

**PROCEEDINGS
OF
THE SECOND CONFERENCE
OF
CENTRAL COUNCIL OF HEALTH
AND
FAMILY WELFARE**

**February 1—3, 1989
New Delhi**

MINISTRY OF HEALTH AND FAMILY WELFARE

**(BUREAU OF PLANNING)
GOVERNMENT OF INDIA**

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AGENDA

1. Family Welfare Programme including MCH & Immunization.
2. Primary Health Care including Minimum Needs Programme and School Health Services;
3. National Malaria Eradication Programme including Kala-Azar Control.
4. National Leprosy Eradication Programme.
5. National Programme for Control of Blindness.
6. National TB Control Programme.
7. National Goitre Control Programme.
8. AIDS—Surveillance and Control.
9. Cancer Research & Treatment Anti-tobacco Measures.
10. ISM & Homoeopathy Programme.
11. Drugs Standard Control including Pr of Drug abuse.
12. Prevention of Food Adulteration programme.
13. Medical Health Education including P Scheme.
14. Review of National Health Policy.
15. Control of Water borne diseases.

**WELCOME ADDRESS BY SHRI R. SRINIVASAN, SECRETARY,
MINISTRY OF HEALTH & FAMILY WELFARE**

Hon'ble Minister of State Kumari Saroj Khaparde, Member Planning Commission, Prof. Srivastava, Hon'ble Ministers of States, distinguished non-official members of the Council, Director General of Health services, Dr. Vishwakarma, officers of the Health Ministry and State Health Departments, distinguished participants from other ministries and organizations, friends.

I deem it my privilege to welcome you, Madam, and all other participants to this second meeting of the Central Council of Health and Family Welfare. Ever since I joined as Secretary four months ago, I had looked forward to this crucial meeting for providing policy guidelines to all of us working in the Ministry and in various State health departments constituting the senior levels of the health workforce. The Council will no doubt review what has been done so far, assess our successes and failures objectively and provide leadership to the large field health workers—doctors, nurses, paramedics, multipurpose workers and community level workers, not forgetting the even larger voluntary agencies working for better health with commitment. In the past, the deliberations of the Council have been useful, pointed and relevant. I am sure your guidance this time too would be equally valuable.

This second meeting of the Council could not have been more appropriate. We have just a year to go for the end of the Seventh Five Year Plan and the perspectives for formulating the Eighth Plan must get decided soon, action to draw up the first draft is underway in the States and the Centre. After reviewing the Seventh Plan progress so far, we must assess the situation with a view to formulating our strategy, objectives, programmes and course of action for the 8th Five Year Plan which will start next year. The Planning Commission has constituted a number of working groups to look into various areas of health sector in detail and make suitable recommendations. What will get decided now as outlay and directions of investment will effectively set the course right up to the end of the century and the country is committed to the global goal of Health for all by 2000. Important inputs will become available from your discussions for these working groups, Ministry and the Planning Commission. While there can be debate on areas for special thrust, our basic objective remains steady, i.e. to ensure Health for All especially through provision of primary health care. During the Seventh Plan we had attempted to set up the framework for a pervasive rural health infrastructure so that communicable diseases could be controlled, maternal and child health augmented, nutrition status improved and adoption of non-terminal methods for family planning with informed consent.

Of course, some priorities may have to be changed, for instance as life expectancy rises, some non-communicable diseases like cancer, heart diseases, etc. would increase or new pandemics like AIDS emerge on the scene. Again medical technology is improving every day and additional investments are constantly

required in diagnostic equipment, vaccine production blood transfusion services, etc. Whatever be our strategy or priorities, it is plain that additional resources are required to make any effective impact on our health scene. Madam, during the Seventh Plan the total allocation for both Health and Family Welfare sector was only 3.7 per cent of the Seventh Plan. This can by no means be considered adequate even in the context of limited resources available for financing the Seventh Plan. Inadequate outlays on health become thinly spread out, tend to be low in cost-effectiveness and run contrary to the proposition that health is not merely an output but is also an important input into growth, as there is no better index of people's welfare than their health status. It is of course necessary that we use our available resources with sustained concern for productive use of capital.

May I in this context dwell briefly on approaches to the Family Planning Programme? It was started in 1951 with a clinical approach and in the mid-sixties, was supplemented with an extension approach. From the late seventies, there has been an attempt at integration of family planning services with maternal and child health and nutrition services for pregnant and nursing mothers and young children. With this integrated approach some good results have been achieved. There is some evidence that the birth rate has declined further ever so slowly and not matching adequately our expectations. From 33.9 in 1984, the birth rate according to SRS data came down to 32.9 in 1985, to 32.6 in 1986, and further down to 32 per thousand in 1987. The death rate has also shown decline from 12.6 in 1984 to 10.8 in 1987. The number of family planning acceptors has increased from 16.44 million in 1984-85 to 22.69 million in 1987-88. As against the target of 25.51 million for all methods for 1988-89, the number of acceptors up to December stood at 15.03 million, which represents an increase of 2.58 million over the corresponding period last year. The progress in regard to sterilizations has been causing some disquiet though, particularly in the more populous States.

The key to long term success in family welfare lies of course in tackling the developmental issues related to provident maternity mother care and child survival, all of which will critically influence the desired family size for the millions of eligible couples in the reproductive age group. Ultimately the true test will always be how to make family size decisions more and more congruent with national family planning goals.

The Universal Immunization Programme as a Mission holds pride of place in our programmes for child welfare. Starting in 1985-86 with only 31 districts in the country, it is now being implemented in 307 districts. In the remaining 135 odd districts this programme will be taken up in 1989-90 "so as to ensure full coverage by the end of the 7th Five Year Plan. We have the second largest immunization programme undertaken anywhere in the world and systematically addressed ourselves to the enormous problems of vaccine supply, logistics of distribution and cost-effective coverage. In 1989-90, we will be covering approximately 25 million pregnant women and 22.7 million infants and in the entire 7th Five Year Plan period, we expect to have covered 90 million pregnant women and more than 80 million infants. The programme has some weaknesses; its urban component requires to be systematized; efforts are on to accelerate self-sufficiency in vaccine production, especially OPV, at the earliest. All States have extended their

cooperation and ensured proper monitoring, though gaps in staffing and linkages continue to exist.

In view of our limited resources, one of our main concern is that health system must work optimally with due emphasis on public health action besides curative care. With this end in view we are engaged in building up a format for collecting base line data capable of computerization which would facilitate monitoring, evaluation and policy formulation. Our epidemiological base has in particular been weak. So we are trying to develop an appropriate epidemiological surveillance system so that morbidity and mortality patterns and focus of epidemics could be constantly kept under review. Proper linkages will be developed between districts, States and the Centre (or transmission of information on a networking arrangement).

At the last meeting in January 1988, the Council had set up a Standing Committee to conduct a review of action taken on the decisions of the Council. Accordingly a Standing Committee was constituted under the chairmanship of the Minister of State for Health. The Standing Committee was able to meet twice during, the intervening year and conducted an exhaustive review of action taken. The minutes of the meeting of the Standing Committee have now been placed before the Council along with our action taken report.

May I on behalf of the Ministry of Health & Family Welfare and on behalf of my colleagues and myself welcome all the Ministers from States, Prof. Srivastava and other members of the Council to this second meeting of the Central Council of Health and Family Welfare. I am sure you will guide the Council to fruitful and successful deliberations.

**INAUGURAL ADDRESS BY MISS SAROJ KHAPARDE, MINISTER OF
STATE FOR HEALTH & FAMILY WELFARE, NEW DELHI**

Member Planning Commission, Prof. Shrivastava, Shri Sam Pitroda, Technology Advisor to Prime Minister, Hon'ble Ministers of States, non-official members of the Central Council, Union Health Secretary, Director General of Health Services, other distinguished participants, friends, we are meeting again after one year to take stock of the progress made and also to chalk out our course for the next year. The meeting of the Council also gives us an invaluable instrument to exchange our views, our experiences and our ideas. I look forward to this occasion also because it gives us an opportunity to discuss and understand better the view points of the State Ministers and the eminent persons in the field of health. I, therefore, personally attach very great importance to the deliberations of the Council. Let me therefore, join Health Secretary, Shri Srinivasan in welcoming you to this meeting of the Council.

You have very heavy agenda before you and there are a number of important issues which would need careful consideration.

We must evaluate, how far we are from providing comprehensive Primary Health Care Services to our population in remotest areas and in areas inhabited by weaker sections such as Scheduled Castes and Tribes. As you know, the creation of Primary Health Care infrastructure in rural areas is of prime importance if we are to achieve the objectives of Health for all by 2000 A.D. Last year I stressed that we have to achieve 100 per cent targets set for the establishment of Sub-Centres and Primary Health Centres by the end of the 7th Five Year Plan period. I reiterate my stand. I pointed out last year that there was serious shortfall in the setting up of these Centres. This year also I find that there have been serious shortfalls. I would request the States and Union Territories whose performance is below targets to make special efforts to set up or operationalise the centres.

I would reiterate by request to the States and Union Territories this year also to give attention to the training and utilization of trained Dais. Though a large number of Dais has been trained in each State, the training has not been taken seriously and no follow up of the Dais has been carried out. It is essential that a strong bond develops between the ANM and the practicing Dais in the villages. The Dais should also be supplied kits immediately after training.

Friends, the strategy of the Seventh Five Year Plan in the health sector was aimed towards the goal of population stabilization coupled with a war on communicable and non-communicable diseases. On the one hand we had to reduce the birth rate and on the other reduce the death rate. You would recollect that birth rate which in 1985 was 32.9 is to be reduced by the end of the Seventh Plan to 29.1 while the death rate

is to be reduced from 11.8 in 1985 to 10.4 in 1990. From the figures now available as per SRS (Sample Registration Scheme) estimates of Registrar General of India, the birth rate has come down in 1987 to 32.0 while the death rate has come down to 11.8 per thousand. This has obvious implication in as much as the growth of population which was to be reduced to 1.9 percent by the end of the Seventh Plan is in fact not likely to be achieved.

One of the reasons perhaps why we have not achieved the desired success in Family Welfare Programme is that we have not been able to make it as broad based as it should be. We have now strengthened or started schemes to make it a really people's movement as our late Prime Minister, Smt. Indira Gandhi, desired it. I quote "Family Planning must become a people's movement—of the people, by the people, for the people—only then can our hopes be realized". Under the centrally sponsored scheme for Voluntary Organizations, the State Governments have now been given enhanced powers to sanction grants up to Rs. 10 lakhs per unit per year. I would urge the States to make greater use of these powers and involve greater number of voluntary organizations.

A very important aspect of our Family Welfare Programme is the Universal immunisation programme for infants and pregnant women. Stressing the importance of the Programme for the health and well being of mothers and infants Prime Minister Shri Rajiv Gandhi has said and I quote "By covering expectant mothers and Infants against six dreaded diseases, the Universal Immunisation Programme aims to protect millions of our people from death and disability and the wasteful effects of illness and poor growth. I appeal to all to support this challenging venture so that our children can have a better and brighter future". A review of the programme shows that the achievements in terms of proportional target for the period April—December 1988 in DPT and BCG were over 100 per cent, in OPV 97 per cent, Measles 80 per cent and TT 71 per cent. This programme will be extended to the whole country next year. There is need to monitor this programme closely. Further efforts on measles and TT are also required. We have also to guard against failure of cold chain.

We must emphasize the preventive and promotive aspects which are in the long run more cost-effective and relevant. Two issues come to my mind in this context. The first relates to health education which needs far greater attention in terms both of content and coverage and the other is community action which requires that health planning must be decentralized additional resources must be made available to the community to generate programmes which meet its felt needs and proper referral system should be developed with its first point of contact within the community itself.

Another area in my view where additional attention is required is that of medical manpower. Though the training of doctors is very important, we must take up a large programme for training of nurses, Para-medics and technical laboratory staff.

We have the Indigenous Systems of Medicine as one of our agenda items. Sometimes I feel that discussion on this item is more a ritual than an attempt at proper appreciation of its role and usefulness for promoting health. As policy makers

and as health professionals we speak of the role of indigenous medicine less from conviction than from a sense of duty. But to do so is to deny the hard facts, namely, the faith of our people in such systems, the large scale availability of health personnel practicing indigenous medicine and the cost-effectiveness of these systems. Many other countries, particularly developing countries, have made successful assays into integrating the indigenous systems effectively in their health infrastructure. It is my earnest appeal that the role of these systems of medicine should be viewed from an unbiased and practical stand point. We should also devote more effort to ensure advancement of such systems for instance by promoting collaborative research between ISM, Homoeopathy and the modern medicine for tackling major health problems.

The first point of contact with the masses is the community health worker and the traditional practitioners. They, in fact, together meet most of the medical and health care needs of the people. If we are able to improve the skills of these categories and provide adequate supplies to them, I am confident that they will be able to meet most of the health needs of our people, particularly those living in the rural areas.

In the context of additional resources for health, we must also take a close look at the way our limited resources are utilized at present. Where money is short we must priorities and not spread our resources so thinly as to be of little or no use.

The resurgence of Malaria in the sixties and the emergence of AIDS during the eighties show that there are no short cuts to the solution of health problems. The phenomena of drug resistance and vector resistance are only indicative of the challenges that we face in the struggle for providing and preserving the health of our people. AIDS has today raised strong signals that unless we improve and set right our blood transfusion services to acceptable international levels, there will be no security. We have taken steps in this direction. But there is need to develop and support an infrastructure which would adequately monitor, evaluate and react to all possible contingencies. This would require dedication, determination and ingenuity. Ladies and gentlemen, your endeavors will in no small way provide the requisite impetus define ways, and help in evolving the strategy that is the need of the hour.

