EIGHTH CONFERENCE OF CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE

PROCEEDINGS AND DECISIONS TAKEN

AUGUST 28 - 29, 2003
NEW DELHI

MINISTRY OF HEALTH AND FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES (BUREAU OF PLANNING)
GOVERNMENT OF INDIA
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Subject</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>CONTENTS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PART-I</strong></td>
<td><strong>INAUGURAL SESSION</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Welcome address by Shri J.V.R. Prasada Rao,</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>Secretary (Health)</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Address by Shri A. Raja,</td>
<td>05</td>
</tr>
<tr>
<td></td>
<td>Hon’ble Minister of State for Health and Family Welfare</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Presidential Address by Smt. Sushma Swaraj,</td>
<td>09</td>
</tr>
<tr>
<td></td>
<td>Hon’ble Union Minister for Health and Family Welfare</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Inaugural address by Shri Bhairon Singh Shekhawat,</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Hon’ble Vice President of India</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Vote of thanks by Dr. S.P. Agarwal, DGHS</td>
<td>27</td>
</tr>
<tr>
<td><strong>PART-II</strong></td>
<td><strong>PROCEEDINGS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>28th August, 2003</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Issues related to Communicable and Non-Communicable Diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Malaria, TB, Leprosy, AIDS, Blindness, Cancer and Mental Health)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Indian Systems of Medicine and Homeopathy</td>
<td>55</td>
</tr>
<tr>
<td><strong>29th August, 2003</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Issues related to Medical Education</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Department of Family Welfare</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Acknowledgement by Ministers from Bihar and Jammu &amp; Kashmir</td>
<td>85</td>
</tr>
<tr>
<td><strong>PART-III</strong></td>
<td><strong>DECISIONS TAKEN</strong></td>
<td>87</td>
</tr>
<tr>
<td><strong>PART-IV</strong></td>
<td><strong>ANNEXURES</strong></td>
<td></td>
</tr>
<tr>
<td>Annexure 1</td>
<td>Powerpoint Presentations</td>
<td>99</td>
</tr>
<tr>
<td>Annexure 2</td>
<td>Notification regarding re-constitution of CCH &amp; FW</td>
<td>175</td>
</tr>
<tr>
<td>Annexure 3</td>
<td>List of Participants</td>
<td>181</td>
</tr>
<tr>
<td>Annexure 4</td>
<td>Programme</td>
<td>201</td>
</tr>
<tr>
<td>Annexure 5</td>
<td>Invitation card</td>
<td>203</td>
</tr>
</tbody>
</table>
INAUGURAL SESSION
WELCOME ADDRESS BY SHRI J.V.R. PRASADA RAO,
SECRETARY (HEALTH)

His excellency, Hon’ble Vice President of India, Hon’ble Minister for Health and Family Welfare & Parliamentary Affairs; Hon’ble Minister of State, Health and Family Welfare; Member, Planning Commission; Secretary, Family Welfare; Secretary, Indian Systems of Medicine; Director General of Health Services; Hon’ble Ministers, In-charge of Health and Family Welfare; Medical Education of the State Governments; distinguished colleagues and friends.

I extend a very warm welcome to his Excellency, the Vice President of India for being so considerate to come for inaugurating this 8th Conference of the Central Council of Health and Family Welfare. In fact, this is the first time that we had the good fortune of having a distinguished personality like the Vice President of India coming and inaugurating the Conference and we are deeply grateful to you sir, for sparing your valuable time and we will be looking to the benefit of your advice and guidance. I welcome Hon’ble Ministers Smt. Sushma Swaraj ji, Shri A. Raja ji for this meeting and in fact it is because of the encouragement given by Smt. Sushma Swaraj ji that we could hold this meeting at such a short notice. In spite of her busy schedule in the Parliament, she has been able to give the two-day time for this meeting and we are very happy to see all the states responding very enthusiastically to this invitation. I extend a warm welcome to all the Hon’ble Ministers coming from the States because we are looking for a very purposeful deliberation in the next two days, today and tomorrow. This meeting is taking place two years after the last meeting and in the intervening period, many path-breaking events have occurred in the health sector. In my limited time, I will briefly mention a few of them so that we can set the agenda for the meeting. The health policy, which was announced in 2002, I think, it is a landmark in the health sector. The earlier policy was of 1983 vintage, so we have been able to come up with a forward-looking Health Policy in 2002. We have also a National AIDS Control Policy and a Blood Policy which were also announced in 2002. During this period, new projects were also launched for disease control programmes. The existing TB Control Programme was also extended to almost
more than 700 million people in the country. Now recently, we have been able to get the Cabinet approval; CCEA approval for the new mental health programme and new capacity building programme in the food and drugs. So quite a few of the new initiatives have now come into force and we will be looking forward to their effective implementation. The important initiative on tertiary health care for the first time, I think since the fifties has been taken, in the form of Pradhan Mantri Swasthya Surakshya Yojana, about which I think the Hon’ble Minister will have the privilege of giving you more details. Then we have a new focus on food and drugs, which, I think augurs very well for the country. So instead of just talking about normal curative health care slowly we are moving into greater amount of awareness on food and drugs side and there have been quite a few debates on giving healthy food, healthy water and healthy medicines to the people of this country. So we have kept a very small agenda on that. There will be a presentation and we look forward to an interesting debate on this. The Central Government Heath Service Scheme has been extended to new areas. The three new States, we are trying to extend are Chattisgarh, Jharkhand and Uttarakhand and also to Orissa, for the first time in Bhubaneswar, we will be extending the CGHS benefits. In the area of medical education, unfortunately I would say there has been a lot of confusion, of late and there was a Supreme Court Judgement last year, that was clarified by another Supreme Court judgment this year and we are having serious operational problems vis-a-vis the Medical Council of India. So I think that will also come up for discussion. I know there are lots of concerns from some of States who are interested in starting new medical college or extending the existing capacity of medical college and we have serious operational issues confronting us, which we need to resolve.

We are also able to access external finances for some of disease control programmes outside the normal pattern from the World Bank and the bilaterals. One of the important advances is the Global Fund for AIDS, TB and Malaria. I am very glad to announce that we have got a grant of about 110 million dollars which includes AIDS and TB grants and for Malaria also we expect to receive an additional grant in the next round of approvals. The Bill Gates Foundation has announced a grant of 100 million dollar for AIDS control in this country and this will be mostly implemented through the civil society partners and we also look forward to very extensive participation by the private
sector in cooperation with the public sector mechanism. We have a good number of State health system projects running in the country and Tamil Nadu, Kerala and Assam projects are on the anvil. We look forward to their approvals very quickly. From Government of India side, we are actively pushing these projects and we hope that these states will be able to get the benefits of them.

The most important message in the last two years has been greater decentralization. In every programme, we have endeavoured to see that greater power, greater authority and greater responsibility is given to the State Governments and we in Government of India even in Centrally Sponsored Schemes, would like to take the role of providing funds, managerial and technical support, for the programmes, where as the States are the ones who are put in the forefront for implementation and for monitoring and evaluation of programmes. Of late, in the last few years, we have number of state societies, which have been formed for various programmes and there is a good move to integrate all the societies into a common society, both at the state and district level that is also being actively encouraged by Government of India. I think that is the ultimate answer for effective channelization of funds, both to the states and district level.

So some of these initiatives have been taken. Today we have assembled here to have the benefit of your advice and your guidance. How do we strengthen this mechanism? How do we see these programmes are implemented better? So we really look forward to a very interesting debate today and tomorrow in all the three areas health, family welfare and the Indian Systems of Medicine. With these few words, I once again extend a very warm welcome to all of you, ladies and gentleman and I look forward to your advice and guidance.

Thank you.
ADDRESS BY SHRI A. RAJA, MINISTER OF STATE FOR HEALTH AND FAMILY WELFARE

His excellency, the Vice President of India; Hon’ble Union Minister of Health and Family Welfare; Ministers of Health & Family Welfare from States and UTs; Member, Planning Commission; Members of Parliament; eminent experts nominated to the council; officials of the Central and State Health and Family Welfare Departments; representatives of media, and other distinguished participants.

First of all, I must thank his Excellency, Vice President of India, who despite his hectic schedule has managed to take out time and be with us to inaugurate the Eighth Conference of Central Council of Health and Family Welfare. His presence has enhanced the prestige of the Council and shown the importance he places on health.

I am happy to be present here today to interact with all of you and wish to you that meetings provide valuable inputs, which help us to formulate appropriate initiatives to provide an acceptable standard of good health to the citizens of this country.

There are many persistent problems in the health sector, which have been defying solution all these years. Whereas significant progress has been made in eradicating diseases like Smallpox and Guinea Worm or achieving near eradication in the case of Polio, certain communicable diseases like Malaria & TB continue to be a cause of concern. HIV/AIDS has assumed menacing levels and has emerged as a challenge for all of us to control.

Urbanization, increasing pollution, changing food habits, sedentary life style and stressful day-to-day living have resulted in increase of lifestyle related diseases such as hypertension, diabetes and cardio-vascular diseases. Over the last few years, morbidity and mortality due to CVD, mental disorders, cancer and trauma has been fast rising. Because of the chronic morbidity and high cost of treatment of non-communicable diseases, there is an imperative need, not only to increase facilities for treatment of these diseases but also focus on their prevention and early detection. There is also a need to
devise ways and means to provide relief to the poorer sections of society inflicted with such diseases. I am sure that the Pradhan Mantri Swasthya Suraksha Yojana as also the Universal Health Insurance Scheme recently launched by the Hon'ble Prime Minister will provide the much-needed relief to this vast segment of population.

The Union Govt. has announced the National Health Policy, 2002 (NHP-2002) and also the National Policy on Indian System of Medicine and Homoeopathy. Majority of the policy prescriptions can be implemented only with the active co-operation of States and UTs and I would like to utilize this opportunity to urge upon all the State and UT Governments to make concerted efforts to implement these policies in so far as it concerns them. Devolution of functions, functionaries and funds in the areas of health & family welfare to the Panchayati Raj Institutions is another important issue, which would go a long way in improving the accountability of the public health care providers, bring about inter-sectoral co-ordination at the grassroot level and thereby enhance health care delivery. The states undoubtedly have to play a proactive role in this endeavour.

It is our sacred duty to protect the people from adulterated food and spurious drugs. It is disturbing to note that lifting of food samples has gone down and cases under litigation have increased. There is need to reverse this trend by a sharper implementation of the provisions of PFA. Union Govt. is launching the Capacity Building Project on Food Safety and Quality Control of Drugs with World Bank Assistance. I invite the State Governments to take advantage of the project and assist in getting rid of this dangerous practice adopted by the greedy and anti social elements in the country.

The paradigm shift for provisioning of services in the Family Welfare Programme during ICPD, Cairo, was translated into action through the Reproductive and Child Programme launched by the Govt. of India during the 9th Five Year Plan. The RCH Programme has been the largest, most intensive and ambitious programme of the Govt. of India for providing comprehensive family welfare services. Though slow to takeoff, the programme has successfully addressed the large number of issues related to the health of women and child, which has led to wider acceptance of the Family Welfare programme. The negotiations with the Donor Agencies for the second phase of the RCH, at an
expected outlay of Rs.9000 crore, are going on.

In an attempt to rationalize the provision of Sub-centres as per 1991 population norm, the Govt. of India seeks to sanction 8868 Sub-centres all over the country. Coupled with provisions of additional ANMs under RCH programme, this provides enough flexibility in the programme for improvement of outreach services, especially in the hilly, tribal and desert areas. In the RCH-II programme, funds are being provided for improvement of logistic systems, which will ensure timely availability of supplies in the States and Districts.

I am happy to inform that the model of MNGO scheme, which was introduced by the Department of Family Welfare in the 9th Five Year Plan, has been acknowledged by the Planning Commission as the model scheme to be adopted by other Ministries and Departments for greater involvement of NGOs. The NGO guidelines of the Department of Family Welfare have been revised recently and the scheme has been decentralized to ensure greater participation of States in the selection, funding, monitoring and supervision of the Mother NGOs and support NGOs. In the same way, the guidelines for social marketing are also being revised to facilitate greater participation of Community Based Organizations and Social Marketing Organizations for provision of contraceptives and other family welfare products and services at the field level. The Department is also working on the modalities for greater involvement of the Panchayati Raj Institutions in the Health and Family Welfare programme. However, the States must take lead in progressive decentralization of funds and programmes to panchayat levels, which is important to make Family Welfare a people's programme.

Indian Systems of Medicine & Homoeopathy have traditionally been dear to us and have a substantial role to play. Because of inherent advantages, such as diversity, modest cost, low level of technological inputs and the growing popularity of natural plant-based products, these systems are attractive, particularly in the underserved, remote and tribal areas. I am happy to state that top priority is being given to help maintain standards of education, in order to check mushroom growth of sub-standard colleges of Ayurveda, Unani, Siddha & Homeopathy.
Greater emphasis is being placed on the implementation of the schemes which address thrust areas like quality control and standardization of drugs, improving the availability of raw materials of ISM&H drugs, time bound research and development programmes and awareness building about the efficacy of the systems, domestically and internationally.

Involvement of ISM&H in the national health care delivery systems including reproductive and child health programme has also been given a thrust. Collaborative efforts with modern hospitals have been initiated for testing the efficacy of the system and for evolving clinical evidence. Ensuring the quality in health sector should be our guiding principle in all our pursuits and the States definitely have an important role to play in this endeavour.

The various issues outlined by the three department are placed before us and I am sure that the Ministers from various States would deliberate upon them and provide concrete inputs for helping us to formulate a plan of action for realizing our objective of achieving an acceptable standard of good health for the citizens of the country.

Thank you, Jai Hind.
माननीय स्वास्थ्य एवं परिवार कल्याण मंत्री, श्रीमती सुषमा स्वराज - अध्यक्षीय भाषण

भारत के समान्तन्य उपराष्ट्रपति, महामहिम शेखावत जी, सचिव स्वास्थ्य, श्री जे वी आर प्रसाद राव, सचिव परिवार कल्याण श्री पी के होता, सचिव भारतीय चिकित्सा पद्धति और होम्योपैथी, श्रीमती मालती सिन्हा, स्वास्थ्य सेवा महानिदेशक, डा.एस.पी. अग्रवाल,सदस्य योजना आयोग, श्री एम सुभाषनिधियो, मेरे मंत्रालय में मेरे सहयोगी श्री ए राजा, देश के विभिन्न राज्यों से आये मेरे सहयोगी स्वास्थ्य मंत्रालय, अधिकारीगण। इस परिषद् के समानित सदस्यों और मित्रों।

सबसे पहले तो मैं आदरणीय श्री शेखावत जी के प्रति हमारे अभार व्यक्त करना चाहूँगी कि हमारे मेरे निम्नन्त्रण को स्वीकार किया। जिस समय यह प्रस्ताव मेरे सामने रखा गया कि हमें यह व्यक्तित्व को चुनना है इस सम्मलेन का उद्घाटन करने के लिए होने का नाम मेरे जहाँ में आया यो शेखावत जी का था। मैं मन से चाहती थी कि हमें आकर सम्बोधित करें इसलिए नहीं कि हमें देश के शीर्ष बड़े पद पर विराजमान हैं, भारत के उपराष्ट्रपति हैं बल्कि इसलिए कि स्वास्थ्य के प्रश्नों को लेकर उनके मन में जो विचार है, उसे मेरे स्वयं बहुत करीब से देखा है। वे राज्यसभा के पहले समाप्ति हैं जिन्होंने पीठ पर बैठक यह आदेश दिया, आनन से आदेश दिया, कि राष्ट्रीय जनसंख्या नीति की चर्चा सदन में होनी चाहिए। वे पहले समाप्ति हैं जिन्होंने यह इच्छा व्यक्त की कि पौलियो मुक्ति अभियान में जनप्रतिनिधियों को जोड़ना चाहिए। वे पहले समाप्ति हैं जिन्होंने यह कहा कि जो आम गांव का स्वास्थ्य का बुनियादी ढांचा है उसे मजबूत करना चाहिए और वे पहले समाप्ति हैं जिन्होंने एक समय में यह घोषणा की कि आयुर्वेद समत हमारी भारतीय चिकित्सा पद्धति की जितनी अन्य पद्धतियाँ हैं, उन्हें राष्ट्रीय स्वास्थ्य परिचय प्रदान करनी है। इस रुप में चीजों से प्रेषण प्राप्त करके मुझे यह लगा कि एक मौका जो सभी स्वास्थ्य मंत्रियों को किल्ले में आने का मिल रहा है तो अच्छा होगा यदि वह स्वास्थ्य स्वयं स्वरूप हो उनसे और अपनी प्रेषण अपने प्रेषक श्रद्धों में हमें दे और हालांकि इसलिए बहुत कम समय था कि जब हमने उन्हें निम्नन्त्रण में लेकिन मैं हम्द से आभारी हूँ शेखावत जी आपकी कि आज आप उपस्थित हैं और हम सब आपका प्रेषक मार्गदर्शन पाने के लिए लालाखियत हैं।

मित्रों, यह परिषद् की आठवीं बैठक है। हर दो वर्ष पर यह बैठक होती है। अन्य विभागों में भी इस तरह की बैठकें होती हैं। हर दो वर्ष पर संस्थापित मंत्री इकट्ठे होते हैं लेकिन आज तक मेरा अनुभव यह रहा है कि आमतौर पर ये बैठकें रस्म निम्नायी
की बैठकें बनकर रह जा हैं। लोग आते हैं, लिखित भाषण लाते हैं, उनको पढ़ते हैं, एक दूसरे के भाषण पर ताली बजाकर उठ जाते हैं। हमने इस बार रस्म निमायी की बैठक न हो, ऐसा प्रारूप बनाने की कोशिश की है। देश में इस समय बहुत से ज्वलांत प्रसन हैं, जो पुर्वी सामने खड़े हैं। हम उनसे बच नहीं सकते। मुझे लगता है कि मंच पर हम तमाम प्रसनों पर हमें खुलकर चर्चा करनी चाहिए, निर्मलमूर्ति करनी चाहिए, विना शब्द चलाये चर्चा करनी चाहिए। उनका समाधान अपनी ओर से रखना चाहिए और अंत में पूरा विचार विमर्श करके कुछ निर्णयों पर पहुँचना चाहिए, पैसों पर पहुँचना चाहिए। फिर उन पैसों को लागू करना चाहिए। आमतौर पर केंद्र सरकार पर यह आरोप लगता है कि केंद्र सरकार स्वास्थ्य को राज्यों का विषय कहकर अपनी जिम्मेदारी से बड़ी हो जाती है। हमने इस धारणा को बदलने की कोशिश की है। भरपूर प्रयास किया है कि किसी तरह से यह धारणा खत्म हो, अभी जिसका जिक्र किया, स्वास्थ्य सत्ता ने, हमने प्राथमिकता स्वास्थ्य सुंक्षा का गठन किया और एक कमी जो पूरे देश में जब खत रही थी, तृतीय (Tertiary) स्वास्थ्य परिसरों में अस्पतालों का अभाव। सरकारी क्षेत्र में, निजी क्षेत्र में अपार अस्पताल आये हैं, बहुत पूर्वी निवेश हुआ है, निजी क्षेत्र में, लेकिन जो गरीब का बिसात से बाहर है, अमीर जाकर उन्हें इलाज करा सकता है लेकिन गरीब बेचारा क्या करे। एक एम्स बना 1956 में। तब से लेकर आज तक केंद्र सरकार के 47 साल के दौरान राष्ट्रीय क्षेत्र में एक और एम्स बनाने की कल्याण की गई और वह भी बन नहीं पाया। या तर जहाँ देखा, तरकारी क्षेत्र में अस्पताल नहीं हैं। इसलिए हमने पूरी योजना बनायी। जो चिकित्सा की व्यवस्था से बिलकुल पिछड़े हुए राज्य हैं, ऐसे छह राज्यों में हम नये एम्स बनायेंगे और देश के हर राज्य में मेडिकल कालेज को उनमें लगाने के स्तर तक पहुंचायेंगे। यह हम लोगों की योजना बनी है। जिन छह राज्यों का चयन किया, वे हैं उड़ीसा, बिहार, राजस्थान, मध्यप्रदेश, उत्तराखंड और चhattisgarh, जहां स्वास्थ्य सेवाओं के नाम पर कुछ ही नहीं। एम्स दिल्ली का सर्ववेश्क किया तो पता चला कि सबसे ज्यादा लोग उड़ीसा और बिहार से आए हैं। बिहार और महाराष्ट्र के साथ तीमार्दार दौड़ते हैं। इस महानगरीय संस्कृति में आकर मरीज को तो एक बार अगर भर्ती कर लिया जाता है तो कम से कम उसका छुट्टाव होता है। अन्दर उसकी देखभाल दाखिल कर लेता है लेकिन तीमार्दार भटकता है और वह होता है। वहां से यहां तक लाने का काफ, उसके बाद यहां के तीमार्दार का काफ। क्यों नहीं हम उसके द्वार पर ते सुंदित दे करते हैं। इसलिए हमने प्राथमिक तीमार्दार सुंक्षा योजना का पहला विन्यास यह रखा। दूसरे में सभी राज्यों में से हमने और चौ: राज्यों का चयन पहले चरण में किया। जम्मू एवं कश्मीर में, एम्स जी पी जी बाई लखनऊ, उत्तर प्रदेश, तिरुपति मेडिकल कालेज, तमिलनाडु, एम्स एम्स हैदराबाद, एम्स एम्स प्रदेश,
आर आई एम एस, रांची, झारखंड, कोलकता मैडिकल कालेज, कोलकाता, पश्चिम बंगाल, ये नहीं चरण की योजना हमारी होगी। इतना बड़ा तृतीयक स्वास्थ्य परिवार का आधारमूल छोटा अगले तीन वर्षों में तैयार हो जाएगा। इसकी समय सीमा रखी है हमने। कितना बड़ा काम ये स्वास्थ्यकर्ता आधारमूल छोटे के क्षेत्र में होगा जो सरकारी क्षेत्र में होगा जहां गरीब पीड़ा के इलाज कर लेंगे।

इसी तरह जननी सुखा योजना परिवार कल्याण में हमने प्रारंभ की है। मातृ मृत्यु दर और शिशु मृत्यु दर, जब हम हिन्दुस्तान की देखते हैं तो मन भरता है। हर एक लाख गर्भवती महिलाएं जो बालक को जन्म देती हैं, उसमें से 407 महिलाएं मर जाती हैं। हर एक हजार नवजात शिशु जो हिन्दुस्तान में पैदा होते हैं, उनमें से 66 मर जाते हैं। इसी तरह मातृ मृत्यु दर, शिशु मृत्यु दर। कारण कि संस्थागत प्रसव (Institutional deliveries) नहीं हो पाते हैं। अस्पताल तक उपकेंद्र (Sub center) बमदरोश हो लेकिन उन्होंने पता लगाया। वह अपने इतिहास कल्याण के चल रहे क्षेत्र में कई योजनाओं को इंटरनेशनल करके हमने जननी सुखा योजना बनाई जिसके तहत यह तय किया गया कि हर महिला जो गर्भ धारण करती, वह तीसरे महिला के कम से कम हमारे उप केंद्र में पहुँच जाये। 6 मह तक उसकी निशुल्क जांच हो। उसे विदेशी की गोली, आइसन की गोली और उसके साथ-साथ यह सलाह कि क्या छोटी-छोटी चीजें जो घर में हैं वह खाकर उससे प्रोटीन ते सकती हो। आइसन ले सकती हो, मंडली चीजें नहीं। उसकी वित्तीय में है लेकिन जानकारी का अभाव है। और इतनी जय तक वह दोसान तक उत्तेजना हुआ है तो उसे अस्पताल तक पहुँचाया जाये। और एक प्रोत्साहन इसके साथ रखा, कि अगर हम संस्थागत प्रसव के लिए अस्पताल आएंगी तो जो गरीब महिलाएं हैं, गरीबी रेखा के नीचे जीवन वापस कर सकती हैं, रेखे के जन्म पर 500 रु. और बेटी के जन्म पर 1000 रु. देकर उसको भेजा जायेगा। क्योंकि इस समय बड़ी आबादी जहां हमारी चिन्ता का अभाव है वहीं बेटे और बेटी के जन्म में असंतुलन होना यह दूसरी हमारी चिन्ता बन गयी है। आंकड़ा कंपनी बांटा है। 1000 लड़कों पर 800 लड़कियाँ पैदा हो रही हैं। हर एक हजार बच्चों पर अगर 200 लड़कियाँ कम हो जाएंगी तो हमारी जनसंख्या का असंतुलन कहां जाकर पहुँचेगा। आज अगर सी करोड़ का अन्दाजा लगाये तो कितनी कमी है इसलिए 'आबादी घटाना मगर बेटी बांटना' इन दोनों कार्यक्रमों को हमने एक साथ जोड़ा है और इसके लिए नेशनल कमिटेंट कम्युनियन, राष्ट्रीय प्रतिबंधाता अभियान प्रारंभ किया है, जिसकी शुरुआत भी अंग्रेज उपराज्यपति जी के हाथों से करवाई थी, उन्होंने ही इस अभियान का शुरुआत किया था और मुझे खुशी है उस अभियान पर बाद में राष्ट्रपति जी ने भी हस्ताक्षर किये हैं और स्वयं उन्होंने अपने आपको इस अभियान से जोड़ा है।
हमने इस वर्ष की जो बालिका पुरस्कार विजेता बच्ची जिसने पूरे भारतीयों का माध्यम उच्चा किया, आमतौर पर शिक्षा की साना मिर्जा, जो विमंडल के टेनिस जीत कर आई थी और कनिष्ठ वर्ग में सर्वश्रेष्ठ का खिताब उसे मिला है उसे इस बार" सेवा दे गर्ल्स चाइल्ड" अभियान का 'अभियान प्रतिक सूत्र" (Brand ambassador) बनाया है ("बेहद बचाओ अभियान का")। वह हमारी अभियान प्रतीक्षू होंगी और इस अभियान को जो हमने प्रारम्भ किया है। आप सब स्वास्थ्य मंत्रियों के माध्यम से, हर राज्य में ले जाना चाहते हैं। हर स्कूल में, एक-एक बच्चे को इस प्रतिबद्धता अभियान से जोड़ना चाहते हैं।

