B-12016/02/2019-RD
Government of India
Ministry of Health & Family Welfare
Directorate General of Health Services
RD Cell
**********
Nirman Bhawan, New Delhi.
Dated :- 07.10.2019.

To,
The Sr. Regional Director/Regional Directors
Regional Office for Health & Family Welfare

Subject: Minutes of the Review Meeting held on 18.09.2019 under the Chairmanship of DGHS at Nirman Bhawan, New Delhi-reg.

Sir,

I am directed to refer to the above cited subject matter and to forward herewith minutes of the Review Meeting of the ROHFWs held on 18.09.2019 under the Chairmanship of DGHS at Nirman Bhawan for perusal and compliance.

2. It is requested to send the Action Taken report on the same to RD Cell immediately for further action.

Encl: As above

Yours faithfully

(Amit Choubey)
DD (A&V)

To:-

1. Director, NVBDCP
2. Director, CBHI
3. Director, (GM)
4. Joint Director, Statistics Division, MoH&FW
5. Sh. Hemant Chaudhary, EM, IQVIA.
6. Sh. Nachiketa Das, Consultant, IQVIA.

Copy for information to:

(i)PPS to DGHS
(ii)PPS to JS (RM)
(iii)ADG (TI)
Minutes of the 20th Review Meeting of Regional Directors, ROHFWs held on 18th September, 2019 at Nirman Bhawan, New Delhi.

The 20th Review Meeting of Regional Directors, ROHFWs was held on 18th September, 2019 under the Chairmanship of DGHS at Nirman Bhawan, New Delhi, on the theme of “Strengthening of ROHFWs” with the following objectives:

- To analyze the current functioning of ROHFWs and prepare SWOT analysis based on the updated data.
- Re-defining and repositioning the roles and responsibilities of Regional Directors.
- To discuss the roles and responsibilities under strengthening of ROHFWs.
- Review of administrative issues.

2. The Meeting was attended by the officers of the Directorate General of Health & Services and other concerned officers along with the 18 Regional Directors of ROHFWs except RD, ROHFW, Guwahati. The list of the participants is attached at annexure I.

3. The meeting started with the Inaugural Programme, where ADG (TJ) welcomed the new DGHS and all other officers of Dte.GHS and participants and explained the reasons for conducting the mid-term review meeting in a short span, in conjunction with Quarterly Review Meeting (QRM) of MoHFW to be chaired by the Secretary(Health).

4. The views were carried forward by JS (RM) stressing on the importance of conducting this meeting and involvement of RDs in order to seek their contribution for strengthening of ROHFWs. JS (RM) also appreciated the involvement of Sr. RDs/RDs in the National Programme by the Ministry and the recognition of their importance by the Ministry in view of the fact that they had been invited for the first time in the QRM. He further defined the new roles of Sr. RDs/RDs for considering the strengthening of ROHFWs. This was followed by a brief introduction by all the participants, informing about their duties and current posting one by one.

5. After individual introduction, DGHS was requested to address the gathering. DGHS specified the importance of health for a progressive nation and emphasized on the development of country in terms of health such as establishment of AIIMS, more number of programmes and reduction of several diseases. DGHS also expressed faith in Sr. RDs/RDs to excel not only in NHM programmes but in other national programmes such as Tuberculosis and prevention of blindness. DGHS also directed the RDs to have a collaborative approach and they should work, keeping in view the deficiency of the States, so that the majority of the people get benefitted.
6. The session began with a presentation by Dr. Chhavi Pant Joshi, DADG (EH) containing a brief background of the recent meetings held in connection with the strengthening proposal of the Regional Offices. She explained the recommendations, key issues, observations, organizational structure envisaging the new roles of RDs as emerging in the Report prepared by the noted Consultancy firm-Ferguson & Co. The views were further extended by JS (RM), highlighting other major observations of Ferguson & Co. such as uniformity in cadre, proper deployment of units (RET, NVBDCP & Family Welfare etc.) and trained manpower.

7. This was followed by the presentations of all RDs who highlighted the current functioning, new roles and responsibilities of ROHFWs and SWOT (Strength Weakness Opportunities & Threats) analysis in their presentation. During the presentations, the major issues of concern that were highlighted included lack of training to staff, no proper guidelines of the programmes, Microscope availability on GeM, scarcity of manpower etc.

8. With regard to issues flagged in the presentation by Sr. RDs/RDs, DGHS asked all RDs (being the HoD) to train their staff by themselves. DGHS also advised that while procuring microscope on GeM or seeking permission to purchase the microscopes proper specifications of the items may be mentioned and each RD may follow-up the same so that the purchases can be done in bulk. DGHS further directed that the posts which are about to fall vacant in the next 6 months may be intimated well-in advance for filling them up. To this, JS (RM) added that till the posts are filled up on regular basis, optimum utilization of the existing staff/resources may be done by the HoDs. In this regard, Dr. Tanu Jain, ADG (TJ) also added that instead of merely cribbing about lack of training and no guidelines of the programmes, it must be endeavored to exploit the given resources adequately. It was suggested that all the RDs should be issue oriented in their approach and should specify the name of the programme for which guidelines are required while making references to the concerned Division. Further, it was decided that NVBDCP may conduct malaria microscopic training as soon as possible.

9. During the course of discussions, all Sr. RDs/RDs were directed by DGHS to observe 'World Heart Day' on 29.09.2019 by creating mass awareness programme in schools, Colleges keeping in view the feasibility in their States. The programme may contain screening for common heart diseases, symposium, panel discussion, health talks etc. on prevention and control of heart related ailments.

10. This was followed by the presentation by Statistics Division, Assistant Director, MoH&FW gave a brief about the establishment of RETs and its expansion. She further threw light on the roles and functions of RETs and the channel to carry out the work. Here, Sr. RD, ROHFW, Bangalore interjected by expressing that RET is the only unit which had not taken a single review in the last decade in order to resolve the issues. JS (RM) pointed out that RET's are working in a mechanical fashion by following the same old schedules and proforma since the inception of the RET unit, and have not adapted themselves appropriately to the changed requirements of the national health
programmes. It was also pointed out that there was lack of clarity whether Statistics Division, MoHFW will continue to provide technical guidance to RETs. The career progression of the Evaluation Officers and Evaluation Assistants were also highlighted and Statistics Division was requested to address the matter immediately.

11. After the lunch, four groups were formulated on strengthening of ROHFWs and a topic was allocated for each group, for discussion and making a presentation, followed by a write-up to be submitted by each group by next day. The following are the details of the groups that were formulated:

<table>
<thead>
<tr>
<th>Group</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
<th>Group D</th>
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<tbody>
<tr>
<td>Facilitator</td>
<td>Sh. Ghulam Mustafa, Director (GM)</td>
<td>Sh. Amit Choubey, Director (A&amp;V)</td>
<td>Dr. Chhavi Pant Joshi, DADG (EH) (TJ)</td>
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</tr>
<tr>
<td>Topic</td>
<td>Rationale &amp; Improving the justification of functioning of ROHFWs</td>
<td>Relevance of ROHFW when Strengthening of ROHFWs</td>
<td>Expected benefits/outcome of major programmes have their own units.</td>
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</tr>
<tr>
<td>Member</td>
<td>Dr. Ravi Kumar</td>
<td>Dr. L. A. Singh</td>
<td>Dr. Satyajit Sen</td>
<td>Dr. Amarjit Kaur</td>
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<tr>
<td>Member</td>
<td>Dr. Aparna Pandey</td>
<td>Dr. Chandana Dey</td>
<td>Dr. S. K. Kar</td>
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<td>Member</td>
<td>Dr. K. K. Mittra</td>
<td>Dr. Anuradha Medoju</td>
<td>Dr. Shazia Wafai</td>
<td>Dr. S. D. Mazumder</td>
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<tr>
<td>Member</td>
<td>Dr. V. L. Gokak/Dr. A. G. Alone</td>
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<td>Dr. Ali Manifkan</td>
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12. After the group discussions, group-wise presentations started with the Group ‘A’. Dr. Ravi Kumar, Sr. RD, Bangalore gave the presentation as a representative of Gr. ‘A’ on rationale and justification of strengthening of ROHFWs and mentioned the following points:

- For proper dissemination of technical guidelines framed by central Health Ministry, ROHFWs are required.
- For providing ground level feedback and real time feedback regarding activities at State level such as in diseases outbreaks and calamities.
- Prominent roles to be played by RDs in the new programmes by Central Government such as in Ayushman Bharat and NHRR for efficient implementation in neighboring states.

13. Subsequently, Dr. Abhishekh, RD Shimla gave the presentation as a representative of Group ‘B’ stressing on the improvement of functioning of ROHFWs.
keeping in view the technical, operation and office management aspect and elaborated the following point:

- Estimation of available manpower keeping in view the career progression, training and evaluation of activities for optimum utilization of staff.

- Mandatory inclusion of RDs in the programme SOP, in all the correspondences relevant to them by SPO & NPOs & in planning monitoring and information sharing by NHM.

- Improvement of office management such as e-office/e-platforms, certificate of appreciation to the best performing ROHFWs.

14. Dr. Satyajit Sen, Sr. RD, ROHFW, Kolkata as a representative of Gr. 'C' explained the relevance of ROHFWs when major programmes have their own units and expressed the following:

- Independent unbiased evaluation of programs by Multi-tasking and provide feedback with real time validation of data both quantitative and qualitative – MCTS (HMIS Data validation & Verification), Leprosy monitoring, NVBDCP, RNTCP, NPCDCS, NPHCE, Mental Health, AYUSHMAN BHARAT etc. (all these programmes have independent evaluation).

- Newer programmes like RKSK, NOTTO, CBRN, NPCDCS which do not have monitoring staff ROHFWs are always providing support to the programmes and carrying out Liaisoning activities between centre and state in establishment of EMR, Skill development centre, TCCs and Cancer centres.

- Technical Competence of RDs (being repository of programme knowledge) and familiarity with the States resulting in cost effective implementation and monitoring of programmes.

15. Lastly, Dr. Amarjit Kaur, RD, Chandigarh gave a presentation on expected benefits/outcomes of strengthening of ROHFWs enumerating the following:

- Rational utilization of central assistance without duplication of funds under different programmes helping in handholding of states for rolling out newer health initiatives.

- Focused monitoring in low performing, underserved, tribal and hard to reach areas and support the States in planning and policy making in health related matters.

- To attain the SDG goals and make a health care delivery available, accessible and affordable to the remotest part of the country, which will eliminate the diseases like Malaria, leprosy, TB etc. as per the Government of India and WHO time lines.

