

**PROCEEDINGS
OF
THE FIRST CONFERENCE
OF
CENTRAL COUNCIL OF HEALTH
AND
FAMILY WELFARE**

**February 15—17,
1988 New Delhi**

**MINISTRY OF HEALTH AND FAMILY WELFARE
(BUREAU OF PLANNING)
GOVERNMENT OF INDIA**

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A G E N D A

1. Family Welfare Programme including MCH and Immunization
2. Primary Health Care including Minimum Needs Programme and School Health Services
3. National Malaria Eradication Programme including Kala-Azar Control
4. National Leprosy Eradication Programme
5. National Programme for Control of Blindness
6. National T.B. Control Programme
7. National Goitre Control Programme
8. AIDS Surveillance & Control
9. Cancer Research & Treatment including Anti-tobacco measures
10. I.S.M. & Homoeopathy Programme
11. Drugs Standard Control including Problem of Drug abuse
12. Prevention of Food Adulteration Programme
13. Medical Health Education including ROME Scheme
14. Review of National Health Policy

**WELCOME ADDRESS BY SHRIS. S. DHANOA, SECRETARY, MINISTRY OF HEALTH
&FAMILY WELFARE, NEW DELHI**

1. Hon'ble Union Minister for Human Resource. Development and Health and Family Welfare, Minister of 'State for Health and Family Welfare, Member, Planning Commission, Members of the Central Council of Health and Family Welfare, invited guests and fellow officers of the States and Union Territories.
2. It. gives me great pleasure to welcome you to this Conference of the Central Council of Health and Family Welfare. I hope you had a comfortable journey and I wish you a pleasant stay in Delhi. We are meeting at a time when 10 years have passed since the declaration—Health for. All goals by the year 2000 A.D.—a declaration which was adopted by the world community in the year 1978 and to which India is fully committed. This Conference has another special significance because it is taking place at a time when 3 years of the Seventh Plan are nearly over and considerable area has been covered under the various programmes set out for the Plan period. This is, therefore, the appropriate time, to take stock of the situation, to assess our performance, to review the functioning of the various schemes and to take corrective steps where required.
3. In the normal course, this would have been the 13th Joint Meeting of the two separate Central Councils of Health and of Family Welfare. It was, however, felt that, as the two areas are really indivisible, we should have a single Council of Health and Family Welfare. The new Council which is meeting to-day is the outcome of considerable deliberations in the Government of India and we could get the notification out only on 6th January, 1988. It is for this reason that we have called this meeting the first meeting of the Central Council of Health and Family Welfare. It also explains the delay, because normally this meeting should have been held some time in the month of September-October last year.
4. One area on which we would invite special attention of the members is the Family Welfare Programme. The population of the country, which is now 77 crores, is posing a big challenge and if we fail to check and reduce the growth rate, we shall literally be swamped by this problem in a few years' time. If we accept this challenge in the true sense of the term, we will have to make family planning a part of our total activities under the Government—wherever there is scope for interaction with sizeable segments of population. We will also require a reaffirmation of commitments at all levels or making family planning a complete success well before the turn of the century, before it is too late. In the note provided with the Agenda on this subject, considerable material has been presented which, I hope, will stimulate pointed debate and bring forth suggestions which will show us the path for future action.

5. Closely associated with population is the problem of providing 'appropriate Health Care Services to the people, particularly in the rural areas, -as near as possible to their homes or their work places. While we have made substantial progress in the setting up of Primary Health "Centres and Sub-Centres, there has been an uneven achievement in various parts of the country. There are also questions in regard to availability of manpower of different categories for manning these Centres. The preventive and promotive health care that we envisage can be provided only if there is active involvement of the community in the delivery of health care services. Perhaps some mechanism of popular committees for each such centre and PHC could be considered. I am sure that the various aspects of Health Care Services, particularly Primary Health Care, will be given careful consideration in the deliberations of this Conference.
6. Training of manpower with appropriate skills and in appropriate numbers assumes great importance in all programmes. There has been, in a way, dichotomous growth of Health Services and manpower, each developing in isolation and without proper linkages in temporal and spatial dimensions. There is a need to remove these distortions. In pursuance of the National Health Policy and the National Policy on Education, which recognize the essential linkages of services, education and manpower, the Government of India has been seriously engaged in involving a suitable manpower policy. An expert committee has recently been constituted with Dr. J.S Bajaj as Chairman to give us a draft for a National Medical and Health Education Policy which had been contemplated in the National Health Policy. It is also in this context that we have proposed significant amendments to the Indian Medical Council Act which are presently before the Joint Committee of Parliament. We sincerely hope that, with the co-operation of all of you, it will be possible to bring about suitable changes and improvements in the educational and manpower policies which will go a long way in enabling us to translate the principles enunciated in the National Health Policy and the National Policy on Education into action. I hope that in the deliberations of this august body valuable guidance will be provided on' this important subject.
- 7 You will also be engaging yourselves on reviewing the performance under the various National Programmes for eradication/control of different diseases like malaria, leprosy, blindness, T.B., goiter, Cancer and AIDS. Prevention of Food Adulteration and Drugs Standard Control Programmes, will also receive your consideration in the deliberations. Indigenous System of Medicine and Homoeopathy have been playing a significant role in the health care of people of this country from time immemorial. There has been tremendous growth in the services under these systems in recent years. Keeping in view the advances made in different aspects of these systems and. also in view of the availability of a massive number of practitioners of these systems in the country, it has to be our constant endeavor to encourage-more and more involvement of the- indigenous systems in our Health Care Programmes including Family Planning Programme. With the help of ISM and Homoeopathy Practitioners we can take our programmes to the people in a more meaningful manner.

Without taking much of your time, I again welcome you to this historic meeting of Central Council of Health and Family Welfare and wish your deliberations a great success.

Thank you.

**ADDRESS BY MISS SAROJ KHAPARDE, UNION MINISTER OF STATE FOR
HEALTH AND FAMILY WELFARE**

It is a matter of great privilege to be with you this morning on the first Conference of Central Council of Health and Family Welfare. We are meeting after a gap of nearly 17 months. The joint Councils for Health and Family Welfare have been reconstituted into a single Council. This is an indication that we must take a holistic view of things and no longer view Health and Family Welfare as separate entities. This was necessary as success in Family Welfare Programme has come about only when the two have got integrated. This is illustrated by the experience of "South East Asian Countries who have been able to move ahead of us in the field of population stabilization, though they had a late start. I think this marks a major shift in policy and emphasis. The first one was change of nomenclature of the programme from Family Planning to Family Welfare.

Today, and for the next two days we must do a thorough examination of all the health and family welfare issues involved and see whether we are moving steadfastly onwards to our goals, without distortions or deviations. We have to examine whether we are still following the beaten track of curative approach and how much of preventive, promotive and rehabilitative aspects of health care we have been able to bring about in our health care approach and what we plan in future. We must evaluate how far we are from providing comprehensive Primary Health Care Services to our population in remotest areas and in areas inhabited by weaker sections such as Scheduled Castes and Tribes. I would like a free and frank discussion of all issues and obstacles coming in the way of our cherished goals.

The creation of Primary Health Care infrastructure in rural areas is of prime importance to deliver the goals set in the National Health Policy. I stress that we have to achieve 100 per cent of the targets set for establishment of Sub-centres and Primary Health Center by the end of the 7th Plan period. I am informed that out of a target of 9233 Sub-centres, 2274 Primary Health Centres and 257 Community Health Centres, the achievement is only 1684, 222 and 22 respectively for this year which is way below the targets. The agenda notes circulated mention the States Union Territories performance in this respect. I would like that States and Union Territories whose achievements are below 50 per cent of targets to make special efforts. They should operationalise the remaining Sub-Centres, PHCs and CHCs by providing essential manpower and functional buildings and by filling up vacant posts, so that targets of 7th Plan are met.

I would request the States and Union Territories to give attention to the training of 'Dais'. They should also suggest to us possible solutions as to how the Dais at the Village level and ANMs at the Sub-centre can be lined to have close cooperation to provide effective maternal and Child health services in the rural areas. It will be no exaggeration to say that MCH services hold the key to improvement of the health of "mothers and children and any major success in this field will have a salutary effect on the psyche of the masses to go in for a small family norm of two children.

Another aspect, we should emphasize, is improvement in the services. We have been lagging in achieving our health and family planning goals not so much because of lack of programme, but because of ineffective delivery. Our programmes will become effective, if we are able to achieve the right degree of coordination between one programmes, unless we succeed in immunization and MCH programme, the acceptance of two child family norm goals will continue to elude us. In this connection, I want to bring to your notice the

various studies which have pointed out that the existing infrastructure is not being optimally utilized mainly because of the inadequacy to provide proper services and relatively unfavorable attitudes of the people. Major inadequacies relate to poor quality of services, non-availability of staff, lack of empathy of staff and poor management. Energisation of the existing infrastructure should figure in our priority of things. In pursuance of the policy directions enunciated by the Prime Minister, Shri Rajiv Gandhi, we have launched an all out drive to improve the quality and quantity of work. The administration should be toned up through enforcement of discipline and accountability. Besides providing motivation to staff, to put in greater efforts, there should be regular monitoring to progress to see that the targets are achieved and public grievances redressed speedily.

Since the last meeting of the Joint Councils, there has been success on several fronts. The total number of acceptors of different family planning methods in 1986-87 was 20.57 million, all time record since the inception of the programme. Method-wise the number of sterilization acceptors in 1986-87 went up by 2.6 per cent IUD by 20.3 percent, conventional contraceptives by 4.7 percent, and oral pills by 30.6 percent over 1985-86. The proportion of rural acceptors of sterilization is going up. It was 70.9 percent in 1985-86 and 71.1 percent in 1986-87. Other welcome trends are lower age of acceptors of family planning methods. In case of acceptors of tubectomy to cite an instance, the mean age declined from 31.8 years in 1974-73 to 30.3 in 1985-86. The mission on Immunization has been well received and it is now up to us to implement it with zeal and care.

Leprosy is a major health as well as social problem. I must congratulate you for achieving success in achieving break through in overcoming this disease.

As you know Tuberculosis is a major public health problem in the country and nearly 1.5 per cent of the population is estimated to be suffering from radio logically active TB disease of the lungs. Under the National Tuberculosis Programme, a District TB Centre is being established in every district of the country to organise community wide District TB Programme in association with all the existing medical and health institutions.

At present out of 435 districts in the country, District T.B. Centres have been provided in 371 Districts. The Village Health Guides are also being involved in essential Health Education activities under the programme.

To reduce blindness in the country from 1.4 per cent to 0.3 per cent by the year 2000, the National Programme for Control of Blindness is providing immediate relief to the needy by camp approach and by establishment of permanent eye care facilities with graded expertise at different levels coupled with 'Health Education' measures.

A Nation-wide blindness survey is being conducted. Guidelines for conducting eye camps by Voluntary Organizations have been reviewed by a Committee of Health Ministers under the Chairmanship of the Union Minister of Health and Family Welfare.

In the National Malaria Eradication Programme there was decline in both total malaria cases and PF cases by 16.5 per cent and 13.85 per cent respectively in 1987 over 1986.

In the National Cancer Control Programme, the main emphasis in the Programme presently is on prevention, early detection and treatment of oral cavity and lung cancers caused by use of tobacco. It has been decided to strengthen the existing nine Regional Cancer Centers. Other major activities to be undertaken are: grants for installation of Cobalt therapy units and grants for Research, studies and health education and publicity for prevention of cancer.

There was a new resurgence in mass education and media activities, marked by major

shifts in the communication policy. The major thrusts in 1987-88 included a halt to the earlier stereo-typed communication with over-emphasis on demographics and a narrow family planning propagandizing and exhortation style to a broader base of social communication.

I have expressed my ideas on some salient aspects of the health and family welfare programmes. There; is heavy agenda before us and a lot of work to be done by various groups on different subjects. I am sure with your mature experience in the field; we would be able to thoroughly discuss and analyze the problems and provide solution or guidelines. I welcome you all and hope that we will be able to give a further thrust to the health and family welfare programme at the close of our deliberations.

**ADDRESS BY SHRI P. V. NARASEMOHA RAO, UMON MINISTER FOR HUMAN
RESOURCE DEVELOPMENT**

Vbraji, Sarojji, Srivastavaji, Dhahoaji, Dr. Viswakarma, my colleagues, Health Ministers from the States, experts and other Members of the Central Council.

I am addressing you in a rather new situation wherein just before convening of the Conference there has been a change in the portfolios of the various Ministries yesterday and it is quite a timely change in the sense that if Voraji wanted to meet you an individually it would have taken six months. I have met most of you so I have no problem, but the problem is of his. By some coincidence the Prime Minister has made the change just before the Conference knowing or without knowing, giving a great advantage in making the changes yesterday. I welcome Voraji, I would also welcome my guest his Excellency, the Health Minister of Ethiopia, I had the honor of receiving him yesterday and discussing with him the Health problems of that country and generally in Africa; very similar; the scale may be different, problem are not identical naturally, but they are similar and perhaps the approach to the problems also somewhat similar.. So it is a good thing that we have one delegation from an African country. Hereafter we would have to do so much in the field of Health in African countries and it is a good augury that he is here along with his experts.

