर्व महानिदेशक, फॉरब्यून इंस्टीट्यूट एंड इंटरनेशनल बिज़नेस, नई दिल्ली,  
पूर्व महानिदेशक, इंस्टीट्यूट ऑफ टेक्नोलॉजी एंड साइंस, मोहन नगर  
गाजियाबाद
3. डॉ. टी.के. जोशी  
सलाहकार पर्यावरण स्वास्थ्य,  
पर्यावरण वन एवं जलवायु परिवर्तन मंत्रालय,  
एक्स-कमिश्नर फॉर इंकवायरी इंटू सिलिकोसिस फॉर राजस्थान,
4. डॉ. हरीश गुप्ता  
सीनियर कंसल्टेंट सर्जन  
डॉ आर.बी. गुप्ता मेडिकल सेंटर, दिल्ली  
चयनित सदस्य, दिल्ली मेडिकल काउंसिल  
पूर्व अध्यक्ष, डीएमए
5. श्री रमेश चंद्रा, आईएएस  
पूर्व स्वास्थ्य सचिव  
भारत सरकार  
पूर्व ऊर्जा सचिव एवं वित्त सचिव, दिल्ली सरकार
6. डॉ. अजय कुमार  
अध्यक्ष एवं विभागाध्यक्ष

- बीएलके इंस्टीट्यूट ऑफ डाइजेस्टिव एंड लीवर डिजीजेज, नई दिल्ली  
अध्यक्ष, इंडियन सोसायटी ऑफ गैस्ट्रोएंट्रोलॉजी,  
पूर्व अध्यक्ष, फोर्टिस एस्कोट्स लीवर एवं डाइजेस्टिव डिजीजेज इंस्टीट्यूट  
पूर्व अध्यक्ष, सोसायटी ऑफ जीआई एंडोस्कोपी ऑफ इंडिया
7. डॉ. शिव कान्त मिश्र  
अध्यक्ष,  
साउथ ईस्ट एशिया रीजनल को-ऑपरेशन ऑफ सर्जिकल केयर सोसायटी (एसएएआरसी),  
निदेशक एवं सीईओ, शिवानी हॉस्पिटल एंड आईवीएफ, कानपुर  
पूर्व अध्यक्ष, एसोसिएशन ऑफ सर्जन्स ऑफ इंडिया
8. डॉ. विजयेन्द्र  
अध्यक्ष,  
नेशनल मेडिकोज ऑर्गनाइजेशन,  
प्रोफेसर एवं अध्यक्ष  
डिपार्टमेंट ऑफ पेडियाट्रिक सर्जरी, आईजीआईएमएस, पटना
9. डॉ. कमल बख्शी  
सीनियर कंसलटेंट  
इंद्रप्रस्थ अपोलो हॉस्पिटल सरिता विहार,  
सीनियर कंसलटेंट, फोर्टिस ला फेमे, ग्रेटर कैलाश II, दिल्ली
10. डॉ. डी.एस. राणा  
अध्यक्ष, डिपार्टमेंट ऑफ नेफ्रोलॉजी  
सर गंगा राम हॉस्पिटल, नई दिल्ली,  
अध्यक्ष, बोर्ड ऑफ मैनेजमेंट,  
सर गंगा राम हॉस्पिटल, नई दिल्ली

**(ज) सरकारी सदस्य:**

- |                                                                                           |   |            |
|-------------------------------------------------------------------------------------------|---|------------|
| 1. सचिव, स्वास्थ्य एवं परिवार कल्याण विभाग                                                | : | सदस्य      |
| 2. सचिव, स्वास्थ्य अनुसंधान विभाग एवं महानिदेशक (आई.सी.एम.आर)                             | : | सदस्य      |
| 3. सचिव, आयुर्वेद, योग और प्राकृतिक चिकित्सा, यूनानी, सिद्ध और होम्योपैथी (आयुष) मंत्रालय | : | सदस्य      |
| 4. सचिव, उच्च शिक्षा विभाग, मानव संसाधन विकास मंत्रालय                                    | : | सदस्य      |
| 5. सचिव, महिला एवं बाल विकास मंत्रालय                                                     | : | सदस्य      |
| 6. स्वास्थ्य सेवा महानिदेशक                                                               | : | सदस्य      |
| 7. आर्थिक सलाहकार                                                                         | : | सदस्य-सचिव |
- (II) उपर्युक्त छ(ii) में क्रम सं. 1 से 10 तक पर उल्लिखित प्रख्यात व्यक्ति परिषद् के सदस्य साधारणतः दो वर्ष के लिए रहेंगे।



