

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

(RESOLUTIONS)

**JULY 14-16, 1993 New
Delhi**



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

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**ADDRESS OF SHRI PABAN SINGH GHATOWAR, DEPUTY MINISTER OF
HEALTH AND FAMILY WELFARE**

Hon'ble Ministers of Health, Members of the Central Council, Secretaries of the Department of Health and Family Welfare, Secretaries from the States, Director General of Health Services, Other distinguished participants and friends.

I am indeed happy to welcome you all to this meeting of the Central Council of Health & Family Welfare which is taking place after a gap of over four years. In the intervening period, the health sector has seen several changes. We have been able to make significant progress in many areas but the emergence of diseases like AIDS have changed the focus of attention also.

There has been significant fertility decline and the total fertility rate having come down from 5.97 per woman in 1961 to 3.8 in 1990. While the Infant Mortality Rates are showing a marked decline, the increasing population in our Country continues to be a matter of serious concern. During the last decade the annual exponential growth rate has come down very marginally from 2.22 to 2.14. This requires us to launch a concerted and a frontal attack on the population problem with the total involvement of the people so that the goal of NRR is not allowed to recede further beyond 2016.

It is encouraging to note that in some States we are making a break through. Kerala, Tamil Nadu and Goa have achieved outstanding success in bringing down the important demographic indicators like the Crude Birth Rate. This success should encourage us to tackle the problem of containing the population growth in States where the demographic indicators are unacceptably high. 90 districts in the Country have been identified where the demographic indicators are unacceptably high. 83 of these 90 fall in the four states of Uttar Pradesh, Bihar, and Rajasthan & Madhya Pradesh. Schemes under the Social Safety Net Scheme with the intention of strengthening the rural health infrastructure in these districts have been formulated. It is imperative that the States where these districts are located make special efforts to implement these schemes which have been designed to bring down the maternal and infant mortality rates, alongside the crude birth rate.

Under the Family Welfare Programme another significant policy initiated during the last year has been the launching of the Child Survival & Safe Motherhood Programme in the Country. This programme takes off from the Universal Immunization Programme which has been in operation for the last 5-6 years. Recent reforms have shown that UIP programme has been a marked success and the IMR has come down considerably during the last few years. The national goal of reaching IMR as 60 per thousand by the turn of the century is very achievable and with your cooperation there is no reason why we cannot achieve the target much before the turn of the century. The programme would be actively taking steps to bring down maternal mortality under the safe motherhood component. This is very important initiative of the Government. I call on all of you to ensure that these schemes that strongly influence demographic change are effectively implemented.

Sustained efforts on promoting spacing methods among younger couples have to be intensified. Spacing is not only a tool to help limit family size, but more importantly, an effective health measure to ensure the well being of the mother and child. Therefore, a very special focus needs to be given to propagating spacing. In this direction special efforts for ensuring regular supply of contraceptives have been, initiated and intensification of IEC activities to spread the message of

spacing has also been taken up.

The necessity of having a reasonably high level quality of the delivery system is a pre-requisite if the demand generated by the Programme in the rural areas has to be met fully. Various schemes and proposals are under implementation which would involve strengthening of the Rural Health Infrastructure, providing essential equipment and supplies and also ensuring that medical and Para medical personnel are trained adequately.

It is important that we realize that Government alone cannot achieve the goal of population stabilization, as fertility behaviors is not a function of supplies. Social factors such as Woman's social status, literacy level etc. is found to have a strong bearing on the adoption of the small family norm. It must, therefore, be our Endeavour to secure greater participation of the community, voluntary and non-government organizations to share the responsibility of facing this challenge. Likewise it is most important that Members of Parliament and Legislative Assemblies take keen interest in this programme and actively associate themselves so as to ensure achieving the family welfare programme goals within the given time frame.

For making the Family Welfare and population stabilization programme a people's movement, we have now a rare opportunity in the 73rd amendment of the Constitution. The Panchayat Raj Bill provides for electoral bodies of people's representatives at the District and village level, 30% of the panchayat members will be women. We need to ensure their involvement to see that the programmes designed for the benefit of the people are made full use of. It would be appropriate if we could come up with a set of comprehensive recommendation to further the programme without diluting its focus and emphasis. Delegation of responsibility to implement and monitor will also need to be carefully deliberated upon. These issues will soon become important in the coming days.

While considerable efforts are being channelized to improve all round health care, we are conscious that sometimes there is a gap between what we plan and the situation as it emerges on the ground. The fact that so many posts of doctors are vacant in the Primary Health Centres is a cause of worry. So also the fact that our health education messages do not appear to reach the population. Numerous illness episodes could be averted if we could raise the awareness among the people. The school Health system is perhaps a channel which could be used highly effectively not only to promote the health of the school children but also to make them messengers of health education ideas, particularly in rural and slum areas.

In the health sector, I think it is time we modernize the assimilation of data and improve the efficiency of disseminating it. With the help of the World Health Organization, we are trying to introduce a simple but efficient Health Management Information System in 10 States and Union territories.

The second phase will depend on the successful off-take of the first phase. I hope the Health Ministers will take interest in this important area.

I feel we ought to also consider the need for augmenting the paramedical manpower. There is a dearth of qualified optometrists, dental hygienists, radiographers, laboratory technicians. Without this back-up, it is questionable how the infrastructure we have built up can function. I expect the Council will consider this and the State Health Minister will see that at least through the vocational stream, we build up a cadre of qualified technicians and Para-medicals.

We are now meeting for the next three days to discuss various aspects of the Health & Family Welfare Department. The intention is to discuss together and seek your counsel and active cooperation in achieving the tasks that we have set forth for ourselves. I am sure that the deliberations will be fruitful and valuable suggestions will emerge. I once again, welcome you all.

**ADDRESS BY PROF. J.S. BAJAJ, MEMBER (HEALTH)
PLANNING COMMISSION**

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

Let me, at the outset; thank the Chairman of the Council, Shri Shankaranandji for asking me to make a few observations at this inaugural session. While so doing, I shall like to share with you the objectives, perspectives, policy framework and resources for health and family welfare sector in the Eighth Five Year Plan.

Human development, in all its multi-dimensions, is the ultimate goal of the Eighth Plan. It is only healthy and educated people who can contribute to economic growth and this growth, in turn, contributes to human well being. The priority sectors of the Plan that contribute towards realization of this goal are health, education, literacy and basic needs, including drinking water, housing and welfare programmes for the weaker sections. In order to achieve these priority objectives, there is a conscious decision to roll back the public sector investments from those sectors of the economy where the private sector can move in so as to enable us to step up our investment in the social sector, agriculture and infrastructural development. Thus, a critical appraisal of the allocations made to the priority sectors in the Eighth Plan shows that nearly 81.7 per cent of the total budgetary support to the central Ministries has now gone to the social, infrastructure and agricultural sectors. This compares with 70 per cent in the Seventh Plan.

It is in this context that the references made in the Agenda Notes regarding financial outlays and expenditure in the health and family welfare sectors need to be examined. Let me emphasize that in all the analytical approaches, we should include every investment for health. What we continue to do, and this is also followed by international agencies, is only to focus on investments in health. The two are different. When we invest for health, we make financial outlays for safe drinking water, for environmental sanitation, for nutrition, for welfare of the handicapped. Does it really matter as to which agency provides safe drinking water in Rajasthan where one of the main objectives is eradication of guinea worm infestation. Simply because the channels of funding do not pass through the Ministry of Health, should we not take this into account? Indeed, the total investments for safe drinking water and sanitation in the Eighth Plan amount to more than Rs.16000crores while the investments in health and family welfare amount to over 14,000crores. Furthermore, providing mid-day meals to a child to ensure physical and mental growth and development is as much a part of health, even if it is not a part of Ministry of Health. We refer to the Alma-Ata declaration and exhibit our commitment to primary health care. While so doing, we sometimes tend to forget the eight components as outlined in that declaration. These include nutrition, safe drinking water and sanitation.

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

A time has come when people's health needs cannot be subjected to the bureaucratic bottlenecks on the one hand and professional non-responsiveness on the other. The recent passage of the Constitution (Seventy-second Amendment) Bill also called the Panchayati Raj Bill; by the Parliament of India aims at creating the essential instrumentality to empower people in the planning and participatory management of health and family welfare infrastructure, and usher in a new era of social and infrastructural development. Accordingly all of us, especially the health planners and administrators, must not only become sensitive and responsive to the felt needs of the people but must also adapt to the instrumentality of the local self-government. The health care systems and the professionals who operate these systems must have an inbuilt resilience and a sharply defined accountability. Till such time that the Panchayats reach an optimally operational mode, existing people's institutions shall need to be strengthened, or new institutions identified, to provide a thrust to the health and population control programme.

We had enthusiastically joined the international -movement of "Health For All by the year 2000'. This is also reflected in the National Health Policy - which bears the indelible imprint of the deep perceptions of Shri Shankaranand. Keeping our priorities for primary health care and development of referral support and linkage services at the district and sub-district levels, we have reiterated in the Eighth Plan our commitment to this effect. However, there is a strategic change. We have emphasized that the Health for All (HFA) paradigm must take into account not only high risk vulnerable

groups, i.e., mothers and children, but must also focus sharply on the under privileged segments within the vulnerable groups. Within the HFA strategy, "Health for underprivileged" will be promoted consciously and consistently. This can only be done through emphasizing the community based systems reflected in our planning of infrastructure.

Family Welfare

Taking cognizance of the fact that population stabilization is critical and crucial to achieve sustainable development the Country's Eighth Plan has included this as one of the six priority objectives. To reinforce a sense of urgency and priority, along with the Directional Paper of the Eighth Plan, Population Control was also included as an agenda item at the meeting of the National Development Council, held on December 23-24, 1991, and a separate paper prepared by the Planning Commission was submitted as the background document. Several major actions including constitution of the NDC Committee on Population have followed.

Without going into the demographic diversity reflected in the data based on the 1991 census, I shall like to emphasize that our commitment to make vigorous efforts to contain population growth is therefore total and absolute. Although there are likely to be commonalities of approach in the general contours of the population policy for the country, it is critical that the programme content must relate to decentralized area-specific planning at the district, sub-district and the panchayat levels, and must be based on an in-depth desegregated analysis of a constellation of socio-biological indices and demographic determinants. It is recognized that the base and basis of the population stabilization programme must be through such micro-planning, within the general directional framework of a national policy aimed at generating a people's movement with the total and committed involvement of community leaders, irrespective of denominational affiliation and , linking population control with the larger programme of female literacy, women's employment, empowerment, social security, access to a package of health services of the requisite quality and outreach, including immunization and mother and child care. Intensified efforts in 90 poorly performing districts closely relate to this strategy.