You have a very heavy agenda. You are meeting for the first time in the Central Council of Health & F.W. As you are aware, we were having Joint meetings of the Central Council of Health and the Central Family Welfare Council earlier. Now we are having single meeting of an integrated, combined Central Council today. As Dhanoaji has stated, it has taken some time and if delay is any indication of the care that has gone into reconstitution of the Council, the obvious inference is that it has been very carefully constituted.

Before you come to the agenda and before I give the floor to Voraji to inaugurate the Conference I must say that we have had a useful and fruitful association during the last year and a half since I was in this Ministry and we have started some new directions to an extent, and I am sure that this will continue. Voraji would have to coordinate with the Ministry of Human Resource Development on a number of new ideas which the Prime Minister has thrown up. So we may have to think in terms of treating the child in India as a whole entity and Pack him up into Ministries of Health, Education, Human Resource Development, etc. To do not know how much in each State the problem is. This is the situation at the Centre itself. There are as many patterns as the States and we have a Central pattern. Time has come when we have to think in terms of certain integration about the child, human being, we have been talking about. We have tried to bring about certain immigration in the Ministry of HRJJ, and certain sections of the programmes under the Health and Family Welfare and this is something we will have to continue and today there will be some interaction between the two Ministries. It does not matter how many Ministers are there so long as v/c accept the ideas and go ahead implementing them.

We have started certain studies, medical education, health related vocational education, education in health and medicines. School Health Programme is both school programme and also a health programme. So it is ultimately anybody's choice whether you put school in health or health in school. So these are integrated programmes hereafter. That is not to the extent it ought to have happened so far. Now we have to concentrate on it in the years to come. I am sure that Voraji will be able to bring about this integration wherever needed with the cooperation of the CCH&FW on one hand and the Central Advisory Board of Education on the other. It should be possible for us to bring about this integration. I was

toying with an idea of having a joint meeting of these two Councils and it is going to be a large number of participants, about five to six thousands and we have to think of a larger place to meet together and a carefully prepared meeting and we will have to think about it. But now I think once this Council comes up with its own recommendations, its own deliberations, and we are going to have CAGE meeting, early next month, and may be after the deliberations of these two Councils, after the results of the deliberations, we will be able to think of a joint meeting. In fact I would like to invite some representative Members of the CCH&FW to the meeting of the CAGE- May be one should have done it in this meeting itself. We could have called some members of the CAGE. But probably that has not been in done. One Member who is common is Prof. Srivastava. We will call a meeting there and also invite some members from here, so that we understand the integrated nature of the problem. It is not just coordination. Coordination is between two separate entities. Integration is the mixing or harmonizing of these entities. These are two concepts. What Prime Minister wanted is integration and not merely better coordination, of course, coordination, being what it is at the moment, better coordination is welcome. But it is something more than better coordination that is wanted. I hope we will be able to bring about these results, changes in the approaches in the Human Resource Development Programme, which spans about 5 Ministries here and may be a large number of departments in the States.

I do not want to take much of your time; I give the floor to Voraji who in his own right is an experienced administrator. The Programme of Health and Family Welfare is a programme for the next few years within which you have to show some results, and I am sure all these are in safe hands.

I wish him all the best and I would now request him to inaugurate the Conference.

INAUGURAL ADDRESS BY SHRI MOTI LAL VORA, UNION MINISTER FOR HEALTH AND FAMILY WELFARE

Shri Narasimha Rao ji. Km. Khaparde, Shri Dhanoa, Shri Srivastava ji, Shri Viswakarma ji, Shri Umashankar Ji, Members and Hon'ble Ministers of all States, our special guest, Health Minister from Ethiopia and friends.

At the very outset, I would like to express my sincerest gratitude to all of you for the warm welcome extended to me. I am extremely grateful to Km. Khaparde for her very encouraging and kind words. I am extremely grateful to Shri P. V. Narasimha Rao Ji, for his love, affection and kindness which I have been always receiving freely. I am fortunate to have known him for long. He has given a new dimension to this Ministry and we hope to get his cooperation in future also because this is the thing which he has started and the whole country has been benefited by his special kindness. I again request Narasimha Rao ji to extend his cooperation as he has been doing us in the past and today also.

I hope Hon'ble Ministers and officials who have come from outside with you had a comfortable journey.

Friends, let me say before welcoming you to this Annual Conference of the Council of Health and Family Welfare that it is a matter of great privilege and honor for me to join this fraternity and to be able to contribute whatever I can towards strengthening and building up the health of the nation, I hope that with your support, co-operation and help, we shall be able to complete the task of eradicating disease and improving the health standards of our citizens so that the productivity and development of the nation can go ahead at an increasing pace.

This Conference of Central Council of Health and Family Welfare is being held at a most opportune time as we are midway in the Seventh Plan period and in a position to review our achievements vis-à-vis the targets to be achieved by the end of the Plan. The Planning Commission has completed its mid-term reviews and the thinking for the approach to the Eighth Five Year Plan is germinating. We should make an objective and realistic assessment of our achievement and shortfalls and work out what we would like to do in the 8th Plan. In my view this is the time for consolidating the gains of the previous years and for identifying the areas in which we are lagging behind. At the same time, we have to find out the ways of overcoming the shortfalls in reaching our goals. In the next few years we have to accelerate the pace of our achievements and make a determined bid to reach our objective of 'Health for All by 2000 A.D.'. Our aim should be to enter the new century with this task completed.

Our goal of 'Health for All by 2000 A.D.' is to be achieved through universal provision of comprehensive primary health care services and a net reproduction rate of unity. The specific goals set by the National Health Policy state that we should achieve a birth rate of 21 and a death rate of 9 per thousand by 2000 A.D. During the same period, infant mortality rate is to be brought down to less than 60 per thousand live births. The life expectancy is to be increased to 64 years and 60 per cent of the eligible couples protected by one or the other family planning method. Accordingly, the goals for Seventh Five Year Plan require us to achieve a birth rate of 29.1 per thousand and a death rate of 10.4 per thousand, and infant mortality rate of 90 per thousand live births and a couple protection rates of 42 per cent. Our concept of Primary Health Care is to provide universal, comprehensive health care services relevant to the actual needs and priorities of the community at a cost which the people can afford. As directed by the National Health Policy we are bringing about a shift in emphasis from hospital based urban medical care to field oriented rural health care- The approach and strategy for development of health care delivery system in rural areas is directed towards the provision of health infrastructure including maternity services within easy access to the people living in villages. The Sixth Five Year Plan had laid down the norms for the development of the health care delivery system which are well known to you.

There has been a vast expansion of the physical infrastructure during the Seventh Five Year Plan period and we hope that nearly 100 per cent of the requirement of sub-centres and primary health centres as per the norms would be established by 1990. However, because of resource constraints, it

will be possible to set up only 50 per cent of the required number of Community Health Centres. By the year 1990, 1,30,000 sub-centres, 23,000 primary health centres, 1500 community health centres and 1500 post-partum centres will be in position. It is possible that all of them may not have full complement of staff, buildings or equipment by that time. Even today, the infrastructure leaves much to be desired. The picture of the basic health services at the grass root levels is at best a mixed one. The problems of vacant posts of medical officers and other trained staff, lack of buildings, equipment, mobility and communication, are all well known. During the Conference, we are having a presentation on primary health care which will highlight our weak as well as strong points and give us food for thought. We should face the problem squarely and take stock of the.

VOTE OF THANKS BY DR. G. K. VISKWAKARMA, DIRECTOR GENERAL OF HEALTH SERVICES

It is, indeed my proud privilege to propose vote of thanks. We are extremely grateful to the Hon'ble Union Minister of Health and Family Welfare, Shri M. L. Vora for his thought-provoking inaugural address that will provide right note for the deliberations of this august body. We are also grateful to the Hon'ble Minister of State for Health and Family Welfare, Saroj Khaparde for her illuminating address. We also thank Shri S. S. Dhanoa, Secretary, Ministry of Health and Family Welfare, for his inspiring address and the remarks.

We are indebted to Hon'ble Minister of Health of the States and their officials who have they very kindly responded to our invitation. We are equally grateful to the officials of the Ministry and Director General of Health who have helped in the preparation of documents for the Conference as well as physical arrangements for its deliberations.

I take this opportunity to draw your kind attention to certain aspects of health status vis-à-vis, National Health Policy. Population stabilization is one of the important parts of National Population Policy. I am sure everybody will agree that while the statistics of births averted and couples protected through family planning methods show a considerable rise over the years seem to be flattering, the other statistics, that the birth rate in 1985 was 34 per thousand as compared to 34.3 in 1977, is rather disappointing. The matter has to be deliberated seriously.

If immunization is the National Health Policy, vaccine is the main tool; to achieve the goal still production remains the main area of our concern. Even now 30-40 per cent, deaths occur due to disease preventable by immunization. It is paradoxical that, on one hand we have got the requisite talent, manpower and also infrastructure; on the other hand, we have failed even to produce polio vaccine and are resorting to continuous imports. It is very hard to understand why; the states are not coming forward and taking lead in producing vaccine. There is no doubt that abundant talent and manpower already exists in plenty in all the States. It is a fact that one of the States even did it, but what followed later was a tragic story. If lesson is taken from this incidence, I think it may not be difficult to diversify the production. I am sure the Hon'ble Health Ministers will certainly give a serious thought to it. Hon'ble Ministers of States, Sir, I am convinced that till the time, the states do not take over the Research and Production, not only in the area of vaccine production, but also in the area of High Technology related to production of the equipments required for medical care, the very idea of self-sufficiency will remain a dream.

In spite of clearly stated National Health Policy till today we find, that there are 12.86 lakh cases of Malaria with 4.2 lakh cases of *P. falciparum*; 4 million cases of leprosy; one million blinds and another 45 cases suffering from visual impairments, 10 million cases suffering from radio logically active tuberculosis of the lungs, 40 million cases of Goitre and 5 lakh cases dieing every year from cancer. It is also true that there is not much respite from incidence of Polio-mylitis. Besides about 6 lakh deaths in children below 5, years are related to Acute Respiratory Infection annually. Same is the story of Acute Diarrhoeal diseases and diseases due to protein malnutrition. Further non communicable diseases like cardiovascular diseases, hypertension, diabetes etc. are on ascendancy. Further, there is outbreak of encephalitis and resurgences of Kala-azar. Hence the need for launching operationally effective integrated Vector Control Programme for Japanese Encephalitis, Kala-azar and Malaria needs to be debated. It is clearly staled in the National Health Policy document that it is necessary to establish a nationwide chain of epidemiological stations.

The location and functions of those stations may be between the primary and secondary levels of hierarchical structures etc. Further, the district health organizations should have as an integral part of its set up, a well organized epidemiological unit to coordinate and superintend the functioning of the

field stations.

I must confess, in spite of the above fact, we have not been successful in evolving and establishing basic epidemiology to study distribution and determination of disease frequency and health status in our population. Nor have we been able to have a study of the determinants or underlying cause of the disease with the result that it is rather difficult to suggest the best means of preventing the disease or controlling its spread. It is sad but true that although we have seduced the duration of training course of epidemiology at the N.I.C.D to 3 months, we could get only 67 participants from the States from 1981—1984.

The training has to be necessarily in-service training programmes as there is no separate cadre. But it is a pity, that when we requested the States to send the names of persons for in-service training this year, we drew blank. Ironically the various international agencies are trying desperately, often uninvited, to enter this area, at a time, when we have ample expertise in this country. Could I take this opportunity to request the Hon'ble Health Minister from States to take up this matter seriously, so that we could train epidemiologists for 437 districts within a very short period for which, I assure you, sir, we have got the, requisite infrastructure.

Another point which National Health Policy document clearly states is that in the establishment of the reorganized services, the first priority should be accorded to provide services to those residing in the tribal, hill and backward areas. In spite of the above, the plight of the tribal community belonging to different ethno, lingual groups, professing diverse faiths, which are at varied levels of socio-economic-development—whose number according to 1981 census is approximately 5.7 crores constituting about 7.76 of the total population is unenviable. Incidentally the term 'tribe' is nowhere defined in our Constitution and in fact, there is no satisfactory definition anywhere. But one fact is true that the health problems and health status of all tribal groups cannot be of the same type and therefore, any "formula approach" for health care delivery is not only unsuitable but also cannot be thought of. Different tribal groups have their own individual characteristics in respect of socio-cultural, socio-biological, socio-economic attributes and in a strict sense they are distinct biological isolates. Hence a distinct scheme for tribal development, Health and Nutrition programmes for tribals, and above all, research in tribal health is required, if meaningful health care has to be provided to them."

Finally, I will like to draw your attention to the menacing disease known as AIDS (Acquired Immuno Deficiency Syndrome) which in fact, is threatening the very existence of mankind. I do not want to waste your time on this subject as it will come up for discussions as an item of the agenda. Although, we have been fortunate, that we have escaped from this scourge so far, there is no room for complacency and surveillance and education will have to go on so that, we do not have to pay the price at a later stage. But at the- same time I do not mean to create panic—as I am sure that we are different ethnically and our, social activities and sexual practices are a bit discreet. I think this, is the main reason why we are getting a different epidemic-logical picture in the Indian Subcontinent in general, and in our country in particular.

Chairman and Hon'ble Minister of Health of States, Sir, 2 years are left for the 7th Plan to come to an end and just 1-2 years to achieve the promised goal of Health for all by 2000 A.D. No denying the fact, we have achieved a lot but there is still so much to be achieved and looking at the time constraint, a sense of urgency is inevitable. The present time is a time for reappraisal; adopt corrective measures wherever necessary with a view to reach the set goal.