16. After the conclusion of all these presentations, JS (RM) pointed certain shortfalls and requested to rectify the same asking all the groups to incorporate the other groups’
prominent points arisen during the discussions and then send a brief write-up with modifications to this Directorate for inclusion of the same in the report of strengthening. The subject wise write-ups of the Sub-Committee are also attached at Annexure II.

17. Thereafter, CBHI presented on National Health Resource Repository (NHRR) explaining its unique features and envisaged outcomes. Since all Sr. RDs/RDs are the Chairmen of the implementation committee constituted with the approval of DGHS for monitoring of NHRR data in States/UTs under their jurisdiction. Following are the action points decided during the meeting:

(1) It was observed that not all Sr. RDs are sending report on spot check done by them in their jurisdiction for identifying completeness of NHRR census. It was ensured that r random spot check for enumeration done by data collection agency (IQVIA) and also shares the report with CBHI (HQ)

(Action: All ROHFWs)

(2) Access of NHRR census data to all Sr. RDs for their respective states.

(Action: CBHI)

(3) To identify number of missing Health Care Establishments (HEs), procuring available list from health authorities and drug controller of their respective states and sharing the list with IQVIA for further completing the enumeration of missing HEs.

(Action: All ROHFWs)

(4) As this is a resource consuming activity, a team of IQVIA will work closely with the regional directors and finishing its task of completeness of census.

(Action: All ROHFWs & IQVIA)

18. In the final session, all the administrative issues were discussed, which were handled by DD (AV). Following were the issues/decisions highlighted/taken as a sequel to the deliberations:

(a) There should be centralized guidelines for the type of reporting of the tour reports conducted by ROHFWs.

(Action: RD Cell)

(b) Sr. RD, ROHFW, Bhubaneswar flagged the issue of their office that 40 microscopes are under condemnation, but the approval of the same has not been received from NVBDCP.

(Action: NVBDCP)

(c) RD, ROHFW, Patna stated that the technical posts such as Insect collector are lying vacant in their office, which need to be filled up by NVBDCP.

(Action: NVBDCP)
(d) Most of the RDs such as RD, Hyderabad, Chandigarh, Bangalore etc. also pointed out that for outsourcing of Gr. ‘C’ contractual staff under NVBDCP Strength, no permission has been received from NVBDCP. This needs to be expedited as it is hampering the work of ROHFWs.

(Action: NVBDCP)

(e) RD, Imphal stated that proposal for purchase of new vehicle for their office may be considered by this Directorate.

(Action: RD Cell)

(f) RD, Imphal further requested to expedite the medical bills pending in NVBDCP.

(Action: NVBDCP)

19. In the concluding remarks, JS (RM) advised all Sr. RDs/RDs that while preparing presentations for any meeting, proper font and size should be selected so as to ensure that the same is legible. Also, the following decisions were reiterated:

(i) Outcome of the implementation of bio-metric machines and their functionality has to be sent to this Directorate. For those whose, bio-metric is non-functional; a 30 day time has been given for the implementation and then forwards the report.

(Action: ROHFWs)

(ii) All the tour programmes/scheduled visits may be sent well in advance to this Directorate.

(Action: ROHFWs)

(iii) To celebrate 'World Health Day' on 29.09.2019 by creating mass awareness programme in schools, Colleges keeping in view the feasibility in their States. In one state, there should be a 'Mega Show', for which DGHS shall be invited.

(Action: ROHFWs)

(iv) The microscope training is to be imparted to the technicians.

(Action: ROHFWs)

(v) Outstanding audit paras from O&M Section are to be issued to all ROHFWs. Copy to be collected from JS (RM)

(Action: RD Cell)

(vi) Annual Action Plan 2019-20 may be forwarded to RD Cell within 10 days i.e. by 28.09.2019.

(Action: ROHFWs)

(vii) An internal meeting with Director, NVBDCP may be called for, discussing the pending issues with NVBDCP.

(Action: RD Cell/NVBDCP)

(viii) Annual Review Meeting, under the Chairmanship of DGHS, is to be held at Shillong before 31st December, 2019.

(Action: RD Cell)

20. Thereafter, ADG (TI) was invited to convey vote of thanks. She expressed heartfelt gratitude towards DGHS and other officers from Directorate. She further
thanked all RDs, and especially officials of RD Cell for excellent organization and successful hosting of the event.

The Meeting ended with a vote of thanks to the Chair.

*****

Annexure-I
## List of Participants

<table>
<thead>
<tr>
<th>S. No</th>
<th>Name &amp; Designation</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>1</td>
<td>Dr. Sanjay Tyagi, DGHS</td>
<td>Dte. GHS, in Chair</td>
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<td>2</td>
<td>Sh. Rajiv Manjhi, JS (RM)</td>
<td>Dte. GHS</td>
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<td>3</td>
<td>Dr. Anuradha Medoju, RD</td>
<td>ROHFW, Hyderabad</td>
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<td>4</td>
<td>Dr. Abhishekh, RD</td>
<td>ROHFW, Shimla</td>
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<tr>
<td>5</td>
<td>Dr. Aparna Pandey, RD</td>
<td>ROHFW, Raipur</td>
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<td>6</td>
<td>Dr. ChandanaDey, Sr. RD</td>
<td>ROHFW, Ahmedabad</td>
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<td>7</td>
<td>Dr. Krishan Kumar Mittra, Sr. RD</td>
<td>ROHFW, Lucknow</td>
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<td>8</td>
<td>Dr. Kailash Kumar, RD</td>
<td>ROHFW, Patna</td>
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<td>9</td>
<td>Dr. L A Singh, RD</td>
<td>ROHFW, Imphal</td>
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<td>10</td>
<td>Dr. R. K. Vyas, Sr. RD</td>
<td>ROHFW, Bhopal</td>
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<td>11</td>
<td>Dr. Ravi Kumar, SR. RD</td>
<td>ROHFW, Bangalore</td>
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<td>12</td>
<td>Dr. AmarjitKaur, Sr. RD</td>
<td>ROHFW, Chandigarh</td>
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<tr>
<td>13</td>
<td>Dr. Roshini Arthur, Sr. RD</td>
<td>ROHFW, Chennai</td>
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<td>14</td>
<td>Dr. S K Kar, Sr. RD</td>
<td>ROHFW, Bhubaneswar</td>
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<td>15</td>
<td>Dr. Satyajit Sen, Sr. RD</td>
<td>ROHFW, Kolkata</td>
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<td>16</td>
<td>Dr. S D Mazumdar, Sr. RD</td>
<td>ROHFW, Shillong</td>
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<td>17</td>
<td>Dr. V. L. Gokak, Sr. RD</td>
<td>ROHFW, Pune</td>
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<td>18</td>
<td>Dr. Deepak Saxena, Sr. RD</td>
<td>ROHFW, Jaipur</td>
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<tr>
<td>19</td>
<td>Dr. Shazia Wafai, Sr. RD</td>
<td>ROHFW, Srinagar</td>
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<tr>
<td>20</td>
<td>Dr. Ali Manifan, Sr. RD</td>
<td>ROHFW, Thiruvananthapuram</td>
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<tr>
<td>21</td>
<td>Dr. Madhu Raikwar, Director</td>
<td>CBHI, Dte. GHS</td>
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<tr>
<td>22</td>
<td>Dr. Aruna Jain, Addl. Director</td>
<td>NVBDCP</td>
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<tr>
<td>23</td>
<td>Dr. Tanu Jain, ADG (TJ)</td>
<td>Dte. GHS</td>
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<tr>
<td>24</td>
<td>Dr. Chhavi Pant Joshi, DADG</td>
<td>Dte. GHS</td>
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<td>25</td>
<td>Sh. Amit Choubey, DD (A&amp;V)</td>
<td>Dte. GHS</td>
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<td>26</td>
<td>Ms. Sunita Chaudhary, AD</td>
<td>Statistics Division, MoHFW</td>
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<td>27</td>
<td>Sh. B. K. Barnawal, SSO</td>
<td>Statistics Division, MoHFW</td>
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<td>28</td>
<td>Sh. Akhil M. Dubey, Consultant, RD Cell</td>
<td>Dte. GHS</td>
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<td>29</td>
<td>Sh. Ashish Verma, ASO, RD Cell</td>
<td>Dte. GHS</td>
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<td>30</td>
<td>Sh. Sushant Kumar, JSO, RD Cell</td>
<td>Dte. GHS</td>
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<td>31</td>
<td>Sh. Jivan Lal, Consultant, RD Cell</td>
<td>Dte. GHS</td>
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<td>32</td>
<td>Ms. Zeba, Office Assistant, RD Cell</td>
<td>Dte. GHS</td>
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<td>33</td>
<td>Sh. Praveen Kumar, MTS, RD Cell</td>
<td>Dte. GHS</td>
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<td>34</td>
<td>Sh. Hemant Chaudhary, EM</td>
<td>IQVIA</td>
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<td>35</td>
<td>Sh. Nachiketa Das, Consultant</td>
<td>IQVIA</td>
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Annexure II

Rationale for Justification and Strengthening of Regional Offices for health & FW (ROHFW)

[As submitted by Group 'A']

India is a vast and diverse country. Though health is a state subject the central health ministry has a major role in planning and budgeting of the national health programmes. To assist the central government in all the states the presence of its representative in the form of RoHFW is required in all the states. There is need for three major areas of focus namely monitoring of the national health programmes, capacity building of state health officials and technical assistance. The RoHFW is already playing a significant role in these activities.

The central health ministry makes technical guidelines for different health programmes. For dissemination of these guidelines the RoHFWs are required. With their wealth of experience, the RoHFW can do a meaningful process of formulation of state specific guidelines that too in local languages.

The central health ministry has a major role to play in collaboration between neighbouring states. This can be facilitated by RoHFW. A good example is surveillance of diseases where cases move across states.

RDs can give ground level feedback and real time feedback regarding the activities at state level. RoHFWs help in better communication with states being the first point of contact regarding special events like calamities, disease outbreaks etc.. RDs are already members of state disaster response organizations.

There are new initiatives and new programmes by central government like NHRR, Ayushman Bharat etc. These would require a definite role by RDs. Many new institutions like skill centers for emergency medical relief, CBRN centers are to be set up in states. These require very pro-active collaboration with states which is possible by RoHFWs. There are also special programmes like NHRR being undertaken by central health ministry all over the country. The RoHFWs are already playing a big role in co-ordinating in this programme. Quality of the survey is also being assessed.

