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I.M.A.G.S.B. NEWS BULLETIN

GUJARAT MEDICAL JOURNAL
INDIAN MEDICAL ASSOCIATION, GUJARAT STATE BRANCH

Vol-19 APRIL-2024 Issue-04

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Hon. State Secretary (Ahmedabad)

Imm. Past President **DR. MAHAVIRSINH JADEJA** (Bhavnagar)

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Women's Hospital & Endoscopy Centre

DR. DIPAK LIMBACHIYA
M.D., D.G.O., Endoscopy Specialist
Specialist in Advanced LAP Gynaec Surgeries &
LAP Onco Gynaec Surgeries

PRESENTING THE FIRST EVER STUDY FROM INDIA ON CARCINOMA ENDOMETRIUM

SURGICOPATHOLOGICAL OUTCOMES AND SURVIVAL IN CARCINOMA BODY UTERUS: A RETROSPECTIVE ANALYSIS OF CASES MANAGED BY LAPAROSCOPIC STAGING SURGERY IN INDIAN WOMEN

Objectives: The context of this article is based on two main titles those being Gynecologic Oncology and Minimal invasive surgery. **The aim of this study was to report the laparoscopic management of a series of cases of endometrial carcinoma managed by laparoscopic surgical staging in Indian women.**

Materials and Methods: This study was conducted in a private hospital (referral minimally invasive gynecological center). This was a retrospective study (Canadian Task Force Classification II-3). Eighty-eight cases of clinically early-stage endometrial carcinoma staged by laparoscopic surgery and treated as per final surgicopathological staging. All patients underwent laparoscopic surgical staging of endometrial carcinoma, followed by adjuvant therapy when needed. Data were retrieved regarding surgical and pathological outcomes. Recurrence-free and overall survival durations were measured at follow-up. Survival analysis was calculated using Kaplan–Meier survival analysis.

Results: The median age of presentation was 56 years, whereas the median body mass index was 28.3 kg/m2. Endometroid variety was the most commonly diagnosed histopathology. There were no intraoperative complications reported. The median blood loss was 100 cc, and the median intraoperative time was 174 min. There were a total of 5 recurrences (5.6%). The outcome of this study was comparable to studies conducted in Caucasian population. **The predicted 5-year survival rate according to Kaplan–Meier survival analysis is 95.45%, which is comparable to Caucasian studies.**

Conclusion: Laparoscopic management of early-stage endometrial carcinoma is a standard practice worldwide. However, there is still a paucity of data from the Indian subcontinent regarding the outcomes of laparoscopic surgery in endometrial carcinoma. The Asian perspective has been highlighted by a number of studies from China and Japan. **To our knowledge, this study is the first from India to analyze the surgicopathological outcomes following laparoscopic surgery in endometrial carcinoma.** The outcome of this study was comparable to studies conducted in Caucasian population.

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QR Code for Entire Article

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FROZEN SHOULDER

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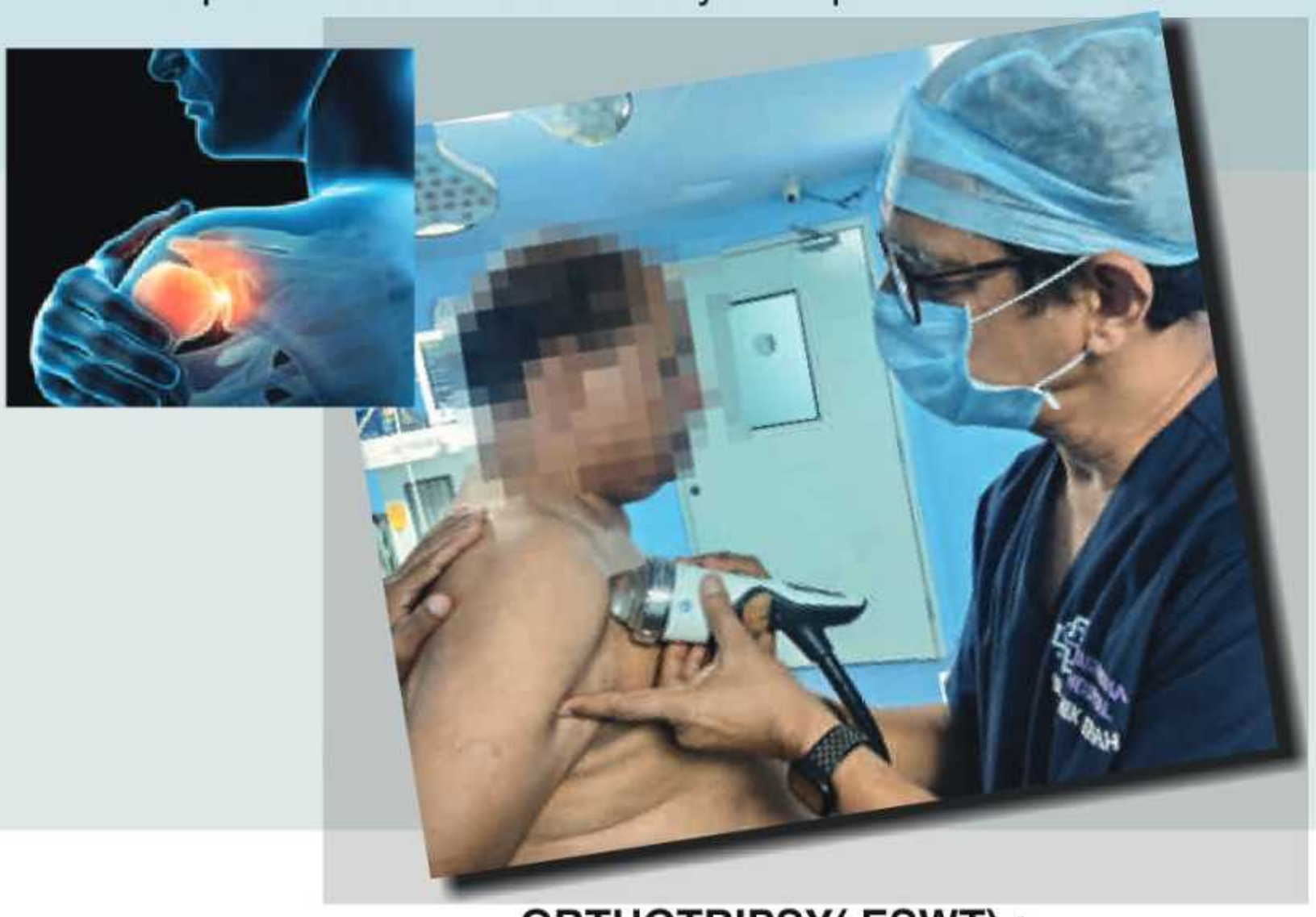
Management is equally difficult and frustrating to both patients and doctors as outcomes are unpredictable. There is a ray of hope in ESWT.



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Orthopaedic Surgeon

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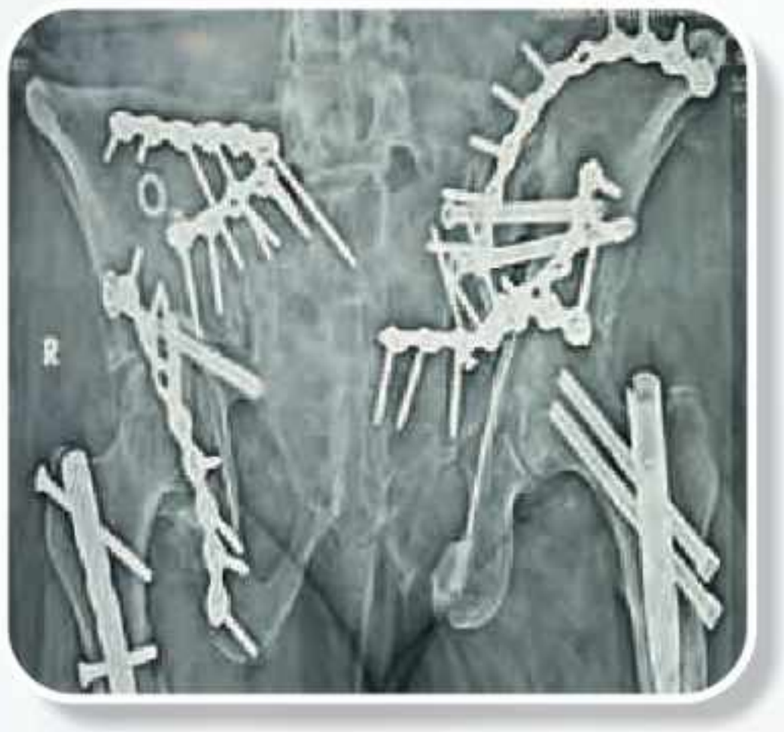

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મલ્ટી સ્ટેટ શિડ્યુલ્ડ બેંક

ફેસ્ટિવલ ધમાકા ઓફર

કાર લોન

વ્યાજદર (વાર્ષિક)

8.25%* (ફીક્સ રેટ)

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- પરત ચૂકવણી - મહત્તમ ૭ વર્ષ
- '૦' પ્રિ-પેમેન્ટ પેનલ્ટી
- ઘિરાણ ઝડપી અને સરળ પ્રોસેસીંગ

* શરતોને આધિન
* વ્યાજના દર વખતોવખતના ફેરફારને આધિન

I.M.A.G.S.B. NEWS BULLETIN

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STATE PRESIDENT'S MESSAGE

Dear IMA Colleagues,

Greetings

ACT IN ALIGNMENT

It was the Central Working Committee which was the most striking event of this month. 231st CWC meeting of IMA held at Chennai on 14th & 15th April 2024. Out own Dr. Ketan Desai was Chief Patron of CWC & it was attended by majority of our state CWC Members under leadership of Dr. Anil Nayak, HSG.

In his presidential address, Dr. Asokan pointed out one main thing which was eye opening for all of us Non reaching Non awareness of information, intimation & guidance to the members residing in fare & distant rural areas of India in due time.

They are regularly doing IMA activities & other social activities autonomously in their own respective limits & boundaries and not according to guidance & protocols of IMA-HQ.

We must put further more efforts in order to have an umbrella system where in IMA-HQ will remain in liaison through different states till last member holding in most remote area of county.

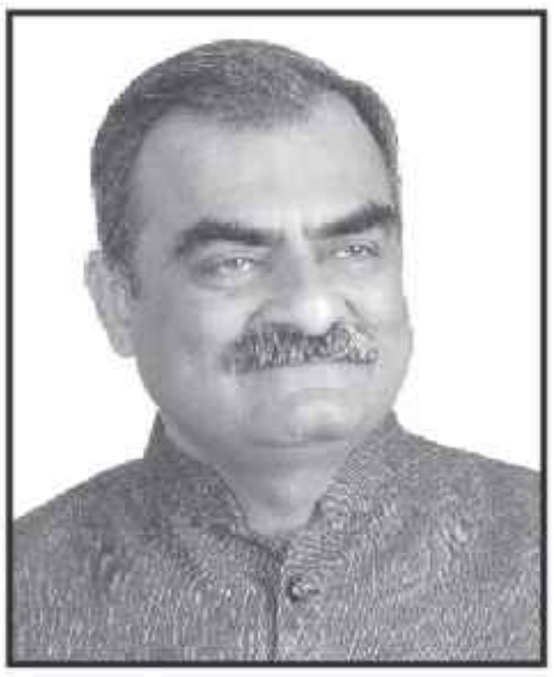
Then only all our official programmes appeals, agitation, etc will have a break through impact on government bodies and other NGOS.

Let as begin with our own home state. As president of all IMA-GSB, I appeal to all members of state to go through all appeals, messages, mails & circular given by state body & to further spread it down the line to other members who might not be aware of current developments.

JAI IMA, JAI JAI GARVI GUJARAT, JAI HIND.

Dr. Bharat M. Kakadia
President, G.S.B., I.M.A.

HON. STATE SECRETARY'S MESSAGE



Doctors Uniting for the Redevelopment of IMA Headquarters: A Call to Action

In recent weeks, a remarkable initiative has been set into motion by doctors from all corners of our nation. The Indian Medical Association (IMA) Headquarters, an institution that stands as a beacon of excellence and solidarity for the medical fraternity, is undergoing a much-needed redevelopment. This endeavor, however, requires the collective support and contribution of doctors nationwide.

