

**SEVENTH CONFERENCE OF CENTRAL  
COUNCIL OF HEALTH AND FAMILY  
WELFARE**

**PROCEEDINGS  
AND RESOLUTIONS**

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**MINISTRY OF HEALTH AND FAMILY WELFARE  
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**GOVERNMENT OF INDIA**

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## **INAUGURAL SESSION**

## **WELCOME ADDRESS BY SHRI JAVID CHOWDHURY, SECRETARY, HEALTH**

Hon'ble Union Minister for Health & FW, Dr.C.P.Thakur, Hon'ble Union Minister of State for Health & FW, Shri Raja, Hon'ble Member, Planning Commission, Dr. Venkatasubramanian, Hon'ble Ministers of Health of State Governments, distinguished ladies & gentleman.

It is my privilege to welcome you all to the 7<sup>th</sup> Meeting of Central Council of Health & Family Welfare, which is being inaugurated to day. As you are well aware that the CCH&FW is the highest deliberative body in the sector of health which is being set up under the provisions of the Constitution. It is the observations of the Hon'ble Health Ministers and other representatives of the State Government, present here, which guide us through our working, through the year on matters of high policy and strategic interest.

Ladies & gentlemen, today we begin a 2 day Session of the Central Council. There is a wide array of agenda covering all three Departments of the Ministry of Health and FW, but if I'm to be partial and identify one subject, which I feel should attract your attention and for which we very keenly await your advice and guidelines and this being a subject which covers all three Departments, I would urge, that you please give your attention to Item no.1 which is the National Health Policy, 2001.

As you know, ladies and gentlemen, the last occasion when the Central Govt. announced the National Health Policy was in 1983 that is a long time ago. The various circumstances, which relate to the health sector have undergone wide scale changes and have in fact been restructured in very substantial ways. All this necessitates the drawing up of a New Health Policy. As you are aware, the major historical diseases, Malaria, TB, Water borne diseases, have not slackened, as we expected; they have shown persistence in the community which is totally unexpected. There is a new virulent communicable disease in the form of HIV/AIDS. The various health indices, which judge the health of the society, have shown improvement no doubt, but still they are far away from the targets earlier set. In all these situations, there is also an additional factor that is an external element on the health sector. As you all know, the country has been undergoing an economic restructuring, which consists of liberalization and globalization. It is a widespread perception that the early impacts of these exercises in economic reconstruction have an uneven impact on different sections of society and in order to ensure that the vulnerable section of society do not feel the impact of any adverse element, impact of restructuring and liberalization, the Central Govt. has had a very deliberate policy of ensuring that there is maximum gainful investment in the social sector, particularly the health sector. It is in this context that the National Health policy, 2001 becomes very important. Not only will we have to take into account the various components of the health scene, but this external factor which imposes itself on the health sector regarding the impact

of liberalization and globalization in the general economy.

Ladies and gentlemen, we are well aware that despite all our efforts, the total investment in the health sector is relatively low. The State and the Central Govt. have made their best effort. Despite all that, the amount of funds available and the impact on the health sector is less than desirable. We are well aware that health indices, though improved, are at unacceptably low levels and as a matter of indication, if I may say, that with all our efforts - Plan, Non-Plan State, Centre, all combined, the investment annually per capita in the health sector is no more than Rs.160. I think one major component of the National Health Policy which will be considered and on which we would be very happy to get the comments, guidance and impressions of the State Health Ministers is as to how to improve this investment so that the impact on the health sector becomes more significant and visible.

Ladies and gentlemen, as you well know that the Central Contribution to Public Health in the country is largely through the major disease control programmes and these disease control programmes have over the years had varying degrees of success. There are some notable successes; polio eradication is a notable success where the end is almost in sight. Leprosy elimination is also near success; if the few States which have a slightly high prevalence give a little importance to this public health initiative, I am sure that the level of elimination of leprosy in the country would be achieved. The public health programmes in respect of TB, elimination of cataract blindness and HIV/AIDS have achieved varying degrees of success. The malaria control programme is a source of some worry and we would welcome suggestions in that regard also.

Ladies and gentlemen, I would particularly request the Hon'ble Health Minister and the representatives of the States to give us guidance on the course correction which may be necessary for these disease control programmes in order to make them more effective, I would expect that the areas which would be of importance, would be the organizational structure under which these programmes are to be executed, the need for deployment of adequate number of staff in these programme bodies so that the duties can be carried out efficiently and also the strategy for association of NGOs and partnerships with Panchyati Raj Institutions; in order to ensure that the interface with the general public, the beneficiary group is best. On all these issues relating to national health control programmes, I would seek the comments and advice of the Hon'ble Health Ministers of the States.

Ladies and gentlemen, though I am in charge of the Department of Health, I have always held the view that the key department in the health sector is the Family Welfare Sector. The stabilization of the population in the country or the moderation of the rate of growth of population in the country is vital. No initiative taken in the Department of Health through various other health

programmes would have any significant impact. In fact, they would be futile, if there is no marked success in the programme for stabilization of the population. The various issues relating to Department of Family Welfare are before us and I am sure that the Hon'ble Ministers will be pleased to offer their guidance and comments in these matters.

Ladies and gentlemen, this Conference is being organized by the Central Government and I would like to express the view of the Centre that the key player in the health sector of the country is always the State Government. Let us understand that this is not only the constitutional provision, because under the constitution, the responsibility is that of the State Government but it is also the reality of ownership of the state administration by the State Governments. All Health Programmes are implemented through the State administration and therefore the success is in the hands of the State administration. We are well aware of the high importance given by the state administration to the social sector, particularly the health sector and I am sure that their advice and comments will help the Central Government greatly in crafting their projects and their initiatives in such a manner that it is most useful to them.

Ladies and gentlemen, before I close, I must give this assurance on behalf of the Central Government that while we recognize the key role of the State Governments, we do not wish to absolve ourselves of all responsibilities. We are there for all supplementary assistance by way of funds and by way of technical inputs. Before closing, ladies and gentlemen, one last sentence, I would like to impress upon the Hon'ble Ministers present here that their guidance, their comments and their policy indications, we treat with the highest importance and will be using them in all our future implementation of programmes.

Thank you.

**ADDRESS BY SHRI A. RAJA, HON'BLE MINISTER OF STATE FOR  
HEALTH AND FAMILY WELFARE**

Hon'ble Union Minister for Health & Family Welfare, Member Planning Commission, State Health Ministers, Members of Parliament, Members of the Central Council, Secretaries of Department of Health, Family Welfare and ISM&H, Secretaries from the States, DGHS, State Directors General of Health Services, Senior officials of Centre and State Governments, eminent experts nominated to the Council, Members from the Press and friends.

I am very happy to be present here today among the cross-section of eminent persons from different areas of the health sector. This Conference of the Central Council of Health and Family Welfare is being held at an opportune time when we have recently adopted the National Population Policy, 2000 and are in the process of finalizing the National Health Policy 2001. NHP 2001 will attempt to set out a new policy framework for accelerated achievement of public health goals and your recommendations will certainly go a long way in helping us in this direction.

Even though health is a State subject, the Central Government has traditionally provided additional funds through Centrally Sponsored Schemes (CSS) for control of some of the major public health problems.

Increasing longevity, demographic transition resulting in rapidly rising numbers of aged population, urbanization, increasing pollution, and change from traditional diets, sedentary life style and increase in the stress of day-to-day living have led to an increase in lifestyle-related disorders and non-communicable diseases.

In order to ensure a smooth flow of resources from the Centre to the programmes operated at the field level and improve monitoring, many of the on-going national programmes have created State or District level societies. The society model experimented in some States has proved to be an effective delivery system for implementation of targeted public health programmes. In order to improve effective integrated functioning, it would be necessary to adopt this model but it would be essential to constitute a single health & family welfare society at State or District level. This would also lead to greater absorption of funds and better implementation of all the programmes in the States.

Committed to the overall objective of attaining "Health for All by 2000" as contained in the National Health Policy formulated in 1983, substantial investments were made in establishing an impressive primary health care system thereby reducing urban bias. However, with no increase in the real health budget over the years, perhaps this investment has been at the cost of secondary and

tertiary care that provided curative services. The impressive achievements in the rural infrastructure have to be viewed with the inability of the State Government to provide the full complement of staff, medicines, drugs & consumables, etc. to understand why a large number of these structures are practically non-functional. This gap has perhaps been filled with the private sector.

The private sector is playing an important role in the delivery of health care services. Available statistics reveals that almost 80% of ambulatory care and 55% of institutional care is being provided by the private sector. At present, there is no effective mechanism to regulate the services being provided in the private sector. Therefore, there is an urgent need to formulate a realistic legal framework to ensure minimum standards for hospitals and nursing homes in the country and we are looking forward to the response of the States to the Draft Bill which has already been circulated to them.

In the food sector, there is a need to combine the current regulatory approach of lifting samples and initiating punitive action with efforts to educate the manufacturers, retailers as well as the consumers on the impact of adulteration on the health of the consumer and how this can be avoided by following simple measures.

One of the major concerns in relation to ensuring uniform implementation of provisions relating to food safety is the fact that we get very little feed back from the States in terms of the prescribed periodical reports on the activities undertaken by them, despite numerous reminders. In fact we have been able to fully compile the data pertaining to PFA activities in the country only up to 1997. You will agree that in this age of information technology this is indeed a matter of concern that we all need to address ourselves on a priority basis.

An important issue related to the enforcement of quality in the drug sector relates to the increasing reports about the presence of spurious drugs in the market. States are required to give a special focus on proper surveillance and on effective liaison with the law and order machinery in the States, so that such unwarranted activity can be curbed. The Central Govt. is trying to introduce measures that will further streamline the work of regulating the drug sector by increasing the span of licenses granted for manufacture and retail activities and for reducing the mandatory number of inspections required to be done by the enforcement agents. Such streamlining will improve the quality of the regulatory work and make it more effective

At the grass root level a number of key issues need to be addressed. Better management, more efficient administration, greater accountability and improved quality of service in the health sector must be ensured.

In order to achieve a stable population, an inter-sectoral approach is essential. Stable population will be the outcome of combined efforts that make reproductive health care accessible and affordable for all, increase the provision

and outreach of primary and secondary education, extend basic amenities, including sanitation, safe drinking water and housing, and empower women and enhance their employment opportunities, and provide transport and communications.

Polio eradication has been a massive struggle and total success in the battle against all vaccine preventable diseases require a significant improvement in the routine immunization programme, the standard and quality of which has been steadily declining in quite a few States, especially the States in the northern and eastern parts of India. Streamlining and improving the outreach of the routine immunization programme is essential to derive a lasting benefit from a crash programme like the pulse polio programme.

A countrywide national programme for strengthening routine immunization has been recently launched with World Bank assistance with the precise objective of reviving the Mission Mode in immunization activities. This also offers some special facilities and assistance to eight weakly performing States. I request all States to take personal interest in this programme and review its performance from time to time.

Keeping in view the stationary and high maternal mortality rate, major initiatives have been launched for those States with an unsatisfactory record of institutional health care and safe delivery. Principal among these programmes are the RCH camps in 102 districts and the Dai Training and Equipping Programme in 142 districts.

Two other hitherto neglected areas on which my Ministry is focusing attention are Tribal Reproductive Health care and Urban RCH. Flexible strategies for improving health care and outreach services in tribal areas and urban slums have been evolved after in depth and wide ranging consultations with experts. Several pilot projects are being launched. The Ministry intends to launch full-fledged programme in these areas in the Tenth Five Year Plan.

In India, we have the good fortune of having already set up a vast infrastructure and we have over 4 lakhs registered practitioners of Indian Systems of Medicine. ISM&H is required to be strengthened and the vast infrastructure of physicians, teaching institutions, hospitals, dispensaries and drug manufacturing units utilized positively in the health care delivery system. Mainstreaming of ISM&H has already begun in the case of the Reproductive & Child Health Project.

There is a world wide resurgence of interest in traditional medicines using medicinal plants and herbs for drugs. The market is expanding rapidly. We must use this opportunity for propagation of our systems abroad which will also help in increasing export of our drugs. We are taking various steps for propagation overseas including participation in promotional events. We look forward to the participation of trade and industry and state governments have to encourage their manufacturers to make use of opportunities created by our missions abroad, by

Confederation of Indian Industry, by India Trade Promotion Organization etc.

Through the combined experience of this august gathering we can certainly develop strategies to be able to use limited resources in the most optimum manner. What is required is a holistic approach, a convergence of ideas, common goals for upliftment of the poor and community participation to ensure sustainability of programmes.

Thank you.

**ADDRESS BY DR. K. VENKATASUBRAMANIAM, MEMBER,  
PLANNING COMMISSION**

Hon'ble Padamshree Dr.C.P.Thakurji, Hon'ble Shri A.Raja, Shri Javedji, Shri Nandaji, Smt.Shailajaji, Dr.Agarwal, Ministers from States, Secretaries, medical experts, ladies & gentlemen.

I have already given my paper and I don't want to read it. I would be very brief. I must first of all, thank Hon'ble Thakurji, for asking me to say a few words. I would like to place on record my deep sense of appreciation of the leadership given by Shri Thakurji and his team towards a very difficult task. We are on very good grounds today we have improved by 13 points as per the latest Human Development Report released day before yesterday.

You must have seen the Approach Paper of the Tenth Plan sent by the Planning Commission to all of you in the States. There our beloved Prime Minister has said that the target will be alleviation of poverty and two thrusts will be education and health. If you give education & health automatically things improve but are we unable to do it that is the problem. When we started India's freedom we had 5% of girls in primary schools, today after 50 years we were able to bring in only 50%. 50% of the girls are outside; the PM for the first time started the Department of Elementary Education in Delhi; though it is a State subject he is concentrating on that. Similarly, the eminent persons here are doing the work on health and family planning, but Sir, I want to just highlight certain areas for your attention.

First of all, I want to pinpoint/underline that this is a State's job. Planning Commission is like the aunt in the house, will give you money, will look at the things but you have to do the job. Thakurji can give you funds, he can give you advice, can push the wheel but you have to pull the cart, which is a very important aspect you should not forget. I would like to say though we have improved our nutrition conditions and doubled life expectancy, it is very good thing, but there are certain areas on which I want you to concentrate, for example, Infant Mortality Rate (IMR). In this country, if continues to be as high as 70 per thousand. The past few years have seen IMR hovering around 71-72 per thousand. The rate is much higher than several other developing countries. In Indonesia, China, Vietnam, Iran, Sri Lanka it has been brought down to 38, 33, 31 37 & 17 respectively. IMR is a crucial indicator of the overall well being of the country.

At the same time, immunization against diseases such as tuberculosis and measles continue to be rather poor. Sri Lanka, for instance, has reached close to 100% immunization level. 97% children are immunized against tuberculosis and 95% against measles. In India, only 55% children are immunized against measles and 72% against tuberculosis. Shri Javed Chowdhury and myself attended a WHO Conference in Europe and they told us that 30% of all TB patients of the world are in India. It is time we take, note of this. The falling immunization levels from various vaccines have been of concern of Health and Family Welfare Ministry for quite sometime. Despite the huge success of pulse polio vaccination,

the immunization levels of all other diseases covered under the programme have shown a decline. This has been leading to sporadic outbreaks of the diseases especially diphtheria and measles from time to time. Even countries ranking much below India on the HDR index such as Mongolia enjoy healthier trend with 97% of the children having received the shots for tuberculosis, and 86 % for measles. Over 50% of children under 5 are underweight here for their age. Poor nutrition continues to be a major problem. An extensive national family health survey conducted all over the country has shown that over 70% of the children in most major States in the country are suffering from non-deficiency - anemia-affecting their overall growth and development. The Survey shows a high rate of anemia, in not just the usual backward States, we always say BIMARU, it is not so; not only in Bihar but this is also prevalent in progressive States like Maharashtra, Gujarat, Punjab. While Bihar showed over 79% of anemic children - they are not able to grow; they are dwarfed, they become orphans in life - Maharashtra was not too far behind with 72.2%, Punjab too had 74.7% and Gujarat 70%. Kerala which showed a better nutritional status of children also reported 42.2% of children having anemia. So Sir, I once again repeat that Thakurji has given an eminent leadership. It is up to the States to follow.

I had recently been to Israel. I found there every administrator keeping a chart. There he says girl children admitted this month equal X, next month it must be X plus; so he watches it, follows it, not only reports, not only seminars and speeches but action.

The one word Sir, I would like to recommend, if you want to succeed, it must be governance, governance and nothing but governance.

Thank you.

**PRESIDENTIAL ADDRESS BY DR. C.P. THAKUR, HON'BLE UNION  
MINISTER FOR HEALTH & FAMILY WELFARE**

Shri A Raja, Hon'ble Minister of State for Health and Family Welfare, Government of India, all the Hon'ble Ministers from different States and UTs, Hon'ble Members of Parliament, Shri Javed Chowdhury, Shri Nanda, Secretary, Family Welfare and Smt. Shailaja Chandra, Secretary, ISM&H, all officers from Central Government, officers from the States, Members of this Council, Members from the Press, Ladies and Gentlemen.

This meeting is being held at a very exciting time of development in health care. Recently, all of you are aware that human genome has been mapped and now in the coming 10-15 years, the medical treatment is going to be based on these genome studies, even at the level of the primary health care, so we have to prepare ourselves for that.

In the recent months, two important elections were held in the World, one in United States and one in England and health was an important issue in both the elections; but in our country health has not got the same importance as it has in the West. So all of us have to try to give importance to health, the Central Government and the State Governments. I agree with the views of Health Secretary and Member, Planning Commission that you are the main player in the health field and we are just behind you. So if you go "ahead, we will always be there to help you, and it is the need of the hour that States should work very hard in the health sector.

Now, I have to read a very long speech as this is an extremely official meeting. As Secretary, Health has already pointed out, we will need your comments on the background paper circulated for National Health Policy; after the comments are received, the Draft Policy will be circulated to different Departments and different bodies and after that it will become a policy.

I think that this Council has also to authorize that after recommendations / suggestions are received on the health policy, the Department will circulate it.

Friends, despite well founded anxieties about the health status of the country, we have had significant achievements. Since the inception of the planning process in the country, Government policy has been focused on reducing morbidity and mortality due to various diseases like malaria, tuberculosis, leprosy, etc. Doubling of life expectancy, halving of infant mortality and fertility rates, eradication of small pox and guinea worm, containment of malaria, reduction of leprosy and its elimination in all but five States in India and the near eradication of polio are some gains witnessed during the past five decades of planned development. There is the credits side.

Notwithstanding the above, the country's health care system faces major

challenges. Resurgence in malaria, limited success in Tuberculosis, the emergence of various other infectious diseases like HIV/AIDS and Hepatitis and life style diseases of cardiovascular, ischemic, cancer, diabetes and care of the elderly because of increase in the life expectancy, as well as neuropsychiatry and trauma related diseases are causes of serious concern as they have grave repercussions on the health of the economy. Future challenges are enormous and meeting these challenges will make a major difference in the quality of life of the common man in India. This is also a worrying problem, how we can provide a good health service to the poor and common man. This problem should be addressed.

In spite of providing strong financial and technical support for the National Malaria Control Programme, we are concerned with repeated outbreaks in various parts of the country leading to avoidable mortality and morbidity. Utilization of funds provided for malaria control programme has also not been up to the mark because of lack of participation and ownership by some of the State Governments. I would request the Health Ministers to concentrate on micro level programme management and timely interventions to prevent outbreaks of malaria and consequential deaths.

Personally, I think that there are so many Committees - AIDS, Malaria, TB, etc. If States want they can make it as one Committee under DM, Civil Surgeon and others and it can be well managed.

The TB Control Programme is set for a large expansion to cover 800 million populations in the country. This would be implemented through a highly decentralized set up in the form of State TB Societies. One of the goals of the proposed Health Policy would be to reduce morbidity and mortality in TB to half the present level in the next ten years. Again, in coming years, resistant TB is going to be treated by gene therapy, why genes have become resistant? So they will develop drug according to that gene.

We have recently launched the second phase of the National Leprosy Control Programme to reach elimination level of one case per ten thousand populations within the next three years. This goal, when achieved, will be an important landmark in disease control in India. Elimination of leprosy depends on our determination.