हमारे 6 कार्यक्रम राष्ट्रीय स्तर पर चल रहे हैं। कश्मीर, मलेरिया, एड्स, कृष्णा, कुर्शोग, वृत्तिहीनता। हमने हर कार्यक्रम पर एक छोटी प्रस्तुति रखी है। हम चाहते थे कि एक-एक पर हम बात करें। टी बी का कार्यक्रम बहुत सफलता से चल रहा है और मुझे बहुत संतोष है। उस पर। डाउट्स कंट्रो जब से आये हैं तब से हमने बहुत रोग्यक्षिप्तदर (recovery) प्राप्त की है। हमारी रोग्यक्षिप्त दर बहुत बढ़ी है लेकिन अभी 70 प्रतिशत जनसंख्या को उससे ला सकते हैं, बहुत ज्यादा उसमें हम चाहते हैं कि 100 प्रतिशत स्वास्थ्य की जनसंख्या को हम उसमें लाये। जहां तक मलेरिया का स्वागत है मुझे संतोष नहीं है उस पर। कंट्रो से जो चीजें दी जाती हैं बहुत से राज्य उसे उठाते ही नहीं है और जो उठाते हैं वो उसका पूरा सदुपयोग नहीं करते हैं। हम लोगों ने तय किया है कि जिन राज्यों में इसलिए नहीं उठाया जाता है कि दुलाई का खर्चा नहीं है। हमारी इस बार के नये कार्यक्रम में उन्हें दुलाई खर्च (Transport) देने की बात की है कि चलाए, हम देते हैं दुलाई खर्च मगर उठाईए। ये वे बीमारियां हैं जिनके इलाज के बजाय रोकथाम करना कहीं ज्यादा प्रभावी होता है। जब हम मलेरिया पर चर्चा करेंगे, तो इस पर और ज्यादा विस्तार से चर्चा कर पायेंगे। एड्स का हमारा पूरा कार्यक्रम राज्यों में गठित सोसाइटियों के माध्यम से चलाया जाता है। अभी तक हमने उन तमाम राज्यों की सोसाइटियों की बेंक बुलाई है। बहुत अच्छी चर्चा हुई, लेकिन एक कमी जो उसमें खलती थी वो कार्यक्रम राज्यों की सोसाइटियों, गैर सरकारी संगठनों के माध्यम से चलाते हैं लेकिन हर गैर सरकारी संगठन हर क्षेत्र में काम कर रहा है और काम केवल सूचना, शिक्षा और संचालन का कर रहा है। हमने कहा कि कार्यक्रम को और रोग कैंस्ट्रिट बनाने की जरूरत है। हमारे अलग-अलग क्षेत्र हैं। एड्स ब्रांड छावनीकार (Commercial Sex Workers) में हैं। एड्स दुकान वालों में है। एड्स के बारे में शिक्षा स्कूलों और कालेज में में देने की जरूरत है, वह एक अलग क्षेत्र है। एड्स नशा खानेवालों (drug abusers) में है। एड्स जो माता-पिता से बच्चे को आता है वह पांच अलग क्षेत्र है। हम गैर सरकारी संगठनों से पूछे कि वे कौन से क्षेत्र में काम करना चाहते हैं और एक क्षेत्र उन्हें सौंप दें। उस क्षेत्र का दायरा उन्हें सौंप दें।
जो व्यावसायिक यौन कार्यकर्ताओं के क्षेत्र में काम कर रहे हैं वो गैर सरकारी संगठन वहाँ पर रह करके उनकी पूरी कंडोमों की आवश्यकता का आकलन करने और उसकी पूरी सदस्यां राष्ट्रीय एड्स नियंत्रण कार्यक्रम (नाको) सुनिश्चित करें। ज्यों दुर्दंश हैं ये बात कहते हुये कि एक नया विवाद छिड़ गया है कि शायद कंडोमों की सलाह हम बंद करना चाहते हैं या कम करना चाहते हैं या घटाना चाहते हैं। मुझे नहीं मालूम ये बात कहां से आयी। मैं एक बात आज दावे से इस मंच पर कह सकती हूँ कि लक्षित अंतरालशेष (Target interventions) के लिए कंडोम सदस्यां ने की जो बात और जो जो मैंने अपने आने के बाद किया है शायद मेरे से पहले किसी भी पूर्वरोची स्वास्थ्य मंत्री ने नहीं दिया। ध्यान वालिया यहाँ पर बैठे हैं ये सुत्र मैंने उन्हीं की बात से पकड़ा था, वे मुझे मिलने आये थे। मैं उन्होंने मुझे जानकारी दी कि मैंडम, हमारे यहां अंतर इतने ज्यादा है। उन्होंने मुझे कहा कि उन्होंने अकेले जी बी रोड का मान्यता बनाया। वहाँ 5000 यौन कार्यकर्ता काम करती हैं और ओसमत आठ अंतरालशेष रोज होते हैं। अगर आठ अंतरालशेष (इंटरवेशन) 5000 यौन कार्यकर्ताओं का है तो 40,000 कंडोमों प्रति दिन की जरूरत है और अगर हम 25 दिन मान कर चलते हैं 1,00,000 प्रति महीने की जरूरत है। तब यह अंतर धूल हो रहा है। वहाँ से सूत्र पकड़कर हमारे (नाको) राष्ट्रीय एड्स नियंत्रण संगठन का कहा कि आप हर इस तरह की बस्ती में गैर सरकारी संगठनों को लगा दिखिए वे पर्यवेक्षण करें, अपनी आवश्यकता बताये और वे पूरी की अवस्था अपनी सदस्यां राष्ट्रीय एड्स नियंत्रण संगठन की (नाको) सुनिश्चित करें। इसका बाल देते हुए हमारे एड्स सोसाइटी को भेजा। जब हम एड्स की चर्चा करते हैं तो एक प्रस्तुति उस पर है बाकी विषय से पर चर्चा करें। इसी तरह कुल्ले का काम काफी से ज्यादा अच्छे से बल कर रहा है बल्कि, मुझे खुशी है समाज में मो धारणा कुल्ले के साथ जुड़ी हुई थी वह धीरे-धीरे ठीक हो रही है। और अब बाहर इलाज करने के बजाय, घर में इलाज करा रहे हैं। कृपयाधीनता में काफी से ज्यादा गति आयी है लेकिन बीच बीच में जो घटनायें हो जाती हैं, यह स्मार्टाविड्स के आपरेशन में आक्षेप खराब होने की बात आती है, समाज देखने की बात आती है उससे झटका लगता है, इस तरह के अभियान को। इसलिए कहीं ज्यादा दुर्दंश है कि ऐसी घटनायें न घटें। रूसी से वे वे हम लोग केन्द्र से संस्थाओं को ही दें इसलिए उससे दिन निकले कि जो ही दें इसलिए उससे कितने की ज्यादा कर्मकर्ता उत्तम नहीं है। मुझे लगता है उसमें जांच के का आवश्यकता है। बहुत से जन जागरण से, किंसरों जा सकते हैं पर किंसर के क्षेत्र में, जो सबसे बड़ा काम हुआ है तो वह हुआ है तबाकू के उत्पादन पर जो विज्ञापन आते थे उन पर प्रतिबंध लगाने वाला। क्योंकि जब हम किंसर की बात करते हैं तो उसमें से 90 प्रतिशत किंसर जो मुख्यो (oral) किंसर हैं, वे तबाकू
के उत्पादन से होते हैं, खासीतौर पर चबाने वाले तम्बाकू से होते हैं मुंह का कर्सर, जबान का कर्सर, होंठ वा कर्सर, गले का कर्सर, 90 प्रतिशत चबाने वाले तम्बाकू से होता है तो एक बहुत बड़ा काम उस विविधता (Legislation) को लाकर हुआ। लेकिन परिवार कल्याण की तरफ एक और बड़ा कार्यक्रम, जिसमें हमें बहुत बड़ा झटका लगा वह है पोलियो मुक्ति का। ये कार्यक्रम बहुत ज्यादा गति से शुरू किया गया, बहुत उत्साह से किया गया, बहुत सफलता से आये बढ़ा। एक लक्ष्य रख लिया हमने 2005 में भारत पोलियो मुक्त हो जायेगा। 1934 मामले (cases), 268 पर आकर खड़े हो गये। हम 4: सुखा चक्र किया करते थे इसमें वर्तमान टीकाकरण के, दो राष्ट्रीय दिवस और 4 उप राष्ट्रीय दिवस लेकिन कहीं न कहीं लगवा लगा कि अगर 268 मामले हैं तो चक्र पर पैसा खर्च करने की क्या जरूरत है। चलो दो चक्र से ही काम चल जायेगा। वे एक ऐसी मूल थी जिसमें हमें विपिस 1634 मामलो में लाकर खड़ा कर दिया। वह जो थोड़ी सी हम कंजुरी कर गये कि शायद अब पैसा खर्च करने की जरूरत नहीं है। अब हमें तीन गुना पैसा खर्च करना पड़ेगा। और अंतर्राष्ट्रीय जगत में जो हमारी किस्मत हुई है जो हमें शरम सार होना पड़ा, उसका तो कोई मूस्ती ही नहीं है, उसकी कोई कीमत भी नहीं है। जिस तरह हम यह कहते हैं कि एक बच्चा छूट जाये तो सुखा चक्र दूर जाता है। इसलिए हम उन राज्यों को दोषी उत्तराधिकार हैं, जिन राज्यों में पोलियो वैपिस आया। हमें यह अंतर्राष्ट्रीय जगत में अगर एक भी देश में पोलियो बच जाता है तो विश्व से पोलियो जाता नहीं, वहां हमें कठिनाई में खड़ा किया गया और कहा गया जब तक भारत से पोलियो वैपिस नहीं होता तब तक विश्व से पोलियो वैपिस नहीं होगा। इसलिए यह एक अभियान ऐसा है जो वैपिस उसी उत्साह से हमें लेना होगा। जिन राज्यों में पोलियो पुन: उद्धृत हुआ है मुझे खुशी है कि जब उनको बात बतायी गयी तो उन्होंने इसको काफी से ज्यादा मुस्तेदी से लिया है और जो पिछले दो चक्र हमारे हुये हैं क्योंकि हमने फिर से तय किया कि हम 4: चक्र फिर से करेंगे, दो राष्ट्रीय दिवस और चार उप राष्ट्रीय दिवस और उन राज्यों में हमें वे उप राष्ट्रीय दिवस पूरे किये जहां इसका पुन:उद्धृत (resurgence) जहां इसके मामले वैपिस आये थे और दोनों बार के आंकड़े, जो दो चक्र हमने किये हैं उसके आंकड़े बहुत ही संतोषपूर्वक है, बहुत ही उत्साह करने वाले हैं, लेकिन कुछ नये राज्यों में एक-एक दो-दो मामले आ गये हैं वे धिनात्मक है। हमें पहले ही जिसे कहते हैं (nip the evil in the bud), शुरू में ही पकड़ना शुरू में ही पकड़ना पड़ेगा कि कटाई किसी तरह की न हो, ढिलाई किसी तरह की न हो, ताकि जो हमने नया लक्ष्य रखा है कि सन 2004 तक हम इसको शुरू स्तर तक ले आयेंगे और तीन वर्ष बाद सन 2007 में हमें पोलियो मुक्त भारत का प्रमाण पत्र मिल जायेगा। कम से कम इस लक्ष्य को हम प्राप्त करें।
मैंने प्रारम्भ में आप से कहा था कि आज की इस बैठक को रस्मी बैठक नहीं बनाना चाहते इसीलिए दोनों दिन जो सत्र चलेंगे, आज चार बजे तक हम स्वास्थ्य के मुद्दों पर बात करेंगे। उसके बाद पूरा एक सत्र भारतीय चिकित्सा पद्धति के तत्माम विषयों को लेकर होगा। कल हम दोपहर के भोजन तक परिवेश कल्याण के कार्यक्रमों की चर्चा करेंगे और आखिर के दो घंटों में जो प्रस्ताव यहां से पारित होंगे उन प्रस्तावों को पारित करके कोई निर्णयात्मक भूमिका यहां से लेकर के चलेंगे। मुझे लगता है कि आदरणीय श्रीकावर्ज जी के प्रेरक शब्दों के बाद एक नई उर्जा, एक नई ताजगी के साथ, हमारी चर्चा की शुरुआत होगी और उस चर्चा का निर्णय इतना समाधान कारक होगा कि अगले दो वर्षों तक हिन्दुस्तान के स्वास्थ्य का परिदृश्य बदलने में हम सब साथ-साथ चलकर उस वेद अन्त में के कारण जिसको खासतौर पर हमने चुना-"समग्र चतुर्वेदी समवेतत्त्व इकट्ठे चलें, इकट्ठे बोलें, इकट्ठे निर्णय करें और निर्णयों को अमली जामा पहनाकर देश के स्वास्थ्य परिदृश्य को सुधारें। उसको हम लोग सार्थक करेंगे।

बहुत-बहुत धन्यवाद, नमस्कार।
महामहिम उपराधूपति, श्री मैथी सिंह शेखावत - उद्घाटन भाषण

श्रीमती सुषमा स्वराज, स्वास्थ्य एवं परिवार कल्याण मंत्री, श्री ए. राजा, स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री, श्री के सुब्रमण्यम, सदस्य योजना आयोग, श्री जे वी आर राज, स्वास्थ्य सचिव, श्री दीपा होटा, परिवार कल्याण सचिव, डा. एस. पी अग्रवाल, महानिदेशक स्वास्थ्य सेवा, श्रीमती मालती सिंहा, सचिव भारतीय चिकित्सा पद्धति एवं होम्योपैथी, राज्यों के माननीय मंत्रीगण एवं अधिकारीगण।

मैं श्रीमती सुषमा जी के प्रति बहुत आभार प्रकट करना चाहूँगा कि आज के समस्त में मुझे आभारित किया। आमंत्रण कृपया दिया गया इसके कारण भी सुषमा जी ने बताया। लेकिन एक कारण और है कि इस देश में एक प्रकार का मिथक प्रचलित है कि जिसे लड़का नहीं होता वो स्वर्ग में नहीं जाता। संयोग से इसके भी एक लड़की है, जिसे ये लड़की है लेकिन इस बात की चिंता नहीं है। मन में तो विश्वास है कि जायेंगे तो ज्ञान में जायेंगे। वे भी एकसंयोग है कि हमारे राष्ट्रपति जी अविवाहित हैं और उनके कोई बच्चा नहीं है। अब देखिए क्या संयोग बैठ रहा है। तो मुझे आमंत्रण दिया उसके लिए में उनका बहुत आभार प्रकट करता हूँ।

मैं ऐसा समझता हूँ कि ये समस्या बहुत विकट है। इस समस्या का समाधान केवल प्रस्ताव पारित करने से नहीं होगा, केवल साधन उपलब्ध कराने से नहीं होगा। इस समस्या का समाधान लोगों के मन में प्रतिबद्धता(Commitment) हो और जनता में उस प्रतिबद्धता को बनाए रखने की प्रेषण दे सकें, उससे इसका समाधान होगा। कई बच्चों से इसमें बदलते आ रहे हैं। कई प्रकार की योजनाएं बनायी हैं लेकिन जैसे अभी सुषमा जी ने कहा कि पोलियो का काम बहुत अच्छा चल रहा था लेकिन उसमें भी जो चीजों अपाहिज थे उनको लाने में जितना प्रयास किया जा रहा था, ये उसका परिणाम था कि लोगों ने चिकित्सा ली और उससे बच सके। मैं यहां कहना चाहूँगा कि पोलियो उन्मूलन (eradication) का काम सबसे पहले राजस्थान के चित्तौड़ जिले में आरंभ हुआ था और जिस समय ये योजना बन कर आयी उस समय केवल इतना था कि एक क्षेत्र में, जिले के एक खंड में यह काम कर पाएं, उस समय की सरकार ने फैसला किया कि इसमें भारत सरकार से जो सुविधाएं मिल रही हैं, वैसे ही सुविधाएं राज्य सरकार से मिलेंगी और पूरे जिले को कवर किया। उसके परिणाम बहुत अच्छे आये। मुझे नालूक नहीं है। जो अधिकारी यहां पर बैठे हैं उनमें से कौन कितीजिए जिले में गये और जबक्षण समय योजना बनायी कि ये योजना पूरे देश में लागू की जाए और फिर विशेष सहायता हमें इस संबंध में मिलने लगी और पूरे देश में योजना लागू हुई। मुझे
याद है जिस समय चित्रीड़ जिले के कलक्टर का यहां दिल्ली में सम्मान किया गया।
वो सम्मानित होकर जब आये तो खुशी से आयू आ गये कि मेरे हाथ से बहुत बड़ा काम हुआ। हमने भी उनका सम्मान किया। उस कलक्टर के बारे में इतना ही कह सकता हूँ कि वो प्रतिबद्ध था। उनको इस बात की आवश्यकता नहीं थी कि गांधी निम्न कि नहीं। लोगों को लोगों की भाषा बोलकर उनको प्रेरित करता था। लूटे, लगड़े, अपहरित लोगों को गोद लेने में संकोच नहीं करता था। लोगों में विश्वास पैदा हुआ कि इस बीमारी से मुक्ति प्राप्त कर सकते हैं। तो जैसे मैंने कहा कि योजनाएं अलग रहती हैं, साधन अलग रहते हैं, साधनों का सदृश्यों हो और योजना के लागू करने वालों में प्रतिबद्धता हो। जिस समय जनता में यह विश्वास पैदा होगा कि प्रतिबद्धता के साथ योजना लागू हो रही है तो मैं आपको विश्वास से कह सकता हूँ कि आज जब 100 रु. खर्च होते हैं वहां 10 रु. में लोग उस प्रकार की व्यवस्था कर सकते हैं।

प्रश्न ये उत्तर है कि हिंदुस्तान में स्वास्थ्य के बारे में चिन्ता की जा तो यह सही है लेकिन आपको मानूस है कि सुप्रीम कोर्ट ने अभी हमारे मौलिक अधिकारों(fundamental rights) के विषय में कुछ वर्ष पहले निर्धारित दिया है कि हमें जीने का तो अधिकार है, इसमें कोई सन्देह नहीं है। संविधान निर्माताओं ने जीने का अधिकार दिया है। लेकिन सुप्रीमकोर्ट ने ये कहा कि "सम्मान के साथ जीना" (live with dignity) उसके बाद, "सम्मान" में "शिक्षा" आ गयी। फिर "सम्मान" में गरीबी का उन्मूलन आ गया। इस "सम्मान" में स्वास्थ्य सेवाएं आ गयी। तो आज हमारे संविधानिक अधिकार (Constitutional rights) हैं। ये किसी का एहसास नहीं है कि इन अधिकारों की पूर्ति करने के लिए, प्रति इन अधिकारों का उपयोग कर सकें। हमें इस प्रकार की व्यवस्था करनी पड़ी जिससे लोग सम्मान के साथ जीना रह सकें। मैं इसलिए कह रहा हूँ कि तीन चीजें परंपरा जुड़ी हुई हैं, गरीबी, स्वास्थ्य और शिक्षा।

इन तीनों का ही एकीकृत (integrated) कार्यक्रम होगा। उस एकीकृत कार्यक्रम के आधार पर हम इसको लागू कर सकते हैं और अगर हमने अलग अलग इन तीनों क्षेत्रों को लिया तो ठीक है ज्यादा काम है, अलग अलग व्यवस्थाएं होगी लेकिन उनका एकीकरण जबरदस्त होना चाहिए।

जैसे हमारी आज देशी दवाई, आयुर्वेद, यूनानी, योगा और एलोपेथिक, होम्योपेथिक इन सारे उपचारों की चर्चा हुई। भाषण जरूर होते हैं लेकिन मैं आज कह सकता हूँ, मेरा गांव का भी रहने का अनुभव है, राज्य में रहने का भी अनुभव है, सत्ता में भी रहने का अनुभव है, विशेष दल में भी रहने का अनुभव है। मैं ऐसा समझता हूँ...
कि आप चाहे उनका कितना ही मनमुड़व दूर करने की कोशिश करें लेकिन काटने वाला कोई अमीरका नहीं आ रहे हैं, काटने के लिए आस्ट्रेलिया से नहीं आ रहा है। ऐत्योपेथिक पद्धति दूसरी पद्धति को आगे बढ़ने नहीं देना चाहती है। दूसरी पद्धति एल्पयोरेथिक पद्धति की बुराइयों की चर्चा करती है। आज होम्योपेथिक है, होम्योपेथिक, डॉक्टर से पूछे तो वो कहे या की वे सारी पद्धतियों करार करता है। केवल में जो सिस्टम चला रहा हूँ, वो सबसे सस्ता है, उससे तुरंत इलाज होता है। इसलिए इन पद्धतियों का एकीकरण किस प्रकार से हो और एकीकरण करने के लिए पहले जो इन (सिस्टम) पद्धतियों से जुड़े हुए हैं उनके दिमाग से इस प्रकार की भ्रातियों दूर हों कि इलाज करने का एकाधिकार केवल एल्पयोरेथिक का है, इलाज करने का अधिकार केवल आयुर्वेद का है या होम्योपेथिक का है। मैं ऐसा समझता हूँ और सुप्रमा जी से विशेष आशा करता हूँ कि पद्धतियों के इस एकीकरण में जितनी भी अड़चनें हैं उन अड़चनों को किस प्रकार से दूर किया जायें, इसके बारे में चेष्टा करें। आज गांव में आयुर्वेद का वैद्य भी इन्जेक्शन लगाता है, वो भी एल्पयोरेथिक दवायों देता है तो ऐसा सिद्ध हो गया है कि डॉक्टर है या वैद्य है, इस में पहचानना बहुत मुश्किल है। इसलिए कोई ना कोई ऐसी व्यवस्था करनी पड़ेगी, जिस व्यवस्था के अधार पर हम ये सब करें।

मुझे याद है कि कुछ दिनों पहले में नेता जी सुभाष चन्द्र बोस, इनकी पुस्तक पढ़ रहा था। उस पुस्तक में एक जगह संदर्भ आया है। हरिपुरा कांग्रेस अधिवेशन में सुभाष चन्द्र बोस क्या बोले में आपके सामने पढ़कर सुनाना चाहीया। "आजजाद भारत के संबंध में, सबसे पहली समस्या जो हल को जानी है वह है हमारी बढ़ती हुई जनसंख्या की।" With regard to free India, the first problem to tackle is that of increasing population." ये 1938 में बोल रहे हैं। आज नहीं बोल रहे हैं। 1938 में सुभाष चन्द्र बोस बोल रहे हैं कि हमारे सामने सबसे बड़ी समस्या है वह है जनसंख्या वृद्धि की। उन्होंने ही "समाज सहित जीवन जीना। To live life with dignity." उसे जीता है। उन्होंने कहा कि जहाँ गरीबी, भूलभुलाई और रोग अपने चरम पर हैं वहाँ हम जनसंख्या का बौखलाव बढ़ाते चले नहीं जा सकते। अतः यह अच्छा होगा कि हम अपनी जनसंख्या को तब तक सीमित रखें जब तक कि हम उन सभी को भोजन, कपड़ा और शिक्षा न प्रदान करें जो कि पहले से मौजूद हैं।

सन् 1938 में जिस समय बच्चा था, मेरी दादी मां जब पूजा करके उत्तरी थीं तो कहती थीं, कि 33 करोड़ देवी-देवताओं की जय हो। हमारे समझ में नहीं आता था कि 33 करोड़ देवी देवता क्या हैं। मेरे घर के पास एक घुनाथ और एक हनुमान जी का मंदिर था। हम तो दो ही मंदिर में जाते जाते परेशान हो जाते हैं। अगर ये 33
करोड़ पर जाना पड़ा तो हमारी स्थिति क्या होगी। तो मैं अपने अध्यापक से पूछा कि 33 करोड़ का मतलब क्या है। 33 करोड़ जनसंख्या है। उस जनसंख्या को देवी-देवता के रूप में पूजा करते थे। आज 102 करोड़ हैं, कहाँ कहाँ जाएं। किसी पूजा करें। किस प्रकार की पूजा पढ़ाती हो। ये बहुत बड़ी समस्या है। तो इस संबंध में भी आज के इस समय में हम चाहते हैं कि राजस्थान सबसे ज्यादा अग्रणी रहे। राजस्थान में जब इस समस्या को देखा तो राजस्थान के अंतर्गत होने के और भी कई कारण थे। राजस्थान ज्यादा प्रकृति पर निर्भर करता है। हमारे यहाँ कई कई बरस, चार बार बरस कहीं हुई, पांचवें वर्ष बरस हुई। कई तरह के संकट थे। लेकिन जनसंख्या लगातार बढ़ रही थी। तो सबसे पहले राजस्थान में एक कानून बनाया। दो बच्चे होने के मानक (2 child norm) का कि दो से ज्यादा बच्चे होंगे या अपात्र (disqualify) हो जायेगा, पंचायत और नगर निगम के चुना के लिए अपात्र के साथ यह कह दिया कि जिसके आज के दिन जितने बच्चे हैं वे चुना लड़ सकते हैं, लेकिन आज के बाद, आज अगर दो हैं, कल तीन हो गए (एक वर्ष का समय अंतराल जरूर दिया गया) वो अपात्र हो जायेगा। अब उसके अनुसार कई प्रकार के कई राज्यों ने कानून बनाया। कानून सुप्रीम कोर्ट में चला गया और सुप्रीम कोर्ट ने कहा कि राज्यों ने जो कानून बनाये हैं उसमें किसी प्रकार की कमी नहीं है। आज दो बच्चे होने के मानक का सिद्धांत अलोकप्रिय नहीं है। कोई इसको कहे कि अलोकप्रिय है। मैं ऐसा समझता हूँ कि मैं उस समय मुख्यमंत्री था। मैंने सभी की और ज्यादा महिलाओं की समाएं की आज लोग कहते हैं कि महिलाओं का विरोध है। महिलाओं का विरोध नहीं है। महिलाएं तो यही चाहती हैं। ये विरोध कर रहे हैं तो पुरुष कर रहे हैं। महिलाओं के विरोध करने का कोई सवाल नहीं होता। इसलिए आज आवश्यकता इस बात की है कि हम इस व्यवस्था को किस प्रकार से लागू करें।

में आपको एक छोटा सा किस्सा सुनाना चाहींगा। जब मैंने कानून लागू किया। ये इस बात की खुशी है कि सर्व सहमति से कानून पास हुआ और किसी ने विरोध नहीं किया। विरोध करने के बाद, एक फिल्म निर्माता मेरे पास आये और कहने लगे कि एक जनसमाधि में हम इस पर एक भाषण को सुनना चाहते हैं। मैं चला गया। हमारे ढेढ हजार आदमी थे। मैंने कहा कि ये भाषण देने की जरूरत नहीं, मेरा संबंध ही हो जाये तो अच्छा है। उन्हें हो समय में मैं भावगत कर लुंगा। तो मैंने उनसे पूछा कि जिसके कोई बच्चा नहीं है वो मेरे साथ फोटो खिचवा ले। दो आदमी आये। मैंने उनसे फोटो खिचावायी। फिर कहा कि जिसके एक ही वो मेरे साथ आ जाये वो भी चार पाच मिल गये। फिर मैंने कहा कि जिसके सबसे ज्यादा हो वो मेरे साथ आए। तो एक ग्यारह वाला आ गया। बड़े संकोच से लोग धक्का दे देकर उसको लाये। मैंने आते ही
उसको धन्यवाद दिया। मैंने कहा तुमने एक घर में फुटबाल की टीम पेदा कर ली।

इसके लिए आपको बहुत-बहुत धन्यवाद! लेकिन उसका जीवन वृतांत टेप रिकॉर्ड है।

मैंने उससे पूछा कि ग्यारह बच्चे हैं उनको कैसे पढ़ता है। उसने कहा कि पढ़ा नहीं पाता है, स्कूलों में भेजता हूँ, जो पढ़ लेते हैं नहीं तो बाहर चले जाते हैं। मैंने कहा कि किसी ने आठवीं पास किया है। उसने कहा नहीं। तेस्री रोटी का क्या प्रबंध है? रोटी का प्रबंध नहीं है। मजबूरी करते हैं। रात को दारू पीते हैं। कई बार मैं शिकार हो जाता हूँ, उनकी मारपीट का। लेकिन मैं भाई के पास रहता हूँ। भाई क्या कर रहा है? जितनी मेरी 23 वीं जमीन है उतनी ही उसके प्राप्त है। उसके दो बच्चे हैं। एक बच्ची और एक बच्चा है। बच्चा तो वकील बन गया और बच्ची डाक्टर बन गयी है।

जयपुर में मकान बना लिया। यहाँ मकान बना लिया। 23 वीं जमीन में एक ट्वूबवेल खुदा लिया। उसी भाई के पास में रहता हूँ। हमने लोगों के सामने इस प्रकार के उदाहरण रखे। यारह बच्चे वाले की क्या निधित्व है। दो बच्चे हैं। उसकी क्या स्थिति है। हमने इस बात का काफी प्रचार किया। हमें इस बात की खुशी है कि इस प्रचार से राजस्थान में इस प्रकार का जनमानस बना। तो हमें इस पर भी विचार करना होगा। अब गरीबी कैसे मिटे। इस गरीबी की समस्या का समाधान करना आसान नहीं है, लेकिन ये जनसंख्या कम होगी तो कम जनसंख्या में व्यापत गरीबी को हम ठीक प्रकार से मिटा पाएंगे।

अब गरीबी के संबंध में हमने 1977 में श्री जय प्रकाश जी के कहने से उनके आदेश से अन्त्योदय का कार्यक्रम लिया था। अन्त्योदय का कार्यक्रम कभी चला कभी नहीं चला। लेकिन अन्त्योदय की अवधारणा(concept) ऐसी थी, जिस अवधारणा में सरकारीकरण नहीं था। जो अन्त्योदय परिवार थे, उनमें एक बार यह विश्वास जगा दे कि सरकारी योजना नहीं है, ये योजना तुर्कार है। उस योजना को यदि तुमने सफल बनाया तो इसका परिणाम वोटों में नहीं आयेगा। इसका परिणाम सरकार की प्रसंसा में नहीं आयेगा। इसका परिणाम इस रूप में निकलेगा कि तुमने अपने घर की व्यवस्था इस प्रकार से कर ली जिसमें आपको किसी प्रकार की समस्या न खड़ी हो। यह इस गरीबी को मिटाने के लिए अब धीरे-धीरे एकीकृत ग्रामीण विकास( integrated rural development) बन गया। बनते-बनते वापिस फिर से अन्त्योदय बन गया। लेकिन अन्त्योदय की अवधारणा उस समय जो थी कि लोगों की प्रतिबद्धता इस प्रकार हो कि सरकारी योजना नहीं है, ये हमारी गरीबी को मिटाने की योजना है। जब तक लोगों की इस प्रकार की मायात्मा नहीं बनेगी, गरीबी उन्मूलन का कोई भी कार्यक्रम हो, जब तक गरीब सक्रिय नहीं होगा तब तक गरीब का शोषण रुकना नहीं, गरीबी मिटेगी कभी नहीं। इसलिए ऐसे कानून जैसे सुधा जो कि मैंने एक बार राज्य सभा में कहा कि ये
दवाएँ में मिलावट आती है। इस मिलावट के संबंध में क्या कर सकता है? उन्होंने कहा कि कानून जिस प्रकार का बना हुआ है, में ज्यादा कोई सक्षम काम नहीं कर सकता। लेकिन उस समय लोगों की इच्छा थी कि दवाओं में मिलावट करने वालों को फायदा की सजा दी जाये तो कोई आपत्ति नहीं होगी। मुझे खुशी है कि उस समय सुषमा जी ने कोई वचनबद्धता (direct commitment) नहीं की। लेकिन ये मेरी भी इच्छा है कि संसद इसको अनुमोदित कर दे तो इस प्रकार के मिलावट करने वालों की मौत की सजा मिलनी चाहिए। अब ऐसी स्थिति में मैं यह कहना चाहूँगा कि दवाओं विना मिलावट की मिलें लेकिन सबसे बड़ी समस्या यह है कि दवाओं की कीमत बहुत बढ़ गयी है। गरीब उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है। मैं अपने गांव में रहता था तो इस समय आयुर्वेद की दो रुपये की सबसे बड़ी गोली दे दी तो मानकर चलते अयोग्य उस कीमत में दवाओं नहीं लेता है।
पकड़ने के बाद उन गरीब रोगियों से पूछा कि दवाईयाँ तुम्हें कैसे मिलती है किसी गरीब ने शिकायत नहीं की। जहां इस प्रकार के साधन सम्पन्न और प्रभावशाली व्यक्ति थे वहां सब प्रकार की शिकायत कर दी। सफाई नहीं है, डाक्टर समय पर नहीं आता, इंजेक्शन ठीक नहीं आते। अंतर यह था कि जब प्राइवेट अस्पताल खुले तो ये पैसे वाले बड़े अधिकारी, उन प्राइवेट अस्पतालों में जाने लगे और सरकारी अस्पताल में उन गरीबों के लिए आवश्यक होने लगे। गरीबों का उपचार होने लगा। तो गरीब से आप पूछे, कि मैं बिल्कुल गरीब हूँ और मैं यदि अस्पताल में चला गया। घर पर खाने को नहीं मिलता, मुझे अस्पताल में दिलिया मिलने लगा। मुझे अस्पताल में दूध मिलने लगा। मेरे लिए दूध और दिलिया ये सबसे बड़ी खुशी थी जो घर पर नहीं मिलती थी और उन लोगों को दूध और दिलिया दे दिया तो बोलेंगे कि दूध में मिलावट है। तो वे दूध किस डेढ़ से आया है किस भाव से आया है। वो डाक्टर और डक्टर को डांटने की कोशिश करें। डाक्तर और कम्पाउन्डर उनसे दूध लाने के लिए कहेगा कि आप अपने घर से मंगवा ले उन्हें। इससे उन सब लोगों की मानसिकता का नंतर घर पर हमें काम करने की कोशिश करनी पड़ेगी।

मैं तो समझता हूँ कि यहां डूब्यू टी ओ का पेटेंट करने की जो प्रणाली है उसके कारण से हिन्दुस्तान में दवाइयाँ महंगी होंगी। उन दवाइयों की मंहगाई से किस प्रकार से बचाया जायेगा उसका भी पूरी तरह से इलाज करना पड़ेगा। यदि हम उसका इलाज नहीं कर पायें तो ठीक नहीं होगा। मेरा कहने का मतलब यह है कि गरीबी मिटे, गरीबी के साथ अशिक्षा मिटे, और शिक्षा के साथ परिवार के पास स्वास्थ्य सेवायें हों, तब तीनों का असर होगा कि हम अपनी जनसंख्या को किसी भी तरह से कम कर सकें। जनसंख्या जब तक कम नहीं होगी तब तक आप साधन बढ़ाते जाओ, जनसंख्या बढ़ती जाएगी। और जैसे आपने कहा कि नई नई बीमारियाँ पैदा होती जायेंगी। नई बीमारियाँ, नये साधन, नई जनसंख्या, ये सब चीजें अगर हो भी गयी तो जितना हम करना चाहते हैं उस प्रकार का प्रबंध हम नहीं कर पायेंगे।

आज का यह सम्मेलन इस दृष्टि से बहुत ही महत्वपूर्ण है। आपको मानना है मानव विकास सूचकांक (Human Development Index) के अनुसार से हम 127 वें स्थान पर हैं। हिन्दुस्तान जैसे देश के लिए बहुत ही शर्म की बात है। कितनी योजनाएं बन गयीं और इतनी योजनाएं बनने के बाद भी हम यदि उसी स्थान पर बैठे हैं तो अफ़ग़ानिस्तान देश को क्या कहेंगे। जहां एयर एयर एयर।
तेजी से फैल रही हैं। कुछ नहीं कह सकते। इसलिए में चाहता हूँ कि एक प्रतिष्ठा का प्रश्न बनाकर बताये दुबारा मानव विकास का सूचकांक बने तो उस समय 127 पर नहीं रहे बल्कि इस प्रकार के अंकों में पहुंचा दे जिसमें सारा संसार भारत से प्रेरणा देने की कोशिश करे कि गरीबी का उन्मूलन किस प्रकार से किया है अशिक्षा का किस प्रकार से उन्मूलन किया है, बीमारियों का इलाज किस प्रकार से कराना शुरू किया है। उस आधार पर यदि हम काम करेंगे तो सबसे बड़ी बात होगी।

जहाँ तक सुषमा जी ने कहा और हमारे सचिव महोदय बोल रहे थे। इससे ये मत समझना कि में राज्य विभाग का प्रतिनिधित्व कर रहा हूँ। लेकिन में एक बात कहना चाहता हूँ कि राज्य के संसाधन (Resources) सीमित हैं। आप यह समझें कि हम राज्यों में बरसाति के हिसाब से बंटवारा कर सकते हैं, जनसंख्या के आधार पर बंटवारा कर दे। राज्य के वास्तविक वित्तीय स्थिति क्या है, उनके सारे वित्तीय साधन कहां जाते हैं, कौन सी आवश्यक चीजें हैं जिनमें राज्यों को उन वित्तीय साधनों से काम लेना पड़ता है, यदि इस बात को ध्यान में नहीं रखा गया और केवल जनसंख्या के आधार पर बंटवारा किया गया तो उससे काम चलने वाला नहीं। कई वर्षों से लगातार 7 राज्यों में अकाल पड़ता आ रहा था। अब आज उनके सामने रोटी का प्रबन्ध करना उनके लिए महत्वपूर्ण है या दवाई का या आपकी योजना को लागू करना उनके लिए आवश्यक है। पहला सबवाल है, रोटी नहीं आयेगी तो आप चाहे जितनी दवाई देंगे उसकी मीठ होगी। लेकिन रोटी का प्रबन्ध करने के लिए राज्य अपने वित्तीय साधनों को लगाते हैं तो वित्त का बंटवारा इसी हिसाब से होना चाहिए कि इस बंटवारे से हम स्वास्थ्य सेवाओं पर ज्यादा से ज्यादा ध्यान दे और इस दृष्टि से में सुषमा जी से यह कहना चाहूँगा, कि सारे राज्य में परिवर्तन नियोजन किस प्रकार से लागू किया जाता है उसको लागू करने में किसको कितनी सफलता मिलती है, उस सफलता का एक मापदंड राज्य के वित्तीय साधनों के साथ जोड़े दे तो ये कार्यक्रम भी निश्चित रूप से आगे बढ़ेगा। और ये कार्यक्रम जब आगे बढ़ेगा तो कई समर्थनों का समाधान अपने आप ही हो जायेगा। में इतना कहना चाहता हूँ कि तीनों चीजें एकीकृत हैं, इनके प्रति यदि एकीकृत दृष्टिकोण नहीं होगा, इनको एकीकृत रूप से अगर हम लागू नहीं कर पाये और इस एकीकृत दृष्टिकोण के लिए हम लोगों में प्रतिवेदन दैव नहीं कर पाये तो कितने ही भाग्य दे, कितनी ही योजनाएं बनायें, ये सब में तो 50 वर्षों से देखता आया हूँ। आज एक दिन कोई उपाय नहीं होकर, मैंने तो कुछ देखा नहीं लेकिन गांव में पैदा होकर उपाय नहीं पहुँचा है। उस समय तक मेरा अध्ययन हर विषय का रहा है। इसलिए में मानता हूँ कि इनका एकीकृत दृष्टिकोण होगा, एकीकृत दृष्टिकोण ही इन तीनों का समाधान कर सकता है।
मेरा विश्वास है कि इस सम्मेलन में इस एकीकृत दृष्टिकोण का आप निश्चित रूप से ध्यान रखेंगे और इसको लेकर एक नई चीज सारे देश के सामने रखेंगे जिससे लोग प्रेरित हों। उस काम को पूरा करने के लिए प्रतिबद्धता करें। इन्हीं शब्दों के साथ में आपको धन्यवाद देता हूँ। पुनः सुषमा जी को कहना चाहता हूँ कि उन्होंने मुझे बुलाकर बहुत ही कृतज्ञ किया है।

बहुत - बहुत धन्यवाद।
VOTE OF THANKS BY DR. S.P. AGARWAL, DGHS

His excellency, the Vice-President of India; Hon’ble Union Minister of Health & Family Welfare; Hon’ble Union Minister of State for Health & Family Welfare; Member, Health, Planning Commission; Hon’ble State Health & Family Welfare Ministers; Hon’ble Members of Parliament; other members of Central Council; officials of the Centre & State Health & Family Welfare Departments and distinguished participants.