I wish you all success in your endeavors.

ADDRESS BY PROF. P. N. SRIVASTAVA, MEMBER PLANNING COMMISSION

Since the attainment of independence, quite a bit of progress has been achieved in strengthening the health services of the country which has resulted in the promotion of health status of our people. Smallpox has been eradicated; infant mortality has declined from 147 per thousand live births to 90 today. The death rate has declined from 27.4 to 10.8 per thousand populations. The life expectancy at birth has increased from 32.7 years to 57 years today. However, we cannot afford to be complacent since a lot has to be done. Steps will have to be taken to ensure a fuller utilization of the huge infrastructure in the shape of sub centres, primary health centres and community health centres which have been created in the country. Necessary inputs and staff will have to be provided specially at grass root levels to optimize the quality of services from these institutions. It is rather sad that most of the States have invariably reduced their MNP budget in the health sector and it is sadder still that even after that the budget remains under utilized. That unfortunately reflects our commitment to the programme. Effectiveness and efficacy of health services will always remain limited if they are not integrated with other health related services such as nutrition, safe drinking water, education, Information and communication.

The main weakness of the health and family welfare services has been the lack of active community participation of non-governmental agencies and voluntary organisations which play a vital role in the health education and in the successful implementation of the national health programme.

Communicable diseases continue to be the major cause for morbidity in India. National Programme for their control, containment and eradication has already been launched but they suffer from a variety of management issues. A critical review of the ongoing national programmes is extremely necessary to ensure their effectiveness particularly for the control of diarrhoeal diseases. Acute respiratory infection continues to be a major child killer in India. AIDS is an emerging and serious threat to Indian health. Till 31st October 1988, 166—566 persons had been screened out of which 532 sero-positive individuals have been detected. I am told this number has increased further. It will take some time before some of these sero-positive cases may be blown up fully. Kala-azar and Japanese encephalitis have in the recent past threatened the health of poor people in some parts of our country. Non-communicable diseases, particularly cancer, cardiovascular diseases, diabetes hyper-tension and mental disorder are emerging as new formidable threat to the health and well being of the people. The average age at which a person gets cancer in Western Europe and U.S.A. is 57 years while it is 47 years in Asia and 37 in Africa.

Health programmes in India suffer the most because of lack of support and supervision and poor management. It must be ensured that all categories of health personnel are given appropriate public health management training and network of State regional public health institutions should be established. The training of health personnel as public health managers must receive high priority.

There are a large number of practitioners of Indian system of medicine and homoeopathy in our country. This vast resource is yet to be effectively mobilized in strengthening the national health programmes. Mechanism to integrate the system into the overall health care system needs to be evolved at an early date.

Reorientation of medical education to make the training and education, problem centered and community based needs will have to be looked by giving greater attention. Health manpower planning has been a neglected area with the result that there is no proper linkage between the various manpower requirements. This has resulted into distortions which have affected the planning, education and management of health professionals. A document "Health Manpower Planning Production and Management" is already in hand and its implementation should be ensured at the earliest.

One of the most crucial problems facing the nation today is the high growth rate of population. I had specially brought this to your attention last year and will like to repeat it again. The population of India was 340 million at the time of independence: the 1981 census gave a figure of 685 million and within the last eight years we have crossed 800 million. We are increasing by about 17 million every year. Most of our problems are because of this huge population. India was the first country in the world to launch a national family planning programme in 1951 but somehow we have not implemented it with all seriousness. The Seventh Plan document had assumed a growth rate of 2.1 per cent during 1981—86 and 1.9 per cent during 1986—91. But the actual growth rate of the population, (based upon SRS estimates) during 1987 period has been 2.14 per cent per annum. With the present trend the actual population size will turn out to be much higher than envisaged if it is not looked into with all the seriousness that it deserves. We shall very soon have to find funds to provide schools for 15 million children and jobs to 4 million persons. Population control programme will have to be a multi-sectoral programme. Though sterilization should continue to be an important means of couple protection, spacing methods like IUD, CC and oral pills should also assume the role of most important means of couple protection. There is a need for greater decentralization both in planning and implementation which can be achieved only by involving the State Governments, local authorities and voluntary agencies more effectively in the programme. The weak performing districts areas in the country should be identified and integrated population control measures including family planning, "MCH, nutrition, ICDS, female education, female employment and income generating programmes in a comprehensive manner should be launched at the earliest. All out efforts should be made to ensure full utilization of huge infrastructure created by provision of all complementary inputs and trained staff required. New initiatives must be taken to improve the quality of services.

At present about 60 to 70 per cent of the total plan outlay under Family Welfare programmes is used for meeting expenditure on committed liabilities leaving very little plan funds for development purposes. It should be examined whether the expenditure on committed liabilities can be transferred to non-plan expenditure of the States. The present modified Gadgil Formula for the release of Central assistance to States may be further amended to provide 10 per cent of the total

Central assistance to the States on the basis of performance of comprehensive population control measures.

The existing package of incentives awards in the programme should be rationalized and introduction of community based incentives awards against individual case incentives may be examined. Incentives awards may be considered not only on the basis of performance in family planning programme alone but on the basis of performance of other health and development activities relevant to fertility decline: like MCH performance, immunization, female literacy and nutrition etc.

I will not hesitate to say that we must consider subtle disincentives also like limiting maternity Leave for two children only, priority for allotment of housing sites, loans etc. for couples with two or less number of children within the Government and organized sector. This may be carefully considered to be introduced in a gradual manner.

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RECOMMENDATION NO.1

I. GENERAL

Taking note of the fact that during the last forty years the population of the country has grown from 341 millions in 1947 to over 800 millions as on now;

Realizing that 17 millions are added to the country's population every year and also that the adequate resources to provide adequate food, clothing, shelter and clean water to these increasing millions are just not available;

Further taking note that the comprehensive Family Planning Programme has not succeeded in reducing the population to the desired levels;

Further realizing the fact that this is going to retard the country's efforts to alleviate poverty to making available resources for social transformation and economic growth more so for creating gainful employment in the coming decades;

The Central Council of Health and Family Welfare in its Conference held from 1st to 3rd February, 1989, strongly urges that Family Welfare strategy should focus on bringing down growth rate, to recruit younger people as acceptors of small Family Norm, enhance the effectiveness of child survival and maternal health strategies, and towards this, the aim of programme should be to:—

- i) Focus on States and area where the programme has not gained momentum and adopt area-specific strategies for implementing programmes towards reducing infant mortality, maternal mortality and making family planning services accessible to all.
- (ii) Mobilize political will at all levels in consonance with the conviction that the programme is to continue as a voluntary programme.
- (iii) Redefine the role of incentives and disincentives on area to area basis.
- (iv) Implement mass education and health education programmes effectively.
- (v) Give preference to Family Planning acceptors in all the Government programme and schemes.
- (vi) Evolve a comprehensive strategy and take steps to raise the age of marriage.
- (vii) Family Planning and MCH services should be offered as a part of packages, beginning with ante natal care through to total Family Welfare Service?.
- (viii) Emphasize female- literacy on time bound frame basis.
- (ix) Take all the necessary steps to counter the deep-rooted beliefs supporting son preference.
- (x) Take effective steps to utilize and operationalise Indian Systems of Medicine and Homoeopathy practitioners spread across the country.
- (xi) Improve quality of services.
- (xii) Improve monitoring and evaluation of the programme.
- (xiii) Take steps to improve the management of the programme
- (xiv) Generate a climate of stronger motivations by involving the local bodies,

panchayats and village health guides and other community leader, and workers.

- (xv) Strengthen Para-medics with necessary skills through continuous training in service.
- (xvi) Immediate steps are taken to locate male multipurpose workers in the sub-centres to make these units functional.

The demographic goal be aimed to be achieved by a mix of "before and beyond contraception" strategies, alongside a gearing up of the contraception promotion and delivery system. In the revised perspective, equal weight age be given to the task of ensuring that at least the minimum age of marriage requirements are met, while promoting still later ages for marriage. Further, composite social development targets on an areas specific basis will be required to be pursued, so that complementarities of efforts creates the climate and circumstances within which later marriage and a smaller family arc viable and can be vigorously propagated.

II. RECOMMENDATIONS OBSERVATIONS OF THE PUBLIC ACCOUNTS COMMITTEE IN 139TH REPORT ON F.W. PROGRAMME:

The Council has gone through with interest the observations recommendations of the Public Accounts Committee and agrees with all of them. Though F.W? Programme has achieved a state of relative maturity yet large number of operational problems exist which have limited the effectiveness of entire programme. This includes inadequate supervision of field workers, resistance to Family Planning among sub groups of population, ineffective information system and inadequate demand of Family Planning. The Council, therefore, are of the opinion that the Family Welfare Programme must be geared up so as to achieve the net reproduction rate of unity by the end of century. The following suggestions be considered by the Centre and the States in this regard-

1. Target setting in terms of couple protection rate for different age groups (15—29) etc.
2. Possibility of introducing compulsory registration of marriage.
3. The social perception to have male children is still a predominating factor in the society and is retarding the growth of Family Planning.
4. Adequate resources be provided for the Family Welfare Programme and as recommended by the Public Accounts Committee the allocation for this programme should be need based and not resource based.
5. Communication strategy has to be adequately re-shaped giving stress en interpersonal media; training of peripheral worker broadening the role of Ministry of Information and Broadcasting appropriately providing adequate time for F.W. Pogramme on Radio and Television, timely production and distribution of films on F.W. by the Film? Division and also undertaking a study on cost benefit ratio of the medium of the film as against other mass media channels etc.
6. The required health infrastructure must be made available by the end of the 7th Plan.
7. In order to make infrastructure really operational, adequate training

facilities and placement of medical and Para-medical staff up to the sub-centre level should be made.

8. Though larger involvement of voluntary organizations have also been sought during 7th Five Year Plan, but it is a fact that the total delivery of Family Welfare services (i.e. including MCH also) has not been made available by these organizations to the population. The voluntary organizations should therefore, also undertake complete Family Welfare activities on a continuing basis preferably in unserved and under-served areas.
9. Financial power; should be delegated to doctors at PHC level so as to enable them to discharge their responsibilities of management effectively.
10. The weak spots in the programme management should be identified from every possible angle so as to ensure immediate effective remedial measures and suitable strategies to suit inter-State and inter-regional diversities should be adopted.

III. VOLUNTARY ORGANISATIONS

The Council strongly emphasizes that the role of voluntary organizations is a vital element in making family Planning a peoples movement. It also notes that schemes under the 'approved patterns' can be sanctioned by the State Governments- up to Rs.10.00 lakhs per annum. It however, states that delays in release of grants still occur, and that this should be remedied as quickly as possible so as not to hamper the continuity of the work and cause hardship.

While some voluntary organizations have played a highly commendable role in promoting the family planning programme so far, there is now an urgent need to expand their numbers, scope out-reach and effectiveness so that they can become a strong force in bringing about the universalisation of the practice of family planning and a reduction in the rate of population growth.

Voluntary or non-governmental organizations are of many types and cover a wide gamut of developmental and economic activities such as in health, education, welfare, women's status, rural work, the organized sector, etc. Each of these sectors have their own special focus, but must be persuaded to undertake some or all aspects of the family planning programme, which in itself is broad-based, involving social change medical technology and human resources development. Government grants and technical assistance to such organizations for their major activities should also take into account how far they can provide an input into promoting family planning.

The mobilization of non-governmental organizations can best be done by established voluntary organizations themselves, which have a good track record in the appropriate fields.

Government on its part can assist such organizations with funds to undertake such mobilization which they can disburse under suitable criteria, with accountability and monitoring as, for example, where the Family Planning Association of India

has been given a Rolling fund to do so.

This would help in the creation of a network of NGOs assisting in the Family Planning Programme including its allied measures which are generally grouped under the phrase "Beyond Family Planning".

IV. FUNDING OF FAMILY WELFARE PROGRAMME

On transfer of some plan expenditure on Family Welfare Programme on to the Non-Plan side, the existing pattern of 100 per cent funding by Government of India should continue by a combination of non plan and plan flow. The Council takes note of the fact that the bulk of 100 per cent Centrally funded Sponsored Scheme funds on F.W. indeed go towards maintenance e.g. sub-centres, vehicles, staff etc. Therefore the CCH had consistently taken the view that the present 100 per cent Central Assistance should continue. But logically, there should be a normal distribution between non plan and plan so that new central outlays do not go on shrinking on account of increased maintenance liabilities especially on pay revision. Therefore, CCH considered the possibility of introducing a non plan concept in FW Programme from 8th Plan. Incidentally, we have 9th Finance Commission award for the same period as 8th Plan. In view of the over-riding importance of FW for all development, the CCH suggest a suitable recommendation in this respect should be placed before the National Development Council.

V. STRATEGY FOR TRIBAL AND HILLY AREAS

The Council resolves that in tribal and hilly areas, family welfare programme should not be implemented mechanically. It is considered essential that due attention be given to strengthening of general health care and MCH services including Immunization and improvement of nutritional status. Also, it is considered necessary to reduce the area of coverage per worker in these areas with a view to providing quality services. Qualification for the recruitment of workers be lowered to ensure that local persons set involved in the health delivery system of the tribal areas.

