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As Parliament considers the nation's priorities during the Budget Session 2026, health must remain a central priority in responsible policymaking.

We begin with chronic respiratory diseases and call for integrated lung health, cleaner air, reliable spirometry, essential inhalers and stronger protection for children and vulnerable groups. We then examine haemophilia, where India must move from episodic treatment to early diagnosis, universal prophylaxis, advanced testing and lifelong preventive care. Patient safety also demands attention. Our article on single-use medical devices urges a clear national framework on reuse, validation, traceability, consent and accountability.

Prevention remains a defining theme. The tobacco control article recognises India's progress but highlights weak enforcement, low taxation of bidis and smokeless tobacco, youth exposure, and industry interference. Retinal disease, especially diabetic retinopathy, requires systematic screening, tele-ophthalmology, timely referral and financial protection before avoidable sight loss becomes permanent. Finally, India's unfinished fight against tuberculosis calls for earlier diagnosis, household contact screening, drug-resistance management, nutrition support, private-sector reporting and stronger social protection.

Together, these contributions make one argument: public health advances when policy reaches patients consistently, safely and early.

We thank all authors and experts for their insight and care. Their work strengthens IMPF's commitment to informed parliamentary action and a healthier India.

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India Must Put Lung Health at the Centre of NCD Action

Breathing should not be a privilege. Yet for millions of Indians, clean air, timely diagnosis and affordable respiratory care remain uncertain. Chronic respiratory diseases (CRDs), especially asthma and chronic obstructive pulmonary disease (COPD), are major non-communicable diseases. They cause prolonged illness, lost productivity, avoidable hospitalisation and premature death. Globally, asthma and COPD affect more than half a billion people and cause nearly four million deaths annually.

India's challenge is particularly urgent. CRDs accounted for a substantial share of the country's disease burden even before recent increases in urbanisation, pollution and climate-related exposure. COPD and asthma dominate this burden, but their effects are often underestimated because breathlessness, coughing and wheezing are normalised, treatment is delayed, and access to spirometry remains uneven.

Young people deserve special attention. Asthma is among the most common chronic conditions in children and adolescents. Their lungs are still developing, making exposure to particulate matter, tobacco smoke, allergens and household fuels especially damaging. Early tobacco use, including new nicotine products, can create lifelong dependence and accelerate respiratory decline. Poorly controlled childhood asthma also disrupts education, physical activity and mental wellbeing.

CRDs cannot be addressed in isolation. They frequently coexist with diabetes, hypertension, cardiovascular disease, obesity and mental health conditions. Tobacco exposure, physical inactivity, systemic inflammation and social disadvantage cut across these illnesses. Primary care must therefore move from fragmented, disease-specific treatment to integrated, person-centred NCD management.

India's National Programme for Prevention and Control of Non-Communicable Diseases provides an important platform. Its inclusion of asthma and COPD within primary healthcare is welcome. However, implementation must become deeper and more consistent. Screening questions alone are insufficient. Health and Wellness Centres and district facilities need reliable spirometry, trained personnel, referral pathways, inhaler availability and follow-up systems. Standard treatment protocols must be translated into everyday practice.



Policy must also move upstream. The government should establish a national lung-health mission within the NCD framework, supported by measurable state targets. School health programmes should include asthma recognition, clean-air awareness and tobacco prevention. Air-quality alerts should trigger health advisories, protection plans for children and outdoor workers, and continuity arrangements for vulnerable patients. Clean cooking, occupational safety and enforcement against tobacco and nicotine marketing must remain core respiratory policies. Air pollution damages lung function, aggravates asthma and increases the long-term risk of COPD and other NCDs.

India also needs stronger surveillance. CRD registries, age-disaggregated data and routine measurement of lung function would reveal where risks and treatment gaps are greatest. Research should examine multimorbidity, women's exposure to household pollution, occupational lung disease and the long-term effects of childhood exposure. Essential inhaled medicines and diagnostic services must be affordable through public facilities and financial-protection schemes.

Government leadership is indispensable, but health ministries cannot act alone. Education, environment, labour, housing, transport, urban development, industry, clinicians, researchers, civil society, youth networks and patient groups must share responsibility. People living with CRDs should help design policies, services and accountability mechanisms.