It is my privilege to extend a vote of thanks to this august gathering of health administrators, experts and eminent professionals, both in the field of modern and Indian System of Medicine & Homoeopathy and family welfare gathered here today to discuss, review and advise for the betterment of country’s health care system and family welfare measures. First of all I must express on my own behalf and on behalf of the council, our utmost gratitude to Shri Bhairon Singh Shekhawat ji, Hon’ble Vice President of India for sparing his valuable time to be with us. Sir, your presence here today symbolizes your concern for the problems pertaining to the health and family welfare sector and is a source of inspiration for all of us. The illuminating and practical ideas given by you shall serve as a model and immensely help the Council in its deliberations over the two days.

It is our good fortune that we have a dynamic leader of the stature of Smt. Sushma Swaraj as Union Minister of Health & Family Welfare and Chairman of the Council. We are sure that under her inspiring leadership and clear vision of the issues involved, the Council shall be able to perform the assigned tasks with great ease. Madam, your thought provoking and far sighted address has set the ball rolling and laid the broad contours of discussion during the Conference. Our sincere thanks are also due to Shri A. Raja, Minister of State for Health & Family Welfare. We always look upon him for guidance. He is a real asset to this Council.

I also thank Hon’ble Health & Family Welfare Ministers from States and UTs, Members of Parliament, eminent experts and Central and State Government officials who have taken the trouble of travelling from all over the country to participate and enrich the deliberations of this Conference. I shall be failing in my duty if I do not express my
thanks to the officials of M/o Health & Family Welfare and DGHS and especially to the Bureau of Planning who have put in hard work in the organization of this Conference.

Various important initiatives and developments have taken place in the area of health, family welfare and Indian Systems since July.2001 when the last Conference of the Central Council took place. Some of these include policy initiatives like adoption of the National Health Policy, 2002; National AIDS Prevention and Control Policy; National Blood Policy; National Policy on Indian System of Medicine & Homoeopathy, 2002; and various other notifications and guidelines relating to drugs, medical ethics and other public health issues.

You are all aware and in fact the whole world community appreciate as to how SARS (Severe Acute Respiratory Syndrome), a serious public health threat was contained recently under the able leadership of our Hon’ble Union Health and Family Welfare Minister, Smt. Sushma Swaraj. SARS is a new disease. Although contained, it is yet to be seen whether how, when and where it might resurface again; hopefully it may not. However, it is important that we take care of five things:

1) Facilities for separate wards with isolation rooms in major hospitals
2) Strict implementation of hospital infection control measures
3) Training
4) Provision of adequate personnel protection equipment (PPE) for the medical staff
5) Upgradation of laboratories as well as infectious disease hospitals along with separate wards with isolation rooms.

This will help in early detection and quick containment, without panic as it happened this time, of any infectious disease, which might inflict us in future.

The well-considered and extensive agenda covering the important health and family welfare issues has been placed before the Conference for guidance in its deliberations.
The observation and experience that each of you bring, I am sure would go a long way in ensuring meaningful and enriching discussions. The seasoned guidance of the Council members would provide not only valuable inputs to formulate a feasible plan of action but also necessary impetus for its implementation of various policies approved and the recent initiatives taken to improve health care of the population of our country.

Thank you all once again.
D/O HEALTH
28\textsuperscript{th} AUGUST, 2003

\textbf{D/o Health}

Presentations were made initially on communicable diseases (malaria, TB, leprosy, AIDS) and later on non-communicable diseases (blindness, mental health, cancer). These are at Annexure 1.

After the presentation, the Union Minister for Health & Family Welfare invited comments of Ministers from various States.

The \textbf{Health Minister} from Kerala emphasized that there should be an unhindered drug supply by the Central Government. He stated that sometimes, they face shortage of drugs, especially for TB. Private institutions, he opined, should be encouraged to get involved in this programme. He shared the experience of Coonor district of North Malabar of Kerala, where all the private hospitals in the districts participated in their programme and free medicines were provided to them from the State. Mentioning about the shortage of funds he requested for help from the Centre. He said that Kerala was the only State implementing TB Combi Plan, a World Bank assisted project. Having achieved 90\% cure rate for TB, Kerala has been selected as the \textit{node}\textsuperscript{3} State for State training and demonstrative Centre. Regarding HIV / AIDS, he stressed the need for enacting appropriate legislation, for discouraging stigma and discrimination of HIV patients. Anti-retroviral therapy he felt, should be extended to all patients with HIV / AIDS. Central Government should take up the responsibility for providing medicines for the patients suffering from HIV. CD 4 & CD 8 Count, and viral load estimation facilities should be provided in all the districts. Provision of drugs for opportunistic infection especially for TB, blood bank and blood transfusion facilities in all first referral units, and a model blood bank in each district should be established. Regarding leprosy, he informed that Kerala had achieved, the state of elimination but in two districts Trivandrum and Palghat- this disease was still there. Special area programme for these two districts was required to be implemented with the support of the Centre. The Minister mentioned about the 3 institutions / sanatoriums which were established in Kerala during the British period. Many people require rehabilitation to reduce disability. He stated that these three institutions were required to be upgraded in order to underta...
reconstructive surgery. He requested for support for renovation and reconstruction of the old dilapidated buildings of these sanatoriums.

Kerala has malaria problem in the border districts of Karnataka and Trivandrum. He informed about the upsurge of communicable diseases like dengue, leptospirosis and malaria in Kerala. He requested for financial assistance for control of these diseases in Kerala and stated that they should be included in the vector control programme. He also requested for support from the Centre for the Rs.16 crore project for the Kerala Institute of Virology.

The Health Minister from Jammu & Kashmir was thankful to the Union Hon’ble Health Minister for selecting J & K as one of the 6 states where one medical college is proposed to be upgraded. He also congratulated her for all the achievements which had taken place in the health sector after her taking over as the Union Health Minister.

For TB, he informed that 8 districts had been covered under the RNTCP Programme. He requested that the entire state should be covered under this Programme. For AIDS, he said that it took around 4-6 months to ascertain if the person is suffering from this disease. Irrespective of the costs, tests which help to detect the presence of AIDS immediately, need to be encouraged so that this disease is ‘nipped in the bud’. He also emphasized on the need for a mandatory testing for this disease before applying for any job. Strict punishment for spurious/substandard drugs was also stressed upon. He also said that all district Headquarters should have a blood bank.

The Delhi Health Minister began by mentioning that although the progress of the tuberculosis programme in Delhi was very good but there was an increase by 5 lakhs population every year in Delhi. Delhi has only 256 DOTS Centres and 131 Microscopy Centres, which are not enough. Therefore need exists to open new DOTS and Microscopy Centres for which he requested for additional funds. Secondly, he informed that there was no provision of funds for registered TB patients. He requested if something could be done for them. Regarding AIDS, he requested that advertisements
should be given, both in electronic and print media from the Centre as this is a serious problem affecting all the states. Advertisement in one channel on TV, he opined, were just not enough. Charity talks by eminent personalities were required to be encouraged on TV, which is a popular mode of media. Shortage of condoms existed but was manageable. He also requested for a bill on HIV / AIDS so that no HIV/AIDS patient is refused treatment. Although Delhi Government was already working on this bill, it would be more effective if this bill came from the Centre. This must be ensured as around 4.85 million cases of HIV/AIDS are from India. Also, he emphasized on the need to work out a strategy for providing anti-retroviral drugs for such patients. Further, he stated that all states should use disposable syringes and have proper biomedical waste management so that such syringes are properly disposed off after use.

The Health Minister from Orissa, conveyed his gratitude to the Union Health Minister for having convened the Conference and facilitating all to put forth their points. He also thanked her for her pragmatic approach to strengthen the health care system in the country, by her decision to establish AIIMS like institutes in States having a high disease burden, including Orissa. He said that he was sure that the foundation stone having been laid, all efforts would be made to start the construction as quickly as possible.

He felt that if the schemes are implemented with right earnest and with the involvement of the general public, then one could reach the goals laid down. Prevalence of leprosy is very high in Orissa and is more than double the national average. DANLEP, which is phasing out in 2003, he felt should be extended up to March, 2005, in order to reduce this high prevalence rate. The Central assistance being received by the State of Orissa was not adequate to meet the problem; and he therefore, requested for greater assistance from the Centre in the implementation of this programme.

Regarding Malaria too, he informed that Orissa was a major contributor to the total number of cases and deaths. Also 85% of the malaria cases in Orissa were of high risk P-falciparum variety. The IEC activity had been geared up with greater involvement of the Panchayati Raj representatives, NGOs, etc. As the prevalence rate was declining
in the EMCP blocks, he requested extending EMCP to the remaining blocks in Orissa. DDT spray was being done and mosquito mats were being supplied but this was not adequate. Hence, he requested for special funding to cater to their requirements, including that of synthetic pyrethroid to help them contain the problem of malaria in Orissa.

The HIV cases, he mentioned, were much less in Orissa. Vigorous IEC activities had been started to carry the message to the rural areas/interiors. Health care, he felt, could be strengthened, if dedicated officers were posted in villages and they took keen interest to ensure that the message reached the poor, tribal etc. He concluded by mentioning about the shortage of doctors which was an acute problem for providing adequate health care services in Orissa.

The Health Minister from West Bengal initiated the discussion by highlighting the observation made during the presentation on malaria viz. the States have to bear the responsibility including financial responsibility; Centre provides some technical support and so on. But the resurgence in malaria, increasing percentage of P-falciparum out of the total cases and increasing mortality, he felt, was a matter of serious concern. He said that malaria programme did not have a vertical structured programme unlike TB, AIDS and Leprosy and it was becoming impossible for States with meager resources to control malaria. Therefore, he questioned on the possibility of having some support for a vertical structure, particularly in high-risk areas like tea gardens, etc., in West Bengal. The other thing about malaria, he felt was a need to look at the pedagogical aspects. Studies are required to be undertaken to determine the extent of the incidence of Chloroquine resistant malaria etc., which is increasing over the years. To illustrate, he shared the example of district Jalpaigudi where ABER is 20% as against a national target of 10%. Despite that, the incidence has not come down there. Such issues, he felt, were of national importance and the State resources were not adequate to deal with such problems. Also, urban areas do not have the health infrastructure and multi purpose workers which exist in the rural areas. This problem is required to be addressed for all programmes and this means increasing resources. The last Central Council of H&FW, i.e. 7th Conference of CCHFW had unanimously passed the National Health Policy that the
public health expenditure in the country is required to be stepped up from 1% of GDP to 2%. So unless higher resources are mobilized, it may not be possible to deal with such problems. For tuberculosis, he stated that every State should be provided culture sensitivity equipment, even though very expensive.

The Health Minister from Tamil Nadu initiated the discussion by stating the two major problems being faced by them in their state, particularly for malaria. Last year, their Chief Minister had announced a free campaign malaria from September to December for about four months. Steps were being taken by them but the problem was lack of funds. He requested the Centre for greater financial assistance. They were also facing the problem of dengue and in the absence of National Programme for dengue, he requested the Hon’ble Minister for a special package for dengue fever.

The Health Minister from Jharkhand started the discussion by stating that Jharkhand was a new State having maximum number of poor, malnourished and illiterate people. The basic infrastructure had been inherited from the State of Bihar. They on their own are unable to handle the disease burden and various health problems. Therefore, he stated that support from the Central Government for a new State was necessary. He felt sorry that Jharkhand was excluded from the decision to construct an AIIMS like institute. Their State had only three medical colleges equipped for providing secondary care and not tertiary. Therefore, he requested for granting permission for a seventh AIIMS for the State of Jharkhand.

Regarding RNTCP, he conveyed his gratitude for selecting all the districts from the Jharkhand State. Recently they had implemented this programme in 6 districts and in the remaining 16 districts, preparatory phase was in full swing. He was sure that they would be able to implement the RNTCP in all the districts within 5-6 months. Mentioning about the shortage of TB drugs, he emphasized about the necessity to ensure its unhindered supply. The State had no STD centre. They have only one sanatorium from the British period. A proposal to establish a STD centre had been sent and he requested for early approval of the same. He supported the proposal from West Bengal
regarding establishing the culture and sensitivity centre in every State. He also emphasized on the involvement of private practitioners in the RNTCP programme.

Jharkhand is known as low prevalence State, fortunately for AIDS. However many vulnerable areas like national highways, mining and industrial areas exist and also lot of immigration of labour and population take place. Many problems were being faced in the proper implementation of this programme in Jharkhand. Out of 22 districts, only 3 districts have safe blood transfusion centres. Therefore, it was necessary to established safe blood bank in the remaining 19 districts with support of NACO. He requested for approval of the proposal to establish the State Blood Bank of Art in Ranchi and also for opening the VCTCs on the national highways to cover the vulnerable areas.

Regarding Leprosy, the prevalence rate was very high, i.e. 18 per 10000 population when Jharkhand became a new State. This had now come down to 6.5 per 10000 population. Despite four successful MLEC, hidden cases were there even today. Lot of voluntary reporting is also taking place. Total integration of leprosy services had been done with the health system. In order to detect new cases, he requested for a 5th MLEC for Jharkhand. He also expressed the need to construct a reconstructive surgery and rehabilitative unit as the old one had become defunct. Regarding malaria, Jharkhand is an endemic State. He was not sure why only 118 blocks had been covered under EMCP. Mosquitoes, he stated, did not differentiate between EMCP and non-EMCP areas. He opined that it was necessary to cover the entire State under EMCP and especially keeping in view the position of hilly tribal and under-served areas and also seeing the neighbouring States like Orissa, West Bengal, Chhattisgarh which were also malaria endemic. Therefore, he suggested that a border district cluster strategy should be adopted for malaria control programme. As insecticides were not obtained as per requirement, spraying could not be done properly. It was necessary to provide synthetic pyrethroides in the high-risk areas. Regarding medicated mosquito nets, special efforts should be taken for their large-scale distribution especially in Jharkhand, where 54% of population live below the poverty line. He requested the Central Govt. to take concerted efforts for this. He hoped for early approval of the proposal sent to establish the State Institute of Communicable Diseases.
The Health Minister of Karnataka congratulated the Union Minister for having convened the National Conference after a lapse of two years. He said that it was unfortunate that malaria and similar diseases were emerging in Karnataka, most particularly in urban areas. He requested for financial support for the integrated disease surveillance project for which a proposal had already been sent to the Centre.

Regarding Leprosy, he opined, that rehabilitation was very important to ensure permanent settlement. The state had already started such a project. He added that a rehabilitation programme should be initiated at the national level too. TB was being effectively tackled. In the absence of ANMs, services of Anganwadi workers were being utilized for which the State is required to pay a minimum of Rs.150 per month. Panchayats and their elected representatives were actively participating in the programme. Unfortunately, Karnataka is high prevalence State for AIDS for which additional assistance was requested. Initiative taken to conduct blood donation camp in each taluk, necessitate establishment of a blood storage unit at the taluk level and also at the CHC level. Funds were requested for this. Blood bank existed in each district hospital, barring six new districts. Funds were requested for establishing blood banks in these districts as well.

The Health Minister from Bihar congratulated the Union Health Minister for the decision to establish an AIIMS in a poor and populous State like Bihar. He urged that it was necessary to move forward along with Bihar as Bihar is a part of India and for this he requested for support from the Centre.

A lot of progress has been made in the area of leprosy. The State would try to eliminate leprosy by 2005. The role of NGOs and their reporting, he felt needed to be clearly elucidated as many things were not transparent. Regarding TB, he requested for coverage of all districts under RNTCP in Bihar as many people were affected by this disease in his State. The Health Minister of Bihar informed that north Bihar was highly affected by Kala-azar and south Bihar by malaria. The medicines for Kala-azar not only did not reach in time, but were also found to be sub standard after testing. Some action was required to be taken on this. Further, he observed that installation of several
equipment provided by the Centre had not been done till date. Such problems were required to be resolved to ensure optimal usage of equipment.

The Health Minister from Rajasthan expressed his gratitude for giving an AIIMS like Institute for their State. Despite adverse conditions, he informed that they had taken many steps to improve the health sector but said that need existed to take many more. In 1999, under the Chief Minister Raksha Kosh, the poor were covered for treatment of dreaded diseases. 23 lakh BPL card holders were given medicines worth Rs. 9 crore. Those not covered under these two schemes were given assistance from Relief Funds. Floods after four years of drought left a lot of water standing in desert areas. That is why a lot of attention is required to be given to malaria to ‘nip it in the bud’. Their State had also sent a request for additional 500 MT for DDT. The Health Minister also requested the entire State to be covered under the RNTCP programme. He further informed that drugs/medicines of AIDS were exempt from sales tax in their state. Lot of training was also being imparted through the involvement of PRIs.

The Health Minister from Maharashtra informed that “ARCON” an organization sponsored by the State of Maharashtra was doing excellent work. Out of the many applicants for global funds, the application of ARCON had been accepted and the project for $ 12.5 million had been sanctioned. However, formalities were required to be urgently completed so that work could start immediately.

Maharashtra had the ability to come forward for proper utilization of plasma. The Government of Maharashtra, he informed, was willing to set up a full fledged plasma functioning centre under the aegis of State Blood Transfusion Council. The Government of India he urged, should participate in the venture, both financially and organizationally. The land could be available in Mumbai. He requested the Centre to initiate this project because Maharashtra was one State where blood collections from voluntary donors had been started at a very high rate. He wondered whether Government of India could consider providing anti-retroviral drugs, either free or at a highly subsidized rates in view of the high prevalence of HIV in Maharashtra.
With respect to Encephalitis, the Minister informed that the death toll was over 100 and till today ICMR or any other agency had not been able to help them to confirm the diagnosis. If diagnosis was done early, panic could be avoided. Dengue fever was also picking up and there was high prevalence in Mumbai, especially in the urban areas. He requested the Centre for support by providing adequate synthetic pyrethroids. He also requested to ensure quality supply of drugs.

The Health Minister from Himachal Pradesh was of the view that the decision of having a DOTS centre at each district level required a reconsideration. He felt that this should be need-based. Further, he stressed on the need to have maximum involvement of people/NGOs at the grass root level as he felt that it was the best way of sending the message right down to the village level. He also emphasized that each pregnant woman should be tested for HIV/AIDS and once a woman was found to be HIV positive she should be allowed to abort. No leprosy case had been detected for the last one year in HP. For Malaria, the Minister stated that the mosquitoes were increasing because of pollution which occurred in water sources. Also plastic which was thrown into these areas blocked the water ways, resulting in breeding areas for mosquitoes. So he urged for some action to be taken on this front.

The Health Minister from Madhya Pradesh thanked the Union Health Minister for giving an opportunity to speak and also for all the cooperation received for the programmes under implementation. He informed about the work done in MP through the involvement of the local people and the PRIs. Rogi Kalyan Samiti had been extended to each district, and a lot of good work had been done through their involvement. Many initiatives had been taken in Madhya Pradesh to meet the shortage of doctors, paramedical staff in interiors and villages.

The Health Minister from Arunachal Pradesh expressed gratitude that all the districts of his State were under RNTCP. The incidence of TB and other respiratory tract infections was high in the foothill area of the Himalayan range. The 6 no. of DTCs presently in his State were not adequate. He also said that the TB control programme in
his State required assistance in the area of capacity building, especially for upgradation of State TB training demonstration centre and setting up of DTC in each district.

He also felt that the blood safety programme of NACO was required to be vigorously implemented with a focus to set up blood banks in district hospitals and blood storage centres in community health centres or first referral units. Secondly, sustained IEC activities would be needed to reach out to people in remote and underserved areas in order to motivate them to protect themselves from HIV. Thirdly, he requested for inclusion of general hospitals at the State Capital, under a scheme of setting up of state-of-the-art blood bank to be launched by NACO. Fourthly, special attention was required for setting up of STD clinics in all district hospitals i.e.15. At present, only 6 STD clinics are financed by NACO.

Under Anti-Malaria Control Programme, the 100% central support since 1994 to all North Eastern States has been a welcome step. However, despite this, the difficulties experienced by these States were highlighted. These included costlier transportation in hilly areas, higher cost of laboratory consumables and logistics, payment of travelling allowances to the field workers who have to stay away from home for days in hospital surroundings, extension of indoor residual insecticide spray and provision of impregnated bed nets in all the districts. He also said that as accessibility to laboratory facilities was poor in most districts, especially in those areas away from district headquarters, the rapid diagnostic kit would prove to be very useful.

Regarding Cancer Control Programme, he emphasized that the provision to set up a Cobalt therapy unit in the State was difficult to implement as Central Government was providing assistance only for equipment. He urged the Central Government to provide funds for building infrastructure to take maximum advantage of such a scheme. Finally, under the blindness control programme, as some funds were provided during the last two years by the Centre for civil work for constructing a 10 bedded eye hospital cum OT complex four such facilities were constructed at four places in this State. He requested for a rethought on the decision to discontinue funds under this head, as had been done from the current year.
The **Health Minister** from Pondicherry informed about exemption of sales tax octroi and entry tax on anti-retro viral drugs and all life saving drugs from 1st Oct, 2001. He also requested for supply of anti-retro viral drugs to all the people having HIV free of cost to all the States, as was being done in other countries like Brazil and South Africa. He informed that HIV awareness amongst women in Pondicherry was as high as 97% as per the NFHS survey II. The UT had now become a low prevalence one from the earlier categorization of medium prevalence State. He said that in the agenda item supplied by Department of Health, Pondicherry had been categorized in Group II, where HIV infection had crossed 5% among high risk group but the infection is below 1% among ante natal women but in the same agenda book on page 60, they had been categorized among the lower group where consecutively for 3 years, they have had only less than 5% HIV infection. In 2000, it was 4% in 2001, it was 2% and in 2002, it was 2.02%. So he requested for an appropriate recategorisation. Finally, he informed that the RNTCP programme would be launched soon after the inspection of the appraisal team.

**Dr Harshvardhan** highlighted that 85% of transmission of AIDS was linked to individual sexual behaviour and 15% was on account of other factors like safety of blood, etc. The thrust of the entire strategy should be on safe sex and use of condoms, etc. Integrity of sexual relationship in marriage was required to be emphasized. Focus for the 85% cases was required to be changed. For 15%, despite stringent laws on blood safety, commercial donors continue to be present, because voluntary blood donation has not gained momentum. An institutional mechanism for individuals/NGOs working in this area needs to be put in place.

The passive search mechanism under RNTCP needs to be changed to an active one. If the wherewithal to treat such cases using DOTS strategy for the entire country is not there, then this is required to be taken up either at the State level or for a few districts, so that in future TB could be controlled, through active search mechanism on a large scale. For malaria and leprosy, where preventive aspect is very strong, need exists to intensify the dissemination activities through TV and other media, which is presently, lacking. Also such important messages need to be spread through school children with the help of positive school health education. He also said that there was a need to fix specific dates for the entire country for cataract control, cancer prevention, safe mother
hood campaign, so that the entire country could come together not only to ensure optimal utilization of resources but also to spread the message.

**Dr. Matrian, Hon’ble MP** initiated the discussion by highlighting that for safe, effective and optimal use as well as for quality medical care, blood component therapy was the order of the day. He opined that instead of having mushroom growth of blood banks in every nook and corner of the country with its attendant risks of collection and other problems, it would be better to have comprehensive blood banks with the blood bank component therapy, say two to four in each district, so that the collection could become more centralized and then distribution could be taken care of. Despite blood component separators having been supplied by the Central Government, he expressed surprise that as many as 23 had not yet been set up. Infact, Bihar Minister had also mentioned that many equipment had not been installed and that may be applicable for other States as well. Equipment not installed for some time, would later become unusable. Considering the load of the cancer patients in the country and seeing the heavy load on each cobalt unit, there was definitely an urgent need to increase the number of cobalt units in various institutions across the country. Also Central Government should come forward not only for establishing oncology wings but also for upgrading the existing facilities. As more than 70% cancers are preventable cancers, he emphasized on the need to increase awareness by organizing screening camps etc., so that early detection was possible. The clinical trials and the database, he opined are the corner stone for further study and treatment. The problem with ICMR registry was that furnishing of information was voluntary in nature. So he questioned, the possibility of declaring cancer as a notifiable disease. This step would make it mandatory for each and each practicing doctor to notify it, thereby enriching the data. He also said that there was an urgent need to upgrade the food testing facilities in the country. Need also existed for financial assistance from the Centre for mental hospital and colleges.

Dr. D.P.S. Sandhu, **Director, Health Services** from Punjab expressed happiness that Centre would be providing funds for transportation of insecticides in the State. He also said that efforts should be made to enact by laws to control breeding sites of the mosquitoes.
Vaid Devendra Triguna emphasized that TB treatment was not useful for TB resistant cases and in such cases Ayurveda medicine had proved to be successful. Also TB treatment had many side effects on liver, etc. Hence, it was necessary to integrate this programme with the Ayurveda system to reap maximum benefits. Perhaps research studies could also be done for such cases.

He informed that some preliminary research in chemical treatment (साधारण विकिरण) had been found to be useful for AIDS. Various benefits of this treatment had been seen like increase in appetite and weight. Gujarat and Maharasthra Government had done some research in this area. So, he urged NACO to also undertake a research project on a national level so that those suffering from AIDS could benefit from this treatment. He emphasized on the need to integrate the Vaidya in each village as also the religious leaders like Pandits, Maulvis, due to their ability to influence the people positively on issues like reducing population, HIV/AIDS, etc. As mentioned by Dr. Harshvardhan, there was a need to change the focus on use of condoms. Good slogans could be formulated through Ayurveda for giving the health of the country a new direction.

Regarding malaria, there have been complaints about patients getting jaundice etc, with the use of drugs. In Ayurveda, medicine exists for providing preventive and curative care. Hence, integration of this system with the national programme was essential. He also said that in order to make the mental health programme a success, use of yoga and ayurveda was very important.

Dr C. P. Bansal, Director Health Services, Chandigarh stated that most of the HIV positive cases from neighbouring States came to institutions like PGI, Chandigarh. So he requested for free provision of anti-retroviral drugs. He also emphasized that State TB training and demonstration centers need to be established in Chandigarh for the neighbouring States. Further, he added that dengue should also be included into the national programme. For the Leprosy programme, the staff would be withdrawn from 2004. But he felt that some staff should remain because of the migrating population in Chandigarh.
Dr. Sayed Khalifudullah emphasized that involvement of ISM practitioners and integration of AIDS Control programme with Unani, Ayurveda and Siddha systems of medicines was necessary for the holistic approach. He also said that it was essential to integrate the large manpower and vast infrastructure of ISM&H with the national health programmes.

Shri S.K. Nanda, Principal Health Secretary, Gujarat mentioned that based on certain statistical data, it had been seen that the poor/migrating people to cities were the ones who bore the brunt of communicable diseases. Also because of their low immunity system on account of low calorie intake, they become more susceptible to non-communicable disease as well. A survey done for the state of Gujarat through two years of researched data revealed that people who were likely to suffer most were the rural urban border tribal migrants. He also said that development in the form of roads had led to a decline in leprosy but at the same time, some roads had brought new diseases like AIDS. Further supporting the idea of convergence, he mentioned about the project taken up in Jamnagar, where such an initiative had been taken. He also emphasized on the need to take up a programme for the adolescents, particularly females who later on become mothers.

Vaid Pt. Sri Ram Sharma emphasized that rather than immediately taking strong medicines with the onset of any disease, efforts should be made to ensure that the disease itself did not occur. For this, the individual also had an important role to play by changing his nature, attitude, life style and also adopting traditional customs. This kind of education was required to be started from childhood itself by the mother. However, he stated that in case of any disease/illness, Ayurveda was very much equipped to handle the same.

