

**CENTRAL COUNCIL OF HEALTH AND
FAMILY WELFARE
(4th Meeting)**

**PROCEEDINGS
AND
RESOLUTIONS**

**OCTOBER 11-13, 1995
NEW DELHI**

**BUREAU OF PLANNING
DIRECTORATE GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA
NEW DELHI 110011**

TABLE OF CONTENTS

ITEM No.	SUBJECT	PAGE NO.
Part I Summary of the Proceedings		1-14
Part II Resolutions		
Working Group I	Family Welfare Programme & Rural Health Infrastructure	15-32
Working Group II	Medical Education & Other Programmes	33-49
Working Group III	Communicable Diseases Control Programmes	50-69
Working Group IV	Non-communicable Diseases Control Programmes	70-90
Working Group V	ISM and Homoeopathy	91-98
Working Group VI	Special Problems Concerning Health Care and Rural Health Infrastructure of North Eastern States and Sikkim	99-108
Part III Annexure		
Annexure-A	Address by Shri Paban Singh Ghatowar, Union Minister of State for Health & Family Welfare	109-113
Annexure-B	Address by Dr. J.S. Bajaj, Member (Health) Planning Commission	114-125
Annexure-C	Inaugural Address by Shri A.R. Antulay Union Minister for Health & Family Welfare	126-132

Annexure-D	List of Participants	133-166
Annexure-E	Notification reg. Reconstitution of CCH&FW	167-172

SUMMARY OF PROCEEDINGS

SUMMARY OF THE PROCEEDINGS OF THE FOURTH CONFERENCE OF CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE HELD UNDER THE CHAIRMANSHIP OF SHRS A.R. ANTULAY UNION MINISTER FOR HEALTH & FAMILY WELFARE AT PARLIAMENT HOUSE ANNEXE, NEW DELHI FROM 11 - 13TH OCTOBER, 1995.

The Fourth Conference of the Central Council of Health and Family Welfare, which is an apex advisory body, was held at Parliament House Annexe from 11th to 13th October, 1995 under the Chairmanship of Shri A.R. Antulay, Union Minister for Health and Family Welfare. Apart from Shri Paban Singh Ghatowar, Minister of State for Health and Family Welfare, Prof. J.S. Bajaj, Member (Health), Planning Commission, Ministers in charge of the Ministries of Health and Family Welfare, Medical Education and Public Health from the States/Union Territories, Members of Parliament and luminaries in the field of Health and Family Welfare as also Senior Officers from the Centre, States and UTs Administration attended the Conference. List of participants is given at Annexure-D.

Shri I. Chaudhuri, Additional Secretary (Health) in his welcome address stated that the present Conference of the Council was of crucial importance in the context of Health for All by the year 2000 A.D. There have been significant improvements in the health care and vast infrastructure has been built up but the provision of health care in the rural areas and urban slums is far from satisfactory. It is not only essential to control and eradicate communicable diseases; the non-communicable diseases as also those associated with old age needed special attention. He mentioned about the joint sector approach being evolved to pool resources for providing health care services to the poor. The Indigenous Systems of Medicine and Homoeopathy need to be encouraged to provide cost effective health care to the masses. Prevention of food adulteration, quality control of drugs, surveillance and management and information systems are the other priority areas.

Shri J.C. Pant, Secretary (Family Welfare) stated that the Conference of the Council was an important forum for determining the parameters and relationship between the Centre and the States in the implementation of various programmes. An onerous task has been taken up for eradicating Poliomyelitis and this requires cooperation and coordination at both the ends. It is envisaged to replace quantitative targets by the qualitative targets so that the quality of Family Welfare programmes is not compromised. Child survival and safe motherhood is a tremendous task and continued to need special attention. He also stressed the importance of improving the social status of women, raising the effective age

of marriage and delaying the first birth as also proper spacing of children.

Shri Paban Singh Ghatowar, Union Minister of State for Health & Family Welfare while addressing the Council stated that the growth in population has been a matter of serious concern. It is true that there is a marginal decline in the exponential growth rate, but it is still high. He stressed the need for frontal attack on the population problem with the involvement of people particularly in those states where the family welfare programme has not gathered the desired momentum. He lauded the efforts made by the States of Goa, Kerala and Tamil Nadu in bringing down the crude birth rate. He pleaded for the intensification of efforts for reduction of fertility rate in Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh and Haryana.

While a reasonable degree of success has been achieved in controlling the menace of communicable diseases, for control of AIDS multi-pronged action is called for. There is also an urgent need to prevent the rising trend of dental diseases.

He laid particular stress on the traditional systems of medicine such as Ayurveda, Siddha and Unani in addition to Yoga, Naturopathy and Homoeopathy. These systems are relatively cheap and free from side effects. The basic approaches of these systems are holistic and treat the individuals in totality. There is need for proper harnessing of large resource of manpower of Indian Systems of Medicine and Homoeopathy for effective implementation of the National Health Policy. (Full text of the address by the Hon'ble Minister is at Annexure-A).

Prof. J.S. Bajaj, Member, Planning Commission in his address stated that the human development as reflected through social indicators reveal improvements in life expectancy, reduced birth rate, death rate and infant mortality rate. Despite these improvements the present levels of indicators of human development are a cause of continuing concern. There exists large differential between States, large variations between rural and urban areas, gender disparities and wide gaps in infrastructure in different parts of the country. While Kerala and Tamil Nadu have been able to achieve net reproduction rate of unity, there is need to intensify efforts particularly in U.P., Bihar, Madhya Pradesh, Rajasthan and Haryana for reduction of fertility rate so that growth of population is checked.

In the Eighth Five Year Plan a provision of Rs. 7582 crores has been included for the Health Sector both in the Centre as well as States but the utilization of funds by the States during the first 3 years of the Eighth Plan has not been satisfactory. There has been a short fall of about 20-30% in the utilization of funds by Uttar Pradesh, Bihar and Madhya Pradesh. Only Rajasthan has done better. Even the allocations for the Minimum Needs Programme have been reduced. The outlay provided for food security, drinking water, sanitation, education and nutrition etc. also vitally contribute in improving the health status of people. He reiterated that social equity in provision of health care is and shall

continue to remain the responsibility of the State.

While private sector has an important role to play in certain areas, joint sector is also being envisaged as one of the possibilities for augmenting the resources for health care for the under privileged and for poorer sections of the society.

There is a need for inter sectoral coordination and it would be futile to expect the village level functionaries and ANM to coordinate and mount a concerted action for the targeted sections of the vulnerable population. In most of the States, the Panchayati Raj system has come into existence and this should be utilized in supervising, monitoring and managing the primary health care system from the village level. This will also ensure inter sectoral coordination at the village level.

Indian Systems of Medicine and Homoeopathy are widely accepted in the country, specially in the rural, remote and difficult areas. Measures for popularization and development of Indian Systems of Medicine and Homoeopathy need to be vigorously pursued. (Full text of the address is at Annexure-B).

Shri A.R. Antulay, Union Minister for Health & Family Welfare and Chairman of the Central Council for Health & Family Welfare in his inaugural address laid emphasis on the Indian Systems of Medicine and Homoeopathy in achieving the goal of "Health for All". The indigenous systems have developed in the form of organized medical systems of Ayurveda, Siddha, Unani, in addition to Yoga, Naturopathy and Homoeopathy. A lot of interest is being taken in the western world in these systems and we are getting their feed back from the secondary channels.

Shri Antulay admitted that the goal of "Health for All" may be achieved only by the year 2015 or even 2020. In spite of laudable achievements, the health care system in India has several lacunae. The state of primary health centres in India is deplorable and in many cases these centres exist only on paper. Shortage of doctors or drugs compounded the problem. He wanted to make it obligatory for medical graduates to spend a certain minimum period in the rural areas as the society is incurring huge cost on their education and training. The exemption from service in rural areas should be made only in exceptional circumstances as the money paid by them can not compensate for the sufferings of the people in the rural areas. Only then we will be able to provide health care to the last man in the last village.

He visualized an important role for the private sector. The infrastructure and services offered by the private sector can be assessed and treated as equity with matching grants from the Government provided the private sector is willing to set aside 30 to 40 percent of the beds for the poor patients. The equity share of the Government could be in the form of financial support by way of land, building, equipment etc.

Health services need to be provided right from the conception of the child to the death of the person and adequate resources need to be provided for that.

For prevention of food adulteration, a Task Force has been set up under the chairmanship of ex Chief Justice of India Mr. Venkataramiah with eminent lawyers like Ashok Desai, F. Nariman etc. so that they could come out with concrete recommendations and legislation for prevention of this malady.

In most of the States the Panchayati Raj System has come into existence which should be utilized in providing the primary health care system. The Village Health Guide Scheme needs to be revamped and implemented effectively as this will maintain links between the community and the Government agencies.

The entire population of the country needs to be covered by insurance for which we have to take necessary steps. No individual particularly the poor should suffer for lack of medical aid. The contributor may pay some amount and the State may a/so pay some portion. The insurance should be for the sake of health and not for the sake of death. (Full text of the Inaugural Address is at Annexure - C).

Dr. A.K. Mukherjee, Director General of Health Services in his vote of thanks stated that the (deliberations and guidance of the Council will be guiding stones in framing future policies and practices for ushering the new health scenario in the next millennium. India has witnessed extensive and intensive health changes during the last fifty years. The mortality rate has declined by two-third and fertility rate has shown a declining turn. India is passing through an epidemiological transition and both communicable and incommunicable diseases will need attention.

After the Inaugural Session, the Plenary Session of the Conference was held under the Chairmanship of Shri A.R.Antulay, Union Minister for Health & Family Welfare. The Chairman requested the Ministers and representatives of Union Territories to express their views about the Agenda Items as also the problems facing them. The important observations made by Ministers/representatives of States/UT are as under:

POINTS MADE BY STATE MINISTERS/REPRESENTATIVES

Shri Virbhadra Singh, Chief Minister of Himachal Pradesh complimented the Chairman for his inspiring address and exhaustive Agenda Notes. He expressed his anguish over the doctors' unwillingness to serve in the rural areas. He felt that under the present system a medical student has to execute a bond to serve in the rural areas after completing the

course, but the doctors' prefer to work in the urban centres or go abroad. Something has got to be done to make it compulsory for the doctors to serve in the rural areas.

Because of the physical and seasonal conditions peculiar to the State the morbidity profile shows high respiratory infection and water born diseases and these needed urgent attention.

A disaster relief strategy involving Government of India and neighboring States should be formulated so that loss of life during natural calamities is avoided/minimized.

Dr. Wilfred D'Souza, Deputy Chief Minister of Goa stated that the doctors in his State prefer to stay in Goa and are not willing to work in a village even if it happen to be only 50-60 kms away.

Dr. M. Satyanarayana, Minister for Health & Family Welfare of Andhra Pradesh (in absentia) suggested that voluntary organizations should be encouraged to adopt specific backward areas for motivation and services under family welfare programme. He also suggested social marketing of contraceptives in selected districts through public distribution system.

Shortage of doctors is affecting the health care services of the State particularly of women and children. He wanted additional vehicles to be provided for new PHCs as well as enhancement of the maintenance grants.

Dr. Bhumidhar Barman, Minister of Health & Family Welfare of Assam wanted the allocation of funds for the health sector to be raised. North Eastern Council should also help in improving the health care infrastructure in the North Eastern Region.

Shri Mahabir Prasad, Minister of Health & Family Welfare of Bihar stated that the poor people are not getting adequate health care and the reasons for it need to be look into. He wanted that the private practice should be stopped.

Shri Nitinbhai Patel, Minister for Health & Family Welfare of Gujarat pleaded for higher allocation for health sector both at the State and Central level. Accelerating investment in human resources has to be the catch word of the 90's for changing the unsatisfactory scenario in the health sector and to improve the quality of life in rural areas. There is also need for intersectoral coordination. Steep rise in the prices of drugs is creating another major problem.

Smt. Kartar Devi, Health Minister of Haryana thanked the Chairman for his excellent

address as also the comprehensive Agenda drawn up for the Conference. She requested the Chairman for establishment of Family Welfare Bureau in five new districts. She also wanted that the amount for POL to be raised for increasing the mobility of staff. The provision for medicines for each sub centre should be enhanced to Rs. 10,000/-.

Shri A. Mohandas Moses, Advisor to the Governor, J & K pointed out that the timing of the Conference was most appropriate. He indicated that the health infrastructure especially in the Valley has been adversely affected and there are shortages of staff, equipments, vehicles, medical supplies etc. and these need to be attended to urgently. Staff shortage has also affected the medical education and tertiary care in the Valley. Difficulties are also being experienced in getting technicians to attend to the servicing and repair of medical equipments. He also requested for a special allotment of ambulances.

Progress of Family Welfare programme in the State has been badly affected due to lack of adequate funding. The funds released by the Government of India during the last year and current year are not sufficient even to meet the salaries of the staff.

Shri H. C. Mahadevappa, Health & Family Welfare Minister of Karnataka stated that the Agenda Notes prepared for this meeting cover a wide range of subjects and the Notes are quite informative and exhaustive. He pleaded for greater investment by the Centre as well as the States on Health Care.

While a measure of success has been achieved in the areas of public and preventive health, the recent outbreak of plague and malaria are cause for concern. There are deficiencies in the working of PHCs and CHCs. Lack of drugs, equipments and infrastructure facilities further compounded the problems.

There is need for reforms in the health sector and user charges need to be levied; allowing greater flexibility and autonomy to hospitals for raising resources and using funds; contracting out some of the non medical services and encouraging NGOs and private sector to function as partners of the State in the health care.

Shri V.M. Sudheeran, Minister for Health of Kerala wanted additional resources to be allocated for health sector. He also stated that the management of waste from hospitals is a growing problem which needed immediate attention. Management and improper disposal of wastes from hospitals has become a source for several other diseases. Hospital waste requires safe disposal as it may otherwise lead to pollution and spread of dangerous diseases.

He wanted special central assistance for setting up urban primary health centres. Additional vector control units need to be sanctioned for malaria and more active surveillance should be undertaken to keep the disease under control.

Shri Ashok Rao, Minister of Health & Family Welfare of Madhya Pradesh indicated that the demographic indicators for the State do not indicate a very healthy picture and lack of adequate investment in health care infrastructure has been identified as one of the important reason. If necessary, international funding may also be sought for this.

There is a shortage of food and drug inspectors and this deficiency needs to be attended to prevent adulteration of food and production of spurious drugs.

Dr. D.S. Aher, Minister of Public Health & Family Welfare, Government of Maharashtra stated that the timing of the Conference was most appropriate in the context of the Health for All by the year 2000 A. D. He wanted additional resources to be allocated for the health sector and sought greater Central assistance to improve the health infrastructure in urban and rural areas. He also called for assistance for strengthening the facilities for assessing drug qualities and provision of services at the community health centres and the district hospitals. There is need to supply ELISA kits for voluntary testing centres. In order to assess the prevalence rate of T.B., a special survey at the National level needs to be taken up.

Shri D.P. Panmei, Minister of Family Welfare Manipur wanted more family welfare bureau and DIOs for all the Districts. He wanted the present system of providing compensation money to the acceptors of sterilization to be continued. He also suggested for enhancement of the rates to attract more individuals to accept sterilization.

Shri C. Chawngkunga, Minister of Health & Family Welfare, Mizoram stated that the State was fortunate to have a unique set up of voluntary organizations with their branches scattered in all towns and villages. They have been of invaluable help in the implementation of various health programme but their full potential is yet to be tapped and they needed adequate funding for mobilization of the services.

Shri S.K. Sangtam, Minister for Health & Family Welfare of Nagaland pleaded for more resources to be made available to the State for health care.

Shri Jaganath Raout, Minister of Health & Family Welfare of Orissa pointed out that in the poorer States private medical colleges are not coming up due to the inability of the people to pay fancy capitation fees.

Shri Rajinder Singh Rathore, Health & Family Welfare Minister of Rajasthan indicated that the State has enacted the two child norm for members of Panchyat Raj Institutions and Corporations for effective implementation of family welfare programmes.

To reduce gender discrimination against girl child and for better family planning, the Government of Rajasthan has initiated Raj Laxmi Yojna and Old Age Pension Yojna.

To strengthen medical services, current year budget for health services has been increased by 125% for rural areas and 70% increase in overall health budget.

Shri Prasantakumar Sur, Minister-in-charge Health & Family Welfare of West Bengal stated that the inspiring address by the Chairman reflected his dedication for extension of health care facilities to the common man. He pointed out that the stabilization of population is of utmost importance and isolated effort of individual States will not achieve the national goal. A concerted strategy at the national level for the implementation of the family welfare programme is called for. The State is determined to utilize vibrant Panchayat system in rural areas and elected local bodies in urban areas for community participation in health programmes. He appreciated the Central assistance but wanted more funds to be allocated for various health programmes.

West Bengal, North Eastern States, Andhra Pradesh, Karnataka, Maharashtra, Madhya Pradesh and Rajasthan have been reeling under the onslaught of Malaria. In view of the gravity of the situation he wanted 100% assistance for tackling the disease in the tribal block areas. Further the arrangements introduced by the modification in the Drugs and Cosmetics Rules is likely to lead to confusion about the collection, storage and distribution of human blood. Fake medical degrees and diplomas are creating serious problems and it is time that immediate action is taken against this nefarious activity.

Dr. Harshvardhan, Minister of Health & Family Welfare, Delhi drew the attention of the Council towards the preventive measures for cancer control with special reference to banning the use of tobacco.

Shri P. Ananda Baskaran Minister for Health & Family Welfare of Pondicherry requested for the strengthening of machinery for prevention of food adulteration.

Ministers from the States of Orissa, Bihar, Rajasthan and Delhi mentioned about the special initiatives taken for control of Poliomyelitis. The representatives of Ministries of Health and Family Welfare from other States complained of inadequate attention by the Central Government for modernization of blood banks, a sine qua non in the context of threat posed by AIDS, and the time consuming procedure adopted for granting of licenses for blood banks. They also called for greater thrust to measures for mitigating health problems posed by droughts, floods and other natural disasters and revocation of the recent order that prescribes graduation in chemistry as a basic qualification for recruitment of staff for taking samples under the Prevention of Food Adulteration Act. They also suggested encouragement to the Indian Systems of Medicine and Homoeopathy so that the health care services could be extended to the common man. There is need for research and cultivation of medicinal plants and the drugs need to be standardized.

WORKING GROUPS:

The Council decided to set up six Working Groups to discuss the Agenda Items in detail. Each Working Group was headed by a Chairman/Co-Chairman who was the State Health Minister. The Council also decided to set up a separate Working Group for discussing the problems facing the North Eastern Region in respect of diseases control and infrastructure. The Six Working Groups constituted for the purpose along with their Chairman and Co-Chairman is as under.

<i>Working Group-I</i>	<i>Chairman</i>	<i>Co-Chairman</i>
National Family Welfare Programmes and Rural Health Infrastructure	Health Minister Kerala	Health Minister Madhya Pradesh
Working Group-II Medical Education and Other Programmes	Health Minister Karnataka	Minister of State for Health & F.W. Gujarat.
Working Group-III Minister Communicable Diseases Control Programmes	Health Minister Rajasthan	Health Minister Haryana
Working Group-IV Non-Communicable Diseases Control Programmes	Health Minister, Maharashtra	Health Minister Delhi
Working Group-V I.S.M. & Homoeopathy	Health & F.W. Minister West Bengal	Health Minister, Orissa
Working Group-VI Special Problems facing North-Eastern region in respect of diseases control and infrastructure	Health Minister Assam	Health Minister Meghalaya

The Working Groups considered the various Agenda Items and proposed 25 draft resolutions. These were considered in the plenary session held on 13th October, 1995 and after due deliberation and careful consideration the Council came out with final resolutions to be adopted.

In the concluding part Shri A.R. Antulay, Chairman of the Council commended the excellent work done by Dr. A. K. Kundu and his team in the preparation of Agenda Notes, technical papers, organizational and other related activities for making the Conference a grand success.

RESOLUTIONS

Ref. Agenda Item No. I

**PROGRESS OF FAMILY WELFARE PROGRAMME IN
TERMS OF ITS IMPACT ON BIRTH RATE, DEATH
INFANT MORTALITY RATE AND COUPLE
PROTECTION RATE**

RESOLUTION

The Council notes the progress made by different States in achieving the goals of the F. W. Programme set by the National Health Policy. The Council would like to place on record its appreciation of the efforts by the States and UTs in the implementation of the Family Welfare Programme. The Council would like to compliment those States and UTs which have already achieved the goals of 2000 A.D. and those which are very close to these goals. The Council strongly urges the other States to continue their efforts in this direction by according a high priority to population and family welfare programmes.