VI. STRENGTHENING THE SUPPORT TO FAMILY WELFARE PROGRAMME

It be resolved that con of medicines and dressings be raised under the sterilization programme Further that Government of India should make higher provisions for POL as also supply vehicles for new PHCs. Provision for medicines should be increased to Rs.60/- "n respect of the NTP operations. Supply of quality Fallopian rings may be undertaken centrally to the States to ensure that quality rings are used in laparoscopic sterilizations and the programme does not suffer any set-back.

VII. GREEN CARD SCHEME

The Council resolves that the Green Card Scheme should continue and be implemented more effectively. Every State should design state-specific packages of services/facilities to be given to Green Card Holders and develop mechanisms of implementation and monitoring to the extent possible.

VIII. SCHEME OF ISSUE OF SECURITY CERTIFICATES FOR PARENTS OF DAUGHTERS ONLY

Gujarat and a few other States have introduced the scheme for giving financial support Security Certificate to the couples having *daughters only*. These schemes be circulated to the States once again and that Ministry of Health and Family Welfare should take up the matter with the Ministry of Finance for issue of specific Family Welfare bonds.

IX. CONCURRENT EVALUATION SCHEME

Concurrent Evaluation proposal is very welcome. However, if any State has some valid technical reasons concerning the agency undertaking the evaluation in that State, it could take up the matter with Department of Family Welfare, Government of India giving their views for the reconsideration of the choice of agency.

X. ASSESSMENT TEAMS

The concept of constitution of 'Assessment Teams' is welcome and it be recommended that such teams should also draw from the expertise available among the officers responsible for implementation of the Family Welfare Programme in States. The officers from one State could go to other States for assessment of the Family Welfare Programme. This should be in addition to the national experts associated with the teams.

XI. MANAGEMENT INFORMATION SYSTEM

Successful and effective implementation of a programme like family welfare requires a sound Management Information System, which may give timely feedback to the Programme Managers so that remedial action may be taken and new inputs required may be introduced in time. Basic records at sub-centres must be maintained. A sound Management Information System is extremely necessary for improving management of Health programmes including Family Planning Programme.

XII. SEX DETERMINATIONS TEST

The Council appreciates that the Government of India is considering to bring out a legislation to regulate Sex Determination Test. States/UTs have been requested to give their opinion on whether States would like to enact their own legislation or would like to have Government of India to make the enactment. States/UTs which

have not yet sent their comments may do so early within a month so that Government of India can take final steps in the matter.

XIII. QUALITY OF SERVICES

Assessing the programme success, use of targets as a means to objective is necessary. However, there is a need to consider monitoring Programme with respect of indicators like measuring birth interval birth order and age of marriage. The programme statistics need to be extended to emphasize a basket of targets and not merely Family Planning method-wise targets. It is felt that micro-level planning relating to the Programme inputs and outputs to the situation existing at grass-root level is extremely useful to the programme but would need a decentralized democratic structure for its effective functioning.

XIV. TRAINING OF VARIOUS FUNCTIONARIES

Appropriate training to various functionaries according to *their jobs* is pre-requisite for improvement of quality of services. Council therefore, recommends that comprehensive training programmes for medical Para-medical and non-medical personnel should be designed. The training programmes should aim at strengthening management at all levels, rationalizing framing infrastructure and making necessary changes in training curricular Training and retraining of functionaries should ensure improvement and updating of their knowledge and skills with 'particular emphasis on counseling communication skills. Training of dais, ANMs and LHVs as also ISM practitioners requires special attention.

XV. STRENGTHENING THE RURAL HEALTH INFRASTRUCTURE

Rural Health Infrastructure requires to be strengthened. To that end the provision for supply of medicines to the sub-centres should be raised from Rs.2000/- to Rs.5000/- and the provision for contingency which is meager now requires to be enhanced.

XVI. FAMILY PLANNING TARGETS FOR 1989-90

The State-wise, method-wise Family Planning targets for 1989-90, circulated under Agenda Note have been noted. The States were, however requested to work out and intimate to Department of Family Welfare feasible targets in consonance with the long term goals fixed for them. The Council resolves that these targets for 1989-90 may be finalized by the Government of India keeping in mind the targets worked out by the States for ensuring achievement of desired couple protection rate by the States.

XVII. SCHEME OF INVOLVEMENT OF PRIVATE MEDICAL PRACTITIONERS IN FAMILY PLANNING PROGRAMME

The Council took note of the findings of the recent evaluation study of the scheme of Involvement of Private Medical Practitioners in the Family Planning Programme. The Council, taking into account all aspects and the utility of the Scheme, recommends that it should be continued with adequate safeguards and appropriate

measures which would make the programme more effective.

XVIII. I.E.C. ACTIVITIES

Reaffirming the endorsement of the revised communication strategy, both by the 12th Joint Conference of Central Council of Health First Conference of CCH&FW, emphasizing a multi-dimensional integrated thrust and, *inter-alia.*, seeking to bring about a shift from.

- Publicity and propaganda to public information, education and motivation.
- A narrow focus on demographic stereotypes and terminal methods to a broader horizon of the family welfare issues embracing the beyond family planning' areas on the one hand and on the other, more detailed, direct information on the range of contraceptive methods.
- paid publicity to a participatory mobilization of other sectors of society as a social responsibility of the concerned sector;

NOTING the initiatives taken at the Centre resulting in improved quality and enhanced output of media materials and programme, but also continuing difficulties and deficiencies in field implementation:

UNDERLINING the fact that further improvements in health and family welfare performance depend equally upon the social and medical structures and, therefore, call for a much greater importance to the role of media, communication and extension work to mobilize community action to achieve the goals of family welfare and Health for All by the year 2000 A.D.

EMPHASISING that communication must be viewed, essentially as the process of empowering people to build their knowledge skills and the ability to act for their own health and family welfare, as also energizing alliances with all sectors of society in support of health and family welfare objectives as a basic task.

THIS COUNCIL CALLS for better integrated health and family programme activities to be planned and implemented in a professional manner to achieve national goals. These will rest on a comprehensive health education programme pursued within the community, of which family welfare is a fundamental, integral and central part. Intra-sector coordination is a key requirement.

For this purpose, the Council resolves that within the health sector—

1. The State MEM Whig. IEC Cells created under Area Projects and State Health Education Bureaux should be integrated amalgamated and the integrated set-up further strengthened to work on the communication and training aspect. The combined structure could enable better integrated planning and implementation of health education and family welfare communication activities and result in optimum utilization of man-power and material resources, minimizing wastage and duplication.
2. The status of the integrated Health Education and MEM set-up be raised to an appropriate level so that the organization is able to function effectively and

meaningfully within the State Health Department, and also other Departments and semi-non-government agencies.

3. The Head be a communication health education specialist and be delegated adequate financial and administrative powers so that the organization has functional autonomy to plan and implement media and extension programmes in a more professional manner. Similar delegation of authority needs to be given to the District Extension and Media Officers so that there is effective supervisory control from the State level down to the block level. This is necessary for planning, implementation and monitoring of media and extension programmes and activities. The extension education personnel should be given a proper role in the supervision and training of grass root powers.
4. Diversion of media resources for non-media purposes be stopped, the media staff, particularly Block Extension Educator and District Media Officers should not be assigned non-media work and AV vans should not be diverted for non-media activities.
5. A crash programme of orientation training be taken up to upgrade the communication and counseling skills of media and extension staff and to provide orientation to those performing medical managerial functions to appreciate the critical role of communication, as also to provide adequate support to communication programmes activities. The updating of these skills cannot be a one-time effort but a continuing process.
6. The budgets of all health programmes should be pooled together. In all health programmes, funds to the tune of 5—10 percent of their budgets should be set aside for Health Education which is considered necessary for the successful implementation of these programmes. The Ministry of Health and Family Welfare and the State Governments need to take immediate action on the above point and report the progress in the next Standing Committee meeting and the next meeting of the Council.
7. Furthermore, the Family Welfare Programme having been accepted as a multi-sectoral national responsibility, the communication capability for its promotion has to become wide-based and integrated as intrinsic charge on all allied social development sectors. In particular, the government owned mass media channels have a critical role to play. A minimum and adequate percentage of time must be allocated on government mass-media channels linked to the most popular programmes and prime time, for the propagation of health and family welfare messages. The mass-media channels must develop and utilize local specific materials and programmes. Greater, use of folk and traditional media must be made, as also local language papers. A wide and extensive display of family welfare and health messages must also be undertaken through the voluntary and free contribution of space opportunity by all agencies and public contact channels available with the State and local governments.

RECOMMENDATION NO. 2

MCH & IMMUNISATION, PRIMARY HEALTH CARE INCLUDING MINIMUM NEEDS PROGRAMME AND SCHOOL HEALTH SERVICES

The Council deliberated the issues relating to Primary Health Care including Minimum Needs Programme, MCH and Immunization and resolved that the task of improving the quality of life of the people of this country and the goal of reaching Health for All by 2000 AD requires strong political and community support in favour of the philosophy of Primary Health Care; as conceived in the plan Document of the Government. In order to achieve the widest political and community support for the concept of primary health care, the Council strongly recommends, that the Government should try to reach all opinion leaders and elected representatives with a document explaining the philosophy and concept of primary health care and how this approach will bring the benefits of a richer life to the people. The concept that 'Primary Health Care is good politics' has to be introduced through simple illustrative examples to the grass root leadership throughout the country.

The Council reviewed the progress of implementation of the resolutions adopted in the first meeting of the Central Council of Health and Family Welfare held in February, 1988 and look note of the progress made in respect of Universal Immunization Programme. The Council expressed satisfaction over the improvement in the implementation of the programme in the field as witnessed in the last two years. Further, the Council stressed the need for maintaining a high level of coverage both for pregnant women and infants and for ensuring the highest quality of service delivery to the population. The Council urged the Central Government to ensure maximum support for streamlining the immunisation programme in urban areas, particularly slums and poor colonies where the normal primary health care infrastructure is still not available in adequate measure.

The States with large urban population concentration must prepare an operational plan by March 1989 for achieving the objective of Universal immunisation in urban areas.

High quality of services is essential to achieve and sustain high immunisation coverage levels. Field monitoring should be strengthened and vaccination coverage evaluation surveys conducted periodically.

In view of the low coverage in certain areas, the Council recommends that the support of private practitioners should be taken and the required vaccine and other consumables should be made available to them for providing free immunisation to identified population. Government institutions of the ISM and Homoeopathy should also be associated and involved in the implementation of immunisation and MCH Programmes.

The Council approved the proposal for introducing the system of a beneficiary card as a first step towards establishing complete family health retained. The Council urges that a system of family health record should be introduced and the card should be retained in the family. The Council urges the Center Health Ministry to provide support for proto-type development.

The Council noted with concern the instances brought up by some States of poor availability of electricity in rural areas which disrupts the cold chains. The Council urges the State Governments to arrange with State Electricity departments for regular and uninterrupted availability of power to Primary Health Centers.

With enhanced coverage being reached in Urge areas, there is need for strengthening of surveillance systems to confirm low or zero incidence of the vaccine preventable diseases, especially of poliomyelitis and neo-natal tetanus. Authentic disease surveillance data is required to refine strategies of operation and to identify reasons for less than expected impact on disease incidence so that follow up measures are prompt and swift to achieve the goal of the control of vaccine preventable diseases.

The Council expressed satisfaction at the pace of progress in respect of establishing new primary health centres and sub-centres in the States. It reiterated the commitment of all States to achieve the expected target for 7th Plan by establishing the required number of units and making them fully operational with manpower, equipment and medicine supplies in the final year of the 7th Plan.

The Council noted with concern the shortage of male health workers at sub-centre level in some States and strongly urged the concerned State Government to make arrangements for fully training and positioning the required manpower according to agreed norms of the Minimum Needs Programme, particularly as the team of male worker and female worker at the sub-centre is basic to the concept of services and health education to every household in rural areas.

The Council reviewed the status of Village Health Guide Scheme and recommended that the Central Government should make arrangements for early payment of honorarium including the arrear payments to all existing village health guides till the end of the 7th Plan. The role and functions of the Village Health Guides as also the question of the Scheme's continuation may be re-examined by the States and a decision taken by them regarding its continuation in the 8th Plan and beyond. The Council is of the view that the Village Health Guide is an effective link between the community and the health system and provides useful channel of inter-action and communication. The spirit of community participation inherent in the scheme of Village Health Guides needs to be nurtured and promoted in order to make Health for all a people's programme.

The utility of giving medicines to Village Health Guides was considered doubtful and it was felt that the objective of health education, promotion of positive health practices and environmental health will be Served more effectively if the Village Health Guide s provided continuous support through education and training supply of medicine kits to Village Health Guides is not favored by the Council.

The Council also resolves that in view of the goal for achieving Health for All by 2000 AD, more resources and skill should be added to the primary health system using the doctor as the focus for public health programmes.

The Council urges that there should be one Medical Officer at every primary health centre at the earliest giving priority to tribal, remote and other difficult areas. Only after the goal of one Medical Officer at every primary health centre is achieved, should the States add a second medical officer to encourage outreach services.

The example of Maharashtra State was noted with appreciation where a pre-placement training programme for PHC medical officers is being implemented. The State also has an arrangement where every district level officer undergoes a programme of formal training in public health community medicine in this regard.