Finally, the National Health Policy lays great emphasis on Monitoring and review of progress. But the feed back received from the States leaves much to be desired.

I am sure that under the present able leadership and unstinted support of community, and by gradually increasing people's participation, we will not, I hope, be disappointed in achieving our avowed objectives and goals.

I thank you Sir, and all those present here, once again.

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RECOMMENDATION NO. 1

FAMILY WELFARE PROGRAMME INCLUDING M. C. H. AND IMMUNIZATION

The first Conference of Central Council of Health and Family Welfare reviewed the achievements in the Family Welfare Programme during 1986-87. The Council noted with satisfaction that the year had, witnessed an all time high record of performance by registering over 20.5 million fresh acceptors in the Family Welfare Programme. This has been possible through hard work, mobilization of all resources and various new initiatives taken by the States /UTs and as such they deserve to be congratulated.

The Council resolved that the national goal of achieving Net Reproduction Rate of one must be achieved by the turn of the century. In other words, our birth rate must come down to 21 per 1000 and Infant Mortality Rate to 60 per thousand. The Council, therefore, took stock of the present situation and tried to identify bottlenecks and suggest ways and means to improve the performance so as to achieve the demographic goals mentioned above. After a thorough discussion, the following recommendations were made:—

1. **Political Administrative and Public Support:**—The Programme must receive strong political support and administrative dynamism to attending, the objective of the programme, certain socio-economic-for the political, administrative and public leadership to take a move for creating consciousness amongst the people about the adverse effects of mounting population on the implementation of socio-economic programmes in the country.
2. **Socio-Economic Co-relates:**—To achieve the objective of the programme, certain socio-economic co-relates which greatly influence fertility behavior are required to be tackled. Special attention must be given for increasing the mean age of marriage, raising the status of women, female literacy, enhancing child survival and development, linkage of small family norm with poverty alleviation programmes and old age security.
3. **Spacing Methods:**—Greater coverage of younger age, groups and low parity groups should be ensured through non-terminal methods of contraception. However, high parity couples should, continue, to get services of terminal methods of contraception.
4. **Improved Quality of Services by way of Training:** — The State Governments should take necessary steps to ensure Improvement in quality" of services. Training and re-training of all the functionaries involved in^ the Family Welfare Programme will go a long way in improving the quality of services. The training component, besides skills, should also include bringing about attitudinal changes in the functionaries conducive to effective implementation of the programme.
5. **Integration of Health & F. W. Programmes:**—The Family Welfare Programme and the Health Programme should be integrated, in the field. It will help in effective implementation of both the Programmes.
6. **Advisory Committees for Community Participation**—Positive inter-action of the Family Welfare workers with the community is essential for creating faith of people in the worker. Appropriate Advisory Committees should be set up at different levels for ensuring participation of the Community in the Programme.
7. **Incentives:**—Incentives under the Family Welfare Programme should be linked with family size rather than with the methods of contraception employed.
8. **Priority attention to first child arid the mother:**—Priority attention must be given to a mother who is to give birth to first child and to the child to ensure survival and good health of both mother and child. It will help in getting confidence of people and also in acceptance of two child norm by the people.
9. **Targets:**—The system of target setting must be reviewed with a view to ensure the

feasibility of achievement of the targets. Targets should be related to the actual situation in the field. The relationship between couple protection rate, birth rates and target must be assessed carefully.

10. **Recognition for Doctors with specialization in Community Medicine and Public Health:** Doctors with specialization in the field of Community Medicine/Public Health should be given due recognition and status. Health Management support and supervision is an area that needs considerable strengthening by proper selection, training, placement, promotion and posting policy. Health management experience and expertise for all categories of health and health related managerial jobs will have to be ensured. The Standing Committee of the Central Council of Health and Family Welfare could examine¹ the question in all its aspects.
11. **Managerial Training:**—All personnel connected with the managerial tasks should be given appropriate training in managerial techniques for enhancing their skills and abilities for managing the" programme successfully.
12. **ANMs Family Welfare training Centres:** - The Auxiliary Nurse Midwife/Family welfare Training centres should be attached preferably to community health centres and rural hospitals for the training programmes so that the training takes place in an atmosphere relevant to their needs.
13. **Practitioners of ISM and Homoeopathy:**—The practitioners of the Indian' System of Medicines and Homoeopathy should be-'given appropriate training in Family Welfare programme. Their services should be utilized for the motivation and implementation of the programme.
14. **Urban Revamping Scheme:**—The urban areas, particularly smaller units with population less than one lakh need support. The Urban - Revamping Scheme with appropriate modifications should be extended to these areas also. The Scheme requires to be reviewed in the light of experience gained in the field. The population to be covered by the units should be reduced- appropriately. Where possible, the services of Voluntary Organizations should be used in the implementation of the Urban Revamping Scheme. This Scheme should be utilized for implementing the Integrated Health and Family Welfare Programme.
15. **Inter-Sectoral Coordination:**—Adoption of Scall Family norm should be achieved by making this an integral part of the various Government-assisted, programmes, particularly those which reach out to large masses of population. All Ministries Departments and other agencies should accept population stabilization as one of their main objectives and reflect it in their programmes, in their messages and in their extension work. The Central Government and the State Governments must immediately undertake an exercise to find out all possible areas of activity and schemes of assistance with which Family Planning can be linked.
16. **Popular Committees:** — The scheme for setting up of Popular Committees at the State, District and Block levels should be continued. The States should implement this scheme effectively.
17. **Green Card Scheme**—States/UTs should review the Green Card Scheme and take measures

to implement it effectively. It should ' be ensured' that the Green Card Holder gets the benefits assured to him under the scheme.

18. **Involvement of Voluntary Organizations:**—Involvement of the Voluntary Organizations in the Family Welfare Programme should be expanded. They should be given full support and encouragement to ensure their optimal involvement in the programme.
19. **Pay Scales of the Family Welfare Employees' of Voluntary Organizations:-** The States should send their views expeditiously on the suggestions of the Government of India that the assistance admissible to Voluntary Organizations in respect of staff is restricted to what would have been admissible to them had they been employed in the State Government set up.
20. **Training of Dais:** — Dai has an important role in the success of the Family Welfare Programme. Training programme for dais should be implemented effectively. Dais should be paid suitably, say not less than Rs. 10 per delivery. Voluntary Organizations may be involved in these training programmes.
21. **Standing Committee of the Council:**—A Standing Committee of the Central Council of Health and Family Welfare should be constituted. This Committee should meet, periodically at least once in three months to review the implementation of the recommendations of the Council and also the Programmes of Health and Family Welfare in general.
22. **Legislation for Amniocentesis Test**—A suitable legislation should be brought up to regulate the Amniocentesis Test. This test should be confined to government institutions and approved institutions in the Voluntary sector and should be solely used for determining genetic-linked disorders without disclosing the sex of the fetus.
23. **Mass Contact Programme:**—The Council notes with appreciation the Mass Contact Health and Family Welfare Education Programme being implemented by the Government of Punjab.
24. **Security Certificates for couples having no son:-** The Scheme adopted by the Government of Gujarat for parents having only two daughters and no son was recommended. The scheme is as follows: “The Parents who adopt sterilizations after only one living daughter will get a special security certificate of Rs.6,000/-. The parents who adopt sterilization after only two living daughters will get social security certificate worth Rs.5,000/-. Parents who adopt sterilization after only three living daughters will get a certificate of Rs.4,000/- and parents adopting sterilization after only four or more daughters during this year only will get a certificate of Rs.3,000/-.”The scheme will help a couple with no sons in old age if the amount of the certificate is reinvested till the sterilized parent attains the age of 55 or 58 or 60 years. This 'scheme will encourage parents with daughters and no sons to accept sterilization without waiting for the birth of a son.
25. **I.E.C. Programme:**—An integrated approach to health and family planning is now a cardinal plank of policy for all activities. Therefore, the communication and educational efforts should be so integrated that the State MEM and HEB bureaux are amalgamated integrated. The functional and administrative Integration of these two set-ups should be brought about forthwith. The pooling of human and material resources of these two set-ups

should be carried out to ensure elimination of duplication of work, resources and efforts and must ensure increased output and improved performance for primary health care education and promotion work, including family welfare as a central component of this revised strategy.

26. The role of the integrated MEM and HHI3 Bureaux is not to be confined to the development of media materials and messages. It should take up IBC work at two levels: the extension cadres and the community. The attitudinal change of the medical and paramedical personnel through reorientation and training for up gradation of communication counseling and social motivation skills, as also the responsibility for binding an interface between IEC (with education including *extension* education) and social action in the community should be part of the revised role assigned to the IEC Wing. Towards this end, the mass education media plus health education set up should be renamed as IHC and Extension Education Wing. The pooled resources of manpower, materials and equipment should be duly reviewed and appropriately strengthened for this task through redeployment of existing available personnel and by idling new requirements through additional allocations for staffing already available. Control of the State IEC and Extension wing over the District and Block extension personnel must be established and the District and Block level functionaries assigned for media and extension education work given adequate administrative and financial authority to enable their effective functioning.
27. Vertical pursuit of any one programme is to be discouraged except as part of a coordinated and planned strategy covering different requirements of the community that may at time need up scaling of effort in one particular area because of the community's felt needs, seasonal requirements of the health programme or endemism of a disease. The funds available under various health programmes for the media and educational component should be pooled and made available to the integrated set up. Further, the funding by the States for health education and media work is noted to be very meager and therefore needs to be augmented so that the integrated set up is not really dependent on the funds available from the Central Schemes.
28. It is now recognized that the first key strategy on family planning communication is delay in the age of marriage. Altogether, much more attention is to be paid to the younger generation which must imbibe another set of values on family formation so that the behavioral changes sought from them for a 2-child norm can become a reality in the next decade. Close collaboration and cooperation with the population education projects being undertaken by the school system, university system and the adult education programme must therefore be ensured at every level. Further opportunities to integrate population education in the vocational training and other skill training activities must be explored and ensured at the earliest. 3 Health—4.
29. The powerful role of T.V. as a means of communication to vault over the barriers of illiteracy has been recognized. In view of the fact that the key target groups needed to be reached by Family Welfare Programmes are mostly outside the capability of independent ownership of T.V, for the present, schemes for community viewing need to be developed, with the active cooperation and contribution of the States and the community. Wherever possible group incentive schemes or otherwise awards for family welfare programme performance etc. should make a provision of T.V. sets for community viewing. States may also ensure organization of T.V. community viewing by linking in with other developmental departments efforts in this direction and mobilize the community to help and support maintenance operations. Health and Family Welfare personnel must be involved in stimulating group discussions around Health and Family Welfare Programmes transmitted.
30. The preparation of software and dissemination of messages through various media and inter personal communication is, to be done in such a manner that synergetic effect is achieved to the maximum. It is, therefore, necessary that the Central Media Units of the Ministry of Information & Broadcasting, the State M.E.M. Organizations, State Departments of Public

Relations and the Publicity set-ups of public sector undertakings and voluntary agencies work in close coordination.

M.C.H. Including Immunization

31. The M.C.H. Programme is a vital element in bringing about the desired results under the Family Planning. The required data base including Registration of eligible couples, birth and deaths, antenatal cases, maternal and infant mortality should be built up and quality of services should be improved at all levels.
32. If the Prophylaxis Programmes and the Immunization programme of pregnant women and infants are effectively implemented, it would go a long way to reduce the maternal mortality, infant morbidity and mortality. It will develop a sense of security in the parents and they would not desire to have more children.
33. The Council appreciated the Government's move in giving the Immunization Programme a Mission approach so as to bring in the necessary flexibility and focus in its implementation.
34. For effective implementation of the scheme the logistics and pie-project activities under the programmes should be suitably worked out. Additional staff required should be posted and trained. Equipments and drugs should be supplied in time and funds be provided as and when required.
35. The additional inputs required in terms of staff, equipment including drugs and funds for the contingencies should be worked out on a need based basis. These may be placed at the disposal of the State Governments well before the districts are brought under the Universal Immunization Programme. There is a need for working out 2 micro plans for operationalisation of the schemes. These plans have to be highly local specific taking into consideration the resources available as well as the local conditions.
36. The entire urban area should be covered with specific delivery models to cover the target population in those areas. This should be linked with the Urban Revamping Structure, This should be done on a war footing to avoid major out-break of diseases in the urban areas, particularly in the slums.
37. The country should become self-reliant in terms of equipments under the cold-chain and vaccines. Specific time frame may be worked out to achieve this goal. This will be of more importance during the maintenance phase of the programme.
38. In view of the specific conditions in which the vaccines are kept the maintenance of cold chain equipments calls for immediate attention. Suitable agencies may be involved in this task for ensuring the efficacy of the vaccines.
39. Vaccines used under the Programme should conform to the standards laid down. Quality control testing facilities may be developed in the field. As far as possible this may be regionalized.
40. Disease surveillance is an important tool in measuring the prevalence of the diseases: An effective surveillance system should be developed as early as possible.
41. Dehydration due to diarrhea among the infants and children is one of the important causes of infant mortality. Therefore, the Oral Rehydration Therapy (ORT) Programme should 'be given sufficient boost so as to take the message and knowledge of preparation of ORS to all the households in the minimum possible time. The supply of ORS and its popularization must be given top priority. The training of both medical and Para-medical staff under the ORT concept needs to be accelerated.
42. Acute Respiratory Infection is another major cause of infant deaths and, therefore, a

programme should be operational zed at the earliest to control it in the current Plan itself. This may be gradually extended, to the whole country within the shortest possible time. The drugs as found suitable under the programme may be standardized and distributed to the Para medicals in the drug kit with suitable instructions.