Ref. Agenda Item No. II

**VARIATIONS IN THE FINDINGS OF NATIONAL FAMILY
HEALTH SURVEY AND COVERAGE EVALUATION
SURVEYS VIS-A-VIS REPORTS SUBMITTED BY
STATES REGARDING IMMUNIZATION STATUS**

RESOLUTION

The Council resolves that reporting and monitoring systems regarding immunization status should be strengthened so that immunization coverage levels in infants and pregnant women are realistically assessed. Over estimation of immunization coverage should be strongly discouraged and avoided.

**REPLACEMENT OF QUANTITATIVE CONTRACEPTIVE
TARGETS BY QUALITATIVE INDICATORS ON PILOT
BASIS; FEASIBILITY OF MAKING AVAILABLE
CONVENTIONAL CONTRACEPTIVES AND ORAL PILLS AS
PRICED COMMODITIES IN THE SAME PILOT AREAS**

RESOLUTION

The Council would like to endorse the initiative taken by the Government of India to replace the quantitative contraceptive targets by qualitative indicators. A few States however expressed a concern that abolition of targets might affect performance and targets fixed by the community would be desirable. The Council would also like to support the efforts to reduce wastage of contraceptives and other supplies and in this regard support the proposed pilot experiment to levy a nominal service fee on the free condoms and oral pills, which can be retained by the service providers. The areas for the pilot experiment be decided in consultation with concerned States. While providing condoms and charging service fee, quality is to be ensured.

Ref. Agenda Item No. IV

**PROPOSED AMENDMENTS TO MTP REGULATIONS
AND RULES FOR CONSIDERATION BY STATE
GOVERNMENTS**

RESOLUTION

The Council resolves to support the modifications/amendments in the MTP Rules & Regulations as proposed by the Government along with the further changes suggested by Council and incorporated in the proposed amendments as in the enclosed statement so as to increase the facilities for safe abortion services.

The Council also takes note of the large number of unsafe abortions taking place and recommends the expansion of safe abortion services especially in the rural areas, in order to safeguard the health of women.

**STATEMENT SHOWING THE MODIFICATIONS/AMENDMENTS IN
THE MTP RULES 1975**

Sl.	Rule	Existing Provision	Modification/Amendments Proposed
1.	Rule 2	Definition in these rule, unless the context otherwise requires.	2(g) add Civil Surgeon
2.	Rule 3	Experience or training etc. for the purpose of clause (d) of Section 2 a registered medical practitioner shall have one or more of the following experience or training in gynecology and obstetrics, namely;	2(h) " Committee be set up at the district level to approve the place for medical termination of pregnancy, chaired by the Civil Surgeon/CMO with specialists in Gynecology and Obstetrics and anaesthesia as members.
		(a) In the case of a medical practitioner who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynecology and obstetrics for a period of not less than three years;	(a) Same as in original
		(b) In the case of a medical practitioner who was registered in a State Medical Register on or after the date of Register on or after the date of the commencement of the Act	(b) In the case of a medical practitioner who was registered in A State Medical Register on or after the date of Register on or after the date of the Commencement of the Act -

			If he has undergone training in medical termination of pregnancy which fulfils the following criteria:
		<p>(i) if he has completed six months of house surgery in gynecology and obstetrics; or</p> <p>(ii) unless the following facilities are provided therein if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynecology:</p> <p>or</p> <p>(iii) if he has assisted a registered medical practitioner in the performance of twenty five cases of medical termination of pregnancy in a hospital established or maintained or a training institute approved for this purpose by the Government.</p>	<p>(i) has performed 10 medical termination of pregnancies under supervision and has assisted in 15 such procedures in a hospital established or maintained, or a training institute approved for this purpose by the Govt.:</p>
		<p>(c) In the case of a medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynecology and obstetrics, the experience or training gained during the course of such degree or diploma.</p>	<p>(c) Same as in original</p>

3.	Rule 4	4.3 On receipt of an application Referred to in sub rule (2) the Chief Medical Officer of the District shall verify or enquire any information contained. In any such application or inspect any such place with a view to satisfying himself that the Facilities referred to in sub-rule (1) are provided therein and that termination of pregnancies may be made therein under safe and hygienic conditions.	4.3 Substitute Committee in Place of Chief Medical Officer.
		4.4 Every owner of the place which is inspected by the Chief Medical Officer of the district shall afford all reasonable facilities for the inspection of the place.	4.4 Substitute Committee in place of Chief Medical Officer.
		4.5 The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or termination of pregnancies may be done under safe and hygienic conditions, at the place, recommend the approval of such place to the Government.	4.5 The committee may, if satisfied after such verification, enquiry or inspection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic conditions at the place, recommended the approval of such place to Chief Medical Officer/Civil Surgeon.
		4.6 The Government may after considering the application and the recommendations of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.	4.6 Substitute Committee in Place of Government.

		<p>4.7. The certificate of approval issued by the Government shall be conspicuously displayed at the place to be easily visible to persons visiting the place.</p>	<p>4.7 Substitute Chief Medical Officer/Civil Surgeon in place of Government.</p> <p>Add 4.8 "The Committee will be given a maximum period of three months time to issue certificate of approval or in default approval will be deemed to have been given. However in such conditions if on later review inspection of such place, if the facilities are not being properly maintained the CMO may temporarily suspend the licenses; report the fact to the committee; for further review and action as indicated in Rule 6.</p>
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SI No	Rule No.	Existing Provision	Modification/Amendments Proposed
4.	Rule 6	<p>Cancellation or suspension of certificate of approval</p> <p>(1) If, after inspection of any place approved under rule 4, the Chief Medical Officer of the District is satisfied that the facilities specified in rule 4 are not being properly maintained there in and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Government giving the detail of the deficiencies or defects found at the place. On receipt of such report the Government may, after giving the owner of the place a reasonable opportunity of being heard, either cancel the certificate of approval or suspend the same for such period as it may think fit.</p>	<p>6. Cancellation or suspension of certificate of approval - modified as follows:</p> <p>(1)(a) If, after inspection of any place approved under rule 4, the Chief Medical Officer/Civil Surgeon is satisfied that the facilities specified in rule 4 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Committee giving the details of the deficiencies or defects found at the place. The Committee will give the owner of the place a reasonable opportunity of being heard, either cancel the certificate of approval or suspend the same for such a period as it may think fit. This information will be intimated to the State authorities</p>
			<p>Add 6(1) (b) "If the owner of the place is not giving monthly information as required under subsection 7, 1 (b), the Chief Medical Officer/Civil Surgeon shall report the matter to the Committee which may suspend the approval of the place for such a period as it may think fit."</p>

5.		<p>(2) Where a certificate issued under rule 4 is cancelled or suspended, the owner of the place may make such additions or improvements in the place as he may think fit and there after, he may make an application to the Government for the issue to him of a fresh certificate of approval under rule 4, or, as the case may be, for the revival of the certificate which was suspended under sub-ruled (1).</p>	<p>(2) Substitute Chairman of the Committee in place of Government. Add 6(c) in case of rejection of his application for issue of certificate for approval by the Chief Medical Officer/Civil Surgeon, the owner of the place may appeal to Director/Additional Director, Family Welfare of the State for reconsideration of his application.</p>
	Rule 7	<p>Review</p> <p>7(1) The owner of a place who is aggrieved by an order made under rule 6, may make an application for review of the order to the Government within a period of sixty days from the date of such order.</p> <p>7(2) The Government may, after giving the owner an opportunity of being heard, confirm, modify or reverse the order</p>	<p>7(1) Substitute Committee in place of Government.</p> <p>7(2) Substitute Committee in place of Government.</p>

**STATEMENT SHOWING THE MODIFICATIONS/AMENDMENTS IN THE
MTP REGULATIONS 1975**

Sl. No.	Existing Provision	Modification/Amendment Proposed
1.	<p>(d) "Chief Medical Officer of the State" means the Chief Medical Officer of the State, by whatever name called;</p> <p>(f) "hospital" means a hospital established or maintained by the Central Government or the Government of Union territory;</p>	<p>(d) Chief Medical Officer of the district "means the Chief Medical Officer of the district, by whatever name called.</p> <p>(f) Add Private practitioner/NGOs of the Union Territory.</p>
2.	<p><u>Custody of forms:</u></p> <p>(1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under Section 3 or Section 5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelop which shall be sealed by the registered medical practitioner or practioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place of the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.</p> <p>(2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under Section 3, there shall be noted the serial number assigned to the pregnant woman in the Admission Register and the name of the</p>	<p>(1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under Section 3 or Section 5 as the case may be placed in an envelope which shall be sealed by the registered medical practitioner or practitioners by whom such termination of pregnancy was performed shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be and the same is asked for by the Chairman of the Committee.</p> <p>(2) Deleted</p>

	registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET"	
	(3) On every envelope referred to in sub-regulation (2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.	(3) Deleted
	<p>(4) On receipt of the envelope referred to in Sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.</p> <p>(5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, a weekly statement of cases where medical termination of pregnancy has been done in Form II.</p>	<p>(4) Deleted</p> <p>(5) Substitute State by District and weekly by monthly</p>
	<p>(6) On every envelope referred to in Sub-regulation (1) pertaining to a termination of pregnancy under section 3, shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and the envelope shall be marked "SECRET".</p> <p>Explanation - The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant women in the Administration Register shall be left blank in Form I in the case of termination performed under Section-5.</p>	(6) Deleted

	<p>6. Admission Register not to be open to inspection - The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorized by such head or owner and save as otherwise provided in Sub-regulation (5) of regulation 4 shall not be opened to inspection by any person except under the authority of:</p> <p>(i) in the case of a departmental or other enquiry, the Chief Secretary to the Government of a Union Territory:</p>	<p>As in original.</p> <p>(i) In the case of a departmental or other enquiry, the District Collector.</p>
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Ref. Agenda Item No. V

**IMPLEMENTATION OF PRE-NATAL DIAGNOSTIC
TECHNIQUES (REGULATION AND PREVENTION OF
MISUSE) ACT, 1994**

RESOLUTION

The Council resolves that appropriate authorities be appointed and advisory committees be constitute immediately of the coming into force of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 and rules there under and FURTHER RESOLVES all action as may be called for be taken ensure effective implementation of the Act and Rules, including building up a strong public opinion against the misuse of Prenatal Diagnostic Techniques which go against gender equality and equity and create an imbalance in sex ratio.

**INCREASING THE EFFECTIVE AGE AT MARRIAGE
AND PROMOTING INFORMATION EDUCATION &
COMMUNICATION IN THE COMMUNITY TO DELAY
THE FIRST BIRTH**

RESOLUTION

The Council resolves that

- (a) Appropriate communication strategies involving the community be adopted for the message on the advantages of girl marriage at eighteen and above for the health of both mother and the child. Delayed first birth should be strongly promoted.
- (b) Community acceptance for at least five years spacing between two births be created. Increased financial provisions be made both at the Central Government, State Government /U.T. level for this purpose.
- (c) Such schemes as would make it attractive to delay the effective age at marriage and delay the first birth be promoted.
- (d) Flexibility to the State Governments to spend the I.E.C allocation according to its needs be given.
- (e) Doordarshan (national and regional level) to give five minutes free time daily during prime time for socially relevant messages on family welfare, and
- (f) Compulsory registration of marriages is recommended.

**REVIEW OF CHILD SURVIVAL AND SAFE MOTHERHOOD
INTERVENTIONS; ADEQUACY, AVAILABILITY AND
IMPROVEMENT OF EXISTING SERVICES; EXPLORING
ALTERNATIVE STRATEGIES FOR SERVICE DELIVERY
THERE OF**

RESOLUTION

The Council resolved that :-

- (a) Para-medicals be given training to identify high risk cases early during pregnancy.
- (b) Specialists be posted at the Community Health Centres (CHCs)/FRUs for the management of obstetric emergencies.
- (c) At least 4 to 6 sub-district level health institutions be established as first referral units (FRUs) in each district.
- (d) Dai training be taken up as a time bound programme to ensure universal access to all pregnant women by trained birth attendants by the end of 1996.
- (e) Delivery rooms be constructed at sub centres and villages where such facilities do not exist, through Rural Development Schemes and steps be taken to promote clean delivery practices through other Schemes.
- (f) The goal of universal coverage of all pregnant women with 1 FA tablets to prevent maternal deaths due to severe anemia is implemented by December, 1996.
- (g) Essential new born care practices be universalized to reduce pre-natal and neonatal mortality rates by December 1997.

- (h) Pulse Polio Immunization campaigning be sustained to achieve Polio mylities eradication by 2000 AD, 100% immunization for all vaccine preventable diseases should be achieved and sustained.
- (i) Health education messages should emphasize importance of nutrition and rest during pregnancy; conduction of deliveries by trained dais or health personnel and advance arrangements for transportation to a hospital in case of an obstetric emergency be ensured.
- (j) Males in the family and the community share the responsibilities of childbirth and play and active role in ensuring safe deliveries.
- (k) Establishment of Baby -friendly Hospitals be encouraged.

AGENDA ITEM NO VIII

RURAL HEALTH INFRASTRUCTURE

- a) UPGRADATION OF FACILITIES AT COMMUNITY HEALTH CENTRES FOR APPROPRIATE REFERRAL CARE FOR PREGNANT WOMEN; ESTABLISHMENT OF PRIMARY HEALTH CENTRES AT 30,000 POPULATION FOR PROVIDING SERVICES TO MOTHERS AND CHILDREN.
- b) POSTING, DEPLOYMENT AND FILLING OF VACANCIES OF SPECIALISTS AND DOCTORS AND MPWs (MALE) TO PROVIDE PRIMARY HEALTH CARE TO RURAL POPULATION.

RESOLUTION

The Council notes with concern the deficiencies in the implementation of the Family Welfare Programme pointed out by the Parliamentary Standing Committee on Human Resources Development, and

Resolves that effective steps be initiated to:-

- (i) Fill up all vacancies of medical and Para-medical staff at Sub-Centres, PHCs and CHCs;
- (ii) Engage private doctors, retired doctors etc. on part-time/contractual basis to overcome the problem of vacancies in rural areas till the posts are filled up on a regular basis;
- (iii) Form District Health and Family Welfare Societies, wherever necessary, capable of receiving funds directly from the Government of India, States and other sources.
- (iv) Devolve powers and responsibilities in the health and family welfare sector to Panchayati Raj bodies and Nagarpalikas along with financial resources;

- (v) Increase the budgetary provisions by Centre and States for supply of medicines at Sub-Centres, PHCs and CHCs;
- (vi) Release Central assistance on time to operational agencies like CHCs/PHCs from the State level;
- (vii) Computerized Health Management Information System be introduced as early as possible in to the Health and Family Welfare Programme so that more effective monitoring of the programmes could be effected;
- (viii) Revise the norms applicable to NGO-run schemes and make finance available to such NGOs on time;
- (ix) To give flexibility to States in the utilization of Central assistance;
- (x) Associate ISM & Homoeopathy Practitioners in Health and Family We/fare Programme.

AGENDA ITEM NO. IX

INVOLVEMENT OF PANCHAYATS IN THE MANAGEMENT AND ADMINISTRATION OF PRIMARY HEALTH CARE INSTITUTIONS

RESOLUTION

The Council resolves that

- (i) In order to meet the shortage of allopathic doctors in the rural areas, suitable amendments be brought into the M.C.I. regulation that a permanent registration will be given to M.B.B.S. doctors only after they have served at least for 3 years in rural areas notified by State Government
- (ii) States consider entrusting the power of appointment of doctors to Zilla Parishads Panchayats at District levels.
- (iii) States take early action to transfer appropriate powers and responsibilities along with financial resources to panchayats at various levels.
- (iv) States take early action to upgrade facilities at Community Health Centres/other referral units and establish PHCs as per norm.
- (v) Financial allocation for health and family welfare be substantially increased by Central/State/UT Governments.
- (vi) Urban Primary Health Care System is introduced on priority to cater to the health care needs of the urban poor.
- (vii) Panchayats be empowered to manage and administer Primary Health Centres and that adequate financial resources be made available to them for effective monitoring and management of primary health care.

Ref. Agenda Item X

PANCHAYAT SWASTHYA SEWA SCHEME

RESOLUTION

Working Group-I resolves not to introduce the new village health guide scheme. In so far as the existing village health guide scheme is concerned, it is left to the State Government to take a decision.

The Working Group resolves further that available resources be used to strengthen the existing health infrastructure and not to introduce new agencies. However, the chairman of the Council advised that this is to be reconciled.

STRENGTHENING OF DRUG QUALITY CONTROL PROGRAMME

RESOLUTION

To ensure uniformly effective control on quality and safety of Drugs and Pharmaceuticals in the country, the Council resolves that:

1. The Pharmaceutical Industry be brought under the Ministry of Health & F. W. after consultation with the Cabinet, if necessary for better monitoring of availability essential drugs
2. The Drug Control Machinery in States as well as Centre be expeditiously strengthened as per recommended norms and the formation of the National Drug Authority as announced under modified drug policy also be expedited.
3. The enforcement and testing personnel working in Drug Control Organization should undergo regular training to keep pace with the advances in Pharmaceutical Sciences. Services of educational institutions and Research Laboratories may also be effectively utilized for this purpose.
4. The State Drugs Controllers shall ensure that manufacturers of drugs and pharmaceuticals strictly follow the Good Manufacturing Practices (GMPS) as laid down in the D & C Rules, 1945 for achieving quality standards of drugs and pharmaceuticals as decided in the Drug Consultative Committee (DCC).
5. Once a harmful/irrational formulation is banned on the recommendation of the experts, under the provisions of the Drugs and Cosmetics Act, 1940 and Rules made there under, the concerned State Drugs Controller shall ensure that the formulation does not move in the market.
6. With regard to the licensing and renewal of licenses of notified drugs viz. Large Volume Parenterals (LVPs), Blood and Blood Products, Vaccines and Sera and Blood Banks, the State Licensing Authority shall ensure the adherence of the protocol relating to inspections prepared by the Drugs Controller of India who is

the Central License Approving Authority (CLAA). The D.C.C. should streamline the procedures so as to avoid any possible delay in licensing of such establishments. The licensing authorities may also give some time to the existing Blood Banks in respect of requirement of space. Applications for licenses cleared by State, and forwarded to the Centre, be dealt with expeditious/y. If within three months no response is received, the State may presume that Centre's clearances has been accorded.

7. State Licensing Authorities shall constitute their own teams of technical experts for advice on rationality of formulations as well as to assist in joint inspection of "notified" drugs.
8. State Drugs Controllers, in-coordination with the police authorities, shall form a Mobile Squad for unearthing spurious drugs.
9. The financial inputs extended by Central Government for augmenting the drug testing facilities under Centrally Sponsored Scheme in the States shall be properly utilized and such utilization certificates shall be sent promptly to Central Government for considering further grants.

**STRENGTHENING OF PREVENTION OF FOOD ADULTERATION
PROGRAMME**

RESOLUTION

The Council having reviewed the functioning of the Prevention of Food adulteration programme resolves that:-

1. The States/UTs which are yet to establish separate Departments for the Prevention of Food Adulteration Programme should immediately set up a PFA Cell/Wing at the Headquarters under the Food (Health) Authority headed by a whole time Officer of the rank of Director or Additional Director of Health Services, for regular monitoring and coordination of the PFA Programme.

Further, the States/UTs are urged upon to create adequate number of posts of Food Inspectors and ancillary staff for proper enforcement of the PFA Act.

2. Augmentation of food laboratories with trained manpower and sophisticated equipments be given top priority. Funds for sophisticated equipments provided by the Central Government under the Centrally Sponsored Schemes be fully utilized for this purpose.
3. Licensing provisions under States PFA Rules be strictly enforced.
4. State Prevention of Food Adulteration Rules be updated and copies be made available to the Central PFA Division for examination, as desired by the Committee on Sub-ordinate Legislation of Parliament.
5. All possible measures be adopted to minimize delay in launching prosecutions for the offenses under the Prevention of Food Adulteration Act, 1954 and the subsequent follow up. Special trial courts/Mobiles courts for quick disposal of PFA Cases be set up as suggested by the Committee on Subordinate Legislation of Parliament.

6. Cases of food poisoning be regularly monitored and feed back be provided to the Central PFA Division.
7. Regular Periodical meetings of the Food Advisory Committee be convened for reviewing the programme of implementation of the Food Laws in the States/UT.
8. Special attention be paid to ensure the hygiene standards and quality of street food served by the vendors at Bus Stops, Railway Stations, in and outside Schools/Colleges and Cinema Halls and in every District.
9. Information Education and Communications (IEC)/activities be intensified for creating Consumer Awareness. Active involvement of NGOs be ensured.
10. The training facilities provided by the Central Government for various functionaries be fully utilized.
11. Periodical Reports (i.e. Monthly and Annual Reports) on the working of the PFA Act be made available to Central PFA Division in time so that information on questions on the subject raised in Parliament from time to time could be supplied.
12. Immediate steps be taken to suitably strengthen the PFA Division in the Directorate General of Health Services with full fledged Secretariat for the Central Committee for Food Standards and its Sub-Committee.
13. Zonal Offices be established for proper co-ordination between the Central Government and States/UTs. Additional Central Food Laboratories be set up.
14. Appropriate infrastructure with respect to manpower and equipments be provided to National Codex Committee for coordinating with international Agencies like Codex Alimentarius Commission of FAO/WHO, formulating of Standards of Food at the international level.