It fills me with immense gratitude to extend heartfelt thanks to our esteemed donors who have already stepped forward to support this vital cause. Your generosity and commitment serve as an inspiration to us all, demonstrating the true spirit of unity and compassion within the medical community.

As we continue on this journey towards the redevelopment of the IMA Headquarters, I urge each and every one of our members and branches to join hands in contributing to the IMA building fund. Your support is indispensable for securing the future of our profession and ensuring that the IMA Headquarters remains a bastion of excellence for generations to come.

Let us rally together, pooling our resources and efforts, to shape a brighter and more prosperous future for healthcare in our nation. For further details on how you can contribute, please reach out to your local IMA branch or visit the official IMA website.

Thank you for your attention, and I eagerly anticipate your continued support and participation in this noble cause.

Dr. Mehul J. Shah
Hon. State Secy., G.S.B.,I.M.A.

ATTENTION PLEASE !!!

IMA LOCAL BRANCHES

Election of President (Ahmedabad Zone) and 7 Vice Presidents of Gujarat State Branch, I.M.A. for the year 2024-2025, has been posted to the Local Branch Secretaries.

RULES AND BYE-LAWS OF THE LOCAL BRANCHES :

(A) A Local Branch shall make its own Constitution to govern itself taking the Constitution of I.M.A. H.Q. and of the State Branch as the guideline. The Constitution, Rules and Bye-Laws of a Local Branch shall not infringe or contravene the provisions of Memorandum of Association Rules and Bye-Laws of I.M.A. Headquarters and / or of the State Branch.

(B) The Constitution, Rules and Bye-Laws so framed by a Local Branch and submitted to the State Branch, shall be forwarded to the Headquarters for approval and ratification with the remarks of the State Branch thereon if any, and it should be implemented only when it has been approved and ratified by the Working Committee of the IMA H.Q.

(C) Till such time as the Constitution of a Local Branch has been approved by the Headquarters, the said Local Branch shall follow Model set of Rules and Bye-Laws and guidelines prescribed by the headquarters and the State Branch for a Local Branch.

(D) The Rules and Bye-Laws of the Indian Medical Association Headquarters shall apply in any matter not covered by the Rules and Bye-Laws of the State Branch or of a Local Branch already ratified by the Working Committee.

N.B. The Nominations must reach by Registered Post with Acknowledgment to the office of the Honorary State Secretary / Returning Officer, not later than **20th May, 2024.** Nominations received after date shall not be considered.

ATTENTION PLEASE !!!

IMA MEMBERS

Election of President (Ahmedabad Zone) and 7 Vice Presidents of Gujarat State Branch, I.M.A. for the year 2024-2025, has been posted to the Local Branch

ELIGIBILITY OF OFFICE BEARERS :

(A) State President shall be a Life Member of Association.

(B) Vice President shall be from the same zone for which they have been proposed.

(C) Hon. State Secretary, Hon. Jt. Secretary, Hon. Asst. Secretary and Hon. Treasurer candidates shall be from amongst the State H/Q.

(D) Candidates for Zonal Posts shall be from amongst the eligible members of Local Branches from the same zone for which they have been proposed.

(E) Eligibility of local branches for nominating the candidate for election of the State Branch.

1) The local branch shall be an active branch not suspended or defunct.

2) It shall have cleared it's S.F.C. for the year by 15th April.

(F) 1) He/She must be a life member of I.M.A.

2) He/She must have seven years continous membership of I.M.A.

3) He/She should have served I.M.A. G.S.B. as a Working Committee member for at least 3 years.

In case of non receipt of valid nomination, any other life member can be considered for that particular post.

For further information, please contact your Local Branch Secretary.

Celebrating World Family Physician Day : The Crucial Role of Family Physicians in India

Every year, on the **19th of May, the world celebrates Family Physician Day,** recognizing the vital role these healthcare professionals play in communities globally. In India, where healthcare accessibility and continuity of care are critical issues, the significance of family physicians cannot be overstated. Let's delve into the importance of family physicians in India and the pivotal role they play in the healthcare landscape.

Importance of Family Physicians in India:

1. **First Point of Contact:** Family physicians serve as the initial point of contact for individuals seeking medical assistance. In a country as vast and diverse as India, where access to healthcare services can be challenging, family physicians act as the first responders, offering primary healthcare services and addressing various health concerns promptly.
2. **Continuity of Care:** One of the most crucial aspects of family medicine is its emphasis on continuity of care. Family physicians develop long-term relationships with their patients, understanding their medical history, lifestyle, and unique healthcare needs. This continuity ensures personalized and holistic care, which is particularly beneficial in managing chronic conditions like diabetes, hypertension, and heart disease.
3. **Comprehensive Healthcare Services:** Family physicians provide a wide range of healthcare services, including preventive care, diagnosis and treatment of acute and chronic illnesses, vaccinations, routine check-ups, and health education. This comprehensive approach to healthcare not only improves health outcomes but also reduces the burden on secondary and tertiary care facilities.
4. **Holistic Approach:** Unlike specialists who focus on a specific organ or disease, family physicians adopt a holistic approach to healthcare. They consider the interconnectedness of various factors such as physical, emotional, social, and environmental influences on a patient's health. This approach is particularly beneficial in addressing the complex and multifaceted health issues prevalent in Indian society.
5. **Health Promotion and Disease Prevention:** Family physicians play a crucial role in promoting health and preventing diseases within their

communities. Through regular screenings, lifestyle counseling, and immunizations, they empower individuals to take proactive steps towards maintaining their health and well-being. This preventive approach is instrumental in reducing the incidence of preventable diseases and improving overall public health.

The Role of Family Physicians in Strengthening Healthcare Systems:

1. Primary Care Gatekeepers: Family physicians act as gatekeepers to the healthcare system, efficiently managing the flow of patients and ensuring appropriate referrals to specialists when necessary. By providing timely and cost-effective primary care services, they help alleviate the burden on secondary and tertiary care facilities, thus optimizing resource utilization within the healthcare system.
2. Community Advocates: Family physicians serve as advocates for their communities, addressing health disparities, promoting health equity, and raising awareness about prevalent health issues. Their intimate knowledge of local communities enables them to tailor healthcare interventions to meet the specific needs of diverse populations, thereby fostering inclusive and patient-centered healthcare delivery.
3. Healthcare Coordinators In an increasingly complex healthcare landscape, family physicians play a pivotal role in coordinating care across different healthcare settings and specialties. They serve as the central point of contact for patients, facilitating seamless transitions between primary, secondary, and tertiary care services. This coordination is essential for ensuring continuity of care and optimizing patient outcomes.

Conclusion:

As we commemorate **World Family Physician Day** this month, let us acknowledge and celebrate the indispensable contributions of family physicians to the health and well-being of individuals and communities in India. Their dedication, compassion, and commitment to providing comprehensive, patient-centered care make them true pillars of the healthcare system. Moving forward, it is imperative to recognize the importance of investing in primary care and strengthening the role of family physicians to achieve the goal of universal health coverage and ensure health for all in India.

Dr. Jaswantsinh Darbar
Director
CGP, GSB-IMA

I.M.A. COLLEGE OF GENERAL PRACTITIONERS
GUJARAT STATE BRANCH
AHMEDABAD MEDICAL ASSOCIATION

FAMILY MEDICINE CONCLAVE

"WORLD FAMILY PHYSICIAN DAY-2024"

Date : 19-05-2024, Sunday

Time : 9.30 am Onwards

Venue : Ahmedabad Medical Association Hall

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In Association with :

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FEDERATION OF FAMILY PHYSICIANS' ASSOCIATIONS OF INDIA

FAMILY MEDICINE CONCLAVE
"WORLD FAMILY PHYSICIAN DAY-2024"

Date : 19-05-2024, Sunday Time : 9.30 am Onwards

Venue : Ahmedabad Medical Association Hall

Registration Fees : ₹ 250/- (Last Date 10-5-2024)

at AMA 97268 88775 & GSB 98795 87370 or any Zonal Coordinator

-: SPEAKERS :-

Dr Gopal Shah
MBBS, MS, MCh, PGDMLPE
Chief Neurosurgeon, KD Hospital
Topic :"Surgical Strike Against Refractory Epilepsy"

Dr. Rajendra Toprani
Head and Neck Oncology Surgeon
HCG Hospital
Topic : Approach & Management of Thyroid Nodule- Clinical Tips

Dr. Hansal Bhachech
Distinguished Psychiatrist and
Prolific Author, Gujarat
Topic : Mental Pollution to Solution

Dr. Akash N Shah
DM (Endocrinologist)
Consultant Endocrinologist, KD Hospital
Topic : Diabetes - Newer Modalities in Diabetes Management

Dr. Ankur Vagadiya
MS (PGIMER), M.Ch (ILBS) HPB and
Liver Transplant Surgery, Zydus Hospital
Topic : Over view of Liver Transplant & Recent Advances in Liver Transplant

Dr. Nisarg Dharaiya
IVF expert,
Chairman, Sneh IVF group
Topic : Infertility & IVF : Basic To Advancement

Dr. Kartik Desai
Consultant Gastroenterologist
DNB Gastroenterology, KD Hospital
Topic : Are we Vulnerable to Fatty Liver?

Dr. Brajmohan Singh
CVTS Surgeon
HCG Hospital
Topic : CABG with LIMA-RIMA-Y (Total Arterial Grafting)

Dr. Nidhi Jain
MD - DM Haemeto Oncologist & Bone Marrow
Transplant Physician, Zydus Hospital
Topic : Thrombocytopenia : How to Approach?

Dr. Parth Jani
Consultant Neurosurgeon,
HCG Hospital, Ahmedabad
Topic : Clinicoradiological Approach to a Patient with Neurosurgical Emergencies.

Dr. Sanjeev Goel
M.D., Paediatrician.
Saakshi Children Hospital, Vadodara
Topic : Your Online Safety in Your Hands

Dr. Samir Shah
Consultant Pediatrician and Adolescent
Specialist Chairperson CMIC chapter of IAP
Hon. Secretary AOP Gujarat VP, Vadodara
Topic : Gadget that Change Your Practice

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Senior Physician (MD),
Head of Geriatrics Dept, Sterling Hospital
Topic : Life Course Vaccination: The Integral Role of Family Physicians in Promoting Lifelong Immunization

Dr Jayendra Kapadia
Senior Family Physician,
Surat
Topic : New Horizon in Family Practice

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IMA/HSG/277/

31/03/2024
New Delhi

To,
Shri Rohit Deo Jha
Joint Director
National Health Authority
Ministry of Health & Family Welfare
Government of India

Subject: Submission of Inputs on Review of Ayushman Bharat Pradhan Mantri-Jan Arogya Yojana

Dear Sir,

Greetings from Indian Medical Association (HQs)!

On behalf of the Indian Medical Association, we would like to express our gratitude for the opportunity to provide our inputs on the review of the Ayushman Bharat Pradhan Mantri-Jan Arogya Yojana (AB PM-JAY), as outlined in the Office Memorandum S-12018/385/2024-NHA dated 26th March 2024.

Having thoroughly reviewed the areas of implementation listed in Annexure-2 of the memorandum, we would like to offer the following insights and recommendations:

HEALTH FINANCING:

IMA advocates a tax-based system of Health financing. Contributory Health insurance offers incomplete coverage and restricted services. General revenues should be the source of UHC. Increased allocation of financial resources for Health is the most important component. The allocation varying from 1.1 to 1.6 % GDP together by the various Governments is one of the lowest in the world. Moreover, the expenditure incurred on Health determinants like drinking water, sanitation should be provided for separately. Thus, the minimum allocation for Health alone should be around 2.5% of the GDP. Despite numerous policy pronouncements prioritizing health, the governments in India at the Centre and state levels have historically underfunded the public health sector, resulting in poor health outcomes and rising inequity in access to health care. India's overall health spending (public and private) is currently estimated to be 3.8% of its GDP, lower than the LMIC average of health spending share of GDP of around 5.2%. India's health system is overwhelmingly financed by out-of-pocket (OOP) expenditures incurred by households (around 63% of all health spending) (NHSRC, 2018b; RBI, 2019). Government funding, provided by both the Central and state governments, currently constitutes approximately one-third of all health spending, with states accounting for nearly two-thirds of total government health expenditure.

PMJAY

One of the very important initiatives in Healthcare delivery has been the implementation of PMJAY. Many incremental steps have been taken in PMJAY since 2018.IMA would want to put up the following suggestions in PMJAY.