It further needs to be emphasized that congruence of goals at the policy planning and convergence of services at the community level, constitutes the critical and crucial input to ensure a successful outcome of our intensified efforts. Thus, irrespective of the nodal ministries which act as programme managers for education, female literacy, women and child development, rural development, health and family welfare, information and broadcasting, small scale industry, labors, there must be 'funneling' effect to ensure target-oriented convergence of the services through village level workers who are a part of the community and enjoy a close rapport with the people.

Performance Audit

We have made every effort to enhance the financial outlay for health and family welfare to the best of our ability including making several exceptions such as ensuring in addition of Rs.270crores in the National AIDS Control Programme, and availability of Rs.250crores for Health and Family Welfare through social safety net mechanism during the first two years of the Eighth Five Plan. Thus the budget estimates for 1992-93 placed outlay for Health at Rs.302crores. Through the modalities I have just mentioned rose to Rs.449crores. In addition, we

have also tried to ensure that these financial outlays are effectively utilized by the States and Union Territories through the introduction of performance audit.

For the first time, there is a paradigm shift in the methodology for providing central assistance to non-special category states. The Planning Commission is now committed to provide incentives to States which perform well in the social sector. The National Development Council has approved a revision in the Gadgil formula for allocation of Central assistance, recognizing and establishing a parity between achievements in the economic and social sectors. Thus under the performance criteria, population control, along with maternal and child health have been identified as specified indicators in the health sector. For this purpose, crude birth rate and infant mortality rate are given equal weight age for performance evaluation. Similarly, female literacy has been included as the criterion for performance in the education sector. Of the total weight age of 7.5% assigned to performances a weight age of 1 % each has been assigned to population and education, on the basis of indicators mentioned. This in itself amounts to Rs.700-800 crores to be allocated amongst non-special category states.

Thus, at the time of Annual Plan discussion, there would be a critical review of achievements by each of the non-special category states in the specified areas of population control, maternal and child health, and literacy of the girl child. Such a review would determine the quantum of allocation of additional Central assistance in the states' Annual Plans, as per the revised Gadgil formula, approved by the NDC.

This is a major step forward since it not only sensitizes the States to the need of effective implementation of family welfare and literacy programmes, but also provides a clearer indication of availability of additional Central assistance to those States which are rated as high achievers on the annual performance audit.

Human Resources for Health

Finally, any system is as good as the people who manage the system. To optimize the performance of health professionals and paraprofessionals, it is important to consider both the optional mix of such manpower which constitutes the health care delivery team, as well as their individual competencies to seek and provide realistic solutions to the health-related issues at the grassroots level. This holistic approach is reflected in the draft of the National Education Policy in Health Sciences. A major effort has gone into its preparation by a Consultative Group that I had the privilege to Chair. The Draft Policy had been widely circulated and responses invited from the Central Ministries, States, Universities, medical and health institutions including colleges of Indian systems of medicine and homeopathy, amongst others. There was an overwhelming endorsement. In addition, several pertinent suggestions were made which have been subsequently included in the final Draft which has now being circulated for your consideration.

Let me conclude by affirming our commitment to the objectives I have narrated. As to the absolute certainty regarding the ultimate success of these efforts, one may draw strength from Bertrand Russell: "For it is not enough to recognize that all our knowledge is, in a greater or lesser degree, uncertain and vague; it is necessary, at the same time, to learn to act upon the best hypothesis without dogmatically believing it".

While the scientists accept the validity of this thesis, it is time that the cynics and skeptics may also do likewise.

**INAUGURAL ADDRESS
SHRI B. SHANKARANAND,
UNION MINISTER OF HEALTH & FAMILY WELFARE
AND CHAIRMAN, CENTRAL COUNCIL OF HEALTH &
FAMILY WELFARE**

Hon'ble Chief Ministers and State Health Ministers, Member, Planning Commission, Deputy Minister, Secretaries of Health and Family Welfare, non-official members of the Central Council, Director General of Health Services, other distinguished participants and friends;

1. Let me join in welcoming all of you to the first meeting of the re-constituted Central Council of Health & Family Welfare, the highest advisory body for this sector.
2. The population explosion is perhaps a single most pressing problem our country is racing today. The increasing population has extremely serious implications for India's socio-economic development, environment and the quality of life of our people. Every year we are adding around 17 million people to an already large population. If the pace of growth of population is not reduced, we will not be able to render socio-economic justice to the millions of poor people. Slowing down the rate of growth of population is, therefore, one of the most important objectives and considered pivotal for the success of all developmental efforts.
3. Some significant achievements have been made. Six children were born per family on an average, in 1951-61. Now the number of children has come down to less than four per family. The infant mortality rate has come down from 110 in 1981 to 80 in 1991. The Crude Birth Rate has been reduced from 37.2 per thousand live births in 1981 to 29.5 in 1991. While these achievements are significant, much more needs to be done to attain population stabilization.
4. Family Planning must no longer remain a un department programme of the Department of Health and Family Welfare at the Centre and the States. It must become a multi-sectoral programme where grassroot functionaries of all Departments together support and promote family planning amongst the people. In pursuance of the 73rd Constitutional Amendment, the village panchayats, intermediate panchayats and district level panchayats can play a major role.
5. As there are marked variations in the impact of the Family Planning Programme from State to State it is essential to adopt differential strategies in those States which have to make special efforts to bring about improvement in the quality of Family Welfare Services provided to the people. Accordingly, 90 districts which are performing very poorly, demographically, have been selected with a Crude Birth Rate of more than 39.
6. A special Social Safety Net Scheme has been launched in these 90 districts. A Child Survival and Safe Motherhood Programme of Rs.1125crores have been launched for reducing maternal mortality, infant mortality and child mortality. Universal Immunization Programme, Oral Rehydration Therapy and Schemes of nutritional anemia are being actively supported. Free distribution of contraceptives is being undertaken. A Rs.950crores programme has been sanctioned for Uttar Pradesh to promote innovative programme of family planning.

7. Several new schemes have been sanctioned for NGOs. Keeping in view the magnitude of the population problem, it is essential to involve Non-governmental Organizations, Voluntary Organizations, Indian System of Medicine Practitioners and the masses in this Endeavour to make it a people's programme. Information, Education and Communication schemes have been decentralized and appropriate material in the local idiom is being produced so that inter-personal communication is facilitated. It is important that States can lay emphasis on improving the quality of care provided by Para-medical and medical staff.
8. Family Planning is not only a function of contraception. Female literacy, age at marriage, socio-economic status of women all influence fertility behavior. It is important, therefore, that there should be convergence of services provided by different social sectors at the ground level.
9. The 8th Five Year Plan is already under implementation and the total allocation for Health and Family Welfare is Rs.7582.20 crores and Rs.6500 crores respectively for the next 5 years. This constitutes 3.24% of the total Government Plan outlay and is only a slight improvement over an assignment of 3.1 % during the 7th Plan. We have also undertaken a review of the goals set out under the National Health Policy of 1983 and they indicate that while we have achieved and even surpassed the goals to some extent, yet we have a long way to go to fulfill all the targets. The infant mortality rate was expected to reduce to 87 per thousand by 1990; we have already achieved an 80 per thousand index. That is a remarkable achievement although inter-state disparities continue to be a matter of concern. The Crude Death rate has also been reduced to 9.8 which is an improvement over the target envisaged up to 1990. The status of the Immunization Programme is satisfactory on some major counts - almost cent per cent as far as DPT, Polio and BCG are concerned. Life expectancy has gone up to almost 60 years. Under the Leprosy Eradication Programme, we have fully achieved the target and the decline in the prevalence rate has been dramatic in areas covered by the MDT Programme. On the other hand, the achievements in lowering the birth rate have been disappointing and we continue to add 17 million to the population each year.
10. We have succeeded in establishing an impressive network of 1, 30,000 Sub-Centres, over 20,000 Primary Health Centres and over 2000 Community Health Centres throughout the country. As part of the need to evaluate and consider how the beneficiaries assess the services provided and to determine how this infrastructure is performing, the Health Ministry had commissioned a number of studies. The review of studies already available have shown that the infrastructure by and large is not performing as it was intended to, for a number of reasons and people are perforce turning to private practitioners having been unsuccessful in receiving a satisfactory return from the public health system. The Primary health infrastructure, you will agree with me, is the basic foundation on which the entire rural health structure of the country rests and if people are not fully utilizing the services either because of their poor quality or dependability, it is indeed a matter of concern. Equally disturbing is the scenario of district and metropolitan hospitals which are under great strain due to the increasing number of patients. All our programmes depend upon this basic health infrastructure and unless it is energized and made more efficient the delivery of all programmes in health and family welfare will remain unsatisfactory. I will like to urge the States to critically examine the differences and take necessary corrective steps.
11. I am equally concerned that funds assigned for health programmes are meager as they are being diverted to meet the ways and means position, salary costs, other inter-sectoral priorities at the cost of the National Programmes which are designed to meet the needs of the vulnerable and the poor. I am surprised that even in a newly introduced programme which has been initiated with the external

assistance of the World Bank viz AIDS, the funds allocated to the States and Union Territories have not been released in time by some States to the concerned authorities for furtherance of the Programme. In a programme like Control of Blindness, there is a huge backlog of cataract cases. There have been reports of some states not fully utilizing the facilities created with the Central grants. It is important that all of us here should be alive to the deficiencies in the implementation of the programme and therefore, the Council should reflect upon the corrective steps that need to be introduced in order to make our task cost-effective.

12. Disease control is the responsibility of the State Governments. The Centre has, however, stepped in to fill critical gaps through the instrument of National Programmes. As the allocation of resources for health was insufficient and expansion of the coverage was unavailable, we ventured to seek external assistance to provide a massive thrust to the management of these programmes. The externally aided AIDS Control Programme is already under way. The approval for a Rs.302 crore programme for the eradication of leprosy has been received and we hope to launch the same very soon. The World Bank assistance would enable the achievement of the target of elimination of leprosy by the year 2000. The Bank has also appraised a project for the Control of Blindness in seven States in the country which had extremely high backlog and incidence levels of cataract blindness and we expect the project to become operational before the close of this year.
13. A mission is expected this year to consider -the project for TB Control which should be operational next year. I must emphasize that an improvement in our track record of using the funds efficiently will go a long way in establishing our credentials and capability in addressing these problems with efficiency and commitment.
14. It has not been possible to reduce the prevalence of Malaria below the figure of 2 million cases recorded in 1989. The inadequacy of the basic infrastructure in most States and low priority given to this programme has impeded further progress, although the Centre continues to provide about 1/4th of Plan resources only for the control of this disease. The tribal inhabitants have probably suffered the most mainly because of their poor living conditions and lack of knowledge. We would like to mount an intensive Malaria Control Programme in the tribal areas with emphasis on the development of health facilities to break the chain of transmission.
15. Tuberculosis has been a major health problem for decades now and to some extent we have made positive progress by arresting the disease through powerful drugs. But the management of the programme upon external evaluation by a team of WHO and SIDA was seen to be deficient in many respects. With the nexus now seen between Tuberculosis and AIDS, a range of strategies will have to be introduced if we are to check the spread of contagion, disability and even death.
16. India is one of the major countries where iodine deficiency problems are endemic. While the production of iodized salt has increased, there has been inadequate demand because the ban orders on non-iodized salt have either not issued or is not being implemented rigorously. Therefore, I would urge all the State Governments to give high priority to Goitre Control Programme.
17. The National Health Policy in 1983 which I had the privilege of getting endorsed by the Parliament of India highlighted the need of a separate National Population Policy and a National Medical Education Policy. The Draft of the National Education Policy in Health Sciences as prepared by Dr. J.S. Bajaj, Member, Planning Commission was circulated to all Central Ministries, State Governments, Universities, Professional Bodies, etc. There has been a general endorsement.