- (III) लोकसभा के सदस्य तब तक परिषद् के सदस्य होंगे जब तक वे या तो लोकसभा के सदस्य हैं या दो वर्ष के लिए, जो भी पहले हों।
- (IV) राज्यसभा के सदस्य तब तक परिषद् के सदस्य होंगे जब तक वे राज्यसभा के सदस्य हैं या दो वर्ष के लिए, जो भी पहले हों।
- (V) परिषद् की बैठकों में भाग लेने वाले गैर सरकारी सदस्यों के यात्रा भत्ते और दैनिक भत्ते, अनुपूरक नियम 190 के उपबंधों तथा भारत सरकार द्वारा उनके अधीन समय-समय पर जारी किए आदेशों के अनुसार नियमित किए जायेंगे।
- (VI) होने वाले व्यय की पूर्ति इस प्रयोजन के लिए स्वीकृत बजट अनुदान में से की जाएगी।
- (VII) केंद्रीय सरकार और राज्य सरकारों के विशेषज्ञ तथा तकनीकी सलाहकार इस परिषद् के सदस्य नहीं होंगे और परिषद् द्वारा निर्णय लिए जाते समय उन्हें मत देने का अधिकार नहीं होगा, किंतु यदि परिषद् द्वारा अपेक्षित हो तो वे परिषद् की बैठक में हाजिर होंगे।
- (VIII) परिषद् का सचिवीय स्टॉफ होगा, जिसमें एक सचिव होगा तथा उतने अधिकारी और पदधारी होंगे जितने केंद्रीय सरकार के अनुमोदन से अध्यक्ष, नियुक्त करना उचित समझे।

## 2. इस परिषद् द्वारा किए जाने वाले कार्यों की प्रकृति:

परिषद् एक सलाहकार निकाय होगा और उस हैसियत से यह निम्नलिखित कार्य करेगा, अर्थात्-

- (क) स्वास्थ्य एवं परिवार कल्याण के मामले में संबंधित सभी पहलुओं पर नीति की मोटी-मोटी रूपरेखा पर विचार-विमर्श तथा सिफारिश करना जैसे-उपचारी, स्वास्थ्यवर्धक और निवारक उपचार का प्रावधान, पर्यावरणिक सफाई, पोषण, स्वास्थ्य शिक्षा एवं प्रशिक्षण और अनुसंधान के लिए सुविधाओं को बढ़ावा देना;
- (ख) चिकित्सा तथा लोक स्वास्थ्य तथा परिवार कल्याण के मामलों से संबंधित क्रियाकलाप के क्षेत्रों में विधान के लिए प्रस्ताव तैयार करना और समस्त देश के विकास के लिए प्रतिमान निर्धारित करना;
- (ग) त्योहारों के अवसर पर महामारियों के फैलने और विपत्ति की स्थिति जैसे भूकंप तथा सूखे की स्थिति में अंतर-राज्यीय संगरोधन के संबंध में व्यापक आधार पर यथासंभव सहयोग की संपूर्ण संभावना का पता लगाना और सामान्य कार्यक्रम तैयार करना;
- (घ) स्वास्थ्य और परिवार कल्याण प्रयोजनों के लिए उपलब्ध सहायता अनुदानों को राज्यों में वितरित करने के संबंध में केंद्रीय सरकार को सिफारिशें करना और इन सहायता अनुदानों के उपयोग द्वारा विभिन्न क्षेत्रों में हुए कार्य की आवधिक समीक्षा करना; और
- (ङ) केंद्र और राज्यों के स्वास्थ्य और परिवार कल्याण प्रशासनों के बीच सहयोग बनाए रखने और उसको बढ़ावा देने के लिए ऐसे किन्हीं संगठन अथवा संगठनों की स्थापना करना जिन्हें उपयुक्त कार्य सौंपे जाएं।

## 3. परिषद् की कार्य प्रक्रिया:

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

- (क) परिषद् हर वर्ष एक या अधिक बार अपनी बैठक करेगी;
- (ख) इस परिषद् की बैठक उस समय और उस स्थान पर होगी जो अध्यक्ष द्वारा इस निमित्त नियत किया जाएगा;
- (ग) इस परिषद् की बैठक के लिए पांच सदस्यों (अध्यक्ष सहित) का कोरम होगा;
- (घ) अध्यक्ष और उनकी अनुपस्थिति में उपाध्यक्ष या कोई ऐसा सदस्य, जिसे पैरा-1 के उप पैरा (I) के खंड (च) में विनिर्दिष्ट सदस्यों में अध्यक्ष द्वारा इस निमित्त नामोद्दिष्ट किया जाएगा, बैठक की अध्यक्षता करेगा;
- (ङ) इस परिषद् की बैठक में उठाए जाने वाले सभी प्रश्नों का विनिश्चय बैठक में उपस्थित सदस्यों (अध्यक्ष सहित) के बहुमत से किया जाएगा।
- (च) मतों के बराबर होने की दशा में, अध्यक्षता करने वाले व्यक्ति का दूसरा अथवा निर्णायक मत होगा।