1. PMJAY could be a game changer in involving private sector with inclusive policies and strategic purchases.
2. In essence IMA feels that Government hospitals should be funded directly by the Government and PMJAY should be exclusively used for strategic purchase from private sector.
3. Pricing of services should be based on independent scientific costing in district level basis.
4. The programme should be fully monetised to provide comprehensive coverage for the defined set of population.

INSUFFICIENT FUNDS ALLOTMENT

a) If the funding has to be raised to atleast CGHS level then money required is around 1,60,000 crores. The money being provided now is 12,000 crores. It is not possible to deficit finance any programme to this level. The huge gap in funding will result in mediocre services at the ground level and wide spread corruption.

b) Insufficient fund allotment is the root cause of unrealistically low package rates.

c) If empanelling was only about public hospitals, there was no need to raise the expectations of the public. When the people become aware that the services are mainly from Government hospitals the possibility of negative backlash is very real. The services are anyway free in public hospitals already. Then it only boils down to transferring the money to public hospitals for their services. The common man does not really feel the benefit. The funds of AB-PMJAY should be exclusively used for strategic purchase from the private sector.

LACK OF CREATION OF HEALTH INFRASTRUCTURE

The scheme is all about demand side. There is absolutely nothing that is being added to the national Health infrastructure either in the Government sector or in the private sector. Ideally there should be a judicious mixture of supply and demand sides.

POTENTIAL ELIMINATION OF SMALL AND MEDIUM HOSPITALS.

Small and medium neighbourhood hospitals are holding the health care cost low in our country. With AB-PMJAY, the most disruptive initiative in Health sector they are left with the Hobson's choice of nôt joining and loosing clients or joining at rates much below their sustainability levels. IMA is apprehensive that AB-PMJAY will wipe away the small and medium hospitals.

INCLUDE PRIMARY CARE IN PMJAY

Sustained underfunding of public sector facilities, and the rapid growth of private sector has contributed to rising OOP costs on health care for households. Of this, a significant share, almost

two-thirds of OOP expenses, are for purchasing outpatient care, especially medicines. Because households bear the burden of the high OOP health expenses in India, more than 55 million people are impoverished each year on account of expenses for ill health.

Ayushman Bharath program is primarily intended for decreasing OOP expenditure in health care and preventing catastrophic health spending leading to poverty. As per NSSO statistics OP services and Medicines contribute to a major portion of OOP. The current governmental mechanisms providing primary care through redesigned Wellness centres and distribution of medicines through

Jen Aushadhi Kendras. Although made some inroads in reducing OOP has not yet addressed the issue in a manner to produce expected impact. Hence OPD services and distribution services may also be included in AB and services of small private clinics and hospitals may be utilised.

Non-inclusion of primary care in AB-PMJAY is a serious gap in its conceptualisation. The easiest route to primary care in door step is to empower the clinics and the less than ten bed hospitals. These are easy to recruit on **retainer basis** and again can be converted into exclusive Ayushman Bharat centers. This will be similar to NHS model of UK. More over with non-inclusion of primary care in AB-PMJAY, such patients will move over to secondary care centers thereby increasing the expenditure.

OPTION TO CO PAY

Among the schemes of independent India Arogya Karnatak Yonjne was relatively successful. It can be seen that the scheme was also efficiently serving a larger population with lesser expenditure. The essential difference was the provision for co-payment. This is an important option if AB PMJAY should survive.

AB-DHM

AB-DHM has no legal sanction. The quality of consent from the data principal appropriation of Data by AB-DHM, the possibility of private Health insurers, private pharma companies and even multinationals masquerading as data fiduciaries are serious concerns.

To sum up, to improve satisfaction of people who use AB-PMJAY following steps might be useful.

1. Priority involvement of small and medium hospitals as exclusive outlets.
2. Inclusion of primary care in AB-PMJAY
3. Evolve a dynamic and transparent costing and pricing system
4. Government and the Hospitals interface to be entirely online eliminating points of corruption like Arogya Mithram and insurance players.
5. Dedicate AB-PMJAY for exclusive strategic purchase of care from private sector.

CONCLUSION:

1. Ayushman Bharat is Macro-economic Allocation Failure.
2. Ayushman Bharat eroding market efficiency of healthcare service delivery and threatening sustainability of efficient private health sector.
3. Ayushman Bharat brings Direct/Indirect price controls on healthcare service delivery and system will face its long-term ill impacts.
4. Ayushman Bharat pricing of services below cost for Pvt Hospitals will lead to collapse of un-cushioned small and mid-segment hospitals and will lead to further access dis-balance.

5. Ayushman Bharat Pricing of Services is not scientific.
6. Low price competition amongst hospitals reducing quality delivery of services.
7. Ayushman Bharat threatening reduced Pvt sector investments in core service delivery segment and Pvt healthcare infrastructures.
8. Ayushman Bharat: U turn on "Assurance vs Insurance Model". A strategic silence or acceptance or in favor of Insurance Co.
9. Ayushman Bharat Increasing excessive bureaucratic and political interference, leading to in- efficient delivery of healthcare and reducing autonomy of healthcare and eroding trust in system.
10. Ayushman Bharat dis-balancing role of Govts as provider, purchaser, regulator and shifting responsibility/accountability to third parties.
11. Role of profit motivated insurance

We believe that addressing these key areas will contribute to the success and sustainability of the AB PM-JAY scheme, ultimately leading to improved healthcare outcomes for the citizens of our country.

This document is not exhaustive. Already we have asked for additional time. Kindly allow us to file additional documents later.

Yours sincerely,

Dr. R V Asokan
National President

Dr. Anilkumar J Nayak
Honorary Secretary Geneal

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Website: www.ima-india.org ; Email: np@ima-india.org | hsg@ima-india.org

CONGRATULATIONS

* **Patel Shaiv Nalinbhai, son of Dr. Nalin G. Patel, Ahmedabad**

  Being got 1077/1400 marks and stood 1st with gold medal in Final MBBS Exam held in December, 2023 by Gujarat University.

* * * * *

Attention : G.S.B. I.M.A. Members

Essay Competition

GIMACON-2024

Subject :

"Prescription for Healing: Strategies to Overcome Stress and Depression Among Young Doctors"

The essay should be in three type copies double spacing on one side of the full-scap paper or e-paper-pdf file on

Email : imagsb@gmail.com

Last Date for Submission at the GSB-IMA Office is 31/07/2024

* * * * *

DISCLAIMER

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HEALTH SCHEME; G.S.B. I.M.A.

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GUJARAT STATE BRANCH

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PHONE : (079) 265 87 370 Email: imagsb@gmail.com

Ref No. A-11/HFC/LM/2024-2025 **Date: 18-3-2024**

Dear Branch Secretary

I hope that this circular finds you in the best of health and spirit. In continuation of our circular **A-11/HFC/LM/2024-2025,** further tabulated information is given below for the revision of fees effective from **1/4/2024.** Local branch share to be collected extra as per individual branch decision/resolution.

If the Local Branch does not have GST number, then sent the following amount to IMA GSB.

Category	Total Fees	Branch Share	GST. Amt. (18%)	To be Sent to GSB IMA including Admission Fee
Single Life	12330-00	840-00	2219-00	13709-00
Couple Life	18201-00	1280-00	3276-00	20197-00

If the Local Branch has GST number, then sent the following amount to IMA GSB. Kindly send challan copy of GST paid to IMA GSB.

For Single Life Member -	**Rs. 11490-00**
For Couple Life Member -	**Rs. 16921-00**

Membership Fees by a Cheque / DD. drawn in favour of **" G.S.B. I.M.A.".**

The above increase of fee Rs. 50.00 in Life Member every year is computed as per the resolution passed in 41st State Council at Nadiad on 12/05/1989.

Yours Sincerely

Dr. Mehul J. Shah

Hon. State Secretary

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Dr Ketan Desai
Chief Patron

Dr Anilkumar J. Nayak
HSG, IMA HQs (New Delhi)

Dr. Bharat M. Kakadia
President,
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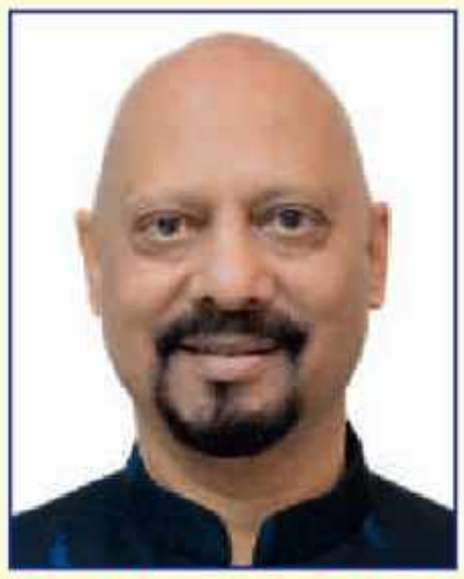

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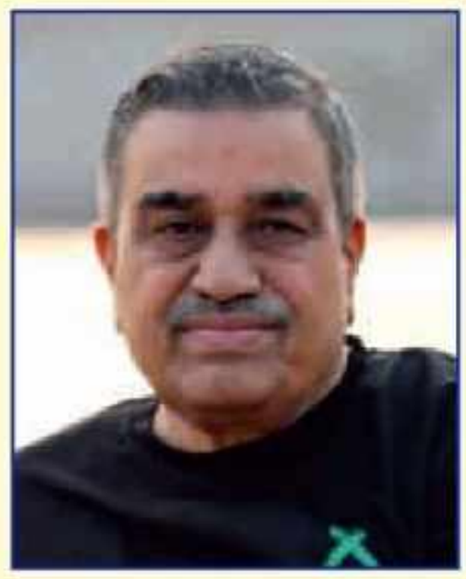

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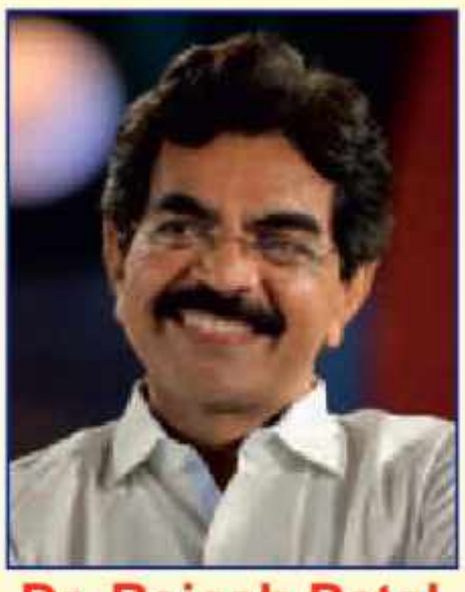

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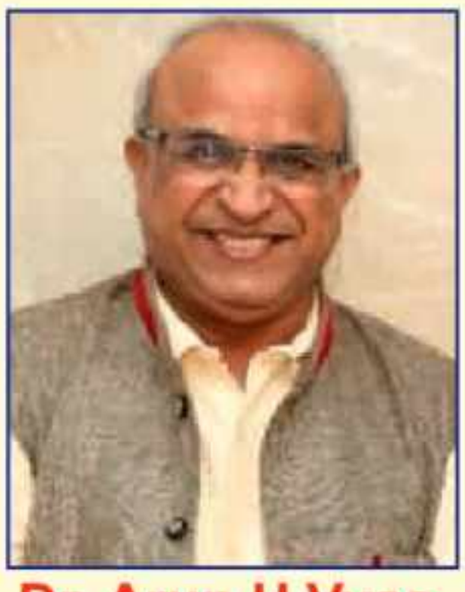

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OBITUARY

We send our sympathy & condolence to the bereaved family

Dr. Pradyuman M. Trivedi	19-11-2023	Anand
Dr. Dalpatbhai S. Doshi	03-01-2024	Viramgam
Dr. Madhavlal C. Shah	13-01-2024	Palanpur
Dr. Ambalal I. Patel	29-01-2024	Anand
Dr. Monaben M. Patel	05-02-2024	Ahmedabad
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Dr. Jitendra C. Shah	11-02-2024	Ahmedabad
Dr. Pravinchandra R. shah	15-02-2024	Valsad
Dr. Ramesh N. Gore	17-02-2024	Ahmedabad
Dr. Bhupendra A. Shah	24-02-2024	Ahmedabad
Dr. Rajulben V. Shah	28-02-2024	Ahmedabad

We pray almighty God that their souls rest in eternal peace.

