

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

**PROCEEDINGS  
AND  
RESOLUTION**

**JANUARY 8-10, 1997**

**NEW DELHI**

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

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## **SUMMARY OF PROCEEDINGS**

**SUMMARY OF THE PROCEEDINGS OF THE FIFTH CONFERENCE OF CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE HELD UNDER THE CHAIRMANSHIP OF SHRI SALEEM I. SHERWANI UNION MINISTER OF STATE FOR HEALTH & FAMILY WELFARE (INDEPENDENT CHARGE) AT PARLIAMENT HOUSE ANNEXE NEW DELHI FROM 8TH TO 10TH JANUARY, 1997.**

The Fifth Conference of the Central Council of Health & Family Welfare was held under the Chairmanship of Shri Saleem I. Sherwani, Union Minister of State for Health & Family Welfare (Independent Charge) at Parliament House Annexe, New Delhi from 8th to 10th January, 1997. The Conference was inaugurated by Shri H. D. Deve Gowda, Prime Minister of India and was attended by Prof. J. S. Bajaj, Member (Health), Planning Commission, Ministers incharge of the Ministries of Health & Family Welfare, Medical Education and Public Health, Indian System of Medicine and Homoeopathy from the States/Union Territories, Members of Parliament and luminaries in the field of Health & Family Welfare as also Senior Officers from the Centre, States and UTs Administration.

Dr. S. P. Aggarwal, Director General of Health Services in his welcome address stated that the present Conference of the Council was of crucial importance as primary health care formed a vital component of the Basic Minimum Services to which the present Government had made a solemn commitment. He further stated that there were several problem areas which needed to be addressed by the Council. Important among these was the need to increase the efficiency and effectiveness for health care so that the common man, particularly, in the rural areas had adequate, prompt and timely access to health care facilities. There was need to minimize inter State and intra State disparities in terms of availability of medical services and health infrastructure and involvement of private medical services in the delivery of diagnostic and curative services ensuring at the same time that they adhered to minimum standards. DG further emphasized the need to involve NGOs in various disease control programmes to supplement the Government efforts in delivery of health care and establishment of an efficient surveillance network and response system for timely action whenever there was outbreak of epidemics.

Inaugurating the Conference, Shri H.D.Deve Gowda Prime Minister of India stated that the poorest of the poor, who had no voice, no lobby and were not in a position to articulate their needs or demands, should be provided primary health services as the first and most important target group. He referred to the proposed setting up of the illness Assistance Fund to render help to poor people for undergoing necessary expensive medical treatment. The Fund at the National level would meet the cost of medical treatment of cases where expenses go beyond Rs.1.5 lakhs per beneficiary and the cost of treatment of poor patients from Union Territories without legislatures. The Prime Minister further mentioned that all the States and Union Territories had been asked to form similar funds at their level, which will be provided financial assistance by Central Government up to 50% of the contributions made by them. He appealed for liberal and generous response from philanthropic bodies, corporate sector, international organizations and individuals for subscription to this fund.

He referred to the compulsory health check up scheme for Scheduled Castes and Scheduled Tribes introduced in Karnataka and felt that if the scheme was adopted country wide, it would provide substantial relief to the disadvantaged and underprivileged segments of the society.

Stating that he was disturbed by the fact that the doctors shied away from rural services, the Prime Minister felt that there was need for taking firm action in implementing our policies. He suggested that the States should consider denying admissions to post graduate courses if the applicants had not completed 2 to 3 years service in rural areas. He urged the Health Ministers and the Medical Council of India to consider the matter seriously and come up with practical recommendations.

The Prime Minister also referred to the spread of HIV and AIDS cases and stated that the number of Sero positive cases as well the actual AIDS cases had gone up considerably in the recent past and we must step up efforts to prevent and contain the spread of the disease. He exhorted that all possible steps must be taken to stop infected blood entering the system and all efforts must be mounted to convince students, the organized sector and the NGOs to give an impetus to the blood donation programme on a National scale.

The Prime Minister drew attention to the high burden of malaria which was a matter of serious concern and further observed that if the nutritional level of people was extremely low, it was impossible for any malarial drug to make an impact. Something had got to be done not only in the health front but also to ensure that the supply of supplementary, nutrition, mid-day meals and iron and folic tablets reached those who needed them the most.

He also underlined the need for taking steps for population control which should be specific to the ethos, tradition, beliefs and life styles of each State.

Observing that the systems of Ayurveda, Siddha, Unani and Homoeopathy, which were based on herbal medicines and drugless therapies for combating diseases for which allopathy has no cure, Shri Gowda said that India had rich resources and trained medical practitioners in these systems of medicine. "We need to exploit these resources fully," he commented. "India could be a forerunner in making the rest of the world aware about the potential of these alternative systems."

The Prime Minister urged the States to see that district level centres for rehabilitation of the disabled were established and three per cent reservation made in jobs in Government and in public sector undertakings for persons with disability.

The Prime Minister also suggested decentralization in purchasing drugs. He also asked the State Governments to keep a watch on spurious drugs. (Full text of the inaugural address delivered by Shri H.D.Deve Gowda, Prime Minister of India is at annexure "A").

Shri Saleem.I.Shervani, Union Minister of State for Health & Family Welfare (Independent Charge) and Chairman of the Council referred to an extensive community based infrastructure built during the last decade or so and observed that access to the health care of the people was much better today than ever before. He further stated that leprosy and guinea worm were near eradication. The Minister informed that he had requested the Prime Minister to invite a few leprosy patients for a cup of tea on 30th January, 1997 with a view to sending a message that leprosy did not carry a social stigma. He appealed to the State Health Ministers to organize similar functions at State and District headquarters.

He expressed concern on the increasing population which was the biggest challenge today. He urged the poor performing States to take specific steps in reducing the fertility rate and have sharp focused programmes on population control. Pulse Polio Immunization Programme carried out last year and also during last month had been very successful, stated Shri Shervani. The School Health Check Up programme aimed at reaching out to the, child population had also been another remarkable success.

Manufacture and distribution of sub standard and spurious drugs, food safety and quality control were the other areas of concern. He informed that the Ministry of Health and Family Welfare was taking steps to enhance financial allocations and also seeking external assistance for upgrading services in the area of food safety and quality control of drugs. He also referred to the need to regulate Private Nursing Homes and Hospitals and requested the States to build up directories of such institutions in large urban centres. The Minister further stated that for up-gradation of health systems in the States, the Ministry had been seeking the assistance of World Bank and so far four such projects had been approved and were being implemented.

Making a reference to surveillance network, the Minister pointed out that it had not been functioning at optimum capacity and emphasized the need for strengthening the Disease Surveillance and Response System so that we were in a state of preparedness for setting in motion systems as the situation demanded. He informed that the National Malaria Eradication Programme Directorate had prepared an action plan and a calendar of activities which when adopted will enable States to take pre-emptive action to prevent outbreak of epidemics. He also urged the State Governments to take up health risk assessment studies whenever large projects were planned so that development itself did not lead to creation of additional health hazards. The Minister referred to the Supreme Court judgment on disposal of hospital waste and impressed upon the States the need to ensure that adequate facilities were created in both Government and private hospitals for proper disposal of bio-medical wastes.

Another disturbing fact, according to him, was the wide disparities in the level of health spending among different States and urged the State Health Ministers to increase the level of spending on health sector.

He made a strong and impassioned plea for increasing the outlays for Health and Family Welfare if we have to make a tangible dent in our health and family welfare programmes. He appealed to the Prime Minister and the Planning Commission to treat external assistance coming from the World Bank and other agencies/countries as additional ties to the overall plan allocations of the Ministry of Health & Family Welfare. (Full text of the speech delivered by the Union Minister of State for Health & Family Welfare (Independent Charge) is at annexure 'B').

Prof. J.S. Bajaj, Member (Health), Planning Commission stated that the country had made rapid strides in improving the quality and outreach of the health care services. Indicators of Infant Mortality Rate, Crude Death Rate and Life Expectancy pointed to substantial improvement in health status of the people. However, the increasing growth in population was a matter of serious concern and there was an urgent need to reinforce family welfare programmes with greater vigour and to accelerate the containment of population.

Prof. Bajaj further stated that the Central Government had provided additional funds to the States/UTs Administration for the Basic Minimum Services and urged the State Governments to accord high priority to the health services in allocation of resources.

While referring to the approach to the Ninth Five Year Plan, Prof. Bajaj indicated that the provision of Primary Health Care constituted the base and basis of rural health infrastructure which remained total and absolute commitment. He also referred to the other objectives of the Ninth Five Year Plan such as food and nutrition security for all, empowerment of women, eradication of poverty and environmental sustainability which closely interact with health and family welfare programmes and emphasized the need for close inter-sectoral coordination. (Full text of the speech of Prof. J.S. Bajaj, Member (Health), Planning Commission is at annexure 'C').

After the inaugural session, the Plenary Session of the Conference was held under the Chairmanship of Shri Saleem.I.Shervani, Union Minister of State for Health and Family Welfare (Independent Charge). The Chairman requested the Ministers and Representatives of Union Territories, Members of Parliament as also the Eminent Individuals present to express their views on the Agenda Items, problems facing them and suggestions for making health care more effective. The important observations made by the Ministers/Representatives of States/UTs and Eminent Persons are as under:

#### **Points Made By State Health/Family Welfare Ministers/Representatives of UTs and Eminent Persons**

In the written speech of Smt. Rajinder Kaur Bhattal, Chief Minister and Health Minister (not present) observed that the State had been able to achieve significant progress in various indicators of human development. A comprehensive child survival and safe motherhood programme was being implemented in the State. Leprosy had been completely eliminated but AIDS was a matter of concern. Mosquitoes had become resistant to conventional insecticides and the introduction of biocides and bio-environmental control measures had become a dire necessity.

Dr. Wilfred D'Souza, Deputy Chief Minister of Goa indicated the steps taken by the State to curb the menace of malaria and stated that the migrant labourers were screened for malaria by issuing them health cards. No Contractor/builder would engage any labour without a valid health card. The State had also a unique scheme of "Medicclaim" under which permanent residents whose annual income was less than Rs.50 thousand were provided financial assistance to the extent of Rs.1.25 lakhs per illness for specialties which were not available in State Government hospitals.

Dr. N. Janardhan Reddy, Minister for Health & Family Welfare of Andhra Pradesh pointed out that the concept of target free approach was giving wrong signal to field functionaries as was demonstrated by low performance during last few months. He also suggested that under the Family Welfare Programmes, the States should be released additional funds to make up for arrears which had accumulated. The programme for AIDS control should be continued as a 100% Centrally Sponsored Scheme after the expiry of World Bank assistance. He also made a request for one time grant to equip the Regional Cancer Centre.

Shri Tahung Tatak, Minister for Health & Family Welfare of Arunachal Pradesh observed that the population in the State was dispersed over large area with low density and the private sector in health care was practically non-existent. The State had low indicators of human development as compared to all India figures. There was need for strengthening Sub Centres and PHCs and filling of a large number of vacancies of super specialists which existed in the State. The State had laid down the guidelines for rural posting of doctors. The Family Welfare programme for Arunachal Pradesh should be reoriented in keeping with the customs and ethos of the tribals.

Dr. K. Kalita, Minister for Health & Family Welfare Assam complimented the Union Minister for convening the Conference of the Central Council at an appropriate time. He stated that the peculiar geographical, climatic and backward conditions of the State called for special efforts for development of health and family welfare sector. Many of the National health care programmes being implemented in the State suffered due to non-availability of drugs, insecticides, equipments etc. Unless health problems were tackled expeditiously, it might cause outbreak of epidemics in the State. He pleaded for special financial assistance for various programmes in the State.

Dr. Mahavir Prasad, Minister for Health, Medical Education and Family Welfare of Bihar stated that malaria had resurged in a big way in Bihar and due to non-availability of insecticides on time, spraying activities had been severely affected. Difficulties were also being experienced in procuring anti rabies vaccines. There was need for generating awareness about AIDS extensively to prevent innocent people becoming victims of the disease. NGOs should also be involved in a big way in various health programmes.

Dr. Anil Joshiyara, Minister for Health & Family Welfare of Gujarat reiterated the need for compulsory rural service of doctors and also clarified that the State would be in a position to offer jobs to medical doctors completing M.B.B.S., in view of vacancies and high turn over among them. He said that there was need-to modernize waste management in large hospitals.

Dr. Ram Lai Thakur, Minister for Health & Family Welfare, Himachal Pradesh stated that due to difficult terrain, health services were not easily accessible to the people living in remote and far flung areas. There was need to lay special emphasis on family welfare programmes so that population was contained. The Central Government had not given timely assistance whenever a calamity occurred in the State and he pleaded for Central assistance.

Smt. Viplove Thakur, Minister for Ayurveda, Himachal Pradesh pointed out that increase in population was a major problem and to make a dent on population control programmes, ISM&H practitioners and institutions should be increasingly involved. She also stated that there was need for parity in service conditions of ISM&H doctors' vis-à-vis allopathic doctors.

Dr.(Mrs.) Kamla Verma, Minister for Health & Family Welfare of Haryana urged the Centre and the State Governments

to provide larger resources for health care so that services of better quality could be provided to the common man.

Dr. Mustafa Kamal, Minister for Health & Medical Education, Jammu & Kashmir observed that health infrastructure in the State especially in the valley and District Doda was adversely affected due to militancy and there were gaps in buildings, equipments, vehicles, medical supplies and staff which need to be attended urgently. The Consultant deputed by the Government of India to assess the requirements for updating the equipments in hospitals and construction of new hospitals on a turn-key basis under a collaborative Foreign Assistance Programme had proposed an investment of Rs.1464 crores. The Minister pleaded for assistance from Centre in this regard. He stated that his State Government fully endorsed the strategy of shifting from quantitative targets to qualitative targets and decentralized participatory planning at grass root level with emphasis on quality of care and client satisfaction for family welfare programme.

Shri H. C. Mahadevappa, Health Minister, Karnataka and Dr. M. Shankar Naik, Minister of Medical Education, Karnataka in their speeches suggested that the Conference of the Central Council of Health & Family Welfare should be held every year to highlight the importance attached by the Government to health care. Family welfare programmes should be taken up as key elements of the programmes being implemented by various departments and there should be close inter-sectoral co-ordination. They also pinpointed the need for filling the gaps in the primary health care as envisaged under the Basic Minimum Services Programme through a country wide project, if necessary, with external assistance. There was a need for assistance for Rajiv Gandhi University of Health Sciences as also provision of grants to meet the unexpected expenditure in improving medical colleges and the teaching hospitals so as to standardize the medical education and maintain quality of service. Most of the ISM&H colleges were not up to the standard prescribed by the Central Government and pleaded for additional grants to improve the infrastructure like buildings, equipments, herbal gardens, research etc. so as to bring these colleges to the desired levels.

Shri A. C. Shanmukhadas, Minister for Health & Sports, Kerala observed that the general morbidity rate in the State was higher than that of the National average. Further the place of communicable diseases was now being taken by non-communicable diseases. He pleaded that just as other States were being assisted to meet the Family Welfare and Health needs of the people, his State also should be assisted to meet its legitimate needs. He stated that there was a need for amending the PFA Rules in keeping with the consumption habits of the people in the States. He also pointed out that while there was need to regulate the private hospitals, we should ensure that we do not stifle them.

Shri Prem Narain Thakur, Minister of Health of Madhya Pradesh stated that though increase in population was a grave problem in the State, the changes in the health and family welfare scenario witnessed of late had given hopes for substantial improvement in the situation. Steps had been taken to effectively control the private practitioners. The State had the largest tribal population in the country and the State Government was striving to provide health care to the tribal population on a large scale. The Minister stated that there was a need to expand the coverage of PHCs by setting up new ones and also strengthening the existing centres. However, the State had no resources for this and the Minister requested the Centre to provide adequate resources for the purpose. He also mentioned that under the programme for

providing Basic Minimum Services the State required Rs. 30 crores. He requested that extra resources may be provided to the State Government for taking up the various programmes.

Shri Narendra Nahata, Minister for Medical Education of Madhya Pradesh pointed out that the position of Medical Education in the State was not good and special attention will have to be given for improving the same. The State Government was striving its best to collect funds through the Patients' Welfare Committees for improving the working of the medical college hospitals at Indore and Bhopal. In this connection he requested that the norms of the Medical Council of India should be reviewed and relaxation may be given in the case of medical colleges catering to the requirements of tribal population. He further requested that the State Government required additional funds to strengthen the ISM Health Care System in the State.

Dr. D. S. Aher, Minister for Public Health, Family Welfare, Medical Education & Drugs, and Maharashtra highlighted the lack of health infrastructure in the urban slum areas which was causing a great problem in the State and asked for waiving the usual norms for establishment of primary health centres. He stated that the Government of Maharashtra had prepared and submitted a project proposal for improving the Health Systems in the State with World Bank assistance for which the response was still awaited from the Centre. He wanted the role of Central and State Governments in the management of health care to be demarcated clearly.

Dr. Chalton Lien Amo, Minister of State for Health, Manipur pointed out that adequate infrastructure had not been developed in the State, particularly at the district and sub-divisional levels. In most of the hospitals there were no operation theatres and supportive services like blood banks, pathology, microbiology units etc. He also stated that there was need for provision of more seats for the State in medical colleges.

Shri Kitdor Syiem, Minister of Health & Family Welfare, Meghalaya pleaded for a separate working group to be constituted for the North-Eastern Region this time also as was done at the time of the Fourth Conference of CCH&FW held last year. While urging the Central Government for provision of interim facilities at the Indira Gandhi Regional Institute at Shillong, he requested for implementation of Phase II and III of the above Institute during the Ninth Five Year Plan period.

Shri H. Lalruata, Minister for Health & Family Welfare, Mizoram wanted that all areas in the State be covered by the scheme for provision of impregnated bed nets and additional 5 lakhs bed nets may be provided for this purpose. Drugs under T.B. control were not being received regularly.

Shri Rajendra Rathore, Minister for Health and Family Welfare, Rajasthan stated that the State had adopted a multi-pronged strategy to contain the population. He asked for extra assistance from the Centre for setting up Sub Centres. He further observed that the usual criteria of population for setting up Sub Centres and PHCs should not be applied in Rajasthan. He indicated that the State had established a few mobile Trauma Clinics for attending to accident victims on

highways.

Dr. D.P. Kharel, Minister for Health & Family Welfare of Sikkim stated that the State Government had been giving top priority for health care programmes in order to reach health services to the door steps of people living in remote and high altitude areas. In this connection he suggested that while setting up of Sub Centres/PHCs and CHCs geographical peculiarities of the States should also be taken into account. Though much improvement had been made by the State in the health scenario, much more remained to be done in this direction. He stated that lack of adequate health infrastructure was one of the main impediments being experienced in the State. He requested for additional funds to be made available to the State so that further improvements could be effected in the health and family welfare sector.

Shri Arcot N. Veerasami, Minister for Health & Electricity, Government of Tamil Nadu urged the Government of India to consider and approve the RCH Project prepared by the State Government on the basis of IMR, and Institutional delivery etc. as the infant mortality rate in the State was high. In the context of externally aided project for India Population Project V, the Health Minister requested the Government of India to approve the DANIDA Phase III and release funds early so that implementation could be initiated. Japanese Encephalitis had emerged as a major public health problem in the State and requested for early import of vaccine.

Shri Bimal Singha, Minister for Health, Tripura drew the attention of the Council to the special problems in the implementation of the health and family welfare programmes due to militancy in the State. He stated that not much had been done in the last two decades for improvement in the health scenario of the State and therefore Tripura required special attention of the Centre in this regard. He stated that Sub Centres, PHCs and CHCs had not been set up as per the population norm and unless special Central assistance was given, achievement of targets was not possible.

Dr. D. K. Arya, Advisor, Health, Family Welfare and Medical Education of Uttar Pradesh suggested that the location of Sub-Centres and PHCs should be based on distance criteria so that the health care facilities were accessible to the people. In the Urban slum areas there was need to strengthen health infrastructure. It was desirable to regulate private hospitals to prevent the exploitation of patients. He also mentioned about bringing out a scheme for providing health care to children engaged in Industries.

Shri Partha De, Minister in-charge of Health & Family Welfare of West Bengal asked for greater allocation to be made for Health & Family Welfare Programme both in the Union and State budgets for a more meaningful implementation of Basic Minimum Services and all National programmes. There was also need to provide for a Union Act to prevent proliferation of spurious ISM&H schools and colleges.

Dr. Harsha Vardhan, Minister of Health, National Capital Territory of Delhi indicated that Government of Delhi was the only one to have enacted a law for prevention of smoking in public places. Smoking had a deleterious effect on the body and needed to be curbed. The Government had launched a pilot project in Eastern zone for making Delhi a Healthy

City. He pleaded for assistance from Health Ministry for setting up a separate channel for control of communicable diseases like malaria and dengue. For improvement of sanitation as also diseases associated with stagnant water, plastic items etc., he requested for increased Central assistance. He did not favor amalgamation of State Health Education Bureau and IEC Bureau.

Shri A. M. H. Nazeem, Minister for Health & Family Welfare, Pondicherry stated that the Union Territory should be provided with sufficient funds to purchase sophisticated equipments for drug testing and food testing laboratories.

Smt. A.B. Wadia, President, Family Planning Association, Bombay welcomed the new shift in the family welfare programme in the adoption of target free approach. Though this approach will have an initial set back in the programme it will certainly gather momentum in the long run and will be more effective than the target approach. She stressed the need for adopting a comprehensive population policy and a system of decentralization.

Smt. Urmilaben Patel, Member of Parliament stated that with the school health check up programme and immunization should be taken up with greater vigour. She pin pointed the mental health problems prevalent among the secondary school students and wanted provision of psychotherapy and necessary guidelines in the schools. In order to make available doctors and nurses in rural areas she suggested that a four year diploma course may be organized for doctors and a nine month to one year course for the nurses. Compulsory marriage registration and the prevention of child marriages should be under taken.