HIV/AIDS has emerged as one of the most serious public health concerns in India. We already have a huge disease burden of about 3.86 million infected persons. The recently-concluded UN General Assembly Special Session on HIV/AIDS highlights the importance of global action for effective prevention and control of this deadly disease. Hon'ble Prime Minister of India is taking personal interest in the monitoring and implementation of this programme. He has recently reviewed the performance of the programme in some of the high-prevalence States with the Chief Ministers. He would also like to continue this review with the Chief Ministers of the low-prevalence States as well. I would

request all the Health Ministers to keep HIV/AIDS as a priority programme and to monitor it closely. This disease is totally preventable; it is because of the ignorance of the persons they get the disease it can be prevented by creating a strong awareness amongst the public.

There is an urgent need to tackle the menace of various diseases by adopting appropriate strategies. Efficient and effective implementation of national health programmes will go a long way in reducing the morbidity and mortality due to various diseases.

The country is passing through a demographic and epidemiological transition necessitating a revision of the 1983 National Health Policy. As already mentioned by Secretary, Health in his welcome address, we propose to have an in-depth discussion on the background paper circulated for the National Health Policy. The objectives and the goals have been detailed. Various determinants like financial resources, equity considerations, role of the States vs. the role of the Centre, human resource development, all of which have a bearing on the health status have been discussed. I am sure, the deliberations today by the eminent experts present here will play an important role in guiding us to formulate a concrete future Plan of Action.

Mortality on account of communicable diseases could come down and valuable lives saved during outbreaks of diseases like malaria, cholera, gastroenteritis, etc. if the responses were quick and effective and a proper surveillance and reporting system is built to enable effective intervention. We plan to take up integrated Disease Surveillance Programme during the Tenth Plan as a Centrally Sponsored Schemes initially for communicable diseases which later would be expanded to include non communicable diseases as well. We are, at present, guided only by the paper report. If we read that there is an outbreak of leptospirosis in Kerala or of malaria in Bihar or deaths from Kala-azar, we immediately send teams there. But with this mechanism we would be able to prevent the disease earlier. I solicit full support from the States for building an effective surveillance system.

Food is an integral part of the life of every citizen in the country and Government is required to ensure that the food consumed by the citizen is safe, of standard quality and is not detrimental to their health. Unfortunately, it is seen that this activity is not being given the kind of priority it deserves in the States. There is an urgent need to ensure that adequate funds are made available for lifting samples as well as for adequately equipping and maintaining the food labs. More important, it is necessary to train the personnel - both enforcers and the analysts in the laboratories - with regard to the importance of testing critical contaminants and adulterants that are harmful to health and not doing testing only in terms of constituents of food mentioned on the label.

In so far as drug regulatory activities are concerned, there is an urgent need for inter State harmonization of regulatory practices so that the provisions of the

Drugs and Cosmetics Act, 1940, are uniformly implemented in the country. This has become a critical necessity with increase in inter State commercial activities and also to provide greater credibility to the quality and safety standards followed by the Indian Pharmaceutical Industry, which has emerged as a major player, even internationally, for supply of reasonably priced, quality drugs, especially for the poor.

There has been an increasing concern over the issues related to overcrowding of general hospitals, spiraling costs of new multi-specialty hospitals, the large scale proliferation of single doctor outlets with little regulation on quality and prices. Surveys and studies have shown that the private sector is emerging to be an important provider both in delivery of primary as well as tertiary health care services. In view of the ground realities of a strong private sector presence in the health sector, a legal framework is being evolved to regulate the private sector in the delivery of health care services in a manner that will ensure it to be more responsible, accountable and accessible. This issue has been discussed at various forums including the last two meetings of the Central Council of Health & Family Welfare. I would request the State Governments to deliberate on this issue and come out with specific suggestions on the draft legislation circulated to all States/UTs. Some of the hospitals take land from the Government at subsidized rates assuring 20% of the patients would be treated free. However, not a single patient is treated free. So all this has to be regulated.

Now, I would like to share with you some of the major successes as also some significant new initiatives in the family welfare sector.

Since the last meeting of this Council, a lot has happened on the population issue. The Government has come up with the National Population Policy in February, 2000. The National Commission on Population has been set up with Prime Minister as its Chairman. The first meeting of the Commission has been held on 22<sup>nd</sup> July, 2000. The next meeting of the Commission is scheduled to be held shortly. An Empowered Action Group has been created within the Ministry of Health and Family Welfare to give focused attention to achieving the goals set in the National Population Policy in the States which have been lagging behind on the population issues. These cover the States of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttaranchal, Jharkhand and Chhattisgarh. A National Population Stabilization Fund with the initial contribution of Rs.100 crore is being set up by the National Commission on Population in the Planning Commission. Working Groups have been constituted for preparing implementation plan for the key areas concerning population stabilization efforts.

The main thrust, will continue to be on family welfare programme which addresses three issues simultaneously, namely maternal and child health, and contraception, supported by information, education and communication. Actually, maternal deaths occurring in India in one week is more than the maternal deaths occurring in whole of Europe in one year according to a study done by some British agency and signed by PM of England.

Another issue, which has come into focus, is the prevalence of female foeticide which seems to be one of the reasons for adverse sex ratio in almost all the states in the age group 0-6, as has been revealed in Census 2001. In order to check female foeticide, the Pre-Natal Diagnostic Techniques (PNDT) Act, 1994 came into operation from 1<sup>st</sup> January, 1996. However, despite the law only a few cases have been reported. The Supreme Court in a PIL has shown its concern on non-implementation of the law and have passed certain directions to the Central Government as well as State Governments and Appropriate Authorities who are the real functionaries to implement the provisions of law. We recently held a Conference of all the Appropriate Authorities at Delhi to sensitize them for their active role in the implementation of the Act. Many suggestions have come up in this Conference. I seek your utmost cooperation in the implementation of the PNDT Act.

In so far as the Pulse Polio Programme is concerned, truly impressive progress has been recorded and it is expected that by the end of the coming winter season, we shall be able to reach the 'zero incidence stage'. As against 92 cases up to June end last year, this year, there have only been twenty cases till July 7. UP and Bihar, where active transmission is confined, we have to make concerted efforts to stop transmission of the virus in the remaining pockets in these two States.

Although our national vaccination programme only includes six basic vaccines the world has since come up with a host of new vaccines [Hepatitis B, MMR, etc.] fit for universal application. Time has now come for India too, to expand the range of its immunization programme. We are shortly going to launch a pilot project on Hepatitis B in a number of districts and States with a consistently good record in routine immunization. I hope during the Tenth Plan the entire country will register an improvement in routine immunization, good enough for introducing the Hepatitis B vaccination programme everywhere.

Stagnation in the decline of IMR, which has been stationery at 70-72 per 1000 live births for the last 3 - 4 years, has become a matter of acute concern. What is more worrying is that IMR seems to have plateaued, even in otherwise well performing States like Tamil Nadu, Andhra Pradesh, Maharashtra and Karnataka. The main reason for high IMR and the arresting of the decline of IMR is high neo natal mortality which still accounts for nearly two-thirds of infant mortality. Since 1992, the Ministry has been supplying new born care equipment and drugs at the PHCs and sub-centre levels. Training in new born care has become an integral part of the RCH training programme for medicals and Para medicals. We have also recently evolved an effective and fruitful partnership with the National Neo Natology Forum, whose members are now implementing a major programme for training and educating medical and Para medical personnel, in both government and private sectors in many States. Recently, I was reading that in England the Health Minister announced that the infant mortality is 8 per 1000 live births and this should be reduced; we on the other hand are plateauing at 72 per 1000 live births; so we have to do a lot in this field.

I request every State Government to make optimal use of these facilities and inputs and focus on neo natal health care.

One of the country's greatest concerns is the unacceptably high maternal mortality ratio which too has not come down during the last decade. Essential and emergency obstetric care are therefore of central importance in the family welfare programme. No doubt, one of the basic objectives of the RCH programme is improvement and expansion of the institutional health care. However, nationally, not more than 25 - 30 per cent of deliveries take place in institutions. While the situation is improving in Tamil Nadu, Andhra and Maharashtra, there has not been much perceptible improvement in institutional or even safe deliveries in UP, Bihar, Madhya Pradesh and Rajasthan, including the newly formed States. Recognizing the ground realities, we have now launched quite a few major initiatives in the RCH programme as already detailed by MOS.

The Indian Systems of Medicine have been practiced in our country for the last many centuries. These systems were well accepted by the people and have their own concepts, philosophy and therapeutic strength. They are efficacious, safe and cost effective in dealing with many common ailments and several chronic diseases.

However, the ISM&H Sector has been facing the problem of quality and quantity of raw materials required for the manufacture of drugs. Adulteration and substitution of ingredients have been affecting the effectiveness of drugs. The Medicinal Plants Board has been set up which will draw up policies and schemes for the development of this Sector with the objective of augmenting the availability of genuine raw drugs for domestic use for export. I urge the States to set up their own Medicinal Plants Board and this is a huge emerging area and a lot of benefits can accrue through the cultivation of medicinal plants. An assessment by the World Health Organization states that in the coming two decades, the world market for medicinal plants will be of around 5 trillion dollars. So it will be a huge market in coming years. China has been doing a lot of export, around Rs. 40,000 crores, we are at around Rs. 400 crores. So we have to do a lot in this field.

Quality assurance is extremely important for enlarging acceptance of ISM&H drugs domestically and overseas. Pharmacopoeial standards have been evolved for a number of drugs and completion of pharmacopoeial standards for remaining drugs has been accorded highest priority. State pharmacies and laboratories are being assisted under a new Centrally Sponsored Scheme to upgrade and strengthen them. Our own laboratories Pharmacopoeial Laboratory for Indian Medicine and Homoeopathic Pharmacopoeia Laboratory are also being upgraded and strengthened to act as Appellate laboratories.

Keeping in view the mushroom growth of medical institutions without adherence to minimum standards, the Central Council had resolved in its last meeting that

no more colleges of ISM&H should be allowed to be established. We all have to address this problem and make concerted efforts to consolidate and improve what we have instead of proliferating more colleges lacking in basic infrastructure.

Homoeopathy is also very popular in our country. A good number of institutions have come up for UG & PG teaching. Availability of Homoeopathic medicines through limited outlets has been causing difficulties in procurement of medicines by users. Now Schedule K has been amended and it will facilitate availability of a number of homoeopathy drugs in all licensed pharmacies. Recently, there has been a worldwide trend that there should be integration of traditional system of medicine with the allopathic systems. Certain countries, like England have evolved modules of how MBBS students can be sensitized to Ayurvedic and other systems. 40% of the practitioners in England give some services in traditional medicines, Ayurvedic, herbal, etc. There was recently a meeting of House of Lords, where they have classified all the complementary medicines in different categories and we sent a team from India that our Ayurvedic should be put in category 1.

We feel that the medical colleges in our States - which were centres of excellence in the past - have deteriorated, because of lack of funds. After in-house-discussion, it was felt that some funding arrangement like University Grants Commission should be established for funding these institutions and strengthening them. We also felt that medical college libraries should be connected with the National Medical Library here. This initiative has already been taken. In each area at least one centre of excellence in medical treatment should be established.

In the area of medical education, some States are going in for three years Licentiate Medical Practitioners (LMP) course because the doctors are not going to the rural areas. This is a major problem in most of the States but this step appears to be retrograde because in those periods when the LMP was there, the view was to have adequately qualified doctors at the level of the primary health centre. Therefore, that system was abolished. Again we are going back to that system. In spite of that, the State Government can ensure the presence of doctors and paramedics at the PHCs/referral hospitals, etc. Primary Health Centre should be made functional - only then can health care improve in rural areas. There should be some medicines in such centres as well.

Some reform is required in the field of medical education. In USA, they teach molecular biology in the first year of medical science. So for the coming two decades, when genetics is going to play a very major role, all these things should be incorporated in our curriculum as well.

With these words, I thank you again. We will be enriched by your suggestions and advice. Thank you.

## **VOTE OF THANKS BY DR. S.P. AGARWAL, DIRECTOR GENERAL OF HEALTH SERVICES**

Hon'ble Union Minister for Health & Family Welfare, Hon'ble Union Minister of State for Health & Family Welfare, Hon'ble State Health Ministers, Hon'ble Members of Parliament, other Members of the Central Council, Secretaries of Departments of Health and Family Welfare and Indian System of Medicine & Homoeopathy and other distinguished participants.

It is my privilege to extend a vote of thanks-to the august gathering present here today of health policy makers, health administrators, experts and other eminent persons in the field of health, family welfare and Indian System of Medicine and Homoeopathy.

We are fortunate in having an eminent leader like Dr. C.P. Thakur as our Chairman to steer us in the right direction. He has been a constant motivating factor and this Conference of the Apex Advisory Body on Health could not have been organized today but for his tremendous initiative and interest. His illuminating and wide ranging address has set the pace for the deliberations during the two day conference. I extend to you, Sir, our sincere thanks, not only on my behalf but also on behalf of the Members of the Central Council of Health & Family Welfare. I would also like to take this opportunity to thank the Hon'ble Minister of State for Health & Family Welfare for his valuable words of advice and his stress on the need for action. He has been a source of inspiration and has provided appropriate guidance wherever required. I also thank Member, Planning Commission for his kind words.

Although we have during the last five decades various success stories to relate in the fields of demographic indicators, control of certain diseases resulting in eradication of small pox and guinea worms, polio eradication in the foreseeable future and a drastic reduction in leprosy, yet the country's health system is faced with critical challenges in the new millennium.

Of the major challenges confronting us, the top priority goes to the increasing population; the high growth rate needs to be arrested speedily through concerted action. The NPP 2000, with its effective implementation and appropriate linkage with the health policy would, I am sure, result in improving the life as well as general health of the masses.

An increasing population of the young and elderly is a direct outcome of the demographic transition which in turn has arisen on account of a decline in the CDR and IMR and an increase in the life expectancy. We are today, also in a phase of epidemiological transition where apart from communicable diseases like HIV/AIDS, TB, Malaria, Kala-azar, we also have to tackle a number of non-communicable diseases like Cancer, CVD and Diabetes. An increasing trend witnessed in the number of trauma cases is also emerging to be a matter of

concern for years to come.

It is imperative to reduce the disease burden on account of non-communicable diseases through massive health education campaigns with the objective of promoting a healthy life style and educating the masses on the dangers of substance abuse, rich diets, absence of physical activity, etc.

In order to prevent the epidemics and outbreaks, it is absolutely essential to strengthen the existing surveillance activities across the country to be able to get early warning signals and initiate follow up action in a timely manner. An integrated National Disease Surveillance System for the entire country, initially for communicable diseases, is the need of the hour and full cooperation of the States is a necessary condition for this to happen.

The regional imbalance in availability of not only qualified medical practitioners but also in nursing and paramedical personnel is another area of concern which needs to be addressed.

I am confident that with the seasoned guidance and advice of the Council Members and Experts, the deliberation during the two day conference would come forth with a purposeful strategy and directions on the major health issues, thus paving the way for the new health policy.

Thank you all.

## **PROCEEDING**

## **Proceedings of the CCH&FW**

The 7 Conference of the Central Council of Health & Family Welfare was held under the Chairmanship of Dr. C.P. Thakur, Hon'ble Union Minister for Health & Family Welfare at Vigyan Bhawan, New Delhi on 12-13<sup>th</sup> July 2001. The Conference was attended by Ministers, In charge of the Ministries of Health & FW, Medical Education and Public Health, Indian Systems of Medicines and Homeopathy from the States/Union Territories, Members of Parliament, and Members of the Councils, eminent experts in the field of Health & FW as also Senior Officers from the Centre, States and UT Administrations. The Gazette Notification constituting the Seventh Central Council of Health & Family Welfare is given at Annexure 'A'. List of participants is given at Annexure 'B'.

### **12<sup>th</sup> July, 2001**

After the welcome address of Shri Javid Chowdhury, Secretary (Health), the Hon'ble Minister of State for Health & Family Welfare, Shri A. Raja gave his address. This was followed by a short address by Member, Planning Commission, Dr. Venkatasubramaniam. Thereafter, the Hon'ble Union Minister for Health and Family Welfare, Dr. C.P. Thakur delivered his Presidential Address.

This was followed by presentation of National Awards for elimination of leprosy which entailed reducing patient load to <1 case/10,000. This award was presented to six States, viz., Nagaland, which was the first State to achieve elimination of leprosy in 1998-99 in all its districts. Other States included Haryana, Himachal Pradesh, Meghalaya, Mizoram and Tripura who achieved this target by March, 2000 during Phase I of the National Leprosy Eradication Programme.

Dr. S.P. Agarwal, Director General of Health Services concluded the inaugural session by delivering his vote of thanks.

This was followed by a brief presentation on the background note of Draft National Health Policy - 2001 by Shri JVR Prasada Rao, Additional Secretary, Deptt. of Health. The members of CCH&FW were then asked to give their views.

**The Health Minister, West Bengal** opined that there should be a separate meeting to discuss the draft national health policy. He also wondered whether the public health expenditure could be stepped up from 1% to 2% of GDP by 2010 as enunciated in the background note of draft health policy. He expressed that States were no better than municipalities on account of the meagre resources at their disposal. The plan expenditure was dwindling and this was all the more so after liberalization. He also stated that the system of Licentiate Medical Practitioners had been scrapped two and a half decades back in the State of West

Bengal. According to him, health should not be viewed in isolation. The performance of the health care system in West Bengal was good not only because of good health care delivery system but also because of land reforms, effective panchayats, etc. Such fundamental issues are also required to be addressed while revising the National Health Policy.

**The Health Minister, Maharashtra** highlighted the increase in urban slums and the associated problems therewith. He informed that the primary health centres were given to the Panchayati Raj Institution on 2<sup>nd</sup> October 2000 in his State. He also stated that there was a Rural Health Department rendering various services in the rural areas and village guides were playing an important role. He added that the school health programmes were doing well in his State. Polio programme had also been successful. The State of Maharashtra is badly affected by AIDS and various measures are being taken to combat this deadly disease. Surveillance activities have been started in three districts. Modern diagnostic facilities are being installed for Cancer and a Cancer Hospital for women has also been set up. For medical education, he stated that it was not possible for State Government to run Medical Colleges as is being done today. In private colleges, 50% of the seats were on merit basis, 35% on payment and the balance 15 % were for the NRIs. He was of the view that the number of post-graduate seats for his State is required to be increased. He stated that he would express his views on the draft background note for National Health Policy within a fortnight.

**The Health Minister, Karnataka** opined that the goals as given in the Health Policy were well set. He raised his doubt on the revival of the system of Licentiate Medical Practitioners (LMPs). He felt that it may be necessary to raise emoluments of doctors working in villages, give them accommodation and other incentives. If China could do well with barefoot doctors with three months' training, he wondered why we could not do better with 18 months' training of ANMs. The ANM training according to him could be made more comprehensive so that they are better equipped to handle the cases at the primary health care level. He was of the view that higher allocation should come from the Centre for Malaria, as the State is not able to afford the kind of expenditure required to implement this programme. He informed that there are many well-established private medical colleges in Karnataka. According to him, in the policy paper, it was rightly emphasized that more and more medical graduates should be encouraged to take up public health degrees so that they are able to man the administrative posts. Doctors including clinicians would then be in a better position to concentrate on crucial aspects of health. He emphasized that in view of the rapid spread of AIDS, stringent laws were required especially for blood banks, etc. Proper investigative facilities in blood bank are required to ensure that the donor is free from diseases like Malaria, HIV/AIDS, Hepatitis, etc. He informed that the health indicators for his State were quite good compared to the national average, though not better than Kerala and Tamil Nadu. He also expressed that the budget given for the purchase of drugs at the PHC was highly inadequate and was required to be increased, if focus is to be on primary health care. He mentioned that good States were sometimes being punished, as their schemes were usually not approved on the plea that there were poorer and thus

more deserving States for funds. Better performing States, he felt, should be encouraged to do even better by providing generous funds.