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

[फा. सं.जैड-16011/01/2019-बी.पी. (भाग-IV)]

प्रीति सूदन, सचिव

## MINISTRY OF HEALTH AND FAMILY WELFARE

### NOTIFICATION

New Delhi, the 26th September, 2019

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

**S.O. 3497(E).**—In exercise of the powers conferred by the Article 263 of the Constitution, the President hereby reconstitutes 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. Organization of the Council:

##### (I) The Council shall consist of :-

- |     |                                                                                                                                                              |   |               |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---------------|
| (a) | The Union Minister for Health and Family Welfare                                                                                                             | : | Chairman      |
| (b) | The Union Minister of State in the Ministry of Health and Family Welfare                                                                                     | : | Vice Chairman |
| (c) | Member (Full time), NITI Aayog                                                                                                                               | : | 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 | : | Members       |
| (e) | A representative each of the Union Territories Dadra & Nagar Haveli, Chandigarh, Andaman & Nicobar Islands, Daman & Diu and Lakshadweep                      | : | Members       |
| (f) | <b>Member of Parliament</b>                                                                                                                                  | : | Members       |
|     | 1. Dr. Arvind Kumar Sharma                                                                                                                                   | : | Lok Sabha     |
|     | 2. Dr. Rajkumar Ranjan Singh                                                                                                                                 | : | Lok Sabha     |
|     | 3. Dr. C.P. Thakur                                                                                                                                           | : | Rajya Sabha   |
|     | 4. Smt. Kanta Kardam                                                                                                                                         | : | Rajya Sabha   |
| (g) | <b>Non-Officials</b>                                                                                                                                         |   |               |
| (i) | Representatives from Health and Family Welfare Sector                                                                                                        |   |               |
|     | 1. President, Indian Medical Association (Ex-officio)                                                                                                        | : | Member        |
|     | 2. President, Family Planning Association of India, Mumbai (Ex-officio)                                                                                      | : | Member        |



- |    |                                                                                              |          |
|----|----------------------------------------------------------------------------------------------|----------|
| 3. | President, Indian Council of Child Welfare, New Delhi<br>(Ex-officio)                        | : Member |
| 4. | Chairperson, Central Social Welfare Board, New Delhi<br>(Ex-officio)                         | : Member |
| 5. | President, Federation of Indian Chambers of Commerce<br>and Industry, New Delhi (Ex-officio) | : Member |
| 6. | President, All India Organisations of Employers,<br>New Delhi (Ex-officio)                   | : Member |

(ii) **Eminent Individuals** : Members

1. Dr. Ashok Panagariya  
Professor Emeritus,  
Sawai Man Singh Medical College, Jaipur.  
Ex-Vice Chancellor, Rajasthan University of Health Science.  
Former Principal Director, Sawai Man Singh Medical College, Jaipur.
2. Prof. Ashok Puri  
Distinguished Professor,  
Jaipuria Institute of Management, Noida,  
Former Director General, Fortune Institute & International Business, New Delhi,  
Former Director General, Institute of Technology & Science, Mohan Nagar, Ghaziabad.
3. Dr. T.K. Joshi  
Advisor Environmental Health,  
Ministry of Environment Forest & Climate Change,  
Ex. Commissioner for Inquiry into Silicosis for Rajasthan.
4. Dr. Harish Gupta  
Senior Consultant Surgeon,  
Dr. R B Gupta Medical Centre, Delhi.  
Elected Member of Delhi Medical Council.  
Former President, DMA.
5. Shri Ramesh Chandra, IAS  
Former Health Secretary,  
Government of India.  
Former Power Secretary & Finance Secretary, Govt. of Delhi.
6. Dr. Ajay Kumar  
Chairman & HOD,  
BLK Institute of Digestive and Liver Diseases, New Delhi,  
President, Indian Society of Gastroenterology,  
Former Chairman, Fortis Escorts Liver and Digestive Diseases Institute.  
Ex. President, Society of GI Endoscopy of India.
7. Dr. Shiva Kant Misra  
President,  
South East Asia Regional Co-operation of Surgical Care Society (SEARC).  
Director & CEO, Shivani Hospital and IVF, Kanpur.  
Ex-President of Association of Surgeons of India.
8. Dr. Vijayendra  
President,  
National Medicos Organization.  
Prof. and Head,  
Dept. of Paediatric Surgery, IGIMS, Patna.