The Council recommends:—

- (a) Schools of public health should be opened in different parts of the country in a phased manner with Central Government support to provide opportunity for all Medical Officers in the system getting public health training after serving for some time in rural institutions.
- (b) Public health community medicine skill should be emphasized and facilities for the same should be strengthened in medical colleges.
- (c) Medical Officers at community health centres, district level and State level should be trained oriented in public health community medicine.
- (d) The public health work of Medical Officers should be recognized by earmarking certain identified posts at higher levels for public health trained staff and by making suitable provision for recording the public health activities achievements of every Medical Officer in his annual assessment.
- (e) Continuing education for medical and paramedical personnel may be encouraged through supply of self-instructional material and professional journals to peripheral institutions. Continuing education of para-medical staff must receive adequate attention. Primary Health care implies empowering communities to be self-reliant in health. To achieve this goal, the Council recommends that the health education programmes be supported at all levels in training research production of media to provide information and skills to the communities.
- (e) ICDS and similar other departmental out-reaches in the periphery wherever available should be involved in MCH care particularly in Health and F.P. Education and delivery of services.

Realizing the importance of Health Education for Community involvement in Primary Health Care activities, the Council urges the State Governments to support and strengthen the State Health Education Bureaux for conducting Training, research, production of communication material and promotion of coordination with other related sectors.

To ensure coordinated, efficient and planned development in the health and related sectors, the Council urges the States to set up a mechanism to draw up district and block level action plans for priority activities including school health and National Health programmes. This approach will materially contribute towards achievement of the goal of Health for All.

The Council recommends that special attention *be* given to the training of Traditional Birth Attendants who are responsible for conducting 80 per cent of deliveries in the rural areas. A strong bond of mutual support between the trained birth attendant and ANM will improve the delivery of MCH services. The system of cash payment to T.B.As for registration of births may be reviewed and the amount may be enhanced suitably and the disbursement procedure simplified.

The Council resolved that the system of supplying sub-centre equipment kit provided in the past through UNICEF assistance should be resumed giving priority to the districts with high IMR and MMR. State may ensure that full complement of staff in position in these identified districts without delay. A special scheme for monitoring the implementation of the activity may be considered.

The Council reviewed the system of providing drugs for sub-centres and recommended that the Central assistance may be continued but in the form of cash support rather than drug supply.

School Health Services

Considering the immense importance of this programme, it is recommended that health education component of the school health services program should be intensified by providing adequate training to the teachers and mobilizing community participation through Parent Teacher Associations PTA Mahila Mandals and similar organizations. Beside active involvement of the students in health education activities also needs to be geared up. Following thrust areas therefore, need immediate attention —

- a. States/UTs should continue State Sector school Health services programmes.
- b. State District level coordination committees should be established for seeking inter-sectoral coordination.
- c. Community participation should be sought through Parent Teacher Associations.

Maternal and Child Health Services

The Council appreciated the thrust given to Maternal and Child Health Services and reiterated that activities which have the mother and child as the focus, should be implemented vigorously. The District Public Health Nurse available under Family Welfare Programme in each district should be made more effective by giving her

suitable support and status.

Oral Rehydration Therapy

As diarrhoea is one of the important cause of child mortality, efforts should be made to expand the ORT programme to cover all sections of people, especially children below 5years. Community education along with appropriate communication strategy should be intensified as part of PHC.

Acute Respiratory Infections (including Rheumatic Heart Disease)

All acute respiratory infection is an important cause of morbidity and mortality among the infants the Council urged the State Governments to take up suitable programme for training of health staff for early identification and treatment of acute respiratory infection.

RECOMMENDATION NO. 3

CONTROL OF COMMUNICABLE DISEASES

National Malaria Eradication Programme

The present strategy for control of malaria was INMALUTED in pursuance of the recommendations of depth Evaluation Committee in 1974 and also consultative Committee of Experts. The modified n of Operation has been introduced from 1st April 11. The strategy consists of two components, viz. interruption of transmission by residual in sectional spraying in areas where two or more malaria cases are reported per 1000 population in a year reduction of reservoir of human infection by cases selection and treatment through surveillance mechanists

The number of malaria cases declined sharply from 2.7 million in 1981 to 1.8 million-in 1986. Parameter, the malaria incidence has not declined markedly and the number of cases has remained at 6 million per annum. The most disturbing factor been the increasing trend of P. falciparum cases alignment malaria) which accounts for about 30 per it of the total malaria cases.

The major problems in implementation of the exciting strategy have been (i) Inadequate coverage of saying operation in terms of time and space in nation to the targets, (ii) Incomplete surveillance I in certain areas total absence of surveillance because of shortage of peripheral health workers. (iii) Reluctance on the part of the community in cooperating with the staff for spray operations.

The 2nd Conference of CCH & FW recommends f the following actions may be taken during the year 1989-90:

The present criteria of API 2 and above for coverage by spray operations may continue but high priority should be given to (ii) hardcore areas especially falciparum areas: (ii) developmental protect areas ere deaths have occurred : (iii) areas with epidemic potential; and (iv) tribal and hilly areas where malaria is persistent.

In these areas the State Governments should in-satisfy the surveillance activities by filling up the posts of peripheral workers.

(b) Integrated Vector Control

It was noted that the Malaria Research Centre RQ under ICMR has conducted field trials for production of the Integrated Vector Control approach (i) Nadiad Taluka of Kheda district in Gujarat: (ii) Shahrahanpur. Haldwani, Haridwar and tankargarh (U.P.): (iii) Berhampur (Orissa): (iv) Madras City (Tamil Nadu) (v) Mandla (M.P) (vi) lapur (Assan) and (vii) Delhi.

In the Integrated Vector Control projects, domestic source reduction methods are

implemented by health education. Peri-domestic source reduction is done by environmental engineering such as preventing water stagnation by earth tilling, introducing herbivorous fish in the tanks and ponds and social forestry. Efforts are made to undertake source reduction methods with local community participation by creating income generating assets such as establishing village wood lots and fish farming in village ponds and tanks.

The Central Council of Health and Family Welfare recommends that the integrated Vector Control approach may be implemented in the first phase in one district each in the States of Gujarat, Madhya Pradesh, Uttar Pradesh, Bihar & Orissa.

During 1989-90 and necessary steps in this regard may be taken by the State Governments in consultation with the Malaria Research Centre (I.C.M.R.) and the Directorate of N.M.E.P.

(c) Developmental Projects:

The CCH & FW notes that developmental projects such as construction of dams, irrigation channels and areas having concentration of migrant labour are contributing towards mosquitogenic conditions. It is recommended that the State Governments should have a high level inter-departmental Committee to screen proposals involving major irrigation and development projects and ensure that the project authorities incorporate anti-malaria components in the project during the planning, construction and in the maintenance stage. The engineers should be trained in anti-malaria operations.

(d) Urban Malaria Scheme:

CCH & FW that malaria is on the increase in urban and semi-urban areas due to construction activities and improper water management and faulty sewage system. The conference recommends that stringent bye-laws be introduced and implemented in all the cities towns to provide safeguards against open storage of water and rectification of drainage system in problem areas.

- (e) The CCH & FW reiterates the earlier procedure of independent appraisal of National Malaria Eradication Program re activities in different States to be revived in order to have the up-to-date situation analysis and to Facilitate taking up timely corrective measures.
- (f) Having noted the importance of Inter-state Border meetings in planning and synchronization of anti-malaria activities especially with reference to use of similar type of insecticides with time scheduling and with inter-state cross reporting of cases for timely remedial measures including movement of labour to project sites, the Council recommends that the concerned Regional Directors will organize Interstate meetings. These meetings will be held in the inter-state border districts and the State, zonal, district level malaria officer's will participate. Two meetings will be organized, every year one before transmission and second after spray operations. Where, necessary international cooperation should be obtained.
- (g) The Council notes with concern the low acceptance of insecticidal spray in problem areas by the community due to nuisance of bed-bugs and other household pests and

the Council recommends that adequate supply of Lfazinon be made to be mixed with D.D.T. or B.H.C. to make spray more acceptable. The Council reiterates that the health education activity needs to be intensified so as to create awareness in the community on the benefits of spray operations and also involving the people and local bodies actively in- the spray operations.

- (h) The Council recognizes the importance of case defection mechanism through active and passive agencies to reduce the infection load in the community and hence recommends that active surveillance through fortnightly house visits by the peripheral health workers and wall stencils as evidence of the visits should be rigidly enforced by the States. The Council also stresses that the passive surveillance including the establishment of malaria clinics in all medical institutions should be strengthened by providing microscopes, drugs and training of at least one person in each of these institutions in malaria microscopy, wherever Laboratory Technicians are not available.
- (i) The Council notes with concern that lack of mobility is affecting the supervision and spray operations under the Programme. The Council recommends that as per the present policy, the State Government should take action to replace old unserviceable vehicles during .1989-90. However, during the 8th Plan, the replacement of old unserviceable vehicles in a phased manner may be financed out of Government of India's .50 per cent share in consultation with the State Governments.
- (j) The Council notes that the contingency amount provided at the rate of Rs.1 lakh for district with population 7.5 lakhs and above and difficult and hilly terrain districts with population less than 7.5 lakhs and Rs.0.75 lakhs for districts with population below 7.5 lakh was fixed in 1976 and since then the cost of petroleum products, rents etc. have increased manifold, the Council recommends that the Government of India should increase the ceiling of contingency amount from Rs.1.00 lakh to Rs.2.50 lakh and from Rs.0.75 lakh to Rs.1.50 lakh to meet the expenditure on the following components:—
 - i. Cost of freight of insecticides drugs and other material.
 - ii. Rents stationery etc.
 - iii. POL. maintenance of vehicles etc.
 - iv. Maintenance of spray equipment and laboratory equipment etc.

III. KALA-AZAR

The CCH & FW notes that two States, viz. Bihar and West Bengal are facing the problem of Kala-azar and that there was an outbreak of Kala-azar in Bihar in 1988. The Committee recommends that the revised action, plan prepared by the Directorate of NMEP in consultation with these States must be implemented from 1989-90. The action plan provides for (i) sentinel surveillance system; (ii) early case detection and prompt treatment; and (iii) intensive vector control methods in areas having high disease endemicity. The special Action Plan for Kala-azar Control may be implemented by the Directorate of NMEP and the governments of Bihar and West Bengal within the outlay provided under the malaria control programme.

IV. JAPANESE ENCEPHALITIS

The CCH & FW expressed concern about the Japanese Encephalitis out break in U.P. during 3 988 and noted that during the last three years, eight States had regularly reported JE cases. The CCH~& FW recommends that action may be taken in is endemic districts reporting cases every year on the following lines:

- (i) *Control measures:* For control of JE, vector control is considered to be the most important measure. Insecticide! spraying (BHC spraying in cattle-sheds and pignites) should be taken up before the expected outbreaks in the States of Assam, Manipur, West Bengal, U.P., Bihar, Andhra Pradesh, Tamil Nadu and Karnataka in areas where the cases are being regularly reported every year. During epidemic, malathion fogging must be undertaken in addition to focal spraying. The State Governments must procure adequate fogging machines for use in the endemic areas. The Para-medical personnel and doctors in the endemic districts of JE must be trained for early case detection and management by National Institute of Communicable Diseases, National Institute of Virology, Pune; School of Tropical Medicine, Calcutta and Centre for Research in Medical Entomology, Madurai (ICMR) and Medical Colleges in JEP endemic districts.
- (ii) *Preventive measures:* Education of Opinion leaders in the endemic areas through health functionaries and voluntary organizations should be organized. The Council noted that field trials with indigenous vaccine are being conducted in the States of Andhra Pradesh, West Bengal Assam and Uttar Pradesh. Serological studies may be carried out in JE endemic areas to determine the sections of the population to be vaccinated keeping in view the availability of vaccine in the country. These studies may be coordinated by N.I.C.D., Delhi.
- (iji) *Curative measures:* The State Governments must ensure that adequate stock of drugs for symptomatic treatment is available in the PHCs Community Health Centres and Hospitals in the JE endemic districts for management of cases. The existing laboratory facilities in the endemic districts may be strengthened in all these institutions for proper diagnosis.

The medical colleges and hospitals in the JE endemic districts may be strengthened to undertake the management and rehabilitation of recovered patients with residual effects. The medical college may also serve as a focal point for providing training to doctors and Para-medical workers in early case detection and management of JE

cases.

II, FILARIASIS

The Council notes that under the Filaria Control Programme, 203 Filaria Control units have been established for anti-larval operations and 186 clinics have been established for detection and treatment of micro-filaria carriers. The CCH recommends that the Filaria Control units should take up preventive and control measures against all the major vector borne diseases prevalent in that area. The Council notes that Filaria is also prevalent in rural areas in some endemic areas and recommends that drugs be made available for distribution to filaria patients through the Primary Health Care System.

RECOMMENDATION NO.4

NATIONAL LEPROSY ERADICATION PROGRAMME

The Central Council expressed satisfaction on the progress of implementation of the National Leprosy Eradication Programme and recommend the following Action to be taken *to* achieve the goal of eradicating the diseases by the year 2000 A.D.:—

1. *Infrastructure*

Infrastructure under the National Leprosy Eradication Programme must be developed in the remaining 98 high endemic districts which have been identified so far being covered under multi-drug therapy by the year 1992.

2. *Lepers Act*

The Lepers Act, 1898 should be repealed by all the remaining States which have not yet repealed the same.