* * * * *

BRANCH ACTIVITY

AMRELI

22-03-2024 CME on “Endovascular management of stroke, Atrial and venous” by Dr. Vikas Jain.

“Emergency management of acute stroke” by Dr. Ketan Chudasama.

“Brain hemorrhage and it's management” by Dr. Jigarsinh Jadeja.

12-04-2024 “Myocardial infarction in young adult” by Dr. Krishankant Sharma.

“Clinical Pearls in critical care case Based Discussion” by Dr. Dhaval Vaidya.

DEESA

29-03-2024 CME on "Liver transplant scenario in Gujarat: present and future" by Dr. Anand Khakhar.

"Transplant ales: Talking ICU challenges in acute on chronic and acute liver failure" by Dr. Himanshu Sharma.

GANDHIDHAM

01-03 to

31-03-2024 Blood Donation Camp. Total 394 units were collected.

29-03-2024 Thalesemia Major Children's Camp. Total 46 children gave samples.

Thalesemia Major Children's Camp. Total 72 children gave samples at Bhuj.

JAMNAGAR

23-03-2024 CME on "Bone Marrow Transplant" by Dr. Nisarg Thakkar.

"Laparoscopics radical right hemi-colectomy" by

Dr. Prashant Vanzar.

KALOL

12-03-2024 CME on "Introduction to PCPNDT Act" by Dr. A.J. Vaishnav.

"All about PCPNDT Act" by Dr. P.L. Dave.

21-03-2024 "Robotic Surgery: A New Horizon for Urological Cancers" by Dr. Raj Patel.

MAHUVA

06-04-2024 CME on "Approach to arthritis" by Dr. Hardik Rathod.

MEHSANA

21-03-2024 CME on "Benign prostatic hyperplasia" by Dr Niraj Patel.

MORBI

01-03-2024 CME on "Updates in Breast Cancer Surgery" by Dr. Vivek Venugopal.

"Recent advance in Oncology " by Dr. M.B. Meenu

07-03-2024	"Maternal Screening and NIPT" by Dr. Pankaj Bardia.
	"Cervical cancer Screening" by Dr. Riddhi Maniar.
	"Diagnostic modalities in recurrent pregnancy loss" by Dr. Lalit Charola.
08-03-2024	"Case based discussion – unraveling the mysteries:" by Dr. Devang Pandya.
16 & 17-03-24	Workshop on "5th Live Surgical (ENT) by Dr. Hitesh Patel, Dr. Preyas Pandya and his team. Total 9 Live Surgeries were demonstrated in this workshop. Over 120 delegates were present and participated.
28-03-2024	"Case based discussion – Pediatric Neurology cases" by Dr. Sagar Lalani.

VADODARA

06-03-2024	CME on "Robot assisted surgery in Cancer" by
08-03-2024	International Women Day Celebration.
15-03-2024	World Kidney day. More than 50 dialysis patients and all technical staff and management staff of NEFRO Department were present.
17-03-2024	Nvya Aesthetics, a state of the art facility with mélange of technology and talent in the field of aesthetic dermatology and surgery.
22-03-2024	"World Down Syndrome Day / Week Celebration" by Dr. Satish Pandya, Dr. Nina Vaidya, Dr. Samir Shah, Dr. Snehal Shirolawala and Dr. Bhupendra Kapadia.
	World TB day. Attended the programme by KMCRI Bharuch.
23-03-2024	FPA Vadodara, FFPAI, HCG Hospital Foundation in Association with Go Colours Organised Cervical Cancer Prevention Camp, In Which 100 Girls were identified for free HPV vaccination at Taj Hotel, Vadodara.
30-03-2024	Down Syndrome Week Celebration.

Health Manifesto for Parliamentary Elections

To
The State President & Secretary
All the IMA State Branches

Greetings from Indian Medical Association, HQs.

We acknowledge the help and cooperation of all the state branches for the past 7 weeks. We have been able to meet with each other individually and severally in Delhi. We could also put together a meeting of the MPs successfully. The most important event in the country this year happens to be the Parliamentary elections.This is a great opportunity for IMA at all levels to intervene in Health issues as well as highlight the issues confronting the medical profession.

Accordingly, IMA HQs has come out with the Health manifesto to be used by IMA State and Local branches. We are herewith forwarding the Health Manifesto drafted through a consultative process. Several experts have contributed in its preparation. You can peruse the document and appreciate its breadth and depth. It is desired that the state branches of IMA print as many copies as required.The StatePresident and State Secretary may kindly make a translation of the initial few pages written by the National Presidentand Hony Secretary General into vernacular as their contribution with their photos and names. It is desired that every state branch conduct a leadership meeting for atleast 5 hours in equipping and training all the local branch Presidents andSecretaries in this regard. A leadership meeting consisting of state office bearers, senior state leaders and local branch Presidents and secretaries may be convened in the first fortnight of March.

This intimation is to enable you to plan your meetings accordingly. The Health Manifesto is for the nation and the people. A charter of demands and the general structure of the leadership meeting are under preparation. This will be sent to you in the following days. The purpose of the exercise is to empower the local branch leaders to interact with the candidates of all political parties highlighting the Health needs of the country and the demands of the medical profession.

This nationwide exercise for the Health of the people and the demands of the profession will be the most powerful intervention that IMA can bring out. We request all the State Branches to align with IMA HQs in making it a great success. We are available over phone or WhatsApp or email for clarification.

Thanking you,

Dr. R V Asokan
National President

Dr. Anilkumar J Nayak
Honorary Secretary General

INDIAN MEDICAL ASSOCIATION

IMA Health Manifesto 2024

ALL INDIA MEDICAL CONFERENCE
98th National Conference
Indian Medical Association

Proceedings from
National Conference of Indian Medical Association
December 26, 27, 28, Kovalam, Thiruvananthapuram

ABOUT THIS DOCUMENT

This Health Manifesto was generated during the Tharang-IMA National Conference held in Thiruvananthapuram, Kerala, on the 26th, 27th and 28th of December 2023. The drafting committee operated as a sub-committee of the national conference's organising committee. The drafting committee worked continuously for two months to develop this document. The organising committee held several meetings with the drafting committee in November and December to assess the progress. A preworkshop meeting was held on 10th December 2023, which was attended by prominent socio-political leaders in addition to large number of public health and medical experts. The health policy workshop at the national conference that took place on 27th December 2023 at KTDC Samudra and attended by various global health leaders endorsed the document. The draft Manifesto was released in the public function on 28th of December 2023 where Dr RV Asokan took charge as the National President of IMA.

IMA'S CONCERNS IN HEALTH AND POLICY POSITIONS

Universal Health Care (UHC)

IMA recognizes Universal Health Care (UHC) as an entitlement to Health security. The state has an obligation to provide appropriate medical care but also to address all the health determinants including drinking water and sanitation. The entitlement should be for a basic Health package for every citizen in primary, secondary and tertiary care. Universal Health care should be ensured primarily by the public sector supplemented with strategic purchase from the private sector. Universal Health Care should move from an aspirational goal to an entitled provision.

Health Financing

IMA advocates a tax-based system of Health financing. Contributory Health insurance offers incomplete coverage and restricted services. General revenues should be the source of UHC. Increased allocation of financial resources for Health is the most important component. The allocation varying from 1.1 to 1.6 % GDP together by the various Governments is one of the lowest in the world. Moreover, the expenditure incurred on Health determinants like drinking water, sanitation should be provided for separately. Thus, the minimum allocation for Health alone should be around 2.5% of the GDP. Despite numerous policy pronouncements prioritizing health, the governments in India at the Centre and state levels have historically underfunded the public health sector, resulting in poor health outcomes and rising inequity in access to health care. India's overall health spending (public and private) is currently estimated to be 3.8% of its GDP, lower than the LMIC average of health spending share of GDP of around 5.2%. India's health system is overwhelmingly financed by out-of-pocket (OOP) expenditures incurred by households (around 63% of all health spending) (NHSRC, 2018b; RBI, 2019). Government funding, provided by both the Central and state governments, currently constitutes approximately one-third of all health spending, with states accounting for nearly two-thirds of total government health expenditure. Sustained underfunding of public sector facilities, and the rapid growth of private sector has contributed to rising OOP costs on health care for households. Of this, a significant share, almost two-thirds of OOP expenses, are for

purchasing outpatient care, especially medicines. Because households bear the burden of the high OOP health expenses in India, more than 55 million people are impoverished each year on account of expenses for ill health.

Accreditation is better option

The advice of the Planning commission committee to choose accreditation for healthcare institutions as the choice for regulation was ignored. The Clinical Establishment Act in the current form is proving to be a burden on small and medium hospitals. Cases of misuse of power are being reported. If registration and quality are the aims the goals will be better served by insisting on accreditation rather than regulation. There is a strong case for exemption of small and medium hospitals from the clutches of the current CEA.

Anti-Microbial Resistance

AMR is emerging as a major threat in the communicable diseases front and has to be tackled with urgency. Anti-Microbial resistance (AMR) is global, regional, and national priority. It increases morbidity and mortality, and results in economic losses. The rates of AMR in the 3 sectors – human, food animal, and environment - have been rising disproportionately in India in the past decades.

The responsible use of antibiotics is a fundamental and effective strategy in containing AMR; however, misuse, overuse, and inappropriate use of these medications contribute significantly to the development and spread of antibiotic-resistant bacteria. AMR containment needs a multi-stakeholder response to raise AMR awareness, training, and capacity development of health professionals, strengthening of infection prevention and control, operational research, and surveillance of AMR, as well as antimicrobial consumption/use and healthcare associated infections.

IMA can play a pivotal role in promoting behavioral change through continuous medical education, peer support, and fostering of responsible anti-microbial use within the healthcare community, and reduction of spread of infections in health care settings.

Quality of Drugs and related issues

The Mashelkar Report of 2003 noted, "The problems in the regulatory system in the country were primarily due to inadequate or weak drug control infrastructure at the State and Central level, inadequate testing facilities, shortage of drug inspectors, non-uniformity of enforcement, lack of specially trained cadres for specific regulatory areas, non-existence of data bank and non-availability of accurate Information. There is much less quality control on the manufacture of medication except perhaps among those recognized as GMP (Good Manufacturing Practice) companies. Quality assurance of the drugs manufactured in the country is a top priority. Similarly, GST on drugs and medical

equipment levied at 5% to 18% needs a reconsideration considering the fact drugs form the substantial portion of out-of-pocket expenditure.

IMS - Indian Medical Services

The COVID pandemic has exposed the vulnerability of the healthcare system in our country. It has also brought to fore the grave paucity of professionalism in health management right from the Sub-District Office level. As such, this mandates towards an acute need for change in the health administration of the country. IMA has proposed to the Government to revive the Indian Medical Services discontinued in 1948. An All-India cadre of doctors would be more sensitive to the needs of the patients and clinicians. It is pertinent to note that 'Law and Order' is a state subject in the schedule appended to the Constitution of India but there is an All India Indian Police Service which is in vogue.

National Medical Commission

1,08,915 MBBS graduates come out of 706 medical colleges of India posing huge challenge for quality maintenance in our medical colleges. IMA desires that NMC should rise to the expectations and trust invested in it. NMC should be sensitive to the issues of young doctors, their career and unemployment. Moreover, the National Medical Commission Act, 2019 needs to be amended to suitably incorporate a provision thereunder for supporting medical education through accruable developmental funds in tune with the provision included at Section 12(B) of the University Grants Commission Act, 1956 governing Higher Education so as to make National Medical Commission a Commission in the truest and realistic sense by vesting it with financial disbursement authority.

In order to invoke quality centricity in all levels of medical education a robust and outcome based analytical accreditation system through Autonomous Accreditation and Ranking Board of the NMC needs to be rolled out immediately in the teeth of recognition granted to it by World Federation of Medical Education vide its Notification dated 20th September, 2023 for a period of 10 prospective years and avail much desired Global parity in the context of the material reality that India turns out to be the largest producer of trained health manpower.

It is also mandated that institutionalized mechanism in the form of Academic Staff Colleges for full time faculty development programme through structured refresher courses for medical education needs to be evoked for fulfilling international parlance on the said count.

Healthcare violence

Violence on Doctors and Hospitals is a national shame. 23 State legislations have been ineffective due to absence of a Central Law.