Smt. A Habibulla, President, Indian Council of Child Welfare complimented the Union Minister for signal direction in health care. She stressed the need for involving NGOs in the implementation of various programmes, greater efforts in immunization of children and setting up of children wings in the hospitals.

Vaidya Devendra Triguna of All India Ayurvedic Congress stated that though the importance of ISM&H had been realized but the funds allocated for the development of the sector had been inadequate. He further stated that the conditions of Ayurvedic hospitals in the States especially in Uttar Pradesh, Madhya Pradesh and Bihar was very bad and requested the State Governments for allocating larger funds for improvement of these hospitals.

Shri Sanatan Bisi, Member of Parliament and member Consultative Committee attached to the Ministry of Health & Family Welfare observed that the funds allocated for the various health programmes were not reaching the targeted beneficiaries. He suggested that 100% Central assistance for the National Malaria Eradication Programme should be extended to the tribal areas of other States also.

Dr. Vallabhai Kathiria, Member of Parliament and member Consultative Committee attached to the Ministry of Health & Family Welfare stated that though it was stated that 6% of the GDP was allocated for the health & family welfare sector, in actual practice it had not been done. He requested the Planning Commission and the Ministry of Finance to allocate increased funds for the development of health and family welfare sector. He stated that all States should have Medical

Universities of their own and suggested that criteria for setting up of PHCs should not only be on the basis of population but also on geographical basis.

Shri Y.N. Chaturvedi, Secretary (Family Welfare) observed that there was wide spread awareness (97%) of the need for Family Planning but the acceptance rate was below 50%. In the States of U.P. and M.P. the delivery system for family planning was still lagging behind. Pulse Polio Immunization had been a success story through social mobilization. School Health Check up programme had also met with a remarkable degree of success. There had to be increased involvement of the community and the non government sectors in achieving success in family planning.

Smt. Santa Sastry, Secretary (Indian Systems of Medicine and Homoeopathy) stated that with the setting up of a separate department, high hopes and expectations had been raised but the financial allocation had not been commensurate with the requirements. ISM was a time tested system, holistic in approach and cost effective. The importance of the System was being realized via the western world. This system could be effective in providing health care in rural areas but it had to be ensured that there is no compromise in the standards of education in schools/colleges imparting training in ISM &H besides maintaining high quality in drugs as well.

Shri P.S. Bhatnagar, Additional Secretary, Department of Health pointed out that a number of useful suggestions had been made during the deliberations and they deserved close examination. For Tuberculosis World Bank assistance was being made available from this year and a programme was being taken up in 39 districts in the first year. For this District TB Societies had to be set up and a number of posts will have to be filled up coupled with appointment of supervisory staff. For National AIDS Control Programme Rs.43 crore was lying unspent with the States. The amount had been released by the Centre but not released for the AIDS Control Programme.

Smt. Shailaja Chandra, Additional Secretary, Department of Health pointed out that Seven Judge Bench of the Supreme Court has raised the issue of minority education institutions. Various minority institutions had also approached the Court indicating their views and also what should be done in this regard. The Government of India was required to fix uniform fee structure in consultation with State Governments within three months. Unfortunately there was no consensus among the Central Government and some of the State Governments in this regard. The Court had ordered that we should place the views of the Central Government before them. While doing so we will also place views of the various State Governments. Some of the State Governments had made an impassioned plea for more funds and insecticides. Use of BHC needed to be banned shortly and not more than 10,000 tonnes of DDT had to be released. Whenever there is upsurge of malaria, State Governments take up spraying. It is essential that we must take measures to stop the breeding of mosquitoes and a calendar of activities for malaria control should be proposed. State Governments were required to set up mental health authorities but they had not yet started functioning in a number of States. To ward off human suffering, it was high time that these authorities were set up.

In the concluding part Prof. J. S. Bajaj, Member (Health) Planning Commission suggested that the Resolutions adopted in the previous Conference of the Central Council of Health & Family Welfare should be acted upon and the Action Taken Report should be placed at the next Conference of the Council. A separate budget head of Basic Minimum Services had been opened and separate allocation was being made by the Government of India and State Governments should try to provide maximum funds for the health care out of the new head. An integrated policy for tobacco should be adopted by agriculture and health sector. For ISM&H efforts will be made in the Ninth Five Year Plan to provide maximum funds.

Shri Saleem I. Sherwani, Union Minister of State for Health & Family Welfare winding up the discussions observed that during the three days deliberation, entire gamut of health sector had been covered. He responded to the various points raised by State Health Ministers/UT Representatives. He stated that in the interest of harmonious development of the health sector, it is imperative that the Centre State relationship continue to be on a sound and cordial basis and the Ministry of Health & Family Welfare will take due consideration of the suggestions made by them in the formulation and implementation of various health programmes.

## WORKING GROUPS

The Council decided to set up five Working Group to discuss the Agenda Items in detail. Each Working Group was headed by a Chairman/Co-chairman who was the State Health Minister and was assisted by various experts in the concerned fields apart from a Convener and Rapporteur who was of the rank of Joint Secretary.

The five Working Groups constituted for the purpose along with their Chairman, Co-Chairman and Convenor/Rapporteur is as under:

<b>Working Group 1</b>	<b>Chairman</b>	<b>Co-Chairman</b>	<b>Convener/ Rapporteur</b>
Working Group I Family Welfare Programmes and Rural Health Infrastructure	Health Minister Himachal Pradesh	Health Minister Rajasthan	Jt Secy.(AM)
Working Group II Communicable Disease Control Programmes	Health Minister Maharashtra	Health Minister Bihar	Jt Secy.(AP)
Working Group III Non-Communicable Diseases Control Programmes and matters relating to Drugs/Food Quality Control	Dy. Chief Min. Goa	Health Minister Andhra Pradesh	Jt. Secy.(RSD)
Working Group IV Other Health Programmes	Health Minister Karnataka	Health & FW Min. Gujarat	Jt Secy.(SB)
Working Group V ISM & Homoeopathy	Health Minister West Bengal	Health Minister Delhi	Jt. Secy.(PB)

The detailed composition of various Working Group is given in Annexure-E.

The Working Groups considered the various Agenda Items and proposed 34 draft Resolution. These were considered in the Plenary Session held on 10th January, 1997 and after due deliberation and careful consideration the Council adopted the final Resolutions.

## **RESOLUTIONS**

**TARGET FREE APPROACH AND DECENTRALISED  
PLANNING FOR FAMILY WELFARE PROGRAMME**

The Council recalls its Resolution on Agenda Item No. III of the Fourth Conference and places on record its appreciation of the efforts made by all the State Governments to implement the Family Welfare Programme on the basis of the Target Free Approach with effect from the current financial year.

The Council urged the Department of Family Welfare to rename "Target Free Approach" to avoid misinterpretations and complacency in implementation of the Programme. It recommends that the approach be continued despite comparative lower quantitative performance in the immediate future. It recommends that Jan Bhagidary Kalyan Yojna (Participatory Planning Programme) as an alternative to the national programme.

The Council urges all States and Union Territories and voluntary organizations to secure the full involvement of the community in the implementation of the Family Welfare Programme, to put into place the system of monitoring and evaluation envisaged, and to provide high quality services to the people, leading thereby to greater and voluntary acceptance of the small family norm.

**Agenda Item No. II**

**SHARING OF THE COST OF FAMILY WELFARE PROGRAMME BY STATES AS RECOMMENDED  
BY THE COMMITTEE ON POPULATION OF THE NATIONAL DEVELOPMENT COUNCIL**

The Council, having taken note of the recommendation of the National Development Council, regarding State sharing of a minimum of 10% of the cost of the Family Welfare Programme, felt that in view of the recent paradigm shift in the Family Welfare Programme the time is not opportune to change the funding pattern in the immediate future. The Council recommends that the issue be again taken up in the 6th meeting of CCH & FW.

**PULSE POLIO IMMUNISATION - REVIEW OF 1995-96 AND  
PLANNING FOR 1996-97**

The Council notes with satisfaction the excellent coverage achieved in the Pulse Polio Immunization round on 7th December 1996.

The Council resolves that all steps be taken to achieve effective and high quality implementation. It further resolved that efforts be continued to achieve one hundred percent coverage in the Pulse Polio Immunization rounds to be conducted on 18th January 1997, 7th December 1997 and 18th January 1998.

In order to expedite eradication of Poliomyelitis, the Council also resolves that immediate and adequate attention be paid to surveillance and the reporting and investigation of all cases of acute flaccid paralysis, to confirm or rule out the diagnosis of poliomyelitis.

**REVIEW OF SPECIAL SCHOOL HEALTH CHECK UP PROGRAMME OF 1996**

The Council appreciates the initiatives taken for conducting the special school health check up for primary school children in 1996

The Council resolves that the health check up of primary school children be made a regular annual feature, and that this programme be implemented between the last week of August and October as per the convenience of the States.

The Council recommends that the Department of Family Welfare also addresses the need for orientation, mobilization and training of manpower deployed for follow up cases. The Council recommends that detection be built into the School Health Check-up Scheme. In order to promote healthy lifestyles and health hygiene and education, the Council recommends that children in school going age be systematically exposed to health education. It also recommends that the State Governments take up active programmes for worm-disinfestations and anemia. The Council also expressed its concern for the out of school children and recommends that they also be covered annually at the nearest primary school.

The Council directs that the States and Union Territories make all provision for effective implementation of the scheme, including appropriate referral and management.

**INCREASING THE EFFECTIVE AGE OF MARRIAGE AND PROMOTION OF INFORMATION,  
EDUCATION AND COMMUNICATION IN THE COMMUNITY TO DELAY THE FIRST BIRTH**

The Council resolves that:

- (a) Appropriate communication strategies involving the community be adopted for disseminating messages on the advantage of marriage of girls at eighteen years or above, for the health of both the mother and the child. Delaying the first birth should be strongly promoted.
- (b) Community acceptance for adequate spacing between two births be created. Increased financial provisions be made both at the Central Government and State/U.T. levels for this purpose.
- (c) Innovative schemes which would make it attractive to delay the effective age at marriage and delay the first birth are promoted.
- (d) AIR should provide more coverage to rural and slum population so that their knowledge about right age of marriage and spacing methods could be improved.
- (e) Doordarshan (national and regional level) to give 5 minutes free daily during prime time for relevant messages on family welfare. Satellite cable operators also be exhorted to carry social messages.
- (f) Registration of marriages to be made compulsory by law.
- (g) In every village Mahila Swasthya Sangh be established involving young women for their betterment; and
- (h) To use all modes of inter-active and inter-personal communication to bring about attitudinal changes in society. The Council also resolves and recommends that State Governments increase convergent action in such areas which will increase income generating skills, education and status of women It also recommends that access to primary education be increased through innovative methods , particularly for girls, their enrollment and retention to schools,

**STRENGTHENING OF PRIMARY, SECONDARY & TERTIARY HEALTH CARE  
DELIVERY SYSTEM**

In view of the judgment of the Supreme Court on the availability of facilities in Government hospitals for treatment of persons sustaining serious injuries, this Council resolves that all States and Union Territories take steps wherever necessary for strengthening health facilities at all levels of health care, so as to provide efficient and adequate care to the seriously ill patients.

**REVISION OF PATTERN OF STAFFING AND CENTRAL ASSISTANCE TO STATES**

The Council resolves that the pattern of staffing and funding of the primary health care delivery system needs immediate upward revision. It recommends that the Central and State/U.T. Governments take up the matter with the Planning Commission for modifying the staffing pattern in the primary health care delivery system and also to provide adequate allocation of funds in their respective budgets.

**REVISION OF NORMS FOR CREATION OF INFRASTRUCTURE**

The Council resolves that taking into account the inaccessible, remote, hilly and difficult tribal areas and the fact that existing manpower is highly overburdened; the norms for creation of manpower and centres should be reviewed.

**COMMUNITY INVOLVEMENT IN PRIMARY HEALTH CARE AT 5000 POPULATION LEVEL**

The Council notes that community involvement is a key factor in the Decentralized Planning Approach adopted by the Department of Family Welfare, and resolves that the community be mobilized to undertake family welfare and health care activities, to disseminate information, and to support the Government programme through community resources.

**Agenda Item No. VII**

**ALL INDIA HOSPITALS POST PARTUM PROGRAMME, URBAN FAMILY WELFARE CENTRES,  
URBAN REVAMPING SCHEME AND RURAL FAMILY WELFARE CENTRES**

The Council endorses that the proposal to link the financial support to result in terms of improvement in CBR and IMR. However, those States which have already achieved the National goals should continue to get hundred per cent support. For others the result oriented scheme may be implemented.

**INCENTIVES AND DISINCENTIVES RECOMMENDED IN THE REPORT OF THE COMMITTEE ON POPULATION OF THE NATIONAL DEVELOPMENT COUNCIL**

The Council, having taken note of the formulation on the subject contained in the draft Statement on National Population Policy, resolves that:

Incentives in cash or kind given by the Central and State Governments for the acceptors of contraception as well as to motivators and service providers will be discontinued in a time-bound manner depending on the conditions in State. Community incentives aimed at encouraging the community to undertake activities resulting in reduction of birth, infant and maternal mortality rates have been introduced. The Council recommends the States to adopt similar community incentives. The Council also recommends that incentives of special increment to government employees be discontinued as the government employees are expected to serve as role models.

The employees of the Central Government, State/U.T. Governments, Municipalities, Panchayats and employees of various public sector undertakings must give the lead in adopting the two child norm. The service rules in the Central and State Governments and their undertakings may be suitably modified to ensure that the two child norm is adopted by their employees. Similarly, all new entrants to the Government who are married before the legal age of marriage may be debarred from recruitment. Promotion policies may be made such that the adoption of the two child norm is encouraged. The entire organized sector (public as well as private) must also take similar steps in order to create an environment where the two child norm is adopted by these relatively better off classes of society.

The Council recommends that the Bill introduced by the Govt. Of India in the Parliament and recommended by the Standing Committee of Parliament for disqualifying persons with more than two children, prospectively, from being elected to Parliament, be moved for consideration and passage of Parliament expeditiously.

**REVIEW OF PREPARATION OF DISTRICT TRAINING PLANS WITH SPECIAL EMPHASIS ON  
TRAINING OF ANMs AS TRAINERS OF DAIS**

The Council notes with satisfaction that guidelines for in service training have been finalized.

The Council resolves that decentralized training of health functionaries for health and family welfare will be imparted in an integrated manner from April, 1997.

The Council further resolves that the six days' orientation training of the ANMs in reproductive and child health will be expeditiously conducted.,

The Council further resolves that training infrastructure created under Central programme be supported and strengthened.

**COMMUNITY AWARD SCHEME AND FAMILY WELFARE PLAN FOR  
WATERSHED PROJECT AREAS**

The Council notes with satisfaction the initiatives taken by the Department of Family Welfare in starting the above-mentioned two schemes for securing community involvement in family welfare and health care. The Council recommends that the performance of these two schemes be evaluated and the schemes expanded and strengthened in future years. The Council also recommends that 10% of the JRY funds be made available to villages which records good performance in family welfare programme in terms of reduction in CBR, IMR, MMR etc.

**Agenda Item No. XI**

**OBSERVANCE OF "MATRI SURAKSHA ABHIYAN" ONCE EVERY MONTH AND OBSERVANCE OF "MATRI SURAKSHA DIVAS" PRIOR TO WORLD POPULATION DAY FOR IMPROVED HEALTH OF WOMEN WITH SPECIAL EMPHASIS ON REPRODUCTIVE HEALTH**

The Council recognizes the importance of initiating measures to increase the outreach of services for reproductive and child health. The Council notes with concern that provision of antenatal care, percentage of deliveries conducted by trained personnel, and referral of emergency cases is less than optimal, with the result that women bear a very high load of avoidable morbidity and mortality.

The Council notes the outreach established under the Pulse Polio Immunization Programme and resolves that the Pulse Polio Immunization posts be activated once a month to provide a comprehensive package of services for reproductive and child health at the door steps of the people.

The Council endorses the suggestion for adoption of July (prior to World Population Day) for the Matri Surksha Divas, to be observed with programmes given in the agenda, to raise awareness on this issue.

## **SPECIAL RESOLUTION**

The Council expresses deep concern at the slow pace of reduction in birth rates in the major states of the country and strongly recommends that an autonomous agency at National and State level be set up to generate and channelise resources for operational level be created and further urges inter-department and inter-sectoral coordinated activities be strengthened.

**EPIDEMIOLOGICAL SURVEILLANCE AND SUPPORT SYSTEM**

1. The Council noted with concern the continued occurrence of outbreaks of communicable diseases in different parts of the country. It was noted that during 1996, Japanese Encephalitis broke out for the first time in Kerala. Malaria resurfaced in a more virulent form in Rajasthan and Haryana and Dengue/Dengue Haemorrhagic Fever assumed threatening form in Delhi and adjoining States apart from sporadic outbreaks of water borne diseases in several parts of the country.
2. The Council also observed that in spite of the recent initiatives of the Government in strengthening the public health system particularly disease surveillance mechanism through a variety of measures viz. Strengthening of various laboratories including that of National Institute of Communicable Diseases(NICD), establishment of National Apical Advisory Committee for drawing up procedures and mechanisms for an effective disease surveillance network, the existing surveillance system often fails to identify outbreaks in their early stages for mounting an early effective response to such emergencies.
3. The Council, therefore, resolves that:
  - (a) The recommendations made during the 4th Conference held in 1995 that a Centrally Sponsored Scheme of National Disease Surveillance Programme with appropriate laboratory support services including entomological services covering the entire country with emphasis on new, emerging and reemerging diseases be initiated and the NICD, to act as the nodal coordinating agency for planning, guiding, monitoring and evaluating the implementation of the programme is reiterated and recommends that the same may be taken up for implementation from the very beginning of the Ninth Plan. The Programme envisages generation of reliable laboratory based/Community based epidemiological data with district as the most important and peripheral focal point. While existing district health infrastructure shall be utilized, expansion and strengthening of laboratories in terms of additional diagnostic facility, equipments, reagents, human resources and training have been envisaged in the National Disease Surveillance Programme. For rapid flow of information, all districts will have computerized data collection and analysis facility and shall be linked through NICNET with State Headquarters, Regional laboratories as well as NICD. The provision of appropriate communication requirement has been made in the National Disease Surveillance Programme. The country has a large number of sophisticated laboratories in different parts of the country. Their expertise is proposed to be harnessed by making them an integral part of network of disease surveillance. These laboratories shall act as referral centres and suitably strengthened with equipment(scientific &communication) consumables and training. Minimal additional manpower for these laboratories is

also proposed in the programme. The programme also will have research and development components for developing low cost rapid diagnostic techniques for wider use in the peripheral areas.

- (b) Noting that several health service projects with IDA assistance are being implemented by several States which will have a significant component of strengthening epidemiological capability and establishment of disease surveillance mechanism, the Council recommends that NICD which is also a WHO Collaborative Centre for Epidemiology and Training initiate appropriate in-service training courses in Epidemiological intelligence in consultation with the State and Union territories to strengthen their epidemiological capability in perceiving, detecting and responding rapidly to the public health threat arising out of disease outbreaks.
- (c) The Council further reiterates the recommendation made in the 4th Conference in 1995 that an expert committee be constituted to look into the notification system of the country and make specific recommendations for uniform notification system in the country with appropriate legal provisions.
- (d) Greater emphasis on community medicine and epidemiology is required to be given in the undergraduate medical curriculum so that the medical graduates have appropriate technical background in understanding epidemics and its prevention and control.
- (e) While implementing the National Disease Surveillance Programme, priorities should be given to epidemic prone districts.

**NATIONAL MALARIA ERADICATION PROGRAMME**

The Council reviewed the programme and noted with concern the recent outbreaks of the disease in certain parts of the country and increasing trend of P. Falciparum Malaria and gave emphasis on the control of the disease with concerted efforts by the States.

Council also took note of the problem of drug resistance in the parasite and resistance to insecticide in the disease vector.

Realizing the need for immediate efforts to be made for containment of this communicable disease council resolves

**1. Strengthening of MIS System for proper monitoring.**

The Council recommends that the State Health Authorities accord top priority to the establishment of District Level Epidemiological Cells to be headed by Epidemiologists with appropriate computer software facilities for handling MIS related to the communicable diseases with special reference to Malaria. The Council recommends that the State Health Authorities may consider linking up of the District Epidemiological Cells with the NICNET facilities at the district level to develop infrastructure for early warning system.

**2. Calendar of events and activities for all vector borne diseases.**

The Council impress upon the States to adhere to the monthly Calendar of activities prepared by the Directorate of NMEP as part of Malaria Action Plan. The State Health Authorities would discuss with the Directorate of NMEP regarding any changes in the Calendar of events

**3. Contingency plan for vector borne diseases including dengue.**

The Council views with serious concern the recent outbreak of Dengue/DHF in Delhi and some other States. In order to contain such sudden outbreaks of vector borne diseases including Dengue/DHF, a contingency plan giving details of the required state of preparedness on the part of the States/Districts was felt essential. The Contingency plan shall be implemented by all States/UTs in the event of outbreak of such diseases.

#### **4. Strengthening of Zonal and State Level Entomological component for area specific vector measures and forecasting.**

The Council reiterates the need for filling the vacancies in the Zonal and State level Entomological component which is essential to ensure integrated vector control strategies to prevent morbidity and mortality due to malaria and to forecast epidemics.

#### **5. Strengthening of Basic Health Services by States.**

The Council resolves that action be taken by the States to ensure that all the vacant posts under Malaria Organizations, especially those of Multipurpose Health Workers and Laboratory Technicians, are filled up immediately to ensure Early Detection and Prompt Treatment of Malaria cases and effective surveillance activities.

#### **6. Urban Malaria Schemes**

In view of the increase of incidence of malaria in urban areas, it is resolved that more towns/cities may be brought under this scheme.

#### **7. Bio-Environmental measures**

The Malaria vectors have developed resistance to conventional insecticides and newer group of insecticide, synthetic pyrethroid, is exorbitantly costly. In view of this, council resolves that more emphasis is to be given for adoption of bio-environmental measures for control of disease vectors.