3. *Creation of public awareness*

For successful implementation of the programme and removal of social stigma attached to leprosy, it is essential that activities in this area be intensified with emphasis on:

- a) Development and distribution of suitable education material in regional languages.
- b) Utilize Mass Media for public education,
- c) Preparation and telecasting broadcasting of TV and Radio spots,
- d) Use of leprosy cured patients in Health Education and ensuring community participation, and
- e) Full utilization of local folk media for community education by the States and UTs.

4. *Filling up of vacancies*

The States may make all efforts to fill up the vacant posts sanctioned under the National Leprosy Eradication Programme, particularly in the endemic districts approved for being taken up under MDT.

5. *Training*

Untrained staff posted for leprosy work in the States should be sent to recognize Leprosy Training Centres for training as soon as possible.

6. *Budget and Central assistance*

Adequate funds be provided to cover all the remaining 98 highly endemic districts under the MDT by the year 1992. National Leprosy Eradication Programme is being implemented as a centrally sponsored scheme with 100 per cent Central assistance for the units created during a particular Plan period. About 9 to 10 years are required for complete coverage of a district under MDT in order to bring the case load to a

negligible level. It is essential that Central assistance is made available to the States for this period to avoid a financial burden on the States as is done in the case of projects.

7. *MDT in low endemic districts*

Low endemic districts should also be brought under MDT through integration of services with Primary Health Care staff by giving them suitable orientation training and supplying free anti-leprosy drugs. Similarly a pattern may also be evolved for integration of leprosy services with other primary health care staff in the districts where the maintenance phase of MDT has been completed and the prevalence rate has come down to 1/1000 population. Some supervisory staff could be retained in these districts out of vertical set-up available at the endemic districts for a limited period.

8. *Feed-back on performance by States/UTs.*

Regular reports from the States are essential for monitoring the programme. The States/UTs should send reports on physical targets, objective targets, achievements and expenditure incurred, to the centre regularly. Even if there has been no expenditure or achievement of targets, the same may be reflected in the monthly reports.

9. *Rehabilitation*

Cured leprosy persons need to be rehabilitated. For this purpose, the states may set up and utilize rehabilitation centres where handicapped persons can be trained in suitable vocations, to be economically self-reliant.

RECOMMENDATION NO.5

NATIONAL TB CONTROL PROGRAMME

1. There are still 69 districts in the country where District TB Centres are yet to be established. District TB Centres be set up by the States in those districts where these are yet to be established. The possibility of setting up of additional District TB Centres may also be explored in thickly populated districts having population of more than 2 million.
2. Short Course Chemotherapy has been introduced in 194 districts of the country and more districts will be covered under this regimen. The Council recommends that the districts where the therapy has been extended should be manned by medical and Para-medical personnel trained in National Tuberculosis Institute, Bangalore and should also be equipped with essential equipment and vehicle. A proper mechanism of monitoring and supervision of their activities may be provided to ensure success of this strategy, which has proved to be very effective in the treatment of T.B. patients.
3. The council reiterates that to improve the quality of sputum examinations at the Primary Health Centres, Laboratory Technicians should be provided at all Peripheral Health Institutions and they should invariably be imparted in-service training.
4. The Council also reiterates its earlier recommendation that Multipurpose workers may not be entrusted with the work of sputum collection of the patients in the field. They may motivate the chest symptomatic to get themselves investigated at the nearest medical institution and maintain a list of diagnosed T.B. patients living in their area and also motivate them and their family members for taking regular and uninterrupted treatment for the prescribed period.
5. The Council notes with satisfaction that the detection of new TB cases is satisfactory. As far as sputum examination is concerned, this activity is also picking up. However, efforts should be continued to ensure that the targets laid both for new TB case detection and sputum examinations at Primary Health Centres are achieved.
6. Sufficient quantity of anti-TB drugs material and equipment viz. Glass Slides, staining materials, microscopes in working condition etc. should be made available at all Primary Health Centres. Facilities for distribution of anti-TB drugs from sub-centres where suitable building and essential facilities are available should be made.
7. The council feels that for effective monitoring, supervision and expansion of the programme, a whole-time trained State TB Officer with supporting staff should be provided in each States/UT and such staff should not be transferred frequently.
8. PHC medical officer should be imparted in-service training for his active involvement in the Programme.
9. The Council reiterates its earlier recommendation that the TB Training and

Demonstration Centres/States TB Centres wherever functioning should be strengthened to play an active role in the implementation of the programme.

10. Involvement of voluntary organizations in the programme may be encouraged and augmented.
11. Health education activity should be augmented under States Health Education Bureau and under the School Health Education Scheme.
12. It must be ensured that all children below the age of one year are given the BCG Vaccination as part of Universal Immunization Programme.
13. The Private Practitioners may be oriented on National TB Programme by State Governments by organizing short term workshops and souvenirs.
14. Research on Tuberculosis both institutional and field may be encouraged by medical colleges.
15. Mobile vans fitted with Odelca Cameras are provided to State where prevalence rate is very high.
16. Where the PHC outreach does not perform the ISM institutions, if available, may be mobilized to play a role as a link in the distribution chain.

RECOMMENDATION NO.6

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

1. Eye Care services at block levels need proper monitoring and stepping up. Qualified Ophthalmic Surgeons should be posted at all Community Health Centres. Ophthalmic Assistants should be posted in all upgraded P.H.C. and the equipment fully utilized.
2. Short term orientation course on N.P.C.B. for District Ophthalmic Surgeons and Medical Officers of P.H.C. should be conducted expeditiously.
3. Services of the Qualified Ophthalmic Surgeons on the State Services should be fully utilized. Stress should be laid on the training curriculum and refresher courses to improve the surgical skills of the eye specialists.
4. The State Programme Officers should engage themselves in intensive monitoring of the field units ensure that equipment provided to different units is properly utilized.
5. The reporting of the performance, infrastructural development of the various units' services in the State should be regular, timely and accurate.
6. All the services units sanctioned by the Centre should be deployed for the programme without delay. Necessary equipment repairs and staff should be provided to keep the units functional.
7. The guidelines issued by the Government of India for the safe and scientific conduct of eye camps should be strictly followed.
8. The State level co-ordination committees should meet regularly for better coordination and implementation of the Programme activities within the States.
9. All out efforts should be made to up-grade the infrastructure and resources mobilized to combat blindness due to Cataract. District Mobile Units already sanctioned under the programme should be deployed and properly monitored without any delay by the States and U.T. Administrations.
7. The monitoring of the N.P.C.B. at the Central level should be strengthened and Monitoring and Evaluation Cell should be created.
10. Regional Institutes of Ophthalmology should actively participate as envisaged in the N.P.C.B-Training of Specialists and other manpower development activities and research should be monitored.
11. Health Education on Eye Health Care should be strengthening with active involvement of State Health Education Bureau and mass media.
12. School Eye Health Services should be strengthened utilizing the services of

Paramedical Ophthalmic Assistants posted at Primary Health Centres. The School Teachers should be actively involved in the preliminary screening procedures.

13. Voluntary Organizations should be encouraged to collaborate with the Central and District Mobile Ophthalmic Units and increasingly take up activities of prevention of blindness. Eye Camp organization and setting up of eye banks.
14. Expenditure returns unit-wise be submitted by the States every quarter so that the release of funds are not delayed and do not lapse

RECOMMENDATION NO.7

NATIONAL PROGRAMMES FOR CONTROL OF IODINE DEFICIENCY DISORDERS

The Central Council of Health & F. W. noted that about 40 million people live in Goitre endemic areas in the States of J & K, Himachal Pradesh, Uttar Pradesh, Bihar, West Bengal, Sikkim, Punjab, Haryana and U.T. of Chandigarh. Endemic goitre is also found prevalent in certain districts of Madhya Pradesh, Gujarat and Maharashtra. Recent studies by All India Institute of Medical Sciences indicate that 4-5 per cent of children in goitre endemic areas could be suffering from varying degrees of mental retardation.

The Central Council of Health & V. W. noted that the Government of India has accepted the policy of iodization of entire (edible) salt by 1992 in a phased manner. The progress made in this regard and the programme for iodization of entire edible salt by 1992 is as under:—

Year	Target (in lakh tonnes)
1986-87	7
1987-88	12
1988-89	22
1989-90	30
1990-91	40
1991-92	50

In order to achieve universal iodisation of common salt the Government has taken the following decisions:—

- i. Since production of iodised salt by public sector units alone was found to be insufficient, it was decided that the private sector will be allowed to freely manufacture and market iodised salt.
- ii. It was decided to give subsidy to iodised salt manufacturers and to supply potassium iodide which is required for iodisation free of charge. At present a subsidy for potassium iodide at the rate of Rs. 20 per tonne of iodised salt is being provided by the Government of India through Salt Commission.
- iii. Railways have accorded the highest priority (Category-B) for the transport of iodised salt by rail from production centres to consumer centres. This will enable- quick movement and transport of iodised salt and in those States which have banned the sale of non-iodised salt by issuing a notification under the PFA Act, the railways will not move non-iodised salt.
- iv. The Salt Commissioner is also assisting for getting; financial assistance through the nationalized banks for setting up iodisation plants.

The PFA Act prescribes the specification of edible common salt and provides that the iodine content shall not be less than 30ppm at the manufacturer's level and not less

than 15ppm at the retail level. The State Governments/U.T. Administrations have been requested to issue a notification under PFA Act banning the sale of non-iodised salt. This will ensure the movement of iodised salt under priority by railways, who have formulated a zonal scheme for transportation and supply of salt to the consuming centres. So far 15 States have issued a notification under PFA Act (Annex.—I).

The Central Council of Health & F. W. recommends that:—

1. The States/Union Territories which have not yet issued Notification banning sale of salt other than iodised salt should do so immediately.
2. The States/Union Territories which have not yet set up Goitre Control Cell in their State Health Directorate should establish the same immediately.
3. The public distribution system should be involved in the sale of iodised salt through their retail outlets.
4. In those districts of the States where the prevalence rate of Goitre is more than 30 per cent, the concerned States should introduce surveillance, monitoring and evaluation system. The AIIMS and ICMR should work out the modalities for involving medical colleges as well as districts hospitals in various aspects of surveillance as well as monitoring and evaluation of Goitre Control Programme in the elected highly endemic districts.
5. The monitoring and evaluation Project of AIIMS being carried out in the State of Uttar Pradesh should be replicated to other States by involving State Governments, medical colleges, etc.
6. Monitoring of the quality of iodised salt both at the production level and at the distribution level is strengthened.
7. Use of iodised salt instead of common salt is popularized by using Mass Media like radio, T.V. and newspaper.
8. Health education material is developed to make people aware of harmful effect of taking uniodised salt in minimizing deafmulism mental retardation and stunted physical growth.

ANNEXURE—I

The following States have issued bin Notification under the prevention of Food Adulteration Action covering the centre State Union Territory.

1. Arunachal Pradesh
2. Bihar.
3. Chandigarh.
4. Haryana.
5. Maharashtra (w.e.f.1-4-1989).
6. Manipur.
7. Meghalaya.
8. Mizoram.
9. Nagaland
10. Punjab.
11. Sikkim.
12. Uttar Pradesh
13. Jammu & Kashmir
14. Himachal Pradesh.
15. Tripura.

PARTIAL BAN

- | | |
|-------------------|--------------|
| 1. Madhya Pradesh | 12 districts |
| 2. West Bengal | 10 districts |
| 3. Andhra Pradesh | 1 districts |
| 4. Gujarat | 2 districts |
| 5. Maharashtra | 7 districts |

RECOMMENDATION NO.8

AIDS—SURVEILLANCE AND CONTROL PROGRAMME

The central council of Health and Family Welfare notes with concern the increasing prevalence of infection as revealed in surveillance studies conducted by I.C.M.R. It is necessary to strengthen control measures to prevent the spread of infection. Up to 31-1-1989, out of about 2 lakh persons belonging to high risk category, viz., prostitutes, STD patients, foreign students and blood donors screened in the surveillance centers 763 were found positive for AIDS infection. All persons found to be infected may not be diseased but transmission to another possible in three ways, viz. (i) Sexual contact, (ii) Transfusion of blood, and (iii) from mother to be during pregnancy and child health

RESOLUTIONS

The Council hereby resolves that a 100 per cent central scheme should ensure the following:—

- (a) *Complete safety of blood transfusion services.*—In spite of serious practical problems, Government of India should lay down statutory requirements under Drugs and cosmetics Act to strictly ensure that only HIV free blood is used in all cases of transfusion fractionation. Since it will take sometime for sufficient testing facilities to be established throughout the country, the programme for provision of facilities may be taken up on a phased manner. In the first phase, the provisions regarding blood testing must be enforced by setting up of blood testing facilities at government cost in cities with a population of 1 million or more. Facilities for testing blood must be established by all firms manufacturing blood Products at their cost. Manufacturing units must be required to establish HIV testing facilities at their own cost by a specified date, pending which they should use only blood certified HIV free in approved red government testing centres. In the second phase, the facility should be available in each medical college hospital. In the last phase, this arrangement should be available to all blood banks upto District level.
- (b) *Extensive health education.*—Massive efforts through mass media and health manpower should be made for educating the masses, especially youth about the nature of diseases, modes of transmission and precautions required to avoid infection. This must be done with special attention to students in college and Senior Secondary Schools. Various central, state and regional I & B set-ups for information and media should be mobilized in these efforts with nodal responsibilities being taken by Ministry of T & P. and backed by Steering Group in the Ministry of Health.
- (c) *Drugs Control.*—When ever any recognized laboratory finds any sample of any blood product positive for HIV antibodies, such information should be immediately communicated to the Drug Controller of India and State Drug Controllers. It will be the responsibility of the State Drug Controller to immediately investigate the matter and take steps where necessary to withdraw the product from the market and stop

further production and distribution until the State Drug Controller is satisfied that the facilities and protocol, followed by the manufacturer will ensure that only HIV antibody free blood shall be used for producing fractionates. It shall be made a condition of license of a manufacturer of blood product-; to set up a mechanism that shall be able to freeze stocks in 24 hours, recall stocks in 72 hours and account for the same all over India.