**RECOMMENDATION
No. 2**

**PRIMARY HEALTH CARE INCLUDING MINIMUM NEEDS PROGRAMME AND
SCHOOL**

HEALTH SERVICES

1. The Council reviewed the progress made towards achieving the target for establishing sub-centres, primary health centres and Community Health. Centres in the States and resolved that the momentum be maintained so as to achieve the targets of the VII Plan. It was stressed, however, that the funds must continue to be made available both from State budget and Central budget if such progress was to be maintained or accelerated.
2. The Central Council noted with anxiety the reports that the quality of service-left much to be desired and hoped that in spite of financial constraints, the quality of service would be improved through better training, community participation and supportive supervision and laboratory services which may be funded, by the Government of India.
3. In view of the necessity for the Primary Health Centres to provide not only curative services, but also preventive and promotive services, it was considered essential that every new P.H.C. should have two medical doctors.
4. The Council recommends that in order to provide full coordination of Primary Health Care Programme at the State Directorate there should be an identified nodal officer of sufficient stature for coordinating all programmes relating to Rural Health Services including, training and manpower, development. Necessary funds for this purpose may flow from Government of India.
5. In order to make the best use of the scarce resources and to promote socially acceptable modes of primary health care, it is recommended that dispensaries of ISM and Homoeopathy may be upgraded into PHCs and responsibility for Primary Health Care may be entrusted to them after providing orientation training to the personnel.
6. Keeping in view the fact that mobility is the key to effective population coverage by all categories of health staff, the Central Council recommends that steps be taken to ensure the availability of suitable transport ran in a form of 4 wheel vehicles at the new PHC and CHC. To motor cycles mooted bicycles for Para-medical staff. Para-medical staff may be provided low or no interest Loan both for MPWs and their supervisors.
7. The Council *urges* that recognition of outstanding work in rural areas by medical and Para-medical personnel should be suitably rewarded and a scheme to be funded from Government of India may be worked out in consultation with the State Governments.
8. Considering the importance of preventive care and epidemiological surveillance in the community and keeping in mind the importance of promoting positive health specially for mothers and children and the paramount importance of these services to make the population accept the small family norm, this Council recommends that the community Health Centres serve not only as the first referral hospital with expertise in Medicine, Surgery, Obstetrics, Gynaecology and Pediatrics, but in addition have a doctor specialized in community medicine who will spearhead and coordinate the preventive, promotive and epidemiological service.
9. The Council recognizes the need for extending support to States by the Central Government for development of rural health infrastructure wherever the deficiency is more pronounced and recommends that the area project approach may be continued in future.
10. Support for development of rural health infrastructure may be obtained from institutions like housing

Development and Financing Corporation, Housing and Urban Development Corporation and Life Insurance Corporation who may be approached to provide help to States [Union Territories Provision must also be made for taking up construction of social assets like primary health centre buildings, sub-centre buildings and community health centre buildings under National level poverty alleviation programmes such as NREP, RLEGP and IRDP These programmes provide for construction of school buildings and the Ministry of Health and Family Welfare should approach the concerned Ministry for allowing construction of rural hospital health institution buildings also under these schemes.

11. The Council urges that primary health care should not be viewed merely as an expansion of health services and manpower. Instead the attempt should be to empower the people towards self-reliance in health matters. Towards this end the process of imparting necessary information and skill to the people should be taken in earnest. Popular committee's may be set up at different levels to provide support and supervision to the primary health structure.
12. To give proper and effective Primary Health Care- efforts must be made to remove the professional

Recommendation No 3 missing

RECOMMENDATION No. 4

NATIONAL LEPROSY ERADICATION PROGRAMME

The Council considered the present status of the NLEP Programme and in order to eradicate the Leprosy disease by the year 2000 A.D. recommended that States should take expeditious action to create the prescribed infrastructure, sanction and fill the post, train the staff so that the goal should be achieved before the target date.

The council notes with satisfaction the drastic reduction in the prevalence rate of Leprosy in the districts which have completed the intensive phase of M.D.T.

Noting the salutary achievement of M.D.T. the Council was of the view that it would help in achieving the targets much earlier and with better quality if the States could identify the Districts for introduction of M.D.T.

Taking note of the satisfactory progress of N.I. F. P ACTIVIES the council commends the work done by the Central Government and the States and recommends that:—

1. Leprosy cured persons should be treated at par with other categories of physically handicapped persons for the purpose of employment in Government and Public sector undertakings and also in the private sector.
2. Reconstructive surgery services should be made available on priority to the deformed leprosy patients. Leprosy patients requiring surgical intervention should have free access to the Government Medical Colleges/Government Hospitals.
3. Vocational rehabilitation service centres run by various agencies, governmental and non-governmental. Should also extend its services to cured disabled leprosy patients.
4. Health Education activities which have paid rich dividends should be continued with vigor and zeal with emphasis on the following:—
 - (i) Development of suitable health education material in regional language.
 - (ii) Preparation and distribution of films, T.V. quickies, radio spots, etc.
 - (iii) Preparation of video cassettes on various facets of leprosy.
 - (iv) Utilizing mass media for health education and publicity.
 - (v) Ensuring active community participation.
 - (vi) Greater use of leprosy cured patients in health education.
5. A suitable strategy should be evolved for stepping up health education activity in urban areas.
6. The Council noted with discontent that T.V. and radio spots on leprosy prepared in various regional languages are not being telecast/broadcast frequently over various Doordarshan Kendras and AH India Radio. In view of the immediate and quicker impact it is recommended that the Ministry of Information and broadcasting should be asked to give wider publicity to these T.V. and Radio spots.
7. All States/UTs should expedite creation of prescribed infrastructure; ensure training of staff in position, adequate detection of cases and their assessment in all the 24 identified endemic districts for introduction of MDT during the current year.
8. The Council reiterated its earlier recommendation that the infrastructure created during a Plan period should continue to be financed out of the Plan funds for at least five years irrespective of the spilling over to next plan period

9. The Council noted that it was proposed to introduce MDT in over 25 districts during the year 1988-89 and for this purpose the State Governments should step up their efforts to put the endemic districts in a State of preparedness by creating the requisite infrastructure, filling up the vacancies, training of manpower, detection of required number of cases and formation of district leprosy societies so that the sanctions could be issued by the Government and funds released for the purpose.
10. The Council notes with concern the slow progress in providing efficient laboratory service under the programme and recommends that special efforts should be made by the State Government's/TJTs. to provide adequate laboratory services. The posts of laboratory technicians already sanctioned should be filled up immediately.
11. THE LEPROSY Act 1898 should be repealed by all the States.
12. The Council noted that the two independent appraisals carried out at the Central level have contributed enormously in strengthening the programme and the Council recommends that such independent appraisal should be continued in future also.
13. The Council noted its concern that monthly expenditure statements are not being furnished by the State Governments/UTs in time with the result that the releases of grants are being delayed. The Council recommended that it should be emphasized on the State Governments/UTs that these expenditure statements should be expedited so that the release of grants is not delayed and the funds are fully utilized.
14. All discriminatory provisions in various Acts regarding leprosy patients should be removed.

RECOMMENDATION No 5

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

The Council recommends that:—

1. Primary Eye Care Services at block levels have to be stepped up. Posting of manpower and availability of equipments as per the norms has to be ensured for the centres which have been covered under National Programme for Control of Blindness.
2. District Mobile Units already^ sanctioned under the Programme should be develop without any delay by the State and U.TV Administrations.
3. The States which have got more than one Director in the State Health Directorate/ having independent responsibilities the activity of the different units/services under the National Programme coming under different Directors should be properly coordinated.
4. The State ophthalmic Cell sanctioned for the major States should ensure the quality of the services and the correctness of the performance figures. The State Programme Officers should engage themselves in intensive monitoring of the field Units, ensure that equipment provided to different units is properly utilized and guidelines laid down for eye camp activities are strictly adhered to.
5. The reporting of the performance as well as infrastructure development of the various Units/
6. Services in the State should be regular and timely.
7. All the Services/Units sanctioned by the Centre should be deployed without delay and necessary equipment and staff are provided.
8. Expenditure returns Unit-wise be submitted by the States every quarter in time so that the releases could be made and the funds are not allowed to lapse.
9. The State level coordination committees should meet regularly for better implementation of the Programme activities within the States.
10. Health. Education on Eye Health Care should be strengthened with active involvement of State Health Education Bureau.
11. School Eye Health Services should be strengthened, utilizing the services of Para-medical
12. Ophthalmic Assistants posted at Primary Health Centres.
13. Grant-in-aid to Voluntary Organizations is increased from Rs. 60/- to Rs. 120/- per intra ocular operation. Where services of Government Mobile Units are utilized by voluntary agencies, grant-in-aid should be Rs. 80/- in place of Rs. 40/- per operation out of which Rs. 40/- be given to Mobile Units for expenses oil drugs and suture material etc.

RECOMMENDATION No. 6

NATIONAL T. B. CONTROL PROGRAMME

1. The Council reiterates that urgent steps may be taken by States and UTs to set up District TB Centres in those of the districts which are still uncovered. The States and UTs may also consider the possibility of setting up of additional district TB Centres in thickly populated districts with more than 2 million populations to ensure proper TB case detection and treatment.
2. Efforts should be continued to ensure that the targets laid for detection of new TB Cases and conduction of sputum examination at the Primary Health Centres are achieved.
3. The Council noted with concern that whereas the number of sputum examinations conducted at Primary Health Centres have, been steadily increasing, the percentage of positive TB cases was going down every year. The Council, therefore, recommends that not only Laboratory Technicians should be provided at all peripheral Health Institutions but they should be imparted in service training so that there is improvement in the quality.
4. The Council was of the view that it may not be desirable, at present, to entrust the Multi-purpose Health Workers in the peripheral Health Institutions with the work of collection of the sputum of patients in the field. The Council, however, recommended that MPWs may motivate the Chest Symptomatic to get them investigated at the nearest medical institutions, and maintain the list of all the diagnosed TB patients living in their jurisdiction and motivate them and their family members for undergoing regular and uninterrupted treatment for the prescribed period.
5. The Council recommends that Primary Health Centres should be provided with anti-TB drugs in sufficient quantities as per their work load. It is also recommended that sub-centres with suitable building and where essential facilities are available should also be identified for distribution of 'anti-TB drugs.
6. The Council recommends that the TB Training and Demonstration Centres State TB Centres wherever functioning should be strengthened to play active role in the implementation of the programme particularly in the sphere of imparting reorientation training to CMQs/DNOs/Civil Surgeons as also for Para-medicals like X-ray Technicians and Lab Technicians etc.
7. The Council reiterates its earlier recommendation that a full-time, trained State TB Officers with supporting staff be provided at the Directorate level in each State and large UTs for effective supervision, monitoring and expansion of the programme.
8. The Council noted with satisfaction that it has been decided to extend short-course Chemotherapy Regimens in more and more districts in a phased manner during the 7th Plan period. In order to ensure the success of this new strategy the Council recommended that the district where short-course Chemotherapy has been extended should be manned by N.T.I, trained medical and Para-medical personnel and equipped with essential equipments and vehicles, and a proper mechanism of monitoring and supervision of the activities provided.
9. In order to ensure active involvement of PHC Medical Officers, they should be imparted in-service training and their performance in TB work should be commented upon in their ACRs-
10. Occupational safety measures may be taken to prevent TB in hazardous employments.
11. Mobile X-ray units for screening patients may be included in the programme.

RECOMMENDATION No. 7

NATIONAL GOITRE CONTROL PROGRAMME

The Council noted that Iodine Deficiency, beside causing Goitre could also result in mental retardation and that the Government had launched a programme for supply of iodized salt throughout the country by 1992. It was also noted that adequate capacity of production of iodised salt (33 lakh metric tonnes) has been established in the country. In order to provide impetus to the **I.D.D.** (Programme, the Council recommends that:

- (1) The State and Union Territory Governments should ensure that a notification under the Prevention of Food Adulteration Act is issued banning the sale of non-iodized salt which will enable the Railways to move iodised salt on priority basis. The Railway Board has formulated a Zonal scheme for transportation and supply of salt to the consuming centres. In notified areas iodised salt will be moved under priority.
- (2) The State Governments in consultation with the Salt Commissioner, who is the nodal authority for production, quality control and distribution salt, should ensure that adequate quantities of iodized salt are available both at the wholesale and retail points. Since normal trade channels would be utilized for the distribution of salt it would be necessary to ensure that wholesale agents procure only iodized salt.
- (3) State Governments should introduce monitor and evaluation system to check the iodine content salt from salt samples to be taken in rural areas and^{HI v} also the iodine content of urine on a sample basis from people residing in semi-urban and rural areas. Facilities for estimation of iodine salt should be established at the PHC level and facilities for estimation of iodine content in urine samples should be established in the district hospitals. Training Programmes must be organized for training Laboratory Technicians in estimating iodine content and salt an; also the iodine content in urine.
- (4) Salt is a basic food item whose availability has to be ensured in remote rural areas. The mechanics of production cost of iodisation, distribution and the resultant increase in the price to the consumer will enquire examination. A committee may be set by the Ministry of Health to examine this issue.