#### **8. Resistance to drug and to insecticides**

Having noted the importance of development of resistance to drug in the malaria parasite and to conventional insecticide in the vectors, the Council resolves that continuous monitoring of the status of resistance of parasite to drug and of vector to insecticide should be carried out.

**NATIONAL AIDS CONTROL PROGRAMME**

The Council taking into consideration the resolutions passed in the 4th meeting of the Council and action taken by the State Governments and keeping in view the rapid spread of HIV/AIDS infection resolves -

- a) that all the States should establish High Powered Committees on the pattern of the Apex committee constituted by the Government of Maharashtra for organizing a massive campaign on AIDS awareness and for effective implementation of the preventive measures;
- b) that the funds placed at the disposal of the State Governments for AIDS Programme are released expeditiously to the implementing agencies;
- c) that "Action Plans" of the State Governments for the year 1997-98 are submitted before the end of the February, 1997; and
- d) that immediate action is taken to furnish disbursement claims so as to enable National AIDS Control Organization to secure reimbursement from the World Bank.
- e) After the available assistance from the World Bank stops, Govt. of India should run the programme as centrally sponsored scheme during the 9th Plan.
- f) The methodology of testing of any person/blood unit should consist of the following steps:
  - 1) Consent
  - 2) Pre-test counseling
  - 3) Minimum two different ELISA tests
  - 4) Post-test counseling
  - 5) Support/Follow-up facilities

For the present, this is already within the policy of the HIV testing. It should however be further developed in the Programme.

## **BLOOD SAFETY**

The Council took note of the Hon'ble Supreme Court directives in the Shri H.D. Shourie versus Union of India and State Governments case and resolves -

- a) the urgent necessity of ensuring that State Blood Transfusion Councils are duly established and registered by due date;
- b) the Council resolves that in view of the difficulties of the States/UTs to implement the requirement of licensing of Blood Banks within a period of one year, the Hon'ble Supreme Court may be requested to kindly give suitable extension for implementing this part of the directive;
- c) the Council resolves that the States/UTs Blood Transfusion Councils take immediate steps to implement Supreme Court directive relating to promotion of voluntary blood donation and phasing out of the professional donor system by December, 1997;
- d) that the Council taking cognizance of the Central Government decision in respect of income-tax exemption for donation to Blood Transfusion Councils take steps to mobilize donation to the State Blood Transfusion Councils: and
- e) the Council taking cognizance of directive to establish facilities for Postgraduate

Medical Education in the field of Blood Transfusion resolves that all concerned may take immediate action so as to ensure compliance with the Supreme Court directive.

**NATIONAL TUBERCULOSIS CONTROL PROGRAMME**

- 1) The highest political commitment should be ensured for the TB programme, for which effective advocacy needs to be undertaken. This Council therefore recommends that Central/State Government should give a high priority to the TB Control Programme and also ensure that it does not suffer from financial constraints.
- 2) In view of unabated transmission of Tuberculosis, effecting all sections of society particularly the poor, undernourished and underprivileged and the consequent economic loss there is need to ensure that objectives and policies of RNTCP (Revised National Tuberculosis Control Programme) is fully supported. The Council therefore fully supports RNTCP and recommends that RNTCP be implemented throughout the country at the earliest possible through the collective efforts of Central/State Governments and Non Governmental Organizations.
- 3) The programme requires effective supervision. The Council therefore recommends that the State Government will suitably upgrade the post of State TB Officer and ensure placement of such officer on full time basis for the programme.
- 4) The Revised Strategy under the World Bank funded project will be expanded only on fulfillment of criteria laid down by the World Bank. The Council recommends that it would ensure fulfillment of all eligibility criteria to facilitate phased expansion of RNTCP in districts.
- 5) The Council recommends that the government will ensure sufficient funds for the programme and in no case the allocation would be less than the budget of the previous year, excluding the additionally provided under the externally assisted component. The State governments will enhance their allocation under the programme to meet the additional costs on monitoring, supervision, training, infrastructure and IEC.
- 6) The Council recommends that the State/UT Governments will ensure timely procurement and free supply of anti-TB drugs for all sputum negative cases in non RNTCP project districts.
- 7) The Council recommends that the State Government will give maximum priority to monitoring and supervision and will ensure that the vehicles provided under the programme at the State and District level are utilized exclusively for supervision of TB Programme activities.
- 8) The Council recommends that the State Government will ensure that vacant posts of key DTC staff, Lab. Technicians in PHIs and MPWs in all project districts are immediately filled up and in other districts within one year.

- 9) The placement of additional staff sanctioned under the World Bank funded project in the RNTCP districts should be done most expeditiously. For districts to be taken up in 1997, this process should be completed by early 1997. The Council, therefore, recommends that in RNTCP project for 1997, the Central/State Government must ensure that 50% of additional staff must be in position by July, 1997 and 90% by December, 1997. In case posts are not filled up, contractual staff should be engaged till regular staff is appointed.
  
- 10) The Council recommends that District TB Societies will be established by March' 97 in each of Districts being taken up for RNTCP, so that funds can be provided to them for monitoring and evaluation of the programme at District level and building up effective co-ordination with NGOs.
  
- 11) The Council recommends that the State Government shall create State Level training facility in the State where there is no State Training and Demonstration Centre.

**NATIONAL LEPROSY ERADICATION PROGRAMME**

The Council reviewed the programme and noted with appreciation the progress of implementation of National Leprosy Eradication Programme and passed the following resolutions to further strengthen the programme to achieve the National objective of elimination of leprosy by the year 2000 A.D. thereby reducing the case load to less than 1 per 10,000 populations. On the line of Pulse Polio Immunization Programme, an intensive community drive be undertaken by all the States/UTs irrespective of level of prevalence of disease, for bringing community awareness and detecting the hidden leprosy cases

**1) INFRASTRUCTURE:**

The National Leprosy Eradication Programme has been largely a vertical programme and therefore, it is important that the vacant posts are filled up by State Government for proper implementation. The State Government should fill up not only the vacant posts under the regular programme, but also appoint staff on contractual basis where required, particularly for the uncovered districts which have been sanctioned MDT scheme. It is, therefore, resolved that the State Government will ensure that the vacant posts under the National Leprosy Eradication Programme will be filled up expeditiously.

**2) PUBLIC AWARENESS ACTIVITY.**

With the reduction in the prevalence rate of leprosy, we are trying to detect patients as early as possible, so that, effective treatment can be given and deformities can be avoided. Under the circumstances, it is very essential that the community is made aware of the fact that leprosy is not a very infectious disease but fully curable. Moreover, we also desire that community gets involved in early detection of leprosy cases. Keeping the above in mind, it is resolved that to remove social stigma attached to the disease and to ensure early detection, public awareness activities will be stepped up through extensive use of mass media, print media, folk media, etc. in all parts of the country. Symbolic tea party should be given by the Chief Ministers and Health Ministers of all the States to leprosy patients during anti-leprosy day/week and such an event should be widely covered by media to create awareness amongst people and to remove social stigma attached to this disease.

### **3) INTEGRATION OF SERVICES UNDER THE NATIONAL LEPROSY ERADICATION PROGRAMME WITH GENERAL HEALTH CARE:**

We are hoping to reach the case load of less than 1 per ten thousand populations by the turn of the century, which would mean elimination of leprosy as a public health problem. If a disease does not exist as a public health problem, then justification for having a large vertical structure cannot be given. In view of this, it is being proposed that orientation training should be given to general health care staff, so that in the long run, leprosy care services can be taken over by the general health care system. In view of this, it is resolved that the State Government will plan out orientation training of general health care staff in diagnosis and treatment of leprosy with the aim of achieving integration of services after the disease has been eliminated as a public health problem.

### **4) DISABILITY AND ULCER CARE SERVICES:**

There are several leprosy patients who even when cured are left with disability and ulcers. It is essential that disability and ulcer care services are provided to such persons. In view of this, it is resolved that the Central Government as well as State Governments should strengthen services with regard to disability and ulcer care in all districts. Reconstructive surgery facilities should also be strengthened by all the States and UTs. Rehabilitation of leprosy cured handicapped persons should be carried out as a part of National Disability Programme for all the handicapped

**STATUS REPORT ON RABIES INCLUDING USE OF ARS IN  
SEVERE BITES**

The Council expresses its deep concern over the continued incidence of large number of Rabies cases and the associated misery of taking about. 14 very painful injections of neural vaccine produced from sheep brain by majority of the affected persons. The alternate tissue culture vaccine is more safe and effective and easier to administer, but because of the prohibitive cost only a small percentage of victims can afford it. The Council also notes with concern the shortage of anti-rabies serum which is to be administered in severe bite cases along with vaccine and its frequent non-availability in many hospitals at times of need resulting in high risk of deaths in large number of cases. The Council also notes the anti-rabies vaccine production and distribution scenario in the country.

2. The Council taking cognizance of the fact that rabies in man/animal is preventable, therefore, resolves thus:
  - i) State/UT Governments should initiate/strengthen rabies control activities with the following components:
    - a) Enhancing public awareness among the general public through various electronic and print media and by holding seminars/workshops at national, state and lower levels.
    - b) Evolve canine control measures through catching/sterilization and discarding by humane methods maimed, obviously unhealthy and disowned dogs.
    - c) Compulsory licensing and vaccination of pet dogs.
    - d) Provide pre-exposure tissue culture vaccine to persons engaged in control activities.
  - ii) Modern techniques of production of safer anti-rabies tissue culture vaccine may be insisted upon the producers and the neural vaccine production may be phased out.
  - iii) Sufficient quantity of anti-rabies serum may be produced and its availability may be ensured in hospitals across the country so that victims of severe bite cases could be saved.
  - iv) Detailed guidelines on various rabies control measures including management and treatment of rabies cases may be prepared and circulated by National Institute of Communicable Diseases.
  - v) The State/UT Governments may ensure proper participation of local bodies in the rabies control programme.
  - vi) It is suggested that the on-going Canine Control Programme being implemented by the Ministry of Agriculture be strengthened by taking up Pilot Projects on Canine Control in the four big metropolises during the Ninth Plan period with the assistance of State Governments/local bodies.

**NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS**

The Council takes note of increase in performance of cataract operations under the National Programme for Control of Blindness and expresses satisfaction that decentralization of the implementation of the programme through District Blindness Control Societies has been a remarkable feature. Though the number of cataract operations has gone up to 2.5 million operations, it should be further increased to 3 to 4 million operations per annum to clear the backlog of over 12 million blind people in India. As the main cause of blindness is cataract (about 80%) the emphasis should be on its treatment. At the same time other causes of blindness, notably refractive errors in children and corneal blindness need significant attention.

The Council recommends that gains should be further consolidated to reduce avoidable blindness by 2000 AD and adopts the following resolutions:

1. The Council resolves that the States should take necessary steps to upgrade the targeted service units for eye care services by filling up sanctioned posts of eye surgeons and paramedical staff, supply of drugs and other consumable items, training of personnel and seeking support of staff available at Primary Health Centre.
2. The States should judiciously draw a realistic plan of action for development of services in each financial year well before the commencement of the financial year. This plan of action should take into account equitable distribution of eye care units in various districts of the States and should be drawn in a need-based manner.
3. The States should submit complete reports on performance, development of services, component-wise expenditure and audit reports to enable Govt. of India to release funds to the States and seek assistance from the World Bank and DANIDA, expeditiously. Proposals for revalidation of unspent balance, if any, should be sent to Government of India in the first quarter of a financial year with details of component wise savings, reasons thereof and manner in which funds are proposed to be utilized.
4. It is strongly recommended to strengthen monitoring of activities under National Programme for Control of Blindness including functioning of District Blindness Control Societies by State Programme Cell. The State Govt. should post full time State Programme Officer of Joint Director rank and requisite support staff as sanctioned under the programme.
5. The Council recommends that though the funds are currently released to District Blindness Control Societies from Central Government on a performance related basis, the States should assume the responsibility of monitoring functioning of DBCS as per guidelines issued by Government of India. However, main features of

DBCS as outlined in Govt. Of India guidelines including its autonomous character, constitution, composition, pattern of expenditure etc. should be retained.

6. The Council feels that utilization of available services in Government sector, both in fixed facilities and eye camps is not optimal. The State Governments and respective District Blindness Control Societies should plan and implement effective Information, Education and Communication (IEC) activities to improve awareness about eye care in general and treatment of cataract in particular, allay the misconceptions of public and inform availability of eye care services. IEC activities should target not only beneficiaries but also community leaders, Panchayat leaders, health staff and providers of eye care services. Improvement in quality of services and established referral system would improve utilization of services.
7. Implementation of NPCB includes collaboration between Government and Non- Govt. organizations. The Council resolves that Central and State Governments should extend full cooperation to NGOs in implementation of various schemes viz. organization of surgical eye camps (outreach approach), organization of screening camps and surgery at base hospital (reach in approach), expansion setting up of eye care units in rural including tribal areas, scheme for screening and motivation and grant-in-aid to eye banks/eye donation centres in voluntary sector.
8. The Council resolves that the National Programme for Control of Blindness should be converted into a comprehensive eye care programme rather than a cataract centered programme. The States should expand activities like School Eye Screening for correction of refractive errors, eye donation and eye banking for reduction in corneal blindness, management of glaucoma and other eye disorders. Follow up of operated cases and provision of corrective glasses should also be emphasized.
9. The Council resolves that additional activities under World Bank assisted project in the States of Andhra Pradesh, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh should include construction of dedicated eye operation theatre, eye wards and dark rooms at PHCs, scheme for cost recovery and training of district eye surgeons in IOL surgery etc. should be undertaken:
10. A large number of young children are visually handicapped on account of corneal disorders. The Council resolves that the Government of India and the States should take measures to enhance collection and utilization of donated eyes to tackle the problem of corneal blindness through motivation, incentives and if necessary, by passing suitable legislation that encourages families to donate eye balls of the deceased.

**NATIONAL CANCER CONTROL PROGRAMME**

The Council noted that there are 2 million cancer patients in the country and about 7 lakhs new cases come up every year. The disease has high morbidity and mortality. Education, early detection, treatment facilities and pain relief measures are to be augmented on a large scale to cope up with the problem. The Council accordingly resolved that,

- 1) The plan funds under the programme be increased considerably for strengthening of the programme and for wide coverage.
- 2) The possibility of alternative sources of funding the programme be explored so as to augment the availability of resources. Creation of societies for mobilizing resources through voluntary donations for the health sector including cancer may be considered seriously. To encourage such public donations, Government of India may consider granting income-tax exemption to such donors,
- 3) The emphasis should be on comprehensive cancer centres for prevention, diagnosis, treatment, pain relief and research activities. Spreading the resources thinly should be minimized under the programme.
- 4) The Regional Cancer Centres provide comprehensive facilities for diagnosis and treatment of cancer patients. These Centres are provided grant-in-aid to some extent under the programme. The possibility of increasing their own resources by the Centres may also be explored so as to reduce their dependence on Government grants.
- 5) The National Cancer Research Programme of the Indian Council of Medical Research be strengthened to provide necessary data for future planning of the programme.
- 6) The Council notes that there is a Scheme for development of oncology wings in Medical College Hospitals for strengthening of therapeutic services. The Council recommends that more Institutions may be covered under the Scheme keeping in view the geographical gaps in the availability of cancer research facilities in the country.
- 7) The voluntary organizations particularly for education and cancer research activities be involved on a larger scale under the Programme. Financial assistance may be provided to such organizations in consultation with the concerned State Governments.
- 8) The Council recommends expeditious enactment of appropriate legislation to discourage consumption of tobacco and its products.

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

1. The Council noted with concern that Iodine Deficiency Disorders (IDD) continued to be a major public health problem in India. It is estimated that in our country about 200 million people are at the risk of IDD. The consumption of iodated salt is the most effective and cheapest method to control this problem.
2. The Council notes with concern that nutritional iodine deficiency directly affects the physical and mental development of the human beings. It must be accorded a high priority by providing appropriate funds to control this problem in the country.
3. The Council also noted with concern that there are a few States/UTs which have yet to issue notifications banning consumption of non-iodated salt in their respective areas. Similarly some States/UTs were yet to set up IDD Control Cells and IDD Monitoring Laboratories.
4. The Council, therefore, recommends that:
  - a. The NIDDCP should be accorded high priority as a major National Health Programme by all States/UTs. A senior technical officer should be made incharge of NIDDCP for appropriate and effective implementation of the Programme in the States/UTs. All officials involved in the programme should be given appropriate training.
  - b. The States/UTs which have not yet issued notification banning sale of salt other than iodated salt for edible purposes should do so immediately and ensure effective enforcement of the same.
  - c. The States/UTs which have not yet set up IDD Control Cells in their respective State/UTs should establish these cells without any further delay.
  - d. The States/UTs which have not yet set up IDD monitoring laboratories should establish these laboratories as sanctioned in the Programme for monitoring the iodine content of iodated salt and urinary iodine excretion.
  - e. The public distribution system should be involved in the sale of iodated salt through their retail outlets.
  - f. To popularize and promote the consumption of iodated salt centre, along with the States/UTs should intensify Information, Education and Communication (IEC) activities highlighting the importance and

benefits of consumption of iodated salt in control of Iodine Deficiency Disorders(IDD)

- g. The States/UTs should encourage installation of local salt iodations plants to eliminate the risk of loss of iodine content during transit.
- h. To monitor the programme effectively there is a need to develop trained manpower of both paramedical and medical personnel. The laboratory technical staff associated with IDD Monitoring is to be trained suitably for monitoring the quality control of iodated salt and urinary iodine excretion.
- i. The Directorate General of Health Services should evolve suitable guidelines for proper collection of salt samples and their analysis. Guidelines on IDD Surveys should also be formulated for making the results more reliable and comparable.

**NATIONAL MENTAL HEALTH PROGRAMME**

**Highlighting District Component**

The Council deliberated upon the mental health scenario in the country and noted with concern that mental health problems have assumed enormous proportions in recent times and there is a dearth of qualified and trained mental health personnel in the country and even the available personnel are concentrated in big cities. The mental health services in some States and UTs are at a very rudimentary level and that they have paucity of resources to tackle these problems. Lack of psychiatric services at the periphery, lack of proper knowledge about mental illness and their causes, myths, misconception and stigma surrounding mental illnesses etc. all result in untold suffering to the patients and their families.

The Council, therefore, resolves that:-

1. Mental health be considered a major thrust area and recommends peripheral services at the district and sub district level to be accorded due priority in planning mental health services. Attempt should be made to integrate mental health with physical health services at all levels in planning.
2. States/UTs may accord due priority for creating adequate trained manpower. For this purpose, States should send suitable and appropriate level of personnel for training in identified Institutions under 'Training of Trainers' programme. These trainers must, in turn, undertake training programmes of other workers like Nurses, Voluntary Social Workers, Anganwadi Workers, Community Health Workers, Teachers and other family members, so that mentally ill patients can be managed at the periphery itself within the community.
3. Improvement of mental hospitals and Department of Psychiatry in general and teaching hospitals in terms of adequate staff and services in all the States needs urgent attention. States must ensure regular and adequate supply of medicines etc. to the district and lower level health centres for treatment of mentally ill patients.
4. Those States and UTs which have not yet formed the Mental Health Authority are advised to do so at the earliest as establishment of Mental Health Authority is the statutory requirement for every State and UT under the Mental Health Act of 1987. States should ensure that they start functioning properly and according to the law which will result in overall improvement in delivery of mental health services.
5. With the recognition and inclusion of disability arising out of Mental illness as one of the disability eligible for benefits under the provisions in the new Disability Act, 1995, rehabilitation of the mentally ill and their

acceptance within the community is an important area needing urgent attention by the States. As a first step Rehabilitation wings should be attached to Mental Hospitals wherever it is non-existent. The quality of services in the existing rehabilitation centres needs improvement.

6. NCERT may be approached for introducing topics on mental illness at an appropriate stage in the student curricula so as to develop proper attitudinal changes among students without prejudice and misconception towards mentally ill and their families. This will result in their seeking necessary timely help and also in their rehabilitation and acceptance by the community after treatment.
7. IEC activities through optimal utilization of Print and Electronic Media and other audio visual methods need to be undertaken.
8. Medical Council of India may be appropriately involved in improving the under graduate curriculum and practical training and also introduce refresher courses to update the knowledge and experience of practicing physicians including those serving in Government.

**Role of Health Sector in Implementation of Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995**

The Council held in depth discussion on the important agenda item and noted that the Act represents an important landmark in the empowerment of persons with disability through creation of equal opportunities, protection of their rights and a barrier free environment based on non-discrimination. The Council felt that Ministry of Health & Family Welfare even though not the nodal Ministry for this purpose does have an important role in early detection and prevention of disability. The Council resolves as under:

1. The Council notes that there are a number of ongoing National health Programmes run by the Health Sector and also by Family Welfare Sector which have a direct bearing on prevention of disability. They are - (i) Leprosy Eradication Programme; (ii) Blindness Control; (iii) Iodine Deficiency Disorders Control Programme; (iv) National Mental Health Programme; and (v) Universal Immunization Programme including the Maternal and Child Health Programme. These Programmes may be further strengthened and focused attention be given towards preventive - and rehabilitation aspects.
2. The Council recommends that State/UT Governments may consider establishment of centres for rehabilitation in the District Hospitals and further adds that the existing health infrastructure be utilized and further strengthened to incorporate the various aspects of prevention and rehabilitation of various disabilities.
3. The Council feels that there is a need for development of trained manpower base to tackle the problems at the periphery within the community and for transfer of technology to grass root level. To achieve this, States and UTs should fully utilize the opportunity for training of PHC doctors and Para-medical personnel to re-orient them to the various aspects of Rehabilitation with the help of training institutions under the Ministry of Welfare as well as Ministry of Health & Family Welfare as a collaborative effort.
4. The Council recommends strengthening of research on causation and prevalence of disability within the community. The Council further recommends that research should focus on developing cost effective and socio culturally acceptable newer aids and devices suited to the common man at the periphery.
5. The Council notes that 3% reservation for persons with disability in Government jobs is an extremely important provision under this Act. It, therefore, recommends quick implementation of this provision in the various Departments of Health & Family Welfare in Centre, States and UTs.