**The Health Minister, Nagaland** was of the view that health although a State subject should receive full support from the Centre. On account of non-availability of MBBS doctors in rural areas, he welcomed the idea of reintroduction of the system of LMPs. He stated that tremors had been predicted for the North-Eastern Region and this has been an important issue engaging the attention of this Region. He stressed on the urgent need to prepare a joint action plan for disaster management and solicited financial and technical support from the Centre. He informed that according to Census 2001, Nagaland had recorded the highest decadal growth rate of population, not only because of natural births, but also on account of infiltration as well as influx for foreigners. In view of the increasing elderly population, the Regional Research Institute (RRI) on Ageing is proposed to be established in Nagaland to conduct research and training on the ageing process and problems associated with the elderly in the North-Eastern Region. Generous support from Planning Commission and Government of India was requested for this endeavour.

**The Health Minister, Jammu & Kashmir** initiated the discussions detailing the good work done in their State for control of TB, Leprosy, AIDS, Pulse Polio, etc. He emphasized that the problem in their State is very different as every day about 20-25 people die and many hundreds are admitted to local hospitals on account of mine-blasts, bullet injuries, etc. The Minister stated that the infrastructure was not commensurate to take care of the increasing health requirements of lakhs of people coming from all over the country for pilgrimage to Amarnath and Vaishno Devi. The only Medical College in this State was about 50-60 years old and this required up gradation. The Minister welcomed the suggestion of Hon'ble HFM of imparting medical education on the pattern of UGC as he felt that State allocation is highly insufficient. He was of the view that the shortages existing at the Sub-Centre / PHC / CHC level as per the 2001 Census should be met. The role of the Sub-Centre was required to be clearly defined and adequate drugs made available so that the Sub-Centre could function properly, especially in remote corners. He subscribed to the view of compulsory service of the doctors in rural areas for a period of 1-2 years before they could become eligible for the PG Course. The Health Policy he opined should clearly give the specific initiatives required to be taken for the people living in tribal and backward areas. The elections of Panchayati Raj Institutions (PRIs) had been recently completed successfully, after a period of 25 years. The Sub-Centres would now be run by PRIs. Support is required through the electronic media for raising awareness and educating the masses on TB, Cancer, AIDS, etc.

**The Health Minister, Orissa** expressed gratitude for the change of approach adopted in the background note on health policy, as he felt that for long one had been talking of 'Health for All'. Over the years, India in addition to the existing disease burden, had acquired the diseases of the developed world as well. He agreed with the focus in the paper on primary health care. He welcomed the idea of investing 55% for primary care. Although, there was a need to develop tertiary

and super-specialty areas, it was necessary to maintain an appropriate equilibrium. It was important to integrate the Western and Indian Health Systems and adopt a holistic approach. While formulating the health policy, he emphasized on the need for convergence and greater community participation. He supported the concept of social security for the poor in which social insurance scheme could be envisaged as also the creation of a sickness fund. 100% assistance should be given by the Centre. The ANM and the Anganwadi workers at the Sub-Centre level were over-burdened. The Centre should give adequate funds for training health workers to ensure community participation, proper coordination at the ground level and improved delivery of health care services. The Minister emphasized on the important role to be played by research in a regime of Intellectual Property Rights. He mentioned the surveillance activities had improved remarkably in Orissa, after the super-cyclone and information was now being obtained till the block-level. Disaster health fund should be created so that Centre could intervene and help whenever required. In view of the increasing life expectancy the National Health Policy should also address the problems of the elderly.

**Dr. Alok Mukhopadhyay**, President, Voluntary Health Association of India, stated at the outset that the expectations from National Health Policy are of a very high order. He emphasized on decentralization and giving more responsibility to the Panchayats and Zila Parishads in planning, monitoring and implementation. He went on to highlight the importance of converging services in health care, illustrating with the example of Polio, which had been very successful albeit at the cost of other immunization programmes. He opined that in order to ensure better public health services, it was necessary to revamp the primary health care. He was of the view that one should learn from the experience of the eight better performing States - 'G8 States'-of India which have made substantial improvements in primary health care infrastructure without much investment. It was important for related Ministries to play a crucial role in strengthening the role being performed by Ministry of Health in order to improve the basic health care, especially of the people below the poverty line. Urban health was required to be given its due importance in view of the fact that one-third of the Indian population would be living in slums by the year 2010. In India, he stated, that extent of urban health infrastructure was not clear. He gave the example of China, where decentralized urban health was doing rather well and community, especially retired people were playing an important role in delivery of health care services. Highlighting the issue of sustainability, Dr. Mukhopadhyay mentioned about the tremendous financial inputs being received from various international organizations. He was of the view that any activity initiated should be sustainable or else the infrastructure set up would become ineffective, once funding ceased. Giving the example of tobacco industries, pesticides, and large developmental projects, he highlighted the detrimental role being played by each one on health. Further, because of large developmental projects, malaria was becoming difficult to control. Therefore, he felt that "Health Clearance" like, environmental clearance should be mandatory before launching large development projects. It was necessary to take various steps to ensure that polluting industries do not destroy all sources of clean water. It was important to also specifically look at strife-ridden States like, Jammu & Kashmir,

Nagaland, Manipur, etc., where because of insurgency the well-developed infrastructure had got completely eroded in the last decade, resulting in tremendous pressure on secondary and tertiary hospitals. Further, although private sector was emerging as an important player, of late he felt that education and health should not be left at the mercy of this sector. He informed that despite the huge expenditure from the State, 46% of the population of USA still did not come under the purview of health insurance. He stressed on the role of NGOs and felt that these should be encouraged.

**The Health Minister, Himachal Pradesh** initiated the discussion by complementing the Centre on the new population policy as also on the anti-tobacco legislation. He emphasized on the important role which the Centre is playing in the field of health and stated that its support is required for developing inter-sectoral linkages, as any health problem should not be seen in isolation. Involvement of other Ministries is also crucial. He sought some more time in giving his comments on the National Health Policy. Although considerable work has been done on developing the alternative systems of medicines, a lot more is required to be done in this area. He informed that a policy document had been made for Himachal Pradesh - "Health Vision 2020". He was of the view that such state documents should be seen in order to avoid overlapping, inconsistencies and also draw on the good initiatives contained therein before finalizing the National Health Policy. The Minister felt that a separate implementation strategy was required for hilly States in the National Health Policy. He opined that a 'primary health service' could be started which would facilitate posting of doctors in rural areas. Various incentives given to doctors in terms of monetary benefits, admission to PG Institutes, full NPA, etc., did not yield much result. Therefore, he felt that some practical initiatives were required to be developed in this area.

**The Health Minister, Delhi** informed that they had been successful in controlling water and vector borne diseases and also in keeping a check on food adulteration. Ban on smoking in public places and sale of cigarettes to children below the age of 18 years and in schools had also been imposed. A decision to have a ban on Gutka is required to be taken by the Centre. Pulse-Polio had been successful, although the performance of immunization for other diseases had gone down. He felt that testing for Hepatitis 'C' should be made mandatory in all blood banks as is currently being done for Hepatitis 'B' and AIDS. There should be free advertisements in the electronic media and radio, regarding the preventive measures required for controlling various diseases. It is important to increase the quality and extent of health care services in Delhi, which caters to a large chunk of patients (around 35%). He gave the details of the medical institutions, which were being planned to be set up during the next few years in Delhi. He did not support the concept of LMPs, as he emphasized that there were certain quality standards, which were essential for treating any patient even if he is poor. Services of Ayurvedic, Unani and Homoeopathic doctors could be appropriately harnessed, especially in rural and remote areas. He emphasized on Nursing

Home Registration Act as well as on registration of Laboratories. He felt that steps also required to be taken to control manufacture of spurious drugs. It was important to work out reasonable terms and conditions for NGOs and Charitable Hospitals so that they come forward in the area of health care delivery.

**The Health Minister, Uttaranchal** explained that they were starting from a clean base in so far as medical services were concerned. He emphasized on the need for a separate policy / focus for hilly States. He felt that there should be a ban on medical representatives disturbing doctors during duty hours. He also spoke of a transfer policy for doctors as is prevalent for various organized services. In view of no medical college in his State, he opined that some percentage of seats should be allocated in medical colleges of other States. Doctors could be taken on contract for a year or so, so that they don't attempt to obtain a transfer. Anganwadi workers have been given appropriate training to dispense a few basic medicines to the patients. Some policy is required to be formulated in order to compensate financially such Anganwadi workers. He emphasized that quackery should be stopped and this aspect should be appropriately included in the policy.

**Dr. S.K. Sarin**, an eminent expert, initiated the discussion by mentioning that health is a management issue and it may not be possible to provide free health at a time, when we are talking of paucity of finances and raising additional resources. He was of the view that there should be greater involvement of the public and health should be a better-managed system as a business or as an industry. At a time when one is speaking of good clinical and laboratory practices and ISO guidelines one likes to have quality assurance in health care delivery and implementation. Keeping this in view, he opined that having 'doctors' with three years training would not be correct. The idea of Medical Grants Commission, according to him, was commendable. However, medical education and training should also be added. This is because MCI has not been able to fulfill the aspirations of doctors in this area. This requires to be revamped with appropriate initiative of the Ministry. It is important to lay down the standards regarding education, training, CME, etc. He felt strongly about the concept of integrating services, which is absent in India. He felt that health education should be flexible and one should have the option of doing two or three courses. He also spoke about the model, which developed countries took up, several years ago, namely, developing "core centres of excellence". No such significant initiative exists here, barring a few in the private sector. According to him, there is definitely a need for providing such "centres of excellence" for disease related issues. Urban health should be given its due importance in view of the increasing urbanization. On account of nil/weak legislation, and no improvement in quality of pharmacists, there is no control of "over-the-counter" drug sales. This problem is also required to be addressed. Areas of research and technology development are also extremely important. He opined that indigenization of medical equipment is badly lacking and this requires a primary focus. He further added that like sports news, health news should be broadcast daily on TV and radio, which could also include the new developments in the area of health care. With effective control, Dr. Sarin felt that tertiary health care could largely be left to the private sector.

**Dr. Alokeyendu Chatterjee**, an eminent expert, emphasized that not a line had been mentioned regarding women's health in the background note of the National Health Policy. The health of the women is required to be seen very critically in a completely different perspective. It should not get diluted with the health of the nation. According to him, the recent curriculum published from the Medical Council of India was not problem oriented. They were making 'organ healers' as against the requirement of good doctors. He was of the view that the present one-year training should become one and a half years training with the last three months mandatory training in community medicine. As we are living in an era of evidence based medicine, he felt that the concept of LMPs and barefoot doctors should be done away with. It would not be correct to risk the lives of the poor people just because they cannot afford to spend on health care. Proper training of a medical graduate cannot be less than 4-5 years. Also the training should be evaluated periodically to ensure that they do evidence based medicine. He also spoke of an insurance scheme for people who can afford to pay, especially, as around one-third of the population would be living in urban area by the end of this decade. For people below the poverty line, he felt that there should be an appropriate mechanism provided by the State Government supported by the Centre and the NGOs. He finally stated that it would be profitable for various States to take advice and learn from the NGOs present during the meeting.

**The Health Minister, Rajasthan** initiated by mentioning that separate parameters/norms should be set up for desert areas. Taking into account, the new population figures, there was a need to strengthen PHCs /CHCs in his State. A need for establishing blood banks on national highways was emphasized. The Minister gave the details of the Blindness, TB, Cancer and AIDS programmes being run in his State. Like Maharashtra, a decision had been taken by the State of Rajasthan to hand over the rural infrastructure to Panchayati Raj Institutions. He detailed specific schemes, which are presently under implementation, in his State to address families below the poverty line. Certain specific steps taken in his State with regard to population stabilization were also mentioned. He stressed on the rational use of drugs and emphasized that manufacture of spurious drugs should be stopped. To address the problem of shortage of doctors in villages, one-two year rural posting should be made mandatory before admission to PG course can be obtained. Alternatively, it could be ensured that the first appointment of an MBBS doctor is in rural areas for a period of three year. The Minister was of the view that the private sector definitely required regulation and felt that necessary steps should be taken to ensure that the bills regarding clinical establishment regulation act as well as maintenance of clinical records Act are expedited. He was of the view that tertiary care should be the responsibility of the Government and not of the private sector. Doctors in Government should be better paid. Brain drain of doctors from the University to the private sector can be controlled, if better emoluments are given to University Teachers. This he felt would go a long way in establishing standards of health education in the country. Although health is a State subject, he emphasized that the National Health Policy once formulated would give an appropriate direction to all the States.

**The Health Minister, Tamil Nadu** mentioned that one of the major lacunae in the health care delivery system in Tamil Nadu, as also in many other States, is the lack of comprehensive urban primary health care delivery system. The population especially those in the slums do not receive any outreach services. Thus, there is an urgent need to put in place a proper primary urban care delivery service with the help of the Centre. As Tamil Nadu is a leader in almost all basic health indicators, the Minister stated, that his State had been penalized for its better performance. The drastic reduction of funds for IEC activity under Family Welfare should be restored. As Tamil Nadu was one of the leading cancer prone States, cancer Control Centers are required to be established in all the districts and the Centers should provide adequate funding. In view of the increasing population in the age group of 65 years and above, geriatric care was important and Government should evolve a National Policy on geriatric care. The allopathic drugs budget norm of a mere Rs. 2000 per sub-centre fixed in 1980, required an upward revision to Rs. 10000 per sub-centre. He advocated that the system of indigenous medicine should be given greater attention. A Medicinal Board should be established at the State level to promote and oversee the cultivation of medicinal herbs with assistance from the Centre. In this year, declared as the year of Mentally Challenged by WHO, the Government should fund specific district level schemes for mental health. Government should also consider including Hepatitis 'B' Vaccination as an integral part of Universal Immunization Programme. Minister requested that Tamil Nadu should be included for RCH camps to improve maternal and child health. As the doctor population ratio was satisfactory in the State of Tamil Nadu, the concept of LMP was not relevant. Doctors, who want to pursue Post-Graduate study, should be made to compulsorily work in rural areas for at least a year. Seats in PG courses should be increased to overcome shortages in deficient specialties. He concluded by stating that a separate meeting should be organized to draft the National Health Policy.

**The Health Minister, Kerala** stated that broadly the policy guidelines contained in the background note were acceptable, barring a few. Adequate resources are required to be provided for promoting centres of medical education. Greater stress is required to be given to indigenous system of medicine in the health policy. The idea of bringing legislation to regulate and control private hospitals is necessary. The Minister felt that tertiary health care should not be left to the private sector alone. He informed that the formation of State Society had been successful in Kerala. Further, he was of the view that health care lessons could be introduced in the syllabus of schools and colleges. Welcoming the suggestion of Medical Grants Commission, he pointed out that the policy did not touch upon the increasing need for geriatric care. He also added that an integrated approach covering related Ministries like, Education, Social Welfare, Environment, etc. was required. The Minister opined that MBBS degree holders should be made to sign bonded obligation as in the case of some para-medical staff in Kerala and Armed Forces Medical Services. As there is no All India Institute of Medical Science in Kerala, students are forced to go to other States for medical education necessitating payment of higher capitation fee. One such Centre should be allowed in the State of Kerala. A request was made by the Minister for increasing

medical seats / Para-medical seats by 25% in his State. Health insurance for people below the poverty line should be introduced by the Central Government. He was of the view that the revival of the LMP Scheme would be a retrograde step, The Minister felt that this step would discourage the quality of MBBS doctors who already exist in large numbers.

**The Health Minister, Arunachal Pradesh** said that health status is an important factor in maintaining socio-economic stability of the country. On account of India being a heterogeneous country formulating a universal national health policy is a major challenge. Because of the peculiar topography of the State of Arunachal, it is difficult to deliver health care services despite best efforts. The prescribed norms for hilly areas **are** inadequate and the State finds it difficult to manage with the existing staffing pattern. The State has witnessed an increase in the number of patients in the last 2-3 years and is finding it difficult to manage in view of the acute financial constraint. Decentralization in the procurement process would definitely help as in the present scenario the drugs etc. in the case Malaria are being received rather late. The State is also finding it difficult to maintain vehicles for leprosy programme activity. The Minister felt that there should be a uniform act for regulating and supervising the private sector. He stressed that hospital waste is an important factor causing environmental pollution. As good health requires clean environment, this problem should be accorded priority. The seven North-Eastern States have to do with only four medical colleges - three in Assam and one in Manipur and this, he felt, is not enough.

**The Health Minister, Assam** felt that health should be priority number one. He emphasized that there should be a uniform act / legislation for the private sector, which is exploiting the masses. The land and various excise duty concessions have been taken by this sector on the promise of rendering free treatment to the poor but the same is not being done. The idea of Medical Grants Commission was welcomed by the Minister. The Minister supported the idea of LMP for he felt that with this step the vacant posts in rural areas would get filled up. He emphasized on strengthening the primary health system. Despite giving incentives to doctors for postings in rural areas, they were reluctant to go because of problems like education of children, etc. A decision has been taken in Assam to have a separate Directorate of Rural Health Service. The biggest challenge in Assam is the inadequate infrastructure as compared to the national norms, particularly for CHCs. Regarding spurious drugs, the law required an amendment to permit stern action to be taken or alternatively States should be vested with appropriate power. Regional laboratories should also be strengthened. Up gradation of State food testing labs had slowed down because of lack of funds for procurement of equipment.

**Mrs. Bathew**, an eminent expert, stated that enough doctors were not there to man the primary health centres on account of their reluctance to go to rural areas. She was of the view that new doctors should serve the rural areas before being allowed admission to PG course. The norm for a Sub-Centre was to cover a

population of 3000 in the hilly areas. Due to the villages being very scattered in such areas, she suggested that this norm should be revised downwards to cover a population of about 1500-2000. Very few specialists were there in the North-East and this was because of an absence of a feeder college for PG course. A medical college could perhaps be given to each of the North-Eastern States. CGHS dispensaries are not available, even at the headquarters at Shillong. Such issues should be addressed appropriately.

**The Health Minister, Haryana** felt that oral health and dental services should be included in the National Health Policy. He welcomed the organization of Health Melas and requested inclusion of all districts for the same. Similar requests of greater coverage were made for the implementation of TB programme, computerization of hospitals, granting of license to blood banks, etc. He also emphasized on the regulatory mechanism for private sector hospitals / nursing homes. For control of AIDS, he informed that Committees had been set at the school level. Some law is also required to be enacted for bio-medical waste management so that private doctors and hospitals also take appropriate care in this regard.

**The Health Minister, Jharkhand** emphasized on the need to improve the quality of life. Significant inter-regional variations within the State, he felt, are required to be addressed. He emphasized on the need to develop appropriate partnerships between providers and the community and involvement of the PRIs to ensure sustained community participation. He gave a detailed account of various health and socio-economic indicators of the newly constituted State. He also informed that the State was planning to develop its own population and health policies. He mentioned that there were various shortfalls in the public health delivery system, covering both human and physical infrastructure. There was no upkeep and maintenance of equipment. The Minister emphasized that the Sub-Centres are required to be strengthened in order to have optimum utilization. The Medical College in the State offers primary and secondary care and negligible tertiary care. There is also a shortage of teaching and non-teaching staff in the medical college. The need for improving implementation of various national disease control programmes was also emphasized. For effective management of national programmes, border district cluster strategy is required to be evolved especially with the States bordering Jharkhand, i.e., Orissa, West Bengal, Chhattisgarh, UP and Bihar. The Minister emphasized that for successful implementation and sustainability of any health programme, creditability of public health institutions is of paramount importance. The need to integrate ICDS with the health sector was emphasized in order to avoid duplication. The Minister also stressed on the need for training both the providers and the users of health care. He further added that ad-hoc arrangements will not work and Government of India should provide financial and technical support to meet the unmet needs of the health sector on priority basis.

**The Health Minister, Bihar** stated that in order to achieve the goal of 'Health for All', certain modifications are required in our policies and programmes. The

population in his state has increased by 5% during the decade 1991-2001 as compared to 1981-1991. He felt that the shortages existing in subcentres, PHCs and CHCs should be looked at, keeping in view the 2001 Population Census. The situation in Bihar has become from bad to worse after the creation of the new state of Jharkhand. He gave a detailed account of the various disease control programmes under implementation in his state and solicited full financial cooperation from the Centre. The budgetary allocation provided for setting up nine diagnostic centres on the recommendation of the 11 Finance Commission is insufficient and requires an appropriate increase. The Minister also felt the need to establish health institutes for mentally retarded as the sole institute at Ranchi is now in Jharkhand. The Population Commission has been set up in Bihar in July 2001. This Commission would prove to be useful for implementation of the State Population Policy. It was also informed that the State of Bihar with the help of UNICEF is in the process of establishing a database on health and nutritional aspects.