The details of the structural modalities, financing and functional framework shall be evolved in due course. It is, therefore, recommended that the draft of National Education Policy in Health Sciences may be given favorable consideration.

18. One of the important subjects which have been engaging the attention of our Government as well as the States is the medical education sector. The promulgation of an ordinance on 27th August last year which led to the enactment being passed by Parliament on 2nd April this year has hopefully put an end to the unplanned growth of medical and dental colleges from mushrooming up in the country. The scheme under which applications for establishing new colleges has to be preferred is comprehensive and will be notified very shortly now that we have secured the endorsement of a cross-section of experts conversant with the issues.
19. The recent judgment of the Supreme Court relating to the allocation of seats in private professional colleges including those of the medical sector is under implementation by the State Governments. We have been informed of certain problems in the implementation of the scheme devised by the Supreme Court but as in the first year the State Governments have been enjoined to evolve the admission criteria both for free and paid students, we are awaiting their response on the experience gained in the process. The Central Government was already in an advanced stage of bringing forward a comprehensive amendment to the Indian Medical Council Act before the Parliament when the judgment of the Supreme Court which dealt with the capitation fee issue was announced. We would like to be guided by the experience of the State Governments in finalizing the comprehensive amendment to the IMC Act and hope that in the next two months the State Governments will undertake an exhaustive exercise and send their observations.
20. An area where much more cost-effective utilization of existing resources could take place is that of the Indian Systems of Medicine & Homeopathy. We must find a way of using the practitioners of these systems and their confirmed healing powers in respect of specific diseases and channelize their efforts to complement, instead of compete with the services, the modern systems of medicine offer. We have, therefore, suggested that State Governments should consider developing specialized treatment centres for ISM & Homeopathy and to try and involve the practitioners from these systems in primary health care. This is already envisaged in our National Health Policy but we must identify a role for these practitioners in order view to integrate them into the primary health care infrastructure.
21. Another area of concern is the quality control of drugs. We are taking steps to strengthen the Drug Controller's Organization and have introduced centrally sponsored schemes to help States to augment facilities for testing and strengthen their enforcement agencies. But the main responsibility lies with the States and unless attention is given to strict enforcement of quality standards and deterrent punishment for those responsible for manufacture and distribution of sub-standard and spurious drugs, we cannot make much headway. In some States and Union Territories, there is still no full time qualified drug controller. I would like to take this opportunity to urge States to take effective and prompt action in this regard.
22. In the last two meetings of the Central Council of Health, specific measures for the effective implementation of the prevention of Food Adulteration were discussed. The Prevention of Food Adulteration Units need to be augmented and work allocated on a zonal basis for tackling inter-State Food adulteration cases. A separate Directorate needs to be set up with adequate, dedicated laboratory facilities and vigil maintained on the eating houses and establishments and deterrent

action taken promptly.

23. The Constitution 73rd Amendment Act, 1992 which came into force on 24th April, 1993 contains provisions for enabling the devolution of funds as well as responsibility to the Panchayat at the District, inter-mediate and village level. We will be circulating a copy of the enactment and I suggest that a group should be set up after the Council meeting to identify how the health programmes can be best entrusted to the Panchayats.
24. I am very glad, many eminent individuals and special invitees have joined us today and I hope that we would be able to cull out from your experience and advice what is best for the country in this important social sector. We have to meet the great challenges ahead together to achieve the goal of Health for all by the year 2000.

**VOTE OF THANKS OF DR. A.K. MUKHERJEE, DIRECTOR GENERAL
OF HEALTH SERVICES.**

Hon'ble Union Minister for Health & Family Welfare and Chairman of the Council, Shri Shankaranandji, Prof. J.S. Bajaj, Member, Planning Commission, Hon'ble Deputy Minister Shri P. S. Ghatowarji, Hon'ble Chief Ministers and Ministers of Health & Family Welfare of States, Secretaries of the Departments of Health & Family Welfare, Other Respected Members of the Central Council of Health & Family Welfare, Distinguished Experts & Officers, Ladies and Gentlemen

Of the major challenges confronting us - the top priority goes to population explosion; the high growth rate needs to be arrested speedily through concerted action. Active involvement of the elected representatives provided in the Panchayati Raj Bill will greatly facilitate acceptance of MCH and Family Welfare services in the community.

We are, today, in a phase of epidemiological transition where apart from communicable diseases like tuberculosis, malaria and leprosy, we also have to tackle a number of non-communicable diseases like cancer, cardiovascular diseases and diabetes. Besides, emerging problems like AIDS and newly observed invasive properties of Non O-1 cholera are matters of concern.

We are fortunate in having developed an extensive network of health care infrastructure, and adequately trained technical manpower available at all levels to effectively carry out the health plans and programmes. But there is a need for consolidation of the existing primary health care infrastructure, which has also been emphasized in the Eighth Plan document. Networking with NGOs would ensure optimum utilization of services and avoid duplication and wastage of precious resources. The recently released World Development Report and the UNFPA Report have also focused attention on gearing up of the Primary Health Care services, and fostering greater community involvement.

Following extensive national level reviews and evaluations carried out recently, revamping of the national health programmes on leprosy, tuberculosis, blindness and malaria is on the cards.

In the field of medical education, a socially relevant medical curriculum has been developed by the Medical Council of India, which would make the medical education more suited to our national needs. Besides, various committees have been formed to study the various aspects of the spectrum of professional education in health sciences.

It is my proud privilege to propose a vote of thanks, first and foremost to Shri Shankaranandji. His illuminating and wide-ranging address has set the pace for the deliberations of this Conference we are fortunate in having a leader of his eminence as our Chairman to steer us in the right direction.

I am grateful to Prof. J.S. Bajaj for giving us an analytical perspective pragmatic view that the goal of Health for All requires redefinition towards the achievable objective of Health for All underprivileged by 2000.

Shri Ghatowarji has been a source of the constant guidance in the planning and organization of this Conference, I thank him for these valuable words of advice.

I am grateful to the esteemed members of the Council and invitees for attending this Conference, in spite of other pressing commitments in their respective places. Shri R.L. Misra, the Union Health Secretary and Smt. Usha Vohra, the Union Family Welfare Secretary has spared no pains to ensure the success of this conference. It would not be out of place to express our appreciation of the commendable work done by Smt. Shailaja Chandra, and the officers and staff of the Ministry and Directorate General of Health Services.

I am confident that, with the seasoned guidance and sagacious advice of the Council members and experts, this conference would come forth with a purposeful strategy and directions on the major health issues confronting us, thus paving the way for an agenda for action.

T H A N K Y O U

INTRODUCTION
OF
THE RESOLUTIONS
RELATING TO THE DEPARTMENTS
OF
FAMILY WELFARE AND HEALTH

**Introduction of the resolutions of the Department of Family Welfare by
Smt. Usha Vohra, Secretary (Family Welfare)**

1. While introducing the resolutions on Family Welfare, Smt. Usha Vohra, Secretary, Department of Family Welfare, Government of India stated that the annual exponential rate of growth had declined marginally to 2.14% in 1981-91. The Crude Birth Rate (CBR) which was 37.2 in 1981 had come down to 29.0 in 1992. This was a significant reduction over a decade. The Infant Mortality Rate of 110 in 1981 has come down to 79 in 1992. The Couple Protection Rate/Contraceptive Prevalence Rate (CPR) which was 22.8 in 1981 had risen to 43.4 as on 31st March, 1993. The Total Fertility Rate (TFR) had declined from 5.97 in 1951-61 to 3.8 in 1990 (SRS). She observed that 60% of women in U.P., Bihar, Rajasthan and M.P. were getting married below the age of twenty years. 40% of the population of the country resided in these four States. The Family Planning performance of these four States would determine demographic profile of the country. The Family Planning Programme is 100% Centrally Sponsored Programme being implemented by the States. The States have to gear up implementation of the Programme. Efforts have to be intensified to promote birth spacing and reducing maternal, infant and child mortality. The State Governments must ensure qualitative improvement and proper implementation of the programme.
2. As regards Resolution on agenda item no. II, Secretary Family Welfare stated that initiatives had been taken for strengthening of Information, Education and Communication to seek mass support for family planning' programmes. The Centre was assisting the States with money, software and materials for promotion of appropriate information, education and information. Almost 50% of the population has no access to TV and radio. As such, interpersonal communication assumes primary importance. Uniform message would not work. Village level planning committees can play a significant role in promoting the acceptance of Family Planning methods by creating awareness, ensuring compliance of the Child Marriage Restraint Act, organizing promotional activities and also monitoring and supervising the work of ANMs, PHCs. They can ensure their delivery of services by the paramedical and medical staff to the satisfaction of the community. State Government may consider establishing village level planning committees in every village for undertaking these tasks.
3. The Resolution on agenda item No. III pertained to implementation of the Social Safety Net Scheme in the 90 poor performing districts in the country. The reason for selection of these districts was that 90% of deliveries in these districts were domiciliary. As maternal mortality is an area of concern, the Deptt. of Family Welfare has stressed upon the States the need to provide lady doctors in rural areas. Women do not visit PHCs for pre-natal and postnatal care. They do not like going to male doctors. It was perceived that institutional deliveries would increase if provision was made for female doctors. The State Governments should make arrangements to post female doctors in the rural areas, so that confidence is created amongst women to adopt safe delivery practices by visiting the Health Centres.
4. CSSM is a new scheme taken up in August, 1992 to reduce maternal and infant mortality and to ensure universal immunization with the additional emphasis on control of diarrhea and respiratory infections. Although funds have been released to the State Governments,

the utilization was lagging behind. Funds released for externally aided projects also need to be efficiently utilized.