6. The Council notes that there is lot of stigma attached to certain illnesses like Leprosy and mental illness. Myths, misconceptions and prejudices surrounding these illnesses are a hindrance for the rehabilitative efforts and their acceptance back as useful productive members within the community. The Council, therefore, recommends undertaking Public Awareness Campaigns through IEC activities using the various available methods of communication and media to bring in attitudinal changes among the public.
7. The Council urges the Central Government to take up with Doordarshan for provision of free slot for telecasting health related issues including disabilities issues.
8. The Council resolves that Medical Council of India recommendation of starting Physical Medicine & Rehabilitation Department in every medical college should be strictly implemented as only 14 out of 140 medical colleges have departments as of now. This will enable doctors and Para medicals to be trained in rehabilitation who in-turn can act as trainers for middle level and gross root level workers.

**STRENGTHENING OF DRUG QUALITY CONTROL**

The Council noted that with the objective of providing abundant availability of safe and effective drugs of good quality to the Consumers, a project for Capacity Building with World Bank assistance is currently under formulation. This would envisage:-

- a) augmenting the capacity for drug testing at the State Laboratories by providing additional equipment and manpower, and undertaking appropriate renovation; and
- b) strengthening the enforcement staff at Central and State Levels,

The Council resolves that;

1. The State Governments participate actively in the proposed World Bank Capacity Building Project and accept the funds to strengthen the Drug Control machinery in the State.
2. The State Governments augment the testing capacity by accepting equipments which may be used by the available manpower, and wherever required upgrade existing skills and add trained manpower for the purpose.
3. The State Governments make a commitment that at the close of the project they will take over the responsibility to sustain the project, so that the momentum built up during the five year project period is maintained.
4. The State Governments agree that the Central Govt. would monitor the effective -implementation of the proposed project, as per GOI/World Bank Guidelines for which they will provide the necessary support facilities.
5. The Council resolved that all the State Governments should provide adequate funds for drugs and ensure an efficient procurement and distribution of essential drugs in public health care institutions. The Council also recommends that the essential drugs concept and rational drug use should be implemented by the Central Government and State Governments.

**VACCINES**

The Agenda item was discussed at length and the Council resolves as under:

1. The traditional neural vaccine used in the treatment of Rabies is very painful to the patients at the time of administration and at times capable of producing neuroparalytic disorder. The Council, therefore, recommends phasing out of the traditional neural vaccine and switching over to a more safe and receptive tissue culture vaccine as and when indigenous production is available.
2. Considering the threat of Yellow Fever in the Asian Region, production of Yellow Fever vaccine may be restarted in the country as a precautionary reserve.
3. Adequate funds and facilities may be provided for scaling up the production of JE vaccine to meet the domestic demand.
4. Indigenous production of Hepatitis B vaccine may be encouraged.
5. Since the public sector institutes are not competitive with the private sector due to paucity of funds, they may be given the requisite assistance to renovate and modernize themselves to be able to contribute meaningfully in the immunization programme which is a national priority.

**STRENGTHENING OF PREVENTION OF FOOD ADULTERATION PROGRAMME**

The Council reviewed the working of the Prevention of Food Adulteration programme in the Country. Noting that the infrastructure for carrying out the responsibilities at the Central Level as well as at the State level is hardly adequate to do justice to the responsibilities assigned under the provisions of prevention of Food Adulteration Act, 1954, the council resolves that :-

1. Immediate steps are taken for augmenting the infrastructure for the Prevention of Food Adulteration Programme both at the Central and State/U.T. Level. The infrastructure at the Central level be strengthened by:-
  - Provision of trained manpower at the HQ.
  - Establishment of new Central Food Laboratories.
  - Setting up of Zonal offices and Import Quality Control Units at Ports.
  - Establishing/Strengthening Management Information Systems.

For this purpose the component of schemes proposed under World Bank Capacity Building Project currently under formulation be sanctioned on top priority.

2. Similarly, the State/UT Governments make a commitment to initiate time bound programmes for strengthening their infrastructure by establishing District Food Inspection Units with facilities for Management Information System and augmenting the food laboratories with trained manpower and equipments utilizing World Bank Assistance. It is further resolved that the additional infrastructure created through World Bank Project during the Project period of five years coterminous with the IXth Plan and should be sustained by the State/UT Governments after the project period of five years is over.
3. The State/UT authorities should pay special attention to curb adulteration at the source by directing the PFA enforcement machinery to concentrate their attention at the level of the manufacturer/Wholesaler/Distributor. Specific survey and Investigational sampling programme need to be organized at large scale commercial places like wholesale Markets/Weekly markets and markets in the slum areas for detection of the actual source of adulteration.
4. The State/U.T. Authorities should ensure that strict vigil is kept by their enforcement machinery on improving quality of Street Food sold in and around Schools/Colleges/Market places/Fairs/Exhibitions etc.

5. Registered Consumer Organizations/NGOs need to be actively involved in the programme of Food Safety and Quality Control. Strong Consumer movement needs to be created by holding Radio Talks/T.V. Telecasts/Hoardings/Pamphlets etc. Importance of Food Safety and Quality Control needs to be explained to students in Schools and Colleges.
6. The progress of the cases launched under the provisions of the prevention of Food Adulteration Act, 1954 by the States/UTs in various courts need to be regularly monitored at every District Headquarter.
7. The States/UTs which are yet to enforce the Licensing provisions under the Prevention of Food Adulteration Act/Rules, should take immediate steps to enforce and implement the said provisions in their States/U.T.
8. State PFA Rules should be updated periodically to move with the time. Fees for analysis of samples of food articles as well as License Fees should also be rationalized from time to time.
9. Attention should be paid to development of trained manpower by sponsoring States/UTs officials both from the laboratories & enforcement wings to the various training programmes organized by Central PFA Division.

## **SPECIAL RESOLUTION**

Steps should be initiated for an integrated non communicable diseases programme to be undertaken during the Ninth Plan using the experience of pilot projects gained during the Eighth plan.

## **HOSPITAL WASTE MANAGEMENT**

The Council discussed the agenda item in depth and notes that:

- a. The factors which brought the hospital waste management into prominence include: (i) rapid increase in waste generation due to the increased use of disposables; (ii) technological advances in medical and surgical care combined with mushrooming of health care facilities without a matching input towards disposal of waste; and (iii) indiscriminate access to rag-pickers to sift through waste and re-cycling of biomedical waste such as disposable syringes, catheters, etc. resulting in greater exposure of general public to the contaminated waste.
- b. Though big hospitals in government and non-government sector have installed incinerators and have introduced segregation of waste at source, there are still gaps in the system making the waste disposal system more fragile and potentially capable of spreading infections.
- c. The Ministry of Environment & Forests has promulgated the Draft Rules on Management of Bio-medical wastes in April, 1995 which provide for control over generation, handling, treatment and disposal of medical waste. These draft rules are under finalization. The Central Pollution Control Board has also developed guidelines for management of hospital wastes and standards for incinerators.

Considering the inadequacy of waste disposal system in the various hospitals and the potential of present day practices for spreading infections which may have adverse impacts on human health, the council resolves that:

1. All hospitals in the country whether in Government sector or Private Sector should initiate an appropriate hospital waste management system. Each hospital should have infection Control and Waste Management Committees to devise policies and procedures for infection control and waste management according to locally available needs and facilities. It is necessary that incinerators /appropriate method of waste disposal be installed in hospitals having more than 50 beds and sharing of common incineration facility be encouraged.
2. The State/UT Governments may formulate plan of action for hospital waste management and include in their State Plans in consultation with the Planning Commission.
3. Keeping in view the issues of environmental pollution, inherent problems of production of ash and toxic emissions associated with the incineration process, alternative strategies of medical waste management such as the reduction of waste (for e.g. use of glass syringes instead of plastic syringes); (ii) composting of organic fraction of waste; (iii) usage of chemical processes which are eco-friendly; and(iv) auto-claving and mechanical

shredding etc. may be explored in utmost seriousness.

4. Central Government may prepare comprehensive technical and management guidelines for Hospital Waste Management wherein cost and economic considerations are also addressed. The guidelines should also incorporate the technical options, requirements of training, creation of awareness and motivation of staff etc.
5. Bureau of Indian Standards may issue detailed specifications and standards for selection of incinerators, disinfection and sterilization procedures and equipments, plastic shredders, compactors, waste containers and other equipments or materials for waste management.
6. Adequate emphasis may be given on training, motivation and supervision of hospital staff on waste management. The State/UT Governments may establish training centres on Hospital Waste Management for organizing basic training and 'training of trainers' programmes.
7. Protection of workers and their safety is essential to prevent infection and injury while handling waste. Adequate protective wears like gloves, aprons, masks and boots must be provided to waste handlers and they may be immunized especially against HBV.
8. Infection control and waste management should be taken up on priority basis in all the projects /programmes where new health infrastructure is being created or existing infrastructure are improved/strengthened.

**INTRODUCTION OF YELLOW CARD SCHEME FOR COMPULSORY HEALTH CHECK UP OF SC/ST  
POPULATION IN RURAL AREAS**

1. The Council recognizes that the poor and the underprivileged sections of the society, especially the SC/ST population in rural areas, continue to suffer from deprivations including lack of access to health and family welfare services. Indicators of health status in respect of these categories remain poor; in spite of the efforts made by the Government.
2. The Council observes that the Government Karnataka have introduced a scheme for compulsory health check-up of SC/ST population in their State and for this purpose, the health check up teams would be deputed to the villages concerned along with necessary facilities for simple laboratory tests in order to identify the persons needing medical treatment or further investigation. The Scheme was introduced initially as a pilot project in five districts of the State and later it was decided to cover the entire State.
3. The Council notes that under the Scheme, the eligible beneficiaries are identified by the district authorities for issue of Yellow Cards with the help of Gram Panchayat Members, especially the women and SC/ST members. The Yellow Cards entitle the beneficiaries to free medical treatment in government/referral hospitals. The World Bank has also come forward to fund the scheme if it is introduced to benefit the most disadvantaged sections of the society.
4. In view of the above, the Council resolves that:
  - a) the States may examine and introduce schemes on the lines of the one already implemented by the Government of Karnataka for compulsory health check up of SC/ST population in rural and urban areas. Alternatively, the States could evolve their own schemes on similar lines, for fulfilling the health needs of the identified deprived groups.

**IMPROVEMENT OF EMERGENCY SERVICES IN GOVERNMENT HOSPITALS**

1. The Council takes notes of the judgment of the Hon'ble Supreme Court of India dated 6th May, 1996 in the case of Paschim Banga Khet Majdoor Samiti Vs. State of West Bengal where in the Hon'ble Court has suggested remedial measures to ensure immediate medical attention and treatment to persons in real need.
  
2. The Council resolves that:-
  - I. The States/UTs may take appropriate action for implementing the orders of Hon'ble Supreme Court of India in setting up emergency treatment facilities for patients in need.
  
  - II. Appropriate schemes may be evolved for this purpose and the financial requirements may be projected to the Planning Commission.
  
  - III. The Central Government/States/UTs may set up additional Trauma Centres.

**RESOLUTIONS ADOPTED FOR AMALGAMATION OF STATE HEALTH EDUCATION BUREAU AND IEC BUREAUX**

1. The Council having deliberated upon the existing status in the field of health education in the Country, and considering that health education provides motivation for self-health care and community participation to achieve the objectives of National Health and Family Welfare and other health programmes leading to realization of goal of health for all resolves that;

- a) The State/ UT Governments could consider amalgamation of Health Education Bureau and IEC Bureau at State/ District/ Block/ Taluka and PHC levels as they are performing similar jobs for health and family welfare.
- b). In view of optimal utilization of available resources, job responsibilities, of the amalgamated bureaux be identified so that Health, Family Welfare, Health Related Vocational Courses and other jobs performed by State Health Education Bureaux are given equal importance including their job security and seniority.
- c) The planning may be decentralized and the local governments empowered with financial support so as to implement IEC strategies through proper training and interaction with local bodies, governmental and non-governmental organizations.
- d) The amalgamated bureaux (i.e. the existing State component) be supported additionally by a Centrally funded scheme and may seek guidance and technical support from Central Health Education Bureau as well as IEC Division of Family Welfare Department.

**STATUS OF THE REPORT ON ENVIRONMENTAL HEALTH &  
SANITATION**

1. The Council while taking cognizance of (I) how environmental factors affect health; and(ii) how current environmental trends are changing the patterns of health risks, noted the work done by Dayal Committee in the formation of a proposal for a comprehensive National Programme of Sanitation and Environmental Hygiene on the lines of a technology mission. The Council further noted that the recommendations made by the Dayal Committee(1995) was discussed in a Committee of Secretaries meeting and it was decided that appropriate action on the priority areas identified in the Dayal Committee report may be taken up by the concerned Ministries/ Departments for implementation during the IXth Plan. The six priority areas identified by the Dayal Committee were: (a) urban low cost sanitation (b) urban waste water management ;(c) urban solid waste management (d) rural environmental sanitation; (e) industrial waste management & pollution control; and (f) strengthening of health surveillance and support services.
2. The Council also noted that the Working Group on 'Environment and Health; Health Education and IEC" constituted by the Planning Commission under the chairmanship of Union Health Secretary also examined the issues related to environmental Hygiene and sanitation for formulation of relevant schemes during the Ninth Plan. The programmes identified by the Working Group broadly relates to environmental health surveillance, water quality monitoring and surveillance, hospital waste management and sensitization of Panchayats and "Nagar Palikas for planning and implementation of environmental health activities at local level.
3. The Council also noted with concern the lack of legislation in the country which takes into consideration health and environment in a comprehensive manner.
4. The Council taking cognizance of the above stated observations resolves thus:
  - I. An Inter-Ministerial group to examine the existing laws of Public Health and Environment be constituted to evolve appropriate recommendations to ensure proper safeguards in the implementation of development projects with due empowerment of State Governments and local bodies.
  - II. The Department of Health and Directorate General of Health Services be suitably strengthened to handle new emerging public health and environmental issues, such as :(a) Drinking Water Quality Surveillance; (b) Hospital Waste Management;(c) Health Impact Assessment; (d) Food and Milk Sanitation; (e) Chemical and Pesticides Pollution Control; (f) Environmental Epidemiological

Surveillance; (g) Policy Guidelines on Environmental Health; and (h) Liaison with other sectors and legal issues.

- III. The concerned departments of the State/UT Governments may initiate suitable programmes related to environmental health and sanitation in the areas identified by Dayal Committee, during the IX<sup>th</sup> Plan.
- IV. Sensitization of Panchayats and Nagar Palikas for planning and implementation of environmental health education and awareness may be achieved through appropriate committees at Panchayat, Block, District, and State level that may have representation from a cross section of Government departments and non-governmental agencies.
- V. The need for drinking water quality surveillance was recognized. States/UTs, may evolve suitable mechanism for achieving this objective.
- VI. The States/UTs, may adopt proper water management procedures to avoid water logging which could lead to increase in malaria vector.

## **Agenda Item NO.XXVII**

### **NATIONAL ILLNESS ASSISTANCE FUND**

The Council noted the progress in the matter of setting up the National Illness Assistance Fund.

1. The Council recommended that all States/UTs where such a Fund has not so far been set up, may do so immediately. States/UTs, may forward their applications to Ministry of Health & Family Welfare for considering financial assistance. It was also recommended that the Central Government may reconsider the existing criteria for assistance/contribution and evolve a uniform one.
2. Since the contributions made to these Funds would be exempted from Payment of Income-Tax, all appropriate steps should be taken to popularize the Funds, so that maximum subscription is received.
3. With the setting up of Funds in the State/UT, individual cases for grant of necessary financial assistance in deserving cases, could be considered by the Managing Committee and all such cases where such assistance required is in excess of Rs. 1.5 lakhs in a single case could be forwarded for consideration by the Management Committee of the National Illness Assistance Fund.
4. The Council cautioned that all contributions received by the Funds may be properly accounted for.

**COMPULSORY RURAL SERVICE/FILLING UP OF VACANCIES  
IN RURAL AREAS**

1. The Council notes that its earlier resolutions specifying measures, administrative and legislative, for meeting the shortage of allopathic doctors in rural areas have been considered by the Central Government.
2. The Council takes note of the fact that a good deal of imbalance between rural and urban areas in the provision of medical care services exist.
3. The Council notes with concern that at present vacancies of medical officers and specialists in health centres in the rural areas are very many and it is not compulsory in some States for doctors to serve in rural areas for 2-3 years immediately after joining States/Central Government service. The State Governments are required to place medical officers, gynecologists, pediatricians, physicians, surgeons in the vacant posts to meet the health needs of the people in rural areas.
4. The Council observes that the Government of Tamil Nadu has divided the State into nine zones and the Public Service Commission, Tamil Nadu is recruiting medical officers zone-wise to serve in rural areas.
5. The Council also observes that Government of Karnataka has given appointment to doctors in rural areas for a maximum period of three years on contract basis to fill up vacancies of doctors in rural areas.
6. The Council also takes note of the fact that the State Government of Rajasthan for ensuring availability of doctors in rural areas has reserved 50% of seats in post-graduate courses for in-service doctors who have put in 2-3 years service in tribal and rural areas.
7. The Council having taken note of these facts, resolves that :-
  - I. States may consider introducing regional decentralized recruitment policy for filling up vacancies of doctors in rural areas and introducing 2-3 years of compulsory rural service.
  - II. A percentage of post-graduate seats may be reserved by State Governments for in-service medical officers. The eligibility condition for joining post-graduate course for in-service doctors may be made five years service including 2-3 years service in rural areas. In case of doctors working in desert and tribal areas, two years service may be counted as rural service for the purpose of admission to post graduate courses.
  - III. The National Service Act, 1972, may be examined with a view to filling up of posts of medical

Doctors/Specialists in rural areas.

**REGULATORY MEASURES FOR PRIVATE NURSING HOMES AND INTRODUCTION OF CHARTER  
MARK**

1. The Council noted with concern that there are a large number of private and voluntary sector hospitals in the country and several of them are being managed without qualified doctors and without adequate equipments and infrastructure.
2. The Council after reviewing the functioning of private and voluntary hospitals in the country resolves that :-
  - a) States may enact laws to provide for registration of only those private hospitals which have minimum facilities for different forms of treatment.
  - b) Monitoring mechanisms should be developed by the State to ensure that the facilities and services created in private and voluntary sector hospitals continue to be available and are maintained at the desired level; and
  - c) Private Hospitals in non-conforming areas which are posing health hazards may be considered for shifting to other areas.
3. The Council noted that the Ministry of Civil Supplies, Consumer Affairs and PDS has formulated a Citizen's Charter Mark Scheme for private as well as Government hospitals to recognize and reward excellence in delivery of public service and to promote improvement in public health services.
4. The Council resolves that the Charter Mark Scheme may be examined and stressed that the focus of the scheme should be on the hospitals which are meeting the immediate felt needs of the patients and their relatives while in hospitals.
5. The Council noted the Australian System of Accreditation under which professional associations like the Association of Surgeons, Physicians, Pediatricians, Gynecologists, etc. meet on a common professional platform to give a star rating to hospitals according to the level of facilities they provide. They obtain registration charges for annual inspection and award a star rating on the lines of hotel classification being given by the Ministry of Tourism.

6. The Council resolved that the voluntary system of accreditation based on peer group assessment may be examined by the Central and State Governments for awarding a professional star rating to hospitals according to facilities they provide.

**STATUS REPORT OF FEES FOR MEDICAL COLLEGES IN PURSUANCE OF SUPREME COURT'S  
ORDER**

The Council noted that the Supreme Court in its order dated 9.8.96 directed the Central Government/professional councils to draw up a workable fee structure within three months, which will be effective from 1997-98. The Central Government has consulted the State Governments and the technical councils, and has also obtained the views of the various State Governments.

The Council noted that the draft proposal of the Government of India on the fee structure is as follows:

- (i) For payment seats-
  - a) Medical colleges: Rs.1.50lacs per student per professional course of 18 months. Out of this amount, a sum of Rs.40 thousand per student per professional course in case of colleges which do not have their own facilities and Rs.20 thousand per student per professional course in case of colleges having partial hospital facilities, will be paid back to the Government/authority running the hospitals utilized by such medical colleges.
  - b) Dental Colleges: Rs.75 thousand per student per annum. Out of this amount, a sum of Rs.10 thousand per student per annum to be paid by colleges which do not have their own hospital facilities to the Government/authority running the hospitals utilized by such dental colleges.
- (ii) For Merit/Free Seats:
  - a) Medical Colleges: Rs.15 thousand per student per professional course of 18 months.
  - b) Dental Colleges: Rs.8 thousand per student per annum.

Council notes that

- I. The Central Government would be placing the fee structure framed by it before the Supreme Court and would also inform the Court of the views of the State Governments.

II. While some States have expressed views which, despite minor differences, are broadly similar to the recommendations made by Government of India, others have expressed widely divergent views. Maharashtra and Tamil Nadu have advocated that there should only be two categories instead of three categories. There is now ample opportunity for the State Governments to place their views before the Apex Court as the Supreme Court has resumed the hearing in the case between TMA Pai Foundation and others Vs. State Government of Karnataka and others in WP(C) No.317/93 wherein the Unnikrishnan Scheme has been re-opened.

**INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY**

The Council resolved that:

1. Minimum standards formulated by Central Council of Medicine and Central Council of Homoeopathy require rationalization and thereafter strict enforcement in all the teaching institutions in the country.
2. To check the mushroom growth of sub-standard ISM & H Colleges, the CCIM and CCH Acts need to be amended. Guidelines, with penalties for non-compliance need to be issued for the period from the stage of an application for setting up a college to the stage of recognition of qualification.
3. Admission tests/Entrance tests for Ayurveda, Unani, Siddha, Homoeopathy and Yoga Colleges should be conducted separately. This will help in selecting candidates with an interest in these systems. State Governments who are admitting students on common merit list basis may continue the existing procedure.
4. Minimum qualifications for admission to Ayurveda / Unani / Siddha / Homoeopathy Colleges for the Graduate courses should be 10+2 with Science (Biology Group). Other provisions should be deleted. Provisions to teach Sanskrit for Ayurveda, Urdu or Persian or Hindi for Unani and Tamil for Siddha may be incorporated in the main course of 4.5 years.
5. Existing Graduate and Post Graduate Colleges of ISM& H may be strengthened by allocating more resources to meet the standards of CCIM and CCH.
6. Reorientation training programmes for in-service/semi-Government teachers, physicians and private practitioners should be organized in a big way by State and Central Govt. For teachers it should be made essential to undergo reorientation training periodically.
7. State/Central Government should open separate degree level Colleges in Pharmacy and Nursing, Diploma in Pharmacy should also be started. Affiliation with Pharmacy Council of India and Nursing Council of India should also be sought otherwise some alternative arrangement be made.
8. National Institutes like National Institute of Ayurveda, Jaipur, National Institute of Homoeopathy, Calcutta, Institute of Postgraduate Training and Research, Gujarat Ayurveda University, Jamnagar, Faculty of Ayurveda, Banaras Hindu University, Faculty of Unani, Aligarh Muslim University and Hamdard Faculty of

Unani be strengthened as apex teaching institutions in the country. The National Institutes of Unani Medicines at Bangalore, National Institute of Naturopathy, Pune, should be strengthened. National Institute of Siddha, Chennai and National Institute of Yoga, Delhi should be established in 9th Plan.

9. Teaching cadres for teachers of ISM&H be separated from the general cadre of the Physicians of ISM&H in the State Governments.
10. Pay scales /promotional avenues of teachers for ISM&H colleges should be on the UGC/CHS pattern to attract talented persons. There should be priority of scales of pay and other service condition between ISM&H physicians / research workers and their allopathic counter-parts.

## **B. RESEARCH AND DEVELOPMENT IN INDIAN SYSTEMS OF MEDICINES & HOMOEOPATHY**

1. There is a need to restructure and reorganize the Central Research Councils i.e. CCRAS, CCRUM & CCRH by amalgamating the smaller units to form larger institutes at least one in each State with adequate staff and resources.
2. R&D is urgently required on national health and family welfare programmes by the Research Councils.
3. Universities, public and private sector research organizations need to be associated in R&D through extra-mural projects from Research Councils/Department of ISM&H.
4. Some of the areas of research may be -
  - a. Drug proving (including clinical verifications and Pharmacological basis of therapeutic uses).
  - b. Drugs standardization/ pharmacopoeia standards
  - c. Research relating to various National health programmes
  - d. Work on those diseases for which modern therapy have no cure
  - e. Preventive and curative role of ISM&H in various epidemics
  - f. Research work relating to promotive health and preventive and social medicines.
  - g. Literary research/translation and publication of rare books especially in ISM
  - h. Research work on folk/tribal community oriented medicinal plants etc.
  - i. Agronomy/Agro techniques of medicinal plants
  - j. Pharmacognosy/phyto-chemistry of medicinal plants

- k. Research on maintenance of good physical and mental health/personality development etc.

### **C. ISSUES RELATING TO STANDARDISATION OF DRUGS AND QUALITY CONTROL**

1. There is need to evolve pharmacopoeial standards for ISM&H. Public sector research institutions should be associated in this work on project basis. Efforts are made to complete this work within the 9th Plan period.
2. Pharmacopoeial Laboratory for Indian Medicine and Homoeopathy at Ghaziabad should be strengthened by providing adequate funds.
3. State Governments should develop their own drug testing laboratories,
4. To maintain quality control of manufacturing of Ayurveda, Siddha, Unani and Homoeopathic drugs, State Government should appoint more Drug Inspectors having qualifications and training in these systems of medicine.
5. The Drug Control Cell in the Department of Indian Systems of Medicine and Homoeopathy should be strengthened.
6. Need to formulate a National Policy on ISM&H drugs.
7. The Departments may consider introducing a scheme on the pattern of "Agmark". "AYUSH" may be considered for this purpose. Only those products which are manufactured in accordance with the standards laid down and prescribed in the official pharmacopeias and formularies be granted permission to use "AYUSH". Existing staff for the Govt. Of India, Department of ISM&H and State Government should be given power to make inspections for ensuring minimum standards of ISM&H Drugs.

### **D. INCREASING AVAILABILITY OF RAW MATERIALS OF PLANT, MINERAL, METAL, MARINE AND ANIMAL ORIGIN USE IN ISM&H DRUGS BY:-**

- a) Formulation of a National Policy on raw material used in ISM&H products.
- b) Development of agro-techniques of various plants used in ISM & H products.
- c) Increasing supply of marine and animal products, minerals and metals.
- d) Establishment of medicinal plants gardens in various agro-climatic zones.
- e) Establishment of "Vanaspati Vans" of bigger areas of a few hundred acres in denuded forests and other areas.
- f) Setting up of germ plasm banks of the medicinal plants used in ISM & H medicines.
- g) Publicity and propagation about the uses of medicinal plants and cultivation techniques to the common masses and farmers.

All State Governments as well as Central Government Departments are requested to formulate schemes to implement the above programmes by allocating more resources for the purposes.

**(E) EFFECTIVE USE of IS&H SYSTEMS FOR "HEALTH FOR ALL" AND FOR BETTER HEALTH CARE THROUGH VARIOUS PROMOTIONAL PROGRAMMES OF ISM & H**

The Indian concepts of health promotion like dincharaya (daily routine), ritucharaya (seasonal behavior), dietary practices, yoga practices, concepts of Sadvritta (good code of conduct), and the concepts of Hifzane-Sehat need to be propagated among the masses for health promotion and prevention of diseases.

All State Governments and Central Governments should utilize services of ISM &H practitioners for the propagation of these concepts by formulating proper schemes/programmes for the purpose.

**(F) NATIONAL PROGRAMMES & CURATIVE MEDICINE**

- (i) With a view to utilizing the wealth of knowledge of ISM &H and the six lakh practitioners of these systems, it is necessary to earmark an ISM &H component in all National Health and F.W. Programmes. These funds be utilized for R&D and the execution of these programmes through ISM &H personnel.
- (ii) Though a net work of private and Government dispensaries exist in the rural and semi-urban areas of the country, there is a shortage of referral hospitals. State/Central Government should establish block level and district level referral hospitals for Indian Systems of Medicine & Homoeopathy. Similarly, referral hospitals at State and National level should also be established. This gap needs to be filled up in the successive five year plans, but a beginning in big way should be started from 9th plan itself.
- (iii) NGOs/private sector having credibility in establishing the hospitals of Indian System of Medicine & Homoeopathy should also be supported to establish specialized hospitals in these systems. State Governments and Central Government should keep track while granting financial assistance to the potential NGOs. This gap needs to be filled up in the successive five year plans starting from the 9th Plan. NGOs/Private Sector be associated in this task.
- (iv) There was concern expressed about the fact that Allopathic Doctors are reluctant to serve in rural PHCs. Consequently, the area covered by the PHC concerned is bereft of health services. It was proposed, as an experimental measure that ISM&H doctors be posted in such PHCs along with paramedical staff and adequate resources for procurement of medicines. If successful, it could be adopted as a standard practice.
- (v) Presently there are 242 Allopathic and 74 CGHS Dispensaries/Units of ISM &H. There is a need to open ISM&H component in the remaining 168 CGHS Dispensaries. A separate budget provision should be earmarked for ISM&H component in CGHS.

- (vi) ISM&H dispensaries should be opened in Railways/P&T Departments. Similarly, specialized clinics should be opened in Army/Air Force Hospitals.

**(G) INTELLECTUAL PROPERTY RIGHT (IPR) CELL OF ISM&H**

- (i) Some plant products like Haldi powder, Derivatives of Neem and Brahmi are being patented in United States. The work of applying for patents is highly technical. Scientists working in the field of ISM&H are not conversant with the procedures. Therefore, a "patent cell" is established in the Department which could take care of the country's heritage in this regard.
- (ii) Interest has been evinced by various foreign countries regarding education, drugs material and techniques of Ayurveda, Siddha, Unani, Yoga, Homoeopathy and Naturopathy etc. There is a need to promote international exchange programmes, increase the export of ISM &H drugs & other materials. It is also suggested that information centres be opened in all embassies for dissemination of information on Indian Systems of Medicine.

**(H) FUNDS FOR DEVELOPMENT OF ISM&H**

- I. Need for ensuring adequate flow of funds for the ISM&H sector by the Central Government and by the State Governments. The Planning Commission should also allocate adequate resources for meeting the above social commitments.

**(I) INVOLVEMENT OF NGOs & PRIVATE SECTOR.**

In view of financial constraints and to increase the flow of funds and utilize expertise available in NGOs/Private Sector, their association in all the programmes of the Department of ISM&H should be encouraged, particularly in the fields of R&D, extension services in preventive and promotive health, in the field of curative medicine by encouraging this sector to set up private hospitals, teaching institutions, cultivation of medicinal plants etc. in accordance with the prescribed rules/regulations.

**(J) PUBLICITY FOR INDIAN SYSTEM OF MEDICINE & HOMOEOPATHY**

- 1. The Council stresses the need for making use of mass media for increasing public awareness about the treatment etc. available under Indian Systems of Medicine and Homoeopathy and resolves that Central Government as well as State Governments shall have separate budget provision for publicity of Indian

System of Medicine and Homoeopathy and steps shall be taken to:

Prepare short films, documentaries, slogans and shots on various treatments available under Ayurveda, Siddha, Unani and Homoeopathy for televising over Doordarshan.

Prepare films on Yoga as a system to develop the individual which would be separately distributed to various primary health centres, schools etc.,

2. Various Research Councils under the Central Government shall prepare pamphlets, booklets and documentaries to highlight the research work done by them in their respective fields.
3. Special efforts shall be made to popularize the good dietary habits and in the ante-natal and post-natal periods and safe and simple methods to protect new-born children from various ailments.
4. Seminars, Workshops and Health Melas especially in rural areas shall be organized.
5. Publish success stories of Indian System of Medicine & Homoeopathy.
6. Pamphlets be prepared in local languages for local distribution.

#### **(K) YOGA & NATUROPOATHY**

Keeping in view the global recognition of the science of Yoga and drugless therapy of Naturopathy, the Central Council of Health & Family Welfare recommends that the Department of ISM&H should examine the feasibility of amending the Indian Medicine Central Council Act, 1970 so as to bring the practice of Yoga and Naturopathy under the preview of this Act.

#### **(L). SEPARATE BUDGET AND ORGANISATIONAL SET UP OF ISM & H.**

All the State Governments/UTs should allocate separate budget for the development of ISM&H. In those States where there is no separate Department of ISM&H, the Directorates of ISM&H should be established. The posts of Directors should be filled up by technical personnel.

## **GENERAL RESOLUTION ADOPTED BY THE COUNCIL**

It was resolved by the Central Council of Health & Family Welfare that the Resolutions adopted in the Fourth Conference should be acted upon and the Action Taken Report should be submitted during the next Conference of the Central Council of Health & Family Welfare.

## **ANNEXURES**

**INAUGURAL ADDRESS OF HON'BLE PRIME MINISTER ON THE OCCASION OF THE FIFTH CONFERENCE OF THE CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE ON 8.1.1997 AT NEW DELHI.**

Shri Shervani Ji, State Ministers of Health, Prof. Bajaj Ji, Members of the Central Council; Members of Parliament; Secretaries and Directors of Health Services from the Central and State Governments, Representatives and Directors of Health Services from the Central and State Governments, Representatives of international organizations and Distinguished medical experts and friends,

I am happy to be present here today amidst this cross-section of eminent persons from different areas of the health sector. The Conference of the Central Council of Health & Family Welfare is being held at an opportune time when we are reviewing the health and family welfare strategies in the light of our Common Minimum Programme.

The health sector has undoubtedly made significant achievements in the last three decades, but despite this, the gap between the provision of services and the off take appears to be widening at places. We have still to contend with age old problems like Malaria, Tuberculosis, Leprosy and Blindness while new challenges like AIDS, Cancer, Cardiac problems etc. confront us. We still have to ensure that the poorest of the poor, those who have no voice, no lobby and are not in a position to articulate their needs or demands are provided primary health services as the first and most important target group.

I have been very concerned about the weaker sections of society in more ways than one. The Scheduled Castes, the Scheduled Tribes and other disadvantaged sections of the population in rural areas continue to be deprived of health facilities. In Karnataka, I had introduced a scheme for compulsory health check up and provision of free medical treatment to such target groups. I had requested my colleague Shri Shervaniji, to get this scheme adopted countrywide, as this single measure could offer substantial relief to the disadvantaged. I understand that the Planning Commission has been asked to include this as a package when the States come up for their Annual Plan discussions.

I had announced the setting up of Illness Assistance Funds at the National and State levels to render assistance to poor people for undergoing necessary expensive medical treatment. I am glad that a two-tier scheme has been worked out by the Ministry of Health & Family Welfare. The Fund at the national level will pick-up the cost of medical treatment of cases where expenses go beyond Rs.1.5 lakh per beneficiary. All the States and Union Territories have been asked to form similar funds at their level, which will be provided financial assistance by Central Government up to 50% of the contribution made by them. Contributions made to these Funds would be exempted from payment of Income-Tax Act. The real success of the programme would now depend on the response from philanthropic bodies, corporate sector,

international organizations and individuals to come forward and subscribe to this Fund in a generous way. I look forward to your active cooperation to motivate all such sources in the Endeavour.

The spread of HIV and AIDS in the country has become a cause of great concern nationally and internationally. The number of sero-positive cases as well as actual AIDS cases has gone up considerably in the recent past and we must step up efforts to prevent and contain the spread of the disease. We have had the good fortune of having planned for the prevention of AIDS well in time and putting into motion a National Programme to spread awareness about the disease. However, much remains to be done in this area particularly with regard to the system for collection of blood and supply of safe blood products.

Everything possible must be done to stop infected blood entering the system and all efforts must be mounted to convince students, the organized sector and NGOs to give an impetus to the blood donation programme on a National scale. I am sure this Conference will address this issue in great depth and come up with solutions whereby our young and hale bodied population can contribute to the collection and supply of safe blood.

The subject of medical education has been great concern throughout the country. New standards have been established in the wake of the 1993 amendments and now the colleges have to scrupulously provide the prescribed facilities before the Central Government approval can be accorded. It is the duty of those who set up medical and dental colleges to ensure that the standards prescribed are followed in letter and spirit. I have already asked the Department of Health to provide what needs to be done to see that the medical education sector is administered with consistency and complete objectivity. The Medical Council of India and the Dental Council of India have to perform the task of both laying down standards and of seeing that they are adhered to.

I am disturbed by the fact that doctors shy away from rural services. We have to be firm in implementing our policies. The States may have to consider denying admission to post graduate courses if the applicant has not completed at least 2-3 years service in rural areas. Many of the States like Rajasthan, Punjab and Himachal Pradesh have adopted innovative measures and have been quite successful in seeing that doctors report to rural areas. I would urge the Health Ministers and the Medical council of India to consider this matter very seriously and come up with practical recommendations. I am also glad to know that the Medical Council of India has given serious thought to the re-registration of doctors every five years and are in a position to introduce this from this very year itself.

One of the most important developmental issues faced by us is that of population growth. All the good things the country has achieved, all the plans that are laid, the enormous power projects, dams, industries, urban infrastructure and housing make no impact whatsoever if the growth of the population remains un-checked. Some States have performed well in this regard. Kerala and Tamil Nadu achieved the goals set out for the year 2000 while States like Maharashtra, Karnataka, Andhra Pradesh and West Bengal are close to achieving them. But large States like Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan have still a long way to go. These States together make up 40% of the country's

population. There is need to ensure that the steps taken for population control are specific to the ethos, traditions, beliefs and lifestyles of each State. Many individual programmes have been taken up but we still have to make resounding dent on this problem, which is the biggest challenge before us.

The high burden of Malaria in our country is also a matter of serious concern. Further, if the nutritional level of people is extremely low, it is impossible for any malarial drug to make an impact. On a recent visit to some flood affected areas in the Mewat region of Haryana, I was particularly disturbed to find extremely low hemoglobin levels of 2 to 6 grams in the women and children. Obviously something has to be done not only on the health front, but also to see that the supply of supplementary nutrition, mid-day meals and iron and folic tablets reach those who need it the most.

We now have a separate Department of Indian Systems of Medicine and Homoeopathy, which is based on herbal medicines and drugless therapies, should now get the opportunity to combat diseases for which Allopathy has no cure. We have rich resources and trained medical practitioners in these systems of medicine. We need to exploit these resources fully. India could be a front runner in making the rest of the world aware about the potential of these alternative systems. Many countries in the world have been fascinated by and drawn inspiration from the Indian way of life - yoga meditation and nature cure has so many practitioners across the globe. I hope the new Department of Indian Systems of Medicine and Homoeopathy will carve out a niche for itself and help people to inculcate healthy life styles, simple eating habits and schedules of daily exercise all of which impinge on life and longevity. The Department as well as the practitioners has an opportunity and a responsibility to promote the Indian way to a healthy life.

All of you are aware that the person with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act has come into force. We have urged the States to see that district level centres for rehabilitation of the disabled are established and 3% reservation is made in jobs in Government and in public sector undertakings for persons with disability. I hope the Health Ministers will give special attention to this important enactment.

Provision of health services to the people is one of the most important and rewarding facets of the work of Government. We must see that we use this opportunity to provide the best possible health facilities to the people. In accordance with the mandate of our Government set out in the Common Minimum Programme, we are vitally concerned about equity in access to health facilities and securing a prominent place for health in the overall development framework.

At the ground level a number of key issues need to be addressed. Better management, more efficient administration, greater accountability and improved quality of service in the health sector must be ensured. Through the combined experience of all those present here, we can certainly develop strategies to be able to use limited resources in the best possible way. There must be a holistic approach, a convergence of ideas, and common goals for upliftment of poor people and community participation to ensure sustainability of programmes.

With these words, I wish the Conference all success.

Jai Hind !

## **ANNEXURE -B**

### **ADDRESS BY SHRI SALEEM I SHERVANI, UNION MINISTER OF STATE (INDEPENDENT CHARGE) HEALTH AND FAMILY WELFARE AND CHAIRMAN, IN THE 5TH CONFERENCE OF THE CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE AT PARLIAMENT HOUSE ANNEXE FROM 8TH JANUARY TO 10TH JANUARY, 1997**

Hon'ble Prime Minister, State Health Ministers, Member, Planning Commission, Members of the Consultative Committee of Parliament, Secretaries from my Ministry, other Central Ministries and the States, Director General of Health Services, experts nominated to the Council and friends.

At the outset let me welcome you to the Fifth Conference of the Central Council of Health and Family Welfare. I am glad to see that so many eminent persons in the Health, Family Welfare and traditional medicine systems have accepted my invitation to attend this annual meeting of the Apex Advisory Body on Health Care. I am extremely grateful to the Hon'ble Prime Minister for promptly responding to my request to be present with us and to kindly agree to inaugurate this Conference. For us it signifies his deep concern for health and health care and we all deeply appreciate his presence here with us today.

Despite well founded anxieties about the health status of the country, we have made significant advances in expanding the Health Care Delivery System and reducing the burden of disease. India as a signatory to the Alma Ata Declaration of 1978 is committed to attaining the goal of Health for All. However, the goals set out in 1983 would now need to be reviewed to be able to target our prime concerns of today which are somewhat different from what was set out 13 years ago. I have set this task in motion. We have built an extensive community based infrastructure during the last decade or so and are now finding ways and means to consolidate and upgrade it through various externally aided projects. Life expectancy has steadily increased from 41.3 years in the early sixties to 61 years at present. The crude birth rate has been reduced from 41.7 to 28.5 per thousand populations during the same period. 197 million births have been averted since the beginning of the Family Welfare programme. Immunization targets are reaching the 100% mark. The infant mortality rate has been reduced from 146 to 73 per 1000 live births. Guinea worm is near eradication; wiping out leprosy appears eminently achievable. Newer methods of prevention and early diagnosis and treatment of diseases like Cancer and Cardiac ailments have been adopted with a high degree of success in both private and public sector hospitals.

The rate of population growth during the eighties and early nineties, though marginally lower than what it was in the seventies, is still hovering around 2% per annum, which implies an addition of around 18 million infants to the Nation's population every year. This is likely to cross the one billion mark by the year 2001, according to present trends. This is by far our biggest challenge today. The Central and State Governments have been implementing a number of large

programmes for controlling the population and for promoting mother and child care. The experience thus far indicates that the decline in fertility rate and in population control has not been substantial in States of Bihar, Uttar Pradesh, Madhya Pradesh and Rajasthan, it might be appropriate for us to devote some time to this aspect and to consider whether these areas where population growth has not so far been controlled require some different strategy and programmes. This would be a suitable time to consider any changes in strategy and programmes which may be called for to effect improvement in this vital aspect.

Despite several interventions in favor of population control, the fertility rate still remains high. The focus of the population programme now is on improving the quality of services and client satisfaction. I have agreed to replace the system of prescribing contraceptive targets by promoting decentralized participatory planning at the Primary health centre level. This was done because we realized that when the mental pressure of fulfilling quantitative targets is removed, the health provider will pay more attention to quality. Greater attention would be paid to counseling, which would enable the couples to make an informed choice.

Social determinants such as female literacy, age at marriage, employment opportunities for women and their status in society are crucial factors in achieving a reduction in infant mortality, in improving health and nutrition of preschool children and providing a comprehensive package of maternal health care services. While we have been able to achieve notable progress in the State of Kerala and some districts of Tamil Nadu and West Bengal, far more vigorous efforts are called for in a number of other States. I trust the recent legislation on Panchayats and reservation of seats for women will prove to be landmarks in the process of empowerment of women.