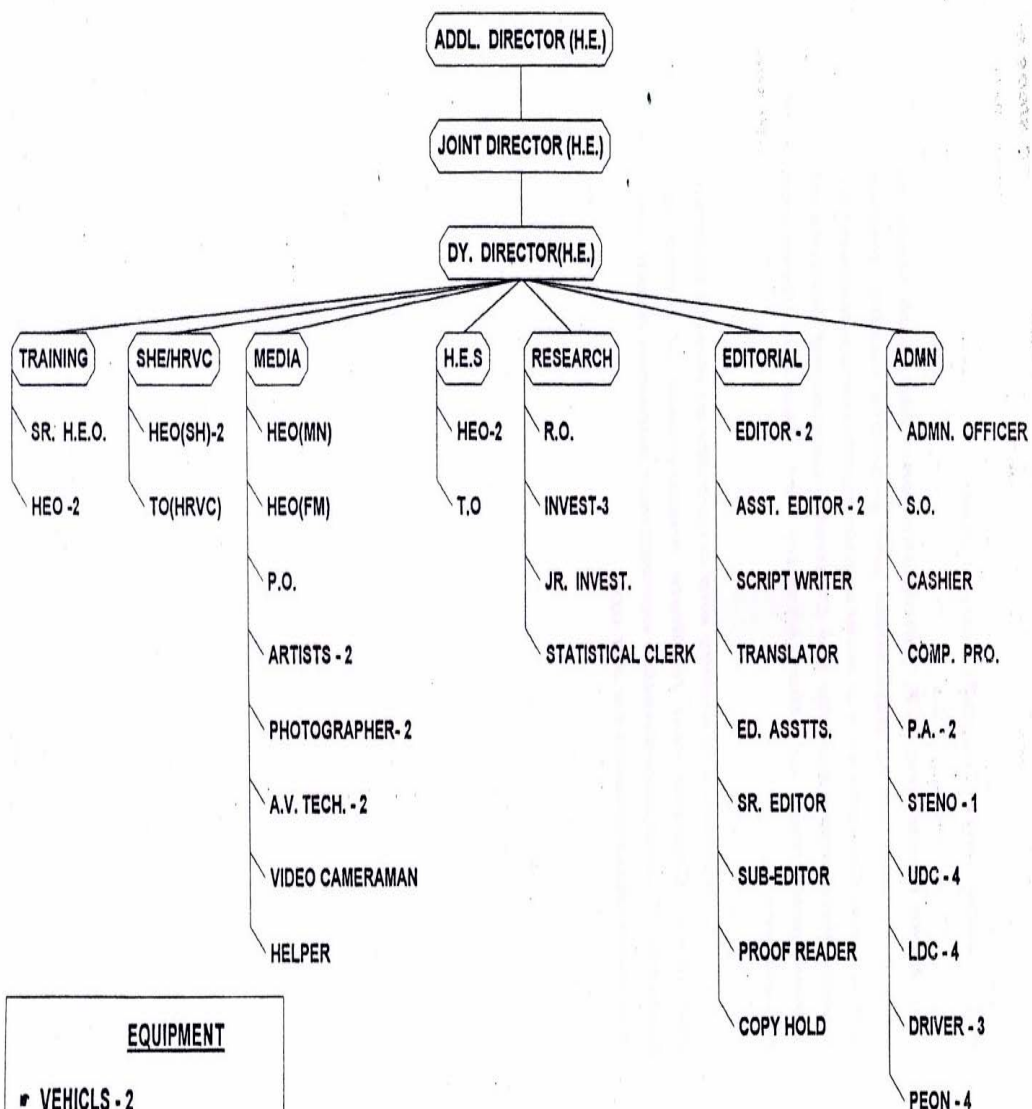
**HEALTH EDUCATION VIS-A-VIS PROMOTION OF HEALTH RELATED
VOCATIONAL COURSES & STRENGTHENING OF STATE HEALTH EDUCATION
BUREAUX**

RESOLUTION

- I. The Council having deliberated upon the existing status in the field of health education in the Country, and considering that health education provides motivation for self-health care and community participation to achieve the objectives of National and other health programme leading to realization of goal of health for all resolves that;
 - a. The Central and State/UT Health Education Bureaux be structured and strengthened as per the suggested pattern by the CHEB and implement the recommendations of 1985 regarding Health Education.
 - b. In view of optimal utilization of available resources a mechanism to establish functional coordination activities and funds between SHEBs and IEC Bureau be set up in all States and UTs preserving structural identities of the two Bureau as far as possible.
 - c. In order to provide leadership in health education to begin with all incharges of SHEBs should be trained at the CHEB within six months of their posing with SHEBs.
- II. Considering that Para-medical services form the backbone of Medical Services and health sector has not been able to train enough para-medical technician, the Council resolves that:
 - a. The State Govts and U. T. Administrations take such steps as may be called for to popularize and promote Health Related Vocational Courses at +2 levels within institutions approved by health departments under the centrally sponsored Scheme of Vocationalisation of the Ministry of Human Resource Development.
 - b. In order to improve the quality and credibility of Health Related Vocational

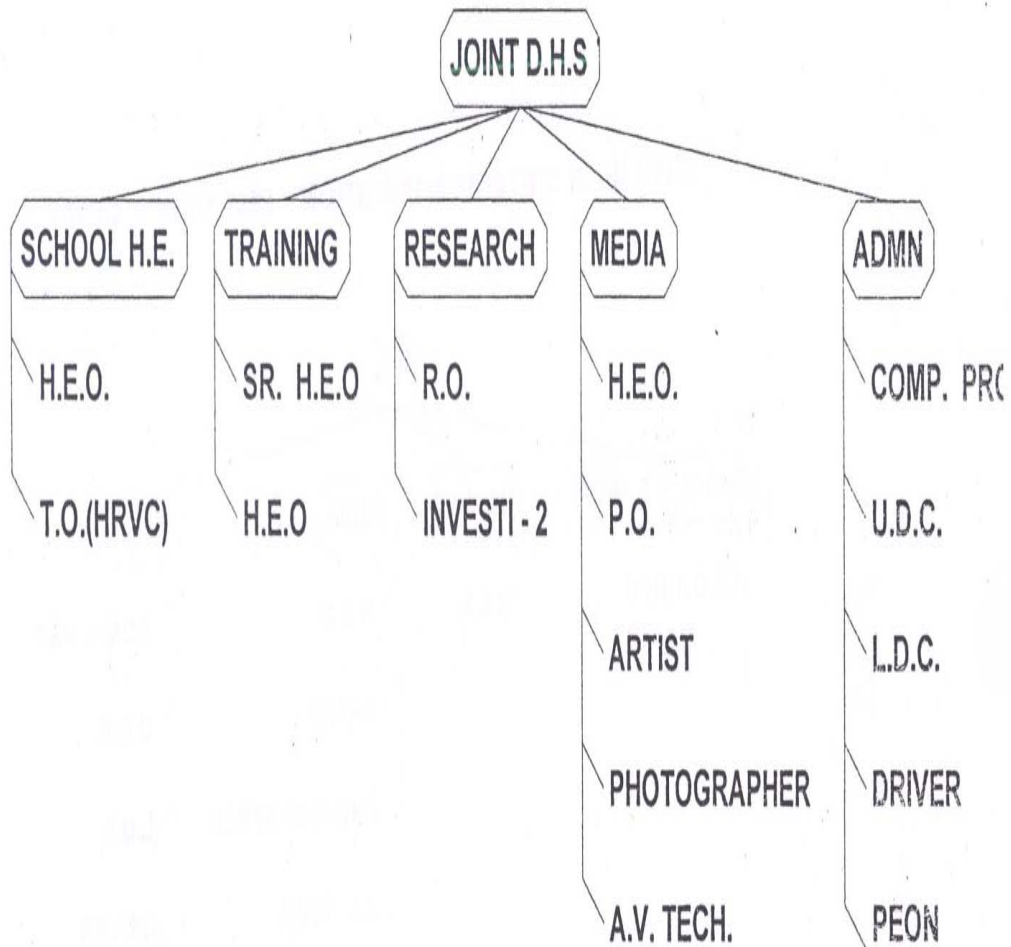
Courses and facilitate employment of pass outs, States/U T. level coordination committees between health and education departments be set up.

SHEB WITH STATE/UT POPULATION - 8 CRORE & ABOVE



EQUIPMENT

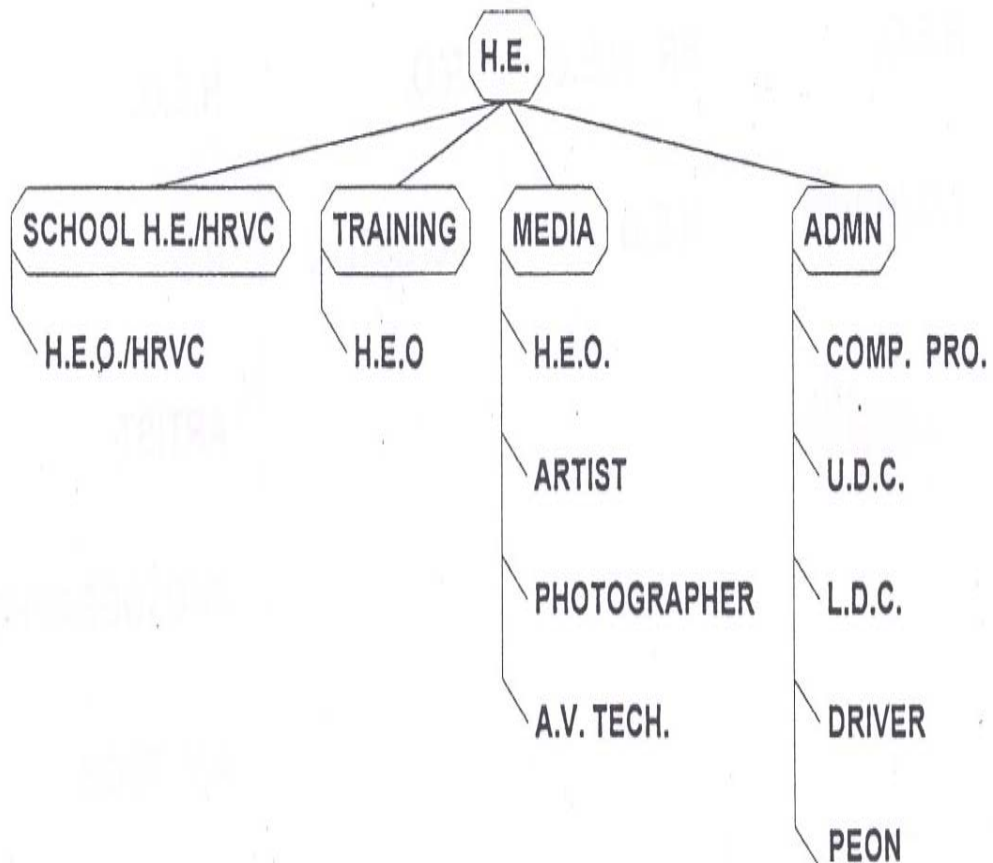
- VEHICLES - 2
- P.C.
- XEROX MACHINE - 2
- ELECTRONIC TYPE WRITER
- A.V. EQUIPMENT
- FAX MACHINE



EQUIPMENT

- VEHICLES -2
- P.C.
- XEROX MACHINE
- ELECTRONIC TYPE WRITER
- A.V. EQUIPMENT
- FAX MACHINE

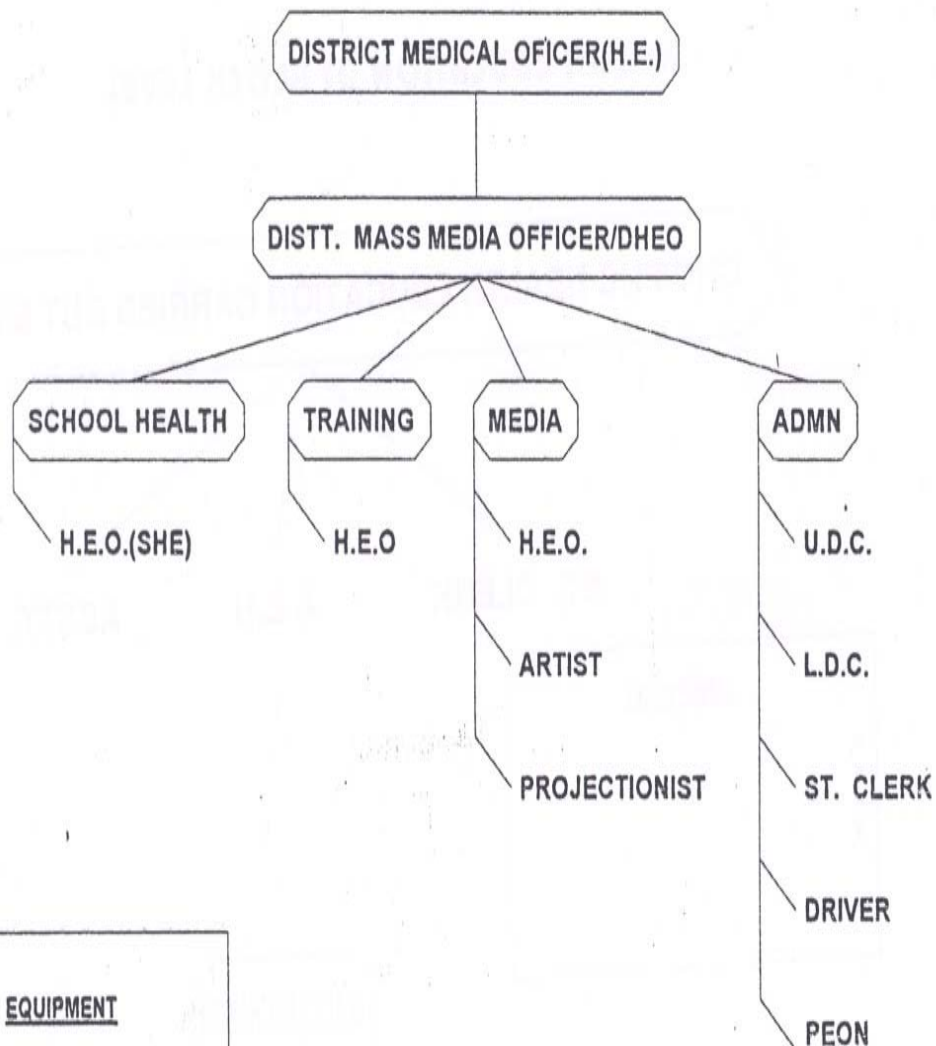
SHEB WITH STATE/UT POPULATION - LESS THAN 2 CRORE



EQUIPMENT

- VEHICLES
- A.V. VAN
- VIDEO ON WHEELS
- P. COMPUTER
- XEROX MACHINE
- FAX MACHINE

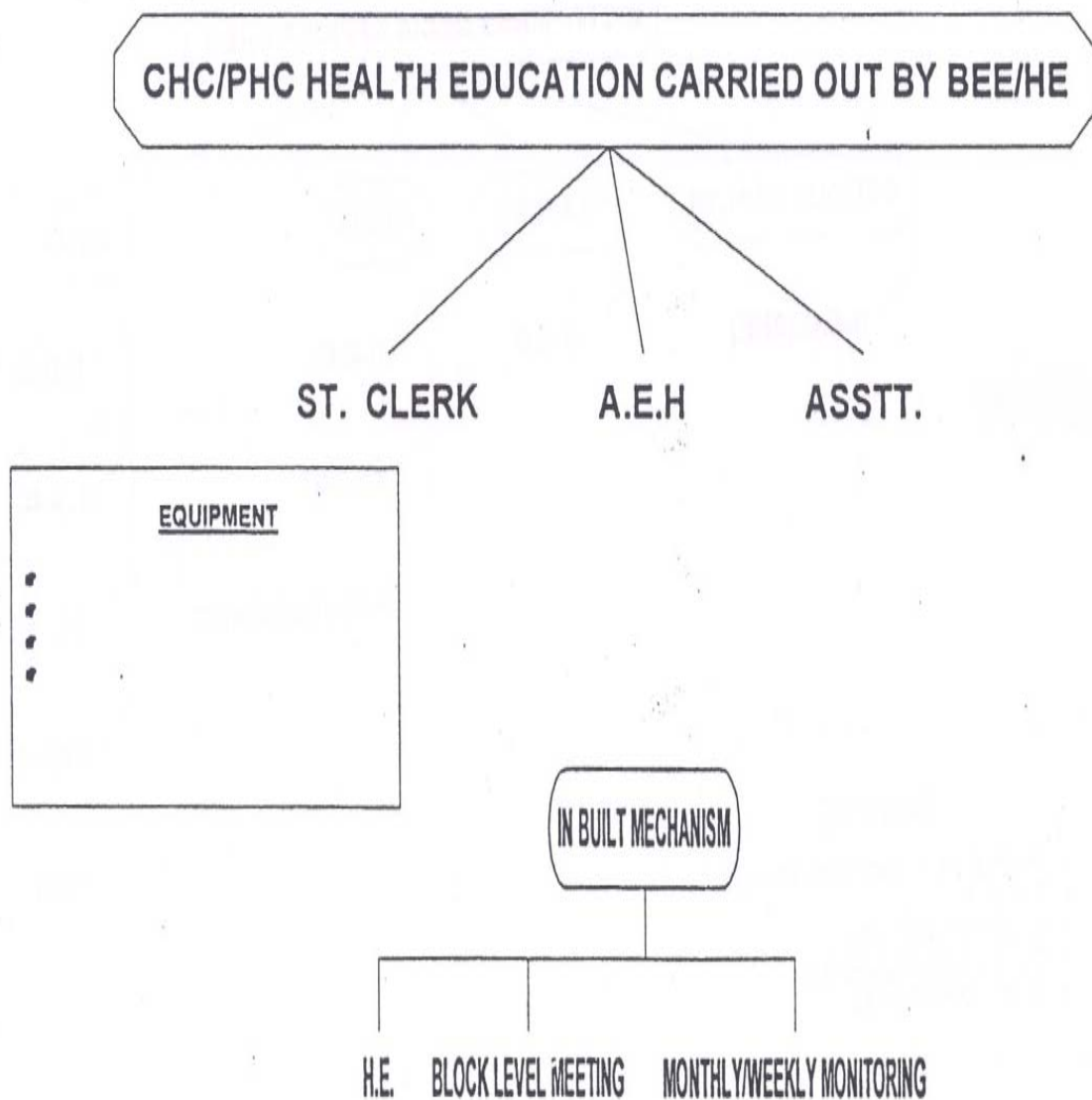
SHEB WITH STATE/UT POPULATION - LESS THAN 2 CRORE



EQUIPMENT

- MOBILE VAN - VIDEO ON WHEELS
- T.V. VCR
- SLIDE PROJECTOR
- OVER HEAD PROJECTOR
- PRINTED MATERIAL

HEALTH EDUCATION AT BLOCK LEVEL



**FORMULATION OF NATIONAL POLICY ON HEALTH AND
MEDICAL EDUCATION, INCLUDING ESTABLISHMENT OF
EDUCATION COMMISSION IN HEALTH SCIENCES AND
DEVELOPMENT OF MANPOWER CELLS AT THE CENTRE
AND THE STATE LEVEL**

RESOLUTION

1. The Council having noted the steps taken by the Central Government in establishment of Education Commission in Health Sciences resolves that the Central Government may establish an Education Commission in Health Sciences immediately, after necessary legislation.
2. The Council appreciates the establishment of the Universities of Health Sciences by Andhra Pradesh and Tamil Nadu Governments. The Council notes that some other States, namely Madhya Pradesh, Maharashtra, Bihar Kerala and Karnataka are already on the way for the establishment of such Universities in their States. The Council resolves that other States should also establish such Universities at the earliest.
3. The Council resolves that an assessment of manpower is required of all categories of medical and Para-medical personnel and this should receive high priority in near future. Appropriate machinery at Centre and State-level should be established and supported.
4. The Council notes with concern the acute shortage of nurses in the country and recommends that nursing education (both in general nursing and specialized nursing) training be given high priority by opening more nursing educational institutions by adopting the norms as suggested by Health Manpower Planning Committee so that the Existing gaps are bridged within a short period. The existing schools of nursing and colleges of nursing may be expanded depending upon the needs, and strengthened with a view to improve the quality of training.
5. The Council notes that there is an acute shortage of Para medical personnel like laboratory technicians, radiographers, male multipurpose workers, physiotherapists, etc, in most of the States and recommends that full utilization of the existing health related vocational courses at 10 + 2 level be made so that adequate trained manpower of appropriate category is available.
6. Government of India may support the State Governments for admission of Non Resident Indians (NRIs) in State Government Medical Colleges. The details may be worked up by a Committee keeping in view the judgments of the Hon 'ble Supreme Court on the issue. Such admissions shall depend upon the provision of extra seats for NRIs after fulfilling the norms prescribed by Medical Council of India and obtaining approval of the Central Government.