Shri Rakesh Kumar Mittal, Principal Secretary, Uttar Pradesh initiated the discussion by agreeing with the suggestion of Dr. Harshvardhan regarding changing the strategy for the AIDS programme. Regarding malaria, he stated that the strategy was changing from time to time. Malathion is increasingly being used in lieu of DDT, which
was effective and used till some time back. The Centre could provide valuable guidance on such issues including availability of items on DG S&D rates, etc.

Further, although funds had been received for strengthening the health services and (18 RDCs had been sanctioned in U.P.) buildings had been constructed, equipment was yet to be purchased. On account of vast variations in specification of machinery, the tender had to be done many times. Therefore, he opined that the Central Govt. should supply the equipment or give standard rates to facilitate the entire process.

Finally, for schemes like Trauma Centre and Cancer Control Programme, he felt that guidance from the Centre regarding submission of proposals, would be very helpful. Also, there could be a consultancy cell in the Ministry to render guidance on such issues and help to develop capacities in the States.

Dr. Ranjit Roy Choudhury emphasized that by rational use of medicine and also through the list of essential medicines of WHO, the accessibility of the medicines to the poor could be increased. In Delhi Govt. hospitals, 90% of the prescriptions made were given free drugs. He requested the Hon’ble Ministers of different States to consider and implement this in their own States. By changing the procurement system, it has been ensured that no sub-standard drug is purchased in the various hospitals. Use of standard treatment guidelines, he opined, would further reduce the cost of treatment.

Shri Rajkumar, Health Secretary, Haryana drew attention to the issue of affordability of medical treatment in India. The DPCO covered only 15% of the drugs and a large number of them had inflated MRPs. In Haryana, he informed, prescribing branded drugs in the Govt. hospitals had been banned. This had resulted in drastic reduction in cost of treatment to the poor patients. The chemists have also been forced to bring down their margins. He requested for some measures to be taken in this area.

Minister of State, Medical Education, Madhya Pradesh thanked the Union Minister of Health and Family Welfare for the decision to establish an AIIMS like institute at Bhopal. She requested for its foundation stone to be laid early. She mentioned
that the state of MP, which had been facing drought since the last few years, had to find a solution by cutting resources across various departments. For this reason, she had not been able to implement her ideas in the area of medical education, accreditation and super speciality centers. Because of shortage of funds, it was not possible for her to upgrade subjects in each of the five autonomous medical colleges. Therefore she requested for assistance from the Centre.

For AIDS, she mentioned that NACO who provide the disposable testing kits do not do so regularly, thus affecting the programme. She requested for early approvals of the requests sent by their State for the Regional Institute of Blindness, mental health institution and upgradation of oncology wings situated at Gwalior, Jabalpur and Indore under the Cancer Control Programme.

In the area of medical education, she mentioned about the problems being faced in the event of any request received to increase the seats in Councils like MCI, Dental Council, Nursing Council, etc. Opening a new medical college was very difficult due to lack of finances. She requested for early approval of proposal sent for opening a new college at Sagar University which was the only headquarter not having any college.

The Minister also highlighted the tremendous shortage of doctors in PHCs located in remote and tribal areas. She opined that there should be a policy whereby every doctor serves in rural areas for at least one or two years after the completion of MBBS. In her state, vacant posts in PHCs were being filled up by Ayurveda and Homeopathy doctors as well.

Regarding PG seats, the all India quota does not get released in time, resulting in delay in counseling and also in examinations. She opined that quota system should be left to the State Govts., so that greater number of candidates of that State were able to get admissions.

**Health Minister, Karnataka** requested for continuation of the Blindness control programme for a further period of five years. He also opined that it was necessary to set
up a Cancer diagnostic centre, Cardiac centre and a mental health facility in each district. He said that his State Government was prepared to provide all the infrastructure, if the Central Government could provide equipment, etc.

**Health Minister, Jharkhand** began by thanking the Union Health Minister for the approval given for establishing a food and drug laboratory in Jharkhand. Expressing concern about the situation of blindness in his State, he stated that none of the district in his State had a provision of 10-bedded hospital. Therefore, he requested the Centre for taking remedial measure for such deficiencies existing in the infrastructure under the blindness control programme.

The situation regarding Cancer in his State was also bad. Meharbai Tata Cancer Hospital was the sole hospital in private sector where radio therapy facilities were available. The Minister requested for early approval of the proposal for opening oncology departments in all the three medical colleges and for establishing a Regional Cancer Research Institute in Ranchi. He also requested the Centre to take necessary steps to organize case detection camps in each district, especially at the PHC level, to facilitate early detection and timely diagnosis so that such patients could be referred for further timely treatment. He said that this was required to be started as a campaign at the grass root level. District Cancer Control Programme, he opined, should be operationalised in each district. He supported the proposal made earlier regarding declaring cancer as a notifiable disease.

Further, he stated that the situation in the two mental health institutes, namely RINPAS and CIP, Ranchi, was very bad. He requested for appropriate support from the centre to upgrade these two institutions. As no medical college in the State has any psychiatry wing, he requested for grant of permission for setting up the same. Establishing the State Mental Health Authority and organizing a training and refresher course programme in psychiatry for medical officers were some of the other initiatives taken in their State. He requested for sanction of the district mental health programme for five districts. He also sought approval for starting PG course and Diploma in psychiatry in RINPAS. He suggested that the various national programmes need to be
discussed not only in this meeting but also in conferences organized periodically at the regional level.

The **Health Minister from Jammu & Kashmir** stated that the figures shown for blindness control programme for Jammu & Kashmir were incorrect. IOL, like drugs, were also substandard. He urged all present to take a pledge not to consume tobacco. People in Jammu & Kashmir, he said, had passed through a lot of turmoil. Proper infrastructure and doctors were lacking to take care of the mental problems being faced by the population of Jammu & Kashmir. He urged the Centre to take some steps to address such issues.
SUMMING UP OF THE SESSION BY SECRETARY (HEALTH)

Shri J.V.R. Prasada Rao, Union Health Secretary, summed up the session by making a few general observations. The biggest problem being faced and what had been raised by most of the Hon’ble Ministers, was the question of adequate finances. In the last 10 years, the health care expenditure in the States which was about 7% of their plan expenditure at one time had come down to 5.5%. So it was necessary to see as to how to restore it back and as per the health policy, how to make it at least 8% by 2010. That itself would make a big difference. He requested all the Health Ministers to put enough political pressure on their own State Governments, to see that their health care expenditure and their budgets could be improved. He mentioned about a request from one State asking for Rs.5 crore to manage an outbreak. That kind of finance, he stated, the States should be able to mobilize for their health care.

Second, in respect of malaria and other vector borne disease, a new programme was on the anvil. The deficiencies in the existing programme were going to be removed. There were observation from Orissa, Jharkhand and other States, that some blocks had been left out. 100 more PHCs were getting added and all the gaps would be covered. Dengue, Filariasis, JE – would be added in the programme and in respect of Kala-azar, whatever little gaps were there in terms of giving wages to sprayers, etc. would also be fully borne by the Govt. of India. So once this new vector control programme was approved, it would definitely be a much more integrated programme and all would be benefited by it. But he stressed on taking up a strategy involving focused spray and not aimless spray that is presently going on, use of other methods like growing of fish and use of medicated mosquito nets. 70% of the budget was presently being spent on spraying without any commensurate result. Such strategies need to be brought in the Malaria programme to make a big difference.

In TB, he pointed out, that Bihar was going to be fully covered under the grant that had been received from Global Fund for TB, Malaria and AIDS. 6 districts had been approved last year but once this grant materializes, the entire State of Bihar would be covered. He also informed that before starting a district coverage, certain advance
preparations were required to be made. A Society has to be registered, committee has to be formed, regular DTOs have to be posted. Unless these preparatory activities are taken, the district cannot be covered. He requested for such preliminary action to be taken immediately in respect of all the districts in Bihar so that the entire State of Bihar could be covered. Even in other States where some districts have still not been covered would be covered shortly. By 2005, the Amsterdam declaration says that the entire country would be fully covered under the RNTCP. So no State should feel neglected. Some points were raised about the drug supply. Generally, drug supply was OK in T.B., because drugs are being purchased well in time and whenever there is dislocation, grants are also taken from the bilateral agencies but there could be some individual cases where there is some dislocation periodically. He requested that such cases should be brought to the notice of the Ministry so that supplies could be streamlined in a much more effective manner.

In respect of AIDS, he voiced concern that the problem of stigma and discrimination and refusal of patients which exists even today in Govt. hospitals, had not been highlighted by any one. This is something which can not be solved by the Govt of India. It has to be done by the States. If some doctor does not treat an AIDS patients, it is for the States to take some disciplinary action against him and set one example at least. This will send the message down the line. The issue regarding legislation on HIV/AIDS was being actively deliberated so that this entire issue of stigma and discrimination could be taken up by Govt. of India. He said that introducing anti-retrovirals in the programmes meant a lot of resources and could not be done at this stage even at the low rates at which the anti-retrovirals in this country are being obtained. Drugs for opportunistic infections are also being given free of cost. These have to be used effectively in the hospitals. Drugs are also being given for post exposure prophylaxis for the doctors. Neviripine is another drug given in the PPCT programme. These are all the drugs supplied under the AIDS programme.

Now in Leprosy, the country was on the verge of coming to elimination stage, but there are still some States where the endemicity is high and in these States, there is still a necessity to carry out one more round of MLEC. Those 8 States would go in for another
round of MLEC. He requested all the States to make adequate preparations, so that whatever active case detection is required to be done, should be done in this round for after that the switch over to the passive mode would be made, where patients would come to get the treatment and there would be integration of leprosy services into the general health care system. But he emphasized that one should not face the situation like what was seen in malaria in the sixties. Malaria was thought to have been eradicated but it came back in full force by the 70's. Such a situation should not happen for leprosy.

In the case of Cancer, the entire programme was being recast because right now the programme is only equipment supply programme. This requires to be reoriented into more of a prevention programme, more of district level programme. This would mean going back to the EFC and the inputs received from all the States would be extremely useful in helping to revise the programme.

Finally, on food and drugs. This is a very important area engaging attention. Both on food and drugs, the Government is moving very fast for modification of the existing laws. He requested for inputs on the issue relating to manufacture of drugs. In drugs, there were two issues, one was the manufacturing license and the second was the trading license. The trading license is being given to the chemist shop and manufacturing license to the manufacturers. Because the manufacturing today is decentralized to the drug controllers at the State level, there are various standards of manufacturers and unfortunately no uniform standard of manufacturing is being followed in the country. In the process, the lives of citizens is put at stake. Very substandard drugs are coming to the market and one of the important reason is the decentralization of the manufacturing licenses. At some stage, the Mashelkar Committee will probably come up with a recommendation that manufacturing is required to be centralized and uniform standards should be followed for drug manufacturers throughout the country. He requested all the States to give a positive and serious thought to this and said that if all agreed then this could be centralized and Govt. of India could evolve very good qualitative and uniform standards for manufacturing of drugs. This, he felt, would make a big difference for the drug scenario in the country.
D/o Indian Systems Of Medicine And Homoeopathy

The comments/observations made by various Ministers of different States/State Secretaries/experts after the presentation on major initiatives and achievements during the last two years in the Indian Systems of Medicine and Homoeopathy (Annexure-1) are as under:

Hkm. Khalifatullah, Former President CCIM:

i) National Aids Programme should include Ayurveda & Unani Systems.

ii) ISM & H doctors serving in Govt. sector need to be utilized in National Health Programmes.

iii) Recommendations of previous conferences of CCH&FW have not been implemented in many states, introspection is required. States are also parties to the resolutions passed at the conferences.

iv) CCIM has no teeth like MCI. As a result, mushroom growth of many Ayurveda & Unani colleges has occurred in the last couple of years.

v) Year-to-year inspection of reputed colleges by CCIM is not proper. It should be discouraged.

vi) There should be proper inclusion of modern medical advancements in the ISM curriculum as resolved by CCIM.

vii) State Govts. may forward the grant applications of Unani colleges in time. The central Govt. may also accept the advance copy of the application and money may be released only after getting NOC from the State Govt.

viii) The rules should be relaxed for PG admission under central nomination till all states have post-graduation facilities.

ix) Research in ISM be given maximum impetus.

x) Number of Unani dispensaries under CGHS should be expanded. Till then reimbursement facility may be extended for the Govt. employees interested in availing unani treatment.

xi) Tibbia College, Karol Bagh, Delhi may be declared as a centre of excellence/university of ISM&H and named after Dr. Ajmal Khan.

xii) ISM should be declared as National System of Medicine as has been done in China and Korea in the cases of their indigenous systems.
xiii) Minimum standards for opening of ISM&H colleges have not been approved. Till date there are no statutory findings on minimum standards. Regulations are already approved but amendments to regulations are yet to be approved. These are pending with the Department for the last two years. The proper course is to first approve minimum standards, then approve regulations and thereafter bring out amendments.

**Vaidya Shri Ram Sharma :**

i) Ayurveda-based preventive health programme should be introduced for educating society about healthy life-style, behaviour and conduct.

ii) More and more Govt. institutions may be covered for ISM related activities

iii) Existing Budget of ISM&H is about 3 to 4 % of the total in Centre as well as States. It should be increased to at least 15 % for proper development of this sector.

iv) In the national and global markets, Ayurveda, Unani & Siddha drugs should be given prominence i.e. by highlighting the name of the system of medicine as such and not as herbal medicine.

v) PHC work should be given 100 % to ISM doctors after 2 to 3 months of training. MBBS doctors should be posted in block & district level hospitals where their referral services can be obtained.

vi) Joint venture with private sector should be discouraged in the case of National Ayurveda Hospital, New Delhi. It should be purely Govt. hospital with sufficient funding so that common people could get the benefit.

vii) Certain raw materials of Ayurveda drugs like Kasturi, Shring, Shankha, Kowrie, Moonga etc. and some medicinal herbs should be made readily available without any restriction to the ISM doctors using them in manufacturing the medicines. Herbs etc. should be allowed to be exported only after genuine domestic demands are met at fair prices.

viii) Central Government should write to States for introducing Sanskrit/Urdu as optional subject at the level of 10+2 Science stream.

ix) Ayurveda education & treatment facilities should be made available in Northeastern States.

x) Govt.& Govt. Aided colleges have failed in fulfilling minimum norms. Centre should write to the States to take action to improve the infrastructure of such colleges.
xi) GMP certification should not be necessary for drug manufacturing units engaged in training and research that are attached to ISM colleges.

xii) All existing ISM colleges should be duly supported to bring up their standards in accordance with the norms laid down by the CCIM.

xiii) Amendment to IMCC Act, 1970 is required to provide more teeth to CCIM.

xiv) One Ayurveda University for education & research should be created in each state.

xv) ISM&H should be utilized in Family Welfare Program.

Vaidya Devender Triguna:

i) Ayurveda may be introduced in Anti-tuberculosis and AIDS Programme.

ii) Religious persons /preachers like pandits, padrees, Moulvis, etc. can be utilized for generating awareness of AIDS among masses.

iii) For success of Mental Health Programme, use of Yoga and Ayurveda should be introduced which is basically health promotive.

iv) Ayurveda & Yoga are recognized independent systems of health care and cannot be classified as traditional medicine or alternative medicine.

v) There should be a post of Adviser-ISM/Ayurveda in the Planning Commission to facilitate smooth disposal of ISM matters and more utilization of budget.

vi) National Ayurveda Hospital being developed in Delhi should be a Govt. Hospital exclusively without involvement of private collaborator. Private party will keep the profit motive uppermost in mind and poor people will not get the facilities. The Government should at least have a 50% shareholding with the private collaborators in order to have an effective say in the management.

vii) A mechanism of medical auditing as prevalent in other countries needs to be introduced and a Medical Tribunal /Medical Grants Commission should be established. This will avoid the hospitals being used as resting places for VIPs at the cost of common people.

viii) Vacant Technical posts in the Deptt. of ISM&H must be filled immediately.

ix) Name of the Deptt. of ISM&H should be in accordance with the names of the systems concerned. Present name does not convey what ISM is. AYUSH could be the ideal name as its letters denote all the branches of the Indian Systems of Medicine.
x) Indicating the date of purchase of raw materials should be mandatory to ensure efficacy of the drugs made from such raw material. Herbs may be purchased through the Medicinal Plant Board.

xi) Cross prescription is a national issue and has to be addressed properly in view of various pros & cons related to integration of medical system.

xii) State Directors of ISM&H should be from the technical persons and not generalists. The conference should meet more frequently.

xiii) A standing committee under CCHFW may be constituted to review various issues related to ISM and to recommend the strategy to be adopted by the Government.

xiv) The Deptt. of ISM&H should play the role of a guide for the states, and the states should implement the Central Schemes on their own.

xv) Good laboratories with reliable test reports should be set up. At present different labs give different test reports for one individual/test conducted on the same day. As doctors insists on test reports from the labs they consider reliable they ask the patients to get the tests done again. This results in more expenditure on tests by poor patient, who can hardly afford it.

xvi) Centres of excellence should be set up in the 10th Plan like Papraula in H.P.

xvii) Some states like Kerala, HP and Rajasthan have done good job in popularizing Ayurveda. Others should also improve.

Dr. Harshvardhan (Former Health Minister, Delhi):

i) Role of Indian approach in prevention of AIDS needs to be highlighted

ii) Yoga and meditation have great healing potential and it should be propagated.

iii) Need of the hour is to integrate various medical systems so that the common man can get the maximum benefit. A training capsule on holistic medicine should be introduced during internship for every medical graduate.

iv) Different ISM units should be established under one roof out of existing resources earmarked for the purpose.

v) Homoeopathy is a cheaper scientific system for different ailments, and it could be promoted as a system for poor people.
Gujarat State:

i) Best of ISM practices should be incorporated in National Programmes for chronic diseases.

Madhya Pradesh (Minister for Education & ISM&H):

i) Posting of ISM doctors in PHCs should be made as a policy by the State Governments.

ii) ISM colleges may not be required to seek year-to-year permission for making admissions to different medical courses. Colleges should be recognized at least for five years.

iii) ISM products should be given a logo for facilitating marketing.

iv) The salary etc. of ISM doctors posted in PHCs be funded through RCH programme where more funds would be available.

v) Pandit Khushi Ram Ayurveda College, Bhopal should be developed as a State model college of Ayurveda for which the Central Govt. should provide financial assistance.

vi) Naturopathy centre in Bhopal may be set up with central assistance.

vii) ISM&H drugs be utilized in National Health Programmes.

viii) U.C.s issued by C.A. should be acceptable in case of autonomous bodies.

ix) Endorsed the idea of common legislation for uniform fee structure etc. floated by the Maharashtra State.

x) Service in rural area must be compulsory for doctors interested to undergo PG course of study.

xi) Year to year permission of ISM colleges be stopped. Colleges may be recognized for 5 years.

xii) State of Madhya pradesh is first in the world to have established Paramedical Council regulating 32 subjects and registration of paramedical personnel.

xiii) ISM&H and their doctors should be utilized in Family Planning program.

Bihar (Shri Shakil Ahmed, Minister for ISM&H):

i) ISM doctors be encouraged to use the prefix Hakim / Vaidya without feeling inferior to allopathic doctors.
ii) Combined entrance examination for admission to MBBS, BAMS, BUMS courses should be discouraged to avoid inferiority complex among ISM students. They should be admitted by direct separate admission test, if necessary by increasing age limit and adding extra subjects.

iii) Purity of practice should be maintained and mixed practice should be made as a punishable offence.

iv) ISM doctors should be posted in all the PHCs.

Rajasthan:

i) A project on preventive health based on Ayurveda concepts would be submitted by the States to the Central Govt.

ii) An independent Ayurveda Ministry may be established.

iii) An Ayurveda doctor should be posted in every modern hospitals of A&B class.

iv) Younger generation needs to be made aware of Ayurveda. Ayurvedic experts should take this initiative.

v) Rajasthan may be made as a model state for Ayurveda. It is the state with oldest Deptt. of ISM&H set up in 1952.

vi) Proposal to deal sternly with manufacturers of spurious medicines is a welcome step.

vii) Kerala earns more through tourism because Allopaths prescribe ISM&H treatment.

viii) Rajasthan Govt. has offered land in Suryanagari, Jodhpur for setting up an Ayurveda University. Foundation may be laid early.

ix) Rajasthan is a famine prone state and depends largely on animal wealth. Help should be given not only in kind but also by increasing the financial help.

Haryana:

i) There should be research centres for different diseases for treatment and drug development. Sufficient funds be allocated to ISM Research Centres/councils.

ii) Drug Testing laboratories should be available in all parts of the country so as to avoid spurious and sub-standard drugs.

iii) Training Centres for nurses, pharmacists, Ayurveda Technicians are essentially required to be established to generate trained/qualified para-medical manpower.
iv) Infrastructure and working condition of ISM&H units should be made impressive and conducive for smooth working and developing patients’ confidence in the doctors of ISM&H.

Orissa:
i) Why the CCIM conducts annual inspection of colleges is not understood. It has to be stopped as it casts a huge burden on managements of colleges.

ii) Tenure of centrally sponsored schemes being five years, the State Finance Department does not agree for the activity covered under the Scheme after five years as it is not sure the scheme will continue thereafter. There should be some relaxation on this.

iii) Pharmacist and Nursing courses in Ayurveda should be started.

iv) Centre of Ayurveda Health Tourism started in Govt. Ayu. College, Puri is giving excellent results and needs central assistance for development of its infrastructure.

v) Ayurveda doctors are being posted in the PHCs and 2000 acres of land earmarked for cultivation of 20 species available in Orissa out of 32 prioritized medicinal plants. Out of 15 projects submitted only 5 have been cleared. Remaining 15 should also be cleared.

Tamil Nadu (Dr. Farouqi):
i) There should be training modules for ISM practitioners for involving them in National Health Programmes.

ii) The knowledge available in palm leaves / manuscripts of traditional medicine be scanned and published.

iii) Close alliance with CSIR, ICMR, CDRI etc. for scientific studies on ISM products should be developed for facilitating export.

iv) CCIM norms and Syllabi need revision.

v) Supported the idea of central legislation for fee structure, admission procedure etc.

vi) The role of State Govts. has to be defined in issuing essentiality certificate for opening a college.

vii) CCIM norms are very stringent, need to be revised as essential and optimum norms.

Karnataka:
i) Entire medical education should be centrally regulated.
i) Supported the idea of Central legislation for fee structure etc.

**Andhra Pradesh:**

i) Central legislation for regulating fee structure etc. will curtail State Govt’s powers, hence not feasible.

**Jammu & Kashmir:**

i) Ayurveda is our own heritage. It should be accepted and propagated as such. Attitude of accepting whatever is approved by major foreign countries has to be discouraged.

ii) Wherever required local names of medicinal herbs must be mentioned in the official publications.

iii) Chief conservator of forest should not be empowered to certify the forest produce used in the ISM sector.

iv) Percentage of profit to NGOs engaged in ISM sector should be fixed by discarding no profit no loss formula.

**Maharashtra:**

i) There should be one comprehensive central legislation regulating the fee structure, admission procedures and allied matters of ISM.

ii) Commission of Medical education needs to be established.

iii) Rationalization of minimum standards of medical colleges like land area, no. of lecture rooms and other infrastructure facility is required to be done.

**Jharkhand:**

i) Service in rural area must be made mandatory after internship for aspirants of PG education.

ii) Supported the idea of central legislation for fee structure etc.

**Family Planning Association of India:**

Involvement of ISM personnel in Family Planning program could be useful to achieve the targets.
29th AUGUST, 2003

Medical Education

After the presentation on Medical Education (Annexure 1), Hon’ble Union Health Minister for Health & Family Welfare invited members from the States to share their experiences regarding medical education and medical institutions.

The Minister on Medical Education, Family Welfare & ISM&H from Bihar stated that 25% of the medical seats in the State were being filled by students from other States and urged the Central Government to provide financial assistance in lieu thereof. Also recognition of private medical colleges is being done by the MCI / DCI / University, only concurrence of the State Government has to be taken as provided under the Act. He questioned the role of the State Government in such a situation when a private medical / dental college is already recognized by a University, but the State Government has not been consulted for giving recognition. A proposal was received to allow the MBBS students (passed from these private medical colleges) to sit for the PG exams. He enquired how the State Government could consider the proposal (for PG seats) when it has not recognized such colleges even for MBBS. He sought clear directions from the Central Government in this regard.

Due to paucity of resources, the state of infrastructure, maintenance, etc. in various medical colleges / institutes is lacking. He inquired as to why the number of seats in various medical colleges could not be increased in view of the increasing population, when Supreme Court has allowed opening of private medical colleges. He sought the directions of the Central Government in increasing the medical seats, 50% of which would be paid seats, some for other states and some for NRIs so that the finances of the concerned institutions would improve, which in turn could be used to improve the basic facilities.

He then thanked the Central Government for opening AIIMS like institutions in various States including Bihar. He said that clarity was required for the patient seeking assistance in the State Government. He made a request for one additional Cancer Centre
and Regional Institute of Ophthalmology in Darbhanga Hospital, although one Regional Cancer Centre and Regional Institute of Ophthalmology already exist in IGIMS.

Finally, he stated that absolute clarity / transparency was required there in executing the Supreme Court orders on the two Committees required to be set up with retired judges and sought a detailed discussion on the role of the State in the entire process.

Shri G.S. Gill, Principal Secretary, Medical Education then spoke on the Supreme Court judgement regarding to medical seats/admissions. He pointed out that each Court interpreted medical education in its own way. He felt that strong comprehensive legislation defining admissions, fee structure, etc. is lacking at the GOI level. He requested that this should be done in consultation with the States to ensure the much required stability in the whole system. Then the Courts would have a limited role to play within the overall policy guidelines.

Both the Central Pool quota and 15% quota are based on the principal of helping those States which do not have enough medical colleges. Government of Maharashtra is contributing 240 seats to the Pool and in return is getting only 2-3 students from the Central Pool. There is a need for a more equitable distribution of the seats, at least in proportion to the population of the State, if not in proportion to the seats contributed. He informed that the Maharashtra Govt. had increased its quota of Central Pool by 40 seats this year, to particularly target those States which have disturbed areas declared under ‘Disturbed Areas Act’ of GOI and those where there are no colleges.

He felt that there was a dire need for consultation with Government Medical Colleges from various States. Despite MCI, the input being obtained into the policy making from the States was very limited. He suggested that there was a need to constitute a ‘Council of Medical Colleges’, particularly the Government Medical Colleges, to enable appropriate policy inputs, especially in the area of health education. The standards for health education could also be deliberated by this Council.
He also pointed out that the doctors are predominantly concentrated in urban areas. Thus despite a very good doctor-population ratio, the rural, hilly & tribal areas are deprived of medical care. Mentioning that sharing of experiences was important, he informed that a small regional cooperation had been started between Maharashtra & Gujarat. Through such a mechanism, he felt that the strengths of each State could be leveraged.

According to him decisions of MCI have been more focused on individual cases, say, ‘recognizing / not recognizing’ issues, rather than contributing any policy inputs. Some of the physical infrastructure requirements prescribed by MCI appear to be obsolete and exacting. For example, requirement of 25 acres of land; 2000 sq. ft. of fully air-conditioned animal house; requirement of an examination Hall for 500 students; and auditorium for 1200 persons. Hence, rationalization of these requirements was necessary.

States, he felt, were powerless as far as medical education was concerned. Once an essentiality certificate was given, the States, he stated, had no role in checking the standards of medical education.

Consultation of the Centre with the States on standards in medical colleges was not binding on the States. He was of the view that there was a need to empower the States even after the issuance of the essentiality certificate, because, ultimately according to this certificate if a particular college is not able to run, then it would be taken over by the State. The State is in any case committing its resources, but there is no control, once the standards of a particular college degrade to a very low level, it has to be taken over by the state.

Finally, he emphasized that dichotomy of instructions is required to be addressed. To illustrate, he stated that GOI had recognized honorary teachers in 2002 for a period of 5 years. But, when this is shown to MCI, they say they do not agree with GOI. So it should be settled as to who prevails - MCI or GOI.
The Minister informed that his State being new was lacking in the sphere of medical education and requested for increasing the number of undergraduate seats from 90 to 150 in RIMS; a regional AIIMS for Jharkhand; providing assistance for establishing one dental college in Govt. sector and two dental colleges in the private sector; permission to open at least three new medical colleges; as also a Regional Cancer and Ophthalmology Centres in Jharkhand. He also felt that after completion of internship, three year rural posting should be made compulsory to ensure availability of doctors in rural areas.

Further, he endorsed the issue regarding central legislation for admission and fee structure, as also for the empowerment of States after issue of essentiality certificate.

Finally, he stated that a Model Clinical Establishment Act for regulation of private hospitals / nursing homes was required to be expedited.

Dr. R. Roy Choudhary opined that state Medical Councils are required to be formed/ strengthened and sought the help of the State Government for this purpose. These Councils should have some role in medical education facilities and setting up new colleges. In view of the increase in number of medical colleges and degrees, he suggested a review of the Medical Council of India’s working and a review of the Act of Medical Council. He opined that the States should have the authority in setting up medical education facilities.

He also said that the Medical Grants Commission should be established as soon as possible. Finally, the relationship between MCI, Medical Grants Commission and State Medical Councils should also be clearly delineated.

Health Minister, Uttarakhand thanked the Union Minister for Health and Family Welfare for establishing an AIIMS in his State. He said in the absence of Government medical colleges in his State, doctors were unwilling to go to hilly and difficult areas. If some seats could be made available in other medical colleges, this problem could be
solved. He also requested for uniformity in the entire country with regard to standards for setting up Para Medical institutions.

Finally, he requested intervention of the Union Minister as MCI had not given recognition to Dr. Sushila Tiwari Trust.

Secretary, Health & FW from Tamil Nadu strongly endorsed the need for a comprehensive legislation on the decisions of the five-bench judgement. In the absence of a comprehensive legislation, the role of the State Governments will be highly diluted as it would be very difficult for the State Governments to have any negotiating power with respect to the institutions. She, further, requested that the legislation should also cover deemed universities as many institutions had acquired such a status, especially in the area of medical education. So, at least, on the admission side, the status of deemed universities as well as colleges run by universities themselves, should be brought into the regime of merit based admission and requested that the central legislation on admission should address these two issues.

The obsolete and stringent norms of CCIM had led to problems in implementation. They have either been breached or have given rise to the possibility of rejection of any proposal based on such norms. Hence there is a need to re-look at the norms to see what is essential and what is optimal, clearly specify the basis for rejection, etc. He requested for a comprehensive approach to look into the normative aspects of approval of medical colleges as well as approval of additional PG courses in medical colleges.

On the issue of essentiality certificates, Courts have passed judgements that have practically removed all the powers of the State Government. Supreme Court has been approached on various issues. One of the judgements has suggested that the Central Government needs to be approached for clarity on what is the role of State in this. He requested for clarity in defining clearly the areas in which a State Government can get into.
The Health Minister of Rajasthan requested for expediting the medical institution at SMS, Jaipur. He also said that with amendment of Nursing Act which has taken place, and will come into effect from 1st January, it was necessary to have a 250-bed hospital. At present, it is 150-bed and that too with an affiliation. He questioned on the possibility of a nursing school having a 250-bedded hospital. He opined that a second look was required to be given to this amendment.