5. She observed that several valuable suggestions have been made and would be taken note of. In response to one of the suggestions, Secretary (FW) stated that as it was difficult to provide assured employment to all women, the States should provide for training of women to facilitate their employment. Regarding the suggestion made by the Secretary, Govt. of Kerala on raising the age of marriage of girls to reduce overall fertility rate, Secretary (FW) informed that the existing Child Marriage Restraint Act should be implemented vigorously by the States.
6. Secretary (FW) further clarified that in 1993-94, no targets for sterilization were fixed. Expected levels of achievement were indicated by the States based on their assessment of voluntary demand for sterilization. Spacing method is being promoted.
7. Secretary (FW) clarified that it is for State Governments to consider the adoptions of incentive scheme. Several States Governments have already introduced incentive scheme for parents who have accepted family planning method and have only a girl child.
8. Secretary (FW) apprised the Council that the MTP Act 1972 was introduced as a health measure. Pre-natal Diagnostic Techniques (Regulation & Prevention of Misuse) Bill 1991 has been introduced in Parliament. This will make it illegal for women to use diagnostic techniques for determining the sex of the child.
9. During the course of discussion, the following observations were made by the various speakers:-
 - (i) There is need to improve the status of women and literacy levels to get the desired results of the Family Welfare Programme.
 - (ii) Evaluation of the success of the Family Welfare Programme should be done on the basis of the impact of the programme and not on the basis of supply of inputs.
 - (iii) Some insurance Scheme should be devised to attract people to adopt small family norm.
 - (iv) The need for introducing family planning methods for women like the use of injectibles etc. was emphasized.
 - (v) As per the 73rd Constitutional Amendment, Panchayati Raj System has to be introduced. Village Planning Committees must be formed to monitor family planning programme. Panchayats should be involved in the health and family planning programme.
 - (vi) NGOs and industrial houses should be involved in specified urban/rural areas for promotion of family planning.
 - (vii) The fact that lady doctors are not available in rural areas was commented upon

as women will not go to a male doctor. This is a reality and has to be faced.

Introduction of the Resolutions of the Department of Health by Shri R.L. Misra, Secretary (Health)

Secretary (Health) stated that the challenges in the health sector were very daunting. The burden of disease was growing because of many factors, primarily the persistence of poverty, in sanitary living conditions, non availability of safe drinking water and growing population. While the life expectancy has increased, communicable diseases have not yet been controlled. Simultaneously, the country faced new challenges of diseases like cancer, cardiovascular diseases, diabetes, cataract, blindness etc. as well as the latest addition, the new epidemic of AIDS, which surpassed all the -previous diseases. A positive dent had to be made towards controlling or, eradicating communicable diseases so that there was better preparedness to divert resources and energies to meet the new challenges. The entire national programme had, therefore, been reviewed and efforts made to attract external assistance to augment our resources to intensify these programmes, improve the quality of delivery and to remove the deficiencies which have been noticed in their implementation. As is well known India had invested less resources on health than most developing countries. Health is primarily a State subject, but the Centre had been trying to make interventions in critical areas through centrally sponsored schemes and national programmes. In these endeavors, certain problems had been encountered. The first resolution which was on Agenda Item No. V(1) dealt with health financing. The problems brought out in this resolution and in Agenda Item were that while with the help of external assistance or even otherwise, numbers of assets were being created, under centrally sponsored schemes, but their sustainability and levels of maintenance had not been assured. It was noted with concern that many assets which were created during the previous plan periods were not being utilized optimally, because the necessary funding support had been withdrawn after these, programmes were transferred to Non-Plan. Secondly, in many of these-programmes, budgetary allocations were not increasing in proportion to the increase in salary and staff expenditure as a result of which the non-salary component of the programmes was being squeezed out. This was seriously affecting the quality of implementation and the quality of services of the programmes which was a matter of concern which the State Governments had to address. Thirdly, under the centrally sponsored schemes, funds were being transferred to the State Governments, with the intention that these funds would be utilized exclusively for the purposes for which these are intended. Unfortunately in certain States, the financial position has been so difficult that these funds have been utilized as ways and means support and there had been considerable delay in transferring these funds to the programme managers. Therefore, while efforts were being made to persuade external agencies, to fund important programmes, and to further pass on these funds as 100% grants to the States, if these funds were not utilized for the purpose for which they were assigned, it could create very serious embarrassment and difficulties in implementing the programme. These are some of the points that had been highlighted in the resolution.

The second resolution was in regard to the agenda item V (2). This was with regard to the National Education" Policy in Health Sciences. As the council would recall, the National Health Policy of 1983 indicated that there shall be a Separate Policy on Medical Education and Health Sciences and in pursuance of that declaration, a draft of the policy was prepared by Prof. Bajaj. Based on the recommendations from State Governments on the draft, a revised policy document has been

prepared which has been circulated along with the agenda notes. The draft takes a holistic view of the requirements of manpower development in the health sector and puts forward two major new ideas, one was the establishment of a Commission for Education in Health Sciences to oversee development of Manpower in health sector and its coordination amongst various disciplines and the second, the setting up of Universities of Health Sciences as distinct from general Universities which were today affiliating the medical colleges. The resolution suggested that this draft policy document may be given the support in principle the detailed modalities will be worked out and placed before the next meeting of the Central Council. A detailed exercise is required, because there are fairly significant financial implications which will have to be worked out and also Planning Commission consulted on how these financial implications would be met. Apart from that, the whole structure of the commission, whether it should be statutory or otherwise, and the extent of its power, what should be its relationship with the different councils etc. would need to be worked out.

The third resolution was in regard to agenda item No. VI relating to AIDS. There was no cure for this disease. There was no vaccine. The only method of prevention or control of this disease was by changing people's behaviors. High presence of STD made affected persons extremely vulnerable to AIDS. What was known today was only the tip of the iceberg while the main problems remained underground. All States and Members of the Council were alerted to the need to pay adequate attention. He emphasized the need to have dedicated personnel for this programme. The facilities for diagnosis and treatment of STD should be integrated with general facilities available in general hospitals, other clinics etc. Another area was to ensure blood safety. Although blood contributed to around 3% or so of the infection but the efficacy_ of transmission of AIDS through blood was as high as 90-95%. Therefore, all the Blood Banks needed to be upgraded, testing procedures to be properly implemented, guidelines and laws properly enforced and steps taken to ensure that the commercial Blood Banks and professional donors were gradually eliminated. The most important point of this programme is information, education and communication. The people must be educated, particularly the health workers. All these aspects have been highlighted in the resolution.

The next resolution related to the Indian Systems of Medicine and Homoeopathy (Item VII). There was considerable interest but unfortunately the progress had been less than expected in this area. Therefore, the educational system had to be properly institutionalized and the standards upgraded to the level laid down by the Central Council of Indian Medicine. Further, as in the case of medical and dental colleges, the mushroom growth of sub-standard colleges of ISM had to be stopped, by bringing about a similar legislation. The ISM should not merely try to copy modern medicine but should develop their own strengths and areas emphasizing of their own importance. Greater attention also needed to be placed on the quality of drugs in the ISM. For this purpose, regional laboratories should be set up, the drug control organization should be strengthened. The Pharmacopeia was being prepared so as to standardize these drugs. Action also needed to be taken to promote, preserve and develop proper exploitation of medicinal plants.

On the next item relating to Malaria, the Secretary (H) stated that the disease seemed to have come back with a bang. There were two reasons. One appeared to be a certain degree of complacency in tackling the disease and the other that the vectors/ parasites were getting resistant the conventional insecticides/drugs. Also the tribal areas alone constituted about 7% of total population but they alone accounted for 35% of malaria cases. Tribal areas, therefore, needed more attention. Since the mosquito cannot be completely eliminated, there was a need to break the chain of transmission by early detection and early medication. For tribal areas, it had been proposed that this programme

should be 100% Centrally Sponsored Scheme so that the Centre was able to give financial support for controlling this problem in the most backward and vulnerable areas.

The next item related to the National tuberculosis Control Programme. T.B. was a major health problem in India! Lately, it had acquired a more dangerous proportion because of its linkage with HIV. Keeping in view the serious implications of this disease in combination with HIV infections, steps needed to be taken right now to prevent an epidemic of T.B. The technological breakthrough was available for the control of this disease in the form of chemotherapy. But the important thing was its early detection and complete treatment. For this purpose, health education, inter-personal communication and assured supply of drugs were necessary:

On the next resolution on Leprosy Eradication, the Secretary stated that this programme had been started in 135 endemic and semi-endemic districts. Under the World Bank Assisted Project, the MDT programme will be extended to the remaining 134 districts which are endemic or semi-endemic to eliminate this disease by the year 2000. The World Bank Assisted Project is expected to be launched in the current year itself. Some changes were now being made in the programme. Firstly, attempts were going on to improve the facilities for surgical corrections and rehabilitation and secondly instead of recruiting a huge army of village-level workers and Supervisors to implement this programme on a permanent basis, it was proposed to be worked on contract basis for five years.

On the National Programme for Control of Blindness, Secretary (Health) stated that there was a need to improve the ophthalmic infrastructure especially in the villages. He stated that seven States had been selected initially to start the programme, with World Bank Assistance. It has also been suggested to create district Blindness Control Societies, to coordinate and include non-governmental participation. The Endeavour was to wipe out the backlog of cataract blindness in the next 5-6 years. The quality of services also needed to be improved so that in District Hospitals and Medical Colleges it was possible to provide even Intra-ocular lens implant facilities to the patients.

Regarding the National Cancer Control Programmes, Secretary (H) stated that facilities for detection and treatment were very unevenly distributed and this imbalance needed to be corrected by strengthening regional centers, developing linkages between districts so that cancer cases could be detected early and referred to the Cancer Centres.

He further stated that Iodine Deficiency Disorder constituted a serious health problem but it had a simple and inexpensive solution i.e. if iodized salt of proper quality was consumed by the population the problem could be solved. Therefore, the States which have not yet banned the use of non-iodized salt for edible purposes should do so immediately and also ensure the testing at manufacturing stage and monitoring at the distribution and consumption stages. A programme has also been drawn up with the assistance of UNICEF to cover all endemic areas, particularly southern Himalayan and North-Eastern areas where the problem was the greatest.

**RESULTS OF 1991 CENSUS, SELECTED INDICATORS AND
STATE PERFORMANCE, NATIONAL HEALTH POLICY
GOALS AND ACHIEVEMENTS**

Resolution

1. The Council noted the variable performance of different States in the implementation of the Family Welfare Programme. Several States had a Crude Birth Rate higher than the national average. It noted with deep concern that the sex ratio of females per thousand males declined from 934 in 1981 to 927 females per thousand males in 1991.
2. The Council recognized that female literacy, age of marriage of girls, socio-economic status of women, poverty and infant mortality rates directly influence fertility behaviors.
3. The Council noted that national population goals and objectives can be achieved through high level of inter-sectoral coordination and by adopting a multi-sectoral approach.
4. The Council resolved that quality and outreach of services especially in rural areas and urban slums must be improved. The implementation of schemes for delivery of family planning services, maternal and child health care services including creation of effective demand for these services must be improved.
 - (i) The States undertook, through intensive training of service providers, training traditional birth attendants, active promotion of birth spacing as a reproductive health measure for women, reduction of incidence of illegal abortions leading to maternal deaths, up gradation of facilities for emergency obstetric care, improving follow-up of acceptors of spacing methods, to strengthen the implementation of the Family Planning Programme.
 - (ii) The States would pay special attention to increase the contraceptive prevalence rates in high fertility areas through inter-personal communication and effective follow-up.
 - (iii) The States, undertook to implement special schemes for
 - a) Raising female literacy
 - b) Providing training for employment to women, and
 - c) Strengthening implementation of the Child Marriage Restraint Act to reduce the overall fertility rate.
5. The Council resolved that Family Planning should not be seen as the concern of one Department at the State or at the Central Government level but a programme in which all Departments must participate actively for bringing about total involvement of masses.