7. The Council notes with great concern the severe scarcity of doctors in rural areas and recommends that rural posting for a specific period be made compulsory and also a pre-requisite before admission to post-graduate courses.

HEALTH SECTOR DISASTER MANAGEMENT

RESOLUTION

The Council taking note of the increasing number of crisis situations (natural and man made in India and views with great concern the resulting human sufferings, disruption of public health and public utility services like water supply and sanitation thus creating favorable environment for outbreak of diseases/epidemics and impeding development activities; and

Taking note of the potential risk of industrial accidents with the increasing number of industries, so important for the economy;

The Council resolves that the existing health delivery system be strengthened to meet the health and medical care needs of the population exposed to crisis situations/disasters. In this direction, the Council specifically recommends for:

- I. Effective implementation of health sector emergency contingency plan for crisis management be drawn up for district, state and national levels and kept in readiness for being put into operation at a very short notice. The contingency plans may also be reviewed periodically for effectiveness, and modified wherever necessary.
- II. Noting that the three phases of disaster (Pre-during and post), management requires concerted and co-ordinate activities among various agencies, namely Health, Public Health Engineering Food, Civil Supplies, Armed Forces and Non-government Organizations, the Council recommends the establishment of a coordinating mechanism between different agencies/departments in the health sector – public health, medical care, health administration, medical colleges and also between the health and the health related sectors, as stated above at PHC, district, state and national level.
- III. Establishment of a Control Room to monitor health related issues such as disease occurrence, movement of health personnel, supply of drugs, vaccines and other materials. The information must flow both ways to facilitate early warning, preparedness and response.
- IV. Strengthening of Disease Surveillance Mechanism (Pre, during and post disaster) at the sub centre, primary health care centre, district and state levels. For this purpose, the States should be encouraged to reorient the existing surveillance mechanisms by providing funds, equipment and training of personnel.
- V. Development and implementation of hospital emergency contingency plan for management of mass casualties at different levels. PHC, CHCs, district hospitals and tertiary level hospitals including medical college hospitals. The required expertise, education and training should be provided to the concerned category of medical, para-medical and health personnel by the Central Government.

- VI. Creation of the special contingency fund at district, state and national level exclusively to be used for health sector to meet immediate medical and public health needs of the affected population during crisis situations.
- VII. With the ever increasing crisis situation in view, as well as to meet public health needs of the vulnerable population, the Council recommends a time bound action plan within the Eighth Five Year Plan and the review of the action plan in the subsequent meetings of CCH & FW.
- VIII. In view of the increasing number of accidents in the country, accident and trauma services be made available on National and State Highways as a part of disaster management system.
- IX. The Council notes with concern the progressive increase in the number of road accidents and deaths due to such accidents in the country and recommends that the Govt. to formulate an "Accident Policy" laying stress, inter-alia, on prevention of accidents and providing adequate facilities for treatment.

**PREVENTION OF AIDS AND NATIONAL AIDS CONTROL
PROGRAMME**

RESOLUTION

(i) PROGRAMME MANAGEMENT

1. The Council resolves that Empowered Committees at State Level be reconstituted under the Chairmanship of the Secretary, Department of Health with representatives from the Finance and other concerned Departments and suitably delegated financial and administrative powers so that their decisions are final and put to speedy implementation immediately.
2. The Council resolves that each State/UT should immediately identify an adequately senior level officer and make him responsible for the implementation of the Programme exclusively.
3. The Council resolves that it may be understood by all that the implementation of Prevention and Control of AIDS Programme is primarily the State's responsibility and the Central assistance should be treated as an additional support.
4. The Council resolves further that States may consider to implement the Programme through the District Health Societies and to release funds directly to these Societies. The Programme should be got implemented by involving the Gram Panchayats also.

(ii) BLOOD SAFETY

5. The Council resolves further that all units of blood/blood products used for transfusion purposes be tested for all blood transmissible infections namely, HIV, Hepatitis and Syphilis so as to ensure the blood transfused is free from these infections.
6. The Council resolves that all the blood banks should strengthen their infrastructure immediately so as to ensure that they meet the licensing requirements as per the criteria laid down under the Drug and Cosmetics Act/Rules. The Act/Rules should be suitably modified so that the States/UTs are also empowered to grant licenses.

(iii) SEXUALLY TRANSMITTED DISEASES.

7. The Council resolves 'that all the existing STD Clinics should be strengthened both in terms of manpower and diagnostic facilities and the medical and para-medical personnel up to the peripheral level be given proper training and orientation in the syndromic approach for early diagnosis and prompt treatment of STD cases.

(iv) INFORMATION, EDUCATION AND COMMUNICATION

8. The Council resolves, that the I.E.C. activities at all levels be stepped up to create adequate awareness for prevention and control of AIDS since there is no cure/vaccine at present.' District level I.E.C. action plans should be formulated and implemented immediately.
9. The Council resolves that AIDS prevention education should form part of educational curriculum at appropriate level in schools and colleges.
10. The Council resolves that social counseling be developed and introduced at all levels including district and periphery, with the objective of prevention of further spread of the disease and at the same time educating the people that innocent persons can also be infected with HIV/AIDS and hence should not be ostracized but treated with love and compassion.
11. The Council resolves that steps should be taken to involve NGOs/Voluntary Organizations/Joint Sector in a larger way in IEC activities.

(v) CLINICAL MANAGEMENT, HOSPITAL INFECTION CONTROL AND RESEARCH

12. The Council resolves that Centre, States/UTs shall provide non-discriminatory medical care to the persons infected with HIV/AIDS.
13. The Council taking note o the fact that Hospital Infection Control and hospital waste management are essential to ensure that infections including HIV infection do not occur accidentally in the health care system resolves that. Hospital Infection Control and waste management will be strengthened at all levels of health care.
14. The Council resolves that the Research Laboratories at the National Institute of Communicable Diseases (NICD), New Delhi and National AIDS Research Institute (NARI), Pune be further strengthened to extend their activities to cover operational research in the field of HIV/AIDS.

NATIONAL TUBERCULOSIS CONTROL PROGRAMME

RESOLUTION

The Council reviewed the National Tuberculosis Control Programme (NTCP) and was concerned about the increasing threat of TB-HIV co-infection, emergence of multi-drug resistant strains of Tuberculosis and low cure rates under the NTCP. The Council expressed an urgent need to strengthen the programme in order to prevent further deterioration in the Tuberculosis situation. The following resolutions are passed by the Council.

1. **Notifiable Disease:** That Tuberculosis should be made a notifiable disease so that all cases detected by different institutions (Government & Private) are reported to the programme.
2. **Increase Budget Allocation:** The Council recommends the Central and State Government to increase the Budget Allocation for Tuberculosis, at least to the extent of providing Standardized Short Course Chemotherapeutic drugs to all patients put on treatment under the NTCP.
3. **Early Detection & Cure:** That effort be made to cure at least 85% of all sputum positive cases and to detect at least 70% of the estimated incidence through the primary health care approach, involving the peripheral health functionaries.
4. **Infrastructure:** The States/UTs fill-up all vacant posts in the State TB Training Centers, District TB Centres and the staff in the Peripheral Health Institutions on priority basis and appropriately train them at the State and National Training Institutes. The diagnostic services at the PHC level should be strengthened for quality sputum microscopy.
5. The Council recommends the Centre/State Govt. to ensure timely, adequate and uninterrupted supply of anti-TB drugs to the most peripheral areas by simplifying and gearing up the administrative procedures involved in the procurement and supply.
6. **NGOs & Private Sector:** Efforts should be made to involve the NGOs and Private Sector in the NTCP. The Council recommends that necessary steps must be taken in this direction by the Centre/States.
7. That short Course Chemotherapy is introduced in each district expeditiously to cover at/least all sputum positive patients.

8. That mobile TB clinic at district level is provided for extension of services to inaccessible areas.
9. That IEC activity is further intensified to improve case-finding and patient compliance.

NATIONAL MALARIA ERADICATION PROGRAMME INCLUDING KALA-AZAR CONTROL PROGRAMME

RESOLUTION

1. Taking note of the fact that 10% of the total malaria incidence of the country is being contributed during the recent years by the 130 cities where Urban Malaria scheme (UMS) is in operation to monitor the Scheme and undertake the control measures; and also considering the fact more and more human population is migrating to urban areas causing mushrooming of slum areas etc., and also realizing the fact that control of public health problem like malaria in the urban situation warrants priority,

The Council recommends that the state and local self administrations accord priority to proper water disposal and perfect sanitation and also supplement the malaria control measures by implementing Active Case Detection (Active Surveillance) in peri-urban slums. The Council urges the states to ensure early measures in the form of model bye-laws and its implementation.

2. Having noted the fact that for the effective implementation of malaria control measures, planning and monitoring at district level are essential as also felt by the Malaria Expert Committee (January, 1995), the Council recommends that the state Governments take immediate steps to build epidemiological capabilities at district level by providing trained public health specialists and epidemiologists. Ancillary components to assist the district epidemiological cell may also be provisioned.
3. Having appreciated that the long felt need of training and re-training of personnel at different echelons, is required to be met with urgently, since the control approaches of vector borne diseases like malaria and their epidemiology have been subjected to various changes.

The Council recommends that adequate funds be earmarked for training at NMEP headquarters as well as Regional Officers for Health and Family Welfare.

4. Taking into account the fact that man made malaria as a consequence to industrial and developmental activities and local ecological changes, is a matter of more concern than nature-fostered endemicity;

The Council strongly recommends that it may be made obligatory for every project involving 25,000 more laborers to have in-built anti-malaria component in the project planning and such projects must get project clearance from the concerned health authorities (NMEP).

5. The Council notes with great concern that the incidence of P. falciparum malaria is increasing and epidemic outbreaks with death due to malaria are being reported from different States. The Council appreciates the move of the Central Government in appointing the Expert Committee to identify the worst affected areas and to suggest specific measures to control the disease. The Council strongly recommends that the States fully implement the Expert Committee recommendations as circulated through the Operational Manual, 1995.
6. The Council resolves that action be taken to ensure that the Malaria Control Organizations have full complement of staff and they are trained. All the vacant posts be filled up including those of the Multipurpose workers, both male and female.
7. The Council reiterates the need for timely spray operations with suitable insecticides covering the entire targeted population. Timely supply of insecticides to the States be ensured.
8. The Council fully endorses the need for early detection and prompt treatment of malaria cases. Proper surveillance, adequate laboratory services at the PHC level, availability of anti malarial drugs at all levels and opening of adequate number of FTDs and DDCs be ensured.
9. The Council resolves that bio-environmental control of malaria as a long term measures be planned. This can be achieved as a multi-disciplinary programme activities including active involvement of the community.
10. The Council resolves that operational research in malaria particularly in use of indigenous systems of medicine be encouraged.
11. Taking notes of the magnitude of the malaria problem including increase in P. falciparum malaria, and the present budgetary provisions are being not sufficient, the problems faced by the States in providing their 50% share, of the Council resolve that the present budget allocation for NMEP needs to be increased as per requirement and the Central State share ratio be 70:30.
12. The Council takes note of the inadequate the infrastructure including Entomological services at the State and Regional level and recommends that the same be strengthened suitably.
13. The Council strongly recommends that the Central Government should take the responsibility of supply of vehicles, spray equipments, microscopes etc. to the States with immediate effect.

KALA-AZAR

The Council notes with satisfaction that intensified implementation of Kala-Azar Control Scheme during 1992 and 1993 has resulted in appreciable decline of 66.89% in morbidity and 73.08% in mortality in 1994 as compared to 1992. However, the Council feels concerned that the scheme is not being provided due and timely budgetary allocations for effective implementation as per strategy by the States since 1994-95. The Council therefore resolves that sufficient funds be allocated to the scheme so that the progress of effective Kala-Azar Control is not arrested and the way is paved for eradication of Kala-Azar from India in due course.

The Council further resolves that the surveillance activities also be suitably augmented.

NATIONAL LEPROSY ERADICATION PROGRAMME
RESOLUTION

Council reviewed the progress of implementation of National Leprosy Eradication Programme. The Council feels that the elimination of leprosy is feasible and not merely a cherished goal. The Council while directing both Central and State Governments to continue and to maintain sustained efforts to achieve elimination of leprosy by 2000 AD, adopts the following resolutions :-

1. MDT TO ALL

- a) The Council notes with appreciation the efficacy and need of MDT in the treatment of leprosy. There is now time to accelerate MDT services and to ensure free MDT treatment to all leprosy patients throughout the country. The Council directs all the State Governments to stop mono therapy forthwith and to provide free MDT treatment to all leprosy patients.
- b) The Council adopts "MDT TO ALL LEPROSY CASES" and directs both Central and State Governments to make this a universal slogan under the programme.

2. EARLY DETECTION OF LEPROSY CASE AND THEIR REGULAR TREATMENT WITH MDT

Early detection of leprosy cases and their regular treatment with MDT ensures complete treatment. MDT also avoids disabilities. All States/UTs are advised to make all out efforts, special campaigns if necessary, to ensure early detection of leprosy cases and their treatment with MDT. The Council further directs the Central Government to ensure timely, adequate and uninterrupted supply of MD T drugs to all States/UTs.

3. INTENSIFICATION OF HEALTH EDUCATION CAMPAIGNS

Leprosy attracts social stigma. There is need for continuous health education campaigns to (i) increase the public confidence, (ii) make aware about true facts on leprosy, (iii) ensure detection of cases in early stage of disease, (iv) avoid disabilities, and, (v) to ensure complete cure with MDT.

The Council further directs that appropriate health education strategies be developed and print and electronic media be extensively involved in propagation of right messages on leprosy.

4. DISABILITY AND ULCER CARE

- i) In the absence of timely treatment, the leprosy may lead to disabilities and chronic ulcers - especially foot ulcers. Many of such disabilities are preventable. The Council directs both Central and State Governments to develop appropriate field based programme along with MDT services to avoid such disabilities and leprosy ulcers. The Council feels, in this direction, special efforts need to be done.
- ii) Effective steps be taken for the greater involvement of NGOs/Joint Sector in the field of reconstructive surgery and rehabilitation of the affected persons.

5. REPEAL OF DISCRIMINATORY PROVISIONS UNDER VARIOUS MARRIAGE ACTS

There are provisions in the various Marriage Acts like Hindu Marriage Act, Muslim Marriage Act and Parsi Marriage Act, etc., under which leprosy may be one of the grounds for divorce. Leprosy is completely curable and adequate treatment is available. Hence the Council feels and directs all to repeal such discriminatory provisions under the various Marriage Acts.

**EPIDEMIOLOGICAL SURVEILLANCE AND SUPPORT SYSTEMS INCLUDING
STRENGTHENING OF HEALTH MANAGEMENT INFORMATION SYSTEM**

RESOLUTION

The Council expresses its deep concern on the recent increase in the number of outbreaks of communicable diseases and re-emergence of some of the diseases which were hitherto considered as controlled and which not only resulted into significant mortality, morbidity and misery but also caused avoidable economic loss for the country. In addition, new diseases like AIDS, cholera due to new serotypes etc are of serious concern to the country.

The Council takes note of the fact that the reasons for increased occurrence of outbreaks of communicable diseases, appearance of new diseases, as well as reemergence of diseases hitherto considered controlled are many and sometimes complex viz overpopulation, inadequate sanitation and environmental hygiene, overcrowding, adverse ecological changes, altered life style, mass and rapid travel and inadequate health awareness and the current disease surveillance system in the country is grossly inadequate to generate authentic data covering the above areas. The existing surveillance system often fails to identify outbreaks in their early stages through recognition of reliable early warning signals to mount an early effective response to such emergencies.

The Council also observes that computerized HMIS introduced in 13 States/UTs of the country is being slowly implemented resulting in poor monitoring and evaluation of national health programmes.

The Council further notes with concern that in spite of repeated recommendations made by the Central Council of Health & FW in the past to develop an effective surveillance system supported by well equipped laboratories and institution of a reliable and efficient health management information system (HMIS) not much has been done so far in this area. It further notes that the provisions in the National Health Policy document which has clearly stated to establish a nationwide chain of sanitary cum epidemiological stations for providing epidemiological support services to improve health care delivery has so far not been implemented.

The Council taking cognizance of existing inadequate disease surveillance system and its adverse impact on the control of communicable diseases in the country and also in the light of recommendations made by the Technical Advisory Committee(TAC) on plague as well as under the proposed National Mission on Sanitation and Environmental Hygiene, resolves :-

1. A Centrally sponsored scheme of National Disease Surveillance Programme with appropriate laboratory support services including entomological services covering the entire country with emphasis on new, emerging and re-emerging disease be initiated and the National Institute of Communicable Diseases (NICD) to act as the

nodal coordinating agency for planning, working out the detailed operational guidelines for implementing States, its monitoring and evaluation.

2. If appropriate resource cannot be generated within the overall provisions of health sector. Government of India may seek assistance from IDA to support the surveillance programme which will greatly strengthen the capabilities of public health system.
3. The Council endorses the proposal submitted by the NICD to initiate the above mentioned programme in 100 Districts including strengthening of laboratory capabilities in the National, Regional Zonal, Medical Colleges and District laboratories during next five years. This will also strengthen basic laboratory services.
4. The Council reiterates its earlier recommendation made in 1969 that an Export Committee be constituted to look into the notification system of the country and make specific recommendations for uniform notification system in the country with appropriate legal provisions.
5. The Council also recommends that the computerized HMIS be implemented in all States/UTs on priority basis.

URBAN SOLID WASTE MANAGEMENT

RESOLUTION

The Council deliberated on the issue of Solid Waste Management at length and resolves that:-

1. Due attention be paid to safe management of urban solid waste including hospital waste so as to minimize health hazards associated with poor urban solid waste management.
2. Pilot project on comprehensive hospital infection control and waste management be initiated in one tertiary care centre in each State during the current year.
3. Recommendations pertaining to the hospital waste management be implemented through Ministry of Health & Family Welfare and the State Health & Family Welfare Departments as a part of their activities for improving the quality of services in hospitals/health centres at all levels. The action taken by the States and implementation of recommendations pertaining to hospital waste management be monitored closely by the appropriate division of the DGHS.
4. Each State/UT should formulate its plan of action for hospital waste management and include this as a part of the State Plan discussion with the Planning Commission during the Annual Plan discussions for 1996-97.
5. Experience gained during the remaining period of the Eighth Five Year Plan be utilized in formulating and implementing appropriate proposals for the hospital waste management under the Ninth Plan, in both State and Central Sectors.
6. Recommendations pertaining to the hospital waste be circulated widely to the health care providers in the Government, NGO and Private Sector.

YAWS ERADICATION PROGRAMME IN INDIA

RESOLUTION

The Council expresses its deep concern on the persistence of Yaws infection in the hardcore tribal districts of Andhra Pradesh, Orissa, and Madhya Pradesh and few other pockets in the tribal areas of other States.

The Council observes that Yaws is a non-venereal tribal treponematoses which among tribes causes deformity and destruction leading to economic loss to the already underprivileged and marginalized community. However, it can be cured and prevented by a single injection of long acting penicillin.

It is amenable to eradication and in the process of doing so will bring collateral benefits in terms of expanding the outreach of health care delivery to the remote areas thus facilitating achievement of "Health for all and in particular for Underprivileged (HFU) by 2000 AD".

The Council further notes that the inputs which are necessary to achieve the eradication are only marginal.

The Council, taking cognizance of persistence of Yaws, and its socio-economic impacts and recognizing that it is amenable to eradication having other collateral benefits and understanding that only marginal inputs are necessary and in light of the Government Policy to uplift the most underprivileged (The Report of the Working Group on Development and welfare of Schedule Tribes during Eight Five Year Plan) resolves that Yaws Eradication Programme in India be initiated as a purely central scheme immediately and National Institute of the Communicable Diseases would act as nodal point for the programme to prepare the operational guidelines, training manuals, and health education material for the implementing states and be responsible for monitoring and evaluation of the programme

INTER-MINISTERIAL CO-ORDINATION IN HEALTH & FAMILY WELFARE SECTORS

RESOLUTION

The Council observes that the subject of human health is a multi ministerial responsibility involving ministries of Health & Family Welfare, Forest and Environment, Urban Affairs & Employment, Rural Affairs & Employment, Human Resources Development, Chemicals & Fertilizers, Industries, Railways etc.