Commissioner (Health), Manipur suggested a Central Pool for PG courses and a reservation for States where there are no medical colleges of their own. As Manipur has no medical college, students do not get a chance for studying in PG course as they seldom get a seat in Central / GOI entrance examination. The Regional Institute of Medical Sciences (RIMS) in Imphal is meant for all NE States and it does not take candidates from the open market. It admits in-service candidates sponsored by the States only.

He felt that there was a need to increase the seats for States in the RIMS, especially in PG Diploma courses in Gynaecology. He said that in the absence of an entrance test examination, XII Standard marks decided the eligibility but where there were entrance test examinations, the marks of the entrance test were the deciding factor, but these two could be in conflict. Manipur faced a very peculiar situation where ST candidates could not qualify in the entrance test examination according to MCI standards. (40%). But they had already qualified according to the XII standard marks. They were disqualified only because examinations were conducted in Manipur. But the State Government did not agree. It relaxed the provision and they were admitted. But this has led to litigations. So either entrance examination for all the States should be conducted for all cases, or else, the entrance test examination should be conducted only for fixing the inter-se merit.

Minister for Medical Education from Madhya Pradesh informed that besides the 15% all India quota, the State gives 27 seats to the Central Pool. One new medical college was opened in Raipur in 1976. 10 seats each from Gwalior, Indore, Bhopal, Rewa were given to this medical college rather than from MCI (when Chhattisgarh was a
part of Madhya Pradesh). So wherever, there were 150 seats in each college, only 140 seats are left. MCI has been approached on various occasion but this quota has not been restored. The Minister requested for restoration of the original 150 seats.

The fee structure for 2003-04 for common entrance examination in Government Medical Colleges had been prepared for M.P., which is Rs.35,000 for free seats, Rs.1.50 lakh for payment seats and Rs.5.00 lakh for management quota.

15% of this has been kept for private medical colleges and dental colleges. In accordance with the Supreme Court judgement, each State would constitute a separate Board and each State would have a different fee structure. The Minister, therefore, made a request to formulate a common legislation so that there is a uniform fee structure across States to avoid problems. Secondly, it was informed that the State government is in a fix in view of different judgements given by Supreme Court in individual cases. She requested for a clarification on this.

Rural Services, it was felt, should be made compulsory for PG examination, even if it meant reducing the course by one year. There is a shortage of students at the PG level for non-clinical streams. If this is exempt from pre-PG examination, this problem could be solved.

She inquired whether old ISM&H colleges could be given permission for 5 years rather than taking permission every year.

For the Nursing Council of India, feasibility and desirability certificates are given by State Governments, but again inspection is done. Once the certificates are given by the State Governments, registration should be done and the need for re-inspection should not arise.

Opening a medical / dental college in the Government sector is very difficult; private sector is coming in but the MCI norms are so stringent that they are finding it difficult to comply with them. So there is a need to take a re-look.
Para Medical Council: State Government of MP has taken a lead in the constitution of a Para Medical Council which was not existing anywhere in the world. 32 subjects are taken and examinations are also being conducted. She concluded by thanking the Union Health Minister for the decision to establish an AIIMS like Institute for the state of Madhya Pradesh.

Secretary (Health), Haryana stated that States had no authority in so far as medical education is concerned. This is vested with MCI / DCI. Medical college Rohtak has no recognition, but private colleges get recognition in no time. This needs to be rectified by having a State-level Committee, which has a nominee of MCI / DCI / University and State Government, so that this Committee can take decisions and have the answerability also. Admission process was still on and they did not know whether the Supreme Court judgement had to be applied in the current year or next year and also about 50 : 50 quota.

Minister from Karnataka demanded that the entire gamut of medical education should be covered a uniform system. MCI, he felt, was required to be streamlined by amending the Act.

Health Secretary from Andhra Pradesh differing from the views expressed by Maharashtra and Tamil Nadu stated that there was a very wide variation in fee structure, mode of admission, management quota that was allowed for by various State Governments.

A proactive State like MP gave only 5% as management quota and Andhra Pradesh gave 25% and both these gave a better deal to the vast majority of student community as compared to what Government had prescribed in its guidelines. If a comprehensive legislation was made, it could curtail the freedom of the States, particularly those States which feel that they could have given a better deal to the student community. If at all a legislation is made, more delegation was required to be given to the States on issues like number of committees to be constituted, the tenure of the committees, the mode of admission, fee structure, etc.
The **Minister** from **Meghalaya** informed that in the North-East, speciality manpower, specialist treatment and modern equipment are required for the health sector. Allotment for North-East from the Central Pool was very important and is required to be continued so that the health requirements of the population in this region are taken care of.

The **Minister** from **Arunachal Pradesh** said that the contribution of MBBS/BDS from the central pool had already come down. The most affected States are of North-East, not having their own medical college, particularly Arunachal Pradesh. Allotment for this year has come down to 22 from last year’s allotment of 24. He made an appeal to the Central Government to restore last year’s quota.

He suggested that the LT solution for this problem is to adopt a policy of granting assistance by the Centre to establish a medical college in North East, at least one in each State.

The **Health Minister** from **Jammu & Kashmir** highlighted the shortage of gynaecologists, anaesthesists and radiologists in J & K and said that MCI norms should be relaxed to meet the requirements. He also requested for 5 seats for Jammu & Kashmir.

**Vd Pt. Ram Sharma**, from CCIM opined that the Centre should write to all States that Sanskrit should be an optional subject for Ayurveda with XII science. Likewise, Urdu for Unani and Tamil for Siddha.

In the North-East, as there was no provision for providing education in Ayurveda, barring one college in Assam, he emphasized on advocacy in the local language for Ayurveda for the population of the North-East.

He mentioned that CCIM visited very old colleges every year. Despite all this, these old colleges have not been able to adhere even to the minimum norms. States
should be instructed to ensure that the minimum norms of all Government / Government aided colleges are fulfilled.

It was mentioned in the Tenth Five Year Plan that Centres of Excellence should be set up for Ayurveda and Unani. Even if this name has been changed to ‘model colleges’, adequate funds, he urged, should be kept for this purpose.

In Ayurveda / Unani colleges, some medicines have to be prepared and shown as a practical test by the students. These are subsequently given to patients, etc. It was said that the Act will not apply to such Ayurveda Colleges and Ayurveda Research Centres who make medicines for their own use. However, when this Act came in to the Parliament, this clause was removed, making it necessary even for such colleges/centers to take licence under the GMP Act. This is impractical and should be removed, as this practice is meant only for teaching the students.

New colleges should be inspected. Existing colleges should be brought at par with the new colleges or else he felt that they would be forced to close down. He also said that amendments were necessary in the IMC Act, in order to ensure that the Council was empowered.

Further, he informed that world over, Ayurveda was gaining popularity. Hence extensive research in various aspects of Ayurveda was necessary and for that, it is necessary to have one Ayurveda Unit in every State, not only for conducting examinations, but also doing research.
COMMENTS OF SECRETARY (HEALTH) ON IMPORTANT POINTS RAISED IN THE DELIBERATIONS ON MEDICAL EDUCATION

Reacting on the comments of the Minister from Bihar, regarding payments for functioning of committees, Secretary, Health clarified that the judgement was very clear. The expenses incurred on setting up of such committees shall be borne by each State. The infrastructural needs and provision for allowances and remuneration of the Chairman and other members of the Committee shall also be borne by the respective State Governments.

The Council of Medical Colleges as suggested by Maharashtra was a very good suggestion. However at present there are more than 110 medical colleges in this country. If a body with 110 medical colleges is constituted one can imagine what would happen.

Request was there for a medical university in each state and this he informed was being seriously pursued with all State Governments. 5 or 6 States have till now constituted medical universities. This, he said, would streamline the whole process of medical education, but unfortunately, many States had still not gone in for formulation of a medical university. If all State Governments had a medical university, then it would have been easy to form a Council of medical universities, which in addition, would have also performed the task of accreditation of colleges. In USA, American Association of Medical Universities, sets standards, renews permission, and does all the work what MCI does here. He, therefore, requested all the States to form the Medical Universities at the earliest.

He informed that three seats under the Central Pool had been allotted to Uttarakhand for the first time so as to meet the special needs of the new State.

Reacting on the comments from Tamil Nadu, Secretary (Health) informed that the GOI does not consider the application of any college without the essentiality certificate from the State. But some colleges go to the courts, get an order and try to bypass the State Government by not insisting on the essentiality certificate. In such cases, it would
be better for the Centre, the State, & MCI to go and appeal. If necessary, this should be
taken to the highest forum as essentiality certificate is a must for starting any medical
college in the private sector in any State.

On the Nursing Council Act, Secretary (Health) stated that the State had insisted
for 250 seats. Now, if the State is stating that this hinders or prohibits the starting of new
colleges, Centre will have a second look at it.

On the Paramedical Council, he announced that the Government was in the
process of forming a Paramedical Council for the country. The legislation is almost
ready. Very soon, for the first time, there would be a Paramedical Council for the entire
country.

The last two judgements of the Supreme Court, he mentioned, had created more
problems than solving what was there in the Unni Krishnan judgement. This judgement
had stabilized medical education quite a bit in the country. But suddenly, the whole thing
was turned upside down. The TMA Pie judgement and the clarification issued by the
Supreme Court have made the position much more complicated. The whole system has
been thoroughly decentralized. GOI today has no role even for issuing guidelines for the
States as Supreme Court has directed two Committees to be appointed. One Committee
will fix the fee structure and every college can have its own fee structure and
management quota. It is not clear how this will function. It is for the State Governments
to agitate in whatever forum is available, since GOI is a party to the case.

He informed that a lot of problems were being encountered in the functioning of
MCI. President of MCI is a member of this Council, but had not come for this
deliberation. There are 40 medical colleges, including Government and private, still
waiting for inspection. But the MCI is not going for any further inspection. The reason
is that GOI in its wisdom and under the powers conferred to it under the ‘Medical
Council Act’ had recently renewed the permission for some of the Government medical
colleges, because of the stipulation of 30th September being the last date for admissions.
However, MCI has taken exception to the decision of the Government to renew the
permissions, saying that without the recommendation of MCI, how did the Government go ahead. So they have refused to carry out any more inspections.

Within the Council also, there are two sets of functionaries - one set are those who are the elected body and functioning as the Executive Committee, another set consisting of three representatives who are imposed upon this Council by the Supreme Court order and these two groups work sometimes at cross purposes. Hence, there is a total confusion and so at some stage, it is necessary to restore the democratic functioning of this Council. GOI has to see that MCI is properly reconstituted. In the draft legislation, being brought out by the Centre, spelling out the membership may reduce the total number of members, as presently it is too unwieldy a body. Another important and unique thing in the Act is that GOI has no power to issue any direction to MCI; No Act contains such a provision. Even under the Act relating to large Municipal Corporations and AIIMS, GOI has the power to issue directions. Somehow or the other, this lacunae is carrying on. This is required to be remedied so that Government has the power to issue directions to MCI to function in a way which is not detrimental to the medical education in this country.

Some of these amendments are being brought in and he solicited support from the states for bringing these amendments. He said that it was necessary to take a resolution expressing serious concern at the way MCI is functioning. A copy of the same should be sent to MCI and also be filed before the Supreme Court.

The Union Health Minister stated that Government medical colleges are not profit motivated. So when permission was given to the four Govt. medical colleges, overruling the recommendation of MCI, they said that they would not do inspection for the remaining forty colleges. She expressed unhappiness at the unfortunate and condemnable action of MCI.
D/O FAMILY WELFARE
D/o Family Welfare

In her opening remarks, Smt. Sushma Swaraj, Hon. Union Minister for Health and Family Welfare, emphasized the overriding importance of the Family Welfare Programme since a stable population is the key to all planning and socio-economic growth of the country. She expressed concern on the trend towards adverse sex ratio in large number of States. There was a need to rally opinion and policy makers, adolescents and school children in favour of the slogan “Beti ho ya beta, rakhein parivar ko chhota”. A National Commitment Campaign had been launched on this theme by Sh. Bhairon Singh Shekhawat, Hon. Vice President of India, on World Population Day. There is a need to carry forth this Campaign to the States.

The Ministers and Secretaries of Health & Family Welfare from States later affixed their signatures on panels, to demonstrate their support to the Campaign.

Sh. P.K. Hota, Secretary (FW), Govt. of India, made a detailed presentation on the Implementation of National Population Policy 2000, recent Initiatives of the Department of Family Welfare and challenges before the Family Welfare Programme. He informed that of the 11 monitor-able goals identified by the Planning Commission for the 10th Five Year Plan, 3 pertain to the Department of Family Welfare, more specifically to reduction in the growth rate of population, Infant Mortality Rate and Maternal Mortality Rate. The medium term goal of the National Population Policy is the attainment of TFR of 2.1 by 2010. The Planning Commission has recently conducted an exercise and has projected that the TFR of 2.1 is likely to be attained by 2016 in view of the present trends in the Family Welfare Programme. If this be so, another 10 crores of population will be added by 2016. Majority of this population increase will be in the EAG States, which are already grappling with the issue of weak infrastructure and major socio-economic challenges. Thus, the States have to take determined action to prevent postponement of attainment of TFR of 2.1. It was also pointed out that the challenge is to address the unmet needs of couples with two children, who need to be advised for limiting their families and provided adequate and appropriate options and services for the same. Recent initiatives by the Govt. of India for strengthening the infrastructure;
provision of additional manpower; improvement of supplies through Social Marketing and Public-Private Partnership; upscaling of NGO involvement in service delivery; etc. were also delineated. There was a need for appropriate political direction to the Family Welfare Programme and to mainstream population stabilization issue in the programmes of all Departments to emphasize the overriding importance of the programme.

Dr. V.K. Manchanda, **DDG (MH), Department of Family Welfare**, made a presentation on proposed Janani Suraksha Yojana (JSY), which aims to improve institutional and safe deliveries, and support the girl child. It also includes component for incentive to Dai Ma for institutional delivery. The ongoing Schemes of NMBS, Referral Transport, Dai Training, 24 Hour Delivery Services etc. have been integrated in this Scheme.

Secretary (FW) appealed to successful States who have personnel and technical capacity, to cooperate with less developed States to upgrade their skills. He accepted the contention of Bihar Government that JSY does not cater to the nutritional needs of pregnant mothers. It was informed that talks are going on with the Department of Women and Child Development to develop alternate strategies for the same. Secretary (H&FW) Bihar suggested inclusion of Rs. 200 in the Janani Suraksha Yojana towards promotion of immunization.

**Health Minister, Rajasthan** informed that under the Rajiv Gandhi Mission the State Government is dedicated to achieve the TFR of 2.1 by 2011. The State Government has adopted a series of incentives and disincentives to promote the two-child norm. However, there is a need to strengthen infrastructure as a measure to build up confidence in the public to seek health services, 24 Hours Delivery of Health services and relaxation of norms for desert areas. He requested funding of Rs. 13.00 crores from Govt. of India, to meet additional burden for maintenance of 132 PP Centres by the State.

**Minister (Health), Bihar** advocated for convergence of AIDS programme with FW activities as both are related to fulfillment of unmet needs for contraception. He requested for funding of pilot projects in the State for installing condom vending
machines in the public toilets. He stated that awareness generation by role models of the society is must to increase male participation in family planning. Minister of State, Bihar suggested that top political leadership should talk about family planning on all forums. MCI may be requested to bring in a Regulation to control the absentism of doctors in government health centers.

Dr. Kamla Verma stated that Panchayats should ensure safe residential facilities for ANMs villages. There is a need for training of AWWs in family welfare activities, and for involving religious/social leaders to generate awareness among the people.

Secretary (FW), Tamil Nadu said that JSY should cover both public and private sector and requested GoI to allow the State to depute village health workers in place of Dai Ma and increase the rate to be paid for X-section cases. She requested Government of India to formulate a Spacing Policy. ANMs should be trained for management of post partum hemorrhage. The strategy adopted by Blindness Control Programme could be adopted for popularizing NSV. She requested Government of India to fund Post Partum Units being managed by NGOs in the State, by treating them as Urban Health Posts.

Smt. Mridula Sinha, Director, Social Welfare Board informed that the 18000 voluntary organizations, 560 family counseling centres, and 7000 Women Self Help Groups funded by the Board, could be utilized for creating awareness generation of Family Welfare Programme. Family Welfare Stories could be introduced in the syllabus for primary and middle classes. She urged that NGOs should be addressed as voluntary organizations, as is being done all over the world.

Secretary (FW), MP suggested that the incentive of JSY should be limited to the second child, transport allowance be increased to Rs. 250 and Gram Sabha be made a focal point for implementing the Scheme. He also requested for relaxing the condition of literacy for Dai Ma selection. Birth/Death registration at village level should be ensured. He appealed to the Government of India to direct the States to declare the posts funded by GOI as non-transferable posts (or mutual replacement posts) as this is the biggest hindrance at the States level for Family Welfare Programme.
Hon. Union Minister for Health and Family Welfare, while dispelling some of the doubts of the States, clarified that under the SWAP Scheme, all the Sub-Centres have been adopted by GoI for funding and it is not true that additional burden has been placed on the State Governments for PP Centres. She informed that JSY aims at promoting institutional delivery and not the two-child norm, hence incentive has not been limited to second child birth. She further informed that GoI seeks to sanction 8200 SCs all over the country and 466 SCs for Rajasthan, specifically for desert areas, as per the 1991 population norm. She requested the States to make a block level cadre for recruitment of ANMs and district level cadre for recruitment of Medical Officers. She urged the States to fill up the vacancies of ANMs at the earliest since the Government of India has accepted the financial responsibility for paying salaries to all ANMs.

Dr. Yogi Raj Sharma, Director (FW), MP, said that the service area of ANM should be co-terminus with the jurisdiction of three Gram Panchayats. He requested for starting a programme for Control of Post Partum Hemorrhage wherein ANM could be trained for using prostaglandin injection and tablets. PHCs should be made to implement Manual Vacuum Aspiration programme to control incidence of Septic Abortion. Looking to the fact that 80% deliveries are home based, he urged for effective involvement of Dai, Jan Swasthya Rakshak, Mothers and Sisters-in-Law in RCH-II.

Next, a presentation on RCH-II was made by Ms Nandita Chatterjee, NPO, WHO. It was stated that the main aim of RCH-II is to consolidate the gains of RCH-I and overcome the areas of weakness observed during the first phase, to strengthen the delivery system. The States need to design their own programme for capacity management, institutional arrangement, logistics and finance taking into account their process indicators. In RCH-II two important steps identified to make the system operational are (i) basic delivery package; and (ii) qualitative improvement. It seeks to involve urban local bodies, vibrant private sector and also inter-sectoral convergence.

Smt. Nina Puri, President, FPAI stressed on behavioural change communication in adolescent population comprising of 300 million people through the medium of folklore as demonstrated by an NGO, JIGYASA in Agra. She suggested improvement in

80
the capacity of ANMs by training them. Indigenous systems could be used effectively for promoting contraception.

**Health Minister, Gujarat** informed that Dai training is being done by the State. An insurance scheme for BPL families is being formulated. He requested special attention for better health care for urban areas and minority populations.

Sh. Asim Burman, **Principal Secretary, Health and Family Welfare, West Bengal**, gave a presentation on the Involvement of Panchayat Raj and Community Participation in the State as a model to be adopted by others. It was informed that all vertical societies working in the State have been merged at district level. Sabhapati of Zilla Parishad is the Chairman of the District Health and Family Welfare Society and District Magistrate is the Vice-Chairman. The political representatives and NGOs are among the members of the Society. The State is in the process to register Societies at Block level which would be responsible for supervision of Sub-Centres. The State is ensuring one Sub-Centre per Gram Panchayat and one ANM for a Gram Sansad. The community participation is to be achieved by payment of Rs. 2 by a household.

**DG, Health, Maharashtra** requested Union of India to introduce injectables as an option for contraception under National Family Welfare Programme. He urged for building a cadre of Public Health Specialists at district level who would act as health managers; and for constituting an All India Medical Service.

**Health Minister, Delhi** supported the demand for inclusion of injectibles in the National Family Welfare Programme. It was informed that a Technical Committee be constituted to study the issue of payment of compensation by doctors in case of sterilization failure.

**Health Minister, Uttarakhand**, requested for the change in the population norms for SCs and PHCs for hilly areas as one SC per 1000 and one PHC per 10000 population. The State aims to achieve TFR of 2.1 by 2010.
Principal Secretary, U.P. requested for projects for Urban Slums and Urban SC/PHCs. He desired that ANM should be used only for MH services and immunization and Health Worker (M) be made to look after all National Programmes. Greater political will would be needed to achieve the goals of National Population Policy 2000.

Secretary (FW), Andhra Pradesh briefed about the achievements under the Family Welfare Programme in the State during last 5 years. Political commitment and women empowerment have been the two main catalysts for the State to achieve 10% drop in decadal growth rate despite having sub average low female literacy rate, higher level of school dropout rate and low age of marriage. It was informed that 50 lakh women in the State have benefited through the Self Help Groups, which gives them social identity and economic empowerment. The State has regularly engaged Medical Officers and ANMs on contractual basis. All the PHCs in the State are equipped with infrastructure and have own budgets for maintenance and repair. Every PHC owns a vehicle. The State has recruited 2000 Addl. ANMs and 300 ANMs for backward areas through the State budget. 75% PHCs are conducting family planning operations on a weekly basis. Rs. 500 is given as an compensation to acceptors of sterilization. The State has conducted a year long campaign on “Age at Marriage”. The Institutional Delivery Rate has improved from 13% to 70% in a decade.

Minister of Health, Himachal Pradesh requested for use of vehicles sent by Government of India as Mobile Health Units for backward areas, specifically manned by women doctors. She wanted GOI to stress on submission of Utilization Certificates by the States to prevent diversion of funds by the State for other purposes. She endorsed the suggestion of having block-wise ANM and district-wise Doctors cadre.

Dr. Harshvardhan suggested that a day in a month be dedicated to Maternal Health under which private sector could also be appealed to work for free. This intervention could be taken up under Janani Suraksha Yojna. Similarly, one week day be dedicated, country-wide, for Routine Immunization. He highlighted the need to include incentives/disincentives for population stabilization.
Health Minister, Jharkhand stressed on the need of having International Projects for the State as it is a new State. He informed that the State is in the process of creating cadres for ANMs and doctors. The State needs a SIHFW and more Health Centres.

Health Minister, J&K highlighted the need for better implementation of PNDT Act in the State. He stressed on the need of equipping SCs with proper building and residential space and working duration of 12 hours.

Dr. Sobhan Sarkar, Deputy Commissioner (CH), Department of Family Welfare made a presentation on Routine Immunization and Polio Eradication. Under routine immunization the reported coverage of various antigens has been hovering around 100 percent from 1990 to 2002-03. The disease incidence of diphtheria and whooping cough has been declining over the period till 1999 thereafter there is marginal increase in the number of cases till Dec.2002. In the year 1984 the IMR was 105 per 1000 live birth which has came down to 66 per 1000 live birth by 2001. The evaluated coverage of fully immunized children showed wide variation between states ranging from 15% to 90%.

On Polio eradication there are only seven countries left globally where wild polio virus circulation is going on. The strategies for polio eradication is to sustained high level of routine polio vaccine coverage and simultaneous administration Pulse Polio doses through National Immunization days (NID) and Sub National Immunization days (SNID). Globally India is contributing 40% of polio cases and 4 of the 8 importation in other countries has been from India. There were 459 cases in 2002 from Jan – July as compared to 112 cases for the same period in 2003. This is lowest ever incidence of polio cases as compared to previous year and is the best opportunity to eliminate polio from India.
ACKNOWLEDGEMENT BY MINISTERS FROM BIHAR AND JAMMU & KASHMIR

Minister for Medical Education, F.W. & ISM, Bihar

This Council thanks the Central Government for the launch of Pradhan Mantri Swasthya Suraksha Yojana, which will create a huge infrastructure for the tertiary healthcare in the country by setting up new AIIMS and upgraded AIIMS for the poor and needy people of this nation.

Health Minister, Jammu & Kashmir

The Council congratulates the Central Government for undertaking effective and timely measures to contain SARS, which had become a very serious threat, not only for public health but also for trade and tourism.
DECISIONS TAKEN
SUMMING UP BY SECRETARY, HEALTH

Secretary (Health) summed up by highlighting the important decisions taken during the course of the deliberations. On the general health care expenditure he stated, that there was general feeling that the States and Govt. of India need to increase the contribution of expenditure in the country. According to the National Health Policy - 2002, this should increase from the present level of 5.5% of the plan expenditure to 7% by 2005 and further to 8% by 2010. This should be taken up as a firm decision of this Council. The Centre would also make efforts to increase the public health expenditure from 0.9% as at present to 2% of GDP by 2010.

The second decision was on HIV/AIDS where two important issues have emerged clearly. First, is the convergence between the AIDS and the RCH programme and the second is the convergence between TB and the HIV/AIDS programmes.

In the case of malaria, a comprehensive vector control programme is required to be launched which includes malaria, Kala-azar, Dengue & Japanese Encephalitis. 100 new PHCs are going to be added under the new programme. Also Kala-azar is going to be fully funded by the Govt. of India not only in Bihar but also in the adjoining states of West Bengal and UP, where Kala-azar is prevalent.

In the case of Leprosy, all endemic states will conduct one more round of the modified leprosy elimination campaign and also integrate leprosy programme into their general health care services.

On the food side, food laws will be amended to include “water” in the Prevention of Food Adulteration Act. A group of experts will be set up to evolve safety norms for drinking water so that once this group of expert comes out with the recommendations, the Government of India will take up notifying the standards under the PFA Act. The enforcement of food laws would also be streamlined, by having differential system of punishments, serious offences will be made cognizable and non-bailable. This would ensure stringent implementation of food laws.
On the drug side, imposition of death penalty on drug offenders who deal in spurious drugs has come out as a clear recommendation from this body. The States have to send their views on centralization of manufacturing licenses. If this can be done, then there can be uniform standards set for drug manufacturing in this country.

On tobacco, all the states have lent strong support for effective implementation of the provision of the Act, especially those relating to ban on smoking in public places and on advertisements.

All States have suggested a central legislation on regulation of medical and clinical establishments, so this is an important recommendation of this body. GOI should come out with a comprehensive legislation on Clinical Establishment Act.

**Medical Education**

1. The existing Indian Medical Council Act needs comprehensive amendment relating to the composition of the Medical Council to make it more compact and more representative in character to ensure its democratic functioning. Government of India should also have adequate powers of supervision including power to issue directions, to supercede the Council in case of its failure to perform it duties in accordance with the provision of the Act. The MCI Regulation on establishment of new medical colleges needs a review with regard to requirement of space, building, faculty and other infrastructural requirements.

2. The recent judgment of Supreme Court in TMA Pai case and Islamic Academy of Education case have cast enormous responsibility on the State Governments without identifying commensurate resources for discharge of these function. Having different fee structures and different management quotas for each college will bring in serious confusion among students and their parents, not to speak of the State Medical Education Departments and the management of medical colleges. The Council urges upon the Government of India to bring in necessary amendment in the I.M C. Act to streamline and rationalize both the fee structure
and the management quota in respect of aided and unaided private medical colleges.

3. The Council took a serious view of the situation arising out of the recent decision of the Medical Council of India, not to inspect colleges any further in view of the decision of Government of India to renew permission in case of some Government medical colleges in accordance with the powers vested with it. The Council decided that the Medical Council of India should be asked to resume inspections immediately in view of the advancing deadline of 30\textsuperscript{th} September, 2003 for completion of admission. A copy of this letter should also be sent to the Supreme Court of India.

4. The Council resolved that Government Medical Colleges should not be equated either with the institution owned by private managements as the Government colleges provide medical education at a lower cost to poor and meritorious students. State Governments stand guarantee for providing adequate financial and technical support to such colleges.

5. The Council noted with satisfaction that the Government of India is bringing in necessary amendments in the Nursing Council Act to ensure mobility of nurses from one State to another. A new Paramedical Council Act is also on the anvil and the States have supported the move to bring in a comprehensive legislation for paramedical services in the country.

6. The Council urged the Central Government to review the Dentists Act so as to bring in appropriate amendment to enable the Dental Council of India to discharge its function and meet its objectives in a more effective manner.

7. The Council urges all the States to contribute to the Central Pool Quota without fail so that the genuine needs of States without medical colleges and of sections like children of war widows, families affected by terrorist attacks are adequately met.
SUMMING UP BY SECRETARY, FAMILY WELFARE

- The Council resolves that all efforts be made for meeting the felt and unmet needs for healthcare of women and children, and that focus be given on improving access to services through adoption of a decentralized area specific approach to planning, implementation and monitoring.

- The Council resolves that a differential strategy be adopted to achieve incremental improvement in performance, especially in the States/Districts that are lagging behind. Special efforts be made to improve access to and utilization of the services in States/Districts with higher mortality or fertility rates.

- The Council calls upon the Government of India and State Governments to bring in important reform measures so that the concept of ‘good governance’ gets strengthened. These measures would relate to adoption of sound personal policies, optimum utilization of infrastructure, reasonable user charges to ensure sustainability of schemes and plans and improvements in financial and physical monitoring. The Council called upon the States to review their existing service rules. The States could continue to recruit doctors and paramedics at State level but amend the rules to create district cadres for doctors at the point of entry and till the doctors continue in Class II or complete 12 years of service (whichever is later), and block cadres for ANMs.

- The Council resolves that the States involve the Panchayati Raj Institutions in implementation of the health and family welfare programmes by progressive transfer of funds, functions and functionaries by training, equipping and empowering them suitable to manage and supervise the functioning of the healthcare infrastructure and manpower, and further, to coordinate the activities of workers of different Departments such as Health, Family Welfare, Social Welfare, Education etc., which are functioning at village and block levels.
• The Council welcomes the creation of the Jansankhya Sthirata Kosh and resolves to support it in creation of a buoyant Public-Private Partnership for population stabilization.

• The Council resolves that earnest efforts be made to create awareness on gender issues in the family welfare programme and to ensure male participation for promotion and acceptance of non-scalpel vasectomy, planned parenthood, care of pregnant and nursing mother etc.

• The Council, while continuing its support for a quality-conscious environment for promotion of reproductive healthcare services through informed choice and consent of citizens, resolves that suitable emphasis on provision of quality accessible family planning services will have to be brought back as an important agenda into the National Family Welfare Programme. This programme, with emphasis on quality of services and populations stabilization, must become one of the central tasks of the District Administration of all the States of the country.

• The Council notes that the issues of population, nutrition, sanitation and drinking water should become the central concern of all Departments of the Government and an integrated approach should be adopted for pursuing these National Agendas at field levels.

• The Council congratulates the Government of India for its proposal to launch a comprehensive ‘Janani Suraksha Yojana’ to address the issue of raising institutional deliveries and to provide greater incentive for the birth of the girl child. The Council urges that this scheme be finalized and launched at the earliest.

• The Council resolves that Central Legislature and State Legislatures adopt a norm of two child for the Central Legislators and State Legislators.
• There should be due convergence of the RCH Project, specifically with ISM and the HIV/AIDS programme, and also with other health programmes, for better delivery and outreach.

• The Council felt that the decline in Polio cases in low transmission season in 2003 should not bring about complacency and effort to eradicate the virus finally should continue with fullest political and administrative commitment to interpret transmission of virus by end 2003 or early 2004.