The RoHFWs already have a significant infrastructure for training activities in terms of training halls, audiovisual equipment etc. The RD and the staff have a rich experience and desired qualification and have been excellent faculty. Thereby capacity building of state health officials is possible at RoHFWs. This capacity can be enhanced also to a greater extent. A good example is training of laboratory technicians in malaria microscopy. Over the years the RoHFWs are doing these activities and are contributing to better surveillance activities. A related activity is quality assurance of malaria microscopy. The RoHFWs are doing the cross checking of blood smears of malaria and thereby contributing to maintaining quality which is an important process for malaria elimination. The RoHFWs have some very specialized capacity in conducting operational research activities drug sensitivity trials of antimalarials. As of now no state government has this capability. The RoHFWs are indispensable in this regard. The various state health departments are weak in terms of entomological activities. The
RoHFWs have technical staff who are doing this activity and guiding them. Also, insecticidal resistance studies of malaria and kala-azar vectors are being conducted.

There are various diseases earmarked for elimination like malaria, filariasis, kala-azar etc. These require better and better surveillance. The RoHFWs are very strong in monitoring the NVBDCP activities and can play a greater role in coming years.

Currently a few RoHFWs are also in charge of airport and port health establishments. The international commitments like health activities at airports and ports are being carried out. There are visits by different country heads to states. This requires co-ordination at airport and ports.

There are visits of health ministers and other high-level officers of ministry to states. These require coordination at state level. The field visits are being coordinated by RoHFWs.

The RoHFWs being specialized technical organizations take part in an important activity of preparedness activities of disease outbreaks. When outbreaks do occur, the RoHFWs take part in epidemiological investigation and suggesting preventive and control activities.

There are number of court cases in high courts in which the central health ministry is a respondent. The RoHFWs represent and defend the ministry in such cases. This would be a continuing need.

Apart from NVBDCP other health programmes do require quantitative and qualitative cross check of activities. The RoHFWs are doing such activities and can do more.

There are other central health ministry units like NCDC, ICMR etc in states. The RoHFWs can facilitate their interaction with states. Dissemination and incorporation of research findings of such organization can be better achieved. Certain programmes which are running as pilot basis which can be converted to regular programmes require presence of RDs.

There are media units like Doordarshan and All India Radio which require participation of central level officers communicating in local languages. The RoHFWS are doing such activities.

New states, new districts are being created. This would require RoHFW in all the new states. All the RoHFWs should have similar units and adequate staff so that all relevant activities can be carried out. The CBHI and Evaluation units are required in all the states.

Dr. K. RAVI KUMAR
Dr. K. K. MITRA
Dr. GOKAK K.K.
Dr. APARNA PANDEY
Dr. DEEPAK SAXENA

[Write up submitted by Group 'B']

Group B was constituted with the following participants
1. Dr. Chandana Dey
2. Dr. L. A. Singh
3. Dr. Anuradha
4. Dr. Abhishekh

The team was assigned the topic “Improvement of functioning of ROHFWs”. After a thorough discussion and deliberation the team members made the following suggestions.

I. Technical Aspect:

   a. Optimum utilisation of existing man power:
      i. Every ROHFW has technical manpower oriented towards specific health programmes. Some of them are overburdened and some of them are underutilized.
      ii. A work study is contemplated to understand the capability of these staffs and assess their utility.
   b. Estimation of optimum manpower: A need assessment on technical manpower necessary to fulfill the organizational objectives in conformity with the increasing workload will be required. This will lead to framing the optimum manpower.
   c. Filling up the extra manpower as per the optimum required HR: In addition to the existing manpower any additional suitable manpower proposed may be approved and appointed.
   d. Training of the manpower: Training of the HR on technical knowledge will enhance their output both in terms of quality and quantity.
   e. Periodic Skill upgradation and evaluation of their activities: As the health programmes undergo changes, the HR in ROHFWs would require skill upgradation correspondingly. In addition the manpower should also be evaluated as per their performances to understand areas of weakness such that remedial measures can be undertaken.

2. Performance based career upgradation: The provision of career upgradation based on a common yardstick will provide a competitive working atmosphere and make them perform better.

3. Capacity building of Regional Directors and other CHS Officers in ROHFWs is required, so as to enable to impart updated technical and operational knowledge to the staffs and to the officials of the concerned states.

II. Operational aspect:

1. Mandatory inclusion of role of RDs in the programme SOPs: The roles of RD is vaguely defined or not defined in many of the health programmes leading to RDs being considered optional for the programme to the implementers.

2. Inclusion of RDs in all the correspondences relevant to ROHFWs between NPOs and SPOs: When the correspondences between NPOs to the SPOs bypass the ROHFWs, a gap in the understanding of the issue arises between ROHFW and SPOs. This makes the monitoring ineffective.

3. Providing access to the programme portals by providing UN and PW where ever required: This will enable RDs to analyse the programme indicators at different levels of Health care institutions and also to understand the trends.
4. Checklist and term of reference for monitoring of different program by RDs in consultation with different program divisions needs to be developed in order to ensure qualitative output from regional offices and duplicity of work and economical use of resources.

III. Improving office management:

1. **Strengthening of Establishment Section and Account Section of ROHFWs**: An appropriate officer who can look after both establishment and Account sections in each office is required, to enable the RDs to focus his/her attention towards improving the output of the office both technically and operationally.

2. **Revision of delegation to financial power to RDs** will go a long way in strengthening of ROHFWs.

3. **Use of e-office and other available e-platforms** with proper training can lead to improvement in the functioning of ROHFWs.

4. **Permanent Office complex of ROHFW**: Many of the ROHFWs are functioning from rented buildings and have to undergo a cumbersome process of periodic renewal, sometimes leading to legal tussle between the lessee and the lease. The time and resource consumed in dealing such cases can be done away with the provision of permanent building complex for ROHFWs.

5. **Separate RDs office / sub ordinate extension of RD office for every state**: Having a separate RDs office / sub ordinate extension of RD office for each state will make it more convenient in terms of monitoring the health programmes and providing technical support.

6. **Capacity building of the subordinate staff of ROHFW needs to be taken up for implementing newer IT driven initiatives of government** to effective implementation of PFMS, BHAVISHYA, EIS, GEM, Official language policy, RTI, Income Tax, GST, Recruitment process and Reservation Roster.

7. **Unified controlling authority for Regional office at DGHS** for CBHI, NCDC, RET, RoHFW and NVBDCP etc on **Technical and administrative matters needs to be created with sufficient manpower and resources** to look after functioning of ROHFW in effective manner. / Clear instructions for communication to be updated.

8. **Half yearly review meeting of RDs needs to be continued** for effective functioning of ROHFW.

[Write up submitted by Group 'C']

**Relevance of ROHFW When Major Programmes Have Their Own Units.**

**BACKGROUND**

Regional Co-ordinating Organizations (RCOs) in 1958 to co-ordinate between the Centre and the States for National Malaria Eradication Programme (NMEP) activities and Regional Health Office (RHO) in 1963 to co-ordinate and supervise the Family Welfare activities were formed. These were later on merged in 1978, as the need for an office of the Government of India in the States to supervise, monitor and co-ordinate the matters of all centrally sponsored Health and Family Welfare programmes was felt and the Regional Office for Health and Family Welfare (ROH&FW) were established. Similarly, four Health Information Field Units (HIFUs) were established in 1981 and two more were added in 1986 to augment the CBHI activities.
There are 19 Regional Offices of Health & Family Welfare under the Directorate General of Health Services (Dte. GHS) which are situated in the various State Capitals and performing various functions.

The relevance of ROHFWs still lies in its capacity to perform the roles for which it was formed i.e. to supervise, monitor and co-ordinate the matters of all centrally sponsored Health and Family Welfare programmes in a cheap and cost-effective manner.

**Roles and Functions:**

The primary objective with which these ROHFW offices have been established was for ensuring proper liaison and coordination between the Centre and State Governments in the context of the implementation of National Health and Family Welfare Programs.

The main functions of the Regional Offices are as follows:

1. **Centre-state coordination**
2. **Monitoring and evaluation of implementation of various National Health and Family Welfare Programmes by the States/UTs.**
3. **Training and IEC**
4. **Qualitative evaluation by Regional Evaluation Team (RET)**
5. **Strengthening and monitoring of Health Information System by Health Information Field Unit (HIFU)**
6. **Monitoring and Supervision through Malaria Operational Field Research Scheme (MOFRS)**
7. **Monitoring and Supervision of Centrally sponsored schemes**

**CENTRE-STATE COORDINATION**

- RDs being senior officers are important as an implementing agency and first contact for information to the states in newer programmes and play a vital role in Centre state coordination like acting as nodal/focal points in disaster or outbreaks, joint monitoring missions and local go between in implementation and handholding as well as liaison on difficult and complicated technical issues.
- This aspect is an important one as by liaising with the states the RDs can help in implementation of core national policies.
- It is the experience with RDs that when newer programs are launched or old programs undertake major policy shifts, RDs play a role in helping the states for implementation and adapting to the policy changes (e.g. Trauma, Burns, ROTTO, RNTCP, NLEP etc.)
- This aspect is still relevant as the program division despite having their separate units can do this cost effectively with very few manpower with help of ROHFWs.

**PROGRAMMES**

- Independent unbiased evaluation of programs by Multi-tasking and provide feedback with real time validation of data both quantitative and qualitative – MCTS (HMIS Data validation & Verification), Leprosy monitoring, NVBDCP, RNTCP, NPCDCS, NPHCE, Mental Health, AYUSHMAN BHARAT etc
- Since Health is a State subject RDs being co-located can provide the states for capacity building and technical guidance TO THE STATES
- Newer programmes like RKS, NOTTO, CBRN, NPCDCS which do not have monitoring staff ROHFWs are always providing support to the programmes
- Carrying out liaising activities between centre and state in establishment of EMR, Skill development centre, TCCs and Cancer centres
• Central level program officers of independent programs are dependent on state feedback which is sometimes biased and prejudiced and RD feedback to the DGHS/Secretary/ASMD is necessary
• RDs being repository of program knowledge and have holistic approach to the programs and hence can help the programs in the state for improvement as there is frequent change of program officers
• Programmes are reliant on consultant network which needs to be verified independently by our own health intelligence system in the form of RDs existing in the states

TRAINING and EVALUATION

• RDs are already providing training for NVBDCP and CBHI hence if support is provided, we can be TOT for other programs in the states (some RDs are already doing this in Leprosy, IDSP, NHM) which is cost effective
• Monitoring and evaluation will be of quality, cheaper and cost effective as compared to other institutes doing independent evaluation which is much higher
• ROHFWs can be GOI training institutes for newer programmes being launched and thereby expenditure of the GOI minimized and decentralized

CONCLUSION

The core competencies of an organization need to be utilized which the ROHFWs are performing and a process of organizational change is the need of the hour. The support that is being provided makes the ROHFWs relevant. The cost effectiveness is an aspect which will continually make the ROHFW relevant. The pillars of relevance are:

1. CENTRE-STATE COORDINATION
2. MONITORING & EVALUATION – QUALITATIVE AS WELL QUANTITATIVE
3. TRAINING ACTIVITIES
4. COST EFFECTIVITY

MEMBERS:

DrChhavi Pant Joshi, Dr S Sen, Dr S K Kar, Dr R K Vyas, Dr S Wafai, Dr A Manifkan.