Without decisive intervention, respiratory illness will deepen health inequities, strain families financially, overload hospitals during pollution peaks, and undermine India's ambitions for a

healthier, more productive and resilient population in the coming decades.

India has the programmes, clinical knowledge and institutional capacity to act. What is now required is urgency, integration and sustained

investment. Protecting lung health will reduce NCD deaths, strengthen human capital and give every child a fairer chance to breathe, learn and thrive.

— **Dr. Shivaji BandappaKalge**
Member of Parliament

Haemophilia Care in India: From Episodic Treatment to Lifelong Prevention

Haemophilia is an inherited X-linked bleeding disorder caused by deficiency of clotting factors. Factor VIII deficiency causes haemophilia A, the commonest form; factor IX deficiency causes haemophilia B; and factor XI deficiency causes the rarer haemophilia C. Severe haemophilia is defined by factor levels below 1%, moderate disease by levels of 1-5%, and mild disease by levels of 5-40%.

India carries about 10% of the global haemophilia burden, yet only around 20% of cases are diagnosed. Because of its inheritance pattern, all daughters of a man with haemophilia are carriers, while a carrier woman has a 50% chance of passing haemophilia to her sons and carrier status to her daughters.

Treatment includes replacement of the missing factor, non-factor preventive therapies, and regular laboratory monitoring. Earlier, factor replacement was largely given on demand after bleeding occurred. Patients could experience nearly 30 bleeds annually, leading to repeated joint damage, disability and poor quality of life. Prophylaxis is therefore essential. It can reduce bleeding to about two episodes a year, lower joint involvement by 83%, prevent disability and allow self-injection at home.

For severe disease, maintaining factor levels above 1% helps prevent spontaneous joint and internal bleeding. Extended half-life products can also be stored at room temperature and provide strong haemostatic response during surgery. Prophylaxis aligns with the World Federation of Haemophilia recommendations and shifts care from crisis management to sustained prevention, independence, and dignity.

Standard half-life factor VIII or IX remains widely used, but extended half-life therapy offers important advantages. It requires fewer injections, may reduce the annual bleeding rate to about 0.84, improves joint health and can be more cost-effective over time. Delhi has added extended half-life factor VIII to its Essential Drugs List.

A major complication is the development of inhibitors, or antibodies, against factor VIII in nearly

30% of patients with haemophilia A. APTT mixing tests should therefore be available at district hospitals, followed by Bethesda assays where required. Patients with high inhibitor titres may need bypassing agents such as recombinant factor VII or activated prothrombin complex concentrate. Factor VIII, factor IX and these bypassing agents are included in the government Essential Drugs List for registered patients at designated centres.

Emicizumab, marketed as Hemlibra, is a non-factor therapy administered subcutaneously and can be effective in haemophilia A with or without inhibitors. However, routine factor VIII and Bethesda assays become unreliable during its use. In emergencies or surgery, specialised chromogenic factor VIII and Bethesda testing is crucial to determine whether less expensive factor therapy can be safely used. These tests are currently available at very few centres, making state-level referral laboratories and clear standard operating procedures necessary.

New rebalancing therapies, including concizumab and fitusiran, may benefit patients with haemophilia A or B, with or without inhibitors. Gene therapy also offers future promise, though present costs remain prohibitive.

India's immediate priority must be universal prophylaxis, preferably with extended-half-life formulations, alongside earlier diagnosis. Medical curricula should strengthen training in bleeding disorders. District hospitals must implement platelet count, PT, APTT and APTT mixing tests, while medical colleges should provide factor and inhibitor assays. Specialised referral centres must support chromogenic and newer drug-monitoring tests. Together, these measures can prevent avoidable bleeding, disability and deaths while enabling people with haemophilia to lead near-normal lives.

— **Dr Prof (Col) Jyoti Kotwal,**
MD, FAMS, FRCP Edin

(Professor and Head, Institute of Haematology and Molecular Medicine, Sir Ganga Ram Hospital and GRIPMER, New Delhi)

Medical Device Reuse in India: Safety, Consent and Accountability

India's healthcare system delivers more complex, device-intensive care than ever before. Interventional cardiology, oncology, neonatology and critical care depend on high-value disposable devices, even as hospitals face tight public budgets, price-sensitive private markets and heavy out-of-pocket spending. In this climate, an uncomfortable but widespread practice has taken root: reusing medical devices explicitly labelled for single use. It is time to call this what it is - a safety-critical failure disguised as a cost-saving measure.