**The Health Minister, Punjab** gave a detailed account of the infrastructure existing at the primary, secondary and tertiary level. He also compared the various health indicators in Punjab, vis-a-vis, the overall Indian figures. He stated that the Government and the NGOs had played an important role in the success of the Pulse-Polio. He gave a detailed account of the serious problem of drug addiction existing in the State of Punjab. In view of this, this problem, he felt, should find a mention in the National Health Policy. Although there are 8 drug de addiction centres in the State, he was of the view that there should be a centre in each of the districts. He advocated not only a ban on the advertisements but also on the production of tobacco and related substances. Emphasizing that the number of MBBS seats should increase, he did not support the idea of LMP. He detailed the position regarding implementation of various disease control programmes in his State. Although greater than 50% of the truck drivers, who are the high-risk group, come from the State of Punjab, the percentage of people suffering from AIDS had come down from 10% to 4% in his State. The sex ratio in the State was rather adverse. In order to control female foeticide, the Minister detailed the initiatives being taken in his state in this regard.

**The Health Minister, Sikkim** initiated the discussion by informing of the high increase in decadal growth rate of population in his State. He informed that the adverse female ratio was on account of the male migrant labour coming for highway projects. He stressed on female literacy and felt that much more is required to be done in the field of awareness generation. With the implementation of the RCH programme, the process to bring about de centralized and participatory planning from the grass root level is being vigorously pursued. The state of Sikkim is striving for hundred percent institutional deliveries and upgrading the facilities at the PHC level. He also stated that there was a shortage of specialists like Anesthetists and Gynecologists at the first referral units. He was of the view that there should be some quota for such specialties to take care of this shortage. The implementation of the family health awareness programme, he felt, is hampered because of budgetary constraints. He was of the view that

Hepatitis 'B' vaccine should be included for children under National Immunization Programme. For the Indian System of Medicine, he informed that there was no separate Directorate. Efforts are presently being made to establish a laboratory for this system in Sikkim. In an attempt at modernizing the tertiary care hospital, the existing hospital at Gangtok is being upgraded.

**The Health Minister, Gujarat** at the outset expressed his deep gratitude for the massive assistance given to his State during the post earthquake period. He informed that despite wide spread destruction, the health institutions functioned in some manner or the other with utmost cooperation from the Government, foreign institutions and NGOs. The Minister was of the view that there were two distinct concepts enunciated in the background note of the health policy viz. regulation and facilitation. While talking of regulation, he stressed on legislation relating to nursing homes and clinics, tobacco, hospital waste management and the Pre-Natal Diagnostic Techniques Act. He felt that these areas of regulation are required to be implemented. Whenever a decline was found in the health related parameters, it was on account of poor implementation, monitoring and coordination and not because of bad policy. The second concept of facilitation is related to focusing on R & D in medical education. This would mean branching to areas like Bio-medical Engineering and certain super-specialties dealing with bio-technology, DNA sequencing, molecular biology, etc. He welcomed the idea of taking up certain "institutes of excellence" in different parts of the State. The Minister was of the view that highest importance should be given to non-clinical subjects, which are the core science foundation subjects of medicine. Specialties like physiology, pharmacology, anatomy, biochemistry, microbiology have become subjects of second order and incentives are required to be given to those students opting for such disciplines. The Minister welcomed the idea of including Hepatitis 'B' as a part of Universal Immunization Programme. The Central Government could along with participation of the State Government address the issue regarding construction of national highway hospitals. The Minister opined that as some States like, Gujarat, Andhra Pradesh, Orissa were prone to disaster, some kind of disaster action plan could be formulated. For the scheme of medical insurance, the Minister opined that modalities are required to be worked out to raise additional money. To address the issue relating to sports' medicine, it was felt that Department of Sports could appropriately tie up with the Department of Health. The use of Internet and information technology is picking up in a big way, paving the way for telemedicine. He was of the view that distant and remote areas could be linked to various medical colleges through this mechanism so that people could be exposed to consultations and some clinical reporting and thereby benefit through technological advances.

The Commissioner, Family Welfare and ex-officio Secretary, Family Welfare from Andhra Pradesh, initiated the discussion by informing that this State has done very well in the area of population control resulting in steep fall in the decadal growth rate. The total fertility rate has also declined. However, not much progress has been made in controlling infant mortality and maternal mortality rates. In order to have an impact on these indicators, it is necessary to increase the percentage of institutional deliveries. She detailed the 'Sukhibhava' scheme,

which had been started in the State of Andhra Pradesh, where the State Government pays for the women to travel to the Institution for safe delivery. Facilities are required to be provided at the primary health centre to be able to make an impact on such health indicators. If in certain PHCs, 24 hours service is ensured, IMR & MMR can be brought down significantly. The ANM is overworked as in addition to family welfare activities, she is also attending to neonatal health programmes. The representative from Andhra Pradesh felt that it was important to increase access to health care at the village level. The National Health Policy should clearly define the exact services, which have to be rendered by the male workers, ANMs, etc. She emphasized on timely and regular supply of drugs and consumables in the Sub-Centres. Assistance from donor agencies, it was felt, should be a part of the budget of State Government and not as an additionally. Citing the success of Pulse Polio, she emphasized that surveillance could be a very powerful tool in controlling communicable diseases and also in family planning. Talking of integration, she opined that if medical officers are not available to go to the PHCs in remote villages, the ISM doctors should be welcomed to deliver health services there. She also said that integration was missing in so far as maternal and child health and nutritional aspects are concerned. This issue is also required to be addressed.

**The Health Minister, Tripura** was of the view that a separate meeting should be organized on formulation of the National Health Policy. From a cursory look at the background note, he stated that no special mention of North-Eastern States as special category States had been made. Leaving the tertiary health services to the private sector would not work for a State like Tripura, which had 67% of the population below poverty line, 90% from backward communities, 31% tribal's, 16% SC and 25% OBCs. In an agricultural country like ours, the Minister was of the view that poverty could be eliminated only through scientific land reforms. The primary health care in the North-Eastern Region, especially for tribals, had been disturbed on account of the insurgency problem. Most health workers are also unable to go to the interiors because of this reason. The norms of manpower for Sub-Centres, Primary Health Centres and Community Health Centres is required to be revised, keeping in view the geographical terrain, poor communication and demographic scenario of most of the North-Eastern States. The new health policy should contain a recommendation to ensure that all the States have a medical college. The Minister was of the view that without community participation, no programme could be successful.

**The Health Minister, Madhya Pradesh** informed that most health indices of the State are quite poor. The results of NFHS 2 survey have shown progress in the education and reduction in fertility levels. However, levels of immunization and nutrition continue to remain causes of concern. New initiatives in the area of health have been taken in the State of Madhya Pradesh. Three-tier Panchayati Raj is in position and health functionaries are accountable to them. The Village Health Committee would now look at the key areas of concern in the health sector like assessment of community needs, selection of Jan Swasthya Rakshak, Dai or traditional birth attendant, coordination of immunization, etc. The Minister also informed that the Health Guarantee Scheme had been launched

recently. This would attempt to address all rural health concerns in a very integrated manner. Besides health, other determinant factors like sanitation, nutrition, education and safe drinking water would also be guaranteed. Door to door village health register had also been started. It is envisaged that by the end of 2002, not a single village in the State would be without a Jan Swasthya Rakshak and every village would have at least one trained birth attendant. Instead of selective management of disease, the Minister emphasized on adoption of a composite health care system. The Rogi Kalyan Samiti Initiative was also detailed by him. Additional resources mobilized through imposition of user charges have been ploughed back into the hospital system for improving services and maintaining equipment as also for providing various basic services for which the Government resources would be insufficient. A mapping exercise has been undertaken to identify gaps in infrastructure. Madhya Pradesh has also set up a "primary health service fund" through which NGOs would be funded and health infrastructure set up in deficient areas, where Government is not able to bridge the gap. The Minister reiterated the need for a stronger regulation and control of the private sector. He was hopeful that the proposed legislation is brought to the statutes soon. On PNDT Act, the State Government was working out detailed guidelines to ensure that the practice of sex determination is controlled. He welcomed the idea of Central Government funding PHCs. He felt that the health policy required having a stronger component of maternal care, as the causative factors of maternal deaths are preventable.

**The Health Minister, Andaman & Nicobar** informed that the health indices in his Union Territory are above the national average, despite remoteness and dispersed nature of islands. There is a complete absence of private sector and the delivery system is entirely through the Government. The problem, which this State faces, is regarding the shortage of specialists. This could be sorted out if there is some reservation for PG seats. Even in the remotest corner, local doctors have been posted. They also have a proposal for setting up a medical college in the private sector. Due to the dispersed nature of islands, the Minister felt that the norms for rural health infrastructure should be relaxed. He also added that most of the supplies were obtained from Medical Store Depot at Calcutta or Chennai. A sub-depot was required to be established at Port Blair.

**The Health Minister, Chandigarh** informed that originally, the health problems in his UT were minimum, but with the increase in slum area population, the health needs of this segment are not being met. The Minister opined that after completion of internship of a year, the doctors should compulsorily spend three months in rural areas. In addition to this, they should serve in rural areas for a period of two years, immediately after recruitment before being given a MBBS degree. Second alternative is to recruit the doctors in a de centralized manner in a particular village on contract basis, by filling up a bond. Third alternative is that the barefoot doctors and quacks, who are already giving first-aid services, and pharmacists and paramedics, who are also providing basic health services in rural areas, should be considered for providing elementary treatment to the villagers with proper training, in the absence of doctors. Yet another alternative would be to introduce mobile dispensaries/hospitals in villages. The doctor for this could

visit from CHCs. In view of financial constraints, for secondary health care, service charges should be collected by the beneficiaries and utilized for up gradation of that very hospital. The tertiary care should be handled by the private sector with some Government share to ensure control of the latter. Psychiatry, a neglected subject in MBBS curriculum, should be made compulsory in order to enable fresh graduates to recognize Psychiatric disorders and provide appropriate treatment. While discussing the PFA Act, the Minister opined that the laboratory services should be made efficient and time taken to analyze and test food and drug samples should be reduced. There should be a uniform procedure for licensing drug formulations by State Licensing Authorities and refresher courses should be periodically organized. As 40-50 % of the population is in the less than 18 age group, there should be strict enforcement of Child Marriage Act. There should also be a proper provision for registration of births, deaths and marriages. For AIDS, the anti-retroviral therapy should be introduced in the programme.

**The Health Minister, Lakshadweep** gave a detailed account of the health infrastructure existing in his UT. He stated that a doctor was posted in PHCs to attend to night calls as well. 70% of the deliveries were institutional and the balance at home was attended by ANMs or trained Dais. He also shared the 2010 targets, which have been laid down, for his UT, for various health indicators, like birth rate, death rate, IMR, TFR. Further, he added that medical officers' posts were filled up by the local people. However, the posts of specialists were not filled up. If a few seats are reserved in PG, then this problem could be solved. He informed that a letter of appreciation had been received by their UT for bringing about a reduction in the population growth rate by 10% in the last decade. Further, he mentioned that not a single institute had reported any case of sex determination in his UT.

**13<sup>th</sup> July, 2001**

**Secretary, ISM&H** initiated her presentation by stating that ISM was a vast sector, despite the small budgetary allocation. She gave a detailed account of the number of dispensaries, medical practitioners, colleges, etc. existing for this system of medicine. She informed that there is a Central Council of Homeopathy for Standards of Education and four Research Councils have been working in this area for the last 30 years. Thereafter each of the agenda points were introduced. Discussing mainstreaming of ISM& H in RCH programme, she urged the august gathering to dwell upon various legal provisions existing on this issue, illustrating with the example of Dr. Mukhtiar Chand and Others, vs. State of Punjab and others. Tamil Nadu, Karnataka, Maharashtra, Kerala and Gujarat are the States with separate State Acts enabling practitioners of Indian Medicine to practice any modern medicine. Then there are 9 States which through special notifications have authorized certain categories of ISM practitioners to practice in modern medicine. In the light of Supreme Court judgment, it is for the States to decide whether or not to permit Ayurveda graduates to practice modern medicines to the extent they have been trained. All the States may review and re-examine this issue and make necessary and suitable

provisions and amendments so that a large group of such ISM practitioners may be fully utilized in RCH programme to the extent they have been trained. Secretary ISM&H informed that the Medicinal Plant Board had been set up at the Centre in November 2000 and all details are available on the website. The State Government is requested to set up similar Boards. She stated that it was necessary to decide which plants are required to be brought into "cultivational status" to ensure quality control of raw material. She emphasized that enough resources had been allocated for the Medicinal Plants Board for undertaking different activities. The Board is adopting schemes of Department of Agriculture and Cooperation, Ministry of Environment and Forests, Department of Biotechnology and Department of ISM&H. There are 5 committees working on cultivation of medicinal plants, viz., on research, demand-supply, cultivation of medicinal plants, patents/IPRs and export-import. There is a proliferation of colleges of Ayurveda and Homoeopathy, and most of the colleges set up are lacking in the basic infrastructure viz. incomplete departments, deficiency of library books, absence of herbal gardens, laboratories, pharmacies and hospital beds, etc. More than 60% of the colleges have been reported to be deficient in minimum facilities for teaching and training. Since medical education is on the concurrent list of the Constitution, strong measures are required to be taken by the Central Govt. However, States also have an important responsibility especially while issuing a no objection certificate in respect of proposals for opening new colleges. Further, Secretary, ISM&H detailed various steps which have been taken to ensure the quality of ISM&H medicine. The States, she expressed have not taken much interest in this area. Already small scale manufacturers had begun a movement that Good Manufacturing Practices (GMP) notified in June 2000, cannot be accepted as these are too harsh. Kerala has a success story to relate in this area. She requested the States to implement GMP and strengthen the State Licensing authorities Secretary, ISM&H informed about the centrally sponsored schemes for strengthening of state drug testing laboratory and pharmacies. She urged the State Govt. who had not availed the assistance to come forward in order to strengthen their laboratories and pharmacies. Secretary, ISM&H added that Schedule 'K' of Drugs and Cosmetics Rule 1945 has been amended to facilitate the availability of certain homoeopathic medicines through licensed pharmacies. 40 such medicines have already been approved for being sold in the chemist shops. States should play a proactive role in popularising the use of these medicines through IEC, as this is a considerable simple way of encouraging public to look after their own health. Secretary, ISM&H further stated that despite huge infrastructure of Govt. dispensaries, hospitals, practitioners, colleges etc. of ISM&H, hardly any state has a separate Director of ISM&H. She urged the States to take urgent necessary action in this area. In view of the tremendous world-wide resurgence of interest for Indian System of Medicine & Homoeopathy, she urged the States to avail of various existing opportunities, which would be put on the website. She gave an account of various initiatives which have been taken by the Department to promote and popularize Ayurveda in other countries. India should make use of the enormous world market, which presently stands at US \$ 62 billion. State Government is requested to interact with the industry in their States and create an interest among them for participation in various fairs and exhibitions organized abroad in order to tap the vast growing world-wide market for

alternative and herbal medicines.

**Secretary, Family Welfare**, stated that HFM and MOS had made some mention of certain aspects of RCH & FW Programmes including Primary Health Care in their speeches. He added that ISM and H is considered a very close and integral part of Family Health and Primary Health Programmes. Shri Nanda stressed on the 3 important areas of concern viz. plateauing of infant and child mortality, slow reduction in maternal mortality, and the situation of Primary Health Care System in certain States. He felt that the success of population stabilization would depend in a large measure on how quickly, strategically and successfully these three issues are addressed. The health of women, he stated, is to be seen in the life cycle approach. Related issues of nutrition, empowerment of women and male responsibility in family welfare also require a focus. Shri Nanda stressed on the strategy relating to decentralized planning, implementation and monitoring. This would involve the community at the grass root level, the Panchayati Raj System, etc. He felt that devolution of both administrative and financial responsibility to the PRI is extremely crucial. Illustrating with the example of Kerala, he stated that 40% of the funds have already been earmarked to the Panchayati Raj System along with the complete devolution of responsibility and power. This has certainly made an impact on the quality of planning, monitoring and implementation. Gujarat, Maharashtra, Karnataka, Tamil Nadu and Andhra Pradesh are also in different stages of devolution. The State of Madhya Pradesh, he informed has started a number of innovative experiments. Similar initiatives, he urged, should be taken by the eight Empowered Action Group States, where the issue of population is at the top of the agenda. He informed that the Govt. had started a scheme for improvement of primary health care system two years back, with a cooperative mechanism through which the Centre and the State Government assured to pay 40% each. The balance 20% was to be shared by the Panchayati Raj Institution, either in terms of land or resources. Response to this scheme has been rather slow, barring West Bengal. Certain States have felt that this scheme could be taken up provided the proportion of funding is changed with major contribution coming from the Centre.

Taking into account, Population Census 2001, there is a large scale infrastructure shortage. For North-East, J&K, desert areas, further relaxation in the norms is being contemplated. He gave a detailed account of the shortages in Sub Centres, Primary Health Centres and Community Health Centres along with the requirement of funds to address the same. The Department of F.W. is trying to meet the contraceptive gap fully i.e. 100%, w.e.f. this year. The total requirement for meeting this gap is assessed as Rs.10,000 crore, during the 10<sup>th</sup> Plan. Primary Health Care is one of the components of Pradhan Mantri Gramodya Yojana (PMGY). Secretary, F.W. opined that this could be utilized by the State Government. to bring about an improvement in Primary Health Care. The RCH programme, informed Secretary, FW, is unlike the earlier FW programmes where a top to bottom approach was followed and every year 10% additional funds was given. Presently, since the last 3 years, efforts are being made to follow a Community Needs Assessment Approach at every village level. Every village has a plan based on a participatory approach. In the rural rapid appraisal

system every household is being visited by Anganwadi workers/ANMs with the help of Self Help Groups who are being given appropriate training. Unless this is done in full earnest, Secretary, F.W. opined that it would be difficult to build up the actual needs and requirements of an area. He added that funds given under RCH and other similar interventions revealed poor utilization as allocation was not based on the actual needs. In Tenth Plan, it is being emphasized, that unless Community Needs Assessment is done, the district will not be given funding. Secretary, FW informed that many States have taken excellent initiatives in convergence of service delivery at the village level. The Department of FW has started a Financial Envelope Scheme for some States. In this Scheme, certain States are given the flexibility and freedom, taking care of community needs to select initiatives/interventions for maternal, reproductive, child health, etc. One of the advantages of the Community Needs Assessment and regular monthly monitoring is that automatically registrations of deaths, births, marriages and pregnancies will become possible through community participation and this would enable proper monitoring of age at marriage. Secretary, FW mentioned about the problem of filling up of vacancies in rural areas, indicating the mismatch between the existing medical education system and the doctors being produced in the country, who are reluctant to do a rural posting. Various alternatives like utilization of doctors of Indian System of Medicine and Homoeopathy, imparting appropriate training to paramedics, etc. could be explored to fill up the vacant posts in rural areas. Shri Nanda mentioned that RCH camps have been started in 102 districts. However, no feed back has been received on the position of funds given to these districts. He emphasized on the formation of integrated health and family welfare societies to ensure quick decision and smooth flow of funds. He also gave details about the scheme of Dai training initiated in 142 districts. Emphasizing on strengthening of routine immunization, Secretary, FW mentioned that unless this is improved and brought to a level of 80% and above, States/Districts will not be eligible to get the new immunization, like Hepatitis 'B', MMR, etc. Self Help Groups, he felt, after proper training, could play an important role in bringing about convergence of service delivery at the village level. He also mentioned about establishing maternity huts, role of trained community midwives, practitioners of ISM&H, etc. in this area. He said that there should be a wider basket of choices in contraception, keeping in view the safety, acceptability and affordability as the main concern. He felt that too much reliance is being given on sterilization and the easy targets are women. He emphasized that No Scalpel Vasectomy (NSV) techniques should be given a focus and proper training imparted in this area. He further informed that some new methods of family planning are expected to come in the near future. Increasing social awareness and introduction of innovative social marketing schemes to reach the household will increase the use of condoms. The emergency contraceptive is also likely to be introduced very soon. In the RCH Programme, Secretary, FW informed that out of 32 States, 7 States had spent less than 25% of the released funds. The Panchayats have been given this fund in many States and it is felt that they are not able to spend this money. He emphasized on the need to have a decentralized IEC approach, especially for the seven demographically weaker States as the funds in those States are not reaching the district level. This requires considerable monitoring. Further, he urged all the States to look into the implementation of PNDT Act.