In spite of long standing felt need to institute such coordination mechanism not much has been achieved in this direction resulting in tardy implementation of several health programmes.

The Council further observes that this coordination mechanism is very vital in the implementation of several health programmes and will strengthen the public health response capability significantly.

Therefore, the Council resolves that such formal coordination mechanism be evolved at all levels and as it pertains to human health, the Ministry of Health & Family Welfare should be the nodal agency for such mechanism.

It further resolves that such mechanism should be developed not only at the Central level but also at the State, District, Taluka, Block and Panchayat level to make the health care delivery system more responsive to the situation. In such coordination mechanism NGOs, important social leaders, opinion leaders etc. should be adequately involved.

Such coordination mechanism established at the Central level should be responsible for formulating guidelines, detailed operational mechanism, responsibilities of individual ministries etc. for the peripheral units.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

RESOLUTION

The Council takes note of the performance of National Programme for Control of Blindness and expresses satisfaction that the decentralization of the programme at the district level has been one of the re-mark able features in the programme.

The dimension of the blindness is mark ably high in India. There are around 12 million blind people in India. Around 2 million blinds are being added every year. 80 percent of the blindness is due to cataract. At present the number of cataract operations performed in the country is around 2 million per year. To reduce the level of blindness, at/east around 3 to 4 million cataract operations are to be performed per year.

The Council while directing both Central and State Governments to continue and maintain the sustained efforts to achieve the reduction of blindness level to 2000 AD, adopts the following resolutions :-

1. The monitoring cell at the state level has to be further strengthened for better implementation of the programme in the states.
2. The utilization of funds by the State Governments is not satisfactory. It should be ensured that the funds allotted are utilized exclusively for the programme activities. The expenditure reporting from the states should be more regular, timely and accurate.
3. The release of funds from the Central Government to the district blindness control societies has to depend on the performance reported by the districts.
4. The Council further recommends that the intensification of IEC is required as the awareness about the eye care activities in the rural, remote and tribal area is not sufficient.
5. There should be identified eye beds and dedicated eye operation theatres in the district hospitals and medical college hospitals in each state.
6. The Opth. Surgeons should as far as possible be placed in surgical posts. At present many of them are engaged in general duty, administration etc.

7. Eye camps are continued in rural, remote and tribal areas. There should be at least one district mobile unit in each district to carry out eye camps.
8. The Council also recommends that the emphasis should be more on quality of cataract performance rather than the number of cataract operations performed.
9. The Council further recommends that other causes of blindness like refractive errors, cornea/ blindness etc. also be given sufficient importance as the blindness due to these mostly affects the children.
10. The Council also recommends that the urban slums should be included in the programme as the population consists of underprivileged people who do not have the access to Eye Surgeons and clinics.
11. The Council further recommends that there has to be proper coordination and interaction with the Social Welfare Ministry regarding rehabilitation of the visually handicapped and the blind as the target group is available within the ambit of the programme for control of blindness. No effort is spared to extend this programme to the remote villages and Gram Panchayat be involved in a big wasp with the programme.

**NATIONAL CANCER CONTROL PROGRAMME & ANTI-TOBACCO
MEASURES**

RESOLUTION

1. The Council notes with disappointment that its earlier resolutions specifying measures, administrative and legislative, for effective curbing of the consumption of tobacco and tobacco products, have not yet been implemented with the vigour they deserved. The council therefore, reiterates that if the growing menace of cancer in this country has to be combated, its earlier resolutions need to be implemented fully in letter as well as spirit.
2. The Council notes with concern that with rising longevity, industrialization and changing lifestyle, the morbidity and mortality due to cancer is increasing steadily. In India about seven lakh new cases of cancer occur every year. The education, detection, treatment facilities need be augmented to tackle the problem. The Council accordingly resolves that :-
 - a) Steps are taken to create mass awareness about the causative cancer factors for which Central/State Govts/UTs should launch special programmes and awareness camps.
 - b) The National Cancer Registry Programme of the Indian Council of Medical Research is strengthened to know the prevalence rate of morbidity and mortality and other data for future planning of the National Cancer Control Programme. The voluntary is recommended in the view of the magnitude of the problem.
 - c) There should be better implementations, monitoring and evaluation of the NCCP at the Central and State levels, particularly in view of the expansion of the programme and increase in funds under NCCP during the 8th Plan. At the Central level the staff in Dte. G.H.S. and the Ministry may be strengthened for over view of the programme and for better coordination with the State Govts./UTs. The State Govts./UTs also need to accord higher priority to cancer control and take appropriate action in the matter.
 - d) The Council notes that health education and early precancerous detection of cancer have a major role in cancer control. There is a scheme for district projects for health education, early detection and plan relief measures under NCCP. The Council recommends that more districts may be taken up under the scheme to give wider coverage to the programme in various States in the country.

- e) The Council notes that there is a scheme for development of oncology wings in medical colleges/hospitals for strengthening of therapeutically services. The Council recommends that more medical colleges/hospitals may be provided assistance for development of oncology wings keeping in view the geographical gaps in the availability of cancer treatment facilities in the country.
- f) The Council emphasis the need for involvement of voluntary organizations in the programme particularly for health education and detection activities in cancer. The voluntary organizations in the field may be encouraged and provided financial assistance on a larger scale under the Programme.

**IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME
(NIDDCP)**

RESOLUTION

The Council recognizes the fact that Iodine deficiency disorders (IDD) are one of the major public health problems in the country. It is estimated that about 167 million people are at the risk of IDD out of which 54 million are having goitre and 8.8 millions have various neurological disorders. The iodized salt is the most effective and cheapest method to control this problem.

The Council notes with concern that the nutritional iodine deficiency directly affects the physical and mental development of the human beings. It must be accorded a high priority by providing appropriate funds to control this problem by the year 2000 A.D. as per the commitments made during the International Conference on Nutrition held in Rome, 1992.

The Council notes with satisfaction that besides National Iodine Deficiency Disorder Control Programme, the Central Government have decided to launch a National Level Pilot Programme against other micronutrient malnutrition specially for Iron, Vitamin A etc. for the whole population at community level with effect from current financial year.

The Council resolves that:-

- (i) All the State/U. T. Governments should accord a high priority to implement the National Iodine Deficiency Disorders Control Programme (NIDDCP) in order to improve the human resource development
- (ii) The States/UTs which have not issued notification for ban on the sale of non-iodated salt should do so immediately and ensure effective enforcement of the same.
- (iii) The States/UTs which have not set up IDD Control Cell in their respective States/UTs should establish this Cell without any further delay.
- (iv) The States/UTs establish the IDD Monitoring Laboratory as sanctioned under the programme in their State for monitoring the iodine content of iodated salt and urinary excretion of iodine.
- (v) The States/UTs take appropriate steps to provide iodated salt at reasonable price to all through public distribution system.
- (vi) The possibility of providing assistance for manufacturing and distribution of iodated salt at subsidized rate may be examined.
- (vii) To popularize and promote the consumption of iodated salt the States/UTs should

intensify Information, Education and Communication (IECI activities highlighting the importance and benefits of consumption of iodated salt in control of Iodine Deficiency Disorders (IDD).

- (viii) An appropriate monitoring system be established for effective monitoring of quality control of iodated salt at various levels, i.e. at production, distribution and consumption level. For this purpose, a district level IDD monitoring laboratory should be set up / strengthen under the Programme.
- (ix) The States/UTs should encourage installation of iodization plants in the concerned area to eliminate the risk of loss of iodine content during transit.

**MENTAL HEALTH - ESPECIALLY DEVELOPMENT OF COMMUNITY MENTAL
HEALTH PROGRAMME**

RESOLUTION

- 1. The Council notes with concern the following important aspects of the mental health status of the country:-*
 - 1.1 Mental illness has become a major public health problem. As per the epidemiological surveys, 10-15% of the population suffers from some form of mental health problems or other. However, the total number of qualified mental health professionals is extremely limited, majority being largely concentrated in cities.
 - 1.2. Efforts are being made to develop a sustainable District Level Community Mental Health Programme, to reach the most vulnerable and weaker section of the community.
 - 1.3. Mechanisms are now available for training non-mental health professionals viz. non-psychiatric doctors and all categories of para-professionals) to effectively transfer the mental health technology to the community level.
 - 1.4. The living and therapeutic conditions in many mental hospitals are grossly inadequate for dignified living. Also, jailing of non-criminally ill mental patients, in violation of law, has attracted adverse criticism by the Supreme Court.
 - 1.5. Though the Central Mental Health Authority is functional and periodic reminders are sent, many States have yet to constitute their State Mental Health Authorities.
 - 1.6. Training in psychiatry, and Behavioral Sciences at under graduate level is unsatisfactory as University level examination is not in the curriculum.
 - 1.7. The National Mental Health Programme, initiated in 1982, had many targets which have not been met. A review of this is pending. There is inadequate monitoring system for implementing the Programme, which requires critical scrutiny. Further, adequate fiscal, administrative and professional support is urgently required.

2. After deliberating on the relevant issues at length, the Council resolves that:-
 - 2.1. The present magnitude of mental problems, and corresponding deficit in qualified manpower, calls for according due priority and full scale operational support to the National Mental Health Programme, specifically identifying "Mental Health" as a major thrust area. Socio-political, professional and administrative forces will have to work in tandem to realize the targets; adequate fiscal back up, and supportive decisions are required.
 - 2.2. All the States are requested to take advantage of the facility provided by the Government of India for training appropriate level of officers in the identified institutions.
 - 2.3. High premium must be placed on appropriate training of the non-specialists, aimed at transferring mental health technology to the grassroots level, thus widening the alternative manpower resource base. Also, there is an urgent need of specialist manpower development (viz., psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses). To meet the needs of the country in implementation of the National Mental Health Programme, some more centres are to be identified for the manpower development in Clinical Psychology and Psychiatric Social Work.
 - 2.4. The present state of the living conditions in the mental hospitals must be improved, ensuring adequate food, drinking water and proper sanitation, basic medical and laboratory facilities, supply of drugs, adequate staff and stimulating therapeutic environment geared to rehabilitative treatment. Voluntary agencies must be involved in the task of rehabilitation of cured/improved patients so that they can be accepted by their families and re-integrated into the community. Rehabilitation centres may also be attached to mental hospitals.
 - 2.5. Under the Mental Health Act, 1987, which came into force with effect from April, 1993, it is the statutory obligation of all the States and U.T.s to set up their own State level Mental Health Authorities etc. Twenty one States and U.T.s, who have yet to constitute these bodies, must do so not later than 1st December, 1995.
 - 2.6. The Medical Council of India (MCI) should lend its support to give strategic importance to teaching of Psychiatry, and Behavioral Sciences, at the undergraduate level. The MCI should be able to effectively introduce appropriate hours of teaching, along with clinical posting, and University level examinations. Further, it is strongly recommended that teaching of Psychiatry in other Post Graduates Medical Courses should be introduced.
 - 2.7. A time-bound action plan is required so that the realistic targets of the National Mental Health Programme, may be met. It is also resolved that the attempts at speedy implementation would necessitate a review of these long pending targets

to be met within the Programme, and revision of these targets, as necessary.

- 2.8. There is an urgent need of special attention towards child mental health, women mental health, mental health of the elderly, and utilization of traditional systems in mental health care, including Yoga and ISM.
- 2.9 It strongly recommends that chronic mental illness be considered as a disability at par with other identified disabilities.
- 2.10 Positive mental health can be promoted through educative intervention. This should be achieved by integrating a mental health education programme with the existing health education programmes, both at the Central and State levels.
- 2.11. To implement, coordinate and monitor preventive, promotive and curative mental health activities in the country, a senior Psychiatrist may be appointed as "Programme Co-ordinate" in the Directorate Genera/ of Health Services

**ORAL HEALTH - DISCUSSION ON DRAFT ORAL
HEALTH POLICY**

RESOLUTION

The Council Resolves that:

1. There is an urgent need for an Oral Health Policy for the nation as an integral part of the National Health Policy.
2. Special, well coordinated. National Oral Health Programme be launched to provide Oral Health Care, both in the rural as well as urban areas due to deteriorating oral health conditions in the country as revealed by various epidemiological studies. Dentist/population ratio in the rural areas is only 1:300,000 whereas 80 % of the children and 60% of the adults suffer from dental caries, more than 90% of adult community after the age of 30 years suffer from periodontal diseases which also has its inception in childhood. In addition, 35% of all body cancers are oral cancers. Large segment of the adult population is toothless due to the crippling nature of the dental diseases and about 35% of the children suffer from maloccluded teeth and jaws affecting proper functioning. In view of the above facts, it is important to launch preventive, curative and educational oral health care programmes integrated into the existing system utilizing the existing health and educational infrastructure in the rural, urban and deprived areas.
3. A post of full-time Dental Advisor at appropriate level in the Dte. G.H.S. should be created as a first step towards strengthening the technical wing of the Dte. GHS in this regard.
4. Studies have revealed that dental diseases have been increasing both in prevalence and severity over the last few decades. There is, therefore, an urgent need to prevent the rising dental diseases in India. The method used for primary prevention of dental diseases aims at achieving primary prevention of periodontal diseases and oral cancers.
5. The Council therefore, resolves that preventive and promotive Oral Health Services be introduced from the village level onwards and accordingly a pilot project on Oral Health Care may be launched by the Ministry of Health and Family Welfare during 1995-96 in five districts, one each in five States.

6. The Council further resolves that legislative measures be adopted to ensure a statutory warning on the wrappers and advertisement of sweets, chocolate and other retentive sugar eatable 'TOO MUCH EATING SWEETS MAY LEAD TO DECAY OF TOOTH'. Similar measures are also called for tobacco and Pan Masala related products.
7. The Council recommends that a National Training Centre be established or the existing centres be strengthened for training of various categories of Oral Health Care Personnel.
8. The Council also resolves that all district Hospitals and Community Health Centres have dental clinics. All Dental Colleges should have course on Dental Hygienists and Dental Technicians.
9. The Council further resolves that the Pilot Project may be extended to all the States at the rate of one District in every State.
10. The Council also resolves that there is an urgent need to have a National Institute for Dental Research to guide oral health research appropriate to the needs of the country.

**ADOPTION OF THE TRANSPLANTATION OF HUMAN ORGANS ACT, 1994 BY
ALL THE STATES.**

RESOLUTION

1. The Council notes with satisfaction that the transplantation of Human Organs Act, 1994 received the assent of the President on 8- 7-1994. It was brought into force on 4-2-1995 in the States of Goa, Himachal Pradesh and Maharashtra and all the Union Territories. The said Act has since been adopted by the States of Kamataka, Tamil Nadu, Kerala and West Bengal only. The A.P. Transplantation of Human Organs Act, 1995 has been enacted separately by Andhra Pradesh on the lines of the said Central Act. All the States, other than those mentioned above, have not adopted the Act so far.
2. The main purpose of the Act is to provide for the regulation of removal, storage and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs and for the matters connected there with or incidental thereto.
3. The Council accordingly resolves that immediate necessary action may be taken for adoption of the above mentioned Act by the remaining States.

**DIRECTING RESOURCES FOR DEVELOPING PUBLIC PRIVATE
PARTNERSHIP AND JOINT SECTOR APPROACH IN FAVOUR OF THE POOR**

RESOLUTION

The Council resolves that:-

With a view to harnessing all the available resources for the health care, especially for the poor and the disadvantaged, it is imperative that all efforts be made to develop public-private partnership through a joint sector approach in collaboration with Corporate Bodies, Non-Government Organizations and Public Sector Units, especially in favour of the poor.

State/Central Governments should consider provision of free/subsidized land, electricity, water, roads, exemption of customs duty on the imported equipment to the extent possible and fiscal incentives, where necessary, in order to lend full support to joint sector ventures. There can be shared partnership in Management.

In keeping with the liberalization policy leading to health sector reforms, the PSUs be encouraged, if necessary with interest free financial assistance for a minimum period of five year, to participate in joint ventures through equity sharing, to facilitate the private sector to raise loans from financial institutions/banks etc. In return the private sector should provide a minimum of 30% beds and 40% out patient / diagnostic services free for treatment of the poor in rural and urban sector.

For that purpose the Hospital Services Consultancy Corporation (HSCC), a Public Sector Undertaking under Ministry of Health & Family Welfare was identified as one such agency which would immediately promote such joint ventures.

DEVELOPMENT OF SPAS AND HEALTH RESORTS

RESOLUTION

The Council notes with regret that the Health Tourism with all its benefits to the people has not yet been developed for the majority of the population in India where healthy life style through Yoga and proper Nutrition could be propagated.

Recognizing that apart from preventive, curative and promotive services for achieving Health For All it is equally important to encourage people to live productive lives and enjoy a sense of mental and physical well being, the Council strongly recommends that Spas and Health Resorts be developed at suitable places, for the young, middle aged and the aged at affordable prices with certain concessions for the poor to enable them to get relief from urban and industrial stress.

STEPPING UP INVESTMENT IN HEALTH AND FAMILY WELFARE SECTOR IN THE COUNTRY

RESOLUTION

The Council notes with concern that the total investment on health and family welfare is still approximately 6% of the Gross Domestic Product and that direct investment by the Government both at the Central and State level constitutes only 1.3% of the GDP as against much higher expenditure on health in not only the developed countries but in many developing countries also.

The Council, therefore, strongly urges the Central Government, Planning Commission and the State Governments to step up health allocation and also to encourage wider participation in health care by the private sector so that direct investment by the Government can be raised to a minimum of 5% of the GDP and the total investment in health goes up to 10% of the GDP.

**SETTING UP OF AN NGO ASSISTANCE FOUNDATION AT
CENTRAL GOVERNMENT LEVEL IN THE MINISTRY OF
HEALTH & FAMILY WELFARE**

RESOLUTION

In order to provide effective financial and other assistance for NGOs involved in delivery of Health & Family Welfare Programmes at the field level, the Council urges the Government to set up a separate foundation with a minimum corpus of P.s.300 crores at Central Govt. level in the Ministry of Health & Family Welfare. The Foundation should be an entity which can receive funds from different agencies, individuals, including national and international donor agencies, for promoting NGO activities in Health & Family Welfare and Indian Systems of Medicine - especially in the interest of the poor. The Foundation should have on its Management Body representatives each from the Central and State Governments and a representative of NGO's. This will greatly facilitate servicing the NGOs through 'one window' approach.

HIGHER ALLOCATION FOR IEC ACTIVITIES

The Council expresses its concern over the low priority being given to preventive and promotive health and family welfare. The Council notes that better health awareness can, in the long term reduce the demands on curative aspect of health and family welfare and therefore, resolves that:

A certain minimum percentage of total budget for health and family welfare (both for Centre and the States/UTs) be earmarked for IEC activities.

Health awareness and promotion be given place of pride in educational/entertainment programmes on the electronic media.

HEALTH INSURANCE & MANAGED CARE

RESOLUTION

The Council urges the Government to initiate urgent measures to introduce "Health Insurance" and managed care in order to ensure access to all to get the quality medical care. State/Central Government should subsidize the insurance fees for those who live below poverty line. However, care should be taken to see that insurance cover does not lead to increase in unnecessary hospital costs by introducing a system of managed care along with Health Insurance.

**PROGRAMMES CONCERNING INDIAN SYSTEMS OF MEDICINE AND
HOMOEOPATHY**

RESOLUTION

1. Separate Budget for ISM and Homoeopathy:

Central Council of Health & Family Welfare recommends that all State Governments should earmark a separate budget for the development of ISM and Homoeopathy. The budget allocation should be adequate for the development of all the systems of ISM & Homoeopathy.

2. Organizational set up:

A number of technical and administrative posts like those of Directors, Deputy Director, Assistant Directors of Ayurveda, Unani, Sidha, and Homoeopathy have been lying vacant in various States for a long time. This Council recommends that urgent steps be taken to fill these vacant posts in the States and the posts in the Department of ISM & Homoeopathy at the Centre. Provisions for establishing a separate Directorates of ISM & Homoeopathy be made in all the States. Guideline should be drawn up by the Government of India, Department of ISM & Homoeopathy for the organizational set up at the State level Directorates and communicated to them.

3. Strengthening of Under Graduate Colleges of ISM & Homoeopathy:

- (i) The Council of Indian Medicine and the Central Council of Homoeopathy have laid down the "Minimum Standards of Education Regulations", it is imperative that these standards are strictly followed by the State Governments. It should be insisted upon that private institutions should also adhere to the prescribed minimum standards and provide the minimum basic infrastructure.
- (ii) The Council recommends that the State Governments should provide adequate resources for the teaching institutions in the systems of Ayurveda, Unani, Sidha and Homoeopathy on the same lines as is being done for Medical Colleges of modern medicine.
- (iii) No new colleges of ISM and Homoeopathy should be started without the prior permission of Central Government and the Central Council of Indian Medicine and Central Council of Homoeopathy as provided under the Rules. Suitable amendments

to the existing regulations be made accordingly.