• The professional training of Medical Officers in 12-16 years service bracket for Public Health, Management and Health Sector Reforms, as introduced by the NIHFW recently, should be made a pre-requisite for promotion to CMOs/Civil Surgeons/Hospital Superintendents to equip them to handle their responsibilities better.
SUMMING UP BY SECRETARY, ISM & H

- The Council resolves that the objectives set down in the National Policy on ISM & H-2002 and the strategies delineated in the policy to achieve the objectives through policy interventions and support should be implemented by the States.

- The States which have not setup a State level Medicinal Plant Board so far should take steps to set up the Board expeditiously. All State level Medicinal Plant Boards should be made functional and vibrant so as to help make cultivation of medicinal plants a mission and a movement.

- States should extend full co-operation to the Central Govt and ensure that State Registers are updated, nomination are made in time for appointment of Returning Officers and once Returning Officers are appointed they are allowed to complete the election work assigned to them for the Central Council of Indian Medicines and the Central Council of Homeopathy.

- On quality control of ISM & H drugs, the decision is that the State Govts. should obtain grant-in-aid for strengthening the pharmacies, laboratories and enforcement mechanism. They should also encourage small manufacturing units to obtain central assistance for improving their infrastructure and the in-house quality mechanism. The States should fulfill the statutory duties cast upon them in the areas of quality control and enforcement.

- On magic remedies, the State Drug Controller should set up their own mechanism for scanning misleading advertisement and enrich their database with information made available by the agency appointed by Deptt. of ISM & H and take concentrated legal action to punish the offenders. The State Drug Controller should attach priority to this area of public concern.
• On good manufacturing practices, the State Drug Controller should enforce adherence to Good Manufacturing Practices by the manufacturers of Ayurveda, Siddha and Unani drugs.

• The available infrastructure should be optimized/or should be optimally utilized in the health care delivery systems, vacant posts should be filled up and regular Directors of ISM & H should be posted. Also separate Directorate should be created in the States where no separate Directorate has so far been established. Separate Drug Controller and Inspectors of ISM should be appointed. Necessary posts should be created expanding the outreach of ISM & H, drugs should be made available in adequate quantity for dispensing. The service condition of the ISM & H physicians be improved and brought on par with that of allopathic physicians.

• The State Govt. should identify good private Drug Testing Laboratories and encourage them to seek the recognition by the Central Govt. for conducting test of ISM drugs.

• The State Governments and private institutions should avail of the grant-in aid schemes to upgrade the standards and infrastructure of the colleges. The State Govt. should also take steps to remove the deficiencies and ensure that minimum standards are adhered to in the existing colleges. States should evaluate the need for establishing new colleges and financial and other capabilities of persons seeking locational clearance for opening new colleges.

• The States should takes steps as considered necessary to implement the pilot scheme on Home Remedies Kits. This should be converted into a regular scheme for supply of drugs to rural areas and wider section of population should be covered under the scheme.
• Steps should be taken by the States to expedite release of funds to the beneficiary institutions, submit utilization certificates for the grants already released to facilitate the Central Govt. to release further grants.

• On mainstreaming and integration of ISM & H and health care delivery system and National Health Programme, the Council resolves (a) that States should reiterate and re-enact or modify State laws governing the practice of modern medicine by ISM practitioners for utilizing their services for a range of options of health care delivery system. The States should keep in view, the judgments of the Supreme Court of India in Civil Appeal no 89 of 1987 in the of Dr. Mukhtiar Chand and others Vs State of Punjab and others passed on 13. 08. 98 upholding the validity of rule 2ee(iii) of Drugs and Cosmetics Act, 1940. The pith and substance of the judgment was that the Ayurvedic and Unani physicians may practice modern medicines to the extent permitted by the State Laws (b) specialist ISM & H treatment centers should be introduced in the rural hospitals and a wing should be created in existing States and district level Govt. hospitals (c) the ISM & H physicians should be involved in National Programme with or without training as considered necessary.
ANNEXURES
ANNEXURE 1

LIST OF POWER POINT PRESENTATIONS

28th August, 2003

Department of Health

1. National Anti Malaria Programme Director, NAMP
   2. Revised National Tuberculosis Control Programme DDG(TB)
   3. National Leprosy Eradication Programme DDG(Leprosy)
   5. National Programme for Control of Blindness DDG(Ophthalmology)
   6. National Cancer Control Programme CMO(NCD)
   7. Mental Health : Challenges Ahead DS(PH)

Department of Indian Systems of Medicine & Homoeopathy

Major Initiatives and Achievements during the last two years. JS(ISM &H)

29th August, 2003

Department of Health

Medical Education JS, D/o Health

Department of Family Welfare

1. National Population Policy – 2000 Secretary (FW)
   2. Janani Suraksha Yojana DDG(MH)
   3. From First Phase to Second Phase of RCH NPO, WHO
   4. Integration of Functioning of PRIs with Health Systems and Other Recent Initiatives in Health Sector Pr.Secretary (H&FW) West Bengal
   5. Family Welfare in Andhra Pradesh Secretary (FW), A.P.
   6. Universal Immunization & Polio Eradication Programme DC(CH)
NATIONAL ANTI MALARIA PROGRAMME

DIRECTORATE GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

NATIONAL ANTI MALARIA PROGRAMME (NAMP)

- Reduction in annual parasite incidence (API) from 11.2 per 1000 in 1976 to 1.8 in 2002.
- Number of cases reduced from 6.46 mln in 1976 to 1.82 mln in 2002 (72%)
- 40% decline in cases from 3.04 mln in 1996 to 1.82 mln in 2002

AREAS OF HIGH TRANSMISSION

- Largest number of cases – Orissa, Chattisgarh, West Bengal, Karnataka, Jharkhand
- Largest number of deaths – Orissa, West Bengal, Assam, Maharashtra, Meghalaya
- Highest API – Arunachal Pradesh, Goa, Orissa, Chattisgarh, Mizoram

EARLY DIAGNOSIS AND PROMPT TREATMENT

- Nearly 3 lakh functional DDCs. The number has doubled since 1997. Performance not uniform in all states
- Improvement in quality through training and supervision
- All villages with API > 2 must have a functional DDC
- Remote, inaccessible villages require higher priority

101
EARLY DIAGNOSIS AND PROMPT TREATMENT

- Still a large gap of several days between collection of blood smear and start of radical treatment. This has to be reduced by:
  - establishing more testing facilities by appointing regular/contractual laboratory technicians or by training other categories of health personnel for part time testing

- Making arrangements for getting the slides from the villages to the laboratories as quickly as possible

- Ensuring that the ABER is 10% or more. It is less than 5% in some large states such as Jharkhand, Uttar Pradesh and West Bengal

INDOOR RESIDUAL SPRAY

- Indoor residual spray in highly selective manner through trained personnel under supervision is an important vector control measure

- At present, quality is poor, by and large, leading to a false sense of security and inappropriate use of scarce resources
  - In a number of districts indoors not sprayed, outer walls sprayed
  - Rooms not sprayed but room coverage reported
  - Discrepancies between reported coverage and quantities of insecticides used

INSECTICIDE TREATED MOSQUITO NETS

- Insecticide treated mosquito nets are a cost effective alternative to IRS but high coverage is important
  - 5.9 lakh mosquito nets provided to 42 districts under EMCP. Must be treated annually, usage monitored and impact documented. Evaluation study indicates good use but irregular treatment
  - 12 lakh will be supplied this year. Guidelines for distribution have been issued. States may consider charging nominal rates affordable by the community
INSECTICIDE TREATED MOSQUITO NETS

- Treat community owned mosquito nets through public/private/NGO partnership. Cost of insecticide to be paid by the individual
- Promote use of mosquito nets through IEC campaigns, advocacy workshops, intersectoral collaboration

LARVIVOROUS FISH

- Larvivorous fish can reduce the mosquito densities and reliance on chemical insecticides
  - Some progress has been made in the districts under EMCP in establishing district and block level hatcheries. This needs to be rapidly expanded
  - Mosquito breeding sites must be listed for fish distribution
  - States may consider high coverage in selected districts for optimal impact

URBAN MALARIA

- 10% of total reported cases from urban areas
- Vector breeds in clean water in man made containers such as over head and under ground water storage tanks, water coolers, tyres, flower vases, ornamental tanks etc
- Urban bye laws must be enacted to control domestic, peri-domestic and workplace breeding of the vectors of malaria and dengue fever
- Only Delhi, Mumbai and Goa have enacted the bye laws. No progress since last meeting of the CCH & FW

INTERSECTORAL COLLABORATION

- Activities of many sectors create conditions for the breeding of mosquitoes. Precautionary measures must be taken
- Many industries and agriculture activities employ contract labour from high malarious zones. This can lead to spread of the disease to low endemic areas. Contract labour must be screened
INTERSECTORAL COLLABORATION

- Many government departments, NGOs, private sector can collaborate in malaria control activities through their existing infrastructure and manpower if technical support is provided.
- Malaria occurs in difficult areas with inadequate infrastructure and high vacancy of staff. District administration can mobilize available resources.

NEW INITIATIVES

- Introduction of pre packaged anti malarial drugs for the radical treatment of adult patients (blister pack with only 4 tablets).
- Use of rapid diagnostic tests in remote inaccessible high risk pockets with high P. falciparum malaria in EMCP States.
- Treatment of community owned mosquito nets with NGO and private sector collaboration in 14 districts.

MAJOR CHALLENGES

- Areas of high transmission in tribal, hilly, forest fringed areas with inadequate infrastructure, many mosquito breeding sites and efficient vectors. Greater efforts are required in these areas.
- High vacancy of field level and supervisory staff.
- Shift from reliance on IRS alone to a mix of integrated cost effective interventions.
- More direct involvement of community, NGOs, private sector and other government departments.

KALA AZAR

- Indigenous cases reported from Bihar, West Bengal, Jharkhand and Uttar Pradesh.
- Overall declining trend in reported cases due to effective indoor residual spray in the early 1990s.
- Increase in cases and deaths reported in several blocks.
- No spray in Bihar for the last two years and inadequate in other states. Allocated quantities of DDT not lifted.
LYMPHATIC FILARIASIS

- Leads to lymphoedema (elephantiasis). Patients are incapacitated due to frequent infections leading to fever and pain
- Management requires simple measures which can be practiced at community level without additional inputs with simple training

LYMPHATIC FILARIASIS

- Estimates of disease burden based on night blood surveys vary widely. Endemic districts may be as high as 261. High risk areas within endemic districts can be mapped by rapid morbidity survey of persons with lymphoedema and/or hydrocele
- Mass drug administration with DEC in 30 districts with varying impact. Scientific evaluation necessary before expansion to more districts

DENGUE FEVER

- Self limiting acute viral infection. Can be fatal in patients with severe form – dengue haemorrhagic fever or dengue shock syndrome
- Has the potential of causing large outbreaks if vector densities are high
- Vector breeds in clean water in man made containers in domestic, peri-domestic areas and work places

DENGUE FEVER

- Risks can be minimized only through surveillance of larval densities and implementation of urban bye laws
- Medical and health personnel must be aware of guidelines for the clinical management of cases
JAPANESE ENCEPHALITIS

- Japanese encephalitis is an acute viral infection with high case fatality rate and high complication rate in those who survive.
- No specific treatment but clinical management of severely ill patients is important in improving prognosis.
- Vector breeds in natural water bodies with dirty/polluted water such as paddy fields and irrigation canals.

JAPANESE ENCEPHALITIS

- Presence of amplifying hosts important. Does not spread from man to man.
- Vector flies long distances and rests outdoors. Indoor residual spray not cost effective. Use of insecticide treated mosquito nets will provide protection.
- Vaccination as a routine immunization provides protection for some years. Booster doses required. Vaccination not recommended as an outbreak control measure.

OUTBREAK CONTROL

- Dengue fever, Japanese encephalitis and malaria are outbreak prone.
- Outbreaks can be controlled effectively only if recognized early and appropriate control measures are taken. Some like JE are difficult to manage.
- Capacity building in terms of training personnel, establishing laboratory facilities and earmarking resources must be done before an outbreak occurs.

OUTBREAK CONTROL

- Centre can provide technical support and assist in laboratory confirmation of the aetiology of the outbreak. Outbreak control is the responsibility of the state government and sufficient funds should be earmarked in the budget. There are no such funds available at the central level.

106
REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

Directorate General of Health Services
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi 110 011

MULTI-YEAR DOTS EXPANSION PLAN FOR INDIA
31st July 2003

India RNTCP (DOTS) implementation status by district, 31st July 2003

PLAN FOR ADDITIONAL COVERAGE

- Chhattisgarh, Uttarakhand & Jharkhand – GFATM-I
- Remaining districts of UP and Bihar – GFATM-II
- Haryana – USAID
- Andhra Pradesh – DFID
- Orissa – DANIDA.

- All the remaining districts have been released initial funds for preparatory activities.

The whole country is planned to be covered by 2005.

107
DISTRICTS WITH DELAYED IMPLEMENTATION

Year-2: Bihar
Maharashtra: Samastipur, Ulhasnagar MC

Year-3: Gujarat
J & K: Kutchch, Chota Udepur
West Bengal: Jammu, Srinagar, Darjeeling

Year-4: Maharashtra: Washim

DISTRICTS WITH DELAYED IMPLEMENTATION (Year 5)
- ABHIS (Andamans)
- ASSAM: Karbi Anglong
- BIHAR: Katihar, Munger, Purba Champaran, Purnia
- GOA: North Goa, South Goa
- J & K: Anantnag, Doda, Kathua, Pulwama
- LAKSHADWEEP: Lakshadweep
- M P: Jabalpur, Panna, Shandel
- PONDICHERRY: Pondicherry
- TRIPURA: South Tripura, West Tripura
- UTTAR PRADESH: Allahabad, Etawah, Faizabad, Gonda, Kanpur Nagar, Khur, Pratapgarh

All districts have now been approved for coverage under RNTCP and funds released for the purpose.

PREPARATORY ACTIVITIES
- Minor civil work - DTOs office, drug store and lab (~1 mth)
- Training of different categories of staff (~3-4mth)
- Hiring of contractual staff and training (~2-3 mth)
- Purchase of computer, Photocopier, Internet connection (~1mth)
- Printing of modules, formats and registers (~2mth)
- Procurement of lab consumables (~2mth)

ACTIONS REQUIRED TO EXPEDITE PREPARATORY ACTIVITIES
- Necessary instructions from State to all preparatory districts
- Greater involvement of DMs & CMOH
- Removing the administrative bottlenecks
RNTCP ACHIEVEMENTS

- ~ 40 fold expansion of DOTS in past 4.5 yrs
  - 2nd largest programme in the world
  - Fastest expansion in the world
- Till date > 20 lakh patients initiated on treatment
  - around 3.5 lakh additional lives saved
- Each month more than 70,000 patients are being initiated on DOTS.
- More than 8 out of 10 patients are successfully treated.

Annualized new smear positive case detection rate and success rate (1st quarter 1999 to 2nd quarter 2003)

Actions required to increase case detection

- Involving all health care providers in the area
  - Govt./ Private/ Corporate sector
  - Medical colleges
- Monitoring referrals from PHI to MC
- Intensifying IEC activities
- Involving of the community, PRIs and SHG
- Regular review by CMOH
**Actions Taken for Involvement of Other Sectors - I**

- Guidelines for involvement of NGOs and private practitioners widely disseminated
  - Decentralized to the district level
  - Around 550 NGOs and 2000 PPs are already involved in RNTCP
  - Maximum number of NGOs are involved in Maharashtra (121) and Delhi (89) followed by Rajasthan (45).
  - Among the Private Practitioners maximum involvement is seen in AP (460) and Maharashtra (399) followed by Gujarat (268) and Tamil Nadu (250).

**Actions Taken for Involvement of Other Sectors - II**

- National level and Zonal task force for involvement of Medical Colleges formed

- All States have initiated action for involvement of medical colleges in RNTCP
  - Around 80 Medical Colleges already involved
  - A microscopy-cum DOT centre is being established
  - Extra manpower - Medical Officer, STLS, LT and TBHV on contractual basis
  - States may issue necessary instructions to all Medical Colleges for following RNTCP guidelines

**Actions Required to Improve Performance in Implementing Areas**

- To make DOT patient friendly
- Strong default retrieval system
- Improvement in supervision
  - Submission of advance tour programmes and tour reports - STS, STLS, MOTCs and DTOs - special emphasis on corrective measures taken on the spot
  - Mobility of supervisory staff to be ensured
- STO and DTO need to be full time
- Filling up of vacant key staff positions - LT, STS, STLS
- Avoid frequent transfer of trained manpower esp - STO, DTO, MO-TC

**Action Taken for Strengthening State TB Cell**

- State TB Society strengthened by way of appointing the required staff on contractual basis
  - Medical Officer, IEC Officer, Accountant, Statistical Assistance, DEO & Driver
- Procurement & installation of necessary equipments such as vehicle, photocopy machine, fax.
- Provision of electronic connectivity.
OTHER ACTIONS REQUIRED TO BE TAKEN

- The States, where STDC does not exist, have been requested to establish STDCs.
- Funds are provided to the STCS for strengthening of existing STDCs.
- In many States DTCs have not been established in all the new districts
  - grant of Rs. 4 lakhs is given for newly created districts for establishment of DTCs.
National Leprosy Eradication Programme

Directorate General of Health Services
Ministry of Health and Family Welfare
Govt. Of India

LEPROSY PREVALENCE IN THE STATES/UTs OF INDIA
As on March 2003
PR 03.23/10,000

Leprosy Elimination Area Population - 291.29 Million
Recorded Leprosy Patients - 0.345 Million
PR/10,000 - 03.23

Thrust Areas In Endemic States

* Decentralization of NLEP to Districts
* District CMHOs of 12 Priority Endemic States being trained on "NLEP Management"
* GHS Functionaries Trained on Leprosy
  To ensure daily availability of Leprosy DX & MDT Services at All PHCs / Sub - Centres, Dispensaries and Hospitals
* Implementation Of NLEP Simplified Information System - MDT Stock And Supply Management
Integration Of Leprosy Infrastructure With GHS In High Endemic States

* Contractual Staff Reduction
  1/3rd By March 03
  100% By March 04
* NLEP Vertical Staff & Infrastructure by March 2004 - Retaining 20 - 30% Staff as State and Distt. NLEP Nuclei to ensure Leprosy Programme implementation beyond March 2004.

Special Efforts for New Leprosy Case Detection & Treatment In Endemic States

* 5th MLEC in 8 Priority States During 2003 - 04
  Bihar, Jharkhand, Orissa, Chhattisgarh, Uttar Pradesh, Andhra Pradesh, Maharashtra and West Bengal
* SAPELS in Rural & Tribal Areas
* LECs in Urban Areas

Prevention of Disabilities (POD) and Care Service Delivery

* State Core Training Teams Already Trained by GOI
* District Core Training Teams being Trained by States

- Training of GHS Functionaries
- Education of Deformed Leprosy Patients for Self Care
- MCR Foot Wear Supply To Deserving Leprosy Cases
- District / Regional / State Level Hospitals to Regularly undertake Reconstructive Surgeries of Correctable Leprosy Deformities

Planning & Implementation of Leprosy Elimination Efforts in Urban Areas

* Lack of Organised Primary Health Care Infrastructure
* Migratory Population
* Increasing Slum Population

Challenge for Leprosy Elimination

Suitable Action Plan involving and Linking Existing Medical & Health Care facilities / Institutions with Proper Coordination.

While Involving - NGOs / VOs
- Pvt. Medical Practitioners
Monitoring of Expenditure

G.I.A. Feed Flow

Monthly SOE by 20th of Month

GOI → SLS → DLS(4)

Reconciliation
Claim(Monthly)

GOI → SLS ← DLS(4)

Consolidated

GOI → World Bank

Consolidated
Audited Acct. 1982-83

GOI ← SLS(4) by 30th June 03.

World Bank by July 03.

* Chhattisgarh * Jharkhand * A & N Islands * Madhya Pradesh * Uttar Pradesh * Sikkim * West Bengal * H.P. * U.T. Chandigarh

THANKS
HIV/AIDS in India

Programme Components

GOI has significantly expanded the program at state level through

- 38 AIDS Control Societies
- Nationwide systems for blood safety, HIV sentinel surveillance
- Behaviour surveillance surveys
- Training for medical and Para-medical Health care Providers
- Facilities for Voluntary counselling and confidential HIV testing
- Prevention of Parent to child transmission of HIV upto district level in six High prevalence states
- Computerized management information system
- Project financial management System
- Large network of NGOs and CBOs
These efforts have contributed to the development of national & state level implementation capacities.

However, the capacity of states to function effectively remains variable. Major challenges remain in raising the quality, coverage, outreach and commitment of state level programmes.

States like TN, Andhra Pradesh, Nagaland and Manipur have demonstrated strong and coordinated responses.

Other states need early strengthening of technical and management capacity, particularly for implementation, supervision and monitoring.

Priority areas for action at State levels

Blood safety

➢ Promotion of rational use of blood
➢ Mobilisation for voluntary blood donation
➢ Strengthening of regulatory systems
➢ Ensuring quality through EQAS
➢ Accreditation of blood banks
➢ Setting up of blood storage centres at FRUs/CHCs and developing linkages with blood banks

Universal precautions and hospital infection control measures

➢ Dissemination of standard operating procedures, already circulated
➢ Capacity building of health care providers at all levels
➢ Supply of essential equipment and materials
➢ Strengthening systems for hospital waste management
➢ Regular monitoring
Care and support

- Integration of clinical care of HIV+ve persons with health care systems
- Dissemination of clinical management guidelines
- Capacity building of health care providers on care of positive persons
- Strengthening of diagnostic facilities
- Management of HIV/TB co-infection
- Post-exposure prophylaxis

Links with the Reproductive and Child health Programme

- Dual protection messages on condoms
- Training of multi-purpose field workers on HIV/AIDS
- NACP has established STI clinics at district level hospitals and department of FW at FRU level, synergy in STI/RTI management
- Integration of prevention of parent to child transmission with maternal and child health care package
- Family Health Awareness Campaign

Inter-sectoral collaboration

- Sensitisation of youth – Department of Education/Sports and Youth affairs
- Workplace intervention- Department of Labour/Industries
- Sensitisation of young girls and women- Department of Women and Child Development
- Social rehabilitation of orphans/widows- Department of Social justice
- Creating enabling environment- Department of Police / Law and justice

Greater Involvement of people living with HIV/AIDS

- NACO has directed SACS to involve people living with HIV/AIDS in the executive and IEC Committees
- Appointing PLHAs as peer counsellors/educators
- Creating an environment for them to live with dignity
- Ensuring that they are provided access to health care services and are not discriminated by health care workers
- Prevention of discrimination at work place/ educational institutions
- Involving them in advocacy programmes

119
Advocacy for Social mobilisation

- Consensus with key influencers such as religious leaders, elected representatives, leaders of social organisations
- Gaining support of the media and other cultural leaders for the AIDS Control Programme
- Involvement of professional bodies, trade unions

Conclusions

- Need to strengthen capacities at all levels
- Need to integrate the multi-sectoral response
- Need to develop and promote an enabling environment for HIV prevention
- Stigma and discrimination must be removed for prevention and treatment to succeed
- Regular monitoring of the programme
- Integration with existing health care systems

Thank you
National Programme for Control of Blindness

Directorate General of Health Services
Ministry of Health and Family Welfare

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

Launched in 1976 as a 100% Centrally Sponsored Programme to reduce prevalence of blindness from 1.4% to 0.3%

Magnitude & Causes of Blindness

Programme Activities

- Identification and Treatment of Cataracts
- Detection & Correction of Refractive Errors
- Eye Donation and Corneal Transplantation
- Training of personnel
- Supply of Equipments and consumables
- IEC activities
- Monitoring and Evaluation
Major Achievements

- Cataract Surgery: 38.50 Lakhs
- IOL Implantation: 77%
- Eye Surgeons Trained in IOL surgery: 1200
- Infrastructure Development: 400
  Construction of Eye OTs/Wards
  - Supply of high-tech Ophthalmic Equipments, IOLs & Sutures: Up to Sub District Level
  - Non-recurring grants to NGOs: 39
  - Increase in coverage of blind persons: 70%
Financial Assistance to NGOs

Free Cataract Surgery (through DBCS):
Conventional Surgery : Rs. 400/- per case
IOL Surgery : Rs. 600/- per case

Non Recurring Grant : Rs. 17.75 Lakh
(for setting up/ expanding Eye Care services in the rural/ remote areas)

Targets for 2002-07

1. Pediatric Ophthalmology Units=50
2. Vision Centres in Rural Areas=4000
3. Fully Functional Eye Bank networks=25
4. Low Vision Centres=50
5. Cataract Surgery : 21 million
6. Post-operative Vision>6/18 in >80%
7. Proportion of IOL Surgery>80%
8. School Eye Screening & supply of free spects to poor children in all States/ UTs

FUTURE CHALLENGES

- Focus on causes of Blindness and visual impairment other than Cataract like uncorrected refractive error, corneal blindness, glaucoma, posterior segment blindness, childhood blindness etc.
- Improvement in Quality of eye care services and follow-up of operated cases.
- Human Resource Development to meet challenges in the 21st Century
- Sustainability of Eye-Care Programme
- Preference for IOL implantation
- Accessibility to under served, poor and under-privileged
- Vision 2020 : The Right to Sight Initiatives

States performing at Cataract Surgery Now above

2002-2003
Issues for Discussion: 1

Prevalence of Blindness - 1.1%
  • Focus should be on Bilateral Blindness to bring it down further to 0.3%

• Non Utilisation of Funds
  • Cash grant released to the State Governments/ UTs yet to be released to the Societies

• Non receipt of UCs and Expenditure Statements in time

Issues for Discussion: 2

• Low priority for Eye Banks - Needs more focus to be given by State Governments/ UTs

• Scarcity of Human Resource in Rural/ Remote areas - PG Qualified Eye Doctors working in PHCs/ CHCs/ SDHS need to be utilised for eye surgery and other Eye Care activities
**Issues for Discussion : 3**

- Non-optimal utilisation of new constructed Eye Care facilities due to lack of eye surgeons and support staff

- Non-filling of vacancy position for medical and para-medical staff

**Issues for Discussion : 4**

- Eye surgeons in Government Sector are not being optimally utilised for Eye Care work as they are given other additional duties

- Few States are lagging behind in new technology for cataract surgery like Intra Ocular Lens implantation

**THANK YOU**
NATIONAL CANCER CONTROL PROGRAMME

Directorate General of Health Services
Ministry of Health & Family Welfare
New Delhi

Cancer Scenario

- Globally 9% of all deaths due to cancer.
- 2-2.5 million cases of cancer in India.
  (7 – 9 lakh new cases every year)
- 3.5 – 4.0 lakh die each year due to cancer in India.
- Tobacco related cancers 50%(m) & 20% (f).
- 2/3rd are advance at the time of diagnosis in India.

Facts about Cancer

- CERVICAL CANCER AND BREAST CANCER ARE COMMONEST IN FEMALES.
- ORAL CAVITY, LARYNGOPHARYNX AND LUNG CANCER ARE COMMON IN MEN
- LIFETIME CHANCE OF CANCER 1:15 MEN & 1:12 WOMEN
- ABOUT 50% CANCERS ARE TREATABLE/‘CURABLE’ NOW.
- EARLY DIAGNOSIS RESULTS IN EFFECTIVE TREATMENT.

Causes of cancer

- Tobacco
- Alcohol
- Genetic factors
- Viruses
- Parasites
- Radiations
- Pollution
- Dietary factors
- Obesity
- Customs habits and lifestyles
- Occupational exposures
- Reproductive factors
- Hormones
- Pesticides
- Infectious agents
Schemes under NCCP

- Assistance for the purchase of cobalt unit etc. 1 crore (NGOs) & 1.5 crore (Govt. institutions)
- Devp. of Oncology Wings in Govt. Medical Colleges (Rs. 2 crores)
- District Cancer Control Programme
- Assistance for NGO’s for prevention & early detection of Cancer (Rs. 5 Lakh)
- Assistance to Regional Cancer Centers for Cancer Research & treatment (Rs. 75 lakh annually)

Achievements of NCCP - 9th plan

- Total expenditure incurred approx. 193 crores
- 7 new RCCs recognised in different states/UTs
- 32 Medical College Hospitals provided financial assistance under Oncology Wing Scheme
- 39 Institutions provided financial assistance under Cobalt Scheme.
- 22 Districts provided financial assistance under DCCP.
- 18 NGOs provided financial assistance under NGO scheme for awareness etc.

Radiotherapy Facilities in India

<table>
<thead>
<tr>
<th>State</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maharashtra</td>
<td>26</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>21</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>22</td>
</tr>
<tr>
<td>Karnataka</td>
<td>14</td>
</tr>
<tr>
<td>Delhi</td>
<td>12</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>13</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>11</td>
</tr>
<tr>
<td>West Bengal</td>
<td>9</td>
</tr>
<tr>
<td>Gujarat</td>
<td>7</td>
</tr>
<tr>
<td>Kerala</td>
<td>6</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>7</td>
</tr>
</tbody>
</table>

- Bihar 5
- Punjab 5
- J & K 3
- Orissa 3
- Chhattisgarh 3
- Assam 6
- Goa 2
- Haryana 3
- Manipur 1
- Meghalaya 1
- Tripura 1
- Jharkhand 1
- Mizoram 1
- Arunachal Pradesh 0
- Nagaland 0
- Uttarakhand 0
- Union Territories 0
- Pondicherry 1
- Chandigarh 1
- Other UTs 0

Total = 178 centres

(Cobalt Units = 248, Linear Accelerators = 42)

Plan ahead for 10th Plan

- Plan Outlay 285 crores. EPC is being revised.
- Focus on DCCP to be operationalised through nodal agency e.g. RCCs, medical colleges, District Hospital etc. and linkage with primary health care delivery system.
- Focus on Government Medical Colleges and hospitals for development of ‘Oncology Wings’.
- Reduce the geographical gaps in the availability of cancer treatment facilities.
- Focus on creating Anti-Tobacco Awareness.
- States may consider carrying out effective cancer awareness campaign in the regional languages also.
Issues for consideration

- There is an urgent need to focus on health education, prevention and early detection of Cancer. Nodal institutions may be identified by states for District Cancer Control Programme.

- States may consider developing 'Oncology Wings' in all Govt. Medical Colleges and Hospitals.

- States with insufficient cancer treatment facilities (geographical gaps) may send proposals for financial assistance. Contd.....

Issues for consideration

- There is a need to ensure the utilisation of money released under NCCP. Utilisation certificates to be sent to MOH along with unutilised funds (if any).

- States may consider carrying out effective cancer awareness campaign in the regional languages especially through mass media i.e. TV/Radio.

- Nodal officer (state) may be designated for co-ordination with NCCP.

Thank You
THE PROBLEM

- 1.2% serious mental disorders (10-20 million)
- 5% minor disorders (50 million)
- Services mainly in public sector:
  - 37 mental hospitals
  - Psychiatric wings of medical colleges.
- Total beds for mental health: 25,000
- Total psychiatrists: 3,000; mainly in urban sector.

THE PROBLEM

- Stigmatization in common due to lack of awareness.
- Basic treatment is cheap but not readily available.
- Conditions in mental hospitals not up to standard.
- Number of beds not adequate and distribution is not proportionate.
- Care is more custodial rather than therapeutic.