India's declining gender ratio, the low birth weight of babies and discrimination against the girl child particularly in their access to food, medical care and education are still a source of great anxiety. We have to do everything in our power to end the phenomenon of child marriages, complications in pregnancy, high maternal mortality levels and premature or low weight babies. It is time that the Panchayats and through them the community is organized in understanding the problems of women - not only relating to maternal and child health but also covering a much larger area of drawing women into cohorts and action groups, capable of motivating their families on the prevention of so many preventable illnesses.

I congratulate the Governments of all States and Union Territories for having achieved outstanding success in the Pulse Polio Immunization Programme carried out last year and again last month. The School Health Check-up Programme, aimed at reaching our child population has been another remarkable success. Both these campaigns have generated unprecedented social mobilization. In the Pulse Polio Programme organized on the 7th December, 1996 more than 11 crore children were administered the oral polio dose. This is an achievement we can all be proud of these programmes have been in the nature of one time campaigns. The nature of the problem however is continuous. Therefore, we should consider how we can institutionalize both these programmes and achieve total coverage by

immunization programme and school health check-up programmes on a continuing basis by institutionalizing these programmes.

Apart from diarrhoea and acute respiratory illnesses, communicable diseases still account for the maximum number of deaths in India. Around 1.5 million Tuberculosis cases are detected every year and nearly five lakh deaths are caused by TB alone. My Ministry has recently negotiated on 13th December, 1996 a World Bank funded project under which we are to implement a revised strategy in 102 districts covering a population of 271 million in a phased manner together with a preparatory phase as well as supply of drugs to all sputum positive cases to cover the remaining districts of the country. A loan of \$ 142.4 million has been negotiated and the project is likely to become effective from March, 1997. The State Governments will have to ensure that under the TB Control Programme emphasis is shifted from diagnosis of cases by radiography to sputum microscopy, from detection of cases to cure of patients and DOTS strategy is adopted in 102 districts which are the mainstay of the revised programme.

We have 0.54 million leprosy cases on record which is about 50% of the world's leprosy victims causing untold suffering mainly due to deformities and the social stigma attached to the disease. We organized an International Conference on Elimination of Leprosy from 11th-13th October, 1996 where we had representatives from 24 countries. We are extending special help to specific areas in Bihar State and we hope that our joint endeavor will make a marked difference to the situation. Madhya Pradesh, Orissa, U.P. and West Bengal also need to step up efforts to eradicate this disease from these States. As a symbolic measure to try and reduce the stigma attached to Leprosy, I have requested the Hon'ble Prime Minister to agree to have a cup of tea with leprosy patients on 30th January, Martyrs' Day. I would urge all of you to consider organizing similar functions to make a symbolic beginning in trying to mainstream the leprosy patients and remove the social stigma attached to the disease.

The National Programme for the Control of Blindness has undertaken to remove the backlog of 12 million cataract operations and conduct 21 million surgeries in a 7 years period. Last year's performance of 2.5 million surgeries was unprecedented and indeed a matter of pride for us. I urge the States to renew their efforts to restore eye sight to millions of people awaiting a simple operation so that they can lead productive and socially useful lives. We ought to jointly plan to achieve the 3 million mark annually through our efforts.

In a short span of about seven year HIV infection has percolated to practically every State in India. Population groups practicing multi partner sex, drug users sharing needles and syringes have served as entry points for the spread of HIV & AIDS. Infection has been building up in these specific groups, following the pattern which was observed in Africa in the mid-1980s. From these groups infection has started to make inroads into the general Population also. Rising trends are now seen among women attending an ante-natal clinic which calls into question why innocent lives should be sacrificed to this pernicious cycle of an incurable infection. As on 31st December, 1996, out of 29, 37,345 numbers of persons screened, 49,527 persons were found Sero-positive. 3,161 AIDS cases were detected during the same period. Since

AIDS has no cure, the programme mainly aims at slowing down and preventing the spread of the disease and although general awareness has grown, personal caution and care do not seem to be keeping pace from the number of cases coming to notice.

Meanwhile 608 blood banks have been upgraded and more than 2200 doctors trained in clinical management of HIV/AIDS since the inception of the programme. The strategy is to ensure blood safety, control sexually transmitted diseases, create awareness and improve surveillance. The Supreme Court has also directed that Councils will be set up at the Central and State levels to inter-alia coordinate the supply of safe blood and blood products and phase out professional blood donation in a time-bound manner. Unlicensed blood banks were to have been phased out by 31st December, 1996. In several cases not even applications for licensing have come. I urge the States to take the responsibilities cast on them with the utmost seriousness.

Reports of manufacture and distribution of sub-standard and spurious drugs is a matter of National concern. We have to take concerted measures to augment facilities and strengthen enforcement agencies to prevent this crime against humanity. We propose to set up a National Drug Authority to control inter-State trade in drugs and establish a licensing authority for key areas of drug manufacture and up gradation of testing facilities, so that the drugs produced in India match international standards. As part of the project for which external assistance is being sought we have decided to establish 6 Regional Drug Testing Laboratories. Andhra Pradesh, Assam and U.T. of Chandigarh have already allotted us the land or a building for the establishment of Regional Drug Testing Labs. Govt. of Karnataka has also agreed in principle to allot the requisite land. However, we are still awaiting for allotment of land/building from Govt. of Rajasthan and Uttar Pradesh.

Another area of concern is food safety and quality control. Reports of the adulteration of spices, milk and other commodities at the hands of unscrupulous elements continue to be reported. Licensing provisions under the PFA Act and Rules although extremely stringent, are yet to be enforced forcefully in a number of States/UTs. The Food Laboratories functioning under the States/UTs must augment the infrastructure particularly for analysis of hazardous contaminants like pesticides but also for the administration of the food safety programme both at the Central and State levels. For upgrading the infrastructure with trained manpower and improved laboratory facilities, the World Bank is inclined to provide assistance for capacity building on food safety and quality control. However, for securing the assistance, the States/UTs have to agree to sustain the additional infrastructure after the project period is over. Gujarat, Karnataka, Manipur, Mizoram, Tamil Nadu, Sikkim, Tripura and the Union Territories of Andaman & Nicobar Islands, Pondicherry, Delhi, Dadra & Nagar Haveli, Daman & Diu and Lakshadweep have given their acquiescence. Despite repeated written communications and personal discussions with the States, the States of Assam, Haryana, Himachal Pradesh, Jammu & Kashmir, Arunachal Pradesh, Kerala, Madhya Pradesh, Uttar Pradesh, West Bengal, Maharashtra, Meghalaya, Nagaland, Punjab, Rajasthan, Goa and the Union Territory of Chandigarh are yet to confirm sustainability of the schemes. I would urge the Hon'ble Ministers and Administrators of States and UTs to confirm their commitment in

writing so that the Bank can be informed. If we do not get a response or get a conditional response we would not be able to include these States in the project as this is a strict World Bank requirement.

At present, some State Governments are enforcing Nursing Homes Acts and Rules under which the minimum standards which must be available in nursing homes and private hospitals have been stipulated. By and large, even where registration of such units has been done by the State authorities, it has been found that it is difficult to keep up the tempo of monitoring in a manner which ensures observance of the prescribed standards. This is becoming an increasing problem with private hospitals and diagnostic facilities charging exorbitant rates and leaving the public with no way of judging either the quality or price of services offered, until a huge bill is preferred. The regulation of the public health sector is becoming increasingly an area of concern and we have to find ways and means to do so without proliferating enforcement staff which has its own problems. We have asked the National Capital Territory of Delhi to make a beginning by bringing out a Directory of Services for at least one zone of Delhi on a pilot basis. I would urge other Metropolitan cities to be covered in a phased manner as this has been the repeated advice of Parliamentary Committees besides being a public demand.

Accreditation of hospitals and nursing homes is a system under which the evaluation of health care facilities is undertaken by senior members of the health profession themselves, using contemporary professionally established standards. This system has been successfully used in Australia. I would urge all the Health Ministers and Health Secretaries to consider establishing a similar system in India, to provide accreditation - a kind of a star rating, as exists in the case of tourism industry, to a range of hospitals, from the very small nursing homes to large hospitals and high-tech hospitals on the basis of their levels of service, efficiency as well as cleanliness. Under the proposed scheme all facilities which are awarded accreditation will need to have their complete range of services evaluated by knowledgeable peers. Each State may think of ways of drawing in the Associations of Specialists, the State Medical Councils, and the professional bodies to agree to jointly inspect and give this star rating. Government need not do the work - it needs only to lay standards and catalyze such a movement.

Hospital waste is a potential hazard leading to increase in the risk of infection to patients, doctors and health care workers besides all those who handle biomedical waste. The matter has been gone into detail by an Expert Committee and a number of useful recommendations has emanated for proper disposal of hospital waste. A copy of the recommendations has been made available to you. The Supreme Court has also mandated that all Government and Private Hospitals with more than 50 beds must have incinerators or waste disposal systems acceptable to the Central Pollution Control Board. I would urge the States that this subject is treated with due emphasis and the proper disposal of biomedical waste should be a priority for each hospital and large nursing home. The States must regulate and enforce practical measures based on the Biomedical Waste Rules published by the Ministry of Environment & Forests.

Another disturbing fact is that the level of health spending varies significantly among the States. Per capita expenditure on Health & Family Welfare in Punjab is three times as compared to Bihar. Over a period of time the difference has

tended to widen still further. To achieve the objective of providing Minimum Basic Services, it would be necessary to increase the level of health spending to make optimal use of the physical infrastructure that we have assiduously built up. Additional resources for a basic package of primary health care services must be provided. Apart from making adequate financial outlays, funds have to be earmarked for the preventive and promotive aspects of health care. Measures like the levy of user charges, raising resources through grant of autonomy to institutions have to be encouraged to make the expenditure viable. Apart from providing additional funds we have to build up managerial capacity for careful, coordinated and efficient utilization of limited resources. The Health Departments ought to be strengthened with adequate capacity to plan, forecast and respond to the rapidly changing health scenario and the most important part of this exercise is to improve the capacity to gather health intelligence, undertake strategic planning and constantly conduct analysis on the returns on investment by improving capacity to evaluate and monitor performance we would also build up a climate of greater accountability. We must strengthen the administrative capability of the Health sector managers to extract accountability. No one will grudge disciplinary action against recalcitrant staff in this area which affects the common man so intimately. On the other hand we must find the time to sit down and understand what afflicts the system and what can be done to sincerely improve its functioning.

During the past decade and particularly in the last 3-4 years we have seen the emergence and the re-emergence of infectious diseases. We have been greatly successful in battling against these diseases in the past. Smallpox is an excellent example of the national will and the ability to control and eradicate the disease. To this will soon be added the elimination of Polio, Guinea worm, Tetanus in the newborn and Leprosy. Despite this success, experts tell us that almost 30 new diseases have appeared on our planet in the last 20 years and the diseases that we thought we had overcome like Plague, Malaria, Kala-azar, Dengue and Cholera have re-emerged with characteristics not witnessed earlier.

Some of the most important factors which have influenced this phenomenon have been poor living conditions, rapid migration to the cities which have not kept pace with efficient waste disposal systems, environmental degradation often caused by unplanned industrialization and energy pollutants. Under the overall umbrella of development, dams and irrigation projects so vital for agriculture have none-the-less created ecological conditions responsible for harboring and promoting vector borne diseases like malaria and filaria. Changes in the land use pattern and encroachments into forest areas have exposed the human population to infections which they did not encounter previously. Unplanned urbanization and excessive population growth have created conditions for entry of infectious diseases in congested squatter settlements. Urban health has become a matter of overwhelming urgency. Changes in human lifestyles and behavior including sexual behavior and food habits have also opened up new avenues for the spread of infectious diseases. All these factors have made the health sector more vulnerable, more answerable for outbreaks and epidemics and the time has come when we have to reach an understanding with the arms of the Government and the private sector who perhaps are unmindful of the magnitude of the health hazards confronting us.

We have repeatedly asked the State Governments to introduce measures to bring public health to a place of prominence. Unless health risk assessment studies are undertaken every time large projects are planned, the problems will only escalate. A portion of the budget for such projects must be assigned for the down-stream public health aspects, right from the time a project is designed through its entire execution. There is a pressing need to strengthen, public health capacities which really means increasing the capacity to perceive threats, detect them, understand them and respond to them. Health risk assessment studies must be included in respect of all major developmental projects before such projects are implemented. I would urge the Health Ministers to give a direction to this as soon as possible as the health sector cannot afford to bear the brunt of health hazards caused by unmindful development.

Of late our surveillance network has not been functioning at optimum capacity. So many outbreaks throughout the country have shown this year after year. In Rajasthan when there was an outbreak of Malaria in 1994 in the desert districts of Barmer, Jaisalmer and Jodhpur which had never seen Malaria on that scale earlier, it came as a surprise to every one. The sudden outbreak of Dengue Hemorrhagic Fever in the Capital of India, New Delhi leading to 346 deaths and 8843 cases was so sudden, so unexpected and unprecedented in magnitude that it took all the might of the Government supported by so many public health experts, clinicians, communication experts to be able to control the situation in 50 days. Meanwhile thousands of deaths of which almost 900 are said to be fever related deaths with malarial manifestations have occurred in the adjoining district of Gurgaon, in the comparatively developed State of Haryana. Assam has again witnessed a growth in Malaria incidence. There is increasing evidence of increase in Kala-azar in Bihar. There is therefore an overwhelming need for surveillance systems which work, particularly as diseases know no geographical boundaries. Yellow Fever has advanced eastward to Kenya. Dengue is seen to be moving westwards. The Chief Secretaries of every State had been requested by the Department of Health to set up High Powered Boards in which all persons connected with agriculture, water resources, urban sanitation and health are involved. I have directed the Department of Health and the National Malaria Eradication Programme to prepare a detailed calendar of activities to be undertaken State to State and month to month for containing malaria. I hope the Health Ministers will themselves review this calendar to see that we are in a State of preparedness and we set in motion systems which the situation demands and impose correctives while there is still time. We have been organizing a malaria week from 15th to 21st June each year. Let us extend this for a month at which time we make concerted efforts to mobilize all the departments and agencies of Government and the public to prevent mosquito breeding. I would urge the States to gear up for this activity in right earnest to prevent the experience and agony of repeated outbreaks which are wholly preventable.

I would also like to say a few words about the Indian Systems of Medicine and Homoeopathy. As you are all aware, the country has been putting all the resources in the development of modern system and in that regard the achievement has been impressive. However, large number of people still relies on the indigenous systems for its health and well-being. These systems however have not had access to plan funds in any notable manner thus far. While in the modern medicine sector, the country has created primary, secondary and tertiary levels and the treatment and health care is of an acceptable quality, in the Indian System, none of these levels is in place in the country as a whole. However,

efforts are being made to rectify the situation. The 9th Five Year Plan beginning from 1997-98 is an opportunity to redress some of the accumulated deficiencies in developing these systems. Efforts are being made to increase the flow of funds to this sector during the 9th Five Year Plan period. Detailed plans have been drawn up not only for the year 1997-98 but for the entire plan period. The thrust areas would be in the fields of up gradation of educational standards, standardization of drugs & quality control, research and development, increasing availability of raw materials used in the manufacture of ISM & H drugs etc. It is also proposed to strengthen the role of this sector in the health care delivery system of the country by utilizing the services of the vast number of medical practitioners in the fields of preventive and promotive health and National Health and Family Welfare Programmes.

Prime Minister, Sir, we are extremely grateful to you for your presence here. But I have to use the occasion to make a strong and impassioned appeal to you for increasing the outlay for Health and Family Welfare if we are to make any progress in this sector. At every possible forum, be it the Parliamentary Committees or the World Health Assembly it has repeatedly been advocated that 6% of the GDP should be assigned for Health. Today, although 6% of GDP is spent on Health just 1.7% is assigned from the public sector. Even as a percentage of the Plan outlay the total allocation for both Health and Family Welfare does not exceed 3.5%. Which ever way one looks at it, with such an acute paucity of resources we can not provide what the country expects, much less bring about a complete change of life styles and health indices. The burgeoning population is a matter of the highest national concern today as it is impinging on every aspect of our lives. None of our overall plans for development can be successful if we cannot make a dent on the population problem. I would urge you to kindly see that at the commencement of the 9th Plan, the Health sector is given the measure of resources commensurate with our needs. Next to controlling the population the control of diseases is of paramount importance and I assure you that every rupee that is assigned to this sector would be used fruitfully. The country would remember you for giving attention to a sector which touches on the lives of people from birth to death.

In order to supplement resources we have been making Herculean efforts to garner funds from external resources. Many projects have taken off and many more are in the pipeline. During the 8th Plan there was a complete and unequivocal policy that funds availed of through external sources would be an additionally and would not cut into the normal plan. We do not have this assurance for the 9th Plan, which questions the very basis of seeking external resources. I would request you to give a direction in this important matter at the earliest, as the 9th Plan discussions are now on the anvil. External funding, particularly soft loans are available only to the social sectors and if we do not avail of them, the funds would be diverted to other countries and we would be the losers. Unless the funds are available *as* an additionally it would be extremely shortsighted to avail of them at the cost of the national programmes which are the direct responsibility of the Government. Your intervention in this critical area is vital and I crave your indulgence to give a firm direction to the matter.

I have tried to cover most of our important concerns as well as the tasks before us. We are eagerly waiting to hear the

Prime Minister. I once again welcome him and all of you and look forward to an exciting and fruitful interaction over the next 3 days.

**ADDRESS BY PROF. Dr. J.S. BAJAJ, MEMBER (HEALTH) PLANNING COMMISSION IN THE 5TH CONFERENCE OF THE CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE AT PARLIAMENT HOUSE ANNEXE FROM 8TH JANUARY TO 10 TH JANUARY, 1997**

Hon'ble Prime Minister, Hon'ble Union Minister of State for Health & Family Welfare, Hon'ble Minister of Health & Family Welfare in the States and Union Territories, Hon'ble Members of Parliament, Union Secretaries in the Departments of Health, Family Welfare and ISM, Director General of Health Services, Eminent Professional Colleagues, and Distinguished Ladies and Gentlemen,

It is indeed an honor and privilege to address such an august gathering in the gracious presence of the Prime Minister of India. The Central Council of Health and Family Welfare has the assigned responsibility to consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects and to make proposals for legislation in these fields of activity, thus laying down the pattern of health development for the country as a whole. It thus provides a forum for policy planning as well as for programme development and implementation. Most importantly, it provides an overarching mechanism for joint deliberations, thereby promoting and maintaining co-operation between the Central and State Health and Family Welfare administrations. Such a role is deeply relevant in the spirit of cooperative federalism that characterizes today's polity.

Planning Commission is committed to advance the principles of political, administrative and economic federalism so that the energies of the people are harnessed to achieve national objectives. Planning, especially health planning, by its very nature is a participative process involving governments at different levels including Panchayati Raj Institutions of local self-governance and people at all levels. Hence, the critical and crucial role that this Council must perform, and the likely impact and outcome of its deliberations and resolutions is of utmost significance

**HEALTH AND POPULATION PERSPECTIVE:**

Since the dawn of independence rapid strides have been made towards improving the quality and out reach of health care services to the people. There have also been some spectacular successes. The infant mortality rate (IMR) is now one-half of what it was in 1951(146 to 73). Crude death rate has declined from 27 in 1951 to 9.8 in 1991. It presently stands at 9.0. Life expectancy has doubled from a mere 32 years in 1951 to nearly 60 years now.

Admittedly, the reduction in birth rate has been less steep declining from 40 in 1951 to 29.5 in 1991, and 28.6 in 1994. As a result the annual exponential population growth has been over 2% in the last three decades. Nevertheless, during the Eighth Plan period the fall in birth rate has been steeper than that in the death rate; consequently annual growth rate is around 1.9% during 1991-95. However, there is an urgent need to reinforce our family welfare programme with greater vigor to accelerate the containment of population growth so as to maximize the benefits of economic growth and

development.

What is of major concern is the fact that demographic trends continue to show a widening of inter-state and intra-state variations as well as rural-urban differences, thus sharpening the contours of demographic diversity in the country. While the infant mortality rate has come down to 16 in Kerala, it is still more than 103 in Orissa. More importantly, whereas IMR in the rural (R) and urban (U) areas of Kerala is nearly similar (R17, U13) there are large differences between IMR in the rural and urban areas in other states such as Orissa (R107, U65), Madhya Pradesh (R104, 1161) and Uttar Pradesh (R89, U67). One third of all babies born today are of low birth weight, weighing less than 2500 gms. Maternal mortality is still unacceptably high. About 1, 00,000 women die every year because of pregnancy-related causes.

### **BASIC MINIMUM SERVICES**

Taking cognizance of the widening demographic diversity in the country, the Conference of the Chief Ministers in July 1996, held under the Chairmanship of the Prime Minister, recommended adoption of seven objectives to be achieved through basic minimum services. These are 100% coverage of provision of safe drinking water, 100% coverage of provision of primary health care; universalisation of primary education, extension of the mid-day meal scheme; public housing assistance to all shelter less poor families; road connectivity to all villages and habitation; and streamlining the public distribution system targeted to families below the poverty line. Indeed primary health care, safe drinking water and universalisation of primary education have been further prioritized, to be attained by the year 2000.

This approach has much to commend itself. The Central Governments' budget presented by the Hon'ble Finance Minister on 2nd July, 1996 provided an additional amount of Rs. 2,466/- crores as Central assistance for State and Union Territory plans to significantly enhance the availability of funds for achieving these objectives. These additional funds as a part of Central assistance have already been provided to the State and Union Territories and communicated to the Chief Ministers during discussions for the Annual Plan 1996-97. It is worth emphasizing that these funds are a part of States' plans and there is sufficient flexibility available to States to meet pre-defined objectives by choosing any one or more of the seven basic minimum services which have been accorded high social priority.

I am happy to report that some of the States such as Rajasthan have accorded high priority to primary health services as is reflected in their allocation of 40% of the additional Central assistance provided to the State for basic minimum services. It should be the earnest Endeavour of all the Hon'ble Health Ministers who are assembled here to ensure that health receives the priority recognition that it deserves in their respective States and that this should be adequately reflected in the resource allocation from the funds provided for the State Plans under additional Central assistance.