- (iv) Selection for admissions to the colleges should be done by the State Government on the same basis as is being done for medical and dental colleges under the modern system.
- (v) Regulations are amended to provide the Central Council of Indian Medicine and Central Council of Homoeopathy and the Central Government to recognize and derecognize the ISM & Homoeopathy institutions offering approved courses in these systems on the pattern of the Medical Council of India.
- (vi) Short-term re-orientation training programmes should be encouraged for specialties of ISM & Homoeopathy periodically to up date the knowledge of the teaching staff and the professionals working in various departments of ISM & Homoeopathy.
- (vii) The Central Council of Indian Medicine and Central Council of Homoeopathy should be evolving syllabi, standards and curricula for training courses of pharmacy and Para-medicals. This Council also recommends that standard courses could be drawn up by these Councils for dieticians by amending the acts and drawing up regulations accordingly.

4. Quality Control in ISM & Homoeopathy:

Keeping in view of the importance of quality control of ISM & Homoeopathy drugs, this Council recommends :-

- i. That pharmacopoeia/ standards of ISM & Homoeopathy be evolve on a war footing and to implement the quality control of medicine be enforced. More regional drug testing laboratories be established by the Government of India. Keeping in view the importance of the issue some of the reputed well-equipped laboratories of the country may be associated to carry out the pharmacopoeia/ work within a period of five years or so.
- ii. Each of the State Government should develop its own drug testing laboratory.
- iii. Independent drug controlling mechanism should be evolved at the Central level for ISM & Homoeopathic Drugs. The State Governments could follow it subsequently.
- iv. The State governments should empower the qualified/trained Drug Inspectors to maintain quality control in the manufacturing of ISM & Homoeopathy drugs and also recommends that licensing authority to A yurveda, Sidha, Unani and Homoeopathy should be the Directors of ISM & Homoeopathy of the States.

- v. Only specialists having prescribed qualifications should function as Advisers to the State Drug Controller. Adequate measures should be taken by the State Governments to appoint suitably qualified Drug Inspectors for the inspection of pharmacies for effective quality control in all the ISM & Homoeopathic establishments.

5. Setting up of Specialized ISM & Homoeopathy Treatment Centres:

The Council takes note of the fact that the Ayurveda, Unani, Sidha and Homoeopathy systems have a number of areas of strength where they can give excellent results in the treatment of diseases like rheumatic disorders neurological disorders, liver diseases, skin disorders, bronchial asthma, fistula-in-ano, piles, behavioral disorders, filariasis etc. recommends that specialized treatment centres in Ayurveda Unani Sidha and Homoeopathy should be established in various parts of the country and Central and State Governments should provide sufficient funds for developing infrastructure for the purpose.

6. ISM & Homoeopathy wards in State/District Hospitals:

An ISM & Homoeopathy Wing offering facilities of treatment should be activated in each District Hospitals of the country. Adequate facilities for this purpose should be made. Drugless Therapies like Yoga and Naturopathy shall form a part of this set up. Government of India should provide one time assistance for this purpose.

7. ISM&H in National Health Programmes:

- i. The Council having taken note the fact that the number of ISM & Homoeopathy doctors in the country is about 5.5 lakhs. The services of these doctors are not optimally utilized in various National Health Programmes. Keeping in view the qualifications, training etc. of these doctors of ISM & Homoeopathy, the Council recommends that the manpower and material resources of these systems should be adequately utilized. The Interventions of these systems could form a part of the National Health Programmes after their efficacy is accepted through pilot programmes taken up in States like West Bengal, Himachal Pradesh, Kerala, Rajasthan, Karnataka etc. where there is good infrastructure of ISM& Homoeopathy.
- ii. Some of the existing Government dispensaries in the States may be selected to act as Primary Health Centres of ISM& Homeopathy in states where infrastructure is adequate.
- iii. A separate National Programme of Prevention of Disease and Promotional Health may

be launched to combat diseases in which these systems have been found effective.

8. ISM & Homoeopathy for Mother and Child Health:

The Council notes that various traditions in practice in the country for the safe motherhood, proper delivery and care of the child are very useful and recommends that there should be propagated in different corners of the country. There is a need to popularize the good dietary habits at ante-natal and post-natal periods and safe and simple method to protect new born children from various ailments.

The Council recommends that the safe traditions and simple remedies should be incorporated in the various national health programmes for safe motherhood and healthy child.

9. Conservation of Medicinal Plants and Propagation of Herbs for Simple Health Problems:

- i. The ISM & Homeopathy Department in the Central Government should act as the nodal department to coordinate the activities of the development and propagation of medicinal plants. Similarly, the ISM & Homoeopathy Departments in the States may act as the nodal departments.
- ii. At least one herbal garden/medicinal farm may be established in each State. A Central scheme may be drawn up for this purpose.
- ii. Demand for raw drugs in each of the systems has to be assessed by each system through market survey and the information received from the various manufacturing units through the State Drug Controllers of ISM & Homeopathy etc.
- iii. Farmers are to be encouraged to grow and collect medicinal plants and the State governments to draw up marketing strategies for the same.

10. Mass publicity of Indian System of Medicines and Homoeopathy

- i. The Council resolves that various do's and don'ts already practiced by ISM& Homoeopathy, such as use of common medicinal plants, principles of diet, personal and social good behavior, seasonal practices etc. needs to be propagated effectively through various means including mass-media.
- ii. Separate chapters highlighting the above may be introduced in the text books at school level.

11. Extension of CGHS facility for ISM & Homoeopathy in States

The Council recommends that the health care facility through ISM & Homoeopathy should be provided under CGHS with an independent full-fledged dispensary in every State headquarters and in other cities where Central government employees are working in significant numbers.

12. Parity in the Service Conditions of ISM & Homoeopathy Doctors with that of Doctors in Modern System of Medicine

The Council resolves that the graduates and post-graduate Doctors of ISM& Homoeopathy be given full parity in the matters of service conditions, pay scales and other facilities with the doctors of modern medicines to attract equally good talent and establish respectability and status to the doctors of ISM& Homoeopathy. The Govt. of India should guide and assist the States in this matter. The State Government should also provide same amount of stipend/internship allowance etc. to the graduate and post-graduates students of ISM & Homoeopathy.

- 13.** The Council resolves that legislative measures need to be initiated by the Central and State Government to stop teaching and practice of unrecognized systems of medical practice which are encouraging quacks.

14. Yoga and Naturopathy:-

Keeping in view the global recognition of the science of Yoga and drugless therapies like Naturopathy, the Council recommends

- i. The setting up of a National Institute of Yoga.
- ii. Encouragement of NGOs involved in the field of Yoga and Naturopathy, so that these two systems are promoted and propagated in the country.
- iii. Introduction of Yoga training in schools.
- iv. Incorporation of Yoga as a system to develop the individual.
- v. The Central Council of Indian Medicine to examine and submit recommendations for inclusion of curriculum and to incorporate appropriate courses both for diploma and degree in Yoga and Naturopathy.

SPECIAL PROBLEMS CONCERNING HEALTH CARE AND RURAL HEALTH INFRASTRUCTURE OF NORTH EASTERN STATES AND SIKKIM

RESOLUTION

1. NORMS:

The Council notes with satisfaction that recognizing the special problems of the land-locked, sparsely populated and socio-economically handicapped North Eastern States, Government of India accorded North Eastern States the status of Special Category States whose entire development programme is funded with 90% Central grants. Nevertheless these States including Sikkim have critical infrastructural gaps, including

- (a) Large segments of rural population which remain uncovered by any Sub-centre or PHC
- (b) Wholly unequipped PHC's,
- (c) ill-equipped CHC's
- (d) Most CHC's and PHC's not yet having been provided either with Ambulance or any other smaller vehicle for basic mobility
- (e) Critical shortage of qualified trained personnel and technical manpower
- (f) CHC, PHC and Sub-centre buildings set up in the past having deteriorated to such levels that they require wholesale renovation/restoration

The Council therefore resolves that the existing parameters and yardsticks as per present guidelines for setting up of basic infrastructure under the Minimum Needs Programme were not suitable for the Special Category States and it was necessary to evolve and follow special parameters and norms for these States.

2. AUGMENTATION OF RURAL MEDICARE FACILITIES:

The Council notes that although a limited network of rural health institutions had been established under the Minimum Needs Programme, large segments of the rural population of these States are yet to be adequately covered by the rural health infrastructure. Most of the Community Health Centres and all the Primary Health Centres are yet to be provided with basic and essential diagnostic facilities such as suitably equipped OT, Blood Bank, basic laboratory, X-ray and other diagnostic facilities apart from the general lack of basic mobility, in addition a majority of the PHC's and Sub-Centres were set up in hired buildings which are unsuitable or buildings which required extensive renovation or restoration.

Also, having regard to the difficult geographic terrain and communication bottlenecks in the

region, it was imperative to develop well equipped District Hospitals which could serve as Referral Centres for the CHC's and PHC's located in the District concerned.

The Council also notes with anguish that the majority of the CHC's and PHC's in the North Eastern States were yet to be provided any type of ambulance or transport facilities although it was most essential for the CHC & PHC level medical and para-medical personnel to reach out to the community, it was therefore vital to provide each CHC and each PHC with an ambulance or any other of suitable vehicle as per usual norms but the resources of the N.E. States do not enable them to meet this requirement.

Keeping in view such critical requirements, the small N.E. States including Sikkim were in desperate and critical need of package assistance for basic essential Health Care facilities.

The Council therefore resolves that a centrally funded scheme be launched to fill the critical gaps in the Healthcare Delivery System of the small and economically weaker N.E. States whose problems are compounded by their geographic and demographic limitations. Resources for the proposed centrally funded scheme could be raised by the Ministry by resorting to suitable Overseas Assistance. The Project Proposals for these States for international funding which had been drawn up and posed for funding should be fully supported and the Ministry should take all possible steps to secure World Bank/European Union/other international assistance for funding these projects for augmentation of the Rural Health Infrastructure including Training facilities.

3. AUGMENTATION OF FACILITIES FOR SPECIALISED AND UNDERGRADUATE MEDICAL STUDIES:

The Council takes note of the fact that most of the small N.E. States do not have a medical college. These States are dependant on seats for under-graduate and post-graduate medical studies made available either from the Central Pool of under-graduate medical seats or the Medical Colleges in Assam or the Regional Institute of Medical Sciences at Imphal. This has led to critical shortage of Doctors, particularly specialists in the N.E. States. Unless something is done to resolve the situation, the smaller States of the North East would not be in a position to get the required Specialized Medical manpower in position, within the next three or four decades.

The Council therefore resolves that a Central Pool of seats for Post Graduate Medical Studies be created on the lines of the Central Pool MBBS Seats, for allocation to the small N.E. States including Sikkim, for a limited period, till their critical manpower gaps are filled, provided such States defray prorata costs for such seats as may be earmarked for their nominees.

The Council also resolves that the existing Medical Colleges in Assam be assisted to expand their intake capacity for MBBS studies by at least 10% for sharing such additional capacity with the N.E. States and Sikkim.

4. NATIONAL MALARIA ERADICATION PROGRAMME:

The Council notes with concern that malaria, mainly of the P. Falcifarum strain has re-emerged in alarming scales in the N.E. Region. The States have made every possible effort to take pre-emptive and remedial measures, but much greater efforts will be required to contain the menace in the years ahead. As at present the N.E. States are faced with the continuing problem of irregular and erratic release of DDT and other sprayants by the manufacturers/suppliers appointed for such purpose by the NMEP authorities.

The Council therefore resolves that a Regional Depot be established within the N.E. Region to facilitate timely release of DDT & other sprayants and anti-malarial drugs. This Regional Depot could also be used for regionalized release of inputs under the National Programmes, to the States of the North East. It is further resolved that keeping in view the severe ness of malaria in N. E. States all malaria affected districts of the region be sanctioned District Level Ma/aria Organization for better and more effective implementation of the renewed campaign for the eradication of Malaria.

It also resolves that a Regional Epidemiological centre be set up within the region with adequate infrastructure to adequately cover all N.E. States.

5. THE NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE FOR HEALTH AND MEDICAL SCIENCES:

The Council notes with satisfaction that the Central Government have reactivated the scheme for establishment of the North-Eastern Indira Gandhi Regional Institute for Health and Medical Sciences and the establishment of the infrastructure for Cardiology and Gastroenterology is expected to be completed within the current year. The Council is however concerned that the Governing Council of the Institute was yet to be reactivated since its last meeting almost a decade ago. Unless the Governing Council meets and authorizes the equipping and staffing of the Institute without any further delay; it would not be possible for the Institute to be made functional according to the scheduled time frame. The required personnel would also have to be recruited and suitably trained in advance.

The Council, therefore resolves that such urgent steps as may be necessary be taken to make the proposed Regional Institute functional, without further delay and with a view to provide the intended services to the people of the region.

6. MENTAL HEALTH CARE:

The Council takes note that most of the N. E. States and Sikkim do not yet have an Organized Centre for Mental Health Care system which is a mandatory requirement as per the latest statutory provisions and Court Rulings thereon. Much as the States desire to set up such facilities, their fragile resource position does not enable them to do so.

The Council resolves that a Centrally Sponsored Programme for establishment of Mental Health Care Centers in the smaller States be launched keeping in view the critical nature of

this requirement.

7. NATIONAL PROGRAMME FOR THE CONTROL OF BLINDNESS:

The Council further takes note that keeping in view the high incidence of Blindness in the N.E. States, every effort had been made by these States to activate the District Mobile Units and the District Blindness Control Societies besides the Central Mobile Units. Their efforts are however handicapped for want of an adequately equipped State Referral Centre, due to resource constraints of these States.

The Council resolves that all small States which do not have a State Level Referral Eye Centre be fully assisted to set up such a fully equipped centre under the National Programme for the Control of Blindness.

8. ESTABLISHMENT OF A REGIONAL INSTITUTE FOR I.S.M.:

The Council also takes note that an immense pool of medicinal herbs and plants abounded in the N.E. region. These resources have been used by local Vaidas and Kaviraj's for centuries. However, efforts for scientific analysis and adaptation of these valuable natural resources were yet to be undertaken.

The Council therefore recommends that a Regional Institute for ISM be set up in the North Eastern Region for systematic, scientific assimilation and analysis of traditional herbal cure practices and their proper adaptation for healthcare. It also resolves that medicinal gardens should be established in each of the N.E. States including Sikkim under a suitable Centrally Funded Programme.

The Council further resolves that the intake capacity of the Assam Ayurvedic College be increased for accommodating nominees of the North Eastern States.

9. CANCER CARE:

The Council notes with concern of the high incidence of cancer in the N.E. Region which had very limited facility for its diagnosis and treatment. A number of NGO's had shown interest in establishment of centres for detection and treatment of Cancer, provided they were suitably assisted.

The Council resolves that wherever suitable NGOs come forward for setting up such Specialized Centres, with or without the recommendations of the respective State Government, such NGOs be assisted with the required financial resources under a suitable Centrally Funded Programme.

The Council also resolves that at least two Cobalt Therapy Units be set up in each of the N.E. States including Sikkim, while the facilities of the Regional B. Barooah Cancer Institute at Guwahati should be augmented.

10. OTHER REGIONAL CENTRES:

Keeping in view the critical necessity of Referral Centres for Leprosy, AIDS, and Tuberculosis in the region, the Council resolves that

- 1) A Regional Leprosy Centre,
- 2) A Regional Centre for the Detection and Treatment of AIDS with facility for Westa Blott Testing.
- 3) A Regional Referral Laboratory for Tuberculosis
- 4) One more Regional Institute for the Training of Pharmacists, preferably at Shillong be established at suitable places within the North Eastern Region under central funding.

11. THE RAJIV GANDHI INSTITUTE FOR LEPROSY AT GUWAHATI:

The Council notes that Assam Government had established a Rajiv Gandhi Institute for Leprosy at Boko for training, treatment and rehabilitation of persons with leprosy.

The Council resolves that the Institute may be converted into a Centrally Funded Regional Institute to cater to the needs of the N. E. States.

12. HONORARIUM FOR VILLAGE HEALTH GUIDES:

The Council notes that the Village Health Guide Scheme was of immense practical value but there was waning interest amongst potential VHGs due to the limited amount of Rs.50/- p.m. being paid as honorarium to the VHGs. The Council resolves that this amount be suitably enhanced to a minimum of Rs.300/- p.m.

13. EXTERNAL ASSISTANCE:

The Council takes note of the fact that except for Assam none of the States in the N.E. Region including Sikkim had been covered by External Assistance in the Health Sector.

The Council resolves that special efforts be made by the Ministry to secure external assistance for Healthcare Projects drawn up and posed by these States.

14. ANTIRABIES VACCINE:

The Council notes with concern that the Pasteur Institute at Shillong could not meet the present requirement of Anti Rabies Vaccine of the North Eastern States.

The Council therefore, resolves that steps be taken to suitably augment the capacity of the Pasteur Institute to ensure that the ARV requirement of the N. E. States was fully met. Adequate financial assistance should be provided to the Pasteur Institute, Shi/long for such purpose.

It also resolves that the facilities at Pasteur Institute, Shi/long be augmented for testing of faecal samples for Polio virus isolation and for Virological laboratory diagnosis.

15. DRUG TESTING LABORATORY:

The Council notes that drug testing facilities in the region are very limited. However the Council notes with satisfaction that the Central Government has decided in principle to convert the present state Drug Testing Laboratory of Assam at Guwahati into a Regional Drug Testing Laboratory considering the extreme necessity for testing of drugs.

The Council resolves that the Regional Drug Testing Laboratory should be made functional at the earliest since the required land and building had already been placed at the disposal of Central Government.

16. MOBILE FAMILY CLINICS.

The Council strongly recommends the introduction of a centrally sponsored scheme of Mobile Family Clinics in the North Eastern States including Sikkim. Under the Scheme, at least one Mobile Unit may be made available for each District to provide periodic medical and family welfare facilities to the population of these areas. The Unit could also undertake IEC functions in the area of health education, as well as family welfare activities.

ANNEXURES

ANNEXURE-A

INAUGURAL ADDRESS OF SHRI PABAN SINGH GHATOWAR, UNION MINISTER OF STATE FOR HEALTH & FAMILY WELFARE, IN THE 4TH CONFERENCE OF CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE, AT PARLIAMENT HOUSE ANNEXE FROM 11TH OCTOBER TO 13TH OCTOBER, 1995.

Chairman Sir, hon'ble Ministers of Health; Member, Planning Commission; Members of the Central Council; Secretary, Department of Health and Family Welfare; Secretaries from the States, Director General of Health Services, distinguished participants and friends,
Your presence at this Conference of the Central Council of Health and Family Welfare is indeed very critical at a time when we have to review our health & family welfare policies in the light of our objective to achieve Health for all by 2000 A.D.

As you all know the growth in population has been a matter of serious concern. It is presently estimated to be about 925 million and expected to cross one billion mark by the year 2000 AD as per provisional estimates. Although during the decade 1981-91 the exponential growth rate had marginally declined from 2.22 to 2.14, it remains a matter of deep concern. The National Health Policy has set a goal of net reproduction rate of unity corresponding to crude birth rate of 1.2 for the year 2000 A.D. Unless we make a frontal attack on the population problem with a firm political commitment, the involvement of people, particularly in those States where the family welfare programme has not gathered the desired momentum, the goal of zero growth will not be achieved.

It is heartening to note that the States of Goa, Kerala and Tamil Nadu have achieved remarkable success in bringing down the crude birth rate. I will appeal to all of you, particularly our friends from Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh and Haryana to intensify their efforts for reduction of fertility rate so that the growth of population is checked.

For making the family welfare programme a success we have to promote information, education and communication to raise the effective age of marriage as also delaying the first birth, apart from spacing of children, female literacy, enhancing the social status of women and comprehensive package of maternal child health. It is here that the voluntary and non-government organizations can make a significant contribution and the thrust of efforts will be to secure greater participation of community in meeting this challenge.

Communicable diseases and maternal and perinatal causes take a heavy toll of individual deaths. Diseases like leprosy, malaria, TB, blindness and recently AIDS remain among the top priorities for action. While we have met with reasonable degree of success in controlling the menace of these diseases through national programmes, for control of AIDS we are launching a multi-pronged action programme through public awareness, blood safety, surveillance, clinical examinations and promoting sex through condoms. At the same time increase in life expectancy has resulted in proportional increase in mortality from chronic and degenerated diseases such as cardio-vascular ailments, lung diseases and cancer.

Studies have revealed that dental diseases have been increasing both in prevalence and severity over the last decades. There is an urgent need to prevent this rising trend. We are on the process of launching a pilot programme on Oral Health Programme to provide oral health care to the entire population in the near future.