**NEW INITIATIVES FOR STRENGTHENING INFORMATION,
EDUCATION AND COMMUNICATION FOR SECURING
MASS SUPPORT FOR FAMILY PLANNING**

Resolution

1. The Council noted the various new initiatives taken by the Department of Family Welfare for strengthening Information, Education and Communication for securing mass support for Family Planning. The Council took note of the special schemes like Mahila Swasth Sangh, special communication training to IEC volunteers at the grassroots level, population education through formal school and college system, non-formal education for adults, training to personnel of industrial institutions and non-governmental organizations, sensitization of opinion leaders, joint training of grassroots functionaries and involving Indian Systems of Medicine practitioners. It took note of the 73rd Amendment of the Constitution.
2. The Council recognized that village family planning committees can play a significant role in promoting the acceptance of family planning methods by creating awareness, persuading couples to adopt family planning methods, promoting maternal and child health care, ensuring compliance of the Child Marriage Restraint Act, organizing promotional activities for Family Welfare, monitoring the work of health providers at sub-centres through community sanction and training of staff of PHCs and sub-centres to make available to the people improved delivery of services, quality of care and proper follow-up.
3. The Council resolved that
 - (i) Village/panchayat level family planning committees, intermediate level family planning committees and district level family planning committees should be set up in the States to promote awareness in regard to reproductive health of women, reduce maternal mortality, infant and child mortality and promote the concept of "Small Family - Happy Family".
 - (ii) The States would establish family planning committees in every village during 1993-94 for undertaking these tasks.
 - (iii) The State Governments may take initiatives to involve members of the Zila Parishads, Municipal Corporations and Panchayats for promoting Family Planning.

**INVOLVEMENT OF NON GOVERNMENTAL ORGANISATIONS AND
VOLUNTARY ORGANISATIONS FOR PROMOTING FAMILY PLANNING AND
FAMILY WELFARE**

Resolution

The Council noted the new initiatives taken by the Department of Family Welfare in the Ministry of Health and Family Welfare for promoting the involvement of NGOs and other voluntary organizations for promotion of Family Planning and Family Welfare.

2. The Council resolved that:-

- i. The State Governments should identify NGOs with good track record and involve them in the promotion of Family Welfare Programmes.
- ii. Identified NGOs and voluntary organizations should be encouraged to generate awareness about the small family norm with special focus on the younger age group couples for adopting spacing methods.
- iii. NGOs in other sectors such as education, rural development, women welfare, nutrition programmes, dairy cooperatives, sugar cooperatives, Khadi and Village industries etc. should also be involved in promotion of Family Planning. While sanctioning grants to such NGOs the promotion of Family Planning should be made an integral part of their activities.
- iv. The district level officers should effectively monitor and evaluate work done by NGOs and Voluntary Organizations. Independent evaluation should be undertaken as may be necessary.
- v. Women's organizations in rural areas and urban slums should be fully involved.
- vi. In all Youth Programmes being implemented, youth should be motivated to spread messages for reducing infant and child mortality, maternal mortality, improving the reproductive health of women through the adoption of spacing methods for Family planning and explain to the people the need to adopt the small family norm.
- vii. Training to NGOs and voluntary organizations should be provided for effective implementation of Family Planning Schemes expeditiously, by the State Governments and suitable NGOs.
- viii. The State Government should encourage and support Industries and Chambers of

Commerce and cooperative institutions to take up the specific geographical areas for promotion of family planning and family welfare work. State Government officers should provide sufficient information and support to Industries and Chambers of Commerce which take up Family Planning and Family Welfare promotion in specific geographical areas.

3. The Council resolved that it is imperative that mass support for Family Planning is promoted to make it a People's Programme.

IMPLEMENTATION OF SOCIAL SAFETY NET PROGRAMME IN 90 POOR PERFORMING DISTRICTS

Resolution

1. The Council recognized that it was necessary to take differential and area specific measures to improve the demographic profile of districts which have a high rate of maternal mortality and infant mortality, low female literacy and a high crude birth rate.
2. The Council noted that Facility Surveys carried out in 90 weak districts have indicated the lack of availability of operation theatres, labour rooms, observation rooms, running water supply and electricity.
3. The Council noted that in 1992-93 five Primary Health Centres per district and in 1993-94 another five Primary Health Centres per district would be assisted by the Central Government.
4. The Council resolved that:-
 - i. Area specific information, education and communication activities to promote mother and child health care and adoption of spacing methods, through training programmes, better counseling and follow up services must be strengthened.
 - ii. The execution of the Social Safety Net Scheme in the 90 weak districts of the States of Bihar, Rajasthan, Orissa, Haryana, West Bengal, Gujarat and Madhya Pradesh should be streamlined through effective monitoring of the progress.
 - iii. The States undertook to provide the services of a lady doctor, Staff Nurse and ANM and a driver in the identified Primary Health Centres in the 90 weak districts.
 - iv. Based on 1991 Census data, after it becomes available, other backward districts may be identified for special initiatives.

CHILD SURVIVAL AND SAFE MOTHERHOOD PROGRAMME

Resolution

1. The Council deliberated on the issues relating to Maternal and Child Health and noted the progress made under the Universal Immunization Programme. While expressing satisfaction over the impact made by this programme on the Infant Mortality Rate, the Council stressed the need for maintaining high levels of immunization coverage both for pregnant women and infants and ensuring the highest quality of service delivery to the population.
2. The Council urged that additional thrust be given to districts which have not yet reached 80% coverage levels.
3. The Council observed that the quality of surveillance system needed strengthening so as to confirm low or zero incidence of the vaccine preventable diseases, especially of poliomyelitis and neonatal tetanus. The Council urged that the reporting of cases of neonatal tetanus and poliomyelitis be made mandatory.
4. Taking into account the progress made so far under the UIP, the Council felt that the goals of neo-natal tetanus elimination by 1995 and polio eradication by the year 2000 A.D. are achievable. The Council, therefore, urged (hat necessary steps to reach the above goals be taken.
5. The Council urged that the Child Survival and Safe Motherhood (CSSM) programme, launched by the Government in the last year, be implemented vigorously to achieve the goal of IMR reduction to less than 60 per thousand live births, Child Mortality Rate to less than 10 per thousand child population and Maternal Mortality to less than 2 per thousand live births by 2000 A.D.
6. The Council urged that measures be taken to increase the availability of ORS through non-governmental sources in the rural areas.
7. The Council supported the enhancement of supplies of IFA under the CSSM programme for controlling anemia through administration of these tablets. Anemia is a leading factor in low birth weight and other high risk factors in the newborn and poor health of the mother besides being a major cause of maternal mortality.
8. The Council noted that the establishment of the First Referral Units (FRUs) may reduce the maternal mortality. The Council urged, in this regard, that State level meetings be organized to accelerate the process of setting up of these units at the sub-district level. The Council emphasized that the posts of gynecologists, in the facilities identified to be upgraded as FRUs, must be filled; staff be trained and physical facilities upgraded to meet the minimum standards laid down.

9. The Council stressed the need to maintain a sound cold chain system for protecting the quality of vaccines. The Council expressed its concern that a number of posts sanctioned by Government are lying vacant. The Council urged that all the supervisory posts, particularly those of refrigeration mechanics, be filled up expeditiously.
10. The Council recommended that the training programme under the CSSM programme be given a high priority so that highest quality of services is maintained.

FINANCING OF HEALTH & FAMILY WELFARE PROGRAMMES

Resolution

The Council noted that existing level of allocations for health both for the Centres and States are very inadequate and would recommend their substantial enhancement.

The Council took note of the trend in financing health programmes which had led to mismatch both in sectoral allocations by the States as well as in ensuring the sustainability of centrally sponsored schemes. It was recognized that unless the funds are made available for particular health sector programmes as well as the specific items of expenditure according to the requirements of the programmes, performance levels would be affected adversely. Moreover, after seeking external assistance to support these programmes and entering into commitments relating to timely utilization of the funds as well as sustaining the programme at effective levels, it would cause embarrassment if these commitments were not honoured.

The sustainability of the assets created under the scheme is also the responsibility of the State Governments and on their transfer to Non-Plan, the assets created must not be allowed to wither or fall into disuse.

Assignments for essential commodities and drugs must be planned in advance and should not be allowed to be depleted as these are vital and ensure the effective sustenance of health care services.

The States are enjoined to utilize the funds from the centrally sponsored schemes for the purpose they are intended and establish suitable mechanisms to effect quick transfer of funds, proper maintenance of assets and monitoring the allocation of resources in the most cost-effective manner.

NATIONAL EDUCATION POLICY IN HEALTH SCIENCES

Resolution

1. The Central Council of Health considered the draft of National Education Policy in Health Sciences which provides for the educational needs and training requirements of all major categories of health care professional and Para-professionals. The Council endorsed the policy document in principle and resolved that this be adopted.
2. The Council endorsed and supported strengthening of statutory professional councils; recognizes the priority need for setting up of Education Commission in Health Sciences and Universities of Health Sciences, and requests urgent action by the Ministry of Health & FW., Govt. of India.
3. The Council recommended that based on the Policy adopted, detailed programme of action may be developed in a time bound manner and placed before the Central Council of Health and Family Welfare at its next meeting.

NATIONAL AIDS CONTROL PROGRAMME

Resolution

The Council took a serious note of the emergence of HIV/AIDS in various parts of the country and urges all the States and Union Territories to take immediate and effective measures to check the spread of the infection. The Council considered that specific attention needs to be paid to the following areas:

(a) Utilization of Funds

The funds released by the Government of India for the National AIDS Control Programme should be released to the Programme Managers or identified institutions immediately so that implementation of the programmes goes on as scheduled. All the posts sanctioned should be created and filled up with experienced persons and as far as possible they may be given a minimum tenure of at least three years.

(b) Programme Management

Control of STD is a vital component of the National AIDS Control Programme. It should be based on the primary health care approach with emphasis on both prevention and control. It should;

- integrate the provision of STD diagnosis and treatment in general health care facilities.
- be based on the syndromic approach to STD case management, keeping the laboratory support reserved for patients who are therapy resistant, or otherwise difficult to diagnose;
- make use of all health care providers including the Private Practitioners Professional bodies and associations where indicated.
- make use of MCH providers for spreading awareness and providing counseling on HIV and child-bearing.

(c) Blood Safety

Blood safety measures must:

- Ensure the safety of blood and blood products for transfusion purposes by strict enforcement of mandatory testing requirements;
- ensure optimal utilization of blood by rational use;

- Promote voluntary blood donation and prevent commercial exploitation of blood transfusion services.