RECOMMENDATION No. 8

AIDS—SURVEILLANCE AND CONTROL

The Council noted that AIDS is not yet a serious public health problem in India and other Asian Countries and the emphasis has to be on preventive action. In America and Europe where AIDS has spread into the general population the W.H.O. has been advocating measures to prevent transmission of infection through information and education and ensuring safety of blood transfusion by screening blood donors, testing of blood products and proper sterilization practices in Medicare. At the instance of the Indian Government the W.H.O. at the World summit of Ministers of Health on programmes for AIDS prevention held at London during the last week January, 1988 has recognized that different strategies would have to be pursued in different countries depending on the epidemiological situation.

The Council noted that Government of India would be taking preventive steps to protect the population by screening persons belonging to the high risk category. It would also be necessary to expand the surveillance infrastructure facilities and develop expertise to detect, diagnose and treat AIDS cases by organizing training programmes for various categories of personnel. Concerted efforts will be required in organizing research studies to help in understanding the nature of HIV infection in India and in the characterization of the virus. Dissemination of information and health education will have to be done selectively to teach the target groups especially those belonging to the high risk category.

RECOMMENDATION No. 9

CANCER RESEARCH & TREATMENT INCLUDING ANTI-TOBACCO MEASURES

It is resolved that the National Cancer Control Programme may be strengthened immediately and the following steps taken without any further delays:—

- (1) States which have not yet set up the Cancer Control Boards may do this before the end of the current financial year.
- (2) States which do not have Regional Centres for Cancer may identify nodal institutions where there is scope for developing them into future Regional Centres in the 8th Plan.
- (3) All recognized Medical Colleges should have cobalt units for Cancer.
- (4) District Headquarters should have Pap smear facilities by the end of this Plan.
- (5) The State Governments and the Central Government should extend Pap Smear Facilities in the community Health Centres by the end of the 8th Five Year Plan period.
- (6) A massive Health Education Programme both for uterine cancer and oral cancer induced primarily by tobacco should be launched. Vigorous action should be taken for promoting anti-smoking measures.
- (7) Training facilities for cyto-technicians paramedical and medical staff should be intensively launched.
- (8) Voluntary organizations should be involved in Health Education, early detection rehabilitation and terminal care of cancer patients.

Anti-tobacco measures

The Council recommends the introduction of a comprehensive package of anti-tobacco measures. The existing legislation, namely 'The cigarettes (Regulation of Production, Supply and Distribution) Act, 1975' provides for incorporating a specified warning in cigarette packets and cigarette advertisements. The Regulation of other tobacco products such as bidis, cigars falls within the purview of the State Government (Entry 26 of the State List in the Constitution of India). The Council recommends that the State Governments should get a resolution passed in the State Legislatures on adoption of a package of anti-tobacco measures to enable the Parliament to enact legislation. The package of anti tobacco measures may include the following:—

- (i) The existing statutory warning on cigarette packets advertisements hoarding that Cigarette smoking is injurious to health' should be expanded to include other telling slogans which may be specified in the legislation.
- (ii) The statutory warning should be extended to other tobacco products such as chewing tobacco, pan masala, gutaka, and tobacco based tooth powders and the warning should be printed in English and Hindi and other regional languages at the point of sale.
- (iii) Prohibition of advertisements on cigarettes, bidis, and tobacco based pan masala and all other tobacco products.
- (iv) Existing rules/regulations concerning nonsmoking in public places of entertainment and transport to be rigidly enforced and extended to other areas such as government offices,

educational institutions, official conferences meetings, railway stations and airports.

- (v) Projection of slides depicting harmful effects of tobacco consumption before every show in Cinema Halls and also in TV and radio programmes,

REVIEW OF I.S.M. AND HOMOEOPATHY PROGRAMME

The Council was of the view that although there has been a growing realization of the significant role that could be played by the practitioners of Indian Systems of Medicine and Homoeopathy spread all over the country, there has not been much progress in the utilization of the services as part and parcel of the health care strategy towards achieving the goal of 'Health for All by 2000 A.D.' The Council made the following recommendations:—

1) *Involvement of ISM and Homoeopathy Practitioners in Family Welfare and Primary Health Care Programmes*

The Council felt that the large number of physicians of various disciplines of Indian systems of Medicine and Homoeopathy numbering about four lakhs should be involved more effectively for realization of the target of Health for All by 2000 AD'. The Union Government and the States should devise specific programmes for achieving this end. More and more practitioners of these systems of medicine should be appointed in the PHCs. The physicians of these systems of medicines enjoy high local acceptance and exert considerable influence on health practices and they can be trained to motivate the private practitioners in the rural areas and other parts of the country in family welfare and primary health care programmes. They may be provided training which may make them more useful for such programmes, particularly Immunization, distribution of Vitamin and Folic Acid tablets and Oral Rehydration Therapy etc.

I. It was pointed out in the meeting of the Council that the Union Government had launched a scheme on pilot basis in the States of Uttar Pradesh and Rajasthan for 'formal involvement' of ISM practitioners in Family Welfare Programme which had not made much progress because of non-availability of funds with the Directorates of Indian Systems of Medicines & Homoeopathy in these States. The Council therefore, resolved as follows:

- a. That, in future, funds for involvement of practitioners of these systems in the Family Welfare Programme should be placed at the disposal of the Directors of Indian Systems of Medicines & Homoeopathy in the States who should also be made the implementing agencies of the programmes. This scheme should cover more States, though the coverage may be confined to somewhat smaller areas;
- b. That the practitioners of these Systems of Medicine should be assigned specific targets in the Family Welfare Programme and primary health care. A three-tier system on par with that evolved for the practitioners of modern medicine should be evolved for the practitioners of these systems separately.
- c. The Union Government should also monitor more effectively the utilization of the funds allocated for this purpose by the States.
- d. 10 percent of the prize money awarded to States for showing exemplary performance in the Family Welfare Programme should be allocated to the ISM system in the States.

II. It was also suggested that incentives on the lines provided to practitioners of modern medicine for family welfare should also be made available to the acceptors when they are treated by the Indian System of Medicine & Homoeopathy practitioners.

III. Studies may be undertaken at micro level to delineate the role of Indian Systems of Medicine & Homoeopathy practitioners in providing family planning services to the people in both urban and rural areas. These studies may be supplemented with actual interventions on pilot

basis in selected areas to identify as to which interventions could be feasible as well as cost effective.

- IV. There is also a need to undertake cost benefit analysis of Indian System of Medicine & Homoeopathy health infrastructure to demonstrate unambiguously the cost effectiveness of these systems.

2) *Medicinal plants*

- (i) Realizing that the debility of drugs of ISM depends largely on the availability of genuine medicinal plants and also keeping in view the fact that many species of medicinal plants are becoming extinct or are endangered, it is recommended that essential and corrective measures should be taken to protect endangered species of medicinal plants and to grow/cultivate those which are in greater demand.
- (ii) The State Governments should set up nodal agencies in their States on the basis of the recommendations made in Regional Seminars which have been forwarded to all the State Governments. These nodal agencies should coordinate with various Departments like Health, Forest Environment, Agriculture, Tribal Hill Department, Cooperative Societies voluntary organizations etc. for the development of medicinal plants.
- (iii) The Union Ministry of Health and Family Welfare should formulate a national policy on medicinal plants with a view to identify areas of thrust. The Union Government should also organize a National Seminar to focus attention of the State Governments on the various aspects of medicinal plants. It would be of immense help if the Union Ministry of Health could highlight availability of various medicinal plants in different parts of the country in this Seminar on the basis of the findings in the Regional Seminars held earlier.
- (iv) It is also necessary that export potential of ISM drugs medicinal plants is explored as also channels outlets are identified in urban and rural areas of the country itself to facilitate the availability of quality drugs to people all over the country.
- (v) The Herbal wealth of the country should be fully utilized by developing a proper marketing strategy so that the valuable herbs going waste in one State are utilized by other States where there is demand.
- (vi) Market survey should be undertaken by practitioners of Indian Systems of Medicine and Homoeopathy regarding availability of medicinal plants.
- (vii) The Union Government should draw up a centrally sponsored scheme to provide financial assistance for the setting up of herbal gardens /herbariums during the VIII Five Year Plan.

3) *Educational Standard in ISM*

- I. The Council reiterates that the quality of education in ISM & Homoeopathy colleges requires to be improved. The State Governments should evaluate the functioning of the ISM & Homoeo Colleges in their States to find out if they have got adequate manpower, well equipped laboratories, modern equipment and sufficient space to bring them on par with the standards as prescribed by the Central Councils of Indian Medicine and Homoeopathy.
- II. The State Governments may expeditiously adopt State Acts at par with IMCC Act, 1970, HCC Act, 1973, to ensure uniformity in educational standards and practice by qualified doctors.
- III. There should be a centrally sponsored scheme for improvement of colleges in the Indian Systems of Medicine & Homoeopathy disciplines so as to bring the standard of education on par with the recommendations made by the Central Council of Indian

Medicine and Central Council for Homoeopathy.

- IV. The States should also stress on these colleges that they should get themselves affiliated to the Universities and the Universities should create faculties for these Systems of Medicine.

4) *Legislation to curb undesirable practices in ISM and homoeopathy*

The Council recommends that the Union Government should introduce legislation at an early date to provide punishment to unauthorized institutions awarding degrees diplomas in ISM & Homoeopathy and to unqualified persons quacks practicing these systems of medicine. The State Governments must also maintain utmost vigilance against these unhealthy practices and take suitable corrective measures.

5) *Extension work on ISM research*

The results of research of the Research Councils in Ayurveda, Siddha, Unani, Homoeopathy, Yoga Naturopathy should be given wide publicity through out the length and breadth of the country with a view to make this knowledge available to the practitioners of these systems and the people at large. The Councils should mail their publications on the research findings to all the Colleges of ISM & H. Post-Graduate Departments and hold seminars. The State Governments should also develop proper liaison with the Research Councils and take necessary steps to promote these systems of medicine in their States. Some pilot project in channelizing the research findings to practitioners at grass-root level may be undertaken with a view to identify mechanism needed for a wide dissemination of research results.

- (ii) It was also resolved that drugs patented invented by Research Councils of Indian Systems of Medicine and Homoeopathy should be utilized in the national programmes.

6) *Mrit Sanjivini Sura*

In the light of the final decisions taken by the Technical Committee in regard to alcohol contents in Mrit Sanjivini Sura and packing etc., the Government of India should issue suitable directions / guidelines to the State Governments for checking the misuse of these drugs.

7) *Electropathy*

In view of the fact that electropathy is not a recognized system of medical treatment, the State Governments should not allow the propagation or practice of electropathy in their States.

Miscellaneous

- i. In the meeting of the Central Council of Health & Family Welfare, the representatives of Indian Systems of Medicine and Homoeopathy should also be involved formally in the Working Groups constituted to review such programmes as National Health Policy and Medical Education, Likewise, representatives of the Research Councils of Indian Systems of Medicine & Homoeopathy should be associated with the Working Groups constituted to look into the national programmes such as malaria, cancer etc.
- ii. There should be separate Directorates in the States for Indian Systems of Medicines.

- iii. There should be separate Directorates in the States for Indian Systems of Medicines.
- iv. It was also suggested that there should be a centrally sponsored scheme for setting up of institutes of excellence in these systems in each State.
- v. It was suggested that the IX Finance Commission should recommend special allocation of funds for the Indian System of Medicine and Homoeopathy while making its recommendations in regard to allocations of funds for the health programmes.
- vi. The Council noted with concern that a number of Ayurveda dispensaries in the States were being converted into dispensaries of modern medicine. It was strongly recommended that this practice should be curbed by the States.
- vii. The Council recommends that the States should introduce parity in the doctors of Indian Systems of Medicine and Homoeopathy and those of modern medicine.
- viii. Yoga can play a significant role in the preventive aspect of health care and teaching of yoga should be made compulsory in all schools all over the country.

RECOMMENDATION NO. 11

DRUGS STANDARD CONTROL INCLUDING PROBLEM OF DRUG ABUSE

Drug control

The Council recommends that: —

1. Each State should increase the strength of Drug Inspectors as per norms given by the Task Force of the Ministry of Health and Family Welfare.
2. Each State should have a fully qualified whole time Drug Controller for effective implementation of the Drugs & Cosmetic Act.
3. Each State should develop full-fledged testing laboratory to effectively monitor the quality of drugs manufactured and sold in that State.
4. Regional Laboratories should be set by the Central Government.
5. Each State should set up a Committee of experts to screen existing as well as new formulations (of fixed dose combinations from the angle of safety, efficacy and Rationality. States should approve only such combination formulations which have been approved by Drug Controller (India).
6. In order to have effective check on the movement of spurious drugs the States should set up special Intelligence Cells consisting of Mobile Squads, Watchers and Drug Inspectors.
7. Prompt action should be taken by the licensing authority on the report of substandard drugs reported from all States.
8. The Drug Inspectors and Govt. Analysts should be properly trained in the training programmes arranged by Central Govt. A training calendar should be drawn up and circulated to the States|UTs,
9. An Essential Drug List should be developed on a National level.
10. There should be a Centrally Sponsored Scheme for assisting the States during the VIIIth Five Year Plan.
11. Drug Control machinery at the Centre should be strengthened.
12. Zonal Committee should be set up to sort out regional problems.
13. The State Governments should set up Adverse Drug Reactions Monitoring Cells in various Govt. Hospitals.
14. The States are required to develop drug information banks and monitoring cells so that the information on various activities can be retrieved immediately. The report on activities should be sent to the Central Govt. regularly.
15. The new proposed amendments on G.M.Ps. should be enforced rigidly by each State.
16. For better consumer awareness the States should under time education of consumers by establishing State level Committees.
17. A Health Award should be instituted for States regarding excellent performance in this programme.