- (d) *State AIDS Committee.*—Each State Union Territory must constitute a State AIDS 'Committee headed by the Chief Secretary and should include the Health Secretary, Home Secretary, three experts from the medical profession having knowledge and/or experience in treating AIDS/STD patients, two social workers engaged in the rehabilitation of prostitutes, head of the ICMR Institute unit located in the State. head of the TV/Radio Station, two representatives from blood banks, State Drug Controller The Committee will (i) prepare a time/work schedule for implementation of AIDS prevention and control activities; (ii) monitor the blood testing, health education and screening programme of persons belonging to high risk groups such as prostitutes, STD patients, blood donors and foreign students. The Health Secretary will be the Convener of this Committee.
- (e) *State AIDS Cell.*—Each State Union Territory must constitute a State AIDS Cell. The Cell should be headed by the Health Secretary and should include the Programme Officer for AIDS control, representatives from State Medical Association, doctors having knowledge and/or experience in treating AIDS/STD patients, microbiologists. Epidemiologists' representatives from ICMR, head of the State Health Education Bureau and Station Director TV/Radio station. The State AIDS Cell will formulate the guidelines for undertaking AIDS Control activities and supervise the implementation of the activities in the field. The Programme Officer for AIDS Control will be the Convener of the State AIDS Cell.
- (f) *Training.*—Training Programmes may be organized by Directorate General of Health Services! ICMR for general physicians working in major hospitals, physicians working in medical colleges hospitals nurses, blood bank technicians, laboratory staff in microbiology departments of medical colleges.
- (g) *Health Care facilities.*—Provision of health care of infected persons may be organized by establishing an AIDS unit in major hospitals in metropolitan cities in the first instance and extended to cities with a population exceeding one million in a phased manner.
- (h) *Role of Voluntary Organizations.*—to take care of Sero-positive cases specially. The Council notes that in view of the present unclear state of knowledge of the disease and absence of affordable curative methods, cure alone may be kept with W.H.O. and an appropriate medium term plan prepared for action by States at the cost of the Centre.

RECOMMENDATION No. 9

CANCER CONTROL PROGRAMME

The Central Council of Health (CCH) & F. W. notes with concern that cancer is a disease which carried a high rate of mortality unless it is detected and treated early. The CCH & FW is aware of the fact that there are nearly 1.5 to 2 million cases of cancer at any point of time and 1/3rd of these are preventable another 1/3rd curable if detected early, and the remaining 1/3rd would need palliative and pain relief measures. Therefore, to strengthen the existing cancer control programme and to strengthen the control measures with emphasis on primary and secondary prevention where the returns would be maximum the 2nd Conference of CCH & FW recommends the following:—

(1) *Regional Cancer Centres*

The CCH & FW notes that there are presently 10 Regional Cancer Centres in the country (9 are given financial assistance by the Health Ministry and one Tata Memorial Centre at Bombay is assisted by the Department of Atomic Energy) providing sophisticated treatment for cancer, early detection facilities training and cancer research. The CCH & FW expects. That the Regional Centres, besides acting as a referral centre for complicated and difficult cases, should also act as apex bodies for taking up such activities as development of diagnostic tests, health education material, training of professional and Para professionals etc. In order to act as such apex bodies they will require fully equipped clinics in various branches such as ENT, Gynecology, Urology, Gastro-entriology, Pediatrics etc., apart from modern blood transfusion and imaging services.

In order to achieve the above standards at the Regional Centres, the CCH & F.W. recommends that the capability of the 9 centres which are assisted by the Ministry of Health should be evaluated by a committee of experts and classified in two groups (i) centres which could be developed as national centres of excellence: (ii) centres which should be developed as regional centres of excellence. The committee should determine the lump sum grant to be provided for equipment and the maintenance assistance to be provided to each of the RCRTC during the 8th Plan.

In States, where there are no Regional Centres medical college hospitals should be identified and developed so that they have the facilities and expertise for treatment of cancers occurring in the State.

(2) *Provision of Cobalt Therapy Facilities*

The CCH & F.W. notes that radio-therapy facilities are available in 99 institutions of the country including the 10 Regional Centres and 49 medical College Hospitals. Radiotherapy is one of the important lines of treatment of cancer cases and therefore there is urgent need to augment such facilities in the forthcoming years.

The CCH & F.W. recommends that by the end of the 8th Plan, all medical colleges

should be provided radiotherapy facilities. This would mean providing radiotherapy facilities to 57 medical colleges in the 8th Plan. CCH also recommends that those districts which do not have a medical college should be provided radiotherapy facilities by strengthening the district hospitals.

(3) ***Oncology Wings in Medical Colleges***

The CCH & F.W. recommends that during the 8th Plan, 50 per cent of the medical colleges in each State should develop an Oncology wing for the appropriate management of the cancer cases. The Departments of Social and Preventive medicine Surgery including allied branches. Obstetrics & Gynecology, Radiotherapy, Medicine, Pathology and Cytology would work together to form such oncological wings. Any one of the departments preferably Radiotherapy or Pathology could coordinate these activities. It is expected that these wings would be developing their own out-reach programmes for early cancer detection and intervention studies. The main activities of these wings would be:

- i. Early detection of cancer.
- ii. To offer optimal management of the cancer cases.
- iii. Establishment of pain relief clinics.
- iv. To evaluate the different treatment modalities.
- v. To raise relevant data on the efficacy of treatment through a hospital based cancer registry.
- vi. Human resource development in the field of oncology.
- vii. Preparation and pre-testing of health education material.

The oncological wings should have the following radiotherapy facilities:

- i. 2 cobalt units.
- ii. Manual after-loading cesium sets.
- iii. A beam localizer
- iv. Insertion of Interstitial Cesium facilities.
- v. All facilities for surgery, chemotherapy and radiotherapy.
- vi. Laboratory support.

(4) Training

- (a) In order to strengthen the cancer treatment facilities at the district hospitals, the CCH & F.W. recommends that doctors in these hospitals should be given updated professional re-orientation in all aspects of early cancer detection and treatment. For this purpose the CCH & F.W. recommends that a national programme for providing training should be jointly organized by the ICMR and Regional Cancer Centres.
- (b) The CCH & F.W. also recommends that the medical colleges should supplement the regional centres in the training of doctors and para-professionals. Medical colleges should provide training to both female and male multipurpose workers and health assistants in cancer control activities. They should also organize training programmes for medical officers of primary health centres and community health centres.
- (c) The CCH & F.W. recommends separate training programme for training adequate number of cytotechnicians and cytotechnologists and cytopathologists. Promotional avenues for such categories of trained professional should be kept in mind by the States. ICMR's Institute of Cytology and Preventive Oncology could act as the apex Institute for this activity.

(5) Tobacco related cancers

Since the mainstay of prevention of tobacco related cancer would be Anti Tobacco Community Education and the Early Detection of Oral Cancer, the CCH & F. W. recommends that massive group education activities against the use of Tobacco which should be focused at youth and non-habitueés to prevent initiation of the habit be initiated. Multiple channels including multipurpose workers could undertake this activity. MPW should also be trained to examine the oral cavities of tobacco users for early detection and referral of such cases. CCH & F.W. also recommended prohibition of advertisement on Cigarettes, Bidies, and tobacco used 'PAN' Masala and all other tobacco products in public places. Though there is a ban on advertisement of Cigarette in T.V. in the advertisement of other products, Cigarette smoking is glamorized. Such advertisements should be prohibited. Existing rules and regulations concerning non-smoking in public places of entertainment and public transport should be rigidly enforced and extended to other areas such as Government offices, educational institutions, official Conferences meetings, Railway stations and Airports.

(6) Cancer of Uterine Cervix & Cancer of Breast

In this context the CCH & F. W. recommends that the strategy for early detection would be to motive the women above 35 years of age to undergo clinical examination of cervix and Pap smear examination atleast once in life time. Intensive health education would be launched to contact the community on the aspects of prevention in the early detection of these cancers. For breast cancer, Breast Self Examination (BSE) would be propagated, Control of Cancers of women should be

closely integrated with the Family Welfare and Maternal and Child Health Programme.

(7) *Pain Relief*

Large number of cancer patients requires pain relief measures at one time or other. Based on, the recommendations of the WHO regarding pain relief the CCH & F. W. recommends that oral morphine should be made available at the P.H.C. for controlled distribution to cancer patients.

(8) *State Cancer Control Boards*

The State Governments of Andhra Pradesh, Assam, Bihar, Haryana, Jammu & Kashmir, Madhya Pradesh, Meghalaya, Nagaland, Punjab, Rajasthan, Sikkim and U. T. Administrations of Delhi, Chandigarh and Pondicherry which have not so far set up Cancer Control Boards should take urgent action to constitute the state Cancer Control Boards to coordinate Cancer Control activities in the respective States and U.Ts. Wherever such Boards have been constituted, a nodal person must be identified to coordinate such activities. The National Cancer Control document (1984) of Government of India should be expanded into an operational document by each of the States according to their needs and priority. Indicators for evaluation and monitoring of the progress should be built in right from the onset.

(9) *Involvement of voluntary Organizations*

The Council recommends involvement of Voluntary organizations on a large scale in spheres of Health Education, Early Detection and Treatment, Rehabilitation and Terminal Care of Cancer Patients. For this purpose the State Governments may identify suitable voluntary organizations of proven record in Cancer Control and possible financial assistance in the 8th Plan.

RECOMMENDATION No.10

CONTROL OF WATER-BORNE DISEASES

The Council took note of the high incidence of water-borne diseases in the country in 1988. These diseases, such as Cholera, Gastro-enteritis, typhoid, infectious Hepatitis and Polio Myelitis, are causing morbidity and mortality in most parts of the country. Morbidity and mortality due to these diseases can be reduced to a large extent, if timely preventive and control measures are initiated. Deaths due to acute diarrhoeal diseases such as cholera, gastro-enteritis and typhoid fever, occur on account of dehydration as a result of loss of electrolytes and body-fluids, which can easily be prevented.

Considering the above the Council recommends the following measures:-

- (1) The health authorities of States|UTs should strengthen their surveillance and monitoring systems for the early detection of water-borne diseases to initiate early control measures, particularly against cholera and gastro-enteritis. The health functionaries at grass root level should be alerted to report any unusual incidence of diseases at PHC level for initiating immediate epidemiological investigations. Medical College hospitals and other major hospitals should undertake surveillance and inter-act with State/UT Health Departments.
- (2) Health Education measures should be promoted so that acute diarrhoeal diseases occurring at the community level are treated initially with home-available fluids ORS. AM severe cases should be promptly referred to the hospital.
- (3) Efforts should be made to supply safe drinking water to the community by providing water hydrants in urban areas and through deep tube-wells in rural areas. All unsafe drinking water sources should be chlorinated and if feasible all water; suspected to be Unsafe, should be boiled before use. Water quality should be periodically checked through bacteriological and chemical analysis.
- (4) Health Department functionaries should inter-act with Municipal Panchayats to ensure that sewage lines, septic tanks, drains are cleaned regularly to maintain proper flow of the sewage.
- (5) In case of infectious hepatitis, no preventive vaccine is available. However, gamma-globulin to high risk groups such as pregnant women should be administered.
- (6) Conventional cholera vaccine gives limited protection (50% of the vaccinated persons) with 2 doses schedule given at an interval of 10-28 days and the immunity lasts only for short durations (3-6 months). It can not reduce the severity of the diseases, nor reduce the carrier state. Important measures such as supply of safe drinking water, chlorination of unsafe-water, safe disposal of human excreta, improvement of food and personal

hygiene and improvement of environmental sanitation should receive greater attention. Vaccination for Typhoid Cholera is, however, useful during natural calamities (floods) and in labour camps at construction sites where normal living conditions are disrupted and where population affected is limited and it is feasible to vaccinate the entire population. Polio myelitis is also spread through faecal-oral route to contamination of drinking water sources. Preventive vaccination against polio myelitis should be undertaken under the Universal Immunization Programme in a phased manner.

- (7) *ORT Programme*: To popularize ORT Programme launched by Government of India, co-ordination between various intra and inter-sectoral, non-governmental, voluntary organizations and other autonomous bodies such as municipalities should be ensured.
- (8) The production of ORS should be augmented and all health Institutions, such as PHCs, Sub-centres, Hospitals, dispensaries should be provided with adequate quantities of ORS packets.
- (9) Health Education to create public awareness for initiation of early treatment of acute diarrhoeal diseases, promotion of ORT should be undertaken through various mass and publicity media, and for improvement of personal, environmental and food hygiene.