The affordability argument does not withstand scrutiny. Regulatory investigations, including one by the Maharashtra FDA, found that cardiovascular catheters were reused and billed to patients at prices close to those of new devices. When savings are not transparently passed on, reuse ceases to be a pragmatic compromise and becomes a commercial strategy masquerading as necessity. Even where billing is fair, safe reprocessing is never free. It requires validated cleaning and sterilisation, functional testing, traceability and trained staff, costs rarely built into India's informal reuse practices.

The clinical risks are equally stark. India bears a heavy burden of hospital-acquired infections, while sterile-processing capacity remains uneven across facilities. Devices with lumens and complex internal geometries are notoriously difficult to clean; simulated-use studies show that even standard automated washing can leave contamination. Reprocessability cannot be assumed - it must be proven, device by device, cycle by cycle.

Beyond infection risk lies a subtler danger: material failure. Single-use devices are engineered for a single clinical episode, and their polymers, coatings, and structural tolerances are not designed to withstand repeated sterilisation. Experimental evidence shows measurable degradation - reduced compressive strength, micro-cracking and coating failure - after only a few reprocessing cycles. A device that appears sterile may no longer perform as intended, turning routine procedures into unpredictable ones.

There is also an ethical fault line. Patients are rarely informed that a device has been reused. Without disclosure, they cannot meaningfully consent to associated risks or assess whether they benefit from any cost savings. This asymmetry of

information, risk and benefit has no place in modern healthcare.



Even the environmental case for reuse is conditional. Life-cycle evidence suggests that genuine sustainability gains materialise only under tightly regulated, validated reprocessing systems, not under informal, variably documented practices common in India. Without such rigour, reuse may simply shift the burden to energy-intensive sterilisation and poorly managed biomedical waste.

India's regulatory framework has not kept pace with this reality. The Medical Devices Rules, 2017 rely on manufacturer-declared intended use but offer no dedicated pathway, validation standard, licensing regime or liability framework for reprocessing single-use devices. The result is a regulatory grey zone that neither prohibits nor governs the practice, leaving patient safety to chance.

Our position is unambiguous: without a national framework for validation, oversight, traceability and disclosure, the reuse of single-use medical devices must stop. Should India permit reprocessing in future, it must be established as a wholly new, tightly regulated activity - grounded in risk-based eligibility, manufacturer-equivalent validation standards, licensed reprocessors, full traceability and genuine patient consent.

Healthcare systems are built on trust. That trust cannot survive ambiguity over whether a needle, catheter or surgical instrument has truly been used only once. Pragmatism has its place, but not when it compromises the basic promise owed to every patient: safety, transparency and accountability, without exception. Patient welfare must remain the priority.

- Pavan Choudary
Chairman & Director General, MTai

Towards a Tobacco-Free India: Progress, Gaps and the Road Ahead

India's tobacco control journey reflects major policy advances alongside persistent implementation challenges. The country has nearly 27 crore tobacco users. About 13.5 lakh Indians die each year from tobacco-related diseases, while millions suffer from cancers, cardiovascular conditions, respiratory illnesses and tuberculosis.

India has emerged as a global leader in tobacco control. It ratified the WHO Framework Convention on Tobacco Control in 2004, enacted the Cigarettes and Other Tobacco Products Act (COTPA) in 2003, and introduced the National Tobacco Control Programme in 2007. It has also implemented large pictorial health warnings, restricted tobacco promotion in films, television and OTT content, prohibited tobacco and nicotine in food products, and banned electronic cigarettes. These steps show that political commitment can produce measurable public health gains. Yet weak enforcement, interstate disparities, affordable products, emerging nicotine products, industry interference and widespread smokeless tobacco use continue to impede progress.

National progress

The Global Adult Tobacco Survey provides clear evidence of improvement. Tobacco use among adults aged 15 years and above declined from 34.6% in 2009–10 to 28.6% in 2016–17, representing nearly 81 lakh fewer users despite population growth. Smoking prevalence fell from 14.0% to 10.7%, while smokeless tobacco use declined from 25.9% to 21.4%.