DRUG DE-ADDICTION PROGRAMME

The Council recommends: —

1. The State Governments/UTs would earmark specific funds in their Plan Budget for this programme henceforth.
2. The State Governments/UTs would identify a nodal institution of excellence in their States.
3. The State Governments should also identify a nodal officer in their Health Directorates which would serve as contact points between the States and the Central Governments for this programme.
4. The State Governments should set up inter-Departmental Committees comprising Health, Welfare, Education, and Excise in Departments to ensure concerted action to check Drug abuse.
5. A coordinated Action Plan for the Centre and the States should be drawn up.
6. State Governments should set up separate de-addiction Centers.
7. Rehabilitation Centres should be set up in each State,
8. The States/UTs would impart training to their personnel concerned with Drug De-addiction in the identified nodal institution regularly and also nominate their officers for training courses arranged by the Central Government,
9. Regional Workshops should be conducted regularly to enable exchange of information.
10. The States/UTs would collect and maintain statistical data on the format prescribed by the Central Government and would communicate these to the latter regularly every month.
11. The Central Government would provide guidelines for treatment of drug addicts which the State Governments/UTs would be required to follow.
12. Health Education regarding drug dependence should be imparted. Publicity material and messages should be carefully screened in order that they do not become counter-productive.
13. The programme should be intensified and central assistance should be given for setting up treatment centres in States particularly where the problem is acute.
14. A Health Award should be instituted for States regarding excellent performance in this programme

RECOMMENDATION NO. 12

REVENTION OF FOOD ADULTERATION PROGRAMME

The Council recommends that:—

- (1) The P.F.A. Cell in the Headquarters strengthened.
- (2) The Central Government should organize regular training courses for the officials of the State Government. A calendar of training programmes should be drawn up and circulated.
- (3) Consumer Education Programmes be given 'top priority' by participation in exhibition, organizing talks through mass media. Educational materials be brought out on food adulteration, food hygiene and safety, labeling provisions, food additives etc.
- (4) There would be a Centrally Sponsored Scheme to assist the States/UTs during the VIIIth Five Year Plan period.
- (5) Uniform and standardized methods of analysis would be compiled by the Central Government and circulated to State Governments.
- (6) Studies on subjects like pesticides residues, food colours etc. would be initiated by the Central Government for which active cooperation of States/UTs would be required.
- (7) A Health Award should be' instituted for States regarding excellent performance in this programme.

(Action Central Govt.)

The Council also recommends that: —

- (1) Adequate Budget provision be made for augmentation of enforcement machineries and strengthening of food testing laboratories.
- (2) The State Governments should utilize the Benefit of training programmes organized by the Central Government.
- (3) Procedure of licensing be streamlined. Every effort is made for ensuring hygienic conditions in eating establishments.
- (4) Monitoring of pesticide residues and colour in food be given 'top priority'.
- (5) State P.F.A. Rules be updated:
- (6) The State Governments should send periodical reports to the Central Government outlining working of P.F.A. Act and thus help the Central Government in monitoring of the programme throughout the country.
- (7) Active participation of voluntary organizations be ensured in implementation of the programme.
- (8) The State Governments should set up Monitoring Cell, Legal Cell and Grievance Cell.

(Action State Govt.)

RECOMMENDATION NO. 13

MEDICAL & HEALTH EDUCATION INCLUDING ROME SCHEME

After reviewing the status of Medical Education particularly in the context of evolving a National Medical Education Policy and recognizing the need for establishing linkages with the general education system and also to create effective linkages between Health Education and Medical Education, the Council makes the following recommendations:—

1. That the Ministry of Health should convene as early as possible a Conference to which Deans and Heads of Medical Faculties, as well as Vice-Chancellors should be invited along with the representatives of professional and statutory bodies like MCI, IMA, Dental and Nursing Councils and Directors of Medical Education, etc. so that their views on various aspects of medical education could be elicited and recommendations considered by the Group constituted by the Ministry for formulating the Medical Education Policy.
2. That planning, coordination and implementation of a well-defined policy on Continuing Medical Education should be encouraged at all levels..
3. That faculty development in medical institutions in the country should receive priority consideration. For attracting the best talents, financial incentives including remunerative and uniform scales of pay, facilities for career advancement and promotional avenues should be considered. The Central Government should also assist the States for fulfilling this recommendation. The Council further reiterates that the distortions in manpower in medical education, especially in relation to pre-clinical and Para-clinical disciplines need urgent consideration and that special measures be initiated along the lines suggested to fulfill the needs of these disciplines as early as possible.
4. That the linkages between the general education system and the medical education should be strengthened at all levels including elementary and secondary education, vocational education, non-formal and adult education, and university education, as indeed has been recommended in the National Education Policy, 1986. The modalities for effecting this coordination should be established by associating both medical educationists and public health scientists with planners of general education at State and national levels.
5. The Council reiterates the recommendation that all States must establish special educational programmes aimed at upgrading the knowledge and skills of Scheduled Caste and Scheduled Tribe candidates for admission to undergraduate medical courses.
6. That Medical Education should be considered a whole-time commitment without any element of private practice by the medical faculty.
7. That with a view to ensuring the quality of medical services, the Central Government and the States should take urgent steps to stop practice by unqualified medical practitioners.
8. That undergraduate medical education should have a strong linkage with the requirements of effective delivery of health care particularly at the peripheral level. Learning experiences in the community setting rather than in the hospital setting and their further re-enforcement during internship must be pursued vigorously.
9. The Council expresses its satisfaction that in accordance with its recommendations, the Government has brought forth a Bill to appropriately amend the LM.C. Act and hopes that this will be passed by the Parliament soon. As this may take some time, the Council again recommends to the States that:—
 - I. No new medical college should be allowed to be opened in any part of the country, or no

additions to the existing admission capacity in the medical colleges should be permitted, as the qualified medical practitioners made available from the existing medical colleges are sufficient for the near future.

- II. State Government may also enact laws to prohibit charging of capitation fees by the medical colleges on the same analogy of laws made by Karnataka and Andhra Pradesh.
 - III. Assistance to the Medical Council of India may be rendered for inspection of medical colleges and deficiencies pointed out by the Council removed quickly so as to enable the Council to recognize or recommend continued recognition of various medical degrees.
10. The health education is an integral part of all the National Health Programmes and Primary Health Care approach, and, as such, it should be an inbuilt component of the overall strategy in implementation of health programmes at various levels, i.e., Central, State, District Block and village levels so that health education can reach up to the periphery. It entails that health education and communication strategies should be developed for each health programme and properly funded, which is not being done at present despite earlier recommendation of this Council in 1983. Adequate funds, as already recommended in previous CCH meeting, are made available.
 11. Health Education should be a component in all the existing educational courses for undergraduate medical students, nursing and other health functionaries and school teachers so that they can shoulder the responsibility of health education to the community based on the local needs. For providing the needed expertise in health education, it is essential to strengthen the CHEB with the required infrastructure. For appropriate and effective coordination of all health educational activities, it is recommended that State Health Education Bureaux should coordinate all health educational activities in respective States and these Bureaux should be appropriately strengthened.

RECOMMENDATION No. 14

REVIEW OF NATIONAL HEALTH POLICY

The Council notes that the National Health Policy was approved by Parliament in 1983 and was circulated to all State Governments and Union Territories and others concerned in 1984. Action on various directions made in the Policy has been initiated by the Central and State Governments and also the Policy was kept in view while formulating the Seventh Five Year Plan. The 1980 Council recommends that the National Health Policy of 1983 should be implemented very vigorously. In this context, there is a need for periodical review of the implementation, of National Health Policy and the guidelines set under it. The Council recommends that the reviews should be held at the State level and then presented annually in the meetings of the Council, so that suitable recommendations could be framed.

ANNEXURE 'A'

MINISTRY OF HEALTH AND FAMILY WELFARE

New Delhi, the 6th January, 1988

NOTIFICATION

Constitution of Central Council of Health and Family Welfare

S.O. 21(E).—In exercise of the powers conferred by article 263 of the Constitution and in supersession of the notification of the Government of India in the erstwhile Ministry of Health No. F- 6-1/51-P, dated the 9th August, 1952, the President hereby constitutes the Central Council of Health and Family Welfare and defines the nature of duties to be performed by it and its organization and procedure as follows, namely.—

1. Organization of the Council: (i) The Council shall consist of—

- | | | |
|-----|---|-----------------------|
| (a) | The Union Minister for Health and Family Welfare | Chairman |
| (b) | The Union Minister of States the Union Deputy Minister in the Ministry of Health & Family Welfare | Vice- Chairman |
| | Person | |
| (c) | Member, Planning Commission | Member |
| (d) | Ministers in charge of the Ministries of Health and Family Welfare, Medical Education and Public Health in the States Union Territories with legislatures | Member |
| (e) | A representative each of the Delhi Admn, Dadra Nagar Haveli, Chandigarh, A&N Islands, Daman & Diu and Lakshadweep | Members |
| (f) | MEMBERS OF PARLIAMENT | Members |
| 1. | Dr. V. Rajeshwaran | Lok Sabha |
| 2. | Kum. Kamla Kumari | Lok Sabha |
| 3. | Kum. Sushila Tiria | Rajya Sabha |
| 4. | Kum. Sayeeda Khatun | Rajya Sabha |
| (g) | Non-Officials | |
| (i) | Representatives from Health and Family Welfare Sectors: | Members |
| 1. | President, Indian Medical Association, (Ex-officio capacity) | |
| 2. | President, Family Planning Association of India, Bombay (Ex-officio capacity) | |
| 3. | President, Indian Council of Child Welfare, New Delhi (Ex-officio capacity) | |
| 4. | Chairperson, Central Social Welfare Board, New Delhi (Ex-official) | |
| 5. | The President, Federation of Indian Chambers of Commerce and Industry, New Delhi (Ex-officio) | |
| 6. | Director General, Indian Council of Medical Research, New Delhi (Ex-officio capacity) | |
| 7. | The President, All India Organisation of Employers, New Delhi (Ex-officio capacity) | |

(ii) Eminent Individuals

Members

1. Dr. Raj Arole, Society of Comprehensive Health Project in India, Jamkhed, Maharashtra.
2. Dr. C. Gopalan of the Nutrition Foundation.
3. Shri Harish Khanna, Executive Director, Family Planning Foundation, New Delhi.
4. Dr. P. Siva Reddy, Adviser (Ophthalmology), State of Andhra Pradesh.
5. Smt. Varna W Ingti, Chairperson, Meghalaya State Social Welfare Board.
6. Dr. Lalit Nath—A specialist in Community Medicine.
7. Dr. Banoo Coyaji, Supdt., K.E.M. Hospital, Sardur Mudaliar Road, Rasta Peth, Pune (Maharashtra),
8. Shri S. P. Mittal, Chairman, Indian Association of Parliamentarians for .population and Development.

(B) OFFICIALS

- | | |
|---|-------------------------|
| 1. Secretary, Ministry of Health and Family Welfare | Member |
| 2. Special Secretary, Ministry of Health and Family Welfare | Member |
| 3. Secretary, Department of Education | Member |
| 4. Secretary, Department of Women and Child Development | Member |
| 5. Director General of Health Services | Member |
| 6. Joint Secretary, Department of Health | Member Secretary |

- (iii) Eminent Individuals at (g) (ii) 1 to 8 shall normally be members of the Council for a period of two years. The Members of Lok Sabha Rajya Sabha shall be Members of the Council so long as they are Members of either Lok Sabha Rajya Sabha or two years whenever is earlier.
- (iv) The traveling and daily allowances of non-official members for attending the meetings of the Council shall be regulated, in accordance with the provision of SR 190 and orders of the Government of India there under as issued from time to time.
- (v) The expenditure involved will be met from within the sanctioned budget grant for the purpose.
- (vi) Expert and technical advisers to the Central Government and State Governments shall not be members of the Council and shall not have any right to vote when any decision is taken by it but shall, if so required by the Council, be in attendance at its meetings.
- (vii) The Council shall have a Secretarial staff consisting of a Secretary and such officers and officials as the Chairman may, with the approval of the Central Government think fit to appoint.

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

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

- (a) To consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects, such as the provision, of remedial promotive and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research:
- (b) To make proposals for legislation in fields of activity relating to medical and public health and Family Welfare matters, laying down the pattern of development for the country as a whole.
- (c) To examine the whole field of possible cooperation on a wide basis in regard to inter-State quarantine during times of festivals, out-break of epidemic diseases and serious calamities such as earth-quakes and famines and to draw up a common programme of action;

- (d) To make recommendations to the Central Government regarding distribution of available grants-in-aid for Health and Family Welfare purposes to the States and to review periodically the work accomplished in different areas through the utilization of these grants-in-aid; and
- (e) To establish and organization or organizations invested with appropriate functions for promoting and maintaining cooperation between the Central and State Health and Family Welfare administrations.