## **APPROACH TO THE NINTH PLAN:**

The Approach Paper to the Ninth Plan which was prepared under the guidance of the Prime Minister as the Chairman and Shri Madhu Dandavate as the Deputy Chairman of the Planning Commission has already received the endorsement of the Union Cabinet. It is pending consideration by the National Development Council that would meet next week, on the 16th January, 1997. It is hoped that the model of additional Central assistance for basic minimum services shall receive the approval of the NDC. It is also proposed that the financial assistance will be made available to the States on the basis of identified gaps in the provision of basic services so that those States which have lagged behind in achieving health and demographic objectives shall receive higher financial support to respond to the felt needs and identified gaps. Social equity must be the essence of any planning process.

May I submit that the primary health care approach which constitutes the base and basis of rural health care infrastructure remains our total and absolute commitment. While private sector and joint sector may play an important role in the delivery of tertiary health care, rural health must be the total responsibility of the State. This along with primary health and sanitation for urban poor shall facilitate attainment of Health for the Underprivileged (HFU) during the Ninth Plan.

## **OBJECTIVES OF THE NINTH PLAN**

The Prime Minister has emphasized 'Growth with Equity' as the socio-economic goal of the Ninth Plan. The enabling objectives include primary health care as a part of basic minimum services that I have referred to earlier, along with containment of population growth rate. In addition, the other objectives of the Ninth Plan include food and nutrition security for all, empowerment of women, eradication of poverty and environmental sustainability; all these interrelate closely with health and family welfare programmes. Given the instrumentality of Panchayati Raj institutions and the commitment to build self reliance, one can perceive a holistic view of the Ninth Plan.

## **EPILOGUE**

Mr. Prime Minister and colleagues, I have confined my observations to the emerging paradigm of health planning as envisioned in the Ninth Plan. I am fully conscious of the changing social norms, and share your concern regarding epidemiologic transition involving communicable and non-communicable diseases, the relentless struggle between man and microbe with emergence of the resistant bacteria and new viruses such as HIV, and the economic transition to the market economy with present resource constraints, I have refrained from making any observations on the issues nor have I touched upon health sector financing, human resource development for health and the role of complementary systems of medicine. All these are a part of agenda for discussion during the next three days and pertinent observations, as and when necessary, shall be made.

Let me conclude by stating that history is likely to judge the soundness of our health policy planning in the 21st century by one major yardstick; have we succeeded in imparting equity, accessibility, affordability, accountability and quality in health care delivery in India. All our actions, including the formulation of a revised national health policy, must be concerned with that judgment. Nevertheless, we must imbibe the wisdom of French philosopher Albert Camus who said: 'Do not wait for the last judgment; it takes place every day'.

I thank you Mr. Prime Minister once again for the opportunity afforded to me to be associated with the inaugural function.

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

- |    |   |          |
|----|---|----------|
| 1. | Shri Saleem I. Shervani<br>Union Minister of State for Health & Family Welfare (Independent Charge) New Delhi | Chairman |
| 2. | Prof. J.S. Bajaj,<br>Member (Health), Planning Commission, Yojana Bhawan, New Delhi 110 001.                  | Member   |

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

- |    |   |        |
|----|---|--------|
| 3. | Dr. N. Janardhan Reddy<br>Minister for<br>Health & Family Welfare, Govt. of Andhra Pradesh,<br>Hyderabad            | Member |
| 4. | Shri Tahun Tatak<br>Minister for Health & Family Welfare<br>Government of Arunacal Pradesh Itanagar.                | Member |
| 5. | Dr. K. Kalita<br>Minister for<br>Health & Family Welfare, Govt. of Assam, Dispur                                    | Member |
| 6. | Dr. Mahabir Prasad,<br>Minister for<br>Health, Medical Education & Family Welfare,<br>Govt. of Bihar,<br>Patna      | Member |
| 7. | Dr. Wilfred D'souza,<br><br>Dy. Chief Ministers<br>Minister for Health & Family Welfare,<br>Govt. of Goa,<br>Panaji | Member |
| 8. | Dr. Anil Joshiyara<br>Minister for  | Member |

Health & Family Welfare, Govt. of Gujarat,  
Ahmedabad

- |      |  |                    |
|------|--|--------------------|
| 9.   | Dr. Kamala Verma<br>Health Minister<br>Govt. of Haryana,<br>Chandigarh                               | Member             |
| 10.  | Shri Ram Lai Thakur<br>Health Minister<br>Govt. of Himachal Pradesh,<br>Shimla                       | Member             |
| 10a. | Smt. Viplove Thakur<br>Minister of State for ISM&H<br>Govt. of Himachal Pradesh,<br>Shimla           | Special<br>Invitee |
| 11.  | Dr. Mustafa Kamal<br>Minister for Health & Family Welfare<br>Government of Jammu & Kashmir Jammu     | Member             |
| 12.  | Dr. H.C. Mahadevappa,<br>Minister for Health & Family Welfare,<br>Govt. of Karnataka,<br>Bangalore   | Member             |
| 12a. | Dr. M. Shankar Naik<br>Minister of State for Medical Education<br>Govt. of Karnataka,<br>Bangalore   | Special Invitee    |
| 13.  | Shri A.C. Shanmukha Das<br>Minister for Health & Family Welfare,<br>Govt. of Kerala.<br>Trivandrum   | Member             |
| 14.  | Shri Prem Narayan Thakur<br>Minister for<br>Health & Family Welfare, Govt. of Madhya Pradesh, Bhopal | Member             |
| 14a. | Shri Narendra Nahata<br>Minister for Medical Education<br>Government of Madhya Pradesh<br>Bhopal.    | Special<br>Invitee |
| 14b. | Shri Direndra Prasad Gritlete<br>Minister of State for Health &<br>Family Welfare                    | Special<br>invitee |

Government of Madhya Pradesh  
Bhopal.

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|-----|--|--------------------|
| 15. | Dr. Daulat Rao Aher,<br>Minister for<br>Health & Family Welfare, Govt. of Maharashtra,<br>Mumbai       | Member             |
| 16. | Shri D.P. Panmei<br>Minister of Family Welfare<br>Govt. of Manipur,<br>Imphal                          | Member             |
| 16a | Dr. Chalton Lien Amo,<br>Minister for<br>Health & Family Welfare, Govt. of Manipur,<br>Imphal          | Special<br>Invitee |
| 17. | Shri K. Syiem,<br>Minister for<br>Health & Family Welfare, Govt of Meghaiaya,<br>Shillong              | Member             |
| 18. | Shri H. Lalruata<br>Minister for<br>Health & Family Welfare, Govt. of Mizoram,<br>Aizwal               | Member             |
| 19. | Shri Rajendra Singh Rathore,<br>Minister for<br>Health & Family Welfare, Govt. of Rajasthan,<br>Jaipur | Member             |
| 20. | Dr. D.P. Kharel,<br>Minister for<br>Health & Family Welfare, Govt. of Sikkim,<br>Gangtok               | Member             |
| 21. | Shri Arcot N. Veerasami<br>Minister for Health & Electricity<br>Government of Tamil Nadu<br>Chennai.   | Member             |
| 22. | Shri Bimal Singha<br>Minister for<br>Health & Family Welfare, Govt. of Tripura, Agartala               | Member             |
| 23. | Shri Partha De<br>Minister for<br>Health & Family Welfare, Govt. of West Bengal,                       | Member             |

Calcutta

24. Shri D.K. Arya, Special invitee  
Advisor to the Governor,  
Government of Uttar Pradesh,  
Lucknow

**Representatives from Union Territories :**

25. Shri A.M.H. Nazeem Member  
Minister for  
Health & Family Welfare, Govt. of Pondicherry,  
Pondicherry 605003.
26. Dr. Harshvardhan, Member  
Minister for Health & Family Welfare,  
Govt. of National Capital  
Territory of Delhi.  
Delhi
27. Mrs.B. Prasad  
Resident Commissioner Andaman & Nicobar Administration  
New Delhi

**Members of Parliament:**

28. Smt. Urmilabehn Patel Member  
Member of Parliament (Rajya Sabha)  
MS Flats, A-7, Opp. Dr. RML Hospital  
New Delhi.
29. Dr. Vallabhai Kathiria Special Invitee  
Member of Parliament (Lok Sabha),  
& Consultative Committee Vidhyasagar Road,  
Rajkot
30. Dr. G.L. Kanaugo Special Invitee  
Member of Parliament (Lok Sabha)  
& Consultative Committee  
174, South Avenue  
New Delhi.
31. Shri Virendra Kumar Special Invitee  
Member of Parliament (Lok Sabha)  
& Consultative Committee  
46, North Avenue  
New Delhi.
32. Shri Sanatan Bisi Special Invitee  
Member of Parliament (Rajya Sabha)  
& Consultative Committee

94, South Avenue  
New Delhi.

**Representatives from Health & Family Welfare Sectors:**

- |     |   |        |
|-----|---|--------|
| 33. | Dr. Kalyan Hazari, President,<br>Indian Medical Association,<br>I.M.A. House,<br>Indraprastha Estate,<br>New Delhi 110 002. | Member |
| 34. | Smt. Avabhai Wadia, President,<br>Family Planning Association of India,<br>Bajaj Bhawan,<br>Nariman Point,<br>Bombay.       | Member |
| 35. | Smt. Habbibulla,<br>President,<br>Indian Council of Child Welfare,<br>4, Deen Dayal Upadhyay Marg,<br>New Delhi.            | Member |
| 36. | Dr.G. V.Satyawati,<br>Director-General,<br>Indian Council of Medical Research,<br>Ansari Nagar,<br>New Delhi 110 049.       | Member |

**Eminent Individuals:**

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|-----|--|--------|
| 37. | Vaidya Devendra Triguna,<br>Ayurvedic Physician, General Secretary,<br>All India Ayurvedic Cong. Dhanwantri Bhawan,<br>Panjabi Bagh,<br>New Delhi. | Member |
| 38. | Dr. V.I. Mathan,<br>CMC, Vellore,<br>Christian Eminent Scientist,<br>Vellore (Tamil Nadu)  | Member |
| 39. | Dr. R.S. Arole,<br>Eminent in Voluntary Action,<br>Director, Comprehensive Rural Project,<br>Jamkhed, Dt. Ahmadnagar,                              | Member |

Mahrashtra.

40. Dr. Bholanath Chakravarti  
20-A, Prithvi Raj Road,  
New Delhi. Member

**Officials:**

41. Shri P.P. Chauhan  
Secretary  
Department of Health,  
Ministry of Health & Family Welfare  
New Delhi. Member
42. Shri Y. N. Chaturvedi  
Secretary,  
Department of Family Welfare,  
Ministry of Health & Family Welfare,  
New Delhi. Member
43. Smt Santa Sastry  
Secretary  
Department of ISM&H  
Ministry of Health & Family Welfare  
New Delhi. Member
44. Dr. S. P. Aggarwal  
Director-General of Health Services,  
Dte. Genl. of Health Services,  
Nirman Bhawan,  
New Delhi 110 011. Member

**List of Special Invitees**

45. Dr. (Mrs.) Prema Ramachandran,  
Adviser (Health & Family Welfare),  
Planning Commission,  
Yojana Bhawan, Sansad Marg,  
New Delhi.
46. Dr. (Ms.) Helen H. Simon,  
Director,  
N.I.H. & F.W., New Mehrauli Road,  
New Delhi
47. Dr. (Prof.) K.J. Nath,  
Director,  
All-India Institute of Hygiene & Public Health,  
110, Chittaranjan Avenue,  
Calcutta.

48. Dr. B.D. Athani,  
Director,  
All-India Institute of Physical Medicine Rehabilitation, Haji  
Ali Park, Clark Road, Mahalaxmi, Bombay 400 034.
49. Dr. B.K. Sharma, Director, P.G.I.M.E.R., Chandigarh.
50. Dr. D. S. Dubey, Director, J.I.P.M.E.R.,  
Pondicherry.
51. Dr. R. K. Srivastava,  
Medical Superintendent,  
Safdarjung Hospital,  
New Delhi.
52. Prof. (Mrs.) Kusum Sehgal, Principal,  
Lady Hardinge Medical College &  
Smt. Sucheta Kriplani Hospital,  
New Delhi.
53. Mrs. B. Bhattacharya, Principal,  
R.A.K. College of Nursing,  
Lajpat Nagar,  
New Delhi 110 049.
54. Dr. Dinesh Chandra  
Dean, Maulana Azad Medical College  
New Delhi.
55. Dr. B. Singh,  
Medical Superintendent,  
L.N.J.P. Hospital,  
New Delhi.
56. Dr. (Mrs.) S.S. Deshmukh,  
President,  
National Academy of Medical Sciences,  
N.A.M.S. Building, Ansari Nagar,  
New Delhi 110 049.
57. Dr. K. Desai,  
President,  
Medical Council of India,  
Kotla Road, Temple Lane,  
New Delhi 110 002.
58. Dr. (Mrs.) M. Sachdeva Secretary

Medical Council of India  
New Delhi.

59. Dr. (Prof.) N. Sreedhar Shetty,  
President,  
Dental Council of India,  
Combined Councils' Building,  
Temple Lane, Kotla Road,  
New Delhi 110 002.
60. Vaidya Pandit Shriram Sharma,  
President,  
Central Council of Indian Medicine,  
Anusandhan Bhawan,  
Plot Nos.61-65, Institutional Area,  
Opp: D Block, Pankha Road,  
Janakpuri,  
New Delhi 110 058.
61. Dr. S.P.S. Bakshi,  
President,  
Central Council of Homoeopathy,  
Anusandhan Bhawan,  
Plot Nos.61-65, Institutional Area,  
Opp: D Block, Pankha Road,  
Janakpuri,  
New Delhi 110 058.
62. Dr. H.R. Goyal, Director,  
Central Council for Research in Ayurveda  
& Siddha, Anusandhan Bhawan,  
Plot Nos.61-65, Institutional Area,  
Opp: D Block, Pankha Road,  
Janakpuri,  
New Delhi 110 058.
63. Dr. M. Khalid Siddiqi,  
Director,  
Central Council for Research in Unani Medicine,  
Anusandhan Bhawan,
64. Dr. Naresh Kumar Brahmachari  
Director,  
Central Council for Research in Yoga and Naturopathy  
Janakpuri  
New Delhi.

65. Dr. D.P. Rastogi,  
Director,  
Central Council for Research in Homoeopathy,  
Anusandhan Bhawan,  
Plot Nos.61-65, Institutional Area,  
Opp: D Block, Pankha Road,  
Janakpuri,  
New Delhi 110 058.
66. Dr. C.H.S. Sastry  
Director,  
National Institute of Ayurveda Ameer Road,  
Jaipur.
67. Dr. Sameer Kumar Bhattacharya, Director  
National Institute of Hygiene  
Calcutta.
68. Shri Alok Mukhopadhyaya, Executive Director,  
Voluntary Health Association of India,  
Tong Swasthya Bhawan,  
40, Institutional Area, (South of I.I.T.),  
New Delhi 110 016
69. Dr. K. Srinivasan, Executive Director, Population Foundation of India,  
B-26, Qutab Institutional Area,  
Tara Crescent,  
New Delhi 110 016.
70. Dr. K.K. Aggarwal, Vice-President,  
Heart Care Foundation of India,  
D-50, Defence Colony,  
New Delhi 110 0

**List of Other Official Invitees**

71. Dr. Vijayan Unni,  
Registrar General & Census Commissioner for India,  
2-A, Man Singh Road,  
New Delhi 110 011.
72. Dr. (Mrs.) P. Singh

Director (FW)  
Employees State Insurance Corporation  
New Delhi.

73. Col. M.R. Mohanchandra  
Director (Health)  
Armed Force Medical Services  
New Delhi.
74. Shri Anil Mainra  
Dy. Secretary  
Ministry of Environment & Forest
75. Dr.(Mrs.) Lakshmi Raghupathi  
Joint Director  
Ministry of Environment & Forests  
New Delhi
76. Dr. Phani Dhar  
Director General of Railway Health Services  
Ministry of Railways  
New Delhi.
77. Dr. Amrish Gupta  
Joint Director  
Health & Family Welfare  
Ministry of Railways  
New Delhi.

### **List of Invitees for Inaugural Function**

78. Dr. N.K. Shah,  
W.H.O. Representative to India,  
Nirman Bhawan,  
New Delhi 110 011.
79. Mr. Wasin-Zamal,  
Country Director,  
U.N.F.P.A.,  
55, Lodhi Estate,  
New Delhi 110 003.
80. Mr. Kristin Hefre,  
1st Secretary Development  
Representative from  
NORAD.  
Embassy of Norway,  
Chankyapuri,  
New Delhi -110 021
81. Mr. B. Jame-Tenson,  
(Councillor Develop  
Royal Danish Embassy, India  
Representative from  
DANIDA.  
F-42, South Ext.,  
New Delhi-110 049
82. Mr. John Rogosch,  
Director of Health & Population  
Representative from  
US AID.  
B-28, Qutab Industrial Area,  
New Mahrauli Road  
New Delhi-110 016

**List of Officials of the Ministry of Health & Family Welfare and Directorate General of  
Health Services**

**Ministry of Health & Family Welfare:**

83. Shri P.S. Bhatnagar,  
Additional Secretary & Project Director (NACO).
84. Smt. Shailaja Chandra,  
Additional Secretary (Health).
85. Smt. Adarsh Mishra,  
Joint Secretary.
86. Shri K.S. Sugathan,  
Joint Secretary.
87. Shri Vijay Singh,  
Joint Secretary & Financial Adviser.
88. Smt Renu Sahni Dhar  
Joint Secretary
89. Smt. Sunila Basant,  
Joint Secretary.
90. Shri Alok Perti,  
Joint Secretary.
91. Shri P. Bhargava,  
Joint Secretary.
92. Dr. Ashok Kumar,  
Dy. Comm. (MCH)
93. Dr. Vijay Bahadur Gupta,  
Dy. Comm. (UHS).
94. Dr. K.C. Tayal,

Asstt. Comm. (AP).

95. Dr. Sobhan Sarkar,  
Asstt. Comm. (UIP).

96. Dr. V.K. Manchanda,  
Asstt. Comm. (ORT)

97. Dr. V.K. Behl,  
Asstt. Comm. (EPI).

98. Dr. Kaushik Banerjee,  
Asstt. Comm. (I).

99. Dr. S.K. Das,  
Asstt. Comm. (RHS).

100. Dr. A.K. Datt,  
Asstt. Comm. (T).

101. Dr. S. Malhotra,  
Asstt. Comm. (CS)

102. Dr. K.S. Srivastav,  
Asstt. Comm. (T.O.).

103. Dr. (Mrs.) Lai Rintlungi,  
Asstt. Comm. (SS)

104. Shri R.L. Narasimhan,  
Director (Mkt.)

105. Shri L Prasad, Director (PH)  
Shri O.S. Veerwal

106. Dr. V.T. Augustine,  
Adv. (Homoeo.)

107. Dr. S.K. Sharma,

Adv. In-Charge (Ay.)

108. Dr. (Smt.) Aliya Aman,  
Dy. Adv. (Unani)
109. Dr. S.P.Singh  
Deputy Advisor(Hom)
110. Dr. M.L.Sharma,  
Deputy Advisor (Ayurveda)
111. Shri A. K. Mehra  
Joint Director
112. Dr. B. N. Sardana  
Joint Director, NACO
113. Dr. M.A. Kumar  
Asst. Advisor (S)
114. Shri Babu Lal  
Joint Director
115. Dr. Eswara Das,  
Asstt. Adv. (Homoeo.)
116. Shri H.N. Yadav,  
U.S. (ME)
117. Shri Lai Singh, U.S. (A-II)
118. Shri Shyam Jindal, U.S.(G)
119. Shri K.S. Nagi, Dy. Dir. (Parlt.)
120. Shri B.B. Lal, Welfare Officer
121. Shri R.N. Singh, C.C. & P.O.
122. Shri Raman Prasad A.V.M.O.

Dte. Genl. of Health Services:

123. Dr. V. P. Bansal  
Addl. D.G.
124. Dr. (Mrs.) Ira Ray,  
Addl. D.G.
125. Dr. P.C. Rai,  
Addl. D.G.
126. Dr. P. Das Gupta,  
Drug Controller General  
Addl.DG.
127. Dr. ShivLal,  
Director (NMEP)
128. Dr. K.K. Dutta,  
Director (NICD)
129. Dr. A.K. Seth  
Director (CBHI)
130. Dr. (Mrs) T. Bhasin  
Director (CHEB)
131. Dr. (Smt.) R. Jose,  
D.D.G. (Ophth.)
132. Dr. R.S. Gulati,  
D.D.G. (RHS)
133. Dr. G.R. Khatri  
D.D.G.(TB)
134. Dr. N. S. Dharmshaktu, D.D.G.(Lep.)

135. Dr. S.Seghal
136. Director (Micro)
137. Dr. G.K. Biswas,
138. Addl. D.D.G.(Stores)
139. Dr. (Mrs.) Promila Singh,
140. Addl. D.D.G. (G)
141. Dr. Ashiwini Kumar, J.D.C.(I)
142. Dr. S.C. Srivastava, D.D.C.(I)
143. Shri R.K. Mukhi Bhattacharya, Director (A. &V.)
144. Dr. B.K. Verma. Director (EMR)
145. Dr. U.K. Tiwari, Adviser (Nut.)
146. Dr. (Mrs.) G. Sharma  
A.D.G. (Pig.)
147. Smt. Debi Mukherjee,  
A.D.G. (PFA)
148. Dr. S.K. Sharma  
ADG (HA)
149. Dr. S. Venkatesh,  
AD.G. (IH)
150. Dr. L.S.Chauhan  
AD.G. (Lep.)
151. Dr. C.M. Aggarwal  
A.D.G. (EPI)
152. Dr. P. Biswal,

AD.G. (T.B.)

153. Dr. Ajai Kumar,

AD.G. (ME)

154. Dr. D. Bachani

A.D.G.(Ophth.)