The Central Government deemed it fit to bring amendments to the Epidemic Diseases Act 1897 during Covid period. Airport and Airline staff are protected by a Central Law. Hospitals should be declared as safe zone. Doctors and nurses deserve to be protected during normal times as well and certainly deserve to be treated as equivalent to airline staff.

Health Manifesto

In a Parliamentary democracy the only way to raise our concerns is to sensitise the common man and create a public opinion. Health of the nation deserves to be an important election issue and IMA strives to streamline its concerns into a Health Manifesto. IMA rededicates itself to the health of our people and to work with the Government to achieve affordable Universal Health Care for everyone.

Priorities

- Tax funded universal healthcare with basic package for all citizens.
- Direct funding of Government Hospitals and human resources with strategic purchase from private sector.
- 5% GDP resources to be allotted by the Governments to Health.
- Re-envision PMJAY to cover outpatient care and cost of drugs.
- Direct patients transfer, copayment and reimbursement models will sustain Health insurance model.

Dr. R V Asokan
National President

Dr. Anilkumar J. Nayak
Honorary Secretary General

07/02/2024
New Delhi

PREAMBLE

The Indian Medical Association (IMA) proudly presents its Health Manifesto, a comprehensive and ambitious blueprint that recommends practical and innovative solutions to substantially overcome the current and ever-growing critical health challenges faced by the country. IMA, the sole representative voluntary organization of doctors practicing Modern Medicine in India stands as one of the largest professional organizations in the world, with a current membership of 367774 doctors. IMA aims for healthcare providers to attain the highest levels of latest scientific knowledge and most desired attitudes while they ensure the best quality in the care, they provide by following evidence-based scientific practices.

While acknowledging all the great achievements made so far by the country in healthcare, this manifesto endeavors to identify the major shortcomings in the health policies of India and to search for remedial actions against the backdrop of the current and emerging challenges in healthcare. It is further intended to add value to the successful policies. The recommendations are in line with the World Health Organization's concept of Universal Health Coverage and broadly aligned with the spirit of the UN Sustainable Development Goals (SDGs). IMA expects lawmakers and decision-makers to use this Manifesto to ensure the best solutions are delivered in healthcare.

IMA's priorities, identified through extensive consultation with experts, reflect the experiences of frontline healthcare workers, academicians, researchers, activists, and policymakers in dealing with suboptimal health services and inequalities in care. Given the resource scarcities and health system challenges of the country, this Manifesto has tried to strike a balance between being visionary and pragmatic. IMA focuses on positive impacts on health in the short and medium terms, alongside sustained approaches to combat long-term challenges.

IMA aspires this Manifesto to be instrumental in enacting policies that would promote better health for all by recognizing the current and future healthcare needs of the country. Though not exhaustive, the Manifesto highlights the priority areas requiring specific and urgent actions to improve health and wellbeing, save lives, and offer future generations the best opportunity for a healthy life. IMA does realize the need for the government to address the public health impacts of the widening gaps between the rich and the poor. Therefore, this Manifesto is built on the commitment to providing equitable, accessible, and affordable healthcare in modern medicine for every segment of the population. It would also serve as a set of guiding principles emphasizing the need for an updated and responsive health policy.

Through this manifesto, IMA reaffirms its dedication to the highest standards of physical and mental health and well-being for our children, youth, women, communities, and society at large. A healthier society becomes achievable only when the right health approaches are prioritized in public health actions. Therefore, IMA urges the Government to prioritize health as a fundamental human right and to develop a robust and compelling public health plan, equally prioritizing physical, mental and social well-being. IMA is committed to creating institutional structures like thematic empowered action groups (EAG) consisting of expert pools in the respective thematic areas. EAG will interface with IMA leadership, and private and public institutions to shape policies and provide technical guidance to the relevant stakeholders.

IMA AS A KEY STAKEHOLDER IN HEALTH

IMA has a record of providing precious contributions to the health of the country many of which have become models in public health. The latest example is the nationwide voluntary services IMA provided during the COVID-19 pandemic. IMA COVID-19 helpline across the country received over 2 million calls. Through its 1700 branches, IMA distributed essential health equipment and food materials to the needy. IMA also launched helpline services for doctors. Sadly, IMA lost over 2000 lives of doctors who succumbed to COVID-19.

In 1993, when HIV/AIDS was a big challenge for society as well as the medical fraternity mainly due to limited knowledge of the disease, lack of treatment, and fear and discrimination in the communities, IMA took the initiative to sensitize and train and played a major role in creating awareness in society about preventing HIV. IMA's HIV sensitization program with assistance from the Clinton Foundation covered nearly 400,000 health personnel. IMA partnered with NACO in the area of early diagnosis, and prevention of infection from mother to child. Since 1997, IMA's active engagement in tuberculosis elimination, especially in engaging the private health sector, is quoted internationally as an innovative, cost-effective, and successful model. Under a Global Fund-aided programmes, IMA Conducted over 10,000 CME programmes and over 100 workshops nationwide in which 234377 doctors were sensitized/trained in TB elimination. IMA has always been heavily engaged in organizing medical camps, vaccination campaigns and other campaigns like Anemia-free India. In 2003, IMA adopted 1040 villages as part of a village adoption programme.

State level and local branches of IMA run about 160 blood banks and over 2500 blood donation camps were organized in 2022. IMA organized campaigns to sensitize all sections of society, through the 'Mission Pink Health Project' for women's empowerment to 'save the girl child'. In this programme, IMA sensitized over 400,000 doctors across India on 'Say No to Pre-Natal Sex Determination'. IMA along with its women doctors and medico-legal experts prepared a comprehensive examination programme of a victim child of sexual abuse/rape for which IMA, UNICEF, and other partners came together with a standardized protocol for medical examination and evidence collection.

IMA has been an active and dominant participant in the antimicrobial-resistance containment program at the national level since 2011. IMA is continuously sensitizing doctors and healthcare workers through regular online and offline meetings on the rational use of antibiotics to reduce AMR. IMA, through its members and branches has worked with the Government to make the pulse polio immunization programme successful. IMA National Initiative for Safe Sound has organized several pilot projects to educate the community about the problem of sound pollution. IMA has active organ donation committees across the country. IMA also has an active road safety program which encompasses training the public on road safety measures, campaigns, training on first aid, safe transport and basic life support, and training to medical personnel. IMA has taken a strong position against the unscientific mixing of different systems of medicines. IMA expects the Government to be more proactive in engaging IMA in all relevant health programmes.

It has been evident that the engagement of IMA in national health policymaking and the implementation of health programmes will benefit the Government and the public. IMA will continue to extend its voluntary services across the nation to strengthen the efforts of the governments to provide scientific, quality-assured, and equitable healthcare services to the people.

1. INTRODUCTION

The Indian health landscape has been witnessing significant transformations since the launch of the last national health policy in 2017. This transformation is driven by dynamic evolutions in epidemiology, healthcare systems, scientific advancements, and the impact of the COVID-19 pandemic. The Manifesto predominantly covers key areas such as communicable diseases, non-communicable diseases, One Health, and digital health, and selected other key areas reflecting a comprehensive strategy towards drastically improving public health outcomes.

Central to this Manifesto is the recommendation to significantly increase the share of GDP allocation for healthcare. Enhanced funding is crucial for prioritizing primary and preventive health, addressing social determinants of health effectively, and strengthening medical education and research. Such fundamental financial decisions are essential for building a resilient and efficient healthcare infrastructure. This Manifesto advocates for a funding model that directly corresponds to the contextual disease burdens and patients' needs across different healthcare delivery systems under the services of modern medicine. This approach would ensure that the allocation of funds is proportionate to the volume of patients and guarantees equitable and needs-based resource distribution, thus ensuring efforts to achieve universal health coverage. Reduction of out-of-pocket expenditures is key to eliminating catastrophic health expenditures for Indian families.

The manifesto also emphasizes disease prevention, health education and health promotion, moving beyond the current trend of disproportionately prioritizing curative approaches, especially in the public health sector. In alignment with this, there should be additional programs to address the health issues of the underserved and marginalized communities. This would include decentralizing healthcare systems and expanding coverage of technology through telehealth, digital health, and other innovative solutions. Special attention should be directed towards gender-specific health disparities, with targeted initiatives to bridge the healthcare gaps for women. The Manifesto also points out the psychosocial and other health challenges faced by adolescents, and the need for interventions for stress management, substance abuse prevention, and mitigation of life-threatening behaviours.

Recognizing the critical and rapidly growing role of technology in healthcare, the manifesto strongly advocates for the integration of advanced technology in healthcare delivery. The Manifesto advocates for further enhancing the medical education standards to ensure high-quality training and practice and addressing the retraining needs of the healthcare workforce. This approach focuses on improving medical education to align with advancing scientific knowledge while ensuring the well-being of healthcare providers. Key measures would include reasonable compensation, better working conditions, and mental health support, especially for those healthcare personnel facing stress and burnout due to excess workload and unfavorable work environments. The Manifesto encourages the need for incentivizing recruitment and retention of personnel to ensure equitable distribution of healthcare workers. Nevertheless, the Manifesto strongly opposes any efforts in the direction of unscientific mixing up of modern medicine with other systems of healing that pose direct dangers to the health of the common man. At the same time, IMA would urge for promoting scientific research across all medical disciplines so that all systems of healing are restricted to practicing evidence-based medicine and thereby people of all sections are protected from the dangers of being subjected to non-standard treatment modalities. IMA urges the governments to strictly prohibit unscientific and unethical practices in healthcare delivery to safeguard the health and well-being of the Indian populace. IMA has strong reservation against the current Clinical Establishment Act and the more than 50 regulatory laws on the hospitals that need amendments or revisions.

IMA firmly believes and affirms that this Manifesto would stand as a comprehensive package to guide and complement a transformative journey towards a healthier, more equitable, and scientifically advanced public healthcare system in India.

2. GLOBAL HEALTH SCENARIO

Since the onset of the 21st century, the world has witnessed remarkable transformations in the landscape of global health. As the incidence of many infectious diseases including HIV, TB and malaria dropped, the risks of dying prematurely from NCDs and injuries declined, child mortality rates halved, and maternal mortality rate fell by a third, and the global life expectancy at birth increased from 67 years in 2000 to 73 years in 2019. These advances are attributed mainly to better access to healthcare services and reduced exposure to risks like tobacco use, alcohol consumption, and child undernutrition. However, progress has slowed since 2015, affecting the timely attainment of the Sustainable Development Goals (SDGs) targets by 2030. This is evidenced by the falling annual rate of reduction in indicators such as the maternal mortality ratio, under-five and neonatal mortality rates, premature mortality from major NCDs, suicides and road traffic mortality rates. The United Nations predicts a nearly 90% increase in the number of people who will die from NCDs by 2048 compared to 2019.

The adverse impact of the COVID-19 pandemic on the health systems and important health programmes is yet to be accurately estimated. The COVID-19 pandemic has severely hampered the performance of countries in many healthcare-related areas thereby reversing the achievements against important health indicators. Healthcare service disruptions have halted the increasing trend in immunization coverage and reversed the declining trends in the incidence of major killer diseases like TB, HIV, and malaria. Moreover, fewer people have received treatment for neglected tropical diseases (NTDs). The COVID-19 pandemic underscores the threat of infectious diseases, which can emerge or re-emerge at any time and affect anyone.

According to the Global Sustainable Development Report 2023, globally, only 12 per cent of the SDGs are currently on track, due to multiple crises including wars, the COVID-19 pandemic, and the increasingly tangible climate crisis. Despite reductions in exposure to numerous health risks, progress has been inadequate in many areas. Exposure remains high, particularly for factors like alcohol consumption and hypertension, with declines only beginning in recent years. The prevalence of obesity is moving in the wrong direction, with no immediate signs of reversal. In addition, the expansion of access to essential health services has slowed after 2015, and there has been negligible progress in reducing the financial burden associated with healthcare costs. Persistent inequalities in access to healthcare, and exposure to health risks continue to affect disadvantaged populations disproportionately, further hindering the efforts towards achieving health equity.

Antimicrobial resistance (AMR) may cause a resurgence of infectious diseases that were previously under control, undermining the achievements. Climate change also erodes the environmental and social determinants of physical and mental health, exposing everyone to enormous risks.