[Write up submitted by Group 'D']

Expected benefits and outcomes of strengthening of ROHFWs

Facilitator: Dr. Tanu Jain

• Dr. AmarjitKaur
• Dr. Roshini Arthur
• Dr. Kailash Kumar
• Dr. S.D. Mazumdar

1. Improved monitoring of National Health Programmes in a cost effective manner:

If RD offices are strengthened with sound infrastructure, good quality equipment, and adequate, trained manpower, the quality of monitoring of National Health Programmes will greatly improve. The availability of a Regional
Office in a state is a cost effective yet efficient method of monitoring, as the team is on site and well versed with the local language of the state and the social and cultural barriers to health.

A strengthened NVBDCP team stationed in the state will more effectively analyze reports from the districts, give regular feedback regarding the gaps found and the measures to be taken to correct them. The team will identify districts needing monitoring based on district data, IDSP and news reports, and carry out an in-depth vector adult and larval surveillance in these areas. IRS activities in the districts will be supervised and vector surveillance activities in and around airports and seaports monitored. The well-equipped, fully staffed malaria labs will more effectively cross check the positive and negative slides from the districts and intimate discrepancies to the districts for immediate corrective action.

2. **Regular monitoring of National Health Programmes in the states:**

Presently RDs with 2-3 states are visiting the states on alternate month so each state is visited only once in two / three months. If RD offices are established in every state, review of NHPs can be done regularly at least once in every month in the state, as travelling distance to remote states will be reduced. The precious travelling time and tour expenditure will also be reduced.

3. **Improved monitoring in unserved areas:**

The monitoring will be more focused in areas that are underserved, tribal, hard to reach and poor performing as RDs have an in-depth knowledge of the demographics and health indicators of the state.

4. **Successful Implementation of newer health initiatives:**

The monitoring by ROHFW is state specific and need based, with special attention given to the newer programmes being implemented in that state.

5. **Capacity building of manpower in various programmes:**

Regular induction training and refresher training of lab technicians will build a team of well-trained technicians in the states which is the backbone of the malaria elimination program. Apart from CBHI and VBD training, capacity building of state health personnel for other national programmes too can be carried out at strengthened ROHFWs.

6. **Supportive supervision of high risk areas in the states going for elimination of diseases:**

For the diseases targeted for elimination like malaria, filaria, leprosy, tuberculosis etc regular monitoring and supportive supervision can be more effectively carried out in high risk areas of the states. In this way RD offices can help in achieving the targets as per Government of India and WHO time lines.

7. **During disease outbreaks and natural calamities:**
The Regional Office team will be as always the first responders in the states in times of outbreak and natural calamities as they are present on the spot. They will support the State Government in its activities and give feedback to the Centre.

8. **Independent Evaluations of the specified programme:**

Independent Evaluations of the specified programme can be performed by ROHFW teams in a cost effective manner as compared to NIMR, ICMR and other agencies.

9. **Other liaisoning activities:**

Liaison activities of the Regional Offices like coordinating with Central teams for visits during outbreaks and disasters will continue to be carried out efficiently. VIP visits will be coordinated and officials visiting the states for inspections and monitoring will be supported. The numerous cases for which the Central Govt. health officials are responders will be better handled by the Regional Office as guided by the Centre.

**The overall outcome of the strengthening of ROHFWs will be reflected in the better efficiency of monitoring, liaisoning and capacity building activities presently carried out by the Regional Offices in the states.**

***
To,

Sr. RDs/RDs
Regional Office of H&FW

Sub: Minutes of the Capacity Building Workshop for Regional Offices of Health & Family Welfare held from 30th January to 01st February, 2019 at Nirman Bhawan, New Delhi.

The undersigned is directed to forward herewith a copy of minutes of the Capacity Building Workshop for Regional Offices of Health & Family Welfare held from 30th January to 01st February, 2019 at Nirman Bhawan, New Delhi for perusal and compliance with a request to send the Action Taken Report on the same.

Encl: As above

Yours faithfully,

(Vangara Prasad)
By Director

Copy for information to:

MoHFW:

(i) PS to Ms. Preeti Sudan, Secretary
(ii) PS to Sh. Manoj Jhalani, AS &MD
(iii) PS to Sh. Nilambuj Sharan, EA
(iv) PS to Sh. Alok Saxena, JS
(v) PS to Sh. Lav Agarwal, JS
(vi) PS to Ms. Vandana Gurnani, JS
(vii) PS to Sh. Vikas Sheel, JS
(viii) PS to Sh. Sudhir Kumar, JS
(ix) PS to Dr. Manohar Agnani, JS
(x)  PS to Dr. S. Venkatesh, DGHS
(xi) PS to Dr. B. D. Athani, Principal Consultant
(xii) PS to Dr. Promila Gupta, Principal Consultant
(xiii) PS to Dr. N. S. Dharamshaktu, Principal Adviser
(xiv) PS to Sh. Rajiv Manjhi, IS
(xv)  Dr. Inder Prakash, Advisor (PH)
(xvi) Dr. Anil Manaktala, DDG (P)
(xvii) Dr. Sangeeta Abrol, DDG (O)
(xviii) Dr. Vasanti Ramesh, Director
(xix)  Dr. Deepak Sule, DDG (MH&I)
(xx)  Dr. Pradeep Saxena, Addl. DDG
(xxi)  Dr. Tanu Jain, ADG (TJ)
(xxii) Dr. Shobhini Rajan, ADG
(xxiii) Dr. Malini Kapoor, Dept. of Microbiology, SJH & VMMC
(xxiv) Dr. Sujeet Kumar Singh, Director
(xxv)  Dr. Sunil Gupta, HOD, Microbiology
(xxvi) Dr. Akash Shrivastava, Head, Centre for EOH & Climate Change
(xxvii) Dr. S. K. Jain, HOD (Epid)
(xxviii) Dr. Maneesh Singhal, Prof. & HOD, Dept. Of Burns, AIIMS
(xxix) PS to Dr. P. K. Sen, Director
(XXX)  Sh. Ashish Kumar, Director
(XXI)  Dr. Sushma Dureja, DC
(XXII) Dr. Pradeep Haldar, DC
(XXIII) Dr. Jai Karma
(XXIV) Dr. Aruna Jain, Addl. Director
(XXV)  Dr. Ruchi Jain, CMO
(XXVI) Dr. Doongar Singh
(XXVII) Dr. Nirmal Joe, CMO (NFSG)
(XXVIII) Dr. Gobinath S., MO
(XXIX) Dr. Himanshu Chauhan, DADG
(XL)  Dr. Raghuram Rao, DADG
(XLI) Dr. Rupali Roy, DADG
(XLII) Dr. Chhavi Pant Joshi, DADG
(XLIII) Sh. Amit Choubey, DD (A&V)
(XLIV) Dr. Suhas Dhandore, Dy Director
Minutes of the Capacity Building Workshop for Regional Offices of Health & Family Welfare held from 30th January to 01st February, 2019 at Nirman Bhawan, New Delhi.

A Capacity Building Workshop for Regional Offices of Health & Family Welfare (ROHFWs) was held from 30th January to 01st February, 2019, at Nirman Bhawan, New Delhi. The Workshop provided update to the Regional Directors on the various National Programmes and initiatives and identify their roles and functions in various areas of capacity building, implementation and monitoring & evaluation of the Programmes across the country as well as supporting rollout of new initiatives in the State. During the Workshop, the programme officers shared their expectations with respect to involvement of ROHFWs in strengthening their Programme (including Capacity Building, Implementation, Monitoring and Evaluation).

2. The Workshop was attended by the Additional Secretaries, Joint Secretaries, Economic Adviser and Officers & Officials of the Ministry and of Directorate General of Health & Services, Director, NVBDCP, NOTTO & NCDC, the Programme Officers/Divisions along with the 18 Regional Directors of ROHFWs except RD, ROHF, Guwahati. The list of the participants is attached at annex I.

3. The workshop was inaugurated by Ms. Preeti Sudan, Secretary (H&FW). The inaugural session began with a welcome address by Dr. S. Venkatesh, DGHS who expressed his gratefulness to the Secretary (H&FW) for having agreed to organise the meeting under her guidance. He emphasized the crucial role played by ROHFWs in the control of Nipah and Zika outbreaks in Kerala and Madhya Pradesh/Rajasthan respectively. Clarity in roles of Regional Directors is required for contributing effectively and efficiently to National Programmes and new initiatives of Ministry of Health & Family Welfare (MoHFW).

4. Secretary (H&FW) interacted with Regional Directors and stated that there is a need for coordination for relevance and to be clear in the achieving of the goals for raising the standards of health in the country. She further asked the Regional Directors to involve themselves in State activities and become part of State conversations through State specific Whatsapp groups of Deptt. of Health & Family Welfare. She exhorted Regional Directors to extend requisite technical support to state agencies in implementation of National Programmes. She also emphasised that the tour programmes of officers from MoHFW are to be communicated to Regional Directors for their involvement and participation in the review activities conducted in the State. She desired that a circular in this regard may be issued.

(Action: MoHFW)

5. Secretary (H&FW) also sought greater involvement and focus of ROHFWs on operationalizing Health and Wellness Centres (HWCs) under Ayushman Bharat and advised them to approach concerned authorities in States in expediting posting of trained mid-level providers in all states. Secretary (HFW) also reminded Regional Directors that they are eyes and ears of the Government; they should play their role effectively. While reviewing UP and Bihar, she advised the Regional Directors to work on containment of JE/AES and immunization in Uttar Pradesh; control and elimination of Kalaazar in endemic districts of Bihar; and combating HIV/AIDS in Nagaland. She also suggested RDs to attend and help in the development of PIPs in the State. A letter to the State Divisions from ROHFW may be issues in this regard for their participation in the PIPs.

(Action: ROHFW)

6. During interaction with the Secretary (H&FW), RDs informed that they have to deal with a lot of court cases and no information is available to them, as to which wing of the Ministry it is to be consulted. Secretary (H&FW) stated that Nodal Officers from the Ministry have been nominated for the same and any such references shall be made to them. Currently, it was informed that Mr. Sanjeeva Kumar, Additional Secretary and Mr. Sudhir Kumar, Joint Secretary are the Nodal Officers for the court cases.
7. Thereafter, JS (RM) gave an overview of the existing units of ROHFWs their roles & functions and the current issues that is being faced by them. He informed at present 19 ROHFWs are operational in the country for over 40 years and 10 more offices are needed to ensure proper coverage of states. Secretary (H&FW) appreciated the role played by Regional Offices in coordinating with State Authorities, wherein she pointed the recent example of the floods in Kerala in 2018, that were managed efficiently with the help of ROHFWs.