155. Dr. S.B. Dhawan

C.M.O. (HE)

159. Dr. Manjeet Singh

C.M.O. (HE)

160. Dr. Ashok Singhal

C.M.O. (M)

161. Dr. Dipankar Das,

C.M.O. (TB)

162. Dr. L.B.S. Dey,

C.M.O. (NFSG)

163. Dr. Brij Bhushan,

D.A.D.G. (EMR)

164. Shri B.N. Tewari,

Stat. Officer (BOP)

**Regional Directors (Health & Family Welfare):**

165. Dr. **K.V.** Krishnamurthy  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
A-11-256/B/1,  
New Airport,  
Prakash Nagar,  
Hyderabad
166. Dr. B.K. Borgohain  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
Felli Ville,  
Lumsohpoh,  
Shillong, Meghalaya
167. Dr. Jawahar Singh  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
Danara House,  
Salimpur Ahara,  
(Behind R.B.I.)  
Patna, Bihar
168. Dr. A.P. Pandya  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
Anand Estate, Industrial Estate Corner,  
Bapu Nagar, Ahmedabad,  
Gujarat
169. Dr. VS. Godhara  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
Ripon Hospital Compound, Shimla.

H. P.

170. Dr. (Smt.) Shazia Wafai,  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
F-711, Prem Nagar (New Plot), Jammu (Tawi),  
J & K.
171. Dr. P.K. Shome  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
Kendriya Sadan  
Bangalore, Karnataka
172. Dr. (Smt.) T.P. Jagdamma,  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
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Chirakulam Lane, Thiruvananthapuram,  
Kerala
173. Dr. (Smt.) Uma Vazirani  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
131/16, Maharana Pratap Nagar,  
Bhopal, M.P.
174. Dr. Gopal Ramaswami  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
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Maharashtra
175. Dr. S.S. Chakraborty,  
Regional Director (H. & F.W.),  
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Sangrilla Uripock Road,  
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176. Dr. S.K. Satpathy,  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
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177. Dr. Shyam Lai,  
Senior Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare  
K-10, Durga Das Path, Malviya Marg,  
Jaipur (Rajasthan)
178. Dr. DhanRaj,  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
25, Ramanathan Street,  
T. Nagar,  
Madras (Tamil Nadu)
179. Dr. P.LJoshi,  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
C-2, B-80, Mahanagar,  
Lucknow (U.P.)
180. Dr. Subhash Chakraborty,  
Senior Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
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Calcutta (W.B.)
181. Dr. J. K. Jain,  
Regional Director (H. & F.W.),  
Regional Office for Health & Family Welfare,  
KothiNo.3281, Sector 21-D, Chandigarh.

**List of States' Health Secretaries:**

182. Ms. Rachel Chatterjee  
Secretary (Family Welfare)  
Government of Andhra Pradesh  
Hyderabad.
183. Shri P.P. Verma  
Health Secretary Government of Assam,  
Dispur.
184. Shri M.L. Mazumdar,  
Health Secretary,  
Govt. of Bihar,  
Patna
185. Shri C.K. Basu  
Commissioner, Health & Family Welfare  
Govt. of Bihar  
Patna.
186. Shri Haarfi Health  
Secretary Govt. of Goa, Panaji.
187. Shri V.R.S. Cowlagi  
Additional Chief Secretary (Health),  
Govt. of Gujarat,  
Ahmedabad
188. Shri Ashok Koshi  
Additional Chief Secretary (FW)  
Govt. of Gujarat,

Ahmadabad

189. **Smt.** Veena Eagleton

Health Secretary,

Govt. of Haryana,

Chandigarh

190. Shri J.P. Negi,

Health Secretary,

Govt. of Himachal Pradesh,

Shimla

191. Shri Iqbal Nandem

Health Secretary,

Government of Jammu & Kashmir

Srinagar

192. Dr. Ved Prakash Gupta, Special Secretary Health & Medical Education, Government of Jammu & Kashmir

Srinagar

193. Shri Gautam Basu,

Health Secretary,

Govt. of Kamataka,

Bangalore 560 001.

194. Shri R.N. Shastri

Health Secretary (II)

Govt. of Karnataka,

Bangalore

195. Shri V. Vijayachandran

Secretary (H&FW)

Govt. of Kerala.

Trivandrum

196. Shri P.K. Mehrotra

Principal Secretary (Health)

Govt. of Madhya Pradesh,

Bhopal

197. Dr. S.C. Majumdar

Principal Secretary (ME)

Govt. of Madhya Pradesh, Bhopal

198. Shri Shiv Raj Singh

Commissioner (Health)

Govt. of Madhya Pradesh

Bhopal.

199. Shri Ramanand Tiwari,

Health Secretary,

Govt. of Maharashtra,

Bombay

200. Shri T.F. Thekkekara

Commissioner (Family Welfare)

Govt. of Maharashtra,

Bombay

201. Shri B.P. Pandey

Secretary (ME & Drug)

Govt. of Maharashtra,

Bombay

202. Shri P.L. Thanga,  
Health Secretary,  
Govt. of Manipur,  
Imphal

203. Ms. Meena Gupta  
Health Secretary  
Govt. of Orissa  
Bhubaneswar.

204. Shri O.P. Behari,  
Health Secretary,  
Govt. of Rajasthan,  
Jaipur

205. Shri Rakesh Verma  
Special Secretary (M&H)  
Govt. of Rajasthan  
Jaipur.

206. Shri R. Poornalingam,  
Health Secretary,  
Govt. of Tamil Nadu,  
Madras.

207. Smt. Aradhana Johri  
  
Secretary (Health)

Govt. of Uttar Pradesh,

Lucknow.

208. Shri **Lov** Verma

Secretary (FW)

Govt. of Uttar Pradesh,

Lucknow.

209. Dr. Bachchi Lal

Special Secretary (Medical & Helth)

Govt. of Uttar Pradesh,

Lucknow

210. Shri L.R.K. Prasad

Principal Secretary (H&FW)

Govt. of West Bengal

Calcutta

211. Shri Ramesh Chandra,

Principal Secretary (Health)

Govt. of National Capital Territory of Delhi

Delhi.

212. Shri M. Kharurujai

Dy. Secretary

Government of Meghalaya

Shillong.

#### **STATE DIRECTORS OF HEALTH**

213. **Dr. S. Vinaya Babu**

Director of Health Services

Government of Andhra Pradesh

Hyderabad

214. Shri CB.S. Venkata Raman  
Director (FW)  
Government of Andhra Pradesh  
Hyderabad
215. Dr. CM. Habibullah  
Director  
Deccan College of Medical Sciences  
Hyderabad.
216. Dr. A.R. Basumatary  
Director of Health Services  
Government of Assam  
Guwahati.
217. Dr. A.C. Baruah  
Director of Medical Education  
Government of Assam  
Guwahati.
218. Dr. Mangtoo Ram  
Director in Chief Government of Bihar  
Patna
219. Dr. N.D. Ghasura  
Additional Director Health & Family Welfare  
Government of Gujarat  
Gandhi Nagar.
220. Dr. A.V. Saklecha  
Director of Health Services  
Government of Goa  
Panaji.

221. Dr. P.L. Jindal  
Director General of Health Services  
Government of Haryana  
Chandigarh
222. Dr. M. T. Himareddy  
Director Health Services  
Government of Karnataka  
Bangalore
223. Dr.(Mrs.) S. Kantha  
Vice Chancellor  
Rajiv Gandhi University of Health Sciences  
Bangalore
224. Dr. G. V. Nagaraja  
Addl. Director (FW&MCH)  
Government of Karnataka,  
Bangalore
225. Dr. S. M. Angade  
Director ISM&H  
Government of Karnataka  
Bangalore
226. Dr. B. Mahilamani  
Director of Health Services  
Government of Kerala  
Trivandrum
227. Dr. L.P. Mathur  
Director of Public Health

Government of Madhya Pradesh

Bhopal.

228. Dr. K.N. Tiwari

Director (ISM&H)

Government of Madhya Pradesh

Bhopal.

229. Dr. M.P. Agarwal

Director, Health Services

Government of Madhya Pradesh

Bhopal.

230. Dr. P. K. Bajaj

Director Medical Services

Government of Madhya Pradesh

Bhopal

231. Dr. Subhash Salunke

Director of Health & FW

Government of Maharashtra

Mumbai.

232. Dr. S.K. Ganeriwal

Director, Medical Education & Research

Government of Maharashtra

Mumbai.

233. Dr. H. Hemchandra

Director of Medical & Health Services

Government of Manipur

Imphal

234. Dr. S. Rabei Singh

Additional Director (FW)

Government of Manipur  
Imphal.

235. Dr. (Mrs.) T. Lallo

Director of Health Services

Government of Meghalaya

Shillong.

236. Dr. Lalengi Khangte

Director Health Services

Government of Mizoram Aizwal

237. Shri B.D. Mahapatra

Director (ISM&H)

Government of Orissa

Bhubaneswar.

238. Dr. S. Bhanik

Director of Health Services

Government of Orissa

Bhubaneswar.

239. Dr. P.S. Jassi

Director of Health Services & FW

Government of Punjab

Chandigarh.

240. Dr. Manmohan Kaur

Director of Health Services

Government of Punjab, Chandigarh.

241. Dr. R.K. Garg

Director, Medical & Health Services

Government of Rajasthan

Jaipur.

242. Dr. G.S. Gahlot  
Director, Medical & Health Services  
Government of Rajasthan  
Jaipur.
243. Dr. N.M. Singhvi  
Director, Medical & Health Services  
Government of Rajasthan  
Jaipur.
244. Dr. T.R. Gyatso  
Director of Health Services  
Government of Sikkim  
Gangtok
245. Dr. S.K. Poroh  
Additional Director Health Services  
Government of Sikkim  
Gangtok.
246. Dr. N. Vijayaraghavan  
Director, Public Health  
Government of Tamil Nadu  
Chennai.
247. Dr. (Capt.) M. Kamatohi  
Director, Medical & Rural Health Services  
Government of Tamil Nadu  
Chennai.
248. Shri Jayaraman  
Director, (IM)  
Government of Tamil Nadu

Chennai.

249. Dr. B. Roy  
Director Health Services  
Government of Tripura  
Tripura
250. Dr. S.C. Vaish  
Director General (Medical & Health Services)  
Government of Uttar Pradesh,  
Lucknow.
251. Dr. R. K. Srivastava  
Director General Medical Education  
Government of Uttar Pradesh  
Lucknow
252. Dr. A.G. Rizwi  
Director General (FW)  
Government of Uttar Pradesh  
Lucknow.
253. Dr. A.K. Yadav  
Joint Director  
Government of Uttar Pradesh  
Lucknow.
254. Dr. C.R. Das  
Director of Health Services  
Government of West Bengal  
Calcutta.
255. Dr. (Mrs.) Jeevan Jha  
Director of Health Services NCT.  
Delhi.
256. Dr. Jotna Sokhey

(Family Welfare & ISM&H)

MCD, Delhi.

257. Dr. Gurnam Singh Ahluwalia

Director Health Services

U.T. Administration

Chandigarh.

258. Dr. S.S. Vaishya

Director (Medical & Health Services)

U.T. Administration

Daman.

**MEMBERS OF DIFFERENT WORKING GROUPS FOR DETAILED CONSIDERATION OF AGENDA ITEMS FOR THE FIFTH CONFERENCE OF THE CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE**

**WORKING GROUP NO.I**

**FAMILY WELFARE PROGRAMMES AND RURAL HEALTH  
INFRASTRUCTURE**

**Venue: Committee Room Main**

Chairman	Health Minister, Himachal Pradesh
Co-Chairman	Health Minister Rajasthan
Members	Health Minister, Kerala, Minister of State for Health Madhya Pradesh, Representative of Lakshadweep Admn.
Eminent person	Dr. R.S.Arole, Director, Comprehensive Rural Project, Smt. Avabhai Wadia, Mrs. H. Habibullah, Shri S.M. Aggarwal, President all India Organization of Employees.
Special invitees	Dr. K.Srinivasan, Executive Director, Population Foundation of India, Prof. (Mrs) Kusum Sehgal, Principal, <b>LHMC</b> , Smt. Vidyaben Shah, SWB, Mrs. B. Bhattacharya, President, MCI, Dr. Vijayan Unni, Registrar General of India
Convener & Rapporteur	Joint Secretary (AM)
Officials	Joint Secretary (S), DDG (RHS), Deputy Commissioner (MCH), Deputy Commissioner (UHS), Deputy Commissioner (TO), Director, NIH&FW, Director Policy (FW), Director (MCH), Director (Marketing), Regional Director, Pune, Regional Director, Jammu, Regional Director, Imphal.
State Officials	Secretary (H) Madhya Pradesh, Secretary (H) Rajasthan, Secretary (FW)

Kerala, Secretary (H) Nagaland, Secretary (H) Himachal Pradesh, Secretary(FW),Andhra Pradesh, Secretary(FW) Uttar Pradesh, Commissioner (FW), Maharashtra, Director(FW) Madhya Pradesh, DHS Rajasthan, DHS Kerala, DHS Nagaland, DHS Himachal Pradesh, DHS Lakshadweep, Director (FW) Andhra Pradesh, Director(FW) Delhi, Director (FW) Uttar Pradesh.

Subjects to be discussed: Target Free Approach and Decentralized Planning. Sharing of Costs of Family Welfare Programme, Pulse Polio Immunization, School Health Check up, Increasing Effective Age of Marriage and Promotion of IEC, Strengthening of Primary, Secondary and Tertiary Health Care Delivery System, Hospitals Post Partum Programmes, Urban and Rural Family Welfare Centres and Urban Revamping Scheme, Incentives and Disincentives as per report of the Committee on Population, Review of District Training Plan for Training of ANMs as Trainer of Dias, Community Award Scheme and Family Welfare Programmes for Watershed Project Areas and Observance of "Math Suraksha Abhiyan"

## WORKING GROUP NO.II

### COMMUNICABLE DISEASES CONTROL PROGRAMMES

Venue: Committee Room Main

Chairman	Health Minister, Maharashtra
Co-Chairman	Health Minister Bihar
Members	Health Minister, Manipur, Health Minister, Sikkim, Health Minister, Arunachal Pradesh, Advisor to Governor, Uttar Pradesh.
Eminent Persons	Dr. CM. Habibullah, Gastroenterologist, Hyderabad
Special Invitees	Shri Alok Mukhopadhyaya, Executive Director, VHAI. Dr. KKJain, Principal, Maulana Azad Medical College, Prof. J.S. Qadari, President, PCI, Dr. (Mrs), S.S.Deshmukh, President, NAMS, Dr. Hazari, President, IMA, Smt. K. Bhandari.
Convenor & Rapporteur	Joint Secretary (AP)
Officials	Director (NMEP), Director (NICD) DDG(NLEP), Advisor (Health), Planning Commission, Director (Micro), NICD, Dy. Director (NACO), RD, Shillong, RD Hyderabad, RD Bangalore, Dr. L.S. Chauhan, ADG(L), Dr. CM. Aggarwal, ADG(EPI). Dr. Venkatesh.ADG(IH), Mr. Kannan,(Dy. Secy),
State Officials	Secretary (H) Maharashtra, Secretary (H) Bihar, Secretary (H) Uttar Pradesh, Secretary (H) Manipur, Secretary (H) Punjab, Secretary (H) Sikkim, Secretary (H) Arunachal Pradesh, DHS Maharashtra, DHS Bihar, DHS Uttar Pradesh, DHS Manipur, DHS Sikkim, DHS Arunachal Pradesh and DHS Andaman & Nicobar Islands, Director(HS) Assam, Director(HS) Madhya

	Pradesh.
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\* Subjects to be discussed: Epidemiological Surveillance and Support System, National Programmes for Control/Eradication of Malaria, AIDS, Tuberculosis, Leprosy and Rabies

### WORKING GROUP III

#### NON-COMMUNICABLE DISEASES CONTROL PROGRAMME & MATTERS RELATING TO DRUGS/FOOD QUALITY CONTROL

Venue: Committee Room B

Chairman	Deputy Chief Minister Goa
Co-Chairman	Health Minister Andhra Pradesh
Members	Health Minister, Tamil Nadu, Health Minister, Meghalaya, and Administrator, Chandigarh, Health Minister Haryana
Eminent Persons	Dr. B.K. Goyal, Cardiologist, Bombay
Special Invitees	Dr. P.K. Dave, Director, AIIMS Dr. B.K. Sharma, Director PGIMER, Chandigarh Dr. B.D. Athani, Director, AIIPMR, Bombay Dr. K.K. Aggarwal, Vice President, Heart Care Foundation, Dr. D.S. Dubey, Director, JIPMER
Convenor & Rapporteur	Joint Secretary (RSD)
Officials	DDG(Opt), Addl. DDG (Dr.Promila Singh), DG(AFMC), Director, NIMHANS, DCG(I), Addl. DG(Stores), ADG(PFA), Advisor (N), RD Lucknow, RD Chandigarh, RD Patna, Dr\ A. Kumar DYDG(i), Dr. Bachchani.ADG(O).
State Officials	Secretary (H) Haryana, Secretary (H) Delhi, Secretary (H) Tamil Nadu, Secretary (H) Meghalaya, DHS Chandigarh, DHS Andhra Pradesh, DHS Haryana, DHS Goa, DHS Tamil Nadu, DHS Meghalaya.

Subjects to be discussed : National Programmes for Control of Blindness, Cancer, Mental Health, Role of Health Sector in Implementation of Programmes for Persons with Disabilities (Equal Opportunities, protection of rights and full participation) and Iodine Deficiency Disorders and Strengthening of Drugs/Vaccines/ Food Quality Control.

## WORKING GROUP IV

### OTHER HEALTH PROGRAMMES

Venue: Committee Room C

Chairman	Health Minister, Karnataka
Co-Chairman	Health & Family Welfare Minister Gujarat
Members	Health Minister, Assam, Health Minister Mizoram, Health Minister, Pondicherry, Minister of Manpower Planning and Medical Education, Madhya Pradesh and Representative of Daman & Diu.
Eminent Persons	Dr. V.L. Mathan, CMC, Vellore, Dr. Pratap Reddy.
Special Invitees	Lt. General D. Raghunath, DG, AFMS Dr. B.N. Sinha, DG, Railway Medical Services, Dr. Bhagat Singh.MS, LNJP Hospital, Shri S.K.Sharma, DG, ESIC and Dr, K. Dasa President.MCI.
Convenor & Rapporteur	<b>Joint Secretary (SB)</b>
Officials	Addl.DG(Prof.V.P.Bansall,Prof.K.B. Logani.DDG (M), Principal, University College of Medical Sciences, Dr. R.K. Srivastava, MS, Safdarjung Hospital, Director, CHEB, Director, CGHS, RD, Shimla, RD, Bhopal, RD, Bhubaneswar, Director(ME), Dr. S.K. Sharma, ADG(Hospital Admn.), Dr. Ajay Kumar, ADG(Medical Edu.).
State Officials	Additional Chief Secretary Gujarat, Secretary (H) Karnataka, Secretary (H) Orissa, Secretary (H)

	Pondicherry, Secretary (H) Assam, Secretary (H) Mizoram, Secretary(PHSME) Madhya Pradesh, Secretary(ME) Maharashtra, Secretary(ME) Uttar Pradesh, DHS Karnataka Additional DHS Gujarat, DHS, Orissa DHS DHS Pondicherry, DHS Mizoram, DHS Daman & Diu, Director(ME) Assam, Director(ME) Madhya Pradesh, Director(ME) Uttar Pradesh, Director(ME)Maharashtra
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Subjects to be discussed: Fees for Medical Colleges following Supreme Court Directive, Compulsory Rural Service and Filling up of Vacancies, Regulatory Measures for Private Nursing Homes, Improvement of Emergency Services in Government Hospitals, Environment and Hospital Waste Management, National and State Illness Assistance Fund, Introduction of Yellow Card Scheme for compulsory health check up for SC/ST population and amalgamation of State Health Education Bureau and IEC Bureaux.

## WORKING GROUP V

### PROGRAMMES CONCERNING INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY SECTOR\*

Venue: Committee Room D

Chairman	Health Minister, West Bengal
Co-Chairman	Health Minister Delhi
Members	Health Minister, Tripura, Health Minister, Jammu & Kashmir, Minister(Ayur)Himachal Pradesh, and Administrator, Dadra & Nagar Haveli
Members of Parliament	Smt. Urmilaben Patel, M.P.
Eminent Persons	Vaidya Devendra Triguna, General Secretary All India Ayurvedic Congress, Hakim Abdul Hamid, Chairman, Hamdard Research Foundation, Dr. Bholanath Chakraborty, Howarah
Special Invitees	Dr. H.R. Goyal, Director, Central Council for Research in Ayurveda and Sidha, Dr. Naresh Kumar Bramachari, Director, Central Council for Research in Yoga and Naturapathy, Dr. D.P. Rastogi, Director, Central Council for Research in Homoeopathy, Dr. M. Kahlid Siddiqui, Director, Central Council for Research in Unani Medicine.
Convenor & Rapporteur	Joint Secretary (PB)

Officials	Advisor (Ayurveda), Director (Sh. Kanwar Rajinder Singh), Director (Sh. B.N. Meena), Director (Sh.O.S Veraval), Dy. Advisor (Homoeo), Dy. Advisor (Ayurveda), Dy. Advisor (Unani).RD Trivandrum, RD Ahmedabad, RD Rajasthan
State Officials	Secretary (H) West Bengal, Secretary (H) Punjab, Secretary (H) Tripura, Secretary (H) Jammu & Kashmir, Secretary (H) DHS West Bengal, DHS Punjab, DHS Tripura, DHS Jammu & Kashmir, DHS Dadra & Nagar Haveli, Director (ISM) Karnataka, Director (ISM) Madhya Pradesh, Director (ISM) Orissa.

Subjects to be discussed: Effective Use of ISM&H System for Health for All for Better Patient Care Systems, Role of ISM&H Dispensaries (Government Sector) in National. Health Care Delivery System and Indian Systems of Medicine and Homoeopathy Medical Colleges.