9. Dr. Kamal Buckshee  
Senior Consultant,  
Indraprastha Apollo Hospital Sarita Vihar,  
Senior Consultant, Fortis La Femme, Greater Kailash II, Delhi.

10. Dr. D.S. Rana  
Chairman, Deptt. of Nephrology,  
Sir Ganga Ram Hospital, New Delhi,  
Chairman, Board of Management,  
Sir Ganga Ram Hospital, New Delhi.

(h) **Officials:**

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

- (II) Eminent Individuals at g(ii) 1 to 10 shall normally be Members of the Council for a period of two years.
- (III) The Members of Lok Sabha shall be Members of the Council so long as they are members of Lok Sabha or for two years, whichever is earlier.
- (IV) The Members of Rajya Sabha shall be Members of the Council so long as they are members of Rajya Sabha or for two years, whichever is earlier.
- (V) The travelling and daily allowances of the non-official members for attending the meetings of the Council shall be regulated in accordance with the provision of Supplementary Rule 190 and orders of the Government of India there-under as issued from time to time
- (VI) The expenditure involved will be met from within the sanctioned budget grant for the purpose.
- (VII) Experts 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.
- (VIII) The Council shall have a Secretarial staff consisting of a Secretary and such officers and officials as the Chairman may, with the approval of the Central Government, think fit to appoint.

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

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

- (a) To consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects, such as the provision of remedial, promotive and preventive



care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research:

- (b) To make proposal for legislation in fields of activity relating to medical and public health and Family Welfare matters, laying down the pattern of development for the country as a whole;
- (c) To examine the whole field of possible co-operation on a wide basis in regard to inter-State quarantine during time of festivals, out-break of epidemics and serious calamities such as earthquakes and famines and to draw up a common programme of action;
- (d) To make recommendations to the Central Government regarding distribution of available grants-in-aid for Health and Family Welfare purposes to the States and to review periodically the work accomplished in different areas through the 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 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 the 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.

[F. No. Z-16011/01/2019-BP(Part-IV)]

PREETI SUDAN, Secy.



# भारत का राजपत्र The Gazette of India

असाधारण

EXTRAORDINARY

भाग II—खण्ड 3—उप-खण्ड (ii)

PART II—Section 3—Sub-section (ii)

प्राधिकार से प्रकाशित

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स्वास्थ्य और परिवार कल्याण मंत्रालय

अधिसूचना

नई दिल्ली, 3 अक्टूबर, 2019

केन्द्रीय स्वास्थ्य एवं परिवार कल्याण परिषद का गठन

का.आ. 3605 (अ).—केन्द्रीय स्वास्थ्य और परिवार कल्याण परिषद का पुनर्गठन करने के लिए भारत के राजपत्र, असाधारण, भाग-II खंड 3, उप-खंड (ii) में प्रकाशित भारत सरकार, स्वास्थ्य एवं परिवार कल्याण मंत्रालय की दिनांक 26 सितम्बर, 2019 की अधिसूचना संख्या का.आ. 3497(अ) के क्रम में निम्नलिखित को अंतर्विष्ट किया जाएगा:

**(छ) - गैर-सरकारी सदस्य, (ii) - प्रख्यात व्यक्ति की क्रम संख्या 10 के बाद**

(ii) प्रख्यात व्यक्ति

डॉ. राजीव कुमार गुप्ता

सदस्य

प्रोफेसर एवं विभागाध्यक्ष

दयानंद चिकित्सा कॉलेज एवं अस्पताल

लुधियाना, पंजाब

[फा.सं. जेड-16011/01/2019-बी.पी.(भाग-IV)]

प्रीति सूदन, सचिव



## MINISTRY OF HEALTH AND FAMILY WELFARE

## NOTIFICATION

New Delhi, the 3rd October, 2019

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

**S.O. 3605 (E).**— In continuation of notification of the Government of India, Ministry of Health and Family Welfare, number S.O. 3497(E) dated 26<sup>th</sup> September, 2019, published in the Gazette of India, Extraordinary, Part-II, Section 3, Sub Section (ii) for re-constitution of Central Council of Health and Family Welfare, the following shall be inserted :

**after serial No.10 of (g) - Non-Officials, (ii) - Eminent Individuals****(ii) Eminent Individuals**

Dr. Rajiv Kumar Gupta  
Professor and Head,  
Dayanand Medical College and Hospital,  
Ludhiana, Punjab.

Member

[F.No. Z-16011/01/2019-BP(Part-IV)]

PREETI SUDAN, Secy.