For this, it is necessary to have an awareness campaign for the value of girl child, marriageable age, dowry, details of punishment for the crime, etc. Delhi and Haryana, he informed, had filed two cases under this Act. 60% of the IEC money (Rs. 45 lakhs given to each State for IEC) should be spent on the PNDT Act. Speaking on the Population Policy 2000, Secretary, FW requested those States who have formulated their health and population policies to send copies of the same. Further, he urged that the State Health and Population Policies should be in consonance with the National Health Policy and National Population Policy. The States should at least adopt the main overall philosophy of the Population Policy, i.e. being voluntary in nature based on the principles of improvement of quality of life, elimination of poverty, convergence approach, emphasis on decentralization, not being based on any disincentives, which are directly, or indirectly anti-women or anti-poor, etc. It would be a better idea to reward every village community/panchayat, if there is improvement in maternal mortality rate, infant mortality rate, child mortality rate etc. rather than having a disincentive in case of exceeding the two child norm. He requested the States to review their population policies and emphasized that all the States which had been successful - Kerala, Karnataka, Tamil Nadu, Punjab - had not gone in for any disincentive or coercive policy. He felt it was important to have an equitable access to health care before imposing any restriction.

**The Health Minister, U.P.** stated that in his state which is sixth in terms of population, the concept of user charges has been initiated in order to upgrade and improve the facilities in various hospitals. Pulse Polio Campaign has been a success in the state of UP. He mentioned that they are striving to meet all targets set under various National Disease Control Programmes. For malaria, he informed, that the health worker has played a very important role. Surprise checks are being conducted to have a control on manufacture of spurious drugs. Talking of ISM & H, he informed that this system which is an integral part of Indian traditions is receiving a lot of encouragement. Based on the Population Policy - 2000, the state policy focusing on education of the girl child, the role of media, NGOs, Panchayati Raj Institutions, etc., has been prepared. He felt that it was important to stabilize population through voluntary measures as has been done in the case of Rajasthan and Gujarat. He also mentioned about the successful health melas, organized at Mathura and Lucknow, in which free treatment was given to the poor and needy for various diseases. He opined that these melas which had received very encouraging response should be organized in other areas as well.

**The Minister of Medical Education, Punjab** initiated the discussion by expressing concern over the mushrooming growth of medical colleges. He felt that the NHP should include some kind of a future plan indicating the number of doctors which would be required in next 10 - 20 years, in different streams, viz., Allopathy, Homoeopathy, Ayurveda, etc. Modernization of medical colleges, he felt, would require assistance from the Centre and/or World Bank as States face paucity of funds. In order to address shortage of lecturers, doctors should be encouraged to go in for teaching. In addition, the retired faculty should also be given permission for part time teaching. He also said that for doctors there

should be a provision of renewal of registration every five years with MCI, rather than one time registration. In view of the latest developments in medical field, he emphasized on the need for organizing refresher courses for doctors. For posting of doctors in rural areas, the Minister opined that the UPSC advertisements should clearly specify that the doctor is being recruited for a particular district/block and transfers would not be permitted. For making use of Ayurvedic doctors in rural areas, the credibility of such doctors is required to be built up. Talking of good manufacturing practice, the centre should play an important role in drug testing. He felt that funds should be utilized for consolidating the infrastructure already built and maintaining it, rather than going in for sophisticated machinery/equipment, etc. Talking of Food Adulteration Act, he expressed that the Act was rather stringent and, therefore, difficult to implement effectively, paving way for corruption. He was of the view that Health Adalats should be organized through the medium of TV/Radio in order to have direct interaction with the Hon'ble Minister.

**The ISM & H Minister, Rajasthan** felt that this Council which is called the Central Council for Health & F.W. should also include ISM to give it completeness. The Minister felt that this system should not be linked to politics or religion. She informed that this system has been going on since the time of the Vedas. In UK, it is a matter of pride that many colleges are imparting education on this system. She said that although emphasis was given on Drug Testing Laboratories, Vanaspati Vans, etc., the budgetary allocation was not sufficient. For her State, Rs.36 crore and Rs.12 crore were being allocated for Health & F.W., respectively, although only Rs.1.30 crore (2.6%) was the allocation for ISM&H. This she felt should be increased to at least Rs.4.00 crore. She gave a detailed account of the vast infrastructure including the large number of dispensaries (3733) working in her State, which she said was the highest in the entire country. Around two crore patients were being treated annually with this system and medicines worth Rs.4.5 crores were being distributed free of cost. She urged the Centre to help in the provision of free medicines, both for indoor and outdoor patients. She gave a detailed account of the use of different herbs for drugs, beauty products, as well as those relating to nutrition. She felt that judicious planning in the area of agriculture would lead to an increase in the production of relevant herbs. She also emphasized on the need to have extensive research in this area. The Minister felt that direct disbursement of funds to Ayurveda Department, rather than through various schemes run by different Ministries was a better option. She emphasized on the need to give importance to the rare herbs which were fast becoming extinct. She enquired whether there would be a separate policy for the Indian System of Medicine as the existing background note did not have any mention of this system. She informed that various colleges were being closed down due to lack of funds, and urged the Centre to help in this direction. She also informed that considerable research work done on this system of medicine could not be published due to paucity of resources. Secretary, ISM & H clarified that for the last 3-4 years all States are being assisted for the UG colleges, for setting up of new PG Departments and also re-orientation of teachers. She felt that, if this assistance has not been availed of, it is probably on account of lethargy and /or lack of knowledge on the part of

the States. Looking for Govt. support is not correct for private colleges as they are taking capitation fees which are being fixed by them. She also stated that a lot of money was being given for extramural research. If any state, college or industry comes forward, assistance can be availed. There is a system of accreditation. Protocols exist, which are required to be vetted. The Centre encourages the States to avail of the existing generous schemes, particularly if this is to prove the efficacy of the drugs.

**Dr. Neena Puri, NGO,** felt that Health and Education are two areas for which the Govt. cannot absolve itself of the responsibility to the people. Person to person contact is very important in these areas. One area which she felt, had not come out in a very focused manner during the discussion, is the interface between Information, Education and Communication (IEC). With IEC, the motivation part is very important. Talking of advocacy, she said that it is not a one way message, but also means creating a demand. She spoke of convergence of all socially relevant sectors suggesting that there should be a regular accreditation system of protocols of this convergence, particularly at the level where these mattered. She spoke of convergence of various audits, social audit, financial management, medical audit, etc. Accountability, she stressed, as an interface is very important. The civil society, she informed, contributes around 3 trillion dollars as far as voluntary input of work is concerned, 50% comes from religious institutions and remaining from volunteers. She informed that Family Planning Association of India was the first organization to talk of Family Planning, population education/sex education which now have become catalytic programmes appropriately interwoven into Govt. Talking of two child norm, Dr. Puri emphasized that this goal at the outset demands survival of these two children. She stated that in the area of Family Planning and Reproductive Health, a major role is required to be played by the men, not only by extending their support, but also adoption of family planning practices. Talking of PNMT Act, she emphasized that it is the commitment from within, which will make this Act successful. For this, IEC and advocacy are very important. She felt that the mental component of health should also be included in the National Health Policy.

**The Health Minister, Jammu & Kashmir,** stated that the short-comings experienced in the Indian System of Medicine had already been detailed by Secretary, ISM&H. He informed that there is a separate Directorate of ISM&H in the state of J&K. Out of 437 dispensaries functioning in the state, 75 have their own buildings, others are housed in rented accommodation. He was of the view that a package should be given to the State Govt. for undertaking various activities under ISM&H, rather than piecemeal funding. A Medicinal Plant Board has also been established in J&K. The Minister further stated that a lot of potential exists for Vanaspathi Vans in his State and specific proposals on this have already been sent to the Govt. He was of the view that doctors -Allopathic, as well as Ayurvedic - from his state should be sent to other States to attend seminars, etc. and learn from experiences across states in order to improve the system. Orientation camps, he felt, should be organized for imparting necessary training to doctors. He emphasized that the shortage existing in infrastructure should be remedied. He stressed on the need to evolve a transparent system for

testing of drugs. However, he felt that drug testing centres should be utilized in such a manner so as not to reveal the details of drugs being tested in a particular Centre. The Minister felt that full medical check up of the child should be done during various stages in schools, for early detection of any health problem.

**The Minister of State for ISM&H, Himachal Pradesh** informed that ISM&H was declared as a priority sector in Himachal Pradesh in 1998 and all efforts have been made since then to develop this sector fully. The budget has also more than doubled during the last 4 years. Primary health care is being made available even to people living in backward areas with the help of Ayurvedic Health Centres. The number of such Ayurvedic Health Centres has increased from 809 in 1998 to 1112 at present. Govt. has also given special attention for secondary health care of ISM. The number of such hospitals which were 16 in 1998 has now increased to 22, of which 3 are in tribal areas. In the year 2000 through these Ayurveda Institutions, a total of 45 lakh patients received treatment. Help of ISM&H doctors has also been taken to fill up the vacant posts in PHCs. 90 such doctors are working in PHCs/CHCs. To overcome the problem of posting of doctors in interior areas, a scheme was formulated in which backward and tribal areas were taken as a sub-cadre and a decision taken that for any new appointment, it would be mandatory for the fresh graduate doctor to work in sub-cadre for a period of 5 years. The Minister also informed that the Ayurveda Departments are working in synergy with the health departments in the implementation of various National Disease Control Programmes. There are a total of 661 Ayurvedic Health Centres through which the diseases control programmes are being implemented by Ayurvedic doctors independently. However, the Minister expressed concern at the pitiable state of the 1112 health centres and sought financial assistance from the centre for this. Himachal Pradesh is also making special efforts to impart Ayurveda education in medical colleges. Numbers of UG seats have increased from 30 to 50 in the only undergraduate college in Kangra District and 3 PG seats have also been started. To establish credibility of Ayurveda Institutions the Minister emphasized on the need to have good Ayurvedic doctors, so that people develop full faith and confidence in this system of medicine. Although Himachal Pradesh is very rich in herbs, paradoxically it is getting such material from Delhi. From this year, a scheme has been formulated to use local herbs not only to save on cost, but also make available fresh herbs. Special focus is being given to develop herbal gardens in Himachal Pradesh and efforts are also on to constitute a Medicinal Plant Board. He also informed that farmers are being trained to increase awareness and improve herbal cultivation.

**Shri Alok Mukhopadhyay** focused on three important aspects. Health and Population policies for all the States should be formulated before the next meeting of the Council within the overall parameters set in the National Health and Population Policy. He was hopeful that with the inputs available from this meeting, the health policy would be finalized in the next 3-4 months. He felt that there is an important need to re-look at the population policy thrust in some of the States. From the discussion it appeared that some population policies had an element of coercion in them. Such States were requested to take a re-look at their policy keeping in view the National Population Policy and its priorities. Shri

Mukhopadhyay felt that it was necessary to have a stricter enforcement of the proposed ordinance relating to female foeticide, in order to take care of social and related problems. He further felt that spurious drugs and food adulteration issues had also become important and emphasized on stricter enforcement of rules and regulations. According to him, the Indian System of Medicine is all about healthy living and promoting a healthy life style which in fact is the key word of Ayurveda. Shri Mukhopadhyay mentioned that all the MPs in the country get Rs.2 crore per year. In a recent review done by him for Parliament, on utilization of these resources, he did not find a single MP from the most difficult States who had used these funds for health related activities. Commenting on the targets contained in the background note for the health policy, he said, that at the outset, it was very essential to ensure availability of safe drinking water and sanitation security. On the one hand, there are low birth weight babies and anemia for expectant mothers and on the other there is a surplus of food grains stored in various godowns all over the country. It may be a good idea; he felt to develop some linkage whereby the vulnerable section of the population is ensured a certain amount of food security through the food grains available in the country. He felt it would be a better idea that in future if senior officials of the Ministry take the responsibility of certain States and visit those States every six months to hear out their problems and arrive at fruitful solutions. He also felt that it was very useful to hear and learn from the incredible experiences of various States which are very often not shared. This sharing is essential, not only among ministers and senior officers, but also with people who are actually implementing the programmes. He was of the view that there could be active information centres which could collect information of this nature where people have experimented and succeeded. This could be shared through newsletters or any other form of communication. Finally, he felt that it would be better to have a plenary session where all States could be heard. Thereafter Working Groups could be constituted to look into substantial issues, which at the end of the meeting could be summed up in the concluding plenary session.

**The Minister, In-charge, Medical Education, Rajasthan** was of the view that seats in various non-clinical disciplines, like Anatomy, Physiology, Biochemistry, etc. normally remain vacant. He suggested that certain guidelines should be formulated in consultation with MCI so that these subjects receive extra incentive. He also felt that in view of the increasing percentage of elderly population, geriatrics as a subject should be added in the medical curriculum. He informed that in Rajasthan various geriatrics centers have been established. In Indian systems, Acupressure - a drugless therapy -is becoming increasingly popular. The Minister felt that a centre for Acupressure should be there in the medical colleges. He opined that there should be reservation of medical seats for Rajasthan in other States, as is done for engineering colleges. He commended the Endeavour to link Jaipur Medical College to National Medical Library (NML) and felt that all the medical colleges as well as the state training health institutes should be linked up with NML to benefit the people. In the area of family planning, figures of unmet needs are very alarming. Those desiring spacing of children, he informed, are not able to get the required contraceptives. He also felt that distribution network should be substantially enlarged with appropriate

involvement of ISM, Homoeopathy, Naturopathy, Vaid, Panchayati Raj Institutions, Gram Sevaks, Cooperative Societies, etc.

**Dr. Alokeyendu Chatterjee** suggested that there should be 'reproductive health education' for all children above the age of 10. He also stated that emergency contraceptives/condoms should be easily available for young boys and girls. With respect to fertility control, he mentioned about the increasing popularity of the use of non steroidal contraceptives in the West. This, he opined, were far superior to the available steroidal contraceptives but required counseling from the doctor. He also focused on another method of spacing the family, viz., long acting injectables which are quite popular in the various South East Asian countries. However, in order to convince the couple to practice spacing, he stressed on the need to reduce prenatal mortality. He also mentioned about advantages of NSV vis-à-vis tubectomy. Involvement of men and bringing about a change in their mind-set is the key to any success in fertility control. Talking on maternity care, Dr. Chatterjee felt that the Community Needs Assessment approach should be able to detect the early pregnant population, particularly in the rural areas. Further, he added that it would be essential to give six months mandatory training before posting fresh doctors - four months in obstetrics care and a month each in Neonatology and Anesthesiology, as essential obstetric care is the key to maternal health. However, during this period of training it would be important to give them full pay as applicable to a medical officer. He also stressed on the need to involve community for all programmes of maternal health. For transporting pregnant women in distress, he felt that the community should take the responsibility through the Panchayats and also help for transportation, could be obtained from the Border Security Force or the defense personnel. Appropriate partnerships, he suggested, could be worked out with the Ministry of Defense in this area.

**The Medical Education Minister, Madhya Pradesh** was of the view that for successful health policy, medical education is very important. Emphasizing the importance of training, he stated that a compulsory week long training package should be organized for medical professors in medical colleges to keep them abreast of the latest development in the field of medicine. The Ministry should give appropriate attention to those areas requiring funds. Psychiatry has been introduced as a subject in very few medical colleges. The Minister felt that this subject required a focus in view of the increasing mental health disorders in the country. A Centre of Excellence on the pattern of PGI, Chandigarh and Sanjay Gandhi Institute, Lucknow should be thought of. In backward areas, where doctors are reluctant to go, trained well qualified licentiate medical practitioners can at least deliver some basic health services. The Minister emphasized the concept of social audit for large private hospitals in the context of rendering services to the poor. A separate conference should be organized for ISM and 20% of the budget should be allocated for ISM.

**Mrs. Bathew**, an eminent expert, stated that despite a vast infrastructure of Ayurveda and related institution in the country, there was only one such ISM college in the entire North-Eastern region in Assam. Thus, the resolution stating

that no new college is required to be established should be reconsidered to include a clause "barring North-East". Despite the fact that North-East is the store house of medicinal plants, especially Meghalaya and Arunachal Pradesh, Ayurveda, Unani, Siddha are not common terms in North-East. Herbal medicines, she informed, is now being recognized as one of the components of complementary medicines.

**The President of Central Council of Indian Medicine** informed that the number of colleges had increased mainly in Karnataka and Maharashtra on account of demand from the population. Various private colleges had to be closed down on account of poor standards. All out efforts are being made to ensure that sub-standard colleges do not come up under political pressure. He urged the Govt. to play a pro-active role in this area to ensure that a requisite number of Ayurveda Colleges open after public acceptability/demand is established.

**Dr. Sarin**, emphasized on the need to have convergence, as he stated that global companies were merging for effective delivery and control. Dr. Sarin opined that strengthening of drug testing laboratories could be added to the Department of Pharmacology in medical colleges and the same could be re-named as Department of Pharmacology and Drug Assessment. Food and adulteration assessment could be best done by the Department of Preventive and Social Medicine in the medical colleges. He further emphasized on the need for having post marketing surveillance for drugs and vaccines, an activity totally lacking in our country. It is also essential to evolve methods of controlling drug combinations which are mushrooming everywhere. Dr. Sarin was of the view that for drugs and medicines there should be a provision that the best is approved and not the lowest. A major resolution arising from the survey done by the Indian Association for study of liver along with several international groups was regarding merging of various blood banks and setting up of a Department of Transfusion Medicine for improving the services. 1<sup>st</sup> December is celebrated as AIDS Day; Delhi Govt. and many others celebrate 4<sup>th</sup> December as Hepatitis Day. As these have similar transmission and prevention, it would perhaps give greater impetus to have an AIDS and Hepatitis week in December. It would be appropriate to have the concept of a Medical University of India which can have Allopathic and Ayurvedic Colleges and doctors could have the flexibility of taking 3-4 courses. Dr. Sarin opined that unless there is an incentive based programme, neither research, nor medical teaching would take off. He emphasized on the need to have a hybrid system as exists in the West who have an MD - Ph.D. programme. He was also in favor of having a hybrid with industry. He felt, that industrial resources would not only strengthen knowledge and equipment, but also help in delivery and application of the system. He emphasized on the need to have a separate Department/Ministry for Medical Education and Research. He was also of the view that the area of medical statistics is required to be greatly strengthened. He further opined that there is a need to have incentives for talent. Dr. Sarin emphasized on the need to develop "Core Centres of Excellence" as has been done in USA, under National Institute of Health.

On the basis of information given in the agenda notes on the major subjects as also the discussion/comments and observations made by various participants, a certain statement of consensus was drawn up. These resolutions were then read out by Secretary (Health) and approved by CCH&FW.

**The DGHS**, at the end of all the resolutions stated that the august body of top level policy makers should take note of the health concerns of the after-math of the massive earth-quake which struck Gujarat. He urged that following resolution should be passed by CCH&FW in this context. "The Council notes with satisfaction, the swift action taken by the Govt., Ministry of Health & F.W., in assisting the Govt. of Gujarat in tackling the after-math of the massive earth-quake on 26<sup>th</sup> January, 2001. As a result of collective efforts, no disease/epidemic was reported. The Council advises all members of state to strengthen proper emergency plan and develop linkages to tackle any such tragedies in terms of earth-quakes, floods, cyclones etc. in future."

This resolution was unanimously passed. The following suggestions were also received:-

- It was felt that the Resolutions urged the States to undertake lot of responsibilities and seldom is there any mention of the responsibilities of the Centre. This has only been mentioned in a general way. The Centre should play a more pro-active role in view of the poor resource position of the States.
- Although on the one hand there is a focus on convergence, on the other the Resolutions have been adopted by vertical disease control programmes.
- Since 1960s, a lot of PHCs etc. have been developed, but they are in a very pitiable condition. The stage has come to think of asset management as an important priority area for the Tenth Plan, both at the state and the centre.