(d) Information, Education and Communication (IEC)

The programme to generate awareness and influence health-seeking behavior must:

- Make sincere endeavor to create awareness about **AIDS** and its prevention;
- Remove fear and prejudices regarding **AIDS** amongst the health professionals, Para-professionals and the general population;
- ensure that no citizen is discriminated against on account of his/her HIV status;
- Mobilize all the sectors - Governmental, Non-Governmental as well as private to participate in the prevention and control of **AIDS**.

INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

Resolution

1. Strengthening of Undergraduate Colleges

- (i) The Council strongly felt that the minimum standards for colleges of Indian Systems of Medicine and Homoeopathy should be fixed in a realistic manner keeping in view that emphasis in ISM & H treatment is mainly on outdoor type of treatment. The standards should reflect uniqueness of each system and should not necessarily follow the allopathic system. There is an equally strong need for ensuring that the minimum standards so fixed are met and that the existing institutions are helped in reaching those standards.
- (ii) The State Governments must provide sufficient budgetary outlays for up gradation of the colleges. The Central Government may also review its scheme of assistance.
- (iii) The Central Government may expedite bringing out an appropriate legislation for checking the mushroom growth of Colleges and practices by unqualified persons.
- (iv) No new College of ISM & H should be started without prior permission of the Central Government as in the case of Medical and Dental Colleges.

2. Development of Specialized Treatment Centers in Indian Systems Of Medicine and Homoeopathy.

Keeping in view the fact that Indian System of Medicine and Homoeopathy have greater acceptance for treatment of certain chronic diseases like Arthritis, Bronchial Asthma, Liver disorders, Skin diseases, hypertension, Psoriasis etc., the Council recommended that Institutes of Excellence in Research and medical care may be set up through regimental therapies. Through these Institutes expertise in these systems on scientific lines should be made available within the easy reach of people throughout the country.

The Council recommended that the State Governments should also develop specialized treatment Centres for ISM & H where such diseases as enumerated above may be treated with great success.

3. Involvement of Practitioners of ISM & H in Primary Health Care

- (i) The State Governments must optimally utilize the services of practitioners of ISM & H, both Government and non-Government in providing Primary Health Care.
- (ii) The Council recommended that special care may be taken to provide in-service training to the physicians of ISM & H already employed for a short period of

- three weeks in the National Health and Family Welfare Programme.
- (iii) The Council further recommended that the State Government should explore the possibility of appointing of such trained ISM & H physicians in the Primary Health Centres".
 - (iv) The Council recommended that appropriate life style enshrined in Yoga and Naturopathy should be promoted.

4. Drug Control in Indian Systems of Medicine

- (i) The quality of ISM and Homoeopathy drugs is a must for establishing credibility of these systems.
- (ii) Emphasis may be given to evolving means for detecting adulteration by dangerous drugs and substances "cortisone methyl spirit", etc. and also for evolving pharmacopoeial standards of the most commonly used drugs on priority basis.
- (iii) To enable the pharmaceutical industry to ensure the quality of good drugs used in preparations of medicines, Regional Laboratories may be set up in ISM & H.
- (iv) The Council also recommended to take immediate and adequate steps to strengthen the existing Drug Control machinery in the States by appointing Inspectors and Analysts in **adequate** number.

5. Development of Medicinal Plants

- (i) The Council recommended that the State Government should give high priority to the development of the medicinal plants and setting up of nodal agencies for making concerted efforts in this regard.
- (ii) The State Governments should take measures for cultivation of medicinal plants which are in greater demand and are being imported.
- (iii) The State Governments may set up Committees exclusively for coordinated development of medicinal plants.

- 6.** The Council recommended that research capabilities in ISM & H should be strengthened to enable evaluation of ISM & H remedies by appropriate scientific methods.

NATIONAL MALARIA ERADICATION PROGRAMME

Resolution

The Council noted with concern that the incidence of malaria has been more or less static at about two million cases a year for the past few years. In particular, the Council expressed its grave concern about the morbidity and mortality caused by the disease in tribal areas. In this connection, the Council appreciated the Central Government's proposal to launch an intensified malaria control programme as a 100% centrally sponsored scheme in tribal areas.

The Council appealed to the States/UTs that appropriate action should be taken to ensure that their malaria organization have full complement of trained staff and all vacant posts are filled up according to a time frame; specifically, the State Malaria Officers should be on their posts for not less than three years in order to provide proper leadership.

Secondly, appropriate budget provision should be made by the States for timely spraying of insecticides.

Thirdly, malariogenic stratification exercise should be expedited and effective follow-up action should be taken.

Fourthly, effective measures should be undertaken for vector control by adoption of newer technologies wherever necessary, particularly in areas where mosquitoes have developed resistance to conventional insecticides.

Fifthly, serious attention needs to be given to areas having a high incidence of drug resistant *P. falciparum* which is the main cause of high mortality.

Lastly but most importantly, the Council urged the States to suitably strengthen the primary health care infrastructure in the tribal areas in order to effectively deal with malaria and other diseases control programmes.

NATIONAL T.B. CONTROL PROGRAMME

Resolution

The Council noted with concern the continuing high prevalence of T.B. and added danger on account of the spread of HIV infection which has worsened the T.B. situation in many countries. It is however noted with satisfaction that Central Government had substantially increased budgetary outlays for T.B. Control. The Council recommends the following steps:-

- i. The greatest emphasis must be on achieving cure of all sputum positive cases through short course chemotherapy. High cure rates are achievable through supervised treatment which implies reorienting the existing mechanism of drug administration by closer involvement of peripheral health functionaries.
- ii. The existing mechanism for monitoring progress should be suitably modified to reflect the greater emphasis on the number of patients achieving cure rather than the numbers of cases detected and treated. More reliance must be placed on sputum examination both for purposes of diagnosis as well as determining cure rather than x-ray examination. This will require augmentation of sputum microscopy facilities at peripheral institutions.
- iii. The drug supply and stocking procedures may be suitably strengthened to ensure that uninterrupted drug supply is always maintained for patients undergoing treatment.
- iv. The Centre and States must immediately mount a public health education campaign to make people aware of the simplicity, safety and reliability of the treatment as well as dangers of taking incomplete treatment.
- v. NGOs and the private practitioners should be appropriately involved to reach the large segment of the population who seek their assistance.
- vi. Incidence of T.B. can be brought under control only if budgetary outlays of Central and State Governments are enhanced to ensure organizational capability and sufficiency of drugs for at least curing all sputum positive cases using short-course chemotherapy, if necessary external assistance may be sought for this purpose.

NATIONAL LEPROSY ERADICATION PROGRAMME

Resolution

The Council reviewed the programme and noted with appreciation the progress of implementation of the National Leprosy Eradication Programme and passed the following resolutions to further strengthen the programme to achieve the declared national goal of elimination of leprosy by 2000 A.D.

1. Infrastructure

With the increased pace of NLEP activities, there is immediate need for continuous monitoring, adequate coordination and proper directions at the State level for successful implementation of NLEP. It is essential to identify and provide a senior officer at the State level as State Leprosy Officer. Frequent transfers of the officials involved in the Programme should be avoided. State Governments should also fill up on priority all the vacant posts under NLEP.

2. Acceleration of the pace of MDT

Treatment of leprosy cases with Multi Drug Treatment is the sheet anchor of the programme. It is necessary that the MDT services are extended to the Northern and Eastern States as early as possible.

It was noted with satisfaction that the World Bank has agreed to provide financial assistance to NLEP for extending MDT services to the uncovered areas in remaining 66 endemic districts. These funds should be used judiciously to accelerate the pace of MDT services.

3. Rehabilitation

To provide care after cure to leprosy patients, new schemes are being introduced under NLEP to arrange for disability care and rehabilitation services in selected districts. After getting the experience, such services should be extended to other districts. Wherever possible, State Governments may set up and utilize such rehabilitation centres.

4. Voluntary Participation

Leprosy has both social and emotional dimensions. The Voluntary Organizations involved in the leprosy programme have always played a pioneering role in the leprosy control activities. The Council appreciated their contributions in the field of leprosy specially community participation, rehabilitation services including improved curative services. Government should encourage their continued participation as a close partner in the fight against leprosy.

5. Creation of Public Awareness

For successful implementation of the programme and removal of social stigma attached to leprosy, it is essential that the IEC activities are further intensified.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

Resolution

The Council took note of the performance of the National Programme for the Control of Blindness and noted the need for accelerating the implementation of the Programme at the State and District level. It was recognized that the performance had remained almost static for some years and the backlog of cataract blindness cases as well as the incidence of blindness was increasing. Special steps were needed to see that the number of operations conducted as well as the quality of outcomes improved in order to realize the goal set out for the year 2000.

The Council enjoined the State Governments as follows:

1. The State level coordination committees should meet regularly for better coordination and implementation of the Programme activities within the States.
2. The State Programme Officers should engage themselves in intensive monitoring of the field units and ensure that the equipment provided to different units are properly utilized.
3. The reporting of the performance, infrastructural development of the various units, services in the State should be regular, timely and accurate.
4. The funds released to the State Government for utilization on various components of the programme should not be diverted to other programmes/expenditure heads.
5. District Blindness Control Societies (DBCS) should be formed in all districts of the country under the chairmanship of District Collector. These societies should be delegated adequate powers and given the necessary financial support so that they can effectively implement the Blindness Control Programme at the District level.
6. Representatives of NGOs and Private Sector Ophthalmologists working in the field of Eye Care should be actively involved in the programme to ensure wider community participation in the programme.
7. Eye camps should continue to provide services in rural and tribal areas. At least one District Mobile Unit be established in each district.
8. Ophthalmic surgeons should be placed on surgical posts as far as possible. Ophthalmic Surgeons posted as General Duty Medical Officers should be redeployed after suitable training, if necessary.
9. Training of Para-medical Ophthalmic Assistants (PMOA) should be appropriately ensured wherever necessary. One PMOA should be posted in each of the block level Primary Health

Centres.

10. A fixed proportion of the beds in the medical college and in the district hospitals should be earmarked for ophthalmic care.

NATIONAL CANCER CONTROL PROGRAMME

Resolution

The Council noted with concern that with increasing longevity and changing life styles, cancer has become a major public health problem. There is about 1.5 to 2 million cases of cancer in the country at any given point of time. Therefore, to strengthen the National Cancer Control Programme.