This progress reflects stronger smoke-free laws, pictorial warnings covering 85% of tobacco packaging, mass media campaigns, cessation services and improved surveillance. India's performance under the WHO MPOWER framework has also strengthened.

Sub-national disparities

National gains conceal sharp state-level differences. Tobacco use exceeds 50% among adults in Manipur, Mizoram and Tripura, and remains above 40% in several other northeastern states. By contrast, prevalence is substantially lower in Punjab, Kerala and Goa. Women's tobacco use is generally low nationally but remains high in parts of the Northeast and eastern India.

These disparities highlight the importance of state leadership and local enforcement. States with stronger public health administration, judicial support, civil society participation and consistent implementation have generally performed better.

Key challenges

Smokeless tobacco remains India's greatest challenge. Gutkha, khaini, zarda, paan with tobacco and locally manufactured products are inexpensive, culturally accepted and easily available in small packs. One hundred high-risk districts across 14 states account for 68% of the country's smokeless tobacco users.

COTPA enforcement also remains uneven. Violations involving smoke-free areas, point-of-sale advertising, sales near educational institutions and sales to minors continue. Despite legal prohibitions, 8.5% of children aged 13–15 use tobacco in some form, with initiation reported before seven years of age.

Taxation is another missed opportunity. India's tobacco tax burden remains below the WHO-recommended level of 75% of retail price. Bidis are especially under-taxed, inexpensive and largely produced in the informal sector. Tobacco industry interference through litigation, surrogate advertising, corporate social responsibility and lobbying further weakens implementation.

The way forward

India must now shift from creating laws to implementing them effectively. All tobacco products, including bidis and smokeless tobacco, should be taxed at comparable, health-protective levels. Tobacco cessation must become a routine part of primary healthcare, with screening, brief advice and referrals through Health and Wellness Centres, quit lines and mCessation platforms.

High-prevalence states, particularly in the Northeast and eastern India, require culturally tailored tobacco-free campaigns. Enforcement of COTPA, the food safety law, the Juvenile Justice Act and related regulations should be coordinated across departments, supported by district-level monitoring. Article 5.3 of the WHO-FCTC must also be applied across ministries to protect policymaking from industry interference.

India has proved that tobacco use can decline despite its demographic diversity and complex federal structure. The next decade must ensure that existing laws reach every district, village and vulnerable population. Progress must become permanent, equitable and strong enough to realise a Tobacco-Free India by 2047.

Dr Shalini Singh¹, Dr Prashant Kumar Singh² and Prof Sonu Goel³

1. Director, ICMR-NICPR, Noida
2. Scientist-E & Associate Professor, Div. of Preventive Oncology & Population Health, ICMR-NICPR, Noida
3. Professor of Health Management, School of Public Health, PGIMER, Chandigarh

Protecting India's Vision: Making Retinal Health a Public Health Priority

India is often described as the 'blindness capital of the world', accounting for nearly one-third of the world's visually impaired population. Although sustained policies and public health programmes have helped reduce cataract blindness, another vision crisis is quietly unfolding and could reverse these gains if left unaddressed.

Retinal diseases are now a leading cause of irreversible vision loss, yet they remain largely absent from public health discourse. Nearly 1.1 crore Indians live with retinal conditions, including diabetic retinopathy and age-related macular degeneration. Unlike cataracts, retinal diseases can cause permanent blindness if diagnosis and treatment are delayed. Much of this loss, however, is preventable through timely detection and appropriate care.

India's diabetes epidemic makes the challenge more urgent. With 101 million people living with diabetes and another 146 million with pre-diabetes, the country has one of the world's largest populations at risk of diabetic retinopathy. Yet awareness remains alarmingly low. Nearly 85 per cent of people with diabetes do not know that the disease can damage their vision, and many have never undergone a retinal examination. By the time symptoms appear, irreversible damage may already have occurred.

The central barrier is not the absence of effective treatment but the lack of systematic screening. Retinal screening has not yet been fully integrated into India's national non-communicable disease programmes, despite diabetic retinopathy being among the most preventable causes of blindness. This is a critical missed opportunity.