## **RESOLUTIONS**

## **DEPARTMENT OF HEALTH**

## **NATIONAL AIDS CONTROL PROGRAMME**

Central Council of Health and Family Welfare in its meeting on 12<sup>th</sup> and 13<sup>th</sup> July, 2001, discussed the emerging threat of HIV/AIDS in detail. The Council recognized it as one of the most formidable human security challenges, which undermines social and economic development and affects all levels of the society -national, community, family and individual. The Council expressed its firm commitment to address HIV/AIDS crisis on priority and recommended the following action:-

1. The challenge of HIV/AIDS epidemic needs to be tackled urgently with multi-sectoral approach that involves political leaders, panchayat leaders, religious leaders, NGOs, Community based organizations, private sector and all the agencies involved in socio-economic development at State, district and local levels.
2. The Council expressed its concern about the denial of health care services to people living with HIV/AIDS and resolved that all health care institutions functioning both in public and private sector should be motivated to provide care and support to HIV/AIDS patients without discrimination.
3. The Council underlined the importance of voluntary counseling and testing for HIV and resolved that such facility should be made available up to the district level hospitals in order to make such services accessible to community by maintaining full confidentiality and privacy.
4. The Council resolved that States/UTs should ensure prompt measures to reduce vulnerability of young people by promoting adolescents' access to education, information related to HIV/AIDS prevention and control by implementing School AIDS Education Programme in all higher secondary schools in the state in a phased manner.
5. The Council stressed upon the involvement of other Govt. Departments, NGOs and civil society in achieving social mobilization for effective implementation of Family Health Awareness Campaign in the States.
6. The Council called for the involvement of non-health sector agencies in public and private sector to integrate HIV/AIDS prevention and control activities into their programmes.
7. The Council stressed the need to increase availability of safe blood in private and public sector blood banks and resolved that States/UTs should gear-up voluntary blood donation movement and regular

monitoring of the blood banks for making safe blood available to patients.

## **NATIONAL TUBERCULOSIS CONTROL PROGRAMME**

The Council notes with satisfaction the significant progress that has been achieved by expanding DOTS strategy in the country. It is happy to note that today more than 400 million population is getting benefited by DOTS strategy. It also notes with satisfaction that despite the massive and rapid expansion of the revised strategy, the quality of programme performance has remained good. The Council resolves:

1. The Council notes with appreciation the commitment of Central Government in decentralizing the programme activities for ensuring more ownership by State Government. It urges upon the member States to complete strengthening of State TB Societies and other infrastructure requirement for total decentralization of the programme. It also urges member States to place the services of a senior independent STO to State TB Society on deputation so as to allow them to function with greater autonomy and flexibility.
2. To ensure effective implementation, much stronger management units at the State level are essential. It is noted that in many States there is only a single senior officer in the State TB Cell while many other priority health programmes have multiple senior officers. The council therefore resolves that at least in all major States, the STO post should be upgraded and there should be a Deputy STO at the senior officer level.
3. The Council is happy to note that a policy decision has been taken for involvement of Medical Colleges in RNTCP and for which certain staff is also being provided. The council urges all the States to ensure that Medical Colleges and large hospitals in all RNTCP districts immediately adopt policy and programme of DOTS.
4. The Council also notes that all the vacant posts of health personnel like Laboratory Technicians, MPW and Supervisors at peripheral level should be filled immediately, so as to ensure an effective delivery of health care services including national health programmes at peripheral level.
5. Supervision being the key aspect of the RNTCP, Council urges member States to have independent DTO's in all districts and ensure that vehicles provided are used exclusively for TB purpose.
6. Training is an important component of TB programme. There are only 16 STDCs in the country for undertaking training activities and 20 States/UT's do not have their own STDC. The council notes that 100% of requirement of anti TB drugs is now being supplied by the Central

Government; therefore, the savings accrued by the States on this account should be utilized for infrastructural development including STDCs in all those States/UTs which do not have them at present. Council also recommends that steps should be taken to ensure setting up of a DTC with its essential staffing in all newly created districts.

7. Council urges member States to ensure participation of NGOs, private hospitals and private practitioners in RNTCP and to ensure community involvement through active participation of Panchayat, women-self help groups and other community leaders and groups.

## **NATIONAL ANTI MALARIA PROGRAMME**

1. In view of the enhanced assistance for Kala-azar control by Government of India, the Conference resolves to provide full infrastructure and man power support by the States to ensure Kala-azar elimination from India in a time bound manner by meticulous planning and implementation of programme strategies. To achieve this, all the vacancies in the primary health care delivery system up to district level shall be filled at the earliest preferably not later than six months.
2. The Council expresses concern for an immediate strengthening of the decentralized planning and implementation of National Anti Malaria Programme at the field level to ensure effective malaria control. Though a few States have taken action to constitute State Malaria Control Societies to facilitate this process, which is noted by the Council with satisfaction, it is urged that all the states should ensure to constitute such societies on priority. This would facilitate local planning as well as decentralized procurement of required commodities / logistics.
3. The Council has noted the declining trend of overall malaria situation in the country but expresses concern for occurrence of out breaks in some areas that are mainly attributed to poor surveillance and programme implementation due to the inadequate infrastructure and manpower at the local level.

The Council recommends that the State governments take up the matter of filling up vacancies of key functionaries at the zonal / district level as well as multi purpose workers and laboratory technicians at Primary Health Centres immediately to ensure effective programme implementation and monitoring with an objective to prevent out-breaks and consequent deaths and suffering due to malaria.

4. Man made malaria is a serious concern particularly in urban areas and to prevent this, National anti Malaria Programme requested States to enact and effectively enforce civic by-laws/ legislative measures. Council notes with satisfaction that such measures have been successfully undertaken in some areas like Mumbai and Delhi. However, there is an urgent need, to ensure an adequate civic by law adoption throughout the urban areas in the country. The Council resolves to ensure this process to be completed by the State Governments / local self-governing bodies within a specific time frame.
5. The spread of drug resistance in the parasite causing malignant malaria (*P.falciparum*) is a cause of serious concern. Government of India is monitoring this problem through specialized teams located across the country, at various Regional Offices for Health & FW.

National Anti Malaria Programme (NAMP) has also taken an initiative to train State officials to carry out this work for ensuring monitoring over a wider area. It is a matter of concern that despite this initiative, the States have not yet established drug response monitoring teams. The Council urges for an immediate action for constitution of such teams for effective drug response monitoring and consequent effective strategy implementation.

## **NATIONAL LEPROSY ERADICATION PROGRAMME**

The Council reviewed the programme and noted with appreciation the progress of implementation of the NLEP and passed the following resolution to further strengthen the programme:

1. The National Leprosy Eradication Programme has shown substantial progress in reducing the case load in the country and 12 States have already achieved elimination level of leprosy. The council recommended that integration of leprosy services with General Health Care should take place with immediate effect in the 27 low / moderate endemic States. In the remaining high endemic States also the process of integration should be started by encouraging greater involvement of General Health Care System for providing MDT services for leprosy patients.
2. As MLECs have proved their effectiveness, it should be implemented in all the States in the current year by adopting suitable strategy for each State.
3. To ensure proper integration of leprosy with general health care, training & reorientation of general health care staff should be done in all the districts/State before doing case detection drive under MLEC.
4. For providing leprosy case detection & treatment services in difficult to access areas, urban slums & industrial labour population, States should implement SAPEL/LEC projects in such areas.
5. All the major 27 States should form a state level society either separately for leprosy or as a part of unified State Health Society.
6. All the States should develop Annual Calendar of event for the 1<sup>st</sup> year of the project and implement the activities.

## **NATIONAL SURVEILLANCE PROGRAMME FOR COMMUNICABLE DISEASES**

The National Surveillance Programme for Communicable Diseases was launched as a pilot programme in 1997-98 in 5 districts (one each in Kerala, Karnataka, Rajasthan, Haryana and Gujarat) with a view to strengthen the disease surveillance system so that early warning signals of outbreaks are recognized and appropriate follow-up action is initiated. The programme is being implemented through the existing health infrastructure and surveillance system involving training of medical and Para-medical personnel, up gradation of laboratories, improvement in communication system. The programme was later extended to cover 20 more districts from 10 States, i.e. Andhra Pradesh, Bihar, Gujarat, Haryana, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh. In 1998-99, the programme activities were extended to 20 additional districts covering 8 new States, i.e. Delhi, Goa, Himachal Pradesh, Lakshadweep, Manipur, Orissa, Pondicherry and Tamil Nadu. The programme is currently being implemented in 80 districts and 20 more districts are to be added in 2002-03.

Keeping in view the importance of the programme, the Council resolves that an integrated disease surveillance system should be evolved, aiming at creating quick data generation, early detection and monitoring disease outbreak and for maximum utilization of the resources, with a view to extending the disease surveillance system so as to cover the entire country.

The integrated programme may be structured so as to strengthen the existing surveillance system at the district, State and National levels and to build up additional capacities for effective communication and technology, up gradation of laboratories etc., ensure involvement of public and private sector institutions, private practitioners and NGOs in the process of effective implementation of disease surveillance programme. There is a need to integrate non-communicable diseases also in the programme, develop proper urban surveillance systems, optimize the utilization of available resources and bring about effective inter-sectoral cooperation among various agencies in the health and non-health Sector.

If need be, financial assistance may be procured from an international funding agency like the World Bank for the purpose.

## **NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS**

1. Targeting the bilateral blind and taking effective steps to transport the identified cases to Government health facilities and thereby, inter alia, improve the utilization of District Hospitals and Medical Colleges.
2. Develop performance indicators for reviewing the output of ophthalmic surgeons of District Hospitals and Medical Colleges, in terms of output per bed and use these indicators in assessing their annual performance.
3. Doctors who are working as Government Duty Medical Officer to be made to work in the Eye care programme.
4. Constitute State Blindness Control Societies / State Health Societies and appoint concerned staff without delay for making them functional.
5. In the World Bank Project States of Andhra Pradesh, Madhya Pradesh, Uttar Pradesh, Maharashtra, Orissa, Rajasthan, Tamilnadu, Uttaranchal and Chhattisgarh, the Civil Works constructed under the project must be made fully functional by September 2001 by completing the furnishing as well as deployment of personnel, if necessary, by taking them on contractual basis.
6. The State must also strengthen field supervision and monitoring to avoid double counting or fraudulent bills by participating units in the Non-Government Sector.
7. To strengthen Primary Eye Care, taking up the following initiatives:
  - a. Engage link workers at the village-level.
  - b. Establish at PHC level optical units for spectacles by identifying educated un-employed under the Self Employment Training implemented by the Department of Rural Development. Under this, educated un-employed youth can be identified for training in optometry in institutions identified by the Ministry of Health and Family Welfare and thereafter obtain a bank loan for setting up the optical units.

## **NATIONAL CANCER CONTROL PROGRAMME**

1. A nodal officer may be designated out of the existing officials at the State headquarter for co-ordination of NCCP as well as for carrying out State Cancer Programmes.
2. Regional Cancer Centres be developed in States having no such cancer centres as at present.
3. State Governments and institutions (including RCCs) should make efforts to generate and mobilize funds to strengthen the cancer facilities in their area.
4. States should consider developing 'Oncology Wings' in all Govt. Medical Colleges.
5. District Cancer Control Programme implementation be reviewed by States. Further funds may be obtained from the centre if the utilization of the funds by district societies already assisted is complete. Unutilized funds need to be refunded to the centre at the earliest.
6. The proposals under NCCP may be sent to Ministry of Health/DteGHS for consideration.
7. Installation of any radiotherapy equipment requires technical clearance by the standing committee on radiotherapy development even if there is no financial assistance. Any such proposal is also required to be sent for technical clearance.
8. The states need to develop the monitoring mechanism for the continued charitable status as well as the free/subsidized treatment of poor patients suffering from cancer, by the institutions that have been recommended by the states for financial assistance under NCCP.
9. S. Referral linkages may be developed between the Govt. health care system and the grantee institutions so that the patients referred from Govt. Health facilities are treated free/subsidized in the grantee institutions.
10. States may consider carrying out cancer awareness campaign in the regional languages, especially through mass media i.e. TV/Radio

## **NATIONAL MENTAL HEALTH PROGRAMME**

1. The Council reiterates its earlier view that mental health is an essential component of positive health. Nearly two decades after its inception the National Mental Health Programme still remains limited in scope and its basic unit. The District Mental Health Programme should, therefore cover more districts in the country in a phased manner. Much more, however, needs to be done and the Council, therefore proposes that a comprehensive National Mental Health Policy with prioritized, time-bound policy objectives may be formulated at the earliest with an ultimate aim of providing basic mental health care facilities within the community to all sections of the population across the country. The Council visualizes the following key policy objectives:
  - a. Extending and energizing the District Mental Health Programme.
  - b. Strengthening of Psychiatric Departments in the Medical Colleges.
  - c. Streamlining and modernization of mental hospitals as per minimum standards of mental health care.
  - d. Strengthening of Central and State Mental Health Authorities for the purpose of implementing the Mental Health Act 1987 effectively.
  - e. Undertaking Research Projects for evolving methods of delivery of cost effective mental health services.
  - f. Expansion of training programme with a view to creating more trained manpower at the grass-root level.
  - g. Creating awareness in the community to ensure the acceptability of mentally ill patients.
2. The Council reiterates its concern for care and support to the more vulnerable subgroups of the population which include:
  - a. Neuropsychiatric problems of senior citizens, such as Alzheimer's disease, other dementias, depressions in the elderly and Parkinson's disease.
  - b. Victims of sexual or other abuse, rape, marital or dowry-related violence, spouse-neglect or abandonment/divorce.
  - c. Those disadvantaged due to poverty, destitution, malnutrition and unemployment.
  - d. Victims of natural as well as man-made disasters such as cyclones, drought and famine, ethnic violence and terrorism.
3. The Council feels that the present medical curriculum is deficient with regard to psychiatric teaching/training at the undergraduate as well as post-graduate level. It urges the Medical Council of India to address this problem and consider expanding the exposure of students to psychiatry.

4. Finally the Council restates its earlier recommendation to the Central as well as State Governments for constituting effective, institutionalized mechanisms for monitoring, on-line audit and review of the various activities/components of the National Mental Health Plan to ensure its effective implementation within the projected time-frame.

## **PREVENTION OF FOOD ADULTERATION PROGRAMME**

1. The Council notes with concern that the Prevention of Food Adulteration (PFA) Programme has not been getting due attention in the country, with the result that the number of food samples drawn has progressively decreased while the number of cases registered under the PFA Act 1954 pending trial in various courts of the country have increased. In order to rectify this situation: -
  - (i) The Council resolves that all the States/UTs shall look into the issue seriously and take immediate steps to augment and activate their PFA enforcement machinery. Fill up all existing vacancies of Food Inspectors and Technical Personnel in their State Food Laboratories.
  - (ii) The Council further resolves that States / UTs shall provide adequate funds for purchase of food samples by the Food Inspectors, especially for lifting more samples of sensitive food products of mass consumption as well as for strengthening and upgrading their Food Laboratories by essential equipments, trained manpower and necessary chemicals required for conducting the tests.
  - (iii) The Council also resolves that efforts shall be made to reduce the cases in courts through systematic monitoring by the State Health Authorities.
  - (iv) The Council also resolves that there is an urgent need for setting up Monitoring Information System (MIS) unit at the State Headquarters under the State Food (Health) Authority to monitor the working of the PFA activities within their respective jurisdictions as well as under the local bodies, liaise with the neighboring States/UTs and to ensure timely and regular submission of periodical reports on the working of the PFA Act to the Central Government.
2. The Council observes that there is a need for greater focus in the approach to enforcement of the PFA Act as samples are generally being drawn on an adhoc basis. Therefore:-
  - (i) The Council resolves that in the interest of public health, special attention needs to be paid when regularly testing food products of mass consumption, for harmful contaminants and adulterants as well as cheaper substitutes.

- (ii) The Council resolves that States / UTs shall immediately ensure that equipment supplied to the labs are made operational and put to full use and that necessary provisions are made in the State budgets for meeting the recurring expenditure on reagents and consumables needed in the labs as well as on the annual maintenance contracts for sophisticated equipment. The Council further resolves that States / UTs shall prepare a roster of personnel trained as well as in need of training in identified areas, so that training facilities offered by the Central Government can be fully utilized in a systematic manner.

## **CENTRAL DRUGS STANDARD CONTROL ORGANIZATION**

1. The State/UTs should ensure that the provisions of Drugs & Cosmetics Rules in respect of the requirements of Good Manufacturing Practices (GMPs) are strictly and uniformly enforced. For this purpose, regulatory officials having special interest and knowledge may be identified and trained in the finer aspects of evaluating GMPs. Interstate harmonization of drug regulatory practices in the country also needs to be ensured.
2. In order to check mushroom growth of drug formulations, the States/UTs should ensure that approval to manufacture drug formulations is done strictly as per provision of rules and that the directions issued by the Ministry of Health & FW in this regard are strictly adhered to by all state licensing authorities.
3. All States/UTs having their own drug testing facilities should ensure that these laboratories undertake speedy and complete analysis of drugs and that the existing testing capacities are further enhanced. The deficiencies noticed during recent technical audit of the laboratories should be expeditiously complied with.
4. In order to address issues relating to the increasing reports of spurious/counterfeit drugs, special attention requires to be given to monitor and unearth such illegal activities by constituting a separate intelligence cell in the respective drug control organizations, and in seeking cooperation of the drug industry, the trade as well as police.
5. States and UTs should ensure that the possibility of collecting blood from professional donors is strictly checked by the concerned state drug control authorities. The modalities adopted by the blood banks specially the private commercial; blood banks for collection of blood should be closely monitored for this purpose.
6. State and UTs should provide adequate infrastructure to ensure efficient enforcement of the provisions of the Drugs & Cosmetics Act and the Rules made there under.

## **MEDICAL EDUCATION**

### **CENTRAL POOL OF MBBS/BDS SEATS**

Keeping in view the needs of the States/Union Territories who do not have Medical/Dental Colleges and to fulfill the other national and international commitments, the Council resolves that the States having medical/dental colleges but presently not contributing any seat may come forward and volunteer to contribute MBBS/BDS seats to the Central Pool. The States who are already contributing may enhance their contribution to meet the growing demand of States/UTs and other Government Departments for increase in the allocation of seats.

### **INTERLINKING OF MEDICAL COLLEGES WITH NATIONAL MEDICAL LIBRARY**

The Council resolves that States where scheme for interlinking of Medical colleges with NML has been sanctioned should implement scheme at earliest possible date.

The Council further resolves that Government of India may consider implementation of 'scheme' in remaining Government Medical Colleges.

## **REGULATORY MEASURES FOR CLINICAL ESTABLISHMENTS**

The Council resolves that the State Governments may seek the consent of State Legislatures on the draft 'Clinical Establishment Regulation Bill, 2000' empowering the Government of India to introduce the same in the Parliament and the recommendations of the State Legislatures may be conveyed to Ministry of Health & Family Welfare.

## **REGULATORY MEASURES FOR CLINICAL RECORDS**

The Council resolves that the State Governments may seek the consent of State Legislatures on the draft 'Maintenance of Clinical Records Bill, 2000' empowering the Government of India to introduce the same in the Parliament and the recommendations of the State Legislatures may be conveyed to Ministry of Health and Family Welfare,

**DEPARTMENT OF FAMILY WELFARE**

**INITIATIVES UNDER THE NATIONAL POPULATION POLICY -**  
**"DECENTRALISATION AND CONVERGENCE OF SERVICES"**

The Council noted that Health care centres are over-burdened and find it difficult to provide satisfactory services with limited personnel and equipment. Absence of supportive supervision, lack of training in interpersonal communication, and lack of motivation to work in rural areas, are all factor responsible for the present state of sub-optimal utilization of RCH services by poor people.