Council recommended the following:-

1. That the existing ten Regional Cancer Centres be further strengthened to act as referral centres for complicated and difficult cases.
2. The Council noted with satisfaction that a scheme for Development of Oncology Wings in medical colleges has been initiated to fill up the geographical gaps in the detection and treatment of cancer. The Council expects that each of the assisted Institutions would carry out outreach programmes for early detection and treatment of cancer and that more such institutions would be developed under the Scheme in the coming years.
3. The Council noted with interest that a one time assistance of Rs. 15 lakhs and a recurring assistance of Rs. 10 lakhs for 4 years are provided to a district under a scheme for District Projects for preventive health education, early detection and pain relief measures. State Governments/UT Administrations should, therefore, bring up more such proposals for assistance under the Programme.
4. The Council noted that a scheme has been initiated for financial assistance of up to Rs.5 lakhs to voluntary organizations for purposes of undertaking health education and early detection activities in cancer. The Council recommended involvement of NGOs on a large scale in the Cancer Control Programme.
5. The Council noted the efforts to strengthen the Programme further during the coming years. Financial assistance for cobalt therapy units has further been increased to Rs.50.00 lakhs per unit and other radiotherapy equipments have been brought under the ambit of the scheme. A sum of Rs. 19.00 crores was spent on the Programme during the year 1992-93 as against the total allocation of Rs. 19.34 crores during the entire Seventh Five Year Plan. A sum of Rs.25.00 crores has been earmarked for the National Cancer Control Programme in the current year. This will suitably augment the cancer treatment facilities in the country. The Council recommended that for effective monitoring of the programme Cancer Control Boards at the National and States levels should be set up and/or suitably strengthened.
6. The Council noted with concern that in a number of cases, there is a long time gap between release of the amount by the Ministry and utilization of the same by the concerned State Government. The Council recommended that in the interest of effective implementation of the Programme the State Governments pay adequate attention to this aspect.

7. The Council noted with concern that in our country, about 50 percent of all cancer cases relate to tobacco use. Similarly, increasing number of lives are being lost every year due to tobacco related diseases. The Cigarette (Regulation of Production, Supply and Distribution) Act, 1975 has not had the desired effect in our country. Nearly 50 percent of the tobacco consumption is in the form of chewing tobacco, pan masala, khaini, snuff, etc. and a vast majority of the smokers smoke Beedis. The Council noted with satisfaction that the Ministry has already initiated action to enact a comprehensive legislation for curbing consumption of all types of tobacco products including Beedi and chewing tobacco. The Council strongly recommended that all States co-operate to bring about the proposed comprehensive anti-tobacco legislation in the country.

**NATIONAL IODINE DEFICIENCY DISORDERS CONTROL
PROGRAMME**

Resolution

1. The Council noted with concern that Iodine Deficiency Disorders (IDD) continue to be a major public health problem in India. It is estimated that in this country, about 167 million people are exposed to the risk of IDD, of which 54 million are having Goitre, 2.2 million are cretins and 6.6 million have mild neurological disorders. Although under the National Goitre Control Programme, initiated in 1962, some progress has been made, yet desired results have not so far been obtained.
2. The Council appreciated the Government's decision to change the nomenclature of the Programme from National Goitre Control Programme to National Iodine Deficiency Disorders Control Programme (NIDDCP). The Council also noted with satisfaction that with UNICEF assistance of Rs.1.2crores, the Government has introduced an intensive IDD monitoring project in four States in 1992 and will be expanding the programme with further assistance of Rs.10.89crores in another nine States during 1993-95, covering a total of 106 endemic districts.
3. The Council, however, noted with concern that there are quite a few States/UTs which are yet to issue notifications banning consumption of non-iodized salt in their respective areas. Similarly some States/UTs are yet to set up IDD Control Cells.
4. The Council, therefore, recommended that:
 - i. The NIDDCP should be accorded high priority as a major National Health Programme by all States/UTs. A senior technical officer should be made in charge of NIDDCP for appropriate and effective implementation of the Programme in the States/UTs. All officials involved in the programme should undergo appropriate training in NIDDCP.
 - ii. The States/UTs which have not yet issued notification banning sale of salt other than iodized salt for edible purpose should do so immediately and ensure effective enforcement of the same.
 - iii. The States/UTs which have not yet set up IDD Control Cells in their respective States/UTs should establish these cells without any further delay.
 - iv. The public distribution system should be involved in the sale of iodized salt through their retail outlets.
 - v. An appropriate monitoring system should be established for effective monitoring of the quality of iodized salt at various levels, i.e. at production, distribution and consumption level. For this the field laboratories should be set up / strengthened under the programme.
 - vi. To popularize and promote consumption of iodized salt the State Governments should

intensify information, communication and education activities highlighting the importance and benefits of consumption of iodated salt.

- vii. States/UTs should encourage installation of iodization plants in the consumption areas to eliminate the risk of loss of iodine content during transit.

PREVENTION OF FOOD ADULTERATION PROGRAMME

Resolution

The Council emphasized the urgent need for strengthening the machinery for the proper enforcement of the Prevention of Food Adulteration Act and the Rules made there under. It noted with concern that the Resolution demanding action on the part of the Central/State Governments in relation to the programme of the enforcement of the Act as adopted by the Central Council in its last meeting remains largely unfulfilled. Therefore, it reiterated that the Central/State Governments should take appropriate measures for implementation of recommendation No. 15 made at the last meeting of the Central Council of Health & Family Welfare.

MINISTRY OF HEALTH AND FAMILY WELFARE
CONSTITUTION OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE
NOTIFICATION

New Delhi,
Dated 20th January 1993

S.O. 63(E). - In exercise of the powers conferred by Article 263 of the Constitution and in super session of this Ministry's Notification No. Z-16011/1/80-B.P., dated 6th January, 1988 published in the Gazette of India; Extraordinary Part II Section 3 Sub Section (ii) dated 7th January, 1988, 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 of:-

(i) The Council shall consist of:-

- | | |
|---|-----------------|
| (a) The Union Minister for
Health and Family Welfare | :Chairman |
| (b) The Union Minister of State/The

Union Deputy Minister in the
Person

Ministry of Health & Family Welfare | :Vice Chairman/ |
| (c) Member, Planning Commission | : Member |
| (d) Ministers in charge of the Ministries of

Health and Family Welfare,

Medical education and Public Health

in the State/UTs with Legislatures | : Member |
| (e) A representative each of the Delhi Administration,
:Member

Dadra & Nagar Haveli, Chandigarh, | |

Andaman and Nicobar Islands,

Daman & Diu and Lakshdweep

(f) Members of Parliament

1. Shri K.H. Muniyappa (Lok Sabha)
2. Smt. Dipika H. Topiwala (Lok Sabha)
3. Km. Sushila Tiria (Rajya Sabha)
4. Km. Sayeeda Khatun (Rajya Sabha)

(g) Non-Officials

i) Representatives from Health and Family Welfare Sectors;

1. President, Indian Medical Association (ex-officio capacity)
2. President, Family Planning Association of India Bombay (ex-officio capacity)
3. President, Indian Council of Child Welfare, New Delhi, (ex-officio capacity)
4. Chairperson, Central Social Welfare Board, New Delhi, (ex-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 capacity)
7. The President, All India Organization of Employers, New Delhi (Ex-officio capacity)

(ii) Eminent Individuals

1. Dr.P.C.Reddy, Chairman, Apollo Hospital, Hyderabad (A.P.)
2. Dr. N.H.Antia, Director, Foundation for research in Community Health, Bombay.
3. Hakim Abdul Hameed, President, Hamdard Research Foundation, New Delhi.
4. Mrs. Thankamma Stephen, former Member,

Monitories Commission, Noida (U.P.)

5. Swami Harinarayana Nand,
President, Bharat Sewak Samaj, Patna
6. Shri S.S.Dhanoa,
Former Secretary to the Government of India,
Department of Health Ministry of Health & F W, New Delhi.
7. Dr.M.Ishaq Jamkhanwala,
President, Anjuman-i-Islam, Bombay.
8. Mrs. A.B. Wadia, President,
Family Planning Association of India, Bombay;

(h) Officials

1. Secretary, Department of Health,
Ministry of Health & Family Welfare : Member
 2. Secretary, Department of Family Welfare
Ministry of Health & Family Welfare. : Member
 3. Secretary, Department of Education : Member
 4. Secretary, Department of Women and
Child Development. : Member
 5. Director General of Health Services : Member
 6. Joint Secretary, Department of Health : Member Secretary
- (ii) Eminent Individuals at (g) (ii) 1 to 8 shall normally be members of the Council for a period of two years. The Members of Lok Sabha/Rajya Sabha shall be Members of the Council so long as they are members of either Lok Sabha/Rajya Sabha or two years whichever is earlier.
- (iii) The traveling and daily allowances of non-official members for attending the meetings of the Council shall be regulated in accordance with the provision of SR 190 and orders of the Government of India there under as issued from time to time.
- (iv) The expenditure involved will be met from within the sanctioned budget grant for the

purpose.

- (v) 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.
- (vi) The Council shall have Secretarial staff consisting of a Secretary and such officers and officials as the Chairman may, with the approval of the Central Government, think fit to appoint.

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

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

- (a) to consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects, such as the provision of remedial promotive and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research;
- (b) to make proposals for legislation in fields of activity relating to medical and public health and Family Welfare matters, laying down the pattern of development for the country as a whole;
- (c) to examine the whole field of possible cooperation on a wide basis in regard to inter-State quarantine during times of festivals, outbreak of epidemic cases 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 cooperation between the Central and State Health and Family Welfare administration.

3. Procedure of the Council:-

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

- (a) the Council shall meet at least once in every year;
- (b) it shall meet at such time and place as the Chairman may appoint in this behalf;
- (c) five members (including the Chairman) shall form the quorum for a meeting of the Council;

- (d) the Chairman and, in his absence vice-chairman, vice-chairperson or such member as may be designated by the Chairman in this behalf from among the members referred to in clause (d) of sub-paragraph (i) of a 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.

[NO.Z.16011/13/89-B.P]

SHAILAJA CHANDRA, Jt. Secy.

Annexure 'B'

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

1. Shri B. Shankaranand
--Chairman
Union Minister for Health & F.W.
2. Shri Paban Singh Ghatowar
--Vice Chairman
Deputy Minister for Health & F.W.
3. Prof. J.S. Bajaj Member(Health) Planning Commission
--Member

Ministers In-charge of Ministries of Health & Family Welfare. Medical

Education and Public Health in the States/UTs with Legislatures:

4. Shri K. Rosaiah
Minister for Finance & Power
Andhra Pradesh
--Member
5. Shri Gegong Apang
Chief Minister
Arunachal Pradesh
--Member
6. Dr. Bhumidhar Barman
Minister for Health & F.W.
Assam
--Member
7. Dr. Karsandas Soneri
Minister for Health & F.W.
Gujarat
--Member
8. Shri Shartisinh Tohil
Minister of State for Health & F.W.
Gujarat
--Member
9. Smt. Kartar Devi
Minister for Health & F.W.
Haryana
--Member
10. Shri P.P. Srivastav
--Member

- | | | |
|-----|-------------------------------------|----------|
| | Adviser to the Governor | |
| | Himachal Pradesh | |
| 11. | Shri Ashok Jaitley | --Member |
| | Adviser to the Governor | |
| | Jammu & Kashmir | |
| 12. | Shri G. Ramakrishna | --Member |
| | Minister for Medical Education, | |
| | Karnataka | |
| 13. | Shri Mohd. Shaft Qureshi | --Member |
| | Governor | |
| | Madhya Pradesh | |
| 14. | Shri J.D. Pohrmen | --Member |
| | Minister for Health & F.W. | |
| | Meghalaya | |
| 15. | Shri Lai Huthanga | --Member |
| | Minister for Health & F.W., Mizoram | |
| 16. | Dr. (Smt.) Kamala Das | --Member |
| | Minister for Family Welfare, Orissa | |
| 17. | Shri H.S. Brar | --Member |
| | Minister for Health & F.W. Punjab | |
| 18. | Shri O. T. Bhutia | --Member |
| | Minister of Health & F.W., Sikkim | |
| 19. | Shri R.D. Sonkar | --Member |
| | Adviser to Governor, Uttar Pradesh | |
| 20. | Shri Prasanta Kumar Sur | --Member |

Minister for Health & F.W.