Global evidence shows that routine retinal examinations as part of standard diabetes care can substantially reduce the risk of sight-threatening diabetic retinopathy. India must therefore strengthen screening capacity at the grassroots level. Frontline health workers should drive

awareness, while primary care physicians, diabetologists, ophthalmologists and retinal specialists should work through an integrated network with clear referral pathways. Early identification, prompt referral and timely treatment can reduce vision loss and ease pressure on tertiary hospitals. Community-based screening can also identify people who rarely visit hospitals, especially older adults, rural residents and economically vulnerable families. Linking these services with diabetes clinics and Health and Wellness Centres would make early detection more accessible, affordable and consistent across India.

India has already demonstrated that large-scale blindness prevention is possible. The National Programme for Control of Blindness and Visual Impairment has reduced cataract blindness through political commitment, targeted funding and coordinated implementation. The same resolve must now be directed towards retinal diseases.

Retinal health is not merely a healthcare concern; it is integral to India's aspiration to become a Viksit Bharat. Vision loss diminishes independence, reduces workforce participation, increases the burden on carers and lowers quality of life. It also imposes severe costs on families, particularly when people with diabetes are the primary earners. Retinal diseases are estimated to cost India 50,000 crore annually through lost productivity, healthcare expenditure and long-term disability.

The path forward is practical. Sustained campaigns must ensure that everyone with diabetes understands that vision can be protected through regular retinal examinations before symptoms appear. Annual screening should become a routine part of national NCD programmes. The government must expand screening infrastructure and train frontline providers in retinal imaging and early detection. Tele-ophthalmology and artificial intelligence-assisted screening can extend specialist expertise to underserved regions.

Finally, dedicated funding for the blindness-control programme is needed to manage retinal disease. Advanced treatments, including intravitreal injections, should be covered under Ayushman Bharat to ensure patients can access timely care. By combining awareness, screening, referral, technology and financial protection, India

can prevent avoidable blindness and protect the vision, productivity and dignity of millions.

– Dr. Vishali Gupta

[President, Vitreo Retinal Society of India (VRSI), and Head of Vitreoretina and Uvea Services, Advanced Eye Centre, PGIMER, Chandigarh]

India's Unfinished Fight Against Tuberculosis: A New Roadmap Beyond 2025

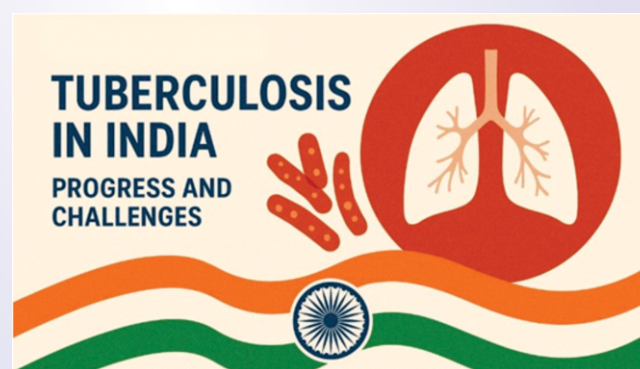
India entered 2025 with an ambition unmatched in global health: to eliminate tuberculosis five years ahead of the Sustainable Development Goal deadline. That target was not achieved. The missed milestone must not be treated as failure alone, but as a moment for honest assessment and a stronger national compact against a curable disease.

The scale remains formidable. India accounted for an estimated 25 per cent of global TB cases in 2024. Worldwide, TB again became the leading cause of death from a single infectious agent, while drug-resistant disease remained a major antimicrobial-resistance threat. India has expanded case notification, molecular testing, digital monitoring and community participation. Yet transmission continues because too many people are diagnosed late, inadequately supported, or missed by routine services.

The next roadmap must begin with earlier diagnosis. Persistent cough, weight loss and fever are still frequently ignored or treated empirically. Rapid molecular testing should become the first-line diagnostic standard for presumptive TB, not a service available only after repeated visits. Mobile screening units, artificial-intelligence-supported chest X-rays and active case finding should be concentrated in urban settlements, prisons, mines, tribal districts, migrant communities and other high-risk settings.