RECOMMENDATION No. 11

GUINEAWORM:

Guineaworm eradication by 1990 is a time bound National Health Programme. At present, 70 per cent reduction in total cases and more than 50 per cent reduction in effected villages has been achieved and Tamil Nadu & Orissa freed from this disease.

- i. The States of Rajasthan, Madhya Pradesh, Gujarat, Maharashtra, Karnataka and Andhra Pradesh should intensify case detection searches and surveillance activity. Extra epidemiological teams should be provided by Centre. (State/Centre)
- ii. A full time special programme officer at the level of Joint/Deputy Director should be put incharge at the State level to ensure effective surveillance which is initially important for eradication. (Central/State)
- iii. Health education campaign should be launched in the effective districts States for maximum community participation. (States)

RECOMMENDATION No. 12

"MEDICAL EDUCATION INCLUDING REORIENTATION OF MEDICAL EDUCATION (ROME)" SCHEME AND NATIONAL HEALTH POLICY

The Second Conference of the Central Council of Health and Family Welfare held from 1st to 3rd February 1989 makes the following recommendations:

1. (PROBLEM OF PRACTICE BY UNQUALIFIED MEDICAL PRACTITIONERS

The Council reiterates its earlier recommendation that there is no Justification for permitting unqualified persons to practice any recognized system of medicine and that the Central and State Governments should invoke penal provisions of the relevant statutes wherever complaints of exploitation by unqualified practitioners are brought to notice.' This is particularly necessary in view of the availability of increasing number of qualified medical practitioners both in the Allopathic and in the indigenous and Homoeopathic systems of medicine. The Council is also of the view that there is need to strengthen the Medical Council of India and the State Medical Councils to enable them to undertake registration of qualified persons effectively so that the unqualified persons could be isolated.

RECOMMENDATION No. 13

2. REORIENTATION OF MEDICAL EDUCATION (ROME) SCHEME

The Council expresses its concern that the implementation of the Reorientation of Medical Education (ROME) Scheme, which was started more than 12 years back has not made the^ required impact. The Council recommends that a measurable standard should be evolved which would make it possible *to* assess the performance of the various colleges and give an indication as to how far the objectives of the scheme are being achieved. The Council also emphasizes the need for involving senior faculty of all departments in medical colleges in the implementation of the scheme. It also recommends that the required physical infrastructure for the students and faculty in attached Primary Health Centres should be built up without further delay. The Council further recommends that on an assessment or the working of the Scheme in exceptional cases the State Governments may consider giving, within an accountable framework, responsibility for primary health care in a designated area to medical colleges successfully carrying out Reorientation of Medical Education Scheme.

The Council further recommends that the present system of funding the Reorientation of Medical Education Scheme as a Centrally Sponsored Scheme should continue in the Eighth Plan also.

3. CURRICULUM AND SYLLABUS

The Council having noted that the Parliamentary Committee on Government Assurances has asked for a very early review of the curriculum and syllabus of medical courses, and having noted that a Sub-Committee of the Medical Council of India is going into matter, recommends that the revised curriculum as found necessary should be formulated very early keeping in view the need for effective delivery of health care services, particularly implementation of National Health and Family Welfare Programmes. The Council also emphasizes in this context the need for proper implementation of the guidelines laid down by the Medical Council of India by the universities and medical colleges through adoption of appropriate teaching methods and examination systems.

4. ELECTION OF MEMBERS TO THE MEDICAL COUNCIL OF INDIA

The Council noted that the Indian Medical Council Act, 1956 is proposed to be amended to ensure that no members of the Council continue; for more than six months beyond the normal term of five years after his election or nomination, urges that in the meantime, the States and universities should take urgent action to elect or nominate, as the case may be eligible candidates to be members of the Medical Council of India as soon as possible after occurring of a vacancy.

5. COMPULSORY SERVICE IN RURAL AREAS FOR MEDICAL GRADUATES

The Council considers that while the merits of a two-year compulsory rural services for undergraduates are debatable, it considers it appropriate that the Central and State Governments should make it compulsory for all those joining Government services to serve for 2 years in rural areas without any exception. The Council is of the view that there is need for exposure of senior faculty of medical colleges to rural conditions and in this context recommends that the possibility of attachment of senior faculty of medical colleges and senior State Health Officers with the Primary Health Centres for short periods should be examined by the Central and State Governments. During this period the senior doctors should also supervise and guide young students while providing patient care to the rural population.

6. POLICY REGARDING ESTABLISHMENT OF NEW MEDICAL COLLEGES

The Council reiterates its recommendation made in the first Conference held in February 1988 that no new medical colleges should be opened nor any addition to the existing capacities should be permitted as the qualified medical practitioners coming out from the existing medical colleges are sufficient for the near future.

7. CONTINUING MEDICAL EDUCATION FOR MEDICAL AND PARAMEDICAL PERSONNEL

The Council notes the action taken by the Central Government to designate the National Academy of Medical Sciences, New Delhi, as the central coordinating agency for providing continued medical education for medical and para-medical personnel. In this context the Council urges the Central as well as the State Governments to provide the required funds on a regular basis for making the continued medical education programme successful. The Council also urges the State Governments and Union Territory Administrations to formulate suitable plans of action and to establish machinery for coordination of such programmes in consultation with the National Academy of Medical Sciences. The Council also urges the National Academy of Medical Sciences to undertake programme of continuing medical education based on the health needs of the various regions and also to make full use of the expertise and experience available in professional bodies such as the Indian Medical Association, Health Sciences Universities and the various medical colleges.

RECOMMENDATION No. 14

NATIONAL HEALTH POLICY

1. The Council reviewed the progress in the implementation of the various provisions of the National Health Policy. The Council urges the State Governments to send their report on the implementation of the National Health Policy regularly to the Ministry of Health and Family Welfare in order to make it possible to have an annual review and also to undertake such modifications in the policy statement as may be required keeping in view the country's commitment for achieving Health for All by the year 2000 AD.
2. The Council recommends that in order to effectively implement the National Health Policy and to achieve the goal of Health for All by the year 2000, the Central Government and the Planning Commission should allocate sufficient funds during the Eighth and Ninth Plan for the Health and Family Welfare sectors. The Council notes with concern the declining share of the health sector in the allocations made in the succeeding Five Year Plans and strongly recommends that during the Eighth Plan the allocation for the health and family welfare sectors should not be less than 7 per cent of the total plan allocation.

RECOMMENDATION No. 15

PREVENTION OF FOOD ADULTERATION PROGRAMME

The Council recognizes the fact that quality control of Food and drugs is very essential since these have a far-reaching impact on the health and well being of the people. It should thus receive priority in terms of funds and other resources. The Council having considered the present conditions of the implementation of the PFA Act & Rules throughout the country makes the following recommendations for achieving qualitative improvements in the area of food quality control and to ensure availability of wholesome and pure food to everyone.

- (1) The States|UTs who have yet to frame PFA Rules relating to Prevention of Food Adulteration for their respective States|UTs according to the guidelines forwarded by the Central Government should do so immediately. State PFA Rules be updated and procedure for licensing be streamlined and simplified. The Council also recommends that draft rules sent by the States should be approved by the Central Govt. as early as possible.
- (2) With a view to simplify the provisions of the PFA Act and Rules, complete review of the Rules is undertaken immediately. If needed, a group is constituted for this purpose.
- (3) Prevention of Food Adulteration enforcement machinery and laboratories facilities is suitably augmented by providing adequate budget provisions for the purpose. States should set up separate PFA directorate, legal cells, monitoring cells and grievances cells, for proper implementation of the provision of the Act.
- (4) Emphasis is given on sampling and analysis of commonly used food commodities, like edible oils and fats, cereals, spices, milk and milk products etc. A nation wide survey to find out the extent of adulteration in selected food items should be conducted. Cases of food poisoning should be closely monitored
- (5) The Council strongly recommends health education and generating consumer awareness by effective utilization of T.V., A.I.R. and holding exhibitions| seminars, publishing pamphlets in regional languages, etc. The Council recommends that time allotted by Doordarshan for health programme may be utilized for consumer education and disseminating knowledge of food quality and effects of adulteration. Percentage of budget for health schemes is earmarked for consumer health education by the State Governments.
- (6) The Council takes note of the inadequate number of food Inspectors in the country and recommends that wherever the need for more Food Inspectors is left, qualified personnel if available be empowered to perform the duties of Food Inspector^.

- (7) In the interest of public health, suitable provision be made in the Rules that every packed food item including tetra packs, tinned and bottled food items should carry the instruction "best for use before" on the labels.
- (8) A centrally sponsored scheme for strengthening and setting up of Food Laboratories in States| UTs should be formulated.
- (9) The Prevention of Food Adulteration Organization at the Dte. General of Health Services be suitably strengthened. As in the Drug Control Organization, zonal offices are set-up for monitoring and coordinating of the PFA activities within the respective Zones and for tackling the cases of inter State Food Adulteration.
- (10) Publication of updated Manual of Methods of analysis of Food is expedited.

RECOMMENDATION No. 16

DRUGS STANDARD CONTROL

1. The Council notes that the expenditure being incurred on Drug Control and PFA is about 1 per cent of the total Health Budget. Quality of Food and Drugs play a meet crucial role in ensuring Health and well being of the people It would, therefore be appropriate if due share is given to these areas in the Health Budget.
2. The Council is of the view that the main task of the Drugs Control Administration is to ensure the following (i) Availability of quality drugs and rational formulations at reasonable prices, (ii) weeding out irrational and harmful formulation: from the market, (iii) emergency intervention to recall drugs reported to cause adverse reactions.
3. The Council notes that the control on the manufacture, sale and distribution of drugs is the responsibility of the State Drug Control authorities. The Central Government is responsible for the quality of imported drugs, registration and approval of new drugs, laying down standards and amendment if Drugs and Cosmetic Act and Rules.
4. A number of difficulties and short-comings in the proper implementation of the Act have been noted these are :—
 - i. Lack of adequate testing facilities in the States. Only 4 States have full fledged laboratories and 10 have facilities to test only non-biological drugs. As a result only about 24,000 samples are tested every year as against millions of batches of drugs manufactured by more than 16,000 manufacturing units.
 - ii. Lack of adequate staff in Drug Inspectorate of States and Centre. There are 664 inspectors in 1he country as against 2689 drug inspectors recommended by the Task Force.
 - iii. Lack of effective action against manufacturers of sub-standard spurious drugs partly due to inadequate staff, testing facilities and also due to lengthy procedure for taking punitive action.
 - iv. Lack of effective mechanism to recall drugs reported to be not of standard quality especially in emergency situations.
5. Keeping the above in view, the Council recommends that—
 - i. A high powered group comprising of Ministers of Health and Family Welfare of 4-5 States, Drug Controller of States where manufacturing Units are concentrated, Drug Controller (India) and Senior Officers of the Union Health Ministry be set up to examine the restructuring of the Drugs Control set up with special reference to the setting up of a National Drugs Control Authority.

This Group will also review the existing powers relating to recall of drugs in emergency situations. Recommendations of this group should be finalized within 2 months:

- ii. Each State should develop a full-Hedged drug testing laboratory to effectively monitor the quality of all categories of drugs manufactured, distributed and sold in the State.
- iii. Each State should have a whole-time Drugs Controller having prescribed qualification for effective implementation of the Drugs and Cosmetics Act and other drugs related legislation. The inspectorate staff should be suitably augmented as per recommendations of the Task Force.
- iv. For effective check on movement of spurious drugs, every State should set up an Intelligence-cum-Legal Cell with facilities for quick mobility and communication and adequate complement of Watchers Drugs Inspectors etc.
- v. Prompt and effective action should be taken by the licensing authorities on the reports of sub-standard drugs.
- vi. The State Drugs Controllers should take early action to enforce the provisions of Schedule amended to incorporate Good Manufacturing Practices.
- vii. Rigid and regular inspections should be carried out by each State Drug Control Organization of firms prior to grant/renewal of Licenses. Requirement of testing laboratories should be insisted upon. No license should be granted to any unit which does not have in-house testing facilities for raw materials and finished formulations.
- viii. Each State Drug Controller should issue guidelines for procurement, storage, distribution and withdrawal of drugs in the Government Hospitals. To ensure supply of drugs of highest quality to these institutions, State Drug Controllers should invariably be associated to identify manufacturers from whom purchases can be made. The list-of such manufacturers should be short listed and their names circulated to all indenting Government agencies. It is also recommended that the quality and not that lowest price should be the main criterion for procurement of drug.
- ix. Every State Government should set up adverse Drugs Reactions Monitoring Cells in various Government Hospitals.

Testing facilities of existing Central Drug Testing Laboratories should be augmented and more regional laboratories should be established by Central Government. For the effective implementation of these recommendations, it is absolutely essential to have adequate strength of drug inspectors and testing facilities as brought out in recommendation No. 3 and 3 above.
- (x) There should be a Centrally Sponsored Scheme during the 8th Five Year Plan to assist the States in strengthening the Drug Control machinery and drug testing facilities.
- (xi) Drug Control Organization at the Centre should also be upgraded and strengthened.
- (xii) The Drug manufacturers whose license is cancelled |convicted in a Court in

one State should be black listed throughout the country.

RECOMMENDATION No. 17

DRUG DE-ADDICTION PROGRAMME

The Council notes with concern the growing prevalence of Drug Abuse and dependence problems in the country. It unanimously agrees that this is a hard fact which has to be recognized, accepted and tackled with the application of appropriate health measures to all dependence disorders as identified by the W.H.O.