The participants were briefed on all the major Health Programmes of MoHFW which are described below:

Session-1: RNTCP-Ending TB By 2025

The session was chaired by Shri VikasSheel, JS, MoHFW Dr. RaghuramRao, DADG (TB) presented Ending TB By 2025 and main points discussed are:

1. Contours of the programme
   - Hon’ble Prime Minister Shri NarendraModi announced targets for Ending TB by 2025, much ahead of the global SDG targets of 2030.
   - Approach towards eliminating TB was described to i) find a TB cases with an emphasis on reaching every TB patient in the private sector, ii) treat a TB cases with high quality anti TB drugs, iii) prevent the emergence of TB in susceptible populations and stop catastrophic expenditure due to TB & iv) build and strengthen supportive systems including enablig policies, empowered institutions and human resources with enhanced capacities.

2. Role of the Regional Directors
   - Role of RoHFW in RNTCP was emphasised. Bidirectional communication between TB Division and RD Cell is needed. RDs are to be invited for Zonal reviews. State scoring based on 8 virtual indications to be shared with RDs. Nikshay user ID and password are to be provided to RDs. RDs to also help in monitoring during district visits.
   - The Potential areas of collaboration identified were HR & Training, PMDT, DBT, TB Free Blocks, active case findings, supervision, M & E, Private Sector Involvement, Diagnostics, Labs& UDST.

Session-2: Blood Transfusion Services Division & National Blood Transfusion Council

Shri Alok Saxena, JS, MoHFW chaired the session and Dr. ShobhiniRajan, ADG, NACO made the presentation on Blood Transfusion Services Division & National Blood Transfusion Council. The main points are as follows:

1. Contours of the programme
   - Blood Transfusion Services have to ensure that Blood/ Components (Whole Blood/ Packed Red Cells/ Plasma/ Platelets) are available (Adequate Blood Collection to fulfill need), accessible (Enough reach where it is needed), affordable (At reasonable costs), safe(Not cause harm, especially TTI), of standard quality (Provide clinical gain).
   - BTS in India comprise 3023 licensed Blood Banks in Govt, NGO, private sectors (1131 NACO supported). Blood Banking Services in India were discussed along with program structure and functioning under NACO.India collects 10% of Blood collected globally. It collects 65% of Blood collected in SEAR region.
   - NACP IV Target was to reach 80% component separation in NACO supported Blood Banks. The achievement has been 69% so far.
2. **Role of the Regional Director**

- Regional Directors can play huge role in strengthening SBTC through representation of NBTC in States, in advocacy for unified control of BTS within States Health Services with adequate resource allocation, in reviewing of licensure of blood banks through State FDA/DGCI, participate in teams for supervisory visits to blood banks, in streamlining NGO participation for Voluntary blood donation, in engaging with Professional Associations for clinical use of blood and hemovigilance reporting.

**Session 3: Ayushman Bharat-Health and Wellness Centres**

The session was chaired by Shri Manoj Jhalani, AS&MD, MoHFW. Dr. Arun Gupta, Director, MoHFW presented on Ayushman Bharat-Health and Wellness Centres. The main points are as follows:

1. **Contours of the Programme**

- The rationale behind Ayushman Bharat were explained as – Selective Primary Health Care, low utilisation of public health facilities, fragmented health care high costs and epidemiological transition to high burden of NCDs.
- Ayushman Bharat envisages provision of continuum of care (through CPHE and PMJAY) with telehealth / referral, expanded service delivery, expanding HR – MLHP & multiskilling, medicines & expanding diagnostics, community mobilisation and health promotion, infrastructure, financing/provider payment reforms, robust IT system, partnership for knowledge & implementation.
- The scheme brings about paradigm shift at multiple policy and operational levels. The milestone and progress of Ayushman Bharat flagship scheme were apprised.
- Some queries raised by RDs were non-availability of new list of poor people in the country and adhaar card for very poor people like rag pickers. It was highlighted that in Rajasthan, Tripura, Andhra Pradesh, Himachal Pradesh and Gujarat, RDs are not invited to the meetings at all.
- Helpline No.14555 and email id mera.pmjay.gov.in was provided to Regional Directors.

2. **Role of the Regional Directors**

- Role of Regional Directors are coordinating with State NHM in planning and operationalization of HWCs as per the MoHFW Guidelines for CPHC through HWCs; Handholding of States; enable districts to prioritise capacity building; support in rolling out of change management required for new paradigms; uptake of IT system and ensuring availability of medicine and diagnostics and supporting in on-going monitoring and process documentation on essential inputs for CPHC.
- It was suggested that in future RDs are to be called for NPCCC meetings. RDs would also be required to participate in CRM of states (other than the parent state) and to be invited for dissemination workshop.

**Session 4: National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)**

The session was chaired by Shri Nilambuj Sharan, EA, MoHFW Dr. Manas Pratim Roy, DADG presented National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS). The main points are as follows:

1. **Contours of the Programme**
Common NCDs in India are Diabetes Mellitus, Cardio-Vascular Diseases (CVDs), Stroke, Cancer, COPD and CKD.

Components of the programme are prevention through Health Promotion; screening & early diagnosis; case management; supervision, monitoring and evaluation; capacity building (Infrastructure, HR & Training).

Newer Initiatives undertaken by NPCDCS were discussed such as guidelines for prevention and management of Chronic Obstructive Pulmonary Disease (COPD) and Chronic Kidney Disease (CKD) under NPCDCS; strategy for “Population-based Screening” for early detection of common NCDs in community, utilising services of Frontline-workers and Health-workers under the existing Primary Healthcare System and national strategy for ‘bi-directional screening’, early detection and better management of Tuberculosis-Diabetes co-morbidities, as a joint collaborative activity between RNTCP and NPCDCS.

2. Roles of the Regional Directors

- Expected Roles of Regional Directors are Supervision & Monitoring of NPCDCS Programmes. To assist and work in close coordination with NPCDCS Programme Officers for activities like review Meetings to monitor programme implementation in States; development of Training Plan and Curriculum for health staff; establishing/strengthening NPCDCS facilities as per PIP targets; monitoring of Pilot interventions/projects and implementation of Multi-sectoral Action Plan.

- Follow up with DHS/Health authority on the progress related to issues highlighted by RDs in their tour reports; Liaise with DHS/MD (NHM) to constitute a State Coordination Committee on NPCDCS programme implementation are also some expected roles of RDs.

National Programme for Prevention & Management of Trauma & Burns (Role of Regional Directors).

An overview of i) National Programme for Trauma Care (NPTC) and ii) National Programme for Prevention and Management of Burn Injuries was given by Dr. Tanu Jain, ADG, Dte. GHS and the main discussion points are as given below:

1. Contours of the Programme:

- Burden of diseases and various programme strategies and components were discussed. It was highlighted that due to RTA’s 3% of GDP is lost.

- RDs may support identification of surgeons from Medical Colleges for 6 months training. RDs may contribute in issues pertaining to capacity building for training programmes ATLS/NELS/BLS and prehospitaltechnicians (PTI) course.

- More than 5 million people die each year as a result of injuries, resulting from violence, road traffic crashes, burns, drowning, falls, poisonings, etc.

- As per 2017 report of MoRTH: 4,64,910 road accidents occurred causing injuries to 4,70,975 persons and claiming 1,47,913 lives.

- As per WHO (2017), Burns are a global public health problem, accounting for an estimated 180,000 deaths every year.

- In India, over 10,00,000 people are moderately or severely burnt every year.

- Objectives of the programme for Trauma care are to establish a network of trauma care facilities to reduce the incidence of preventable deaths, develop proper referral and
communication network, develop National Trauma Injury Surveillance and capacity building centre, and to develop trauma registry centres for quality control.

- Components of NPPMBI are: Prevention, Treatment, Rehabilitation, Training, Monitoring and Evaluation, and Research activities.

2. Role of the Regional Directors

- RDs were requested to support the Prog. Division in identification of Surgeons from Medical Colleges for undergoing a 6 months training programme on neuro-trauma.
- RDs may coordinate with States for strengthening the capacity building activities under the Programme, including ATLS/ BLS/ Pre-hospital Trauma Technician (PTT) course, 6-days course on burns injury management and training of paramedics including dressers.
- Regional Directors are required to undertake as monitoring and inspection; liaison with the DHS, DME and the office of Principal Secretary (H) for implementation of the programme; liaison with the technical and state nodal officer nominated by the State; to assist the MC/DH in various issues pertaining to implementation of the programme; liaison with the State AG office for audited SOE and UCs for the funds released under the programme; liaison with the programme division in Dte. GHS.

Session-5: Maternal and Child Health Services

The session was chaired by Dr. Ajay Khera, DC, Immunisation, MoHFW. The session contained two presentations by Dr. SushmaDureja on Rashtriya Kishore SwasthyaKaryakram and Dr. PradeepHaldar on Universal Immunisation Programme. The main points that emerged are as below:

1. Contours of the Programme

- Universal Immunization Programme is one of the largest Public Health Programme with an annual coverage target of 2.67 crore newborns and 2.9 crore pregnant women. The vaccination is delivered through 90 lakh sessions. There are 27,000 cold chain points for storage and distribution of vaccines. Two main milestones achieved are: 1) on 27th March 2014, South-East Asia Region of WHO, including India, certified POLIO-FREE and 2) on 14th July 2016, WHO certified India for eliminating maternal and neonatal tetanus.
- The rapidly changing landscapes of Universal Immunization Programme were discussed. Improving quality involves areas like NCCRC / NCCTC, EVM assessment, eVIN expansion, Capacity building of HR. New Vaccine such as Rotavirus vaccine, Pneumococcal Conjugate Vaccine (PCV), Measles Rubella (MR), Japanese Encephalitis (JE) vaccine and Tetanus & adult Diphtheria (Td) vaccine were discussed.
- Mission Indradhanush was launched on 25th December 2014 with the goal to increase full immunization coverage to 90% and sustain it through RI. The strategy of the mission was discussed along with the achievements.
- RDs could play a vital role in monitoring cold chain, maintain logistics and improving vaccination coverage.
- RashtriyaKishorSwasthyaKaryakram has undergone a paradigm shift in its approach and realigns the earlier clinic-based curative approaches to focus on a more holistic model. Based on a continuum of care for adolescent health and development needs through the three-tier public health system. It includes multi-component intervention targeting both determinants of health problems and their consequences.
- RKSK Implementation Framework was discussed in detail. It covers 10-14 & 15-19 years, girls & boys, unmarried & married, rural & urban, in-school & out-school. Adolescent vulnerabilities
included are anemia, early marriage, substance misuse, contraceptive use, teenage pregnancy and suicides. It has Facility Based Approach, Community Based Approach and School Based Approach.