Xth five year plan

- Total outlay: 190 crores
- Strengthening of mental hospitals (37)
- Up gradation/creation of psychiatry wings of medical colleges and Government Hospitals (75).
- Expansion of district mental health programme to 100 districts.
- IEC activities
- Research.

Other action: Increasing seats for post graduation in psychiatry as well as introducing appropriate mental health care curriculum in undergraduate medical education.
Summary Slide

- Prepare proposals in format to be sent for one time grant for upgradation of mental hospitals. Ceiling 3 crores.
- Prepare proposals in format to be sent for one time grant for upgradation of psychiatry wings of medical colleges. Ceiling 50 lakhs.
- Identify districts for DMHP. 73 more to be added.
- Strict implementation of Mental Health Act by regular monitoring and feedback.
- Fill up vacant posts in medical and nursing cadres.
National Policy on ISM&H 2002

For the first time, a separate National Policy on Indian Systems of Medicine and Homoeopathy 2002 approved for focused development of ISM&H.

The policy clearly defines the objectives and delineates the strategies to achieve them.

.CONTD.

National Policy on ISM&H 2002

The basic objectives of the Policy are:

- To promote good health and expand the outreach of health care to people
- Expand the outreach and ensure affordable ISM&H services to the people
- To improve the quality of teachers and clinicians by revising curricula to contemporary relevance.
- To facilitate availability of raw drugs which are authentic and contain essential components as required under Pharmacopoeia standards.
- To integrate ISM&H in health care delivery systems in the National Programmes.
- Reinvent and prioritize research in ISM&H.
- Create awareness about the strengths of these systems in India and abroad.
- To provide full opportunity for the growth and development of these systems and utilisation of the potentiality strength and revival of their glory.
The IMCC Act, 1970 and the HCC Act, 1973 amended

To implement the recommendation of the Council to curtail mushroom growth of substandard colleges of ISM&H, the Department of ISM&H has amended the Indian Medicines Central Council Act, 1970 and the Homoeopathy Central Council Act, 1973, vesting the Central Government with the powers to grant permission for opening a new college, increase seats and open a new or higher course of study. This will ensure that colleges which would meet laid down standards would be permitted to impart education.

Central Pharmacy Council of ISM&H

In pursuance of the recommendations of the Council, the Department of ISM&H has taken steps for regulating education and practice in ISM&H pharmacy education.

National Medicinal Plants Board and State Medicinal Plants Board

National Medicinal Plants Board was set up to coordinate all matters related to medicinal plants including drawing up policies and strategies for conservation, proper harvesting, cost effective cultivation, research and development, processing, marketing etc., have become fully functional and taken a number of initiatives and funded 324 projects worth 25 crores. Through constant dialogues and persuasion, the National Medicinal Plants Board has been instrumental in the establishment of 27 State Medicinal Plants Board

Good Manufacturing Practices (GMP)

Good Manufacturing Practices have been made legally enforceable w.e.f. June, 2002. This brings in much desired reform. This will enhance credibility and ensure wider acceptability, domestically and internationally of ISM drugs.
Schemes to be implemented in Tenth Plan for the development of the ISM&H

Twenty-five (25) Central Sponsored and Central Sector Schemes have been approved for implementation in the Tenth Plan (2002-2007). The salient features of these schemes are:

- Most of the schemes are new.
- Existing schemes for the development of ISM&H institutions have been substantially expanded and augmented by adding new components.
- Six schemes would be implemented in the areas of Drug quality control.
- Three schemes have been approved for implementation aimed to integrate ISM&H.

---

**Centrally Sponsored Schemes**

A. Development of Institutions
1. Development of ISM&H U.G. Colleges
2. Assistance to P.G. Medical Education in ISM
3. Re-orientation of In-service training programme
4. Information Technology
5. Renovation and strengthening of ISM&H facility (patient care services) in ISM&H teaching colleges/hospitals & other hospitals.
6. Establishment of model colleges

---

**Centrally Sponsored Schemes**

B. Hospitals and Dispensaries
7. ISM Polyclinics with Regimental Therapy (Panchkarma, Yoga & Naturopathy)
8. Specialty Clinic on ISM&H
9. Setting up of ISM wing in district hospital
10. a) Essential Drugs for Ayurveda, Siddha, Unani & Homoeopathy (ISM&H) dispensaries for Rural and backward areas
    b) Supply of Medicinal kits (Home Remedies/Health for all/Health for all through preventive & promotive programme of ISM&H)

---

**Centrally Sponsored Schemes**

C. Drug Quality Control
11. State Drug Testing Laboratory & Pharmacies
12. Use of modern technology and Bio-technology
13. Support to ISM&H industry for creation of laboratories/Quality Control facilities
14. Strengthening of enforcement mechanism for Quality control
15. Assistance to units obtaining GMP certification
16. Information, Education & Communication
17. International Exchange Programmes/Seminars/Workshops on ISM&H and Scholarship scheme for foreign students in ISM&H

---

135
Central Sector Schemes

18. Programme for training/ fellowship/ exposure visit/ upgrading of skills etc. for ISM\&H personnel
19. Incentives to ISM\&H industry for participation in the fairs/ conducting market study for creating a developing market opportunity
20. Publication of text books
21. Manuscript publication and acquisition
22. Extra Mural Research Projects through Research Institutions (PM\&R/ BMI/ Govt/ Kowt/ Universities/ NGOs etc.
23. Innovative Scheme for development of Medicinal Plants
24. Survey on usage & acceptability of ISM\&H systems
25. Scheme for Pharmacopeia standards

Traditional Knowledge Digital Library (TKDL)

Traditional Knowledge Digital Library (TKDL) for Ayurveda covering about 35,000 formulations in the first phase, would be completed by 31.8.2003.

Establishment of Traditional Knowledge Digital Library (TKDL) for Siddha, Unani, Yoga and Naturopathy has also been undertaken.

The Second phase of TKDL for Ayurveda will be undertaken soon.

Establishment of National Institutes/National Laboratories

(a) National Institute of Siddha, Chennai

Establishment of National Institute of Siddha for P.G. teaching and research at a cost of Rs. 47 crores undertaken. Construction has been started. A six-year project would be completed in two years.

(b) National Institute of Unani Medicine, Bangalore

The first phase of NIUM, Bangalore for PG teaching and research is scheduled for completion in September, 2003. PG Teaching expected to start in 2004-2005
Establishment of National Institutes/National Laboratories

(c) Morarji Desai National Institute of Yoga and Naturopathy, New Delhi

The construction of state-of-the-art new complex of MDNIY started. It will be completed in one year.

Establishment of National Institutes/National Laboratories

(d) Pharmacopoeial Laboratory for Indian Medicine and Homoeopathic Pharmacopoeia Laboratory (PLIM & HPL, Ghaziabad)

The construction of new buildings of PLIM & HPL Ghaziabad started in Feb., 2003. Likely to be completed by Feb., 2005. These are Apex Level laboratories and Appellate as well.

Establishment of National Institutes/National Laboratories

(e) National Ayurveda Hospital, New Delhi

A state-of-the-art National Ayurveda Hospital would be set up at New Delhi in joint venture with private sector. 4.5 acres land acquired from DDA. Steps taken to identify joint venture partner. Department attaches highest priority to this project.

Home Remedies Kit

A pilot scheme for making available Home Remedies Kit for 15 identified common ailments in rural areas through ISM&H launched. The pilot scheme will be implemented in 21 states, one district each covering about 100 villages in each district.

The pilot scheme is proposed to be converted into a regular scheme.
**Good Laboratory Practices (GLPs)**

Guidelines for Good Laboratory Practices formulated and circulated.

---

**Recognition of Private Drugs Testing Laboratories**

Enabling provision has been made in the Drugs & Cosmetics Rules to recognise private drugs testing laboratories for testing of ISM drugs.

---

**Important issues for consideration of the Council**

1. **Implementation of National Policy on ISM&H - 2002**

   The objectives of National Policy on ISM&H -2002 through the strategies determined may be implemented.

2. **Mainstreaming and Integration of ISM&H in Health Care Delivery System and National Health Programme**

   The Council made following recommendations in its meeting in 1999 and 2001 for integration:
   - One ISM&H physician in PHC.
   - Vacancies caused by allopathic physicians to be filled up by ISM&H physicians.
   - Specialised treatment of ISM&H in rural hospitals, district hospitals and State level hospitals.
   - Identify specific areas which can be entrusted to ISM&H physicians.
   - Legislative, administrative and schematic changes be brought by the States to achieve objectives of utilising these physicians to the best advantage.

---

**Important issues for consideration of the Council**

3. **Utilisation of grants-in-aid scheme**

   The utilization of grants-in-aid scheme is very sluggish. Continuity and new schemes should be avoided if the utilization certificate for the grants already sanctioned are not in the possession of the concerned States. States should address this issue in all earnestness and provide utilization certificates.

4. **Good Manufacturing Practices**

   Adherence to Good Manufacturing Practices is statutorily required since 23.6.2000. The State Drugs Control Authorities are required to enforce them.

   Tiny manufacturing units etc. represented for relaxation from observance of GMP. The Department of ISM&H has advised States to provide details of such units and a view to examine if any relief is needed and can be provided.

---

138
Important issues for consideration of the Council

5. **Drugs & Magic Remedies (Objectionable Advertisements) Act, 1954**

As per provisions in the Drugs & Magic Remedies (Objectionable Advertisements) Act, 1954, advertisement for cure of 54 specified disease conditions can’t be made. Exaggerated claims for being made through print media and guilty public are being cheated. State Drugs Control Authorities are required to initiate penal action against such offenders.

State Governments should address this area with all seriousness and penalize the offenders.

Contd

Important issues for consideration of the Council

6. **Election to Central Council of Indian Medicines and Central Council of Homeopathy**

The Councils are constituted for a period of 5 years. They are re-constituted after 5 years based on fresh election. The process of election is delayed due to non-updating of State Medical Registers and frequent change of Returning Officers. Conduct of election is a statutory responsibility cast upon the Central and State Governments. State Governments are requested to extend full cooperation in conducting election expeditiously.

Contd

Important issues for consideration of the Council

7. **Establishment of State Medicinal Plants Board**

Only 27 States have so far set up Medicinal Plants Board. Remaining States should set up Medicinal Plants Board expeditiously.

Contd

Important issues for consideration of the Council

8. **Infrastructure Development of ISM&H**

Most of the States have established separate Directorate of ISM&H. However, most of the States have not posted regular Director of ISM&H. Also, the various posts of ISM&H including the posts of physicians in the PHCs, dispensaries and hospitals are vacant. Vacant posts should be filled up and regular Directors of ISM&H should be posted. Separate Directorate should be created in the States where no separate Directorate has so far been established. Separate Drugs Controller and Inspector of ISM should be appointed. This service condition of ISM&H physicians be improved and brought on par with that of allopathic physicians.

Contd
Important issues for consideration of the Council

The following actions may be taken towards mainstreaming and integration:

a) The States should reiterate, re-enact or modify State laws governing the practice of modern medicine by ISM practitioners for utilizing their services for a range of options in Health Care Delivery Systems. The States should keep in view the judgments of the Supreme Court of India in Civil Appeal No 89 of 1997 in the case of Dr. Mulkhir Chand & Others vs. State of Punjab & Others passed on 13.8.1999 upholding the validity of Rule 2 (ee) (iii) of the Drugs & Cosmetics Act, 1940. The pith and substance of the judgment was that the Ayurvedic and Unani physicians may practice modern medicines to the extent permitted by State Laws.

Important issues for consideration of the Council

b) Specialist ISM&H treatment centers should be introduced in rural hospitals and a wing should be created in existing States and district level Govt. hospitals.

c) The ISM&H physicians should be involved in National Programme with or without training as considered necessary.

d) One ISM&H physicians should be posted in PHC.

e) The vacancies in PHC etc. should be filled by ISM&H physicians.
Government of India
Ministry of Health & Family Welfare

Eighth Conference of the
Central Council of
Health & Family Welfare

MEDICAL EDUCATION
Prominent Issues:

- Central Pool of Allocation of MBBS / BDS Seats
- Supreme Court decision on Admission and Fee Structure

Central Pool of MBBS/BDS seats

- Central Pool of seats maintained since 1949

- Seats are pooled from voluntary contribution from States having medical / dental institutions

Central Pool of MBBS/BDS seats

- This pool caters to the needs of the States not having medical / dental colleges like North Eastern States, A&N Islands, Lakshadweep etc.

- The pool also serves Ministries of External Affairs, Defence, Home Affairs, Cabinet Secretariat, Bravery Award Winners etc.
Central Pool of MBBS/BDS seats

- The size of the pool began shrinking in 1988 following withdrawal of contribution by donor States

- In 1988-89 it was 296 MBBS and 42 BDS seats; came down to 238 MBBS and 21 BDS seats in 2003-04

Central Pool of MBBS/BDS seats

- There is demand for allocation of additional seats from beneficiaries but unable to fulfill

- States like Andhra Pradesh, Punjab, Tamil Nadu, Karnataka, Orissa and Goa not contributing to the Pool

Central Pool of MBBS/BDS seats

- Gujarat, Maharashtra and Himachal Pradesh have either withdrawn or reduced contribution in 2003-04

- About 1000 additional seats sanctioned in Government colleges during the last three years

Central Pool of MBBS/BDS seats

- Repeated requests made for contribution of seats to Central Pool

- CCHFW in the last meeting adopted a Resolution seeking more contribution from States, but no positive response from any State
Central Pool of MBBS/BDS seats

- All States are requested to enhance contribution to Central Pool to help the under-served States / Union Territories

SUPREME COURT DECISION ON ADMISSION AND FEE STRUCTURE

Supreme Court decisions

- 11 Member Constitution Bench delivered judgement on 31.10.2002 in T.M.A.Pai Foundation case

- 5 Member Constitution Bench delivered judgement on 14.8.2003 interpreting the judgement on admission process and fee structure

Supreme Court decisions

- For admission of students, merit shall be the criteria for both minority and non-minority professional institutions

- States would prescribe certain percentage of seats for management depending on the local needs
Supreme Court decisions

- In case of minority professional colleges, this percentage for admission by management should also cater to the needs of minority community

Supreme Court decisions

- The managements can select students for their colleges on the basis of common entrance test held by the States;

  OR

- On the basis of a common entrance test conducted by an association of colleges

Supreme Court decisions

- State Governments shall appoint a Committee headed by a retired High Court Judge to ensure fair and transparent examination

- Exemption may be granted by the Committee for institutions established 25 years ago having their own admission procedure

Supreme Court decisions

- On fee structure, Hon’ble Court declared that there should be no profiteering and charging of capitation fee

- Each institute has freedom to fix its own fee structure
Supreme Court decisions

- A five member Committee to be set up by each State to be headed by a retired High Court judge to finalise the fee structure

- Once fixed, the fee will be applicable for three years

For the current year, the State Governments and the management share the seats in the ratio of 50:50

Role of State Governments

- Fixation of percentage of seats to be filled by management:

  - Both in minority and Non-minority private unaided institutions

Role of State Governments

Establishment of the two Committees –

i. For deciding fee structure;

ii. Admission by management
Role of State Governments

- Facilitate formation of association of colleges for conduct of examination for management seats

THANK YOU
FAMILY WELFARE PROGRAMME
- AN OVERVIEW

National Population Policy - 2000

The important goals are:
- Address the unmet needs for contraception, health care infrastructure & health personnel, and to provide integrated service delivery for basic reproductive & child health care.
- To achieve a TFR of 2.1 by 2010 through vigorous implementation of the Family Welfare Programme

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Current Level</th>
<th>10th Plan 2007</th>
<th>2010 goals as per NPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality Rate</td>
<td>66 (2001)</td>
<td>45</td>
<td>30</td>
</tr>
<tr>
<td>Maternal Mortality Rate</td>
<td>400 (1999)</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>3.2 (1999)</td>
<td>2.3</td>
<td>2.1</td>
</tr>
</tbody>
</table>
### X Plan and NPP - Strategies

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Strategies</th>
<th>Current Level</th>
<th>10th Plan 2007</th>
<th>2010 goals as per NPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR</td>
<td>Full Immunisation</td>
<td>54.2% (98-99)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Neo-natal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>Institutional Delivery</td>
<td>34% (98-99)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Janani Suraksha Yojana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TFR</td>
<td>Sterilisation</td>
<td>36%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spacing</td>
<td>6% (98-99)</td>
<td>15%</td>
<td></td>
</tr>
</tbody>
</table>

### Family Planning Strategies
- Commitment to Target Free Approach
- No coercion or compulsion
- No substandard family planning operations through haphazard camps
- Target Free does not mean performance free – Community Needs Assessment Approach
- Family Planning effort to drive better service delivery

### Performance
- Continuous Reduction in Vasectomy - Contribution in 1970 (66.1%), 1980 (21.4%), 1990 (6.2%), 2000 (2.3%)

- Reduction of sterilisations - Target vs Target free era (in lakhs)

<table>
<thead>
<tr>
<th>State</th>
<th>1995-96</th>
<th>1996-97</th>
<th>02-03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bihar</td>
<td>2.66</td>
<td>0.82</td>
<td>1.89</td>
</tr>
<tr>
<td>U.P.*</td>
<td>5.30</td>
<td>2.66</td>
<td>4.99</td>
</tr>
<tr>
<td>Karnataka</td>
<td>3.82</td>
<td>3.84</td>
<td>3.96</td>
</tr>
<tr>
<td>Tamil N</td>
<td>3.10</td>
<td>3.16</td>
<td>4.17</td>
</tr>
<tr>
<td>Andhra Pr</td>
<td>8.20</td>
<td>6.13</td>
<td>8.33</td>
</tr>
<tr>
<td>India</td>
<td>44.2</td>
<td>38.7</td>
<td>47.31</td>
</tr>
<tr>
<td>* Undivided</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Points for Qualitative Family Planning Services
- Classification of couples for proper counselling - Spacing to couples upto two children, with younger child three years of age –Permanent methods for the rest.
- Average number of children for couples to be less than three at the time of sterilisation, to be backed up with qualitative services
- Payment to Private sector for sterilisations/ IUD services by the State.
Achieving Family Welfare and Family Planning Goals through Improved Services

- Tenth Plan Goals of Family Planning – Two Prong Strategies
- District Administration – Panchayat Raj to be the Centre of Implementation
- Strengthening Primary Health Institutions to take up Primary Health Care Services, particularly Family Planning Interventions, neo-natal care of Children and care, and Referral for expectant mothers.

Good Practices Followed

Andhra Pradesh model.

- Literacy Rate not very high.
- About 40% BPL as per state estimates.
- Health & Family Welfare is in the main Agenda of the state.
- Family Planning & Health infrastructure gets priority by the Chief Minister.
- Resulted in highest decline in the total fertility, supported by a strong sterilization programme (more than 72% of couples with 2 children are sterilised in 98.99 as against 11% in U.P.).

Institutional Arrangements – Power to People through Panchayat Raj System

- Health fund for Panchayat

Obtaining Peoples support

- Can we consider field level institutions like – Block level, RCH Societies
- Gram Panchayat involvement in Health issues; all inter-sector agenda works with ANM as the key figure
- Gram Sabha Society
Reforms & Efficiency

- State level policies regarding personnel/ Minimum tenure of posting
- District based cadres of Doctors
- Transfer policies
- District level recruitment of ANMs/Block Cadres
- Is single Doctor PHC operationally optimal for giving Health Care services?

Management of the Programme - Financial Aspects

- Decentralisation - Empowering CHC/PHC level for day to day financial management
- Smooth flow of funds/utilisation certificates/accounting bottlenecks
- Finance Manager in the Programme
- Role of Health Societies in ensuring flow of funds to the target institutions
- Induction of professional finance personnel – At least inter-CA or inter-ICWA personnel

New Initiatives

- No scalpel Vasectomy - A preferred method in advanced countries - To boost men's involvement in Family Planning
- Janani Suraksha Yojana
- Janasankhya Sthiratha Kosh
- Urban Health Infrastructure – Urban Poor & Slums
- Services of Private sector Gynecologists & Anesthetists at PHC/CHC's
- Initiating Blood Bank facilities at FRU's

Public - Private Partnership

- Involvement of Private Sector Doctors in Government infrastructure for Service Delivery
- Similarly, Government Doctors to actively involve in the efforts of the NGOs in issues of Public Health, Service Delivery in respect of Family Welfare/Health related activities.
- States to find innovative ways depending upon the ground realities.

- Janasankhya Sthiratha Kosh
A Stronger Family Welfare Programme through Family Planning Programme

- In order to reach the target of TFR 2.1 at rational level, the need is:
- Doubling the number of Sterilisations at rational level by the end of Tenth Plan
- Tripling the IUD users in the country
- Individual State Targets have to be met by the end of X Plan leading the country towards TFR of 2.1

Population Growth

- As per normal trend, the population is projected to be about 120 crores in 2010.
- As per the goals of NPP 2000 with a TFR of 2.1, the population is likely to be around 110 crores.
- Can we avoid increase of more than 10 crores population
- 60% of Births are expected in BPL families
- KEY IS GOOD GOVERNANCE

Janani Suraksha Yojana

Janani Suraksha Yojana

Current Status

- More than 80% deliveries at home
- About 85% of these in hands of Dhais and Relations
- More than 60% BPL women-anemic
- Neonatal, infant and maternal mortality higher in low socio economic group families.
- Female / Male Ratio imbalanced
- High MMR of more than 400 per 1 lakh live births
Goal and Objectives

- Scheme for pregnant women belonging to the BPL families
  Aims to
  - improve institutional deliveries at hospitals/health Centres
  - Support nutritional food intake of lactating mothers
  - Neo-natal child care
  for
  Bringing down neonatal, infant and maternal mortality.

Janani Suraksha Yojana

- Integrating existing schemes
  - National Maternity Benefit Scheme
  - Referral Transport Scheme,
  - 24 Hour Delivery Services and
  - Provision of Emergency Obstetric Care
  - Dai Training

- Linking Dhais to Health Centres.
  - Dhai Ma - a well trained practicing Dhai empowered to be a CATALYST

Janani Suraksha Yojana

Benefits to Mother
Rs. 1000 for birth of female child,
Rs. 500 for birth of male child.

Benefits available to
- Women who are 19+
- For first TWO live births
- Benefit also for 3rd birth if family accepts sterilization

Janani Suraksha Yojana

DHAJ MA - A key supplementation to ANM
- To be selected from the literate, practicing Dhai’s from the village;
- 2 to 3 per village as available
- To be selected by ANM with support of Gram Sabha
- If not available, to be selected and trained

Can She also be a part time health volunteer engaged by Gram Panchayat?
Janani Suraksha Yojana

Involvement of Dhai Ma
- Dhai Ma to be encouraged to
  - taking care of woman during antenatal period,
  - identify high risk cases with guidance from ANM
  - refer women for Institutional deliveries
  - accompanying woman during delivery
  - providing post natal & newborn care for first month
- Act as a catalyst for counseling on FP issues and obtaining the services
- Rs. 200 to be paid to Dhai Ma in 2 installments

Janani Suraksha Yojana

Transport Assistance:
Payment of up to Rs. 150/- to all pregnant women for going to health centres for delivery

Janani Suraksha Yojana

Involving Private sector for Emergency Obstetric Care

- In case of any beneficiary developing a complication of pregnancy & unable to reach a Public health facility - Up to Rs. 1500 will be paid to private providers for caesarian section
- Anesthetist & Gynecologist can be hired to help in Government FRUs. from this Rs.1500/-

Janani Suraksha Yojana

Certification:
- By Gram Panchayat/ Municipalities
- Based on BPL card or certification by Panchayat.
- Dhai Ma/ ANM to help women in obtaining the Certificate right from ante natal stage

153
Janani Suraksha Yojana

Disbursement
- Delivery must be Institutional at a recognized health centre/hospital
- Disbursement by ANM before woman leaves hospital/health centre
- Recoupable Imprest of Rs 5000 to be kept with ANMs
- ANM to get approval from Gram Panchayat/MO, PHC

THANK YOU
From First Phase to Second Phase of RCH

Major Lessons Learnt from first phase of RCH
- State ownership critical
- Flexibility based on state needs and capacities
- Adequate institutional arrangements need to be in place
- A sound personnel policy

Major Lessons Learnt
Management capacity to be strengthened in the areas of
- Planning
- Supervision
- Finance
- Logistics management including engineering

Major Lessons learnt
- Process and output indicators to be agreed upon upfront
- Performance be linked to financing
- Establish linkages between RCH and Family Planning services
- Establish regular monitoring and supervision systems
Major Lessons Learnt

• Involve communities and local elected bodies in planning, management and monitoring of program performance.
• Involvement of private sector to enhance availability of services.

Major Lessons Learnt

• Need to build bridges with other critical sectors such as Rural development, Urban development, Sanitation, Public health, Nutrition, Women & Child development sectors.

Proposed strategies in the second phase

• Making RCH sector vigorous and output oriented.
• Establish a basic service delivery package in all states to be adopted as a minimum service delivery package comprising:
  - Operationalizing all FRUs for emergency obstetric care and referrals
  - Making at least 50% Block primary health centers render 24 hour essential obstetric care
  - PHC upwards to provide for treatment of sick neonates

Proposed strategies under second phase of RCH

• A package over and above the basic minimum delivery package that the states intend to implement as prioritized from their analysis.
PROPOSED STRATEGIES UNDER RCH SECOND PHASE

- Dedicated manpower arrangements to improve program management
- States own the program while looking at outputs upfront
- Decentralized planning and implementation through involvement of PRIs and ULBs
- Differential approach

PROPOSED STRATEGIES UNDER RCH SECOND PHASE

- Integrating referral networks among primary, secondary and tertiary facilities
- Strengthening quality aspects of service delivery
- Bring about a comprehensive integration of Family planning, safe motherhood and child health
- Inter-sectoral collaboration and convergence
- Increasing the involvement of the Private Sector

RCH SECOND PHASE COMPONENTS

- MATERNAL HEALTH
- RT/ISTI
- NEW BORN AND CHILD HEALTH
- ADOLESCENT HEALTH
- POPULATION STABILIZATION
- URBAN HEALTH
- TRIBAL HEALTH
- NGO INVOLVEMENT
- INFRASTRUCTURE MAPPING & STRENGTHENING
- BEHAVIORAL CHANGE COMMUNICATION
- TRAINING

Design process for the state

- Formation of a design team with a nodal official to lead the process.
- Drawing experts from the state itself
- Looking at outputs upfront
- Interpolating process indicators and working out annual plans and budgetary requirements
Design process for the state

- Conducting a sector analysis
- Drawing on good practices
- Attempting decentralization through PRIs/ULBs

Thank you
INTEGRATION OF FUNCTIONING OF PRIs WITH HEALTH SYSTEMS AND OTHER RECENT INITIATIVES IN HEALTH SECTOR

BY

GOVERNMENT OF WEST BENGAL

GOALS Of GoWB

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Goal</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Infant Mortality Rate from 51 to below 30 per 1000 live births.</td>
<td>2010</td>
</tr>
<tr>
<td>2</td>
<td>Under age 5 mortality rate from 68 to 40.</td>
<td>2010</td>
</tr>
<tr>
<td>3</td>
<td>Birth rate from 20 to 14</td>
<td>2010</td>
</tr>
<tr>
<td>4</td>
<td>Maternal mortality ratio to below 100 per 100000 LB.</td>
<td>2010</td>
</tr>
<tr>
<td>5</td>
<td>% of institutional deliveries from 47 to 80.</td>
<td>2010</td>
</tr>
<tr>
<td>6</td>
<td>% of safe deliveries from 55.6 to 100.</td>
<td>2010</td>
</tr>
<tr>
<td>7</td>
<td>New borns with low birth weight (LBW) from 25% to 10%</td>
<td>2010</td>
</tr>
<tr>
<td>8</td>
<td>% of mothers receiving antenatal care from 64 to 100.</td>
<td>2010</td>
</tr>
<tr>
<td>9</td>
<td>% of children fully immunized form 56 in 2001 to 100.</td>
<td>2010</td>
</tr>
<tr>
<td>10</td>
<td>Contraceptive prevalence rate 44 to 70</td>
<td>2010</td>
</tr>
</tbody>
</table>

STRATEGIC FRAMEWORK FACILITATES

- Holistic understanding of health problems
- Evolution of alternate strategies
- Prioritisation
- Acquiring resources
- Involvement of stakeholders

REFORM AGENDA PRIORITIES

- Decentralisation towards PRI
- Capacity building of PRI
**A NEW APPROACH**

Integration of Planning and Monitoring Activities of PRIs with Implementation Activities of DoHW.

**ROLE OF DISTRICT HEALTH & FW SAMITI**

- Management of health institutions/offices,
- Inter-sectoral co-ordination and community participation in planning, monitoring and management of the health and family welfare programmes' and
- Co-ordinate activities of workers of different departments/stakeholders such as Health & Family Welfare, Social Welfare, Education, etc.

**ROLE OF BLOCK HEALTH & FW SAMITI**

- Management and supervision of functioning of health care related infrastructure and manpower such as subcentres (SCs) Primary Health Centres (PHCs) and Anganwadi centres;
- Co-ordinate activities of workers of different departments/stakeholders such as Health & Family Welfare, Social Welfare, Education, etc. functioning at village and block level,

**ROLE OF BLOCK HEALTH & FW SAMITI (Contd.)**

- Improve the acceptance of different components of the different health and family welfare programmes through increased community participation, and
- 100 per cent registration of births, deaths in the villages so that this vital information is available for planning and monitoring of the RCH and other disease control/eradication programmes.
STRENGTHS OF SOCIETY STRUCTURES (Contd.)

- It harnesses the strength of both the public health sector and the three tier PRI,
- Involves wider participation of stakeholders, including NGO/Private sector,
- Ensures direct community participation,
- Offers larger degree of transparency,
- Offers flexibility in restructuring the organization and the functions,

ADVANTAGES OF DHFWS & BHFW (Contd.)

- Cultivates modern management techniques in planning, implementing, monitoring and evaluating health services from the community to district administrative levels,
- Facilitates convergence and co-ordination of the different functionaries at service delivery, supervisory and administrative levels, thereby complements and supplements the services of different stakeholders,

ADVANTAGES OF DHFWS & BHFW (Contd.)

- Integrates the peripheral services with the secondary level care by establishing the referral system, and
- Decentralisation of funds, functions and functionaries are gradually built with Capacity building.

DECENTRALISATION & CAPACITY BUILDING

- HAND IN HAND WITH CAPACITY BUILDING
- POLICY GUIDED BY HIGH POWERED STATE LEVEL CO-ORDINATION COMMITTEE
- IMPLEMENTED BY STRATEGIC PLANNING & SECTOR REFORM CELL
Restructuring of Health Organisation

- To have one subcentre in each Gram Panchayat Head Quarter,
- These subcentres would be manned by a trained ANM and their services would be placed under the GP,
- Long hierarchy of (the second and third tier) supervisors will be done away with. Instead at each GPHQ subcentre there will be one Health Supervisor, Male or Female, belonging either to the third or second tier, who will supervise the functioning of the Health Assistants of the subcentres located within a particular GP.

Restructuring of Health Organisation (Contd.)

- To meet the need of Health Supervisors, existing eligible Health Assistants would be promoted,
- Each subcentre will have one Health Assistant (Female). The Head Quarter subcentre will have in addition one Health Assistant (Male),
- There will be one honorary male volunteer at each subcentre. Besides there will be one volunteer, preferably woman, for each of the Gram Sansads. These volunteers will act as link persons between the community and the subcentres. They will be paid a small performance based honorarium.