West Bengal

21. Smt. Chhaya Bora --Member

Minister of State for Health & F.W.

West Bengal

22. Shri P. Ananda Baskaran --Member

Minister for Health & F.W.

Pondicherry

**Representatives from the Delhi Administration. Dadra & Nagar Haveli,
Chandigarh and Daman & Diu:**

23. Shri R.S. Sethi --Member

Secretary(Medical)

Delhi Administration

24. Dr. L.N Patra --Member

Director Medical & Public Health

Dadra & Nagar Haveli

25. Dr. Gurnam Singh Ahluwalia --Member

Director of Health & F.W.

Chandigarh Administration

26. Smt. Sindushree Khullar --Member

Development Commissioner

& Secretary(Medical)

Daman & Diu and Dadra & Nagar Haveli

27. Dr. S.S. Vaisya --Member

Chief Medical Officer

Daman & Diu Administration

Non-Officials:

28. Dr. V.C.Velayudhan Pillai --Member

President

Indian Medical Association

29. Mrs. Avabhai B. Wadia --Member

President

Family Planning Association of India

30. Smt. Vidyaben Shah --Member

President

Indian Council for Child Welfare

31. Dr. N. Hamsa --Member

Joint Secretary

Federation of Indian Chambers of Commerce and Industry and All

India Organization of Employers

I.C.M.R.

32. Dr. S.P. Tripathy -Member

Director General

Indian Council for Medical Research

Eminent Individuals:

- | | | |
|-----|--|----------|
| 33. | Dr. Prathap C. Reddy | --Member |
| | Chairman | |
| | Apollo Hospital, Hyderabad | |
| | Andhra Pradesh | |
| 34. | Dr. N.H. Antia | -Member |
| | Director, Foundation for Research in Community Health Bombay | |
| 35. | Smt. Thankamma Stephen | -Member |
| | Former Member, Minorities Commission | |
| | NOIDA (U.P.) | |
| 36. | Swami Harinarayanand | -Member |
| | President, Bharat Sewak Samaj, Patna (Bihar) | |
| 37. | Shri S.S. Dhanoa | --Member |
| | Former Secretary to the Govt. of India | |
| | Ministry of Health & F.W. | |
| 38. | Dr. M. Ishaq Jamkhanwala | --Member |
| | President, Anjuman-i-Islam | |
| | Bombay | |

Officials:

- | | | |
|-----|---------------------------|----------|
| 39. | Shri R.L. Misra | --Member |
| | Secretary(Health) | |
| | Ministry of Health & F.W. | |

40. Smt. Usha Vohra
Ministry of Health & F.W.
--Member Secretary(F.W.)
41. Dr.(Mrs.) D. Rebello
Joint Secretary
Department of Education
-Member
42. Mrs. Lata Singh
Department of Women & Child Development
--Member Secretary
43. Dr. A.K. Mukherjee
Director General of Health Services
44. Smt. Shailaja Chandra
Joint Secretary, Ministry of Health & F.W.
-Member Secretary

Annexure 'C

**ATTENDANCE AT THE CONFERENCE OF
CENTRAL COUNCIL OF HEALTH & FAMILY
WELFARE**

State Governments Andhra Pradesh

- Shri B.V. Ramarao
Principal Secretary
Health, Medical & F.W. Deptt.
- Dr. M. Innaiah Director(FW)
- Dr. B. Nandraj Singh Director of Health
Services
- Dr. P. Ramanarao Director of Medical
Education

Arunachal Pradesh

- Dn Hage Lodor

Joint Director of Health Services(FW)

Assam

- Shri Harish Sonowal
Secretary(Health & F.W.)
- Dr. Nabashyam Das Director of Health Services

Bihar

- Shri Anil Sinha
Addl. Health Commissioner-cum-Special Secretary
- Dr. R.M. Sharan
Dy. Director of Health Services

Gujarat

- Ms. S.K. Varma Addl. Chief Secretary & Commissioner(FW)
- Shri T.C.A. Rangadurai
Commissioner of Health, Medical Services and Medical Education

Goa

- Shri B.G. Sharma Officer on Special Duty

Harvana

- Shri Raghbir Singh
Secretary (Health)
- Dr. P.K. Jain Director (Ayurveda)

Himachal Pradesh

- Shri S.K. Sood
Commissioner & Secretary (Health & F.W.)
- Dr. J.K. Kakkar Director (Project)

Jammu & Kashmir

- Dr. Ali Baksh
Special Secretary (Health & F.W.)

Karnataka

- Shri C. Gopal Reddy
Secretary (Health & F.W.)

Dr. T.R. Achar
Director of Health Services

Dr. Honnabovi Add. Director(FW)

Kerala

- Shri G.K. Pillai
Secretary (Health)

Madhya Pradesh

- Shri N. Natrajan
Adviser to Governor

Shri G.S. Shukla Principal Secretary (Health)

Dr. R.A. Siddiqui Director of Health &F.W.

Dr. R. K. Jain Director(Hospitals)

Maharashtra

- Shri K.S. Sidhu
Secretary (Public Health)

Shri R.N. Chinmulkund
Joint Secretary
Medical Education & Drug Deptt.

Dr. N.T. Joshi
Addl. Director of Health Services(FW)

Manipur

- Shri H.Jel Shyam
Addl. Chief Secretary

Dr. N. Devendra Singh Director of Health Services

Dr. L. Nobin Singh Addl. Director(FW)

Meghalaya

- Dr. F.N Kharkongor
Director of Health Services

Mizoram

- Dr. Lalengi Khaingte
Director of Health Services(FW)

Dr. N. Pallai
Dy. Director of Health Services(FW)

Nagaland

- Shri R.S. Panday
Resident Commissioner

Orissa

-Shri R. M. Senapati
Principal Secretary (Health & F.W.)

Punjab

- Shri G.P.S. Sahi
Secretary(Health & F.W.)

Dr. Dalbir Singh Director(Health)

Rajasthan

- Shri V.N. Bahadur
Secretary(Health & F.W.)

Dr. B.L. Gupta
Director, Medical & Health Services

Dr. G.S. Gahlot
Director, Medical & Health Services

Sikkim

- Shri Pasong Namgyal
Secretary(Health & FW)

Dr. S.K. Pradhan
Jt. Director of Health Services

Tripura

- Shri Anil Mishra
Secretary (Health)

Dr. K.H. Roy
Director of Health Services

Uttar Pradesh

- Smt. Sumita Khandpal
Principal Secretary,
Medical, Health & F.W.

Dr. Bachchi Lai Special Secretary Medical Health & F.W.

Dr. V.B Sahai
Director of Medical Education

West Bengal

- Shri K. Chaudhuri
Commissioner, Health & F.W.

Pondicherry

- Shri Nathu Ram
Secretary(Health & F.W.)

Chandigarh

- Dr. Gurnam Singh Ahluwalia
Director Health Services

Dadra & Nagar Haveli

- Shri Sindhushree Khullar
Dev. Comm. & Secy. (Health)
D.& N. Haveli and Daman & Diu

Dr. L. N. Patra Dadra

Dadar& Nagar Haveli

Daman & Diu

- Dr. S.S. Vaisya
C.M.O.
Daman & Diu Administration

Delhi

- Shri R. S. Sethi
Secretary(Medical)
Delhi Administration
- Dr. V. P. Varshney
Director of Health Services
Delhi Administration

Government Organizations and Autonomous Institutions:

- Dr. I.C. Tiwari

Advisor(Health)

Planning Commission
- Dr. A.K.N. Sinha

President

Medical Council of India
- Dr. P. Narasimha Rao

Vice-President

Medical Council of India
- Dr. M. Sachdeva

Secretary

Medical Council of India
- Dr. J.S. Qadry

Acting President

Pharmacy Council of India

- Dr. S. K. Kacker

Director, A.I.I.M.S.

- Dr. J.P. Gupta

Director, NIHFV

- Dr. Ashish Bose

Professor, JNU

- Shri T. V. Antony

Ex-Chief Secretary (Tamil Nadu)

- Dr. Banoo Coyaji

Director

K.E.M. Hospital Research Centre

Pune

- Dr. Jagdish C. Sobti

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Rashtriya Sahara.

Annexure 'D'

**MINISTRY OF HEALTH AND FAMILY WELFARE CONFERENCE OF CENTRAL
COUNCIL OF HEALTH & FAMILY WELFARE
14th July to 16th July, 1993**

PROGRAMME

09.30 hrs. to 10.00 hrs. 10.00 hrs. to 11.00 hrs. 11.00 hrs. to 11.30 hrs. 11.30 hrs. to 13.30 hrs. 13.30 hrs. to 14.30 hrs. 14.30 hrs. to 15.40 hrs. 15.40 hrs. to 16.00 hrs. 16.00 hrs. to 18.00 hrs.	Venue: Parliament House. Annexe Registration Inaugural Session Address by state Health Ministers. Lunch Address by State Health Ministers and other members of Central Council of Health & Family Welfare to continue. Tea Address by State Health Ministers and other members of Central Council of Health & Family Welfare to Continue.
10.00 hrs. to 11.30 hrs. 11.30 hrs. to 11.50 hrs. 11.50 hrs. to 13.30 hrs. 13.30 hrs. to 14.30 hrs. 14.30 hrs. to 16.00 hrs. 16.00 hrs. to 16.20 hrs. 16.20 hrs. to 18.00 hrs.	Discussion on Agenda Notes and adoption of relevant Resolutions. Tea Discussion on Agenda Items and adoption of relevant Resolution to continue. Lunch Discussion on Agenda Item and adoption of relevant Resolutions to continue. Tea Discussion on Agenda Items and adoption of relevant Resolutions to continue.
10.00 hrs. to 11.30 hrs. 11.30 hrs. to 12.00 hrs.	Discussion on Agenda Items and adoption of relevant Resolutions to continue.

12.00 hrs. to 13.00 hrs.	
13.00 hrs.	Tea Concluding Session. Lunch