The Council resolved that

- State Governments should encourage panchayats to involve village self-help groups in organizing and providing basic RCH services
- State Governments should ensure the implementation of a single-window integrated and coordinated service delivery package for basic health care, family planning and maternal and child health related services at the village level ownership of the community is essential for the success of such a programme
- At village level, the anganwadi centers may be made the pivot of basic health care activities
- A Maternity Hut in the care of a mature and competent midwife should be established in each village for regular use as the village delivery room. The community or the Panchayat should assume responsibility for its proper maintenance.

**UNMET NEEDS IN CONTRACEPTION, HEALTH CARE,  
INFRASTRUCTURE AND HEALTH PERSONNEL**

The Council noted that the gaps in Health infrastructure, health care, meeting the needs in contraception and inadequacy in the availability of skilled human resources are major constraints in implementing the National Family Welfare Programme.

The Council resolves that:

- The State Governments should ensure that a sizeable share of additional central assistance is utilized towards putting in place the required infrastructure for primary health care, construction of buildings.
- In view of the absence of trained health personnel in rural areas, the Council calls upon the States to decentralize authority for making contractual appointment of Health professionals, Para-medical staff at the district level and fill up the existing vacant positions of health personnel.
- The State Governments should ensure fulfillment of unmet need of contraception in urban slums, hilly and remote areas by instituting community based distribution strategies, by associating Panchayati Raj institutions, private practitioners, municipal and local medical authorities, voluntary organizations and local leaders and opinion builders.
- The States should ensure integration of medical services at the Gram Panchayat level so that all functionaries and services converge for optimal benefit of end-users and thus develop a single window delivery services to enhance out-reach in rural, tribal, hilly and remote areas.
- The Council requests the Planning Commission to earmark sufficient funds for National Family Welfare Programme so as to meet the entire unmet need of contraception in EAG States.
- To begin with, the eight States comprising Empowered Action Group States namely Bihar, Jharkhand, Uttaranchal, Uttar Pradesh, Madhya Pradesh, Rajasthan, Chhattisgarh and Orissa where social development indices are weak should be assisted for meeting the total unmet need of contraception. The Council urges both the Centre and States to collaborate in this Endeavour.

- The State Governments should ensure smooth distribution of contraceptives by strengthening the logistics system i.e. creating adequate and appropriate storage capacities at State, Region and district levels, streamlining the distribution channel and developing a proficient MIS.

## **REPRODUCTIVE AND CHILD HEALTH PROGRAMME**

1. The Council feels that that effective implementation of programmes addressing the health issue of Women and Children is crucial to the realization of the Goals of National Population Policy 2000. The Council appreciates the efforts of Department of Family Welfare and the State Governments for introducing new schemes to address unmet needs of the population, improving outreach and providing flexibility to states in implementing the schemes. It urges the states to take all possible measures for implementation of schemes for strengthening of outreach, streamlining logistics, monitoring and supervision in order to improve the quality of services provided through the primary health care infrastructure.
2. The Council notes with concern the slow progress in the operationalisation of the First Referral Units (FRU) for improving emergency obstetric care, neonatal services and health care of young children. The Council urges the State Governments to identify gaps in availability of specialists and other trained medical personnel and taking measures for meeting the shortages. The Council takes note of the shortage of trained medical manpower particularly in certain disciplines like Anesthesia and urges upon the medical profession in general and the Medical Council of India to assist the Government in finding practical solutions for meeting these shortages early and in a consensual manner.
3. The Council notes with satisfaction the excellent progress in polio eradication over last three years and appreciates the efforts of the Ministry of Health and Family Welfare and State Governments, the voluntary sector and the people at large for making it possible. It calls upon every body to renew and sustain the effort until the country is certified as free from polio. It urges the State Governments of U.P. and Bihar, where the polio cases are still occurring, to intensify their efforts and ensure universal reach of polio activities, improve leadership in high-risk districts and mobilize the unreached communities. It reiterates its earlier call to strengthen routine immunization for buttressing other immunization activities by drawing upon the rich experiences of polio campaign.
4. The Council notes with concern the situation in regard to vacancies of the key programme staff at the State, district and field levels particularly in the cadre of female and male health workers for improving outreach and delivery of quality services to the community. The Council urges upon the State Governments to immediately fill up such vacancies and address systemic and structural factors contributing to such shortages.
5. The Council notes with concern the limited progress in the implementation of its earlier recommendation for integrated Health and Family Welfare Societies at State and district levels by merging all the vertical societies. The

Council once again impresses upon the States the need to constitute unified societies at state and district levels keeping in view the larger objective of developing synergies between the programmes, optimizing results and eliminating redundancies.

- 6 The Council notes that, taking into the consideration the improvement of basic health indicators, four southern States, Punjab & Maharashtra were specially offered a flexible package of interventions, chosen by the States themselves, for addressing their own felt needs. Such programmes -Financial Envelope Scheme for maternal and child health in six above mentioned States and the Sector Investment Programme offered to 11 States - do not seem to have made much visible progress. The Council feels that this experience is likely to constitute a set-back to the larger objective of decentralization of family welfare programme, which has remained, by and large, 100% centrally funded and operated programme. The Council, therefore, urges all the State Governments to assume real ownership of the programme and also to delegate or devolve enough powers to the elected governments at the district/local level for taking charge of the programme at their levels. Many large States, especially weakly performing States identified in National Population Policy, will need to come up with strong, flexible and transparent mechanism for quick and appropriate decision-making and implementation. The Council requests the Central Government and Planning Commission to not only mobilize physical and financial support for the States but also to help them in designing and creating such implementation mechanisms.

**IMPLEMENTATION OF THE PRE-NATAL DIAGNOSTIC  
TECHNIQUES (PNDT) ACT. 1994**

The Council noted that the Census of India held in 2001 revealed that the sex ratio in 0-6 age group has declined in the last decade in almost all the States, more steeply in the States of Punjab, Haryana, Himachal Pradesh, Rajasthan, Gujarat, Chandigarh and Delhi. The lower sex ratio for females may be due to several socio economic reasons, which may include higher preference for the male child and sex-selective abortions based on sex determination. The Council noted the concern voiced by the Hon'ble Supreme Court of India about the phenomenon of increasing female foeticide and its direction to the Central and State Governments for full and timely compliance of all the relevant provisions of the PNDT Act, 1994. The Council also noted the various steps initiated recently by the Central Government to ensure proper implementation of the legislation and to activate the Appropriate Authority.

The Council resolved that States/UTs may mount an effective awareness campaign through workshops, seminars at State, district and sub-district level, involve voluntary organizations to make the public and service providers aware of the provisions of the PNDT Act. The States/UTs shall also give protection to social activists and Non-Governmental Organizations for giving information or filing complaints against violation of provisions of the PNDT Act. The States/UTs should ensure registration of all facilities including ultrasound machines/clinics under the Act and filing quarterly reports as prescribed under the Rules.

## **IMPLEMENTATION OF THE COMMUNITY NEEDS ASSESSMENT**

### **APPROACH (CNAA)**

The Council noted that the Department of Family Welfare is implementing the Community Needs Assessment Approach throughout the country. Important steps have been taken by the Department to operationalise this approach in all the states where the systems have not yet been fully implemented, including the establishment of a fully computerized information system by providing NICNET connectivity to 540 district authorities of Health and Family Welfare, all the State and UT Headquarters and the Centre. As an important component of this computerized network system, all district authorities are being provided shortly with full computer systems (the computer, printer, UPS, modem etc.) connected with the NICNET. This system will facilitate data transmission directly from the district authorities to the State Headquarters as well as the Centre (i.e. Department of Family Welfare), and thus ensure proper monitoring the RCH Programme. It is hoped that all district authorities and States will fully utilize this modern technology to successfully operationalise CNAA and implementing RCH programme under Decentralized Participatory Planning Approach. A series of workshops at the district level have already been organized in eight states for sensitizing and educating the Health functionaries in operating this system. The council hopes that this direct interaction with the district authorities will motivate the district authorities fully, thus accelerating the pace of implementation of RCH Programme throughout the country.

**POPULATION POLICY - SOME POINTS REGARDING TWO CHILD  
NORM AND INCENTIVES/DISINCENTIVES**

The Council noted the contents of the Note circulated and endorsed the view that the government should promote the 'Small Family norm' by providing information, services and supplies enabling couples to decide upon the number and spacing of their children. Individual incentives and disincentives which generally tend to be coercive should be discouraged, as history has already demonstrated their counter productive effects.

**DEPARTMENT OF ISM&H**

## **MAINSTREAMING OF ISM&H IN RCH PROGRAMME.**

The Central Council noted that the National Population Policy 2000 envisages for mainstreaming of ISM&H in RCH practices. The proposed operational strategies in the action plan include training and utilization of ISM doctors, utilization of ISM&H institutions for disseminating the best concepts and practices of these systems for the welfare of women and children. There are about 23000 ISM&H dispensaries in the country and over 6 lakhs practitioners. The Central Council resolves that the States may quantify the availability of practitioners of ISM&H in rural areas, both institutionally trained and the bare foot practitioners and identify the gaps that exist in respect of availability of medical manpower in PHCs/CHCs and also identify ISM & H dispensaries where RCH Programme can be implemented.

It further resolved that the States should review and select effective ISM&H drugs and practices which can augment the existing RCH approach to be introduced in respective dispensaries and make them available in these dispensaries.

It was decided to identify areas where ISM&H practitioners can be used more effectively by upgrading their knowledge and skills by conducting short term training programme at each District Headquarter.

Keeping in view the judgment of the Apex Court in Civil Appeal No.89 of 1987 in the case of Dr. Mukhtiar Chand and others v/s. State-of Punjab in the order dated 13.9.1998 wherein the validity of Rule 2 (iii) of the Drugs & Cosmetics Act 1940 and Rules there under was upheld, the Council resolved that State laws and notifications be re-examined to see how best these practitioners would be used effectively in RCH practices especially in places where no modern practitioners are available.

It further resolved that each State may bring out significant legislative, administrative and schematic changes which need to be introduced to achieve the objective of utilizing these practitioners to the best advantage.

## **MEDICINAL PLANTS BOARD**

The Central Council noted with appreciation the initiatives taken by the Central Government in establishing a Medicinal Plants Board to coordinate all matters related to medicinal plants, including drawing up policies and strategies for conservation, proper harvesting, cost effective cultivation, research and development, processing, marketing, etc.

1. The Council resolves that State Governments should set up state level medicinal plant boards/high powered committees to develop medicinal plants sector.
2. The Council resolves to simplify the various States acts which restrict the inter-district and inter-state movement of cultivated plant materials. Procedure for getting cultivation certificate should be simplified.
3. The Council resolves that each State, Department of Forests, Department of Agriculture and Department of Ayurveda/ISM&H should initiate action to generate data on the demand and supply position of the plant based materials to have meaningful developmental programmes.
4. The States should identify the areas for plantation of medicinal plants in forests, Government or panchayats land etc. Awareness for the medicinal plants and commercial use of medicinal plants need to be increased with the various initiatives under IEC programme. It was also resolved that forest laws wherever necessary be streamlined to facilitate this.
5. The Council resolved that Vanaspati Van Scheme and the Scheme to create awareness of ISM&H remedies under RCH programme should continue.
6. The Central Council resolved that the potential NGOs as well as private bodies interested in the cultivation as well as plants related developmental activities should be provided spare land/forest land by the State Governments.

## **MEDICAL EDUCATION IN ISM&H**

The Central Council noted that at present 196 colleges of Ayurveda, 161 colleges of Homoeopathy, 39 of Unani and 2 colleges of Siddha system of medicine exist in the country. In some States, their number has reached a saturation point and there seems no scope for opening any more colleges. The Central Council noted with concern the decline in the standards of education. The Central Council reiterated its earlier Resolution to bring a check on the establishment of new ISM&H colleges. It resolved that the State Governments, Universities and the regulatory councils should work in tandem to ensure that no new colleges are permitted to be established. This, however, should not be applied if ISM&H colleges are established in NE States. It further resolved that minimum standards of education must be followed by the colleges for which the State Government., universities and the regulatory councils should evolve mechanism for effective periodical inspection and maintenance of standards. Appropriate action should be taken against the colleges not coming up to minimum standards.

The Central Council also noted that Central Government has been implementing schemes for assistance to UG/PG colleges for upgrading their infrastructure and for conducting re-orientation programme for their teachers and physicians. The off-take of these schemes is not very encouraging. The Central Council resolved that the State Government should avail of these schemes for upgrading the infrastructure of ISM&H colleges in State and private sector.

**QUALITY CONTROL AND STANDARDIZATION OF AYURVEDA,  
SIDDHA, UNANI & HOMOEOPATHY MEDICINES**

1. The Council resolves that it is necessary to have separate drug controllers for ISM&H drugs in the Central and State Governments.
2. The Council resolves that it is necessary to appoint separate drug inspectors for ISM&H to have an effective quality control system on ISM&H drugs.
3. The Council resolves that the States should strengthen their drug testing laboratories as well as manufacturing pharmacies of ISM&H by infusing funds and providing required technical personnel.
4. The Council resolves that PLIM and HPL be upgraded by way of constructing their own buildings and appointing the requisite staff.
5. The Council resolves to expedite completion of the pharmacopoeial standards of ISM&H drugs on priority basis.
6. The Council resolves to implement GMP for ASU drugs. The State Licensing authorities should expedite implementing these provisions.
7. The Council endorsed the need to collect market samples and have them tested for quality in the interest of giving the consumer reliable and effective products.

**CENTRALLY SPONSORED SCHEME FOR STRENGTHENING OF  
STATE DRUG TESTING LABORATORIES (DTL) AND PHARMACIES**

The Central Council appreciated the initiative of the Government of India to strengthen the State Drug Testing Laboratories and Government Pharmacies through the centrally sponsored scheme. This is a very important step to ultimately improve the quality of medicines. The Central Council resolved that central and state resources should be pooled to strengthen these laboratories by improving the infrastructure, equipment and manpower. The State Governments should avail of the central assistance for strengthening their pharmacies and laboratories. It was also resolved that Central assistance be provided for establishing new laboratories in the States.

**COMMONLY USED HOMOEOPATHIC MEDICINES FOR SALE IN  
ALL LICENSED PHARMACIES.**

The Central Council noted that Schedule 'K' of Drugs and Cosmetics Rules, 1945 has been amended to facilitate **the** availability of certain Homoeopathic medicines through all licensed pharmacies. This notification will facilitate the licensing authority to promote sale of listed Homoeopathic medicines through licensed pharmacies and would greatly facilitate users in obtaining these medicines.

The Central Council resolved that Central as well as State Drug Control Organization may issue instructions to all the licensed pharmacies/chemists to stock and sell listed Homoeopathic medicines published in the Gazette of India: GSR 218 (E) dated 28.3.2001 for the convenience of the users.

### **INFRASTRUCTURE STATUS OF ISM&H**

The Central Council noted that there is vast infrastructure of dispensaries, hospitals, educational institutions and practitioners. Most of the States have separate Directorate of ISM&H. However, it also noted that most of the States have not posted regular Director of ISM&H. Also, the various posts of ISM&H including the posts of physicians in the PHCs, dispensaries and hospitals are vacant.

The Central Council resolved that the available infrastructure should be optimally utilized in health care delivery systems, vacant posts should be filled up and regular Directors of ISM&H should be posted. Also, separate Directorate should be created in the States where no separate Directorate has so far been established. It also resolved that necessary posts be created expanding the outreach of ISM&H, drugs should be made available in adequate quantity for dispensing. The service condition of ISM&H physicians be improved and brought at par with that of allopathic physicians.

## **GLOBALISATION OF INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY.**

The Central Council noted with satisfaction that there is a worldwide resurgence of interest in traditional medicine using Medicinal Plants and herbs. In the areas of drugless therapy - Yoga is becoming extremely popular. In order to take advantage of the growing demand for drugs, cosmetics and food supplements based on medicinal plants and herbs in the global market, the Department of Indian Systems of Medicine & Homoeopathy under International Exchange Programme participates in activities like participation in fairs/exhibitions, workshops, dissemination of information through brochures, publications, booklets etc. It has been observed that drug manufacturing industry of ISM&H do not show required enthusiasm to participate in national/international fairs, exhibitions and only some large players use the opportunities. The Central Council resolves that the State Govt. may interact with the industry in their states and motivate them to participate in such fairs/exhibitions so that India could tap the vast growing market for alternative and herbal medicine worldwide and propagate our systems of medicine. Further, Department of ISM&H should undertake propagation and development of our systems as well as drugs in foreign countries by using audio-visual aids in a concerted and sustained manner.

## **ANNEXURES**

**ANNEXURE-A**

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

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

**NO. Z-16011/2/2001-B.P.  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH AND FAMILY WELFARE  
NEW DELHI-110 011**

**NOTIFICATION  
ON**

**New Delhi, the 10th July, 2001**

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

S.O. ( ) in exercise of the powers conferred by the Article 263 of the Constitution and in supersession of this Ministry's notification No. Z 16011/1/98-B.P., dated 6th April, 1999 published in the Gazette of India:

Extraordinary Part - II Section 3 Sub-Section (ii) dated 6th April, 1999, 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<br>Chairman<br>Health and Family Welfare  |         |
| (b) | The Union Minister of State<br>Chairman<br>in the Ministry of Health and<br>Family Welfare   | Vice    |
| (c) | Member, Planning Commission  | Member  |
| (d) | Ministers in charge of the Ministries<br>of the Health and Family Welfare,<br>Medical Education and Public Health<br>in the States/ Union Territories with Legislatures. | Members |
| (e) | A representative each of the<br>Dadar Nagar Haveli, Chandigarh,<br>Andaman and Nicobar Islands,<br>Daman and Diu and Lakshadweep   | Members |

- (f) **Members of Parliament:** : Members
1. Dr. Madan Prasad Jaiswal Lok Sabha
  2. Dr. (Smt.) C.Suguna Kumari Lok Sabha
  3. Dr. A.K.Patel Rajya Sabha
  4. Dr. (Ms) P.Selvi Das Rajya Sabha

(g) **Non-Officials:**

- (i) Representatives from Health : Members  
and 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 Organization of Employers, New Delhi (ex-officio)

(ii) Eminent Individuals:

1. Vaidya Devendra Triguna, Ayurvedic Physician, General Secretary, All India Ayurvedic Congress, Dhanwantri Bhawan, Punjabi Bagh, New Delhi.
2. Shri Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India, Tong Swasthya Bhawan, 40 Institutional Area, South of NT, New Delhi-110016
3. Prof. Aiokendu Chatterjee, Ex President. The Federation of Obstetric & Gynecological Societies of India (BA-49, 1st Avenue, Sector-1, Salt Lake City, Calcutta - 700064.

4. Prof. D.D.Guru, former Professor of Economics, A.N.Sinha Institute, Patna.
5. Dr. Ganesh Rane, Rotary International, R.R.R. Industries, A-109, Ansa Industrial Estate, Saki Vihar Road, Mumbai -400 071 .
6. Dr. S.K.Sarin, Professor and Head, Deptt. of Gastroenterology, G.B.Pant Hospital, New Delhi.
7. Prof. K. Mathangi Ramakrishnan, former Chairperson and Professor of Plastic Surgery at Kilpauk Medical College and Hospital, Chennai.
8. Mrs. Rose Millian Bathew (Kharbuli), former Chairman, Union Public Service Commission.

(h) **Officials:**

- |  |                     |
|--|---------------------|
| 1. Secretary, Department of Health :<br>Ministry of Health & Family Welfare                                      | Member              |
| 2. Secretary, Department of Family :<br>Welfare, Ministry of Health & Family Welfare                             | Member              |
| 3. Secretary, Department of Indian :<br>Systems of Medicine & Homoeopathy<br>Ministry of Health & Family Welfare | Member              |
| 4. Secretary, Department of Education:<br>Ministry of Human Resource Development                                 | Member              |
| 5. Secretary, Department of Women and :<br>Child Development   | Member              |
| 6. Director General of Health Services :   | Member              |
| 7. Deputy Director General of Health:<br>Services (Pig.)   | Member<br>Secretary |

- (iii) Eminent individuals at (g) (ii) 1 to 8 shall normally be members of the Council for a period of two years. The Members of Lok Sabha shall be Members of the Council so long as they are members of Lok Sabha or two years whichever is earlier.
- (iv) The Members of Rajya Sabha shall be Members of the Council so long as they are members of Rajya Sabha, or till 9th July, 2003 whichever is earlier.
- (v) The travelling and daily allowances of the 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 there under as issued from time to time.
- (vi) The expenditure involved will be met from within the sanctioned budget grant for the purpose.
- (vii) 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:**

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 proposal 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, outbreak 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 procedures, 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 as it may, with the approval of the Central Government, lay

down from time to time.