Restructuring of Health Organisation (Contd.)

- The community will also be required to contribute nominated user fees towards payment of honorarium of the volunteers. The community participation would instil their sense of belonging to health related activities.
- Health Supervisor, Health Assistant (Male) and Health Assistant (Female) posted at the concerned GP have been made nominated members of 'Siksha-O-Swastha Upa-samity' of the GP for ensuring effective Health and Family Welfare service coverage and its monitoring.

Futuristic Activity:

Commissioning an Organisational Development Study for Restructuring State & District Level Health Organisation.
**Family Welfare in Andhra Pradesh**

Department of Health, Medical & Family Welfare
Government of Andhra Pradesh

---

**The Success in A.P**
Decadal Growth Rate - AP & India (1961-2001)

![Graph showing decadal growth rate comparison between AP, Tamil Nadu, Kerala, and India from 1961-2001.]

---

**Performance despite odds**

- High levels of maternal and child health
- High investment in health sector
- Low infant mortality rate
- High contraceptive prevalence rate

---

**Political Commitment**

- Constant support from political leaders for population stabilization
- Ownership by the Chief Minister himself
- State Population Policy (1997) sets out demographic goals
- All political leaders (Sarpanches, MPP Presidents, MLAs, Ministers, irrespective of party affiliations) talk of FP and all Reproductive & Child Health issues.

---

163
Women's Empowerment

- Total literacy campaign
- Self-help Group movement
- Women gain social identity & economic independence
- Women exposed to health communication take key decisions

Women's empowerment is the key to success

Designing services for target group

- Eligible couples
- Pregnant women
- Infants

Streamlining services at PHCs & Sub-Centres

- Regular recruitment of Medical Officers & ANMs
- Recruitment on contract
- Emphasis on stay at headquarters
- Massive infrastructure with OT / Labour room / Lab facility in every PHC
- Maintenance & repairs budget with PHCs
- Increased budgets & streamlined supplies of drugs / consumables / surgicals
- Apart from Kit A & B, ANMs provided with additional kits from State Govt.
- Improved mobility for all PHCs

Expanding access to services

- One PHC for each mandal
- ANMs strength increased
  - by 1658 in rural areas
  - by 295 in urban slums
- In tribal areas
  - have 8500 CHWs
  - all PHCs provided with two doctors
  - tribal health services separated
- In backward area
  - have 1500 CHWs
  - provided with additional Staff Nurses
- In urban areas
  - Urban Health Centres in urban slums
  - outreach sessions in all urban slums in the State
**Interventions for eligible couples**

- Small family norm not only agenda for the public representatives but for all departments
- Motivation family wise by ANMs
- Skills upgrade of doctors in conduct of operations
- At least 75% the PHCs provide services for FP operations once a week
- Provision of vasectomy services too
- Very close post-operative follow up

**Interventions for eligible couples (contd.)**

- Increased budgets at district level for drugs / consumables / surgical to ensure quality services
- Increased compensation from Rs.120 to Rs.500 for the acceptors
- Arogya Raksha - A health insurance scheme for creating confidence of child survival
- Increased usage of spacing methods through social marketing, training community and involving RMPs

**Interventions for safe motherhood**

Pre Nataal Care
- Increased coverage of ANC cases
- Protocol for ANC check-up by ANM and Medical Officer
- Every ANC to have a check-up by the doctor at PHC
- Improved lab facilities for ANC check-up at PHCs

Safe Deliveries
- Institutional deliveries a priority indicator
- Increase services provide at PHCs
- Services reviewed in Govt. hospitals
- Deliveries also reviewed in Private Hospitals
- Age at marriage
- Year long campaigns
Two major initiatives

470 Round the Clock PHCs
- Additional ANM & staff for services at night
- Telephone & vehicles in all the PHCs
- Gynaecology & Paediatric services also made available
- Deliveries gone up from 10,817 to 39,087 to 61,549 in these PHCs from 2000 to 2001 to 2003

Sukhribawa Scheme
- Cash assistance of Rs.300/-
- To meet travel expenses for deliveries at Government hospitals
- Initiated expanded Sukhribawa with private institutions

Increase in Institutional Deliveries

- Institutional Deliveries increased from 33% in 1992-93 to 49% in 1998-99
  - 33%
  - 1992-93
  - 1998-99
  - 49%

- With recent focus, deliveries increased as per reporting to 58% in 2001-02, 70% in 2002-03.

Need for focus on increasing Institutional Deliveries for high risk cases

Interventions for Child Care

Strengthening routine immunization by
- Reviewing the plan for outreach sessions
- Monitoring the outreach sessions
- Introducing AD syringes as part of sale injection practices
- Pharmaceutical responsible for cold-chain & vaccine logistics

Implementing Pulse Polio Campaigns effectively

Interventions for Child Care (Contd.)

Conducting annual campaign for
- Home-based care of diarrhoea and
- Early referral for acute respiratory infections

Constituting 'Janani' teams
- One team in each habitation
- Sarpanch heads the team
- ANM, AWW, women group & youth group are members
- Team provides for community support & coordination with AWW
Accountability & Monitoring Systems

- Hospital Advisory Committees for all PHCs
- Performance Indicators standardized & monitored
- House-hold register & service register of ANMs standardized
- Auditing maternal and infant death
- Independent survey district-wise on coverage
- Computerization of PHCs
  - Name-based follow-up of target groups
  - Services delivered monitored
  - Schedule of services for the next month generated
  - Enable more comprehensive coverage of target groups

THANK YOU
Universal Immunization & Polio Eradication Programme

An Update

8th Conference of Central Council of Health & Family Welfare
28-29 August 2003

Universal Immunization Programme
Reported coverage 1985-2003

VACCINE PREVENTABLE DISEASE SURVILLANCE
Incidence of Diphtheria

VACCINE PREVENTABLE DISEASE SURVILLANCE
Incidence of Whooping cough

Source: CBHI

VACCINE PREVENTABLE DISEASE SURVILLANCE
Incidence of Neonatal Tetanus

VACCINE PREVENTABLE DISEASE SURVILLANCE
Incidence of Measles

Source: CBHI
Strategies for polio eradication

1. Routine immunization: sustaining high levels of coverage with 3 doses of oral polio vaccine in the 0-1 years age group
2. Pulse Polio Immunization (PPI): Simultaneous administration of 2 doses of OPV, 4-8 weeks apart, to all children in the age group of 0-5 years
   - National Immunization Days (NIDs)
   - Sub National Immunization Days (SNIDs)
3. Surveillance to detect areas of polio cases
Global proportion of polio cases 2003

2000

- WB 9%
- UP 13%
- Rest of India 16%
- Rest of World 62%

2002

Polio Importations
Examples of wild poliovirus importations into polio-free areas, 1999-2003

4 of the 8 known importations in 2000-2003 were from India.

Monthly incidence of polio in India
January 1997 – August 2003

SNID-NID, 2003-2004
Opportunity

- This is the best opportunity in history to eliminate polio from India forever
- However, it may also be the last opportunity, since the disease threatens to spread throughout the country again after the outbreak of last year
- WE ALL NEED TO ENSURE A LIFE FREE OF HANDICAP DUE TO POLIOMYELITIS – A LEGACY WE LEAVE BEHIND TO OUR CHILDREN
ANNEXURE 2

MINISTRY OF HEALTH AND FAMILY WELFARE
NOTIFICATION
New Delhi the 13th August, 2003

CONSTITUTION OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE

S.O. 931(9). – In exercise of the powers conferred by the Article 263 of the Constitution and in supersession of this Ministry's notification No.Z.16011/2/2001-B.P., dated 10th July, 2001 published in the Gazette of India: Extraordinary Part - II Section 3 Sub-Section (ii) dated 10th July, 2001, 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 organisation and procedure as follows, namely :-

1. **Organisation of the Council:**

   (i) The Council shall consist of :-

   (a) The Union Minister for Health and Family Welfare : Chairman

   (b) The Union Minister of State in the Ministry of Health and Family Welfare : Vice- Chairman

   (c) Member, Planning Commission : Member

   (d) Ministers in charge of the Ministries of the Health and Family Welfare, Medical Education and Public Health in the States/Union Territories with Legislatures. : Members

   (e) A representative each of the Dadar Nagar Haveli, Chandigarh, Andaman and Nicobar Islands, Daman and Diu and Lakshadweep : Members

   (f) **Members of Parliament:**

      1. Dr. Madan Prasad Jaiswal : Lok Sabha
      2. Dr. (Smt.) C.Suguna Kumari : Lok Sabha
      3. Dr. A.K.Patel : Rajya Sabha
      4. Dr. V. Maitreyan : Rajya Sabha

175
(g) Non-Officials:

(i) Representatives from Health and Family Welfare Sectors

1. President, Indian Medical Association (ex-officio)

2. President, Family Planning Association of India, Bombay. (ex-officio)


5. The President, Federation of Indian Chambers of Commerce and Industry, New Delhi. (ex-officio)

6. Director General, Indian Council of Medical Research, New Delhi. (ex-officio)

7. The President, All India Organisation of Employers, New Delhi (ex-officio)

(ii) Eminent Individuals:

1. Dr. Harshvardhan, Former Health Minister, Govt. of NCT of Delhi, E-8, A-14, Krishna Nagar, Delhi – 110051.

2. Vaidya Devendra Triguna, Ayurvedic Physician, General Secretary, All India Ayurvedic Congress, Dhanwantri Bhawan, Punjabi Bagh, New Delhi.


5. Dr. Jugal Kishore, 86, Golf Links, New Delhi – 110003.
6. Dr. Nagendra, Vivekananda Institute of Yoga, Bangalore.

7. Dr. Kamla Verma, Former Health Minister, State Govt. of Haryana.

8. Dr. Syed Khleefatullah, Ex-Chairman, CCIM, 49, Bharathi Salai Triplicane, Chennai – 600005.

(h) **Officials:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Name and Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Secretary, Department of Health Ministry of Health &amp; Family Welfare : Member</td>
</tr>
<tr>
<td>2.</td>
<td>Secretary, Department of Family Welfare Ministry of Health &amp; Family Welfare : Member</td>
</tr>
<tr>
<td>3.</td>
<td>Secretary, Department of Indian Systems of Medicine &amp; Homoeopathy Ministry of Health &amp; Family Welfare : Member</td>
</tr>
<tr>
<td>4.</td>
<td>Secretary, Department of Education Ministry of Human Resource Development : Member</td>
</tr>
<tr>
<td>5.</td>
<td>Secretary, Department of Women and Child Development : Member</td>
</tr>
<tr>
<td>6.</td>
<td>Director General of Health Services : Member</td>
</tr>
<tr>
<td>7.</td>
<td>Deputy Director General of Health Services (Planning) : Member- Secretary</td>
</tr>
</tbody>
</table>

(iii) Eminent individuals at (g) (ii) 1 to 8 shall normally be members of the Council for a period of two years. The Members of Lok Sabha shall be Members of the Council so long as they are members of Lok Sabha or two years whichever is earlier.

(iv) The Members of Rajya Sabha shall be Members of the Council so long as they are members of Rajya Sabha, or till 12th August, 2005 whichever is earlier.

(v) The travelling and daily allowances of the non-official members for attending the meetings of the Council shall be regulated in accordance with the provision of Supplementary Rule 190 and orders of the Government of India thereunder as issued from time to time.
The expenditure involved will be met from within the sanctioned budget grant for the purpose.

Expert and technical advisers to the Central Government and State Governments shall not be members of the Council and shall not have any right to vote when any decision is taken by it but shall, if so required by the Council, be in attendance at its meetings.

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

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

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

(a) to consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects, such as the provision of remedial, promotive and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research;

(b) to make proposal for legislation in fields of activity relating to medical and public health and Family Welfare matters, laying down the pattern of development for the country as a whole;

(c) to examine the whole field of possible co-operation on a wide basis in regard to inter-State quarantine during times of festivals, out-break of epidemics and serious calamities such as earth-qua kes 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 utilisation of these grants-in-aid; and
MEMBERS PRESENT AT THE CONFERENCE OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE

1. Smt. Sushma Swaraj - Chairperson
   Union Minister for Health & FW

2. Shri A.Raja - Vice-Chairman
   Minister of State for Health & FW

3. Shri K. Venkatasubramanian - Member
   Member, Planning Commission, N.Delhi

Ministers In-charge of Ministries of Health & FW, Medical Education and Public Health in the States/UTs with Legislations

Dr. T. Tapak - Member
Minister of Health & F.W.
Arunachal Pradesh.

Shri Sakuni Choudhary - Member
Minister of Health & FW.
Bihar

Akhilesh Prasad Singh - Member
Minister of State (Health & FW)
Bihar

Dr. Shakeel Ahmad - Member
Minister, Medical Education, FW & ISM
Bihar

Dr. A. K. Walia - Member
Minister of Health
Delhi.
Shri I.K. Jadeja
Minister of Health & F.W.
Gujarat

Dr. M.L. Ramya
Minister of State for Health
Haryana.

Smt. Chandresh Kumari
Minister of Health,
Himachal Pradesh.

Shri Ch. Lal Singh
Minister for Health & Medical Education Deptt.
Jammu & Kashmir.

Dr. D.K. Sarangi
Minister of Health, F.W., Med. Education & Research
Jharkhand.

Shri Kagodu Thimmappa
Minister for Health & F.W.
Karnataka.

Shri Bala Bachchan
Minister for Public Health & FW
Madhya Pradesh.

Dr. (Ms.) Vijay Laxmi Sadho
Minister for Medical Education
Madhya Pradesh.

Shri Digvijay Khanvikar
Minister of Public Health & F.W.
Maharashtra.
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shri Eknath Gaikwad</td>
<td>Member</td>
</tr>
<tr>
<td>State Minister of Public Health &amp; F.W. Maharashtra.</td>
<td></td>
</tr>
<tr>
<td>Shri Suresh Shetty</td>
<td>Member</td>
</tr>
<tr>
<td>State Minister of Public Health &amp; F.W. Maharashtra.</td>
<td></td>
</tr>
<tr>
<td>Dr. Chalton lien Amo</td>
<td>Member</td>
</tr>
<tr>
<td>Minister of Health.</td>
<td></td>
</tr>
<tr>
<td>Manipur.</td>
<td></td>
</tr>
<tr>
<td>Shri B.G. Momin</td>
<td>Member</td>
</tr>
<tr>
<td>Minister of Health &amp; F.W.</td>
<td></td>
</tr>
<tr>
<td>Meghalaya.</td>
<td></td>
</tr>
<tr>
<td>Shri P.C. Ghadai</td>
<td>Member</td>
</tr>
<tr>
<td>Minister, Health &amp; Family Welfare.</td>
<td></td>
</tr>
<tr>
<td>Orissa.</td>
<td></td>
</tr>
<tr>
<td>Shri E. Valsaraj</td>
<td>Member</td>
</tr>
<tr>
<td>Minister of Health</td>
<td></td>
</tr>
<tr>
<td>Pondicherry.</td>
<td></td>
</tr>
<tr>
<td>Shri R.C. Dogra</td>
<td>Member</td>
</tr>
<tr>
<td>Minister of Health &amp; F.W.</td>
<td></td>
</tr>
<tr>
<td>Punjab.</td>
<td></td>
</tr>
<tr>
<td>Shri Tayyab Hussain</td>
<td>Member</td>
</tr>
<tr>
<td>Minister of Health.</td>
<td></td>
</tr>
<tr>
<td>Rajasthan.</td>
<td></td>
</tr>
<tr>
<td>Shri Radheyshyam Ganganagar</td>
<td>Member</td>
</tr>
<tr>
<td>Minister of State for Ayurveda</td>
<td></td>
</tr>
<tr>
<td>Rajasthan.</td>
<td></td>
</tr>
</tbody>
</table>
Shri N. Thalavay Sundaram  
Minister of Health.  
Tamil Nadu

Shri Tilak Raj Behad  
Minister of Health & F.W.  
Uttaranchal.

Members of Parliament:

Dr. (Smt.) C. Suguna Kumari  
M.P. Lok Sabha

Dr. A.K. Patel  
M.P. Rajya Sabha

Dr. V. Maitreyan  
M.P. Rajya Sabha

Eminent Individuals

Dr. Harshvardhan  
Former Health Minister  
Govt. of NCT of Delhi  
E-8, A-14 Krishna Nagar  
Delhi – 110 051.

Vaidhya Devendra Triguna  
Ayurvedic Physician  
General Secretary,  
All India Ayurvedic Congress,  
Dhanwantri Bhawan, Punjabi Bagh,  
New Delhi.

Prof. Ranjit Roy Chaudhury  
Emeritus Scientist  
National Institute of Immunology  
Aruna Asif Ali Marg,  
New Delhi – 110067.
Dr. B.K. Srinivas Murthy, FRCP
Consultant Physician
First Cross, Gandhinagar,
Bellary – 583103
Karnataka.

Dr. Jugal Kishore
86, Gold Link,
New Delhi –110003.

Dr. Kamla Verma
Former Health Minister
No. 951, Prem Nagar,
Yamuna Nagar – 135001.
Haryana.

Dr. Syed Khleefatullah
Ex Chairman, CCIM
49, Bharathi Salai Triplicane
Chennai – 600 005.

Non-Officials

Dr. Sanjiv Malik
Hony. Secretary General,
Indian Medical Association.

Smt. Mridula Sinha
Chairperson,
Central Social Welfare Board,
New Delhi.

Vd. Shri Ram Sharma
K.G.M.P. Ayur College,
Mumbai.

Officials

Shri J.V.R. Prasada Rao
Secretary (Health)
Shri P.K. Hota
Secretary (FW)

Smt. Malti S. Sinha
Secretary (ISM&H)

Dr. S.P. Agarwal
DGHS

Dr. (Mrs.) Urmil Mahajan
Dy. Dir. General (P)

- Member
- Member
- Member
- Member Secretary
STATE GOVERNMENTS

**Andaman & Nicobar Admin.**

Dr. (Mrs.) Namita Md. Ali
Director of Health Services,
Port Blair.

**Andhra Pradesh**

Smt. M. Chaya Ratan
Pr. Secretary, Health Med. Welfare.

Smt. Neelam Sawhney
Secretary (FW)

Smt. Laxmi Rajyam
Director (Health)

**Arunachal Pradesh**

Dr. C.L. Pegu
Jt. Director of Health Services
(Planning & Development).

**Assam**

Dr. H.N. Dolly
Director of Health Services.

**Bihar**

Shri Afzal Amanullah
Secretary, Med. Edu, FW & Indian Medicine.

Shri Ashok Kumar Choudhary
Commissioner & Secretary (Health)

Dr. Yogendra Chowdhury
Director-in-Chief, Health Services.

Dr. Durga Prasad Mandal
State TB Officer

187
Chandigarh

Dr. C.P. Bansal
Director, Health Services.

Dr. B.K. Aggarwal
ACFA

Shri N.K. Dureja
Resident Officer

Daman & Diu & DNH

Dr. S.S. Vaishya
Director, Medical & Health Services &
Special Secretary (Health).

Dr. L.N. Patra
Chief Medical Officer
Dadra & Nagar Haveli, Silvassa.

Delhi

Dr. (Mrs.) Avinash Kaur Mehta
Director, Family Welfare.

Dr. R.N. Baishya
Director Health Services.

Gujarat

Shri S.K. Nanda
Secretary (Health)

Shri V.A. Sathe
Health Commissionerate

Shri C.J. Thakker
Jt. Secretary (Family Welfare)
Gandhinagar –382010.

Dr. K.N. Patel
Addl. Director (Family Welfare)
Commissionerate of Health & F.W.,
**Haryana**

Shri Raj Kumar  
Secretary,  
Health & Family Welfare,

Dr. B.S. Dahiya  
Director General, Health Services.

**Himachal Pradesh**

Dr. P.C. Kapoor  
Secretary (Health)

Dr. J.P. Nadda  
Director.

**Jammu & Kashmir**

Shri Showket Ahmed Mir  
Addl. Secretary,  
Health & Medical Education Deptt.

Dr. Muzaffar Ahmad  
Director, Health Services,  
Kashmir Division.

Dr. Jasbir Singh  
Director, Health Services,  
Jammu Division.

**Jharkhand**

Shri P.P. Sharma  
Secretary,  

Dr. Raj Mohan  
SPO(NPCB), D/o Health & FW.

**Karnataka**

Dr. G.B. Desai  
Director I/C, Health & F.W. Services.
Kerala

Shri E.K. Bharat Bhushan
Secretary, Health & FW.

Dr. V.K. Rajan
Director of Health Services.

Shri K.C. Thomas
Addl. PS to Health Minister.

Madhya Pradesh

Shri P.D. Meena
Secretary & Commissioner
Public Health & F.W.

Smt. Aruna Sharma
Secretary, Medical Education.

Smt. Saleena Singh
Controller, Food & Drug Admin.

Dr. Ashok Sharma
Director, Medical Services

Dr. Rita Marwah
Reader, Ayurved University, Bhopal

Dr. Sashimeren Aier
Addl. Director (Medical)

Shri Mesh Mundra
Director (ISM&H)

Maharashtra

Shri Naveen Kumar
Pri. Secretary, (Health)

Shri Man Mohan Singh
Pri. Secretary (FW), Public Health Deptt.

Shri G.S. Gil
Pri. Secretary, Med. Education & Drugs Deptt.
Dr. S.R. Salunke
Director General of Health Services.

Dr. C.P. Taware
Director of Med. Education & Research.

Shri Ramesh Chandra Kanade
Project Commissioner & Ex-Officio, Secretary
Maharashtra Health System Dev. Project.

Dr. Usha P. Dave
Jt. Res. Director (CREMERE)

Shri Sagar D. Meghe
OSD (Health)

**Manipur**

Shri A.R. Khan
Commissioner (Health)

Dr. Ch. Chandramani Singh
Director (Health).

Dr. S. Rabei Singh
Director (FW)

**Meghalaya**

Shri W.M.S. Pariat
Principal Secretary (Health)

Shri Shreeranjan
Commissioner & Secretary
Health & FW

Dr. O.P. Agarwala
DHS (MCH & FW)

**Mizoram**

Shri Van Hela Pachuau
Secretary (Health & FW)
Shri C. Zosanga  
DHS

Shri Lalkailian 
DHS (PCB)

Dr. Lalsangluaia Sailo  
Dir (Hospital & Med. Education)

Dr. Rothangliawa  
Jt. Director (Health)

**Nagaland**

Dr. G.B. Chettri  
Director, Health Services,

**Orissa**

Shri R.N. Senapati  
Commissioner-cum-Secretary,  
Health & Family Welfare Deptt.

Dr. P.K. Senapati  
Director of Health Services.

Shri B.K. Das  
Director, Indian Medicine & Homoeopathy.

**Pondicherry**

Dr. D. Thammara  
Director (Health & FW)

**Punjab**

Dr. Devendra Pal Singh Sandhu  
Director, Health & FW

Dr. K.K. Sharma  
Director, Health Services, FW.

Dr. G.L. Goyal  
DHS(SI) & Director, Ayurveda.
Dr. B. ipan Chander Sharma
Registrar, Ayurvedic Board cum OSD,
Dte. of Ayurveda.

Dr. N.K. Singla
Asstt. Dir. (Homoeopathy).

**Rajasthan**

Shri G.S. Sandhu
Secretary, Health.

Dr. Kanak Prasad Vyas
Director, Deptt. of Ayurveda, Ajmer.

Shri G.K. Tandon
Spl. Asstt. to MOS (Ayurveda)

**Sikkim**

Smt. Suchitra Rasaily
Asstt. Resident Commr.

**Tamil Nadu**

Shri Girija Vaidyanathan
Secretary (Health & FW)

Shri M.L. Farooqui
Commr. of Indian Medicine & Homoco

**Tripura**

Shri S.K. Roy
Commissioner, D/o FW

**Uttaranchal**

Shri Alok Kumar Jain
Secretary,
Health, Med. Edu. & F.W.

Dr. I.S. Pal
Director General,
Medical & Health
Dr. B.C. Phatak  
Addl. Director (RK)

**Uttar Pradesh**

Shri R.K. Mittal  
Prin. Secretary, Med. & Health.  
Shri Sujit Banerjee  
Principal Secretary, Family Welfare.

Dr. R.D. Tripathi  
Director (Health).

Dr. P.C. Kannaujiya  
Joint Director, Family Welfare.

**West Bengal**

Shri Asim Barman  
Pr. Secretary (Health & FW).

Prof. Indira Chakravarti  
Director,  
Indian Inst. of Hygiene & PH.
Ministry of Health & Family Welfare

Department of Health

Smt. P. Jyoti Rao
Addl. Secretary

Smt. Meenakshi Datta Ghosh
Addl. Secretary & PD (NACO)

Shri Anshu Prakash
PS to HFM

Shri S.K. Verma
OSD to HFM

Shri Ajoy Kumar
PS to MOS

Shri Anurag Goel
A S&FA

Shri Deepak Gupta,
Joint Secretary

Smt. Bhawani Thyagarajan
Joint Secretary

Shri B.P. Sharma
Joint Secretary

Shri A.S. Chauhan
Chief Controller of Accounts

Shri S.K. Rao
Director

Shri Rajesh Bhushan
Director

Shri Anil K. Jha
Director

Dr. Srinivas Tata
Dy. Secretary
Dr. P. L. Joshi  
Addl. Project Director, NACO

Dr. P. Salil  
Jt. Director (BS), NACO

Dr. A.S. Rathore  
Jt. Director (Trg.), NACO

Dr. Sadhna Rout  
Jt. Director (IEC), NACO

Department of Family Welfare

Shri N.S. Kang  
Joint Secretary

Shri S.S. Brar  
Joint Secretary

Dr. K.V. Rao,  
Chief Director

Shri S.K. Das  
Chief Director

Dr. Lalrintuangi  
Dy. Commissioner

Dr. Sobhan Sarkar  
Dy. Commissioner

Shri S.C. Srivastava  
Director

Shri A.K. Mehra  
Director

Smt. Madhu Bala  
Director (PNDT)

Shri T.V. Raman  
Director

Shri K.D. Maiti  
Director
Shri Mohan Singh  
Director (BOP)

Dr.P.Biswal  
Asstt.Commissioner

Dr.(Mrs.) Saroj Dhingra  
Asstt.Commissioner

Dr. D.C. Jain  
Asstt.Commissioner  
Dr. B.B. Panda  
Asstt.Commissioner

Dr.B.Kishore  
Asstt.Commissioner

Smt. Shubra Singh  
Dy.Secretary

**Department of ISM&H**

Shri L.Prasad  
Joint Secretary

Shri R.B.S. Rawat  
CEO (Medicinal Plants Board)

Shri Bala Prasad  
Director

Shri K.L. Taneja  
Director

Ms. Sangeeta Goel  
Director

Shri S.B. Sharan  
Dy. Secretary

Dr.S.K.Sharma  
Adviser (Ayurveda)

Dr.S.P.Singh  
Adviser (Hormoeo)
Prof. Anis A. Ansari
Adviser (Unani)

Vaidya Nand Kishore
Dy. Director

**Directorate General of Health Services**

Dr. R.K. Srivastava,
Addl. D.G.

Dr. Shiv Lal
Addl. D.G. & Director (NICD)

Dr. (Smt.) R. Jose,
DDG (O)

Dr. L.S. Chauhan
DDG (TB)

Dr. Ashok Kumar
DDG (Lep)

Dr. V.K. Manchanda
DDG (MH & Trg.)

Dr. Y.N. Rao
DDG (M)

Dr. V.K. Behal
DDG (ID)

Dr. Jotna Sokhey
Director (NAMP)

Dr. P.C. Das
Director, CHEB

Mr. Ashwini Kumar
DCG (I)

Dr. B.M. Das
Addl. DDG (G) & Dir. (EMR)

Dr. (Mrs.) L. Nongpiur
Director (CGHS)
Shri J.B. Mathur
WHO Consultant (Capacity Bldg. Project)

Shri Sanjay Chaudhary
WHO Consultant (Food Safety)

Dr. Shruti Sehgal
WHO Consultant (RNTCP Medical)

Shri A.P. Jain
Consultant (F), NPCB

Dr. J. Tonsing
WHO Consultant

Shri R.K. Kapoor
Statistical Officer (BOP)

Shri Rakesh Kumar Maurya
Asstt. Director (TDP)
Schedule for the Eighth Conference of Central Council of Health and Family Welfare
28th and 29th August, 2003

28th August, 2003

9.00 AM – 9.30 AM
Registration

9.30 AM – 9.32 AM
Lighting of Lamp by Hon’ble Vice President of India

9.32 AM – 9.35 AM
Presentation of bouquets

9.35 AM – 9.40 AM
Invocation

9.40 AM – 9.45 AM
Welcome address by Shri J.V.R. Prasada Rao, Secretary (Health)

9.45 AM – 9.50 AM
Address by Shri A.Raja,
Minister of State for Health & Family Welfare

9.50 AM – 10.05 AM
Presidential address by Smt. Sushma Swaraj,
Union Minister for Health & Family Welfare

10.05 AM – 10.20 AM
Inaugural address by Shri Bhairon Singh Shekhawat,
Vice President of India

10.20 AM – 10.25 AM
Vote of thanks by Dr. S.P. Aggarwal,
Director General of Health Services.

10.25 AM – 10.45 AM
Tea/Coffee

10.45 AM – 1.45 PM
Issues of Department of Health
Communicable Diseases
  • Malaria
  • Tuberculosis
  • Leprosy
  • AIDS

Discussion
Lunch

Non-Communicable Diseases
  • Blindness
  • Mental Health
  • Cancer

Tea/Coffee

Issues of Department of ISM&H
201
29th August, 2003

9.00 AM – 11.00 AM
Issues of Department of Health
Medical Education

11.00 AM – 11.15 AM
Tea/Coffee

11.15 AM – 2.00 PM
Issues of Department of Family Welfare
Lunch

2.00 PM – 2.45 PM

2.45 PM onwards
Decisions Taken and Summing up.
श्रीमती सुषमा स्वराज  
केंद्रीय स्वास्थ्य और शांति कल्याण मंत्री  
केंद्रीय स्वास्थ्य और शांति कल्याण परिषद्  
के आठवें सम्मेलन  
में आपको सार्वजनिक आमंत्रित करती हैं  

श्री नरेंद्र मोदी  
भारत के माननीय उपराष्ट्रपति  
बुधवार, 28 अगस्त, 2003 को प्रातः 9.30 बजे  
हाल नं. 5, विज्ञान भवन, नई दिल्ली में  
इसका उद्घाटन करेंगे  

दर्शनाभितारी  
टेलीफ़ॉक्स: 23015028  
23017288  

उद्घाटन संबंधी व्याख्याएँ पीछे लिए गए हैं  

203
28th August, 2003 - Inaugural Session

9.00 AM - 9.30 AM  Registration
9.30 AM - 9.35 AM  Welcome address by Shri J. V. R. Prasada Rao, Secretary (Health)
9.35 AM - 9.40 AM  Address by Shri A Raja, Minister of State for Health & Family Welfare
9.40 AM - 9.55 AM  Presidential address by Smt. Sushma Swaraj, Union Minister for Health & Family Welfare
9.55 AM - 10.10 AM  Inaugural address by Shri Bhairon Singh Shekhawat, Hon'ble Vice President of India
10.10 AM - 10.15 AM  Vote of thanks by Dr. S. P. Agarwal, DGHS
10.15 AM - 10.30 AM  Tea/Coffee