2. **Role of the Regional Directors**
   - Role and Function of Regional Director were identified as reinforcing the need of effective implementation of RKSK programme at state level; ensuring constitution and effective functioning of State and District Committee for Adolescent Health; regularizing review meeting of RKSK programme at regional and state level; Bringing greater focus on convergence between departments for effective implementation of the programme; focusing on capacity building of service providers-MOs, ANMs, counsellors; establishing effective community linkages through outreach by counsellors; FLWs and PEs; Strengthening procurement and supply chain management of IFA and Sanitary Napkins and assuring optimal utilization of allocated funds.
   - It was proposed that a one day orientation of RDs may be organized on RMNCHA exclusively.
   - The small booklet on RMNCHA to be shared with RDs.
   - RDs are required to keep themselves updated with meetings and participate in new launches, supporting supervision, evaluation, studies and capacity building.

**Session-6 National Vector Borne Disease Control Programme**

A talk was delivered by Dr. P K Sen, Director, NVBDCP. The main points which emerged are as follows:

1. **Contours of the Programme:**
   - 19 ROHFWs exists under Dte. GHS, MoHFW of which 6 are under NVBDCP. But in principle all work under and should contributetowards NVBDCP activities. NVBDCP is the largest programme of VBD & NTDs in the world. All states and UTs are covered. Malaria has a long history of decline & resurgence in the post independence era. World Health Report 2018 shows a decline of 24% in malaria cases in India. However, 11 countries have shown increase worldwide.
   - Newer initiatives like RDTs, ACT & LLIN which have been introduced under the programme were discussed alongwith challenges such as cases going to the private sectors not reported in the Public Health System and shortage of manpower especially of entomologists.
   - Kala Azar cases have decreased to less than 5000 currently and 92% of endemic blocks have achieved elimination targets. Post elimination strategy needs to be defined.
   - A number of vector borne diseases have emerged in the recent time like Scrubtyphus, CCHF, KFD and West Nile Fever.
   - JE/AES is an important disease covered under the program. JE positive cases account for only 10% of AES. In the past very good vaccination campaigns could control AES in West Bengal and Malkangiri but not in Gorakhpur.
   - Dengue is the fastest spreading arboviral disease. All States & UTs are affected. Case fatality rate has been brought down to 0.2%. However, a surveillance system does not exist for dengue till sub-centre level. Surveillance is being done through 750 sentinal sites across country through weekly reporting.
   - Existing vector control measures are being strengthened and are also under revision. A software for surveillance is being developed and tested which will be expanded pan India. A dashboard will also be generated.
2. **Role of the Regional Directors**
   - RoHFWs are required to be integral part of the all above components in areas such as capacity, surveillance, monitoring and evaluation.

**Session 7**

**National Leprosy Eradication Programme**

Dr. Rupali Roy, DADG, Dte. GHS gave presentation on National Leprosy Eradication Programme. She emphasised upon the main points as follows:

1. **Contours of the Programme**
   - Leprosy is caused by Mycobacterium leprae. The disease epidemiology was described in detail.
   - The main programme strategies were discussed alongwith Sparsh Leprosy Awareness Campaign (including SAPNA), National Leprosy Eradication Programme (NLEP), LCDC and SLAC.

2. **Role of the Regional Directors**
   - Regional Directors are already reviewing the programme’s flagship innovations LCDC & SLAC. During LCDC days and Anti Leprosy Day respectively, supporting in monitoring of programme in key States/UTs as a member of Joint Monitoring Investigation and Advisory Group (JMIAG) and giving regular review of the programme activities, especially in data collection on new innovations. It is expected that this involvement would continue in the future as well.

**National Iodine Deficiency Disorder Control Programme**

Dr Pradeep Saxena, Addl. DDG, Dte. GHS presented the following points on National Iodine Deficiency Disorder Control Programme:

1. **Contours of the Programme**
   - National Goitre Control Programme (NGCP) started as 100 percent centrally assisted Programme in 1962. In August, 1992, the National Goitre Control Programme (NGCP) was renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP) with a view to prevent and control wide spectrum of iodine deficiency disorders like mental and physical retardation, deaf mutism, cretinism, still births, abortions etc.
   - Objectives were defined as to prevent and control iodine deficiency disorders. (IDDs) in the entire country; to bring down the prevalence of IDDs to below 5% in the country and to ensure 100% consumption of adequately iodated salt (>15ppm) at the household level.
   - Activities undertaken and implementation of programme in the state was discussed. The status of prevalence of Iodine Deficiency Disorders, vision NIDDCP (2030) and programme achievements were apprised.

2. **Role of the Regional Directors**
   - Regional Directors may contribute by meeting Senior Officers and State Programme Officers (NIDDCP) of State/UT to review programme; may visit State IDD Cell, IDD Lab. at State Hqrs; coordinating with States/UTs for organising review meetings regularly & participate; during field visits, observe testing of salt by ASHAs at community/ household levels;
attending NIDDCP Review Meetings at National/Regional levels and facilitate participation by SPO of States/UTs; and by providing feedback to Nutrition & IDD Cell regarding implementation of NIDDCP in their respective States/UTs.

Session 8

The session was chaired by Dr. Inder Prakash, Adviser (PH), Dte. GHS. The session included 4 presentations as below:

National Programme for elderly

The National Programme for Health Care of Elderly (NPHCE) was presented by Dr. Gouri N Sengupta, ADG(PH), Dte. GHS. She emphasised the following:

1. Contours of the Programme
   - Challenges of Aging Population such as double burden of diseases; increased risk of disability; care for elders and ethics & inequities were discussed.
   - National Policy on Older Person NPOP-1999 formulated by MoSJ&E, seeks to assure older persons that their concerns are national concerns and they will not live unprotected, ignored or marginalized.
   - Objectives of the NPHCE, its programme strategies and its components and implementation were discussed.
   - The Package of services at sub-district level to district level and tertiary level were apprized.

2. Role of the Regional Directors
   - Role of Regional Directorate was identified to overview all district hospitals of the country for provision of geriatric care services; overview 19 Regional Geriatric Centers for provision of geriatric care services, training and research; support states in dedicated geriatric service delivery at CHCs and PHCs and home based care services through peripheral staff.
   - The main role of Regional Directors is monitoring and timely submission of progress report for district level as well as RGCs as per Performa shared during meeting.

National Patient Safety Session

Dr. Chhavi Pant Joshi, DADG(EH) presented National Patient Safety Implementation Framework (2018-2025). The main points are as follows:

1. Contours of the Programme
   - Estimates show that in developed countries as many as 1 in 10 patients is harmed while receiving hospital care. The harm can be caused by a range of errors or adverse events. Of every 100 hospitalized patients at any given time, 7 in developed and 10 in developing countries will acquire health care-associated infections (HAIs).
   - In recent years, there is growing recognition that patient safety and quality of care are critical dimensions of Universal Health Coverage (UHC). Therefore, MoHFW, Govt of India developed the National Patient Safety Implementation Framework (NPSIF 2018-2025). National Patient Safety Framework (NPSIF 2018-2025) was launched by Hon’ HFM on 18 April 2018 at the Kayakalp Award Function at PGIMER & Dr RML Hospital Auditorium, Delhi. The steps or measures been taken so far by Dte.GHS, MoHFW to implement the NPSIF (2018-2025) were described.

2. Role of the Regional Directors
• RoHFW are required to facilitate the following with the States in order to implement NPSIF (2018-2025). In the short term: Constitute Committee on Patient safety subsuming infection prevention and control and biomedical waste (subcommittees can be formed on subthemes); committee should harmonize with the State Quality assurance (QA) under NHM; identify a technical institution/agency such as Medical College for Patient Safety to act as state level resource centre and develop a network of medical colleges for participation in NPSIF at tertiary level care; develop State Patient Safety Action Plan and include patient safety components in state PIP under QA. In the long term: Training of health care functionaries as per Guidelines and Modules on Patient Safety issued by Centre; strengthen Communication on patient safety through dissemination of IEC package; routine monitoring on patient safety in public health care facilities on regular basis; maternal and child safety checklist, surgical safety checklist to be implemented; initiate reporting from public health facilities on patient safety indicators provided as part of operational guidelines; promote use of non-mercury devices; promote accreditation in private sector especially for insurance purchase under various govt schemes.

Bio-medical Waste Management

Dr Malini Capoor, Professor, VMMC & Safdarjung Hospital presented Biomedical Waste Management. The main points are mentioned below:

1. Contours of the Programme
• Unregulated biomedical waste management (BMWM) is a public health problem. She highlighted that improper and inefficient disposal of BWWM can lead to infectious hazards, malignancies, fetal malformations, chronic cardio-pulmonary diseases, endocrinal disturbances, air, land and water pollution for not only this generation but for generations to come.
• Safe and reliable methods for handling BWWM are of paramount importance. BMWM is not only a legal necessity but also a social responsibility for health care sector. A brief overview of Biomedical Waste Rules (2016) was provided to participants and grey areas were discussed.

2. Role of the Regional Directors
• The Role of Regional director was identified as monitoring implementation of BMWM (2016) in facilities of state health systems and informing MoHFW of the status of implementation.
• All Regional Directors to facilitate 3 nominations per state for the IGNOU certificate programme on Health Care Waste Management and communicate the same to Dte. GHS.

Antimicrobial Resistance Containment - Role of Regional Directors

Dr. Sunil Gupta, HOD, Microbiology, NCDC presented on Anti-Microbial Resistance Containment and made the following main points:

1. Contours of the Programme
• AMR is caused by inappropriate use (overuse, underuse & misuse) of antimicrobials in clinical medicine (50% antibiotics prescribed inappropriately), veterinary medicine (>60% antibiotics used in animals), agronomic and industrial practices (environmental pollution). There is poor Infection prevention and control in health care settings and use/availability of poor quality antibiotics. AMR issues in India such as high burden of infections were discussed.
• AMR challenges, awareness activities and NAPAMR strategies were discussed. State Action Plans for Containment of Antimicrobial Resistance (SAPCAR) are critical for action on the ground.

2. **Role of the Regional Directors**
   • Role of Regional Directors is to liaison between state and national authorities and different stakeholders like Public health experts, Clinicians, Microbiologists, Pharmacologists/Pharmacists, State drug control authority and liaison with other Depts (Agriculture, Food/FSSAI, Environment/SPCB etc) for implementing NAPAMR.