Rao)

(J.V.R.Prasada

Addl. Secretary to Govt. of India

No. Z-16011/2/2001-B.P.

#### **ANNEXURE-B**

#### **MEMBERS PRESENT AT THE CONFERENCE OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE**

- |    |  |               |
|----|--|---------------|
| 1. | Dr. C. P. Thakur,<br>Union Minister for Health & FW                  | Chairman      |
| 2. | Shri A. Raja,<br>Minister of State for Health & FW                   | Vice-Chairman |
| 3. | Shri K. Venkatasubramanian,<br>Member, Planning Commission, N. Delhi | Member        |

#### **Minister's In-charge of Ministries of Health & FW, Medical Education and Public Health in the States/UTs with Legislations**

Dr.Bhumidhar Barman,  
Member  
Minister for Health & FW,  
Assam

Dr.Tangor Tapak,  
Minister for Health & FW,  
Arunachal Pradesh

Member

Shri Shakuni Choudhary,

Member

Minister for Health & FW Bihar	
Shri Akhilesh Prasad Singh, Minister for State for Health & FW, Bihar	Member
Shri Shital Ram, Minister of State for ISM&H, Bihar	Member
Shri M.L.Ranga, Minister for Health, Haryana	Member
Shri Jagat Prakash Nadda, Minister for H&FW, Himachal Pradesh	Member
Shri Mohan Lai Minister of State (Ayurveda-in-charge) Himachal Pradesh	Member
Mian Altaf Ahmed, Minister for Health, J&K	Member
Dr.Dinesh Kumar Sarangi, Minister of Health, Jharkhand	Member
Shri P.Sankaran, Minister for Health, Kerala	Member
Shri Digvijay B Khanvilkar, Minister for Health, Maharashtra	Member
Neiba Ntang, Minister for Health, Nagaland	Member
Shri Debi Prasad Mishra, Minister of State for H&FW, Orissa	Member
Dr.Baldev Raj Chawla, Minister for Health, Punjab	Member

Shri Manoranjan Kalia, Minister for Medical Education & Research, Punjab	Member
Shri Keshab Mazumdar, Minister for Health & FW, Tripura	Member
Shri Rajendra Choudhary, Minister for Health Rajasthan	Member
Ms.Indira Mayaram, Minister of State Ayurveda and Devasthan Rajasthan	Member
Shri D.D.Bhutia, Minister for Health, Sikkim	Member
Shri S.Semmalai, Minister for Health & FW, Tamil Nadu	Member
Shri Sardar Singh, Minister for FW, Uttar Pradesh	Member
Shri AjayBhatt, Minister for Health, Uttaranchal	Member
Dr.S.K.Mishra, Minister for Health & FW, Panchayati & RD, West Bengal	Member

#### **Representations from the UTs**

##### **Andaman & Nicobar**

Dr.(Mrs.) Namita Mohamed Ali, Member  
Director of Health Services

##### **Chandigarh**

Dr.Rameshwar Chander, Member  
Director of Health Services

### **Lakshadweep**

Dr.P.K.S.Koya, Member  
Director of Medical & Health Services

### **M.Ps**

Dr.A.K.Patel, Member  
M.P.(Rajya Sabha)

### **Eminent Individuals**

Smt. R.M.Bathew,Member  
Madan Laban, Shillong

Dr.Alokendu Chatterjee,Member  
BA-49, 1st Avenue,  
Sector-I Salt Lake City,  
Kolkatta

Dr.S.K.Sarin,Member  
Prof. & Hd, Deptt. of Gyastroenterology,  
G.B.Pant Hospital,  
New Delhi

### **Non-Officials**

**Prof.N.K.Ganguly**,Member  
DG.ICMR,  
New Delhi

**Dr.Nina Pun**, Member  
President,  
Family Planning Association of India, Mumbai

### **Officials**

Shri J.A.Chowdhury, Member

Secretary (Health)

Shri A.R.Nanda, Member

Secretary (FW)

Smt. Shailaja Chandra, Member

Secretary (ISM&H)

Dr.S.P.Agarwal, Member

DGHS

Dr.(Mrs.) Madhuri Sharma, Member

DyJDir. General (P) Secretary

### **STATE GOVERNMENTS**

#### **Andhra Pradesh**

1. Nilam Sawhney  
Secretary (FW) & Commissioner (FW)
2. Dr. P.V.Raj, Addl. Director,  
Commissionerate of Indian Medicine & Homoeopathy,  
Hyderabad

#### **Assam**

1. Shri Alok Perti,  
Commissioner & Secretary, Health & FW
2. Dr.Parthajyoti Gogoi,  
OSD (Health), Govt. of Assam & Director-in-Charge  
(RDTL)
3. Dr.B.C.Kro, DHS,  
Assam

4. Prof.A.C.Borah,  
Director of Medical Education,  
Assam
5. Shri P.C.Das,  
PS to Minister (Health),  
Assam

### **Bihar**

1. Shri C.K.Anil,  
Addl.Secretary (Health),  
Bihar
2. Shri Ashok Mohi,  
Deputy Director (IEC)

### **Delhi**

1. Dr.R.N.Baishya,  
Director of Health Services,  
Delhi
2. Dr. L. L. Agarwal,  
Drugs Controller,  
Delhi.
3. Dr.S.K.Bansal,  
State Programme Officer,  
National Programme for Control of Blindness,  
DHS,  
Delhi

### **Goa**

1. Dr.AV.Salelkar,  
Director of Health Services,  
Goa

## **Gujarat**

1. Smt. S. K. Verma  
Add I. Chief Secretary Government of Gujarat
2. Dr.Joy Cheenath,  
Commissioner Health, Medical Services and Medical Education, Govt. of  
Gujarat
3. Shri S.P. Adeshara,  
Commissioner Food & Drugs Govt. of Gujarat
4. Km. Binduben Gamit,  
Joint Secretary & Director ISM&H
5. Dr. G. Ashah,  
Gujarat
6. Dr.Suresh Shah

## **Haryana**

1. Shri Madhavan G.,  
Secretary (H)
2. Dr. P. L.Jindal,  
DGHS,  
Haryana
3. Dr. J. L. Chaudhry,  
DHS,  
Haryana
4. Dr. R. N. Sachdeva,  
DHS-cum-SPC,RCH, SIHFVV,  
Haryana
5. Dr. Paramjit Singh,

Director (Ayurveda)  
Haryana

**Himachal Pradesh**

1. Dr.G.Verma,  
Secretary to Health Minister
2. Shri Vineet Chawdhry,  
Secretary (H)
3. Smt R. S. Dhar,  
Financial Commissioner-cum-Secretary (ISM&H)
4. Dr. K. S. Rana,  
Director of Health Services
5. Dr.Rakesh Pandit,  
OSD, D/o Ayurveda
6. **Shri Prem Shyam,**  
Programme Officer, Director of Health

**Jammu & Kashmir**

1. Shri H.L.Kadlabju,  
Principal Secretary, Health & Medi.Edu.
2. Dr.Muzzafar Ahmed, DHS,  
Kashmir, Srinagar
3. Dr.Jasbir Singh, DHS,  
Jammu

4. Shri Abdul Rehman,  
Jt.Dir.Health & Medical Education,  
J&K, Srinagar

### **Jharkhand**

1. Dr.Jobra Hellen Soren,  
Addl.Dir of Health Services

### **Kerala**

1. Shri N.Chandrasekharan Nair,  
Principal Secretary,  
Health & FW, Govt. of Kerala
2. Shri K.Ramamoorthy,  
Secretary (Health), Govt. of Kerala
3. Dr.V.K.Rajan  
Director of Health Services,  
Kerala
4. Dr.Jyotish,  
PS to Health Minister

### **Karnataka**

1. Shri A.K.M.Nayak,  
Principal Secretary
2. Shri Sanjay Kaul,  
Commissioner, Health & FW.
3. Shri R. Anandarajasekhar,  
Drug Controller

4. Dr.G.V.Nagraj,  
Director, Health & FW
5. Dr.R.Sethalakshmi,  
Director, M.Edu.
6. Dr.B.Guruswamy,  
Director, ISM&H

**Lakshadweep**

1. Shri F.G.Mohammad,  
Laision Officer

**Madhya Pradesh**

1. SmtAlka Sirohi,  
Principal Secretary, Health & FW
2. Shri Hoshiyar Singh,  
Secretary, Medical Education
3. SmtSaleena Singh,  
Controller, Food & Drugs
4. Dr.P.K.Bajaj, Director,  
Medical Services
5. Shri D.M.Chincholikar,  
Licensing Authority, Food & Drugs

6. Shri G.C.Dixit, Professor,  
Directorate of Med.Edu.
7. Dr.J.P.Sharma,  
Prof.& Head of Radiotherapy Deptt, Gandhi Medical  
College, MP

### **Maharashtra**

1. Shri Manmohan Singh,  
Principal Secretary.PHD (FW),
2. Shri S.Shahzad Hussain,  
Secretary, Public Health
3. Dr. Subhash Salunke,  
Director General of Health Services

### **Manipur**

1. Dr. S.Rabei Singh,  
Director, Family Welfare
2. Dr.Th.Suresh Singh,  
Addl.Dir(Health), Medical Director to Govt. of Manipur
3. Dr. Khomdon Singh Lisam,  
Project Director,  
Manipur State AIDS Control Society,  
Manipur
4. Shri P. Sharat Chandra,  
Resident Commissioner

### **Meghalaya**

1. Dr.K.D.Laloo, Addl.DHS
2. Dr.(Smt) M.Chen, DHS
3. Dr.M.Ghosh Mizoram

### **Mizoram**

1. Shri Lalmalsawma,  
Secretary (Health)
2. Dr.R.TIangkunga,  
Director, Hosp.& Med.Edu.
3. Dr.Lenghaia,  
Jt.Director of Health Services
4. Dr.Jane R.Ralte,  
PO(Hosp.;; Dte.of HS

### **Nagaland**

1. Dr.Kepelhusie,  
Addl.Director of Health Services

2. Dr.Khanlo Magh,  
Dy.Dir.of Health Services
4. Dr. Neiketou Amgami, Dy.Dir. of Health Services

**Orissa**

1. Ms Meena Gupta,  
Principal Secretary, Health & F.W.
2. Dr.H.K.Das,  
Director of Health Services

**Punjab**

1. Shri N.S.Rattan,  
Principal Secretary, Medical Education & Research
2. Shri P.K.Verma,  
Principal Secretary, Health & FW
3. Dr.G.S.Preet,  
Director of Health Services, Punjab
4. Dr. Joginder Singh,  
Director of Health Services (FW)
5. Shri Sat Narain,  
Joint Director,  
Information & Public Relations,  
Punjab Bhawan,  
New Delhi

### **Pondicherry**

1. Dr.D.Thamma Rao,  
Director of Health & FW/ISM

### **Rajasthan**

1. Shri B.P.Arya,  
Secretary to Govt., Medical & Health Deptt.
2. Shri Vipin Chandra Sharma,  
Secretary to Govt., Ayurveda & Devasthan Deptt.
3. Dr.R.K.Garg,  
Director, Medical & Health
4. Shri Mahendra Surana, IAS,  
Director, FW & IEC
5. Dr.K.P.Vyas,  
Director, Deptt. of Ayurveda, Ajmer

### **Sikkim**

1. Dr.(Mrs.) Uma Pradhan  
Addl.Director, Family Welfare
2. Dr. T.Yethenpa  
Jt. Director, Deptt. of Health & FW

### **Tamil Nadu**

1. Shri S.Munir Hoda  
Secretary, Health
2. Shri M. F. Farooqui  
Commissioner, Indian Medicine
3. Ms.Leena Nair,  
Commissioner, MCH&W
6. Dr. P.Krishna Murthy  
Director, Public Health

### **Tripura**

1. Shri G.Kameswara Rao  
Commisioner-cum-Secretary, Health & FW
2. Dr.Bimal Bhowmik,  
Director of Health Services
3. Dr.Mrinal Kanti Bhowmik, Director of FW & Preventive Medicine

### **Uttar Pradesh**

1. Shri J.P.Sharma  
Secretary, Health & FW
2. Dr. H.C.Vaish  
Director General of Health Services
3. Dr. S.G.Prasad  
Drug Controller

4. Prof. B.N.Singh,  
Principal, National Homoeopathic Medical College,  
Lucknow
5. Dr. A.K.Sachan  
Managing Director, Shekhar Hospital,  
Lucknow
6. Dr.Vinod Kumar, CMO,  
Ghaziabad

#### **Uttaranchal**

1. Shri Alok Kumar Jain  
Secretary (Health)
2. Dr.I.S. Pal  
Director General (Medical)
3. Dr.R.C.Arya,  
Addl.Director, Medical, Health & FW
4. Dr.S.R.S.Rana,  
Incharge Training Programme

#### **West Bengal**

1. Shri Ashok M. Chakrabarti  
Principal Secretary, H&FW Deptt.
2. Prof. C.R.Maity,  
Director, Medical Education
3. Dr. Sujay K.Das

Director of Health Services

**Government Organizations, Autonomous Institutions and Others**

1. Dr.Alicia Poucinski  
World Bank
2. Dr. Prema Ramachandran  
Adviser (Health) Planning  
Commission
3. Vd.Shri Ram Sharma  
President, CCIM
4. Dr.M.K.Siddiqui  
Director,  
Central Council for Research in Unani Medicine  
New Delhi
5. Dr.R.Shaw  
Director  
Central Council for Research in Homoeopathy
6. Dr. K.D.Sharma  
DDfTech,)), CCRAS & Director Incharge of CCRYN,  
New Delhi
7. Shri S.C.Goyal  
Dy. Secretary  
Indian Red Cross Society,  
New Delhi
8. Shri Vikramaditya  
Homoeopathic Pharmaceutical Lab Ghaziabad
9. Shri R.U.Ahmed

PLIM Ghaziabad

10. Shri Swami Pranavanand  
OSD (Yoga & Naturopathy)
11. Shri Ranu Kulshreshtha  
PO, FICCI
12. Dr. Sharmila Neogi  
PFI, PO(RCH)

**Ministry of Health & Family Welfare**

1. Shri J.V.R.Prasada Rao  
Addl.Secretary
2. Shri Govind R. Patwardhan  
Addl.Secretary
3. Shri Sanjeev Ranjan PS to HFM
4. Shri Keshav Murthy OSD to HFM
5. Ms. Sujata Rao  
Joint Secretary
6. Shri Deepak Gupta,  
Joint Secretary
7. Shri Gautam Basu  
Joint Secretary

8. Shri A.K.Gupta  
Joint Secretary
9. Smt.Bhawani Thyagarajan, Joint Secretary
10. Shri L.Prasad  
Joint Secretary (Deptt. of ISM&H)
11. Shri Jawahar Thakur,  
Chief Controller of Accounts
12. Dr.V.K.Manchanda  
DDG(MH)
13. Dr.S.K.Satpathy  
Dy.Commissioner
14. Dr.V.B.Gupta  
Dy.Commissioner
15. Shri P.K.Saha,  
Chief Director
16. Dr.K.V.Rao,  
Chief Director
17. Shri Rajendra Mishra  
Director
18. Shri T.K.Manoj Kumar  
Director

19. SmtGopa Sen  
Director
20. Shri S.C.Srivastava  
Director
21. Shri Babu Lai  
Director
22. Shri S.K.Rao  
Director
23. Shri N.S.Kang  
Director
24. Shri O.S.Veerwal  
Director
25. Dr.S.K.Sharma  
Adviser (Ayurveda)
26. Dr.P.LJoshi  
Jt.Director (Tech.), NACO
27. Smt. Neelam Kapur  
Jt. Director (IEC), NACO
28. Shri K.V.Krishnan  
Economic Adviser
29. Dr. CHS Sastry,

OSD(ISM)

30. Smt. Shubra Singh  
Dy. Secretary
31. Shri N.N.Sinha  
Dy. Secretary
32. Dr. Srinivas Tata  
Dy. Secretary
33. SmtSadhna Shankar  
Dy.Secretary
34. Dr.P.Biswal  
Asstt.Commissioner
35. Dr.S.Sarkar  
Asstt.Commissioner
36. Dr.S.Malhotra  
Asstt.Commissioner
37. Dr.B.Kishore  
Asstt.Commissioner
38. Dr.(Smt) Anuradha M. Joshi  
Dy. Adviser (Ayurveda)
39. Dr.Eswara Das  
Dy.Adviser (Homoeopathy)

40. Dr.M.Shamoon  
Dy.Adviser (Unani)
41. Dr.S.P.Singh  
Dy.Adviser (Homoeopathy)
42. Dr.M.A.Kumar  
Dy.Adviser (Sidha)
43. Dr.M.LSharma  
Dy.Adviser (Ayurveda)
44. Dr.(Col.) I.B.Sareen  
Consultant (HRD&Trg.) Ophthalmology Division
45. Shri R.N.Bansal  
US(P)
46. Smt.Madhu Bala

Directorate General of Health Services

1. Dr.Ira Ray  
Addl.DG
2. Dr. R.K.Srivastava  
Addl. D.G.
3. Dr. Shiv Lai  
Addl. D.G.
4. Dr.R.N.Salhan  
OSD

5. Mr.Ashwini Kumar  
DCG(I)
6. Dr. (Smt.) R.Jose  
Consultant (O) / DDG (O)
7. Dr. G.R.Khatri,  
DDG (TB)
8. Dr. N.S.Dharamshaktu  
DDG (Lep)
9. Dr. R.C.Kalra  
DDG (RHS)
10. Dr. Y.N.Rao  
OSD
11. Dr. Ashok Kumar  
Director (NAMP)
12. **Dr. Sangeeta Khanna**  
DDG (G)
13. Prof. A.S.Bais,  
DDG (M)
14. Dr.Sudhir Chandra,  
Addl.DDG(M)
15. Dr. K.K.Dutta

Director, NICD

16. Smt. Urvasi Sadhwani  
Addl.Economic Adviser
17. Dr.B.K.Tiwari,  
Adviser, Nutrition
18. Dr.S.B.Taraneker  
ADG (Lep.)
19. Dr.Sudhir Gupta  
CMO (NCD)
20. Dr.S.K.Kaakran  
CMO, Safdarjung Hospital
21. Shri R.B.Gupta  
Statistical Officer

## ANNEXURE-C

### **Schedule for the Seventh Conference of Central Council of Health and Family Welfare - 12<sup>th</sup> and 13<sup>th</sup> July, 2001.**

#### **12<sup>th</sup> July, 2001**

9.00 AM- 9.30 AM	Registration
9.30 AM - 10.45 AM	Welcome address by Secretary (Health) Address by MOS Presidential address by HFM Presentation of National Awards for elimination of Leprosy. Vote of thanks by DGHS
10.45 AM - 11.00 AM	Tea/Coffee
11.00 AM - 1.30 PM	National Health Policy
1.30 PM- 2.30 PM	Lunch
2.30 PM - 4.00 PM	Issues of Department of ISM&H
4.00 PM- 4.15 PM	Tea/Coffee
4.15 PM - 6.00 PM	Communicable Diseases <ul style="list-style-type: none"><li>▪ AIDS</li><li>▪ TB</li><li>▪ Malaria</li><li>▪ Leprosy</li><li>▪ Surveillance Programme</li></ul>

**13<sup>th</sup> July, 2001**

9.30 AM-11.00 AM

Blindness

Cancer

Mental Health

Medical Education

11.00 AM - 11.15 AM

Tea/Coffee

11.15 AM- 1.30 PM

Food and Drug Administration

Regulatory measures for private

Practitioners / Nursing homes

1.30 PM- 2.30 PM

Lunch

2.30 PM - 4.30 PM

Issues of Department of Family Welfare

4.30 PM - 4.45 PM

Tea/Coffee

4.45 PM- 6.00 PM

Summing Up.