While we have been according priorities to communicable diseases, maternal and child health and family welfare services, there has been increasing evidence that with rising longevity, industrialization, change in life style and progressive control of the major communicable diseases, morbidity and mortality due to Non-communicable diseases like cataract induced blindness and other geriatric problems and cancer is steadily increasing. Our health care system has to be geared up in these directions.

While the out turn of Doctors, Specialists and Super-Specialists is fairly adequate, there is dearth of qualified nurses, optometrists, Dental Hygienist, Radiographers and Laboratory Technicians etc. We have to make concerted efforts to remove this mismatch. The thrust of our efforts in the years to come will be to build up a cadre of qualified nurses, technicians, and Para-medicals through vocational system.

As you are aware, the National Health Policy of 1983 envisages the need for organized measures to enable each of the Systems of Indian Medicine that is Ayurveda, Siddha, Unani, as well as Homoeopathy to develop in accordance with its genus. The Policy proposes for planned efforts to find an appropriate role and place for these different systems in the overall health care delivery system in the country.

Traditional Medicine has developed in India in the form of organized system of Ayurveda, Siddha and Unani in addition to Yoga, Naturopathy and Homoeopathy. These systems are relatively cheap and free from side effects. Basic approaches of all these Systems are holistic and treat the diseased individuals in totality.

We have a large resource of over 4 lakh practitioners of Indian System of Medicine and 1.8 lakh practitioners of Homoeopathy whose services need to be fully utilized for the effective implementation of the National Health Policy. There are about 230 colleges for pursuing studies in Indian System of Medicine and Homoeopathy producing about 9000 graduates and diploma holders every year. The time has come to promote the Indian System of Medicine and Homoeopathy. We have also to make efforts for strengthening the education and research in ISM & H apart from standardization of drug quality control, cultivation of medicinal plants, development of specialized centres etc. I look forward to the co-operation of the State Governments in propagation of ISM & H.

I am glad that many eminent individuals and special invitees have joined us and I do hope that we will be able to derive benefit from your experience and advice for the improvement of the social sector, which is so critical for the well being of the people in our country, especially for women and children.

Thank you.

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SPEECH BY

PROF J.S. BAJAJ
Member (Health)
Planning Commission

AT THE

CONFERENCE OF CENTRAL COUNCIL OF
HEALTH AND FAMILY WELFARE
(October 11-13, 1995)

NEW DELHI

October 11, 1995

Hon'ble Minister of Health and Family Welfare, Government of India, Hon'ble Chief Ministers and State Health Ministers, Union Minister of State for Health and Family Welfare, Union Secretaries for Health and Family Welfare, non-official members of the Central Council, Director General of Health Services, and distinguished colleagues;

Let me at the outset thank the Chairman of the Council, Shri Antulay ji for asking me to make a few observations at this inaugural session. While so doing, I shall like to share with you the objectives, perspectives, policy framework and financial resources for health and family welfare sector in the Eighth Five Year Plan period. As we have already completed three and a half years of the Plan period, it would also be timely to not only highlight our achievements, but more importantly, to also recognize our failures, identify the lacunae at the level of planning as well as policy implementation, and to solicit your collective wisdom regarding future remedial action.

Human development, in all its multi-dimensions, is the ultimate goal of the Eighth Plan Social development is not only an indicator but also a determinant of human development. It is only healthy and educated people who can contribute to economic growth and this growth, in turn, contributes to human well being. The priority sectors of the Plan that contribute towards realization of this goal are health, food security ensuring adequate nutrition, literacy and basic needs, including drinking water, sanitation, housing and welfare programmes for the weaker sections. In order to achieve these priority objectives, there is a conscious decision to roll back the public sector investments from those sectors of the economy where the private sector can move in so as to enable us to step up our investment I in the social sector, agriculture and infrastructural development.

The indicators of social development have undoubtedly shown an improvement over the years, as shown in the following Table. .

Indicators of Social Development

	1951	1981	1993
Crude Birth Rate (per 1000)	41.7	33.9	28.5
Crude Death Rate (per 1000)	22.8	12.5	9.3
1 . Infant Mortality Rate (per 1000)	146.0	110.0	74.0
2. Life expectancy at birth (years)	32.1	52.3	61.8
3. Literacy rate (1991)			
Total	18.33	43.56	52.11
Male	27.16	56.37	63.86
Female	8.86	29.75	39.42

In spite of these improvements, the present overall levels of indicators of human development are a cause of continuing concern. There exist large differentials across states, large variations between rural

and urban areas, gender disparities, and wide gaps between the need and the availability of health infrastructure in the country. For example, Crude Birth Rate in 1993 was 17.4 per 1000 in Kerala (lowest) against 36.2 per 1000 in Uttar Pradesh (highest) IMR was 13 per thousand in Kerala while it was 110 in Orissa in 1993. Finally, Kerala and Tamil Nadu have already achieved NRRI and we commend these two states, but some other states continue with a CBR of around 35 or above. Indeed, let me confess, the coefficients of variation in relation to demographic indicators show a widening hiatus between different states. While every effort is being made to bridge the gaps and narrow the differences, let me affirm our commitment to play a key role in the provision and maintenance of health infrastructure as a core determinant of overall social infrastructure.

Financial Outlay for Health

The Eighth Plan has targeted an outlay on Health of Rs.1,800 crore (1991-92 prices) in the Central Sector, Rs.5,308 crore (1991-92 prices) in the States' sector and Rs.468 crore (1991-92 prices) for the Union Territories. As against the expenditure of 60 per cent on a pro rata basis during the first three years of the Plan, States and UTs have fallen short with about 43 per cent expenditure, while the Central Sector has performed satisfactorily with 68 per cent.

However, allocations for rural health in States and UT's Plan finance, as "Minimum Needs" have declined. What is even more worrying is the fact that in several states earmarked outlays have not been fully utilized. Health services being a state subject, the state governments have primary responsibility for providing resources for public health care. The States such as Bihar, Madhya Pradesh, Orissa and Uttar Pradesh with low demographic and human development indicators are also the ones where the expenditure by the governments has been 20 to 30 per cent lower than the all states' average, on per capita basis, though the need for health services in these states, as reflected in infant mortality and the overall death rate is significantly higher. The only State in this category which has increased the expenditure to a level higher than the All-India average is Rajasthan, and we commend such efforts.

Let me state unequivocally that social equity in provision of health care is, and shall continue to remain, the responsibility of the State. A commitment to that effect was made by the Founding Fathers and is enshrined in the directive principles in the Constitution wherein it is stated that 'the State shall regard the raising of the level of nutrition and the standard of living of people and the improvement of public health as among its primary commitments'. Let the votaries of total privatization remember what the Prime Minister of India has stated in the Foreword to the Eighth Plan: "there is today recognition that in many areas of activity, development can best be ensured by freeing them of unnecessary controls and regulations and withdrawing State intervention. At the same time, we believe that the growth and development of the country cannot be left entirely to the market mechanism. The market can be expected to bring about an 'equilibrium' between 'demand' -backed by purchasing power - and 'supply', but it will not be able to ensure a balance between 'need' and 'supply'." The quality and outreach of health care must be ensured in order to achieve the balance between the people's needs and delivery of such essential services.

Having expressed strongly against total privatization especially in health sector let me suggest that privatization may play a role in the high-tech high cost areas of tertiary health care. This may provide a possible answer to the basic question: how do we justify allocation of substantial resources for optimizing the quality of health care for the elitist few, at the cost of compromising the access to any health care by the vast majority? I suggest that investments in high cost tertiary care may be provided through a joint sector approach where in private and public sector join together to respond to the tertiary care needs. While so doing, it should be considered a necessary pre-requisite that such

facilities would also be available, free of cost, to those who cannot afford to pay for such services. A distinct advantage of such an approach would be that by minimizing investments in the tertiary care sector, we shall be able to substantially step up our investments in the basic health care infrastructure in the rural areas and accordingly strengthen primary care, and to the extent possible, district level secondary health care. This needs your kind consideration.

We had enthusiastically joined the international movement of 'Health for All by the year 2000'. Keeping our priorities for primary health care and development of referral, support and linkage services at the district and sub-district levels, we have reiterated in the Eighth Plan our commitment to this effect. However, there is a paradigm shift. We have emphasized that the Health for All (HFA) paradigm must take into account not only high risk vulnerable groups, i.e., mothers and children, but must also focus sharply on the underprivileged segments within the vulnerable groups. Within the HFA strategy "Health for underprivileged" (HFU) is being promoted consciously and consistently. This can only be done through emphasizing the community based systems reflected in our planning of infrastructure, and by ensuring that our funding for Minimum Needs Programme (MNP), primary health care, rural health infrastructure, safe drinking water, food security and nutrition receive priority consideration and adequate financial support.

Let me therefore reiterate that in the overall strategic planning, we must include every investment for health. What we continue to do, and this is also followed by international agencies, is only to focus on investments in health. The two are different. When we invest for health, we make financial outlays for safe drinking water, for environmental sanitation, for nutrition, for welfare of the handicapped. Does it really matter as to which agency provides safe drinking water in Rajasthan where one of the main objectives is eradication of guinea worm infestation. Simply because the channels of funding do not pass through the Ministry of Health, should we not take this into account.

Furthermore, is the provision of adequate nutrition to a preschool child or a pregnant or a lactating mother a health-related activity or not? Does it matter whether financial support of more than Rs.2000 crores for Integrated Child Development Services flows through the portals of Nirman Bhawan or Shastri Bhawan. Same applies to major investments in such social programmes as Mid-day meal programme to school children which aims to ensure physical and mental growth and development of a child and is therefore as much a part of health, even if it is not a part of Ministry of Health. We refer to the Alma Ata declaration and exhibit our commitment to primary health care. While so doing, we sometimes tend to forget the eight components as outlined in that declaration. These include nutrition, safe drinking water and sanitation. With over 14000 crores for Health and Family Welfare, more than 16000 crores for safe drinking water and sanitation and more than 2000 crores for nutrition, the total Eighth Plan allocation aimed at health-related activities is over Rs.32,000 crores. This is not to say that more financial resources are not required. It is only to emphasize the need to maximize our returns from such major investments for human health.

May I therefore submit that it is axiomatic that convergence of services at the periphery must be recognized as an essential pre-requisite to the attainment of health objectives. If intersectoral coordination remains only a cliché at the highest level, it would be futile to expect the village level functionaries such as anganwadi worker and the ANM to coordinate and mount a concerted action for the targeted segments of vulnerable population. This needs a serious deliberation: how to maximize our returns from our investments in all health-related activities irrespective of the social sector denomination. In this context, the instrumentality of Panchayati Raj institutions may be most appropriate if we empower such institutions adequately and provide necessary financial resources for these activities. States like West Bengal are already doing this, and these models must be studied, adapted and replicated.

I shall make only three additional observations at this stage as these items are listed on the agenda for detailed discussions.

1. Family Welfare

Containing population growth has been identified as one of the six priority areas during Eighth Five Year Plan. Planning Commission has within overall availability of resources, made maximum incremental allocation of funds to the Deptt. of Family Welfare during the Eighth Five Year Plan and also during the Annual Plans for the programmes aimed at containing population growth in the country. In order to give a new thrust and dynamism to Family Welfare Programme an area-specific micro planning was suggested in a background document submitted by Planning Commission as a result of which a Sub-Committee of the NDC on Population under the Chairmanship of Shri Karunakaran ji was constituted in 1991. The report of NDC Sub-Committee on Population was considered at the NDC Committee meeting held on 18th September, 1993 and the recommendations were endorsed. The Department of Family Welfare has initiated steps for the implementation of the recommendations of the NDC Committee. At the meeting of the NDC Committee, it was also resolved that the Department of FW may initiate necessary action to convene the meeting of the Chief Ministers of the States and opinion makers for wider consultations on the future course of action needed for the implementation of the Report of the NDC Committee on Population. The Department has indicated that such a meeting will be convened shortly.

In order to encourage better performance in the implementation of the Family Welfare Programme, performance in Family Welfare Programme has been given a weightage of 1.0% for the allocation of Central Assistance for State Plans in respect of the 15 non-special category States under the Gadgil-Mukherjee formula approved by the National Development Council (NDC) in December 1991. The two performance indicators for the Family Welfare Programme chosen under this formula are Birth Rate and Infant Mortality Rate." Each of these criteria is given equal weightage. The allocation of Central Assistance based on performance in Family Welfare Programme under the Gadgil Mukherjee formula for 1994-95 and 1995-96 has been Rs.72 crores and 84.35 crores with States such as Kerala, Tamil Nadu and Goa as largest beneficiaries based on the performance audit.

2. Indian Systems of Medicine and Homoeopathy

Indian systems of Medicine and Homoeopathy are widely accepted in the country specially in the rural, remote and difficult areas. There are 5.65 lakhs practitioners belonging to these systems who are available and provide health care at affordable cost in remote rural areas. Measures for popularization and development of Indian systems of medicines and homoeopathy are being vigorously pursued during Eighth Plan.

A categorical commitment in this aspect was made in the Eighth Plan document, and was approved by the NDC under the Chairmanship of the Prime Minister. It was stated:

"Separate departments, directorates and drug control organizations at the Central and State government level will be established, wherever they do not exist currently."

I am therefore pleased to mention that this has now been realized by the establishment of a separate department of ISM at the Centre. We are now focusing sharply on other areas such as:

- i) Maintenance of the quality of products of ISM&H produced in the country
- ii) Research and Development for the production and standardization of drugs of ISM&H.

- iii) The cultivation, conservation and regeneration of medicinal plants.
- iv) Strengthening of the Central Councils for Research in ISM&H.

In addition, our future plan of action must relate to defining the role that the ayurveda and related systems of medicine can play in the effective delivery of primary health care to large segments of masses especially in rural areas. Based on nearly four decades of experience, I, firmly believe that almost 70-80 per cent of the illnesses encountered in the primary health care setting can be effectively managed by the ISM&H, and more importantly, at a cost which is just a fraction of what would be required if drugs of modern system of medicine are used for similar purpose. In addition, adverse drug reaction following the use of drugs such as potent antibiotics for treatment of simple ailments like cough and cold add to the load of iatrogenic diseases in the community. Furthermore, at the level of tertiary health care, with shifting epidemiological scenario, non-communicable diseases such as diabetes, hypertension, cardiovascular diseases and cancer are showing an increasing prevalence. As changing life styles, altered dietary patterns and ever-increasing stresses of modern life are playing an important role in the causation of these, disorders, traditional systems of medicine along with therapeutic interventions such as meditation and yoga, may constitute an important approach in the management. Finally, some of the available ayurvedic remedies may provide effective therapeutic management of mental health disorders.

3. Health Manpower Planning, Production and Management

I had made a detailed presentation at the last meeting of the Council, of the National Education Policy in Health Sciences, prepared by a Committee which I had the privilege to Chair. The Hon'ble Members of the Council had endorsed the policy and prioritized the need for the establishment of Education Commission in Health Sciences. I am pleased that the necessary legislative action is now being processed. I must, however, reiterate that any system is as good as people who manage the system. The foremost need is to produce adequate number of paraprofessionals like nurses, laboratory technicians, radiographers etc. to ensure the right manpower mix and to optimize the efficiency and effectiveness of health care team.

In summary we have been able to protect and enhance financial allocations in health-related sectors, in spite of the apprehensions expressed in the past that this would not be possible with economic restricting in the country. However, behind these hard health statistics and financial allocations, Loom the stark realities of life and death in many villages and towns in this country. We can impart meaning and purpose to the planning process only by ensuring the outreach of services of the poorest man in the remotest village of the country. There are difficulties - there would be obstacles - but let me quote Iqbal

“Why the eagle should get perturbed by the hard wind blowing from the opposite direction, it is meant to make eagle soar higher in the sky”

**INAUGURAL ADDRESS OF SHRI A.R. ANTULAY, UNION MINISTER FOR
HEALTH AND FAMILY WELFARE AND CHAIRMAN OF THE COUNCIL AT
THE FOURTH CONFERENCE OF THE CENTRAL COUNCIL OF HEALTH
AND FAMILY WELFARE AT PARLIAMENT ANNEXE ON 11TH OCTOBER,
1995.**

My distinguished colleague Shri Paban Singh Ghatowar, my wise colleague Prof. J.S. Bajaj, the intellectual team of eminent persons, Shri Pant, Secretary (Family Welfare) , Dr. Mukherjee, Director General, Additional Secretary Shri. Chaudhuri, Hon'ble Chief Ministers, Ministers, distinguished guests and Officers.

You have heard the learned speech by Prof. Bajaj, preceded by an equally learned and precise observation by my colleagues Shri Ghatowar, Shri Pant and Shri Chaudhuri. I am a very practical man coming from a village and the sophistication has not touched me so far and therefore I will speak in a very rustic language that is India. The declaration of Health for All was made in 1978 and Parliament of India also endorsed it in 1983. Twelve years have gone by after Indian Parliament dedicated itself to provide health care to all. We are at the fag end of the century and there are hardly four years and odd months left. Let us put our hands on our conscience and be honest. Howsoever we fall shy today; it is going to be as clear as day light by the time 2000 A.D. crosses into 2001 A.D. I am afraid having assumed the charge of this Ministry precisely four months and one day ago, I tried to understand and grapple with the problems. I tried to understand the situation. I kept the Declaration before my mind as well as with a naked eye. Practically I have been discussing every day with my officers and colleagues as well as interacting with learned friends, not in the sense as it is said in the court but in the genuine sense. I find myself in wilderness and let me honest about it.

When I go to the country side and visit the Primary Health Centres things which at least ought to be there are non existent. The personnel who should be there are absent. Forget the lower part of 5000 which is supposed to have a sub centre which is below the Primary Health Centre and supposed to cater to 30,000 people. There is also one more ladder which is called Community Health Centre, which is meant for 1,20,000 folks and the last one is the district hospital. I am not aware as to how many of the PHCs will exist and how many will die out. On paper PHC does exist so does the sub centres, Community Health Centres and district hospitals. I am trying to be forthright and honest. Whether we like it or not but the people will not forgive us nor the history because we have committed ourselves. We have made a Declaration to the people, we have made a solemn commitment, with all sincerity, to be fulfilled. When we set the goal we slipped either in mileage or in terms of time. If I have to reach that particular goal either I will either go through the short cuts or change the course. If I can't reach through this and change the course I must know how long will it take in reaching the destination? If I can't reach I should not unnecessarily mislead the people.

It is true that achievements have been made, in many cases great there is no gain saying the facts. That the last man in the last hut in the last village will get Medicare/health care by the year 2000 A.D. will not be realized. We have no moral responsibility or democratic rights to say so. But having made the commitment, we must ponder whether we have accelerated our speed. Are we going in the right direction. I will be going to the floor of the House after six months and say that by the year 2015 or 2020 we are going to realize the goal of Health for All and that through the sciences of Yoga, Siddha, Ayurvedha or Unani Homeopathy, Naturopathy. I am very clear in that.

My prudence tells me that by commissioning all the systems to which references have been made by my two colleagues, it will be possible but we have not been doing much in that direction. We have established a separate Department of Indian System of Medicine and Homeopathy. We have a Council at the Central level and its meeting has been held for assistance and guidance.

In ancient India we did not have tertiary health care but people were much healthier and we should be proud of our own ancient culture. The knowledge that we had from our different Systems is now being transmitted to the western world and we are getting the feedback from secondary sources. We do not recognize the efforts put in by the local people. We only recognize what comes to us via the western world. When Dr. Bhavaskar made a research people were apprehensive. I have sent the reply and my officers have also seen it. We have seen a demonstration and presentation and the top cardiologists were present and they all were satisfied. We should welcome such a research and presentation. We have a rich forest wealth. It so happened that I have been to Chicago within few days after I took the charge of this Ministry. The research of herbal medicine is being carried out in the USA for cancer and I am told that the treatment is quite effective. In fact the number of doctors may be large if you take into consideration those who were working in Canada, Germany, U.K. and the West. Thousands of Indian doctors are there and they have made a mark. I have talked to them and they are willing to do something for their motherland and they are welcomed back. They are prepared to set up a cancer hospital and a trauma centre.

Tertiary care is expensive and may not be affordable so far as a small man is concerned. I rightly emphasize that anybody putting up a hospital should earmark 30% of the beds for the poor. When you put up a hospital in the joint sector to which reference has been made by Shri Chaudhari, 30% of the beds will be reserved for the poor. So that the medical attention at present is being provided to the richest will be available to the smallest and the humblest and the poorest man of India. There should be a commitment not of mind but of heart.

Let us first look at the villages where PHCs are located. Let there be the doctor and medicines. The doctors are not ready to go to the rural areas. I am told by the Chairman of the Medical Council that there is fraudulent clause that if somebody pays money he can get away. Why should the doctors not go to the villages. Why allow them to get away. We are spending a lot of money and that through the nose. After they have attained a degree, they must be made to serve in the rural areas. They should not be allowed to get away from it and that too only in exceptional circumstances on humanitarian grounds. We should also take advantage of those who have retired.