At the Central Level the Ministry of Health and Family Welfare is basically responsible for the treatment aspects of the drug abuse problem so as to ensure that the patients are not deprived of required medical facilities. For this purpose seven hospitals have been identified for setting up of separate 30 bedded drug de-addiction centres. The Council makes the following recommendations:

1. Since the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 makes it obligatory for Health Services to provide treatment to drug addicts, all States must set up at least one identified centre. They should involve Voluntary Organizations and also some leading private hospitals.

The Council further recommends that the Central Government should take the following action:—

- (i) As envisaged in the Expert Committee's Report on Drug De-addiction services an Apex Centre for manpower development and training should be set up.
- (ii) The Narcotics Control Bureau at the Centre should keep the Ministry of Health and Family Welfare informed on the fresh transit channels detected in various States in order that the Ministry of Health and Family Welfare is kept aware of the affected areas.
- (iii) There should be an attempt not only to identify States where the problem exists and also the areas in which it is acute.
- (iv) Since the Ministry of Health and Family Welfare has to liaise with the Ministry of Welfare and Narcotics Control Bureau at the Centre and also the States in order to facilitate programme implementation, it should create a nodal cell within its existing Drugs Section to ensure speedy collection and dissemination of information and better coordination. The Cell should be adequately staffed and equipped.

The Council recommends the following specific actions by the State Government.

- i. As the Central Level, the State Health Departments should also coordinate with the State Home, Narcotics and Welfare Departments to achieve better results in tackling the problem in a comprehensive manner.
- ii. State Governments should earmark at least ten separate beds for de-addiction in existing hospitals in the acute problem areas of the State as per DGHS norms. Two trained doctors and two trained nurses should be

provided. Voluntary Agencies should be linked to these hospitals for provision of after-care, counseling and family re-education programme.

- iii. A Committee of eminent individuals should be formed in each State which could act as a think-tank for tackling the problem in a coordinated manner as envisaged above.
- iv. The State Governments should formulate a suitable plan of action for drug de-addiction including earmarking of funds specifically for this programme and nomination of a nodal officer. The Plan should take cognizance of the need for counseling and rehabilitation after clinical treatment is over and identifies voluntary organizations who can take up this responsibility.
- v. State Governments/U.Ts should identify a nodal institution of excellence in their States for training, treatment, applied research and data collection. They should also avail of training activities provided by the Central Government.
- vi. All States should prepare health education material in regional languages against drug-addiction. This should be used extensively for health awareness/education amongst vulnerable groups.

RECOMMENDATION No. 18

INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

The Council after reviewing various issues relating to promotion of Indian Systems of Medicine & Homoeopathy and the measures undertaken to bring these systems in the main stream of Health Care delivery programme settled though over a period of 40 years. These systems have made some progress, yet special efforts are required to give a fillip to the various programmes particularly in the field of standardization of education, quality control of ISM drugs, research activities especially in respect of incurable diseases and improvement in Health Care Services. Considering, the fact that there is a vast human resource in the shape of Private Practitioners of Indian Systems of Medicine and Homoeopathy who are available in rural and remote areas and are acceptable to the people, the Council felt that their services have not been adequately utilized in the field of Primary Health Care and National Health Programmes.

Recent studies indicate that the doctors of ISM and Homoeopathy are keen to be involved in the National Programmes and they have a good knowledge and perceptions about Primary Health Care and Family Welfare Programme. The Council noted with concern that very little action has been taken on the recommendations of the last conference. It expressed its regret over the still persisting general apathy towards these systems which is retarding their pace of development.

Taking into account all the above factors, the Council made the following recommendations:—

1. SEPARATE DEPARTMENT DIRECTORATE GENERAL FOR ISM AND HOMOEOPATHY

Taking into account the important role that can be played by the Indian Systems of Medicine and Homoeopathy in the health care programme, the Council recommended that to develop these systems according to their potential a separate department in the Ministry headed by an Additional Secretary should be set up to look after these systems. Likewise, a full-fledged Directorate General of Indian Systems of Medicine and Homoeopathy on the lines of the Directorate General of Health Services with necessary infrastructure is established. It also recommended further that since the Planning Commission played a major role in providing funds for the development of various systems, an Adviser (ISM & H) may also be appointed in the Planning Commission. Likewise there should be separate Directorates for Indian Systems of Medicine as well as Homoeopathy in each State.

2. DEVOLVEMENT OF ISM PRACTITIONERS IS PRIMARY HEALTH CARE AND FAMILY WELFARE

- i. The State Governments must optimally utilize the services of practitioners of Indian Systems of Medicine and Homoeopathy—both Government and non-Government in providing Primary Health Care and Family Welfare Services. Special steps may be taken to provide training to these doctors.

While entrusting the above responsibilities, supplies |services must be ensured in an organized manner

- ii. The Council reiterates that the States of U.P. and Rajasthan who have been sanctioned a specific scheme of mobilizing the Private Practitioners of I.S.M. and Homoeopathy for providing Family Welfare and Primary Health Care Services speed up the process of implementation of the scheme through the Director of I.S.M. and make it target and result oriented.

3. APPOINTMENT OF THIRD DOCTOR BELONGING TO ISM & HOMOEOPATHY AT PRIMARY HEALTH CENTRES

The Council noted that even after repeated recommendations made by the Central Council of Health and Family Welfare only a few States have appointed one doctor of ISM & H in limited number of Primary Health Centres. Even these doctors, have not been provided adequate facilities to enable them to function effectively. The Group, therefore, recommended that the already appointed doctors in Primary Health Centres should be provided necessary facilities and their services may be continued in these centres. However, in future, 50 per cent of the new Primary Health Centres should be manned and managed by the doctors of ISM & H.

4. ROLE OF ISM & H IN NATIONAL PROGRAMMES

- i. The Council resolved that the I.S.M. and Homoeopathy systems be actively involved and made responsible in National Programmes for communicable as well as non-communicable diseases. This could be ensured by strengthening ISM & H Dispensaries |Hospitals and providing orientation training to the doctors and para-medicals.
- ii. Further the Council recommended that the funds made available for the development of Indian Systems of Medicine and Homoeopathy should be treated as a part of the Minimum Needs Programme and should not be diverted for any other purposes.

5. EDUCATIONAL STANDARDS IN ISM & HOMOEOPATHY

- i. The Council strongly feels the urgent need to improve the standards of education in Indian Systems of Medicine and Homoeopathy Colleges so as to conform to the minimum standards laid down by the Central Councils of Indian Medicine and Central Council of Homoeopathy. These Institutions

need strengthening in terms of modern equipment, adequate space buildings, staff, library etc.

- ii. Considering the present resource constraint in the States, the Group strongly recommends that during the 8th Plan the Planning Commission should provide additional funds both in the Central and State Sectors. A minimum of Rs.100crores outlay in the Central Sector and the increase in the State Sector outlay is recommended during the 8th Plan for this purpose.
- iii. The existing scheme of providing assistance of Rs. 160 lacs by the Central Government to the Undergraduate Colleges needs to be enlarged in scope so as to provide at least Rs. 5 lacs per Institution. Funds for the centrally sponsored scheme for up gradation of post-graduate education also need to be augmented.
- iv. The Central Government may expedite bringing out the legislation on checking the mushroom growth of Colleges and practices by unqualified persons.
- v. No new College of ISM & H should be started without the prior permission of CCIM|CCH.
- vi. Separate agencies may be established for continuing education in Indian Systems of Medicine and Homoeopathy.

6. QUALITY CONTROL OF DRUGS

The quality of ISM and Homoeopathy drugs is a must for establishing credibility of these systems. In the absence of laying of pharmacopoeial standards the adulteration in medicines in these systems cannot be checked fully as per the existing laws. It is, therefore, essential that the pace of laying of pharmacopoeial standards for both single and compound drugs is accelerated.

(ii) To enable the pharmaceutical industry to ensure quality of crude drugs used in the preparation of medicines, regional laboratories may be set up by the Pharmacopoeial Labs, of Indian Medicine and Homoeopathy. The Drug Controllers should provide adequate training to the Inspectors for supervision of ISM drugs. The States should also take immediate steps to appoint Drug Analysts for ISM & H drugs.

7. SETTING UP OF REGIONAL INSTITUTES

Keeping in view the fact that the Indian Systems of Medicine and Homoeopathy have greater acceptance for treatment of certain incurable diseases like Arthritis, Bronchial Asthma, Liver-disorders, skin diseases, hypertension, Psoriasis, Filariasis etc.; the Council recommends that Institutes of Excellence may be set up on Regional basis in these systems. Through these Institutes expertise in these systems en scientific lines should be made available within the easy reach of the people throughout the country Such Institutes could be developed on the lines of PGI, Chandigarh; AIIMS, New Delhi, to provide Research, Medical Care and Higher education.

A centre of excellence in research [medical care could initially be set up on the above lines for all the systems.

8. DISSEMINATION OF RESEARCH FINDINGS

The Council feels that there is an urgent need to evaluate the functioning of the Research Councils of ISM and Homoeopathy and, if necessary, to redefine their objectives in keeping with the present day-needs and the overall objectives of the National Health Policy. The emphasis has to be on research on identified diseases, in which these systems have the potential to provide effective treatment and can be operationalised at grass root. The Council recommends that an apex body with separate Working Group for each system may be set up to go into these aspects and make necessary recommendations.

9. MEDICINAL PLANTS

- i. The Council reiterates that the State Governments should give high priority to the development of medicinal plants and setting up of nodal agencies for making concerted efforts in this regard.
- ii. The Seminars |Workshops organized by the Central Ministry of Health and Family Welfare in various States has created awareness about the importance of the medicinal plants. This awareness is now required to be converted into action through nodal agencies. The State Governments should take measures for cultivation of medicinal plants which are in greater demand or are being imported. Setting up of data bank herbal |demonstration farms and use of modern techniques for preservation conservation of plants which are getting endangered |extinct should also be taken in hand. National Information Centre may also be involved in processing of data on medicinal plants.
- iii. In order to enable the State Governments to take up special programmes |schemes for setting up of herbal gardens/data banks, etc. the Council recommends that during the 8th Plan substantial funds at least of the order of Rs.25crores in the Central Sector and Rs.50 lakhs per State in the State Sector need to be provided. With these funds the State should be in a position to implement the various schemes for development of Medicinal Plants through Department of Forest, Horticulture, Agriculture Universities, Voluntary Organizations Co-operative Societies, etc.
- iv. The Council also recommends roadside plantation of trees of medicinal value under the Social Forestry Scheme.
- v. The State Governments may also consider the possibility of setting up of small herbal gardens in each village/block/taluka along with a small pharmacy to manufacture ISM drugs.

10. INTEGRATED APPROACH IN MEDICAL CARE

The National Health Policy provides for meaningful phased integration of the indigenous and modern systems of medicine. The Council recommends that appropriately located hospital facilities of 500 beds of ISM & H with modern pathological facilities and laboratories may be set up, so that proper scientifically sound clinical findings can be established. This hospital should admit patients suffering from diseases for which the modern system of medicine does not provide cure. The diseases should be diagnosed by the doctors of modern medicine where after treatment should be provided by physicians of indigenous systems of medicine. After the patient has been fully cured, he should, be again checked up by combined team of I doctors of modern medicine and ISM & H and thereafter if the medicines prescribed by the physicians of Indian Systems of Medicine are found to be effective; this should be adopted on national scale.

11. YOGA

- i. The Council reiterates that Yoga may be made compulsory in all schools and the teachers should be duly trained in a phased manner.
- ii. A Yoga Centre may be established at state level hospital in each State to start with.

**VALEDICTORY ADDRESS BY MISS SAROJ KHAPARDE, MINISTER OF
STATE FOR HEALTH & FAMILY WELFARE, NEW DELHI**

Shri Srivastava, Hon'ble Health Ministers, non-official members of the Council, Union Health Secretary, DGHS, Officers of the Central and State Governments, friends,

We have now reached the conclusion of our deliberations. During these deliberations we have covered important issues concerning Family Welfare, immunization, primary health care, the national programmes on communicable and non-communicable diseases, medical education, drugs, prevention of food adulteration, indigenous system of medicine and Homoeopathy.

Council has passed a series of resolutions which not only highlight the need to strengthen some of the nuts and bolts of the programme but also throw up valid issues relevant to Family Planning policies and programmes. The growing population will erode away all the gains of development and we will find it very difficult to come out of the vicious circle of poverty and population trap. The resolutions highlight our concerns in this regard and the suggestion to focus the programme on some of the important areas including those of raising age at marriage, female literacy, enhancing child survival are essentially the main planks of our strategy. The need to attain these things through mechanisms that can be operationalised will require in fact all our administrative and management skills.

The role of voluntary organizations in promoting Family Planning as a people's movement is extremely important. We will have to make conscious efforts to promote the participation of voluntary organizations in our programme and for this purpose we should not only give them full assistance but also give it timely. I find the recommendations of the Council in this regard extremely appropriate in the overall context of making Family Planning Programme a success.

The Universal Immunization Programme has been reviewed by the Council. It is clear that high quality of services is essential to achieve and sustain high coverage levels. The Council has approved the proposal for introducing the system of beneficiary card as the first step towards establishing complete family health record. Emphasis is also being placed on training of village health guides, traditional birth attendants, and provision of drug supply to sub-centres. These and other recommendations in the field of immunization and Primary health care will receive full attention of my Ministry.

The recommendations on the Indian Systems of Medicine and