Household contact investigation also needs greater urgency. Every notified patient should trigger systematic screening of family members, testing for eligible contacts and prompt tuberculosis preventive treatment. Children, older people and immunocompromised individuals cannot depend on passive symptom reporting. Districts should be assessed not merely by notification numbers, but by the proportion of contacts screened and protected.

Drug-resistant TB requires a distinct mission approach. Universal drug-susceptibility testing,



faster laboratory turnaround, uninterrupted access to shorter all-oral regimens and careful management of adverse effects are essential. Treatment adherence improves when care is respectful, decentralised and convenient. Digital tools can assist, but they cannot replace counselling, home-based support and trust between patients and providers.

Nutrition must move from an auxiliary benefit to a clinical intervention. Undernutrition increases vulnerability to TB, worsens treatment outcomes and contributes to preventable mortality. The increase in support under the Ni-kshay Poshan Yojana is welcome, but timely payment, inflation-linked assistance and nutrition assessment are equally important. Severely undernourished patients need enhanced food support and clinical management, not a uniform cash transfer alone.

The private sector remains another critical gap. Many patients first seek care from private clinics, pharmacies or informal providers. Mandatory notification must therefore be combined with simple reporting systems, free diagnostics, treatment linkage, clinical mentoring and accountability for standards of care. Penalising non-reporting without enabling participation will achieve little.

TB is also a social and economic disease. Wage loss, migration, stigma, crowded housing and transport costs can interrupt treatment. Social protection should include paid medical leave,

workplace safeguards, travel assistance and convergence with food-security and welfare schemes. No family should fall into debt because one member develops TB.

India now needs a post-2025 strategy with transparent annual targets, district-level public dashboards, independent reviews and meaningful participation by survivors. Health departments cannot succeed alone; nutrition, labour, housing, prisons, tribal affairs, local government, industry and civil society must share responsibility.

The missed deadline should sharpen, not weaken, India's resolve. Ending TB will require finding people earlier, treating them completely and protecting families before infection becomes disease. The science exists. The programmes exist. What India needs now is sustained execution, social protection and accountability equal to the scale of its promise.

- Dr Jayanta Kumar Roy
Member of Parliament

Maha Stroke Summit Calls for Wider Access to Advanced Stroke Care

Mumbai, 6 March 2026: The Maha Stroke Summit 2026 brought together policymakers, clinicians and industry experts to discuss ways to strengthen stroke care across Maharashtra. Chaired by Dr Anil Bonde, Member of Parliament and Chairperson of the Indian Medical Parliamentarians' Forum, the summit featured Maharashtra Public Health Minister Shri Prakashrao Abitkar as Chief Guest. Discussions focused on bridging treatment gaps, improving emergency response and expanding access to thrombolysis and mechanical thrombectomy. Experts also examined clinical evidence, the impact of including stroke treatment under the Mahatma Jyotirao Phule Jan Arogya Yojana, and the need for a hub-and-spoke model supported by technology and strategic partnerships. The event was organised by IMPF, EBC and Medtronic India. It reaffirmed a shared commitment to timely, affordable and equitable stroke treatment.



National Stroke Summit 2026 Highlights Roadmap for Better Stroke Care



New Delhi: The 3rd National Stroke Summit 2026, on 24 March, 2026, at FICCI in New Delhi, brought together policymakers, clinicians, researchers, emergency-care teams, industry leaders, and public health experts to strengthen India's stroke response. In his message, Union Health Minister Shri J. P. Nadda described stroke as both a medical emergency and a major public health challenge, stressing that every minute matters. He called for timely recognition, rapid referral and access to quality treatment to save lives and prevent disability. Highlighting the government's commitment to accessible, affordable and technology-enabled healthcare, he cited Ayushman Bharat's digital and health infrastructure initiatives.

Nadda urged stakeholders to advance a National Stroke Action Plan, identify Stroke Ready Centres, expand specialist training in tier-2 and tier-3 cities, and leverage digital platforms to deliver care more quickly. The Summit also discussed thrombolysis, thrombectomy, hub-and-spoke models, telemedicine, artificial intelligence and state-level best practices for equitable stroke care nationwide. The 3rd Stroke Summit was organised by FICCI in collaboration with IMPF and the World Stroke Organisation.

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