3. Procedure of the Council: —

The Council shall in its conduct of business observe the following procedure, namely: —

- (a) The Council shall meet at least once in every year;
- (b) It shall meet at such time and place as the Chairman may appoint in this behalf;
- (c) Five members (including the Chairman) shall form the quorum for a meeting of the Council;
- (d) The Chairman and, in his absence vice-chairman vice chair person or such member as may be designated by the Chairman in this behalf from among the members referred to in clause (d)- of sub-paragraph (i) of paragraph 1 shall preside at . the meeting;
- (e) All questions which may come up before the Council at a meeting shall be decided by a majority of votes of the members (including the Chairman) present at the meeting;
- (f) In case of equality of votes, the person presiding shall have a, second or casting vote;
- (g) The Council shall, observe in the conduct of its business such other procedure as it may, with the approval of the Central Government, lay down from time to time.

ANNEXURE 'B'

LIST OF MEMBERS PRESENT AT THE 1ST CONFERENCE OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE

1. Shri M. L. Vora, Union Minister for Health & Family Welfare—Chairman
2. Miss Saroj Khaparde, Union Minister of State for Health & Family Welfare—Vice-Chair person
3. Prof. P. N. Srivastava, Member (Health) Planning Commission—Member
4. Shri D. Venkateshwara Rao, Minister of Health & F. W. Andhra Pradesh—Member
5. Shri Techai Takkar, Minister of Health & F.W. Arunachal Pradesh—Member
6. Shri Chandra Mohan Potowary, Minister for Health & Family Welfare Assam.—Member
7. Shri Sheikh Hassan Haroon, Minister for Health & Family Welfare Goa —Member
8. Shri Vallabh Bhai Patel, Minister for Health & Family Welfare Gujarat—Member
9. Smt. Kamla Verma Minister for Health & Family Welfare Haryana.—Member
10. Shri Kaul Singh Thakur Minister for Health & Family Welfare Himachal Pradesh—Member
11. Shri B. Rachaiah, Minister for Health & F.W. Karnataka—Member
12. Shri A. C. Shanmughadas. Minister for Health & F.W. Kerala—Member
13. Smt. Rajani Satav, Minister of State (Health) Maharashtra—Member
14. Shri N. Phungazotham, Health Minister, Manipur—Member
15. Smt. Mayasalin War, Health Minister, Meghalaya—Member
16. Shri Ghutoshe Sema, Health Minister, Naga-land—Member
17. Shri Niranjana Patnaik, Health Minister Orissa —Member
18. Shri Raghunath Bishnoi, Health Minister, Rajasthan—Member
19. Shri Kashiram Reang, Health Minister, Tripura —Member
20. Shri Lokoati Tripathi. Minister for Health & F.W, Uttar Pradesh.—Member
21. Shri Prassanta Sur Health Minister, West Bengal—Member
22. Shri P. Kannah Health Minister, Pondicherry— Member
23. Shri Baijisa Lai Chauhan Executive Councillor (Health), Delhi Administration—Member
24. Dr. Gopal Singh. Administrator, Dadra & Nagar Haveli—Member
25. Shri K. K. Kandaswamy Counsellor (Health) A&N Islands—Member
26. Dr. V. Rajashwaran, Member of Parliament (Lok Sabha)—Member
27. Kum. Kamla Kumari. Member of Parliament (Lok Sabha)—Member
28. Kum. Sushila Tiria. Member of Parliament (Rajya Sabha)—Member
29. Kum. Sayeeda Khatun, (Member of Parliament) (Rajya Sabha)—Member
30. Shri K. K. Shah. President Indian Medical Association—Member
31. Smt. Avabai Wadia, President Family Planning Association of India—Member
32. Smt. Sasmeeta Srivastava, Chair person Central Social Welfare Board—Member
33. Dr. A. S. Paintal D.G. (ICMR)—Member
34. Dr. Raj Arole (Society of Comprehensive Health project in India)—Member.
35. Dr. C. Gopalan (President, Nutrition Foundation of India)—Member.
36. Shri Harish Khanna, (Executive Director Family Planning Foundation)—Member.

37. Dr. P. Siva Reddy [Advisor (Ophthalmology) to Govt. of Andhra Pradesh]—Member.
38. Smt. Verma W. Ingti (Chair person, Megha-laya State Social Welfare Board)—Member.
39. Dr. Lalit Nath (A Specialist in Community Medicine) —Member.
40. Dr. Banoo Coyaji (Supdt. KEM Hospital) — Member.
41. Shri S. S. Dhanoa, Secretary Min. of Health & Family Welfare New Delhi—Member.
42. Shri P. K. Umashankar, Special Secretary Ministry of Health & F.W. New Delhi—Member.
43. Miss Roma Mazumdar. Secy. Deptt. of Woman, Child Welfare New Delhi.
44. Dr. G. K. Vishwakarma, Director General of Health Services New Delhi—Member
45. Shri R. K. Ahooja, Joint Secretary Ministry of Health & Family Welfare New Delhi—Member Secretary.

Besides Ministers of the allied portfolios from the following States also attended the Conference:—

1. Smt. Biva Rani Nath Minister of State Tripura.
2. Shri Ram Lai Thakur Minister of State Law & Ayurveda, Himachal Pradesh.
3. Smt. Kamla Bhil Minister of State Rajasthan.

The following States/UTs were represented by their respective Senior Officers:

- Bihar
- J & K
- Madhya Pradesh
- Mizoram
- Punjab
- Sikkim
- Tamilnadu
- Chandigarh
- Daman & Diu
- Lakshadweep

**ATTENDANCE AT THE WORKING
GROUPS (16th FEBRUARY 1988)**

Working Group I

1. Shri Vallabh Bhai Patel, Health Minister, Gujarat—Chairman.
2. Smt. Kamla Verma, Health Minister, Haryana—Co-Chairman.
3. Miss Sayeeda Khatoon, Member of Parliament, Rajya Sabha—Member.
4. Shri Harish Khanna, Director, Family Planning, Foundation—Member.
5. Dr. Banoo Coyaji, KEM Hospital, Pune—Member.
6. Mrs. Avabai Wadia, President, Family Planning Association of India—Member.
7. Mrs. Verna W. Ingty Chairperson, 'Meghalaya State Social Welfare Board—Member.
8. Shri P. K. Umashankar, Spl. Secretary (FW) Union Ministry of Health & Family Welfare.
9. Mrs. Rami Chhabra, Adv. (M.M.&C) Union Ministry of Health & Family Welfare.
10. Pr. Harcharan Singh Adv. (Health) Planning Commission, New Delhi.
11. Shri Palat Mohan Das, Joint Secretary, Union Ministry of Health & F.W.
12. Shri B. B. Lai, Secretary (Health), Bihar.
13. Mr. V. Ranchan, Secy. & Commissioner (FW) Gujarat.
14. Shri Dilip Singh, Special Secretary & Commissioner (Health & Family Welfare) Meghalaya.
15. Shri T. C. Dutt, Secretary (Health & FW). West Bengal.
16. Dr. (Mrs.) Deborah Roy DHS (MCH & FW) Meghalaya.
17. Dr. B. C. Amin, Addl. Secretary, IMA.
18. Dr. A. K. Mukherjee, Joint Director, Management Information System West Bengal.
19. Dr. B. N. Singh, Addl. Director (FW & MCH) Andhra Pradesh.
20. Dr. T. M. Ramesh, Addl. Director (FW & MCH) Karnataka.
21. Air vice Marshal E. S. Lala. Secretary General F.P.A.I.,
22. Dr. L. M. Murry DHS, Nagaland.
23. Dr. (Mrs.) H. Lepcha, Addl. DHS, Sikkim.
24. Dr. Mohan Sansguiri, Dy. Director Health Services Goa.
25. Dr. G. M. Dhar, Director FW & MCH Jammu & Kashmir.
26. Dr. J. D. Sharma, Drugs & Food Controller, Jammu & Kashmir.
27. Dr. S. Indira, Director Health (IPP&FW) Kerala:
28. Dr. G A. Panse, Addl. Director of HS(FW) Maharashtra.
29. Shri R. Tiwari, Joint Secretary (PH) Maharashtra.
30. Shri S. S. Srivastava, Joint Registrar General Union Ministry of Home Affairs.
31. Shri V. K. Sharma, Spl. Secretary (Med. & Health) Government of Uttar Pradesh.
32. Dr. R. P. Saxena, Addl. Director (FW) Uttar Pradesh.
33. Dr. S. C. Dutt, Regional Director (H&FW) Gujarat.
34. Dr. S. B. Purohit, Regional Director (H&FW) Himachal Pradesh.
35. Dr. G. Harpalani, Regional Director H&FW Rajasthan.
36. Dr. H. Lai Mohan, Additional Director (FW) Manipur.
37. Shri S. L. Goyal, Asstt. Director (Health Services) Haryana.
38. Dr. Inderjeet Singh. Joint Director (FW) Haryana.
39. Mrs. C. K. Gariyali, Director of F.W. Tamil Nadu.
40. Dr. A. C. Patowary, Director of Medical Education Assam.
41. Dr. T. P. Sharma, Director (PH & FW) Madhya Pradesh.
42. Dr. Bachittar Singh, State Family Welfare Officer Punjab.
43. Dr. J. K. Khanna. Dy. Director (Health) Punjab.

44. Dr. M. A. Owaisy, DC (TO) Department of F.W. New Delhi.
45. Shri Ramesh Chandra, Under Secretary (P) Ministry of Health & Family Welfare, New Delhi.
46. Shri R. L. Narasimhan, Joint Director (N) Min. of Health & F.W., New Delhi.
47. Dr. (Miss) Jotna Sokbey, A.C. (I) Department of F.W., New Delhi.
48. Dr. P. C. Roy, ADG (D&CD) DGHS New Delhi.

Working Group II

1. Shri Lok Pati Tripathi, Health Minister, Uttar Pradesh—Chairman.
2. Shri Chandra Mohan Patowary, Health Minister, Assam—Co-Chairman.
3. Shri P. K. Mehrotra, Jt. Secy., Union Minister of Health & F.W.
4. Dr. C. Gopalan, President, Nutrition Foundation of India, New Delhi—Member.
5. Mrs. Maysalin War, Minister of Health, Meghalaya—Member.
5. Dr. Lalith Nath, Prof. & Head of Deptt. of SPM, AIIMS, New Delhi—Member.
6. Dr. Raj Arole, Society of Comprehensive Health Projects in India—Member.
7. Dr. Pirthipal Singh, DHS, Punjab
8. Mr. M. P. Parekh, Addl. Chief Secretary, Gujarat.
9. Dr. P. L. Sanjeeva Reddy, Secretary (Medical Health & FW), Andhra Pradesh.
10. Dr. S. G. Jami, Addl. Director Medical Services, Gujarat.
11. Dr. D. J. Tilak, Director Public Health Centres, Director of PH & Preventive Division, Tamil Nadu.
12. Dr. Mahendra Dutta. DDG (P), DGHS.
13. Shri T. D. Jogpal, Commissioner & Secretary, Haryana.
14. Dr. A. K. Kundu, Dy. Adviser (H&FW), Planning Commission.
15. Dr. C. L. -Malhotra, Director Health Services, Himachal Pradesh.
16. Dr. B. Lai, Special Secretary (Medical Health) Uttar Pradesh
17. Dr. K. P. Gupta, Director Health Services, Uttar Pradesh.
18. Dr. S. Lai, Regional Director (Health & FW). Uttar Pradesh.
19. Dr. Mahabir Dass, Director-in-Chief, Health & FW, Bihar.
20. Dr. M. R. Chandra Kapure, Director Health-Services, Maharashtra.
21. Dr. C. Prasanna Kumar, Joint Director (Health & Planning), Karnataka.
22. Dr. (Mrs.) V. K. Bhasin, Director (CHEB), DGHS.
23. Mrs. C. K. Mann, DADG (CHEB), DGHS.
24. Dr. S. R. Meegum, Director of Medical Health Services, Lakshadweep.
25. Dr. S. S. Narvekar, Assistant D.H.S., Maharashtra.
26. Dr. J. S. Nagra, DHS, A&N Islands.
27. Dr. R. Sethuraman, Dy. Secretary <AP>, Min. of Health. & F.W., New Delhi.
28. Dr. A. K. Bhattacharya, Dy. Director General <RHS>, DGHS.
29. Dr. (Mrs.) D. Lahiri, Director CBHI, DGHS.
30. Dr. S. C. Sharma, ADG (HA), DGHS.
31. Dr. (Miss) A. Bhardwaj, AC (Trg.). F.W. Deptt. New Delhi.