**Session 9**

The session was chaired by Dr. Promila Gupta, Principal Consultant, Dte. GHS. There were 4 presentations. Each presentation with main points is described as follows:

**National Organ and Tissue Transplant Programme**

Dr. Vasanti Ramesh, Director NOTTO presented on National Organ and Tissue Transplant Programme. The main points emphasized are:

1. **Contours of the Programme**
   • The main features of the Act and Rules under transplant of Human Organs Act (THOA) were appraised. The amended act enlarges the scope of donors. THOA has to be passed by State legislation Assembly. The organization of SOTTO and ROTTO was described.
   • The main challenges identified was that data is not being shared at national level. Most Southern States have deceased donor data but not living donor data.

2. **Role of the Regional Directors**
   • Bangalore RD was suggested to strengthen the Brain declaration for ethical reasons and for ensuring donation to correct recipient in light of medical tourism and court cases.
   • All Regional Directors to facilitate sharing of State Registries with NOTTO.

**Clinical Establishments Act**

Dr. Anil Kumar, Addl. DDG, Dte. GHS presented on Clinical Establishments Act 2010. The main points are as follows:

1. **Contours of the Programme**
   • Act is applicable to States like Arunachal Pradesh, Himachal Pradesh, Mizoram and Sikkim and 6 Union Territories. States who have adopted the Act are Uttar Pradesh, Uttarakhand, Rajasthan, Bihar, Jharkhand, Assam and Haryana.
   • CEA covers all clinical establishments providing diagnostics and therapeutic services under all systems of medicine. It can be implemented in a phased manner. Salient Features of the Act were described. Issues and Challenges faced in implementing clinical establishment act were discussed.

2. **Role of the Regional Directors**
• Role expected to be supported by RoHFWs are support the notification of State Rules under Section 54 of the Act; constitute & notify the State Council of Clinical Establishments and District Registration Authorities in all districts; to identify a Nodal officer with a team at the state level for the implementation of the provisions of the Act.A demo of the website of CEA was also done.
• Some other works to be undertaken by RoHFWs are seeking funds through State NHM PIPs; appointment of staff; organizing sensitization meetings and workshop; to start the process of provisional registration (online); dissemination of the CEA and Rules at various levels and among stakeholders; dissemination of information about minimum standards and Standard treatment guidelines; to determine Standard Cost of Medical procedures; to share monthly progress report with the MOHFW.
• It was proposed that RDs may be called for State Council meetings as special members.

National Programme For Control Of Blindness

Dr. Sangeeta Abrol presented National Programme For Control Of Blindness. The main points are as follows:

1. Contours of the Programme
   • The strategies and achievements of National Programme for Control of Blindness and Visual Impairment (NPCB & VI) were discussed. NPCB plays a role as policymaker, budget provider, infrastructure developer, guide and supporter of stake holders (NGOs), training of young ophthalmologists, monitor & evaluator.
   • Expectations from RDs are to support states in providing free cataract surgery, school eye screening, providing free specs to school children, collecting donated eyes, organizing free keratoplasty, diagnosis and treatment of diabetic retinopathy, squint, glaucoma, low vision and cataract.

2. Role of the Regional Directors
   • RDs to follow up with States on clearing programme backlogs. If States plan to take focused interventions on refractory errors then NPCB at Centre may be informed.

National Programme for Prevention and Control of Deafness

Dr. Sangeeta Abrol presented National Programme for Prevention and Control of Deafness. The main points are as follows:

1. Contours of the Programme
   • Goal is to prevent and control major causes of Hearing Impairment and deafness amongst Children. Objectives of NPPCD and programme strategies were discussed.

2. Role of the Regional Directors
   • Expectations from RDs are to facilitate the states and SNOs to procure equipments, recruit manpower on contractual basis, submit utilization certificate in the prescribed GFR 19 along with audited statement of accounts; supervise effectively and take review meetings with district personnel.

Session-10
The session was chaired by Shri LavAgarwal, JS, MoHFW. The main points of presentations are as follows:

**Emergency Medical Relief**

Dr. U B Das presented on Works of Emergency Medical Relief, Division of Dte. GHS, MoHFW. The main points discussed were:

1. **Contours of the Programme**
   - Roles and responsibilities of EMR, Dte. GHS are to be nodal agency of MoHFW to prepare and implement crisis management plan and Disaster Management Plan for Health Sector; prevention, mitigation, preparedness and response measures for public health emergencies; medical care arrangement for VVIPs/VIPs; medical care arrangements for National events; Implement Central Sector Schemes.

2. **Role of the Regional Directors**
   - Role of Regional Directors are to liaison with State Health Departments during visit of Central Team for outbreak investigation; be member of Govt of India teams for damage and loss assessment after any major disaster; ensure implementation of National guidelines/protocols for Epidemics/Pandemics; be member of Central Team for inspection of Medical colleges/Hospitals for skill centres and CBRN centres and emphasise upon State Health departments, Medical Colleges for timely submission of utilization certificates.

**Outbreak Monitoring and Containment: Role of RD Office**

Dr S K Singh, Deputy Director, NCDC presented on Outbreak Monitoring and Containment & Role of RD Office. The main points are as follows:

1. **Contours of the Programme**
   - Outbreak detection is done by assessing the occurrence of cases of an illness, specific health-related behavior, or other health-related events clearly in excess of normal expectancy. Various technical aspects of outbreak detection and containment were discussed.
   - It was acknowledged that RoHFW, Thiruvananthapuram played an important role in Nipah Outbreak, containment in Kerala.

2. **Role of the Regional Directors**
   - RD Office should establish first level of contact between State and Central Govt. RD Office can play a role in initiating rapid control measures. RD Office Kerala staff, with NCDC and EMR was part of first rapid response team mobilized for Nipah outbreak containment. Regional Directors should organise field visits to identify exposures of the index case. They should establish contact tracing and assess hospital infection control practices.
   - RD Offices can utilise prior liasoning and networking with State officials; can facilitate inter-sectoral coordination at state level and between centre and state; can support in outbreaks of new and emerging diseases such as zoonotic diseases, disease due to climate change and unusual syndromes.

**Integrated Disease Surveillance Program (IDSP)**

Dr. SuhasDhandore, Deputy Director, NCDC presented Integrated Disease Surveillance Program (IDSP) and Implementation of Integrated Health Information Platform (IHIP). The main discussion points are:
1. **Contours of the Programme**
   - Objectives of IDSP are to strengthen disease surveillance system for epidemic prone diseases and to detect and respond to disease outbreaks. Main components of IDSP were discussed.

2. **Role of the Regional Directors**
   - Role of Regional Directors is to participate in monitoring of IDSP programme implementation in the States, monitor the strengthening of laboratory services under IDSP for diagnosis of epidemic prone diseases and to support the roll out of implementation of IHIP in the states.
   - User ID and passwords for IHIP have been given to RDs which should be used because it gives direct access to critical data. RDs should also follow up data recording and reporting by the state into IHIP.
   - It was proposed that a regional training on IHIP can be organized for improving the proficiency of RDs.
   - RDs should pursue with states for reflecting requirements of ANMOL tablets in state PIPs.

**Climate Resilient Health Services**

Dr. Akash Shrivastava, Joint Director, NCDC presented on climate resilient health services. The main points are as follows:

1. **Contours of the Programme**
   - Prime Minister's Council on Climate Change (PMCCC) in India, identified an additional mission - 'Health Mission' on 19th Jan 2015. NAP on Climate Change and Human Health (NAPCC&HH) has been developed by MoHFW.
   - States should formulate State Action Plan on Climate Change and Human Health. The main components of this action plans should be IEC dissemination on heat related consequences, air pollution related consequences; integrated IEC – IEC of NCDs, VBDs, WBDs, Disaster Mgmt.; capacity building of healthcare personnel; workshop on heat related consequences, air pollution related consequences; sensitization of policy makers, senior programme officers, field workers; involve Medical Education Department; issue of advisories for health institutions on CSDs management; review of existing programmes of health and non-health sector for CSD; review and design strategy to strengthen existing disease surveillance programmes to account for potential rise in burden of CSDs.

2. **Role of the Regional Directors**
   - Regional Directors may support development of State Action Plan in Climate Change & Human health. (SAPCC&HH).

**International health regulations (2005) and role of Regional Directors at points of entry**

Dr. Deepak Sule, DDG(MH&IH), Dte. GHS presented International Health Regulations (2005) and role of Regional Directors at points of entry. The main points which emerged are:

1. **Contours of the Programme**
   - Minimum Core Capacities at Designated PoEs were identified. Major Functions at APHOs and PHOs were discussed.
• Vector Surveillance & Control activities at PoEs are undertaken keeping Airports & Seaports mosquito free as a mandatory requirement under IHRs.

2. **Role of the Regional Directors**

• RoHFWs are expected to coordinate these surveillance rounds and also to support the PoEs in vector control activities.

• Presently most of the new established units are managed by RoHFWs as temporary arrangement. Regional Directors supervise financial and administrative control and infrastructure support till PoEs have their own infrastructure. DDO power may be with RDs with separate DDO code for PoE. Most of the new units of APHO/PHO and some existing units are having only 1-2 regular officers hence RDs may be the member of various committees; in future RDs can support all existing and new units for vector control activities and surveillance; MoHFW/Dte. GHS can support procurement/ supply of logistics (medicines/PPEs etc.) and inspection of facilities applying for starting New Yellow Fever Vaccination Centers.

• A great deal of liaison work with other department is required in the initial stages. The experience of the Sr. RDs is required to operationalise the new units.

• Contractual manpower is not authorized to handle finances. So, it is expected that RDs gradually establish the PoEs as independent units – financially and administratively. Handholding support to the newly posted Medical Officers and creating separate DDO codes for PoEs is also expected.

• During the times of PHEIC, RoHFWs are expected to mobilize the surge capacity required at PoEs. Manpower and material mobilization from the State to be catalyzed by Sr. RDs. Multi-stakeholder coordination can be done by RoHFWs.

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**National Mental Health Programme**

Dr. AlokMathur, Addl. DDG, Dte. GHS presented the National Mental Health Programme and made the following main points:

1. **Contours of the Programme**

• Activities undertaken by NMHP are provision for Out-Patient and In-patient Mental Health Services at the District Hospital Level; engagement of Staff and training of medical and Paramedical Staff; availability of Drugs; outreach Activities; psychosocial and targeted interventions suicide prevention services; awareness generation of mental health issues through IEC activities.