These challenges require scaling up efforts and accelerating progress towards the SDG targets for 2030. Global, regional, and national priorities and interventions should aim to eliminate deaths from preventable injuries, maternal and child mortality, and infectious diseases, as well as to delay NCD deaths by reducing their underlying risk factors. Equitable access to essential health services should be increased while minimizing the risks of catastrophic costs. Timely, reliable and disaggregated data, estimates, and forecasts are essential to inform policy and guide actions at all levels for maximizing health gains and eliminating inequalities. Enhanced technical assistance from the global UN agencies like WHO and other technical partners, and increased financial assistance from international donors will be the key to success in revamping the global efforts to achieve universal health care.

3. INDIAN HEALTH SCENARIO

Over recent decades, India's health sector has made steady and significant progress. The average life expectancy has surpassed 70 years, and there is a noticeable decrease in infant and under-five mortality rates, as well as overall disease incidence. Major achievements in recent years include the eradication of diseases like polio, guinea worm disease, yaws, and tetanus. Despite various programs and initiatives run by the government, private sector, NGOs, and other healthcare organizations to address healthcare challenges, India, as of 2023, ranks 112th out of 162 countries in the SDG Index, according to the United Nations' Sustainable Development Solutions Network. India's health sector faces significant challenges due to one of the lowest allocations of health funding as a percentage of GDP globally. India's healthcare system faces numerous challenges, including a large population (1.4 billion estimated in 2023), social and gender disparities, geographical gaps, and a shortage of resources.

Communicable diseases continue to be a major public health concern in the country, posing significant threats to both national and international health security. The COVID-19 pandemic has highlighted the vulnerabilities in the health systems of the country and the need for robust infectious disease surveillance and response mechanisms. Older diseases, such as HIV/AIDS, TB, malaria, and neglected tropical diseases, continue to challenge the country's public health efforts. Additionally, vector-borne diseases, such as dengue and acute encephalitis syndrome, remain areas of concern. Moreover, the growing problem of antimicrobial resistance poses a significant global health challenge, necessitating immediate and comprehensive action.

India is undergoing a significant health transition marked by an increasing burden of non-communicable diseases (NCDs) that account for 66% of all deaths in the country. Cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases constitute approximately 80 per cent of these NCD-related deaths. These conditions are primarily driven by lifestyle factors such as tobacco use, harmful alcohol consumption, unhealthy diets, and physical inactivity, each of which plays a significant role in the development and progression of these diseases. India is also facing a significant demographic change, with the number of individuals aged 60 years or older expected to increase to almost 20% of the total Indian population by 2050, which will be equivalent to 319 million people. This change is likely to result in a rise in the prevalence of conditions like dementia. At present, approximately 8.8 million Indians aged 60 years or older are living with dementia, which is considered an emerging epidemic. Non-Alcoholic Fatty Liver Disease has emerged as one of the leading causes of cirrhosis, hepatocellular carcinoma, and Liver transplant in India. The burden of liver disease is significant because it alone contributes to 18.3% of the two million world liver disease-related death.

The country continues to experience high maternal and infant mortality rates, largely due to inadequate access to healthcare, prevalent malnutrition, and limited awareness of maternal and child health practices. Nutritional issues, manifesting as undernutrition, micronutrient deficiencies, and obesity, variably affect different population segments across regions. Mental health issues are increasingly recognized as critical public health concerns, aggravated by stigma, a lack of awareness, and inadequate mental health care infrastructure. Moreover, significant disparities in healthcare access and infrastructure persist between urban and rural areas, resulting in unequal healthcare services and outcomes. Environmental factors, notably air and water pollution, further contribute to a range of health issues, including respiratory and waterborne diseases.

The private healthcare sector in India caters to a considerable share of healthcare needs. However, this sector is highly diverse, consisting of healthcare providers ranging from state-of-the-art urban hospitals to quacks in many rural areas. The lack of consistent and uniform application of regulations has led to the emergence and flourishing of self-proclaimed healers, unscientific mixing of different systems of healing by a large number of practitioners, and unauthorized and irrational prescriptions of life-saving medicines, including antibiotics, that further muddle the already complex health systems, resulting in people receiving widely variable quality of care across healthcare facilities. Despite this, the authorized private health sector with qualified healthcare providers plays a substantial role in the country, while major issues related to accessibility, affordability, and standardization persist.

4. MAJOR HEALTH PROBLEMS IN INDIA: CHALLENGES AND RECOMMENDATIONS

4.1 COMMUNICABLE DISEASES

Global Scenario

According to the WHO, communicable diseases such as tuberculosis (TB), HIV/AIDS, malaria, viral hepatitis, sexually transmitted infections, and neglected tropical diseases (NTD) are the leading causes of death and disability in low-income countries and marginalized populations. In 2019, 13.7 million people worldwide died from communicable diseases. Globally, an estimated 10.6 million individuals contracted TB worldwide and 1.3 million people lost their lives to this disease in 2022, making the disease the world's second leading cause of death from a single infectious agent after coronavirus disease (COVID-19). TB caused almost twice as many deaths as HIV/AIDS (0.63 million in 2022). Theglobal TB incidence rate rose by 3.6% between 2020 and 2022, reversing the previous trend of about 2% annual decline observed over the previous two decades, possibly due to the disruptions in TB services caused by the pandemic. As of 2020 data, 296 million people globally had hepatitis B, and 58million had hepatitis C, causing 1.1 million deaths. Global coverage of the hepatitis B vaccine was 83%, with 42% of children receiving a birth dose to prevent mother-to-child transmission. In 2022, there were 249 million cases of malaria globally, 5 million more cases as compared to 2021. There are emerging and re-emerging diseases such as SARS, Nipah, Zika, Ebola, MERS, H1N1, Measles, Dengue, Cholera,and Lyme disease. Diseases of zoonotic origin and growing threats of antimicrobial resistance (AMR)are making the scenario worse; AMR alone was directly responsible for 1.27 million deaths in 2019. NTDs like Schistosomiasis, Onchocerciasis (River Blindness), Lymphatic Filariasis, Trachoma, Soil- Transmitted Helminthiasis, Dengue Fever, Chagas Disease, and Leishmaniasis, primarily affect tropical and subtropical regions, often in low-income countries. STDs like HIV/AIDS, Gonorrhea, Chlamydia, Syphilis, Herpes Simplex Virus (HSV), Human Papillomavirus (HPV), Hepatitis B and C, Trichomoniasis, Mycoplasma dentalium, Bacterial vaginosis (BV) have significant global impact. Theprevalence and distribution of STDs vary across regions and the efforts to control and prevent these diseases such as research focusing on developing vaccines, improving diagnosis, and understanding the epidemiological dynamics of these infections to devise effective control strategies are ongoing. 'Disease X' is a term used by the World Health Organization (WHO) to denote a hypothetical, unknown, or unexpected disease that could potentially cause a future epidemic or pandemic. In the remaining six years of the sustainable development goals (SDG) of the UN, there must be accelerated efforts globally and in high-burden countries to address the burden of major communicable diseases tosignificantly progress towards SDG targets.

Indian Scenario

In India, the landscape of communicable diseases presents formidable challenges. Tuberculosis (TB) stands out, with 2.8 million cases in 2022, contributing to 27% of the global burden, and 600,000 cases went unreported to the National TB Elimination Programme (NTEP). COVID-19 has significantly impacted the nation, recording 45 million confirmed cases and 533,295 deaths. Estimated 2.4 million people are living with HIV/AIDS, primarily in the 15-49 age group, with women constituting 42% of cases. An estimated 40 million people are infected with Hepatitis B virus, with 21 million annual infections due to unsafe injections. India reports 1.4% of global Malaria cases and 0.9% of deaths, Plasmodium vivax malaria contributes to 66% of cases. Vector-borne diseases like dengue (94,198 cases, 91 deaths), chikungunya, and Zika remain prevalent. As per NVBDCP, the active Indian cases of dengue increased by 23.21 % in 6 years from 2015 to 2022. Nipah virus caused over 100 deaths since the first outbreak in 2001 and the last case was reported in Kerala in 2023. Communicable diseases like dengue (188,366 cases, 247 deaths), Acute Encephalitis Syndrome (5,946 cases, 216 deaths), Kala-Azar (1,353 cases, 28 deaths), and Japanese Encephalitis (754 cases, 66 deaths) pose ongoing health threats, emphasizing the complex public health scenario in India. In India, 550,000 cases of lymphedema and 150,000 cases of hydrocele were reported in 2022 across 339 districts in 20 states/Union Territories. As of 2022, over 336 million children in India require preventive chemotherapy for soil-transmitted helminthiasis is caused

by soil contamination from human waste, leading to nutritional and physical impairments. Intestinal worm infestations contribute to iron deficiency anemia, increasing the risks of maternal and infant mortality, as well as low birth weight. In India, the latest cholera outbreak in July 2023 impacted over 400 people. In 2019, H1N1 cases numbered 28,798 cases, resulting in 1218 deaths, adding to the multifaceted challenges faced by the country's healthcare system. Due to COVID-19 pandemic, these numbers have drastically reduced to 2752 confirmed cases and 44 deaths in 2020 and 778 confirmed cases and 10 deaths in 2021.

Actions so far in India

The National Strategic Plan (NSP) for tuberculosis (2017-25) has a goal of ending TB by 2025. The National AIDS and STD Control Program (NACP) aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. The National Frameworkfor Malaria Elimination in India 2016–2030 was initiated with the goal to eliminate malaria (zero indigenous cases) throughout the entire country by 2030 and maintain malaria-free status in areas where malaria transmission has been interrupted and prevent re-introduction of malaria. The Government of India provides IgM MAC ELISA test kits free of cost through NIV Pune to maintain uniformity and standard of diagnostics for dengue. In 2023, India launched a nationwide Mass Drug Administration campaign, employing door-to-door anti-filarial drug distribution, particularly in high-burden districts of 10 states, with the goal of eliminating lymphatic filariasis by 2027. The influenza surveillance is conducted through structured influenza surveillance network of DHR-ICMR Virus Research and Diagnostic Laboratories (VRDLs), and its National Influenza Centre (WHO-NIC) housed at ICMR- NIV Pune (also a WHO CC for GISRS) since July 2021. Under surveillance, a network of 29 sites is collecting the data and monitoring the influenza activity round the year.

Major Issues Considered

India's dense urban population accelerates communicable disease spread due to overcrowded living conditions, poor waste management, and stagnant water fostering vectors. Inadequate sanitation, diminishing access to clean water, and social determinants like poverty and limited healthcare exacerbate the prevalence of water and vector-borne diseases.

The prevention and control of communicable diseases face new challenges, including climate change, emerging zoonotic diseases, and antibiotic resistance. Increased human-animal interactions heighten the risk of zoonotic diseases, emphasizing the importance of a comprehensive one health action plan. Climate change is anticipated to elevate vector-borne diseases like malaria and dengue, altering vector dynamics. Rising temperatures expedite the lifecycle of vectors, potentially enhancing the transmission of disease-causing pathogens. Antimicrobial resistance (AMR) is exacerbated by the misuse of antibiotics, anti-malarial drugs, and anti-retroviral drugs, fueled by unrestricted access without qualified prescriptions and inadequate drug resistance surveillance. In India, timely disease reporting and surveillance, particularly in remote areas, pose challenges. To address this, there's a need to investin technology for real-time reporting, online dashboards, and collaboration between public and private healthcare providers. Challenges include a shortage of trained human resources, insufficient healthcare workers, and the need for equitable access to testing and diagnostic services, especially in underserved regions. Additionally, disparities in health outcomes persist due to social determinants like poverty, education, and unequal access to healthcare, highlighting the necessity for uniform integration of disease control programs into the general health system nationwide.

Tuberculosis (TB), Malaria, and HIV/AIDS are the major disease contributing to India's morbidity and mortality. The COVID-19 pandemic disrupted TB management services, resulting in a backlog of undetected cases globally. The reported increase in TB cases post-pandemic, both globally and in India, reveals the impact of resuming health services and addressing backlogged cases. Challenges include poor coverage of WHO-recommended testing, inadequate private sector engagement, and the escalating

threat of multidrug-resistant TB (MDR-TB). TB prevention efforts face obstacles such as insufficient preventive treatment coverage, absence of an effective adult vaccine, and prolonged antibiotic regimens leading to non-adherence. Inadequate financial support and the absence of services like nutritional supplementation during and after treatment impose significant socioeconomic burdens. Societal stigma surrounding TB hinders community cooperation and engagement, complicating disease control initiatives. COVID-19 surveillance faces challenges due to the absence of continuous clinical and genomic surveillance systems, hindering professional analysis and scientific research. The lack of online dashboards detailing genetic data on newer variants further impedes independent assessments. India doesn't have upgraded COVID-19 vaccines, creating the need for booster shots, particularly for vulnerable populations. Development of a subunit vaccine, considered safer than mRNA vaccines, is crucial to meet the evolving needs of COVID-19 cycles. HIV/AIDS has varying prevalence across regions and populations. Despite progress, the UNAIDS 95-95-95 targets for ending the HIV epidemicby 2030 stand off track with an interim target of 80-87-87 against the achieved target of 77-84-85. The latest data on India shows that out of the individuals who are affected by HIV, only a mere 79% of themare aware of their status, only 68% are receiving the necessary treatment, and only a mere 63% have achieved viral suppression. Stigma and discrimination faced by patients prevent appropriate care seeking and disclosure of diagnosis in critical situations putting themselves and others at risk. Engaging adolescents and young adults in testing and treatment is hindered by misconceptions and lack of awareness.

In the group of eleven High Burden to High Impact (HBHI) countries, India has witnessed a decrease in malaria-related deaths, yet it remains a significant contributor to the overall malaria burden among these nations. The emergence of drug resistance poses a substantial challenge to effective malaria management, while insecticide resistance hampers vector control efforts. Mutations like PfHRP2/3 gene deletions further complicate diagnosis using rapid diagnostic test kits. Malaria's prevalence among migrant populations raises health concerns due to tracking difficulties and the potential for spreading the disease. The government's reduced emphasis on leprosy as a top public health priority has impeded progress, particularly with the cessation of active case finding. Limited engagement of stakeholders, including private providers, further hampers meaningful involvement in leprosy control efforts. Growing resistance to anti-leprosy drugs and high relapse rates pose significant challenges. Insufficient awareness, diagnostic skills, and commitment among general health personnel, coupled with community ignorance, contribute to delayed diagnosis and patient self-reporting, perpetuating the challenges in leprosy eradication. Rabies encephalitis disproportionately affects the impoverished in rural areas. The absence of a coordinated national program hinders efficient reporting and tracking efforts. Widespread lack of awareness about pre- and post-exposure prophylaxis contributes to preventable cases and deaths. Addressing breakthrough infections post-vaccination poses a significant challenge.

India faces challenges in timely disease reporting and surveillance, especially in remote areas. Hence it is recommended to enhance disease surveillance systems, by investing in technology for real- time reporting, including maintenance of online dashboards, strengthening collaboration between public and private healthcare providers.

Recommendations General

Recommendations

1. Strengthen the primary healthcare infrastructure by ensuring appropriate focus on early diagnosis and treatment of communicable disease.
2. Establish a simple and unified digital portal for reporting communicable diseases of public health importance for surveillance..
3. Develop integrated evaluation frameworks for the implementation of vertical programmes on communicable diseases at district and subdistrict levels.

4. Engage IMA at all levels to facilitate intersectoral coordination and for establishing effective and long-term partnership with Private sector.
5. Establish a multi-sectoral accountability framework for disease elimination at national and subnational levels.
6. Introduce fast-track prevention efforts (vaccines and preventive treatment) for multiple diseases that could move towards elimination.
7. Recruit dedicated focal points both at national and state levels with responsibilities for antimicrobial stewardship.
8. Constitute committees to review the challenges and actions of major health programmes and to recommend focused action including redesigning and integrating disease control programs.
9. Expand international collaboration to strengthen global health security measures.

Disease-specific Recommendations

TUBERCULOSIS

- **Enhance Detection and Surveillance:**
  - Improve community-based active case finding and household contact investigations.
  - Strengthen disease surveillance systems, integrating digital tools for simplified notifications and follow up of treatment.
- **Testing Modalities and Private Sector Engagement:**
  - Increase the coverage of WHO-recommended testing modalities for early diagnosis of TB disease and newer skin tests for TB infection to ensure easy access of these to people seeking care from private sector.
  - Enhance partnerships for TB elimination through quadrilateral partnerships among TB programme, private TB care providers, intermediary agencies and civil society ensuring accountability of each stakeholder.
- **Preventive Measures and Financial Assistance:**
  - Expand coverage of TB preventive treatment for vulnerable populations and individuals using shorter regimens.
  - Provide financial assistance to alleviate the economic burden on TB affected families.
  - Establish systems to roll out new vaccines.
- **Nutritional Support and Technology Integration:**
  - Offer nutritional support through rations and subsidies for TB affected families.
  - Incorporate technological advancements like Video-Observed Treatment for treatment adherence.
- **Research and Awareness:**
  - Support research for newer vaccines, leveraging India's role as a vaccine manufacturing hub.
  - Conduct research for shorter drug regimens, especially for MDR/RR TB.
  - Implement awareness programs to dispel misconceptions and address knowledge gaps.
- **Surveillance and Logistical Management:**
  - Establish molecular or genomic surveillance systems for accurate prediction and actions. Establish a robust surveillance mechanism for quality assured TB treatment including peer audit of prescriptions and health facility based antibiotic stewardship.
  - Improve logistical and supply chain management to prevent shortages and stockouts of TB drugs.

COVID-19

- **Genomic Sequencing and Surveillance:**
  - Conduct genomic sequencing for identifying new variants.
  - Implement comprehensive surveillance of pathogens.
- **Real-Time Data and Rapid Response:**
  - Develop online portals for real-time data accessibility.
  - Establish mobile testing centers for early detection and confirmation of new variants.
  - Deploy rapid response teams to contain outbreaks.
- **Public Health Platforms:**
  - Develop country-wide platforms offering public health data on COVID-19.

HIV

- **Tailored Care and Training:**
  - Provide tailored care services, including community-based testing for high-risk groups.
  - Implement a comprehensive healthcare training curriculum for providers.
- **Universal Sexual History Inclusion:**
  - Mandate the inclusion of sexual history in healthcare inquiries.
  - Establish a National Condom Bank for free distribution.
- **Enhanced Clinic Services and ANC Screening:**
  - Enhance clinic services with sexual wellness offerings.
  - Screen for HIV during the first trimester of pregnancy.
- **Migrant Population Tracking and Awareness:**
  - Facilitate migrant population tracking through unique IDs.
  - Increase awareness among youth through educational campaigns.

Malaria

- **Biological Vector Control and Research:**
  - Expand biological vector control methods for sustainable strategies.
  - Earmark funding for intensifying research on newer drugs to overcome parasite resistance.
- **Cross-Border Collaboration and Diagnostic Modalities:**
  - Establish programmes to collaborate with neighboring countries for cross-border malaria control addressing malaria transmission.
  - Establish mechanisms to control malaria transmission due to interstate migration.
  - Scale up RDT-based testing and introduce newer diagnostic modalities.

Leprosy

- **Targeted Case Detection and Community Awareness:**
  - Set up projects to accelerate new case detection in high-endemic areas.
  - Asses the community awareness and start campaigns to reduce stigma.
- **Digitalization and Research:**
  - Incorporate digital tools in leprosy diagnosis and treatment methods.
  - Allocate additional funding for research to study the current trends in transmission.

Rabies

- **Vaccination Coverage and Public Awareness:**
  - Increase vaccination coverage, especially among stray dogs.
  - Raise public awareness on pre- and post-exposure prophylaxis.
- **Quality Control and Gene Therapy:**
  - Implement quality control measures for vaccine standards.
  - Explore newer treatment regimens, including gene therapy.

Zoonotic Diseases

- **High-Level Suspicion and Public Awareness:**
  - Orient medical professionals to identify zoonotic outbreaks.
  - Create public awareness on potential sources of zoonotic diseases.
- **Source Animal Monitoring and Research:**
  - Monitor source animal colonies for early outbreak warnings.
  - Encourage research on preventing zoonotic spillovers.

Mosquito-Borne Diseases

- **Meticulous Vector Control and Legal Measures:**
  - Implement regular vector control measures for mosquito-borne diseases.
  - Consider legal measures, including fines, during outbreak seasons.

Water and Food-Borne Diseases

- **Deworming and Health Education:**
  - Strengthen periodic deworming initiatives.
  - Enhance health education to prevent re-infection.
- **Sanitation Facilities and Vaccination:**
  - Improve sanitation facilities to reduce soil contamination.
  - Increase the use and availability of vaccines during outbreaks.

4.2 NONCOMMUNICABLE DISEASES

Global Scenario

Non-communicable diseases (NCDs) account for 74% of total deaths, leading to a loss of 41 million lives each year. More than three-fourths of these deaths occur in low- and middle-income countries. The Sustainable Development Goals (SDGs) envisage a reduction in NCD-related deaths by one-thirdthrough targeted prevention and treatment. Over 80% of premature NCD deaths are attributed to cardiovascular diseases (CVDs), cancers, chronic respiratory diseases, and diabetes. CVDs are the leading cause of death globally, taking an estimated 17.9 million lives each year. More than four out of five CVD deaths are due to heart attacks and strokes, and one third of these deaths occur prematurely in people under 70 years of age. Out of nearly 10 million cancer-related deaths worldwide in 2020,70% were in low-and-middle-income countries. In all, 537 million adults were living with diabetes in 2021, with expected rise to 643 million by 2030 and 783 million by 2045. An estimated 1.28 billion adults aged 30–79 years worldwide have hypertension. In 2019, 545 million people globally had chronic respiratory conditions, with chronic obstructive pulmonary disease (COPD) causing 3.23 million deaths, representing 90% of respiratory-related fatalities.

Indian Scenario

In India, nearly 6 million people die from NCDs every year, which accounts for 66% of total deaths. CVDs are the leading cause of death accounting for 28% followed by COPD (12%), cancer (10%), anddiabetes (4%). The national prevalence rates for various health conditions are as follows: diabetes at 11.4%, prediabetes at 15.3%, hypertension at 35.5%, generalized obesity at 28.6%, abdominal obesityat 39.5%, hypercholesterolemia at 24%, and high LDL cholesterol at 20.9%. Changing consumption patterns, rapid urbanization and increasing longevity have contributed to the rise in NCDs which account for about 55% of DALY loss in the country. Based on current estimates, 101 million individuals have diabetes, which is expected to rise to over 134 million by 2045. Only about 15.7% people with diabetes in India have their diabetes under control. In approximately 57% of these individuals with diabetes, the condition remains undiagnosed. An estimated 33% of urban and 25% of rural Indians arehypertensive. Of these, only 25% of rural and 42% of urban are aware of their hypertensive status. Only about 12% of people with hypertension have their blood pressure under control. India witnesses over 1.3 million new cancer cases annually and one in nine people are likely to develop cancer in their lifetime.Lung and breast cancers were the leading sites of cancer in males and females, respectively. According to the Global Burden of Disease project, there were about 1.2 million new cases of stroke in India in 2016. The annual incidence rate of stroke ranges from 105 to 152 per 100,000 individuals. India has a severe shortage of mental health professionals, with only 0.7 professionals for every 100,000 people, and far below the recommended ratio of three psychiatrists per 100,000 population.

Actions so far in India

Recognizing the rising burden of NCDs, India started its comprehensive NCD program in 2010. The current program is the National Program for Prevention and Control of NCDs (NP-NCD) which was launched in 2023. NP-NCD focuses on strengthening infrastructure, human resource development, health promotion and awareness generation for the prevention, early diagnosis, management, and referral to an appropriate level of healthcare facility. The NCD program is implemented through the primary healthcare system, especially by delivering services through Health and Wellness Centre's (HWC) and by engaging ASHA workers for delivery at the last mile. The National Action Plan has a specific target to reduce premature deaths from NCDs by 25% by 2025. The 75/25 initiative aims to help 75 million people with hypertension and diabetes to be put in standard care by 2025.

Major Issues Considered

There are gaps in the access to care, barriers to early detection, initiation of treatment, continuum of care and palliative care. Similarly, there are implementation and operational challenges in NP-NCD like difficulties in access to essential medicines, shortages in human resources and inadequate levels of dedicated staff. Addressing the differentials in NCD prevalence and outcomes among vulnerable populations, including rural communities, tribal groups, and marginalized urban populations is important. Governments' recognition and meaningful involvement of civil societies and professional bodies including people living with NCDs, organizations and communities in the NCD response has been too slow and suboptimal.

Lack of standardized services, particularly within the private health sectors, contributes to significant challenges in addressing NCDs. Even though 50-70% of NCD patients seek treatment from the private health sector, they are still not systematically integrated into the national surveillance system. This lack of inclusion hinders comprehensive tracking and analysis of NCD trends, thereby limiting the efficacyof public health interventions. There is a lack of common data standards to facilitate interoperability between public and private health systems. Heavy reliance on the private sector is accompanied by a concerning trend of out-of-pocket spending, resulting in catastrophic health expenditures for individuals. The prevalence of modifiable risk factors such as tobacco smoking, excessive alcohol consumption, unhealthy diet, and poor physical activity is notably high among the younger population. Despite the higher prevalence among older individuals, these behaviors often originate in young adulthood. This underscores the significance of School Health Promotion activities to address and

modify these behaviors early on. The suboptimal integration between programs like the National Program for Health Care of the Elderly (NPHCE) and the National Mental Health Program (NMHP) poses a barrier to effectively controlling NCDs. For example, depression, linked to behaviors like alcohol consumption and tobacco dependence contributes to increased NCD risk. Half of the low-income population of rural India cannot afford a balanced diet. India has also been undergoing a nutritional transition owing to rapid economic growth and urbanization, characterized by a decrease in intake of healthy foods such as whole grain cereals, pulses, fruits and vegetables, and a corresponding increase in processed meat and ready-to-eat energy dense and high salt foods.

There is a pressing need to shift health systems from being disease-centric to people-specific, providing continuous support throughout individuals' life courses. The current gap in the continuum of care for those with chronic diseases, especially older adults, and bed-ridden patients during extreme climatic events, exacerbates health challenges.

The widespread prevalence of hypertension and diabetes is primarily attributed to a lack of awareness and education regarding the disease's risk factors, combined with urbanization, unhealthy diet, obesity and sedentary lifestyle. Limited access to screening, early detection, and affordable, high-quality healthcare services exacerbates the burden of hypertension and diabetes, leading to significant out-of-pocket expenditures for disease management. Co-morbidities and complications associated with hypertension and diabetes further contribute to the overall disease burden. Inadequate community mobilization and weak coordination between civil societies, private sectors and government agencies hinder effective disease management. Additionally, suboptimal access to basic prevention and management of hypertension and diabetes in primary healthcare settings, including affordable medicines, diagnostics and consumables results in premature deaths.

Multiple factors contribute to a significant number of individuals not seeking medical assistance for stroke. These include a lack of awareness about stroke symptoms and urgency, considerable distances to the nearest hospitals equipped to provide diagnosis and management of stroke, inadequate ambulance services and transportation options. Additionally, the perception of alternative therapies as effective post-stroke care, and financial constraints also hinders access to necessary care.

In many of the peripheral hospitals physicians facing challenges in identifying fewer common causes of stroke, lack of skilled health workforce combined with limitations in diagnostic facilities and inadequate ambulance services hampers timely diagnosis and management of stroke. Patients face increased agony due to the unavailability and inaccessibility of rehabilitation and palliative care, resulting in a significant reduction in their quality of life and DALYs. The suboptimal availability of real-time data updates in the nationwide stroke register impairs the timely utilization of crucial information on stroke incidence and prevalence.

Hospital data on cardiovascular morbidity and deaths may not fully capture the entire burden of cardiovascular diseases. Structured data collection methods for cardiac mortality and morbidity are not in place, with most deaths occurring at home without knowing the exact cause of death. Alarmingly, up to three-fourths of patients with coronary artery disease (CAD) do not receive guideline-recommended basic therapy drugs, contributing to increased morbidity and mortality. This complex interplay of factors underscores the multifaceted challenges in addressing cardiovascular health in the Indian scenario.

India faces significant challenges in the spectrum of cancer care, necessitating urgent attention. There is a low rate of cancer registration which only covers 16% of total cases. The lack of screening guidelines tailored to the Indian context for early detection and treatment of common cancers, coupled with insufficient infrastructure development for implementation, poses a significant challenge.

In India, one among every two people with chronic respiratory illness is suffering from COPD, resultingin

a loss of 70% of their potential healthy years. COPD stands as the second-leading cause of death and disability-adjusted life years (DALYs) in the country. Several challenges faced by public and healthcare professionals hamper early diagnosis, exacerbated by restricted access to gold-standard diagnostic like spirometry. Even after diagnosis individuals face challenges with insufficient infrastructure for specialized care, medication cost barriers, and continued exposure to risk factors like tobacco smoke, indoor air pollution, and urban smog.

Social stigma and discrimination impede help-seeking by the people with NCDs and mental health diseases. It also curbs their accessibility to healthcare and often exacerbates the existing disparities. Particularly in rural areas, there is a scarcity of qualified mental health professionals which leads to a significant knowledge gap that hinders early identification and intervention, potentially leading to chronicity and adverse outcomes. Stigma and negativity around mental health in India leave countless young people struggling in silence, despite widespread mental health challenges. These challenges restrict the ambitious goals of the NMHP.

Lack of robust planning and implementation of health policies for building healthcare facilities in rural, semi urban India has resulted in missed opportunities to strengthen primary care and establishseamless referral pathways for combating NCDs. This lapse has a significant effect on the increasedburden on tertiary care facilities and in turn compromised the quality of services they delivered.

General Recommendations

1. Create platforms within the NPCDCS national programme for collaboration among government agencies, civil society, healthcare providers, and private sector stakeholders, for comprehensive and effective implementation of strategies for NCD management.
2. Develop a comprehensive framework for public-private cooperation and a roadmap for coordination through the National Multisectoral Action Plan for prevention and control of NCDs.
3. Establish a project under the NPCDCS to build the capacity of the private sector to manage complications of diabetes and hypertension.
4. Engage the private and other non-public healthcare providers in the NCDs program to ensure protocol-based management of hypertension, diabetes, cancer and other NCDs.
5. Using IMA as an interface agency, engage the private sector in setting up/expanding NCD surveillance systems and support the private sector in notifying the diseases and their outcomes.
6. Formally designate focal points from the private sector for a geographical area like a block or a district to aid in the engagement of the private sector.
7. Create formal mechanisms for facilitating private sector linkage to the NCD portal in a phased manner.
8. Make the diagnostics and medicines under the NCD program free of cost and available for private-sector patients by adhering to national protocols and data-sharing policies with provisions for incentives to private providers.
9. Link the private sector to a telemedicine platform to provide teleconsultation services and to ensure seamless care using ABHA ID.
10. Introduce programmes targeting behavior-change interventions among the youth against rising NCD risk factors..
11. Establish and incentivize employers of restaurants to implement comprehensive wellness programs at workplaces which shall include health screenings, fitness activities and stress management.
12. Expand the roles of healthcare workers by implementing task-shifting strategies. Empower nurses, pharmacists, and community health workers to provide basic NCD care and education, under the.

Supervision of qualified personnel, thereby increasing access to services, especially in rural and underserved areas.

13. To control the widespread availability of unhealthy food items high in fat, salt, and sugar, the government shall take steps such as higher tax rates, elimination of subsidies, and exclusion from start-up benefits to restrict their production, distribution, and sale.
14. Promote production and consumption of healthy food like fruits and vegetables.
15. Develop Health Insurance policies, specifically tailored to address NCDs among the elderly population, including geriatric care services, regular health check-ups, and support for caregivers.
16. The provisions of Cigarettes and Other Tobacco Products Act – 2003 (COTPA) should be enforced strictly to reduce tobacco use further. WHO guidelines for restriction of alcohol consumption shall be implemented.
17. Age-friendly and disability-friendly infrastructure should be incorporated into urban planning and public transport. Pedestrian-friendly infrastructure should also be integrated ensuring that sidewalks are included and accessible in all areas, especially near busy roads and intersections.
18. Environmental policies have to be revised to reduce NCD risk factors which would include measures to reduce air pollution, promote green spaces, regulate industrial emissions, and improve water quality, all of which impact NCD prevalence.
19. Meaningful involvement of people lived with NCD for prevention and control of NCD to be encouraged

Recommendations on Cancer

- Strengthen national prevention policies and establish screening guidelines relevant to the Indian context.
- Develop a common platform for addressing risk factors for breast, prostate, and colorectal cancers.
- Build a comprehensive cancer care workforce, including training for nurses, social workers, genetic counselors, surgeons, and oncologists. Provide mid-level service providers with hands-on training for early detection of breast and cervical cancers.
- Regulate and standardize the highly specialized field of cancer treatment, incorporating genomic information and personalized care. Develop guidelines, quality control measures, and standardization.
- Advocate for policy changes, substantial investment, and infrastructure development in cancer careacross the country.
- Address challenges such as limited availability of comprehensive multimodality treatment emphasizing life-threatening illnesses and promoting palliative care.
- Streamline regulatory processes for swift approval of diagnostic tools. Encourage international cooperation to amplify efforts in molecular diagnostics.
- Implement discounted rates for diagnostic tests to make them financially accessible. Negotiate cost-effective pricing models with laboratories and diagnostic facilities.
- Recognize the need for innovation in medical research within the educational system. Advocate for increased investment in basic medical research, especially for cancer, to ensure relevance to the Indian population. Emphasize the importance of not solely relying on data generated in Western labs for applicability to Indian medical scenarios.
- Strengthen clinical and basic research. Increased funding for clinical and basic medical research, emphasizing its relevance to the Indian population.
- Public Education on evils of Alcohol, Tobacco and Junk food to be actively promoted

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Thrombocytopenia in Children - The common, the confusing and not so easy ITP

Thrombocytopenia in children in quite common and other than infections and medications the most common cause is Idiopathic thrombocytopenia (ITP)

□Most commonly seen in 2 to 6 years old.

□Is divided in Acute, persistence and chronic types based on duration.

Diagnostic Principles

1. **History: Isolated bleeding symptoms without constitutional symptoms (e.g. signi□cant weight loss, bone pain, night sweats).**
2. **Physical examination: Absence of hepatosplenomegaly and lymphadenopathy**
3. **CBC: Isolated thrombocytopenia**
4. **Peripheral blood smear: Identi□ed platelets should be normal to large in size.**
5. **Bone Marrow Evaluation**
   - **Bone marrow examination is unnecessary with the typical features**
   - **The presence of abnormalities in the history, physical examination, or the CBC and peripheral blood smear should be further investigated with bone marrow.**
   - **The goal of all treatment strategies for ITP is to achieve a platelet count that is associated with adequate hemostasis, rather than a normal platelet count.**

Treatment strategies in Children

- **The majority of patients with no bleeding or mild bleeding can be treated with observation alone regardless of platelet count.**
- **First-line treatment includes observation, corticosteroids, IVIg, or anti-D immunoglobulin (anti-D).**
- **If previous treatment with corticosteroids, IVIg, or anti-D has been successful, these options may be used as needed to prevent bleeding.**
- **If previous treatment has been unsuccessful, subsequent treatment may include thrombopoietin receptor agonists, rituximab, more potent immunosuppression or splenectomy.**
- **Bleeding and trauma precautions are strictly followed and advice on approved medication use is given.**

ITP in Pregnancy:

- **Pregnant patients requiring treatment should receive either corticosteroids or IVIg.**
- **For pregnant women with ITP, the mode of delivery should be based on obstetric indications.**

I.M.A.G.S.B. NEWS BULLETIN "Registered under RNI No. GUJ ENG/2006/17132 Published on Last Date of Every Month &
Permitted to post at Ahmedabad PSO on last date of every month under
Registered under Postal Regd. No. GAMC-1561/2022-2024 Valid upto 31-12-2024
License to Post without Prepayment No. PMG/NG/63/2022-2024 Valid upto 31-12-2024

Publication on 30-04-2024

If undelivered
Please Return to :

INDIAN MEDICAL ASSOCIATION
GUJARAT STATE BRANCH
A.M.A., 2nd Floor,
Ashram Road,
Ahmedabad-380 009.

Publisher : Dr. Bipin M. Patel
Editor : Dr. Devendra R. Patel
A.M.A. House, 2nd Floor, Opp. H. K. College, Ashram Road, Ahmedabad - 380 009. TELE. 079-26587370
Press : Jay Brahmani Printing Press, 38, Ajay Estate, Dudheshwar, A'bad (M) 99740 65219 E-mail : ashwinprajapati99@gmail.com