Working Group III

1. Shri Kaul Singh Thakur, Health Minister, Himachal Pradesh—Chairman.
2. Shri Ghotoshe Sem/a, Health Minister, Naga-land—Co-Chairman.
3. Dr. G. K. Vishwakanna, Director General of Health Services—Member.
4. Miss. Meera Seth, Addl. Secretary (Health), Union Ministry of Health & F.W.
5. Shri J. Vasudevan. Joint Secretary, Union Min. of Health & F.W.
6. Dr. P. Siva Reddy, Adviser (Ophthalmology), Sarojini Devi Eye Hospital, Andhra Pradesh-

7. Prof. Madan Mohan, Adviser (Ophthalmology), Min. of Health & F.W.
8. Shri L. Rynjah, Secy. (Health & F.W.), Assam.
9. Smt. C. Narayana Swami, Secy. (Health & FW), Orissa.
10. Shri N. Narayanan, Health Secretary, Tamil Nadu.
11. Dr. D. Sundara Rao, Director (Health & FW), Andhra Pradesh.
12. Dr. J. G. Phira, DHS, Arunachal Pradesh.
13. Shri G. Basu, Secretary (Health), Karnataka.
14. Dr. J. L. Javale Gowda, Director of Health & FW, Karnataka.
15. Dr. M. Krishna Bhargava, Director, Kidwal Memorial Institute of Oncology, Bangalore.
16. Dr. P. Vijayalakshmani Menon, Director, Health Services, Kerala.
17. Dr. D. T. Joseph, Health Secretary, Maharashtra.
18. Dr. S. K. Prabhu, State Family Welfare Officer, Sikkim.
19. Dr. S. C. Bhalla, Director Medical & Health Services, Uttar Pradesh.
20. Dr. K. K. Bhattacharjee, Director, Health Services and Ex-Office Secy. West Bengal.
21. Dr. J. L. Kole, Regional Director (Health & FW), Bhopal, Madhya Pradesh.
22. Dr. Y. D. Joglekar, Regional Director (Health & FW), Maharashtra, Pune.
23. Dr. V. M. Bedi, Regional Director (Health & FW), Chandigarh.
24. Dr. S. P. Gupta, National Consultant & Coordinator (TB), WHO.
25. Dr. (Mrs.) Saraljit Sebgal, Director (Incharge), N.I.C.D.
26. Dr. N. K. Chakravorty, Dy. Director, N.M.E.P.
27. Dr. B. N. Mittal, ADG (Leprosy), Dte. G.H.S.
28. P. M. Kapoor, A.D.G. (Ophthalmology), Dte. G.H.S.
29. Dr. A. K. Sur, A.D.G. (TB), Dte. G.H.S.
30. Dr. (Mrs) C. Palit, A.D.G. (NCD), Dte. G.H.S.
31. Dr. K. S. Ganeshan, D.S. (PH), Ministry of Health & Family Welfare.
32. Shri P. S. Tandan, U.S. (PH), Ministry of Health & Family Welfare.
33. Shri G. K. Nair, U.S. (MS), Ministry of Health & Family Welfare.
34. Shri S. S. Mathur, S.O. (PH & Mai.), Ministry of Health & Family Welfare.
35. Dr. K. K. Dutta, A.D.G. (AIDS), Dte. General of Health Services.

Working Group IV

1. Shri B. Rachaiah, Health Minister, Karnataka Chairman.
2. Shri R. K. Ahooja, Joint Secretary, Ministry of Health & Family Welfare.—Member-Secretary,
3. Dr. Indra Bhargava, D.D.G.(M), Dte. General of Health Services.
4. Dr. K. K. Shah, President, LEA.-Member.
5. Smt. Vineeta Rai, Secretary (Health), Delhi Admn.
6. Dr. G. Santha Kumari, Director (Medical Education), Kerala.
7. Shri V. Krishnamurthy, Health Secretary, Kerala.
8. Shri K. S. Rastogi, Health Secretary, Rajasthan.
9. Dr. Chandra Prakash, Director-Principal, Rohtak Medical College, Haryana.
10. Dr. N. C. Panda, Director of Medical Education & Training, Orissa.
 - a. Dr. H. C Mkhra, Director Health Services, Orissa.
11. Dr. S. G. Nagalinga Setty, Director of Medical Education, Bangalore, Karnataka.
12. Dr. J. L. Javare Gowda, Director, Health & Family Welfare, Karnataka.
13. Dr. "Gilbert Benjamin, Director, Health & Family Welfare, Pondicherry.

14. Shri V. V. Nathan, Principal Secy. (Health), Govt. of Bihar, Patna.
15. Dr. G. S. Sharma, Director Health Services, Haryana.
16. Dr. S. Arumugam, Director of Medical Education, Tamil. Nadu.
17. Dr. A. Dutta, Regional Director (H&FW), Andhra Pradesh.
18. Dr. B. N. Barkakaty, Regional Director (H&FW), Shillong.
19. Dr. O. P Gupta, Director Medical Services & Medical Education, Govt. of Gujarat.
20. Dr. Balwant Singh Tunk, Director Research & Medical Education, Govt. of Punjab.
21. Dr. N. K. Vaidya, Director Medical Education Govt. of Himachal Pradesh Shimla.
22. Shri R. Hi Kumavat, Joint Secretary (Med. Education & Drugs) Govt. of Maharashtra Bombay.
23. Dr. A.K.N'. Sinha, President M.C.I., New Delhi.
24. Dr. P.S. Jain Secretary (MC1) New Delhi
25. Prof. B. N. Tandon, (Medicine) A.I.I.M.S., New Delhi.
26. Dr. (Mrs) B. K. Maini, Excutive Director National Board of Examination. New Delhi.
27. Dr.- S, K. Lai, Secretary & Executive Director, National Academy of Medical Sciences (INDIA) New Delhi.
28. Dr. K.K. Sen, A.D.G (ME) Dte; General of Health Services
29. Shri Sarweshwar Jha D. S, (M) Ministry of Health & Family Welfare
30. Shri R. Srinivasan US (ME) Ministry of Health & Family Welfare
31. Dr. J. J. Sood, Hony. General Secretary I.M. A.
32. Prof. I. S. Bajaj Prof, of Medicine A.I.I.M.S.

WORKING GROUP V

1. Shri D. Ventateshwara Rao, Health Minister Andhra Pradesh—Chairman.
2. Shri Raghunath Bishnoi Health Minister Rajasthan
3. Shri Kashi Ram Reang Health Minister Tripura.
2. Shri S, V. Subramaniyan Joint Secretary (S) Ministry of Health & Family Welfare-
3. Dr. A. K. Mukherjee Addl. D.G.(PH) Dte. General of Health Services.
4. Shri K. B. Shukla Secretary (H&FW) Arunachal Pradesh.
5. Shri V. G. Nigam Principal Secretary Public Health & Family Welfare Madhya Pradesh.
6. Dr, Prem Kumar Gupta Drugs Controller (I),Dte- General of Health Services.
7. Dr. G. V. S. Nagabhushana Rao,., Addl. Director Medical & Health Services, Andhra Pradesh.
8. Dr. D. K. Jagdev Director Med. & Health Services Rajasthan.
9. Dr. S. P. Bhattacharjee DHS & Drugs Controller Meghalaya.
10. Dr, Ananda Helecar Director Health Services Goa.
11. Dr. P. K, Singh Director Health Services Manipur.
12. Dr. T. D. Purkayastha, Regional Director (H&FW) Imphal.
13. Dr. B. N, Srivastava Regional Director (H&FW) Bhubaneswar.
14. Dr. B. S. Cheema Director Health Services Punjab
15. Shri Lipokmeren Jamir Joint Secretary (H&FW), Nagaland.
16. Smt. Anindita Kishore US(Drugs) Ministry of Health & Family Welfare
17. Shri J. C. Jaisani ADG (PFA) Dte. General of Health Services

WORKING GROUP VI

1. Shri Ram Lai Thakur Minister of State for Law Ayurveda Himachal Pradesh—Chairman
2. Shri Techi Takkar Minister of State Arunachal Pradesh—Co-chairman
3. Shri S. K. Alok Joint Secretary (A) Ministry of Health & Family Welfare.
4. Dr. (Mrs.) Ira Ray Addl. D. G. (M) Dte. General of Health Services.
5. Sh. Banshi Lai Chauhan Executive Councilor (Health Delhi Adm.)—Member
6. Shri K. R. Kandaswamy Councilor (Health A&N. Islands—Member.
7. Swami Dharendra Brahmchari Director C.C.R.Y.N New Delhi.
8. Mrs. C. Narayanaswamy Health Secy. Orissa
9. Miss N. Nanda Secy. (Medical) Goa.
10. Shri S. K. Mukherjee Director Indian Medicine, Homeopathy Orissa.
11. Dr. K. V. Vaitheswaran Joint Director (ISM) Tamil Nadu.
12. Shri K. S. Salathia Addl. Secy. (Health & M.E.) Jammu & Kashmir.
13. Shri A. K. Vijayabhanu Commissioner, Secretary (JM) Tamil Nadu.
14. Dr. A. C Saxena Director (Homeopathy) Uttar Pradesh.
15. Shri S. B. Goel Director (ISM) Ministry of Health & Family Welfare.
16. Dr. D. P. Rastogi Director C.C.R.H. New Delhi.
17. Shri S. K. Mukherjee Director Indian Medicine, Homeopathy Orissa.
18. Dr. K. V. Vaitheswaran Joint Director (ISM) Tamil Nadu.
19. Dr. S. P. Gupta Director (Ayurveda Unani) Uttar Pradesh.
20. Dr. H. S. Kastura Director (ISM&H) Gujarat.
21. Dr. Jugal Kishore President (C.C.H) New Delhi.
22. Dr. V. N. Pandey Director C.C.R.A.S New Delhi.
23. Dr. S. S. Sarkar Director Health Services Delhi Admn.
24. Dr. A. K. Das Regional Director (Health & FW) West Bengal
25. Dr. S. N. Pandey A.R.O. (NL) C.C.R.Y.N. New Delhi,
26. Dr. G. S. Lehri DFWO UT CHD Chandigarh (UT).
27. Acharya R. K. Jain Registrar-cum-Secv. C.C.LM. New Delhi.
28. Dr. N. Debbarman Director Health Services Tripura.
29. Dr. CHS Sastry Dy. Adviser (Ay) Ministry of Health & F.W. New Delhi.
30. Shri R. S. Mathur U.S. (ISM) Ministry of Health & F.W. New Delhi.
31. Dr. P. L. Verma Register-cum-Secy. Central Council of Health New Delhi.
32. Dr. V. T. Augustine Deputy Adviser (Homeopathy) Ministry of Health & F.W New Delhi.
33. Dr. S. K. Mishra Adviser (A&S) Min. of Health & F. W.
34. Dr. P. K. Jain Director Ayurveda Haryana, Chandigarh.
35. Miss S. Brar Joint Secy.-cum-Director (AY) Himachal Pradesh.
36. Shri T. S. Sivaprakasham Director (Indian Medicine & Homeopathy) Tamil Nadu.
37. Hakim Syed Khaleefathullah President C.C.LM. New Delhi.

ANNEXURE 'D'

**PROGRAMME OF THE 1ST CONFERENCE OF THE CENTRAL COUNCIL OF
HEALTH & FAMILY WELFARE FROM 15TH TO 17TH FEBRUARY, 1988.**

Venue : Vigyan Bhawan

Commission Room 'H' NEW DELHI

<p><i>Monday, February 15, 1988</i></p> <p>10.00 A.M. to 11.15 A.M.</p>	<p>—Inaugural Session.</p>	4-00 P.M. to 4.15 P.M.	TEA in the Lounge.
	<p>- Welcome Address by Shri S.S. Dhanoa, Secretary, Ministry of Health & Family Welfare.</p>	4-15 P.M. to 6.00 P.M.	— Discussion (continues) and Formation of Working Groups.
	<p>- Address by Miss Saroi Khaparde, Minister of State, Health & Family Welfare.</p>	<p><i>Tuesday, February 16, 1988</i></p>	—Venue : To be announced.
	—Address by Shri P.V. Narasimha Rao, Union Minister for H.R.D.	10.00 A.M. to 11.00 A.M.	—Working Group Discussions.
	—Inaugural Address by Shri M.L. Vora, Union Minister for Health & Family Welfare.	11.00 A.M. to 11.15 A.M.	—TEA in the Lounge.
	—Remarks by Prof. P.N. Srivastava, Member, Planning Commission.	11.15 A.M. to 01.00 P.M.	—Working Group Discussion (Continue)
		1.00 P.M. to 2.30 P.M.	—LUNCH BREAK
		2-30 P.M. to 4.00 P.M.	—Working Group Discussions (Continue)
		4-00 P.M. to 4.15 P.M.	—TEA in the Lounge.
		4.15 P.M. to 5-00 P.M.	Formulation/finalization of Working Group Reports.

11.15 A.M to 11.30 A.M	<p>—Family Welfare Awards for 1985-86 & 1986-87</p> <p>—Vote of Thanks by Dr. G.K. Vishwakarma, Director General of Health Services.</p> <p>—Address by Shri S.G. Pitroda, Adv. to P.M. on Technology Missions.</p>	<p><i>Wednesday, February, 17, 1988</i></p> <p>9-30 A.M. to 11.00 A.M.</p> <p>11.00 A.M. to 11.15 A.M.</p> <p>11.15 A.M. to 1.15 P.M.</p>	<p>Venue : Commission Room 'H'</p> <p>- Presentation of Reports of Working Groups and adoption of recommendations.</p> <p>- TEA in the Lounge.</p> <p>- Presentation of Reports of Working Groups and adoption of Recommendations (Continue)</p>
11.30 A.M to 1.30 P.M	<p>—TEA in the lounge.</p>	1.15 P.M. to 1-30 P.M.	<p>—Concluding Remarks by Shri M.L. Vora, Union Minister for Health and Family Welfare.</p>
1. 30 A.M to 2. 30 P.M	<p>—Discussion on the Agenda Items.</p>		
2.30 P.M. to 4.00 P.M	<p>—LUNCH in the Dining Hall adjoining Vigyan Bhawan.</p> <p>Discussion (continues)</p>	1.30 P.M.	-LUNCH BREAK