• Under the new Mental Health Act suicide has been decriminalized and mental health patients are to be treated in general health system. IEC needs to be given at ground level to improve health seeking behavior and stigma management. The State shall train Medical Officers (MBBS graduates), Psychologists, Psychiatric Social Workers and Psychiatric Nurses in the NIMHANS Digital Academy to increase the number of skilled mental healthcare professionals in the State. ROHFWs may expedite these at the earliest.

2. **Role of the Regional Directors**
The RoHFWs shall ensure immediate action for implementation of the following provisions of the Mental Healthcare Act, 2017 such as establishment of State Mental Health Authority (Section 45); creation of State Mental Health Authority fund (Section 62); constitution of Mental Health Review Boards (Section 73); rules to be made by State Governments (Section 121); regulations to be made by the State Mental Health Authority (Section 123).

- The RoHFWs shall take necessary immediate steps for establishment of adequate number of halfway homes, sheltered accommodations and supported accommodations as mandated by the Rights of Persons with Mental Illness, 2018 framed under the Mental Healthcare Act, 2017. The number of such facilities established by the State under the Act shall also be intimated to MoHFW.
- The RoHFWs shall expedite expenditure under DMHP. Quarterly reports of expenditure, implementation of DMHP in districts and status of HR shall be furnished on time to this Ministry.

The last session on administrative issues was Chaired by JS (RM) and co-chaired by Director, NVBDCP. JS (RM) briefed the RoHFWs with the current administrative issues pertaining to all ROHWFs and provided the details of the actions as decided in the last Review Meeting. Director, NVBDCP then addressed the RoHFWs and guided them with their issues pertaining to NVBDCP. During the course of discussions, various points were raised by the Regional Offices, as enumerated in the subsequent points.

I. Filling up the Vacant Posts

One of the common areas of concern that emerged during the course of discussions was regarding filling up of vacant posts in the various Regional Offices. It was given to understand that most of the Technical posts, which figured under the strength of NVBDCP such as Laboratory Assistant, Insect Collector, MTS, etc. continued to remain unfilled despite the matter having been apparently flagged to the parent organization from time to time. Director, NVBDCP assured that the matter would definitely be looked into and some tangible action taken. For this, it was desired that the details of existing vacancies, the date from which they were vacant, the action taken for filling up these posts in the interim (including on outsourced basis) and as to how work was being managed during the absence of requisite personnel and other relevant details may be forwarded to NVBDCP for immediate action. It was also underlined that in case the vacant posts had already entered the deemed abolished category, then a proposal for their revival may be sent to RD Cell/NVBDCP in the prescribed proforma of Department of Expenditure. After revival of these posts, only then recruitment action can be initiated. Regarding secretarial/administrative posts such as LDC, MTS, it was urged that requisite proposal may emanate from the concerned office and be forwarded to RD Cell on priority with all concomitant details for ensuring reporting of vacancies to SSC as soon as the window opens for that particular category of posts.

(Action: NVBDCP/ ROHFWs)

II. Purchase of Staff Car

Another issue highlighted during the meeting was regarding purchase of new staff cars. In this regard, DD (AV) informed that as per extant orders of the Government, purchase of new Staff Cars is banned, save against condemnation. In case, an existing official vehicle has outlived its utility i.e. it has travelled more than 1.5 lakh Kms or been in use for more than 15 years and as such, further repairs being not economically viable, then immediate action may be taken for getting the vehicle condemned by getting it evaluated through the requisite Government agency and its recommendations forwarded thereof to Dte.GHS for getting the approval of IFD for condemnation of the vehicle. As a sequel thereof, a proposal for purchase of requisite model of vehicle required may be sent by ensuring that the Net Dealer
Price (NDP) of the vehicle is within the ceiling of Rs. 4.75 lakhs as stipulated vide Department of Expenditure’s OM No. 03(1)/E-IIA/2009 dated the 6th August, 2014. It is also required to be certified in the proposal that no vehicle has earlier been purchased against the vehicle condemned and that sufficient funds are available under Office Expenses (OE) for purchase of the new vehicle. All the units were advised to take action for purchase of vehicle accordingly, if any, by adhering to the said check points.

(Action: ROHFWs)

III. Pending Court Cases

Regarding pending court cases it was observed that most of them had not been uploaded/updated in LIMBS. As a consequence, the same could not be monitored properly leading to defeat of the motive for installation of the new system. All the Regional Offices were urged to take immediate action for uploading details of pending court cases in LIMBS. Furthermore, all the Regional Directors were advised that the timelines for compliance of various court orders may be tracked properly so that no adverse consequence is faced by the Ministry/Directorate due to contempt cases arising due to non-compliance of orders.

(Action: ROHFWs)

IV. License Fees

The attention of the Chair was also invited to the issue of increasing license fees that had to be paid by the various Regional Offices. It was requested by various RDs to make provisions for the same at the RE stage in the budget 2018-19. It was assured that efforts would be made to accommodate the requirements of each office to the maximum extent possible as per funds to be made available under RE 2018-19. As this would be a recurring feature, it was suggested that the Regional Offices should try to get in touch with NCDC and try to find a place in their new complexes, which are coming up in various parts of the country. This would not only result in saving of precious Government funds but would go a long way in synergy of the two prestigious field offices of the Dte.GHS.

(Action: RD Cell)

V. Outsourcing of Staff

In the course of discussion, it was pointed out by RDs that the permission for outsourcing of the contractual staff is being accorded by RD Cell on timely basis, however no such communications are being received from Dte. of NVBDCP for the vacant posts pertaining to them. This may lead to the vacant posts under the strength of NVBDCP to fall in the deemed abolished category. It was, therefore, urged to Director, NVBDCP that permission for outsourcing of staff on contractual basis for the post lying vacant under their strength may be accorded to ROHFWs from time to time, for smooth functioning of work in the ROHFWs and to safeguard the posts from falling into the deemed abolished category. Director, NVBDCP assured the RDs that the matter may be taken up by them and permission will be accorded to all RDs as discussed.

(Action: NVBDCP)

VI. Raipur Staff

RD, ROHFW, Raipur stated that there is no staff posted under ROHFW, Raipur, therefore, she alone has to manage all the work, tours, etc. Further, she is the head of RLTRI, Raipur and have to look after the work of the Institute as well. She requested to provide the staff, urgently for efficient and effective work of ROHFW, Raipur. It was suggested to RD, ROHFW, Raipur to put up a proposal to this Directorate, requesting for staff, to consider her request.
The valedictory function was graced by DGHS. He addressed all the RDs and interacted with them regarding the experience of the workshop. He guided them regarding various National Programmes and to work in a manner that presence of ROHFWs is felt in the Ministry. In their feedback all RDs expressed their gratitude towards DGHS for giving them an excellent platform to understand all new initiatives of Dt. GHS & MoHFW and interact with Senior Officers of Dte. GHS and Ministry. RDs were also ensured that the issues addressed by them in the administrative session will be settled in time. DGHS also promised that a second level meeting of ROHFWs will be organized to keep the pace going.

All programmes division are expected to share latest Programme guidelines and supervision checklist with RoHFWs.

(Action Point: All Programmes)

Contact details of RoHFWs are to be shared with all Programme Division and contact details of all programmes divisions to be shared with RoHFWs.

(Action Point: RD Cell, Dte. GHS)

DGHS also suggested that an e-mail may be created for all Sr. RDs/RDs, and this id and password may be shared with all, so that a common portal is available for dissemination of important information. Considering the recurring expenditure on rent as regular basis, he advised that accommodation may be allotted to ROHFWs in the new NCDC branches, being opened in various states.

(Action: RD Cell)

Lastly, Adviser (PH) was invited to give a vote of thanks. He expressed his heartfelt gratitude towards DGHS, and other officers from Directorate. He further thanked all RDs, and especially officials of RD Cell for excellent organization and successful hosting of the event.

The Meeting ended with a vote of thanks to the Chair.

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Annexure-1

**List of Participants for the Workshop held at Nirman Bhawan, New Delhi.**

On the Chair:

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<th>S. No</th>
<th>Name &amp; Designation</th>
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<tr>
<td>1</td>
<td>Dr. Preeti Sudan, Secretary</td>
<td>MoHFW</td>
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<td>2</td>
<td>Dr. S. Venkatesh, DGHS</td>
<td>Dte. GHS</td>
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<td>3</td>
<td>Sh. Manoj Jhalani, AS &amp; MD</td>
<td>MoHFW</td>
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<td>4</td>
<td>Sh. Alok Saxena, JS</td>
<td>MoHFW</td>
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<td>5</td>
<td>Sh. Nilambuj Sharan, EA</td>
<td>MoHFW</td>
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<td>6</td>
<td>Sh. Lav Agarwal, JS</td>
<td>MoHFW</td>
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<td>7</td>
<td>Ms. Vandana Gurnani, JS</td>
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<td>8</td>
<td>Sh. Vikas Sheel, JS</td>
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<td>Sh. Sudhir Kumar, JS</td>
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<td>10</td>
<td>Sh. Rajiv Manjhi, JS</td>
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<td>11</td>
<td>Dr. B. D. Athani, Principal Consultant</td>
<td>Dte. GHS</td>
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<td>12</td>
<td>Dr. Promila Gupta, Principal Consultant</td>
<td>Dte. GHS</td>
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<td>13</td>
<td>Dr. N. S. Dharamshaktu, Principal Adviser</td>
<td>Dte. GHS</td>
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Other Officers:-

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<td>1</td>
<td>Dr. ManoharAgnani, JS</td>
<td>MoHFW</td>
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<td>2</td>
<td>Dr. Inder Prakash, Advisor (PH)</td>
<td>Dte. GHS</td>
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<td>3</td>
<td>Dr. Anil Manaktala, DDG (P)</td>
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<td>Dr. SangeetaAbrol, DDG (O)</td>
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<td>5</td>
<td>Dr. Deepak Sule, DDG(MH&amp;IH)</td>
<td>Dte. GHS</td>
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<td>Dr. Pradeep Saxena, Addl. DDG</td>
<td>Dte. GHS</td>
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<td>7</td>
<td>Dr. MaliniCaptor, Dept. of Microbiology, SJH &amp; VMMC</td>
<td>SJH &amp; VMMC</td>
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<td>8</td>
<td>Dr. Vasanti Ramesh, Director</td>
<td>NOTTO</td>
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<td>Dr. Sujeeet Kumar Singh, Director</td>
<td>NCDC</td>
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<td>10</td>
<td>Dr. Sunil Gupta, HOD, Microbiology</td>
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<td>11</td>
<td>Dr. AkashShrivastava, Head, Centre for EOH &amp; Climate Change</td>
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<td>Dr. S. K. Jain, HOD (Epid)</td>
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