If the environment and water is unclean, nothing will give good results so far as poor are concerned. Almost every city has become polluted. There are false notions and ideas which have to be given up. Environment and forests are meant for the people. When ever I go to any rural area a lot of complaints come. I bring them to the notice of Director General of Health who is committed to the service of the poor and village people. Whenever I visit the native place of Sardar Patel, who has done a glorious service to the Nation by integrating the States, I am informed that the people and this notion has to be removed that they were more happier before Independence. In this context I must refer to the brilliant work done by one of the lady members who was looking after deliveries without fan no hot water and local people were giving donations to the tune of Rs.50000/-.If this can happen in a village why not over the entire country side.

From whatever quarters the health care comes whether from NGOs, the NRIs or the industrialists it is welcome for the CHCs, PHCs, District Hospitals and other referral centres. Unfortunately we have been very conservative and not exploiting the full potential.

Looking at the allocations for health, they have not been adequate. Health is the first thing that the human being needs from conception till his death. And health care is needed for him so long as he is alive.

One of the phenomenal problem that needs to be grappled and Prof. Bajaj has rightly said is population control. A space of at least five years should be kept between two children. At the age of 20 there should be first child and at 25 there will be the second and then 35. We have to see the problem of population realistically not only of the world but also of our own population.

Well my friends have said about universal immunization programme, communicable diseases and non communicable diseases and both are fatal. One should see goodness in the neighbors and protect them by keeping the disease within the four walls. But this is not happening. At least non communicable diseases like cancer can be stopped. Why should we not have pre Cancer Survey for early detection. T.B. is communicable. Why should we not have early detection. Like pulse immunization programme, which is going to be a national endeavour, we should have programmes for their control. Blindness can be stopped. I don't think we lack funds. Why should we not be able to prevent it right now.

As rightly pointed out by Prof. Bajaj the Constitution of India has gone to the grass root level viz Panchayati Raj. From Delhi nothing can be done, nor from the State Capital or even from the District. We have to go to the grassroot and the grassroot is the Panchayat and we should enlist the last man for the health care.

There have been many complaints about food adulteration. The Act is of 1956. I was invited to a meeting and I said that there should be a Task Force. I told them that the Task Force should first be appointed and the terms of reference and the scope shall be set by the Task Force. The legislation should be drafted. A Committee has been constituted. I requested the Ex-Chief Justice of India Mr. Venkataramiah to head it. I had mentioned a few names and I shall recall them Shri F. Nariman, Shri Ashok Desai, Shri K. Parasharan, Shri P. P. Rao, Ms. Shyamala Kapoor, Shri Daniel Latif etc. They have had two meetings and are about to come with legislation. It is a national task which they shall be discharging and somebody has to do it. The lawyer community is prepared to give a lot of time and the services needed provided good words are said. The moment we say that the nation needs their services; they are prepared to do it on a war footing. Earlier when there was an invasion from Pakistan or an aggression from China, the entire nation stood as one man. Let us also do it on a war footing. It is also an invasion. Outside invasion is visible but it is sabotage or undermining which is invisible.

We have got to have a surveillance system. The term surveillance should be replaced by detection. The word deduction is better than surveillance. If you can survey a disease, we can survey the remedy. There is not a single malady whose remedy is not created before. But we have to find where does it lie. It may lie either in the man made laboratories but it surely lies in the God made laboratories.

The entire forest wealth is rich of herbal medicines. The forest is a limited source but it is certainly rich and should be tapped with a missionary zeal, which requires and acquires piety in the eyes of God. Any person who renders himself useful to another human being, especially who is in misery or disease attracts piety in the eyes of God.

I now say about the Village Health Guide Scheme and the country needs it. It was a very good scheme but there were complaints that it was not properly harnessed. Just as we are now changing the name like from surveillance to detection, let us call it Panchayat Swasthya Seva Scheme. We can easily call it PSS. That person should be trained and there are many persons who are available to do the same.

They cannot come to us of their own as each person has an ego. The ego need not be deplored and therefore whether it is World Bank, WHO, UNICEF, SIDA or any other externally assisted or loan, we should take the full advantage.

The system of honorary doctors has been done away with. It fails to pass my comprehension. If each doctor devotes two hours in the Government Hospital, which are meant for the poor, and by abolishing this system we have not done any harm to the honoraries who are experts in their field, but we have made the poor patient poorer who cannot afford to pay the fees to the top persons like the top cardiologist, the top physician, the top diabetetian. We have deprived the poor of the consultant's services as they cannot afford to pay the fees. It is poorest of the poor who have to be provided with the consultant services.

I will end up with the up gradation of the blood banks. There are many reports in the news papers about blood. The blood should be pure and tested not only when it collected but also when it is being transfused. The up gradation of the banks is called for.

Health insurance is last item about which I will now refer. The entire population has to be covered by insurance and for which we have to take the necessary steps for the benefit of the poor. I have said on the floor of the House that the insurance should not for the sake of insurance. No individual should suffer for lack of medical aid. The contributor may pay some amount and the State may also pay. The insurance should be for the sake of health and not for the sake for death. The insurance should be for health for all. We should be able to provide the infrastructure and cover the entire population by insurance.

As regards Health for All I do not think that we shall be able to achieve the goal. Let the goal be extended. I don't mind of extending it up to 2015 or 2020 but it should be practically possible.

Members present at the Conference of Central Council of Health and Family Welfare

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| 1. Shri A.R. Antulay,
Union Minister for Health & Family
Welfare, New Delhi 110011. | Chairman |
| 2. Shri Paban Singh Ghatowar,
Minister of State for Health & Family
Welfare, New Delhi 110 011. | Vice-Chairman |
| 3. Prof. J.S. Bajaj,
Member (Health), Planning
Commission, Yojana Bhawan, New
Delhi 110 001. | Member |

**Ministers' In-charge of
Ministries of Health & Family
Welfare, Medical Education and
Public Health in the States/UTs with
Legislatures:**

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| 4. Shri T.L. Raj Kumar,
Minister for Health & Family Welfare,
Govt. of Arunachal Pradesh, Itanagar 791
111. | Member |
| 5. Dr. Bhumidhar Burman,
Minister for Health & Family
Welfare, Govt. of Assam,
Dispur 781 006. | Member
Memb |

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| 6. | Shri Mahabir Prasad,
Minister for Health, Medical Education
& Family Welfare, Govt. of Bihar,
Patna 800 015. | Member |
| 7. | Dr. Wilfred D'souza,
Dy. Chief Minister &
Minister for Health & Family Welfare,
Govt. of Goa, Panaji 403 001. | Member |
| 8. | Shri Nitin Bhai Patel,
Minister for Health & Family Welfare,
Govt. of Gujarat,
Ghandinagar. | Member |
| 9. | Smt. Kartar Devi,
Minister for Health & Family Welfare,
Govt. of Haryana,
Chandigarh 160 007. | Member |
| 10. | Shri Virbhadra Singh,
Chief Minister & Minister for Health &
Family Welfare, Govt. of Himachal Pradesh,
Shimla 171 001. | Member |
| 11. | Dr. H.C. Mahadevappa,
Minister for Health & Family Welfare,
Govt. of Karnataka,
Bangalore 560 001. | Member |
| 12. | Shri V.M. Sudheeran,
Minister for Health & Family Welfare,
Govt. of Kerala.
Trivandrum 695 001. | Member |
| 13. | Shri Ashok Rao,
Minister for Health & Family
Welfare, Govt. of Madhya Pradesh,
Bhopal 462 001. | Member |

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| 14. | a) Dr. Daulat Rao Aher,

Minister for Health & Family Welfare,
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| 15. | (a) Shri D.P. Panmei
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| | (b) Dr. Chalton Lien Amo,
Minister for Health & Family Welfare,
Govt. of Manipur,
Imphal 795 001. | Member |
| 16. | Shri K. Syiem,
Minister for Health & Family Welfare,
Govt. of Meghalaya, Shillong 796 001. | Member |
| 17. | Shri C. Chawng Kunga,
Minister for Health & Family Welfare,
Govt. of Mizoram,
Aizwal 796 001. | Member |
| 18. | Shri S.K. Sangtam,
Minister for Health & Family Welfare,
Govt. of Nagaland,
Kohima 797 001. | Member |
| 19. | Shri Jagannath Rout,
Minister for Health & Family Welfare,
Govt. of Orissa, Bhubaneshwar 302 001. | Member |
| 20. | Shri Rajendra Singh Rathore,
Minister for Health & Family Welfare,
Govt. of Rajasthan, Jaipur 302 001. | Member |

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| 21. | Dr. D. P. Kharel,
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| 22. | (a) Shri Prasanta Kumar Sur,
Minister for Health & Family Welfare,
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| | (b) Smt. Chhaya Bera
Minister of State Health & Family
Govt. of West Bengal,
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| 23. | Shri P. Ananda Bhaskaran,
Minister for Health & Family Welfare,
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| 24. | Dr. Harsh Vardhan,
Minister for Health & Family Welfare,
Govt. of National Capital Territory of Delhi.
Delhi. | Member |
| 25 | Shri G.S. Chima,
Administrator,
Lakshadweep. | Member |

Member of Parliament

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| 26. | "Smt. ILA Panda,
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| 27. | Dr. Jagdish C. Sobti,
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| 28. | Smt. Avabhai Wadia,
President,
Family Planning Association of India,
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Bombay. | Member |
| | | |
| 29. | Smt. Habbibulla,
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| | | |
| 30. | Smt. Amarjeet Kaur,
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| | | |
| 31. | Shri A.K. Rungta,
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| 32. | Dr. G. V. Satyawati,

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| 33. | Vaidya Devendra Triguna, | Member |

Ayurvedic Physician,
General Secretary,
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| 34. | Dr. V. I. Mathan,
CMC, Veilore,
Christian Eminent Scientist,
Vellore (Tamil Nadu) | Member |
| 35. | Hakim Abdul Hamid,
Chairman,
Hamdard Research Foundation,
Hamdard Nagar,
New Delhi. | Member |
| 36. | Shri J.C. Pant,
Secretary,
Department of Family Welfare,
Ministry of Health & Family Welfare,
New Delhi 110 011. | Member |
| 37. | Dr. (Mrs.) Sarla Gopalan,
Secretary,
Department of Women & Child
Development,
Ministry of Human Resource Development,
Shastri Bhawan,
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| 38. | Dr. A.K. Mukherjee,
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Dte. Genl. of Health Services, Nirman
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| 39. | Dr. A.K. Kundu,
Deputy Director General(P)
Dte.Genl. of Health Services, Nirman | Member Secretary |

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Special Invitees

40. Shri N.R. Krishnan,
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41. Shri K.B.Saxena,
Secretary,
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42. Shri C. Gopalan,
"Ministry of Labour, Shram Shakti Bhawan,
New Delhi.
43. Shri Bhaskar Ghosh, Secretary,
Ministry of Information & Broadcasting,
Shastri Bhawan,
New Delhi.
44. Shri Viney Shankar, Secretary,
Ministry of Rural Development,
Krishi Bhawan,
New Delhi.
45. Shri C. Ramachandran, Secretary,
Ministry of Urban Development,
Nirman Bhawan,
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46. Shri N.R. Banerjee, Secretary,
Department of Chemicals & Petro-chemicals,
Ministry of Chemicals & Fertilizers,
Shastri Bhawan,
New Delhi.
47. Vice Admiral (Dr.) Inderjeet Singh,
Armed Forces Medical Services,
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48. Shri I. Chaudhuri,
Additional Secretary
Ministry of Health &
49. Shri P.S. Bhatnagar,
Additional Secretary & Project Director (NACO).
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50. Dr. (Mrs.) Prema Ramachandran,
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51. Dr. Dinesh Paul,
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58. Prof. (Mrs.) Chandarama Anand, Principal,
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- 207. Shri R.S. Sajwan,
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- 208. J.C. Mohanty, Commissioner,
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- 210. Shri Rachel Chatterjee,
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- 212. Dr. B. Tada,
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- 213. Shri Harish Sonowal,
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- 214. Dr. (Mrs.) P. Dh'ar,
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215. Dr. A.R. Basumatary,
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216. Shri D.S. Mukhopadhyay,
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218. Shri H.A. Arfi,
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223. Shri J.P. Negi,
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- 224. Shri Balram Sharma,
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- 225. Dr. K.L. Kapoor,
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- 225. Shri A.Mohandas Moses,
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- 227. Dr. V.P. Gupta,
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- 228. Shri Verghese Samuel,
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- 229. Shri Gautam Basu,
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- 231. Dr. G.V. Nagaraj,
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- 255. Dr. Viu Meru,
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Govt. of West Bengal,
Calcutta.

279. Shri A.K. Mukherjee,
Joint Director,
Govt. of West Bengal,
Calcutta.
280. Dr. Shanmugam,
Director of Health Services,
Andaman,
281. Dr. N.M. Sharma,
AIDS Programme Officer,
Chandigarh Administration,
Chandigarh.
282. Shri Felix Sequeira,
Health Secretary,
Govt. of Pondicherry,
Pondicherry 605003.
283. Dr. N. Vengatesvaro,
Director (AIDS),
Govt. of Pondicherry,
Pondicherry.
284. Shri Ramesh Chandra,
Health Secretary,
Govt. of National Capital Territory of Delhi.
Delhi.
285. Dr.S.K.Chaudhuri,
Director Health Services, Govt. of
National Capital Territory of Delhi,
Delhi.
286. Shri Chaman Lal,
Health Secretary,
Andaman & Nicobar Islands Admn.,
Port Blair 744 101.
287. Dr. G.S. Aluwalia,

Director Health Services,
Chandigarh Administration,
Chandigarh 160 017.

288. Dr. L.N. Patra,
Chief Medical Officer,
Dadra & Nagar Haveli Admn.,
Silvassa 396 230.
289. Dr. S.S. Vaishya,
Chief Medical Officer,
Daman & Diu Administration,
Daman
290. Shri G.S. Chima,
Administrator,
Lakshadweep Administration,
Kavaratti 673 555.
291. Dr. K.A.Koya,
Director, (Medical & Health Services)
Lakshadweep Administration,
Kavaratti 673 555.

List of Invitees for Inaugural Function

292. Dr. Uton M. Rafei,
Regional Director for South-East Asia,
W.H.O. House, Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi 110 002.
293. Dr. N.K. Shah,
W.H.O. Representative to India,
Nirman Bhawan,
New Delhi 110 011.
294. Dr. John E. Rohde,
Director, UNICEF House,
73, Lodhi Estate,
New Delhi 110 003.

295. Mr. Wasin-Zamal,
Country Director,
U.N.F.P.A., 55,
Lodhi Estate,
New Delhi 110 003.
296. Mr. Hans-Vonsponeck,
Resident Representative,
U.N.D.P.,
55. Lodhi Estate,
New Delhi 110 003.
297. Ms. V. Sukuntha,
U.N.D.P., 55. Lodhi Estate,
New Delhi 110 003.
298. Mr. Feodor-Starcevic,
Director, U.N.I.C.
55, Lodhi Estate,
New Delhi 110 003.
299. Mr. J.K. Shirazi,
Chief of Mission,
World Bank, 55, Lodhi Estate,
New Delhi 110 003
300. Mr. Kristin Hefre,
1st Secretary Development
Representative from NORAD.
Embassy of Norway,
Chankyapuri,
New Delhi - 110 021
301. Mr. B. Jarne-Tenson,
(Councillor Develop Royal Danish Embassy,
India Representative from DANIDA.
F-42, South Ext.,
New Delhi - 110 049
302. Mr. John Rogosch,
Director of Health & Population

Representative from US AID.

B-28, Qutab Industrial Area,
New Mahrauli Road
New Delhi - 110 016

303. Mr. Y. Fuwa,
Chief Representative from O.E.C.F.,
Japan
2nd Floor, DLF Centre,
Sansad Marg,
New Delhi - 110 001

ANNEXURE-E

**TO BE PUBLISHED IN THE GAZETTE OF INDIA EXTRAORDINARY
PART II SECTION 3 SUB SECTION (ii)**

**CONSTITUTION OF CENTRAL COUNCIL OF HEALTH AND FAMILY
WELFARE**

**NO.Z.16011/1/95-B.P.
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NEW DELHI-110 011**

N O T I F I C A T I O N

New Delhi, the 21st September, 1995

So () In exercise of the powers conferred by article 263 of the Constitution and in supersession of this Ministry's notification No.Z.16011/13/ 89-B.P.,dated 20th January,1993 published in the Gazette of India : Extraordinary Part-II Section 3 Sub Section (ii) dated 22 January, 1993, 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
State in the Ministry of
Health and Family Welfare | Vice chairman |
| (c) | Member, Planning Commission | Member |
| (d) | Ministers in charge of the
Ministries of Health and Family Welfare, | Members |

Medical Education and Public Health

in the States/Union Territories with Legislatures.

- (e) A representative each of the **Member**
Dadar Nagar Haveli, Chandigarh,
Andaman and Nicobar Islands,
Daman and Diu and Lakshadweep.

(f)	<u>Members of Parliament</u>	:	Members
1.	Kumari Sushila Tiriya		Lok Sabha
2.	Dr. Laxminarain Pandey		Lok Sabha
3.	Shri Gufran Azam		Rajya Sabha
4.	Smt. Ila Panda		Rajya Sabha

(g) **Non-Officials**

- (i) Representatives from Health and : Members Family Welfare Sectors
1. President, Indian Medical Association (ex-officio)
 2. President, Family Planning Association of India, Bombay, (ex-officio)
 3. President, Indian Council of Child Welfare, New Delhi, (ex-officio)
 4. Chairperson, Central Social Welfare Board, New Delhi, (ex-officio)
 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)
 7. The President, All India Organisation of Employers, New Delhi (Ex-officio)

(ii) **Eminent Individuals** : **Members**

1. Dr. Pratap C.Reddy, Chairman, Apollo Hospital Group, Madras.
2. Dr. C.M.Habibullah, Gastroenterologist, Baitul Habeeb Venkateswara Colony Narayanaguda, Hyderabad (A.P.)
3. Dr. B.K.Goyal,,Dean, Bombay Hospital & Institute of Medical Sciences, Bombay.
4. Vaidya Devendra Triguna, Ayurvedic Physician, General Secretary, All India Ayurvedic Cong. Dhanwantri Bhawan, Punjabi Bagh, New Delhi.
5. Dr. V.I.Mathan, Christian Medical College, Vellore (Tamil Nadu).
6. Dr. R.S.Arole, Director, Comprehensive Rural Jainkhed, Dt. Ahmadnagar, Mahrasbtra.
7. Hakim Abdul Kamid, Chairman, Hamdard Foundation, Hamdard Nagar, New Delhi.
8. Dr. Bholanath Chakraborty, 5, Subal Koly Lane, Howrah, West Bengal.

Officials

1. Secretary, Department of Health -. Member
Ministry of Health & Family Welfare.
2. Secretary, Department of Family Welfare : Member
Ministry of Health & Family Welfare.
3. Secretary, Department of Education : Member
Ministry of Human Resource Development.
4. Secretary, Department of Women and : Member
Child Development.
5. Director General of Health Services : Member

6 Deputy Director General of Health : Member-secretary
Services (Pig.)

- iv. 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 shall be Members of the Council so long as they are members of Lok Sabha or two years whichever is earlier.
- v. The Members of Rajya Sabha shall be Members of the Council so long as they are members of Rajya Sabha, or till 2nd December, 1995, whichever is earlier.
- vi. The travelling and daily allowances of non-official members for attending the meetings of the Council shall be regulated in accordance with the provision of Supplementary Rule 190 and orders of the Government of India thereunder as issued from time to time.
- vii. The expenditure involved will be met from within the sanctioned budget grant for the purpose. 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.
- viii. The Council shall have a Secretarial staff consisting of a Secretary and such Officers and officials as the Chairman may, with the approval of the Central Government, think fit to appoint.

2. Nature of the duties to be performed by the council: -

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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 co-operation on a wide basis in regard to inter-State quarantine during times of festivals, out-break of epidemics 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 any organization or organizations invested with appropriate functions for promoting and maintaining co-operation between the Central and State Health and Family Welfare administration.

3. Procedure of the Council :-

The Council shall in its conduct of business observe following 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-chairperson 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 meeting shall be decided by a majority of vote of the members (including the Chairman) present at the meeting :
- (f) in case of equality of votes, the person presiding shall have a second or casting vote;
- (g) the Council shall observe in the conduct of its business such other procedure at it may, with the approval of the Central Government, lay down from time to time.

No.Z-16011/1/95-B.P

(I. Chauhan)
Additional Secretary

The Manager,
Government of India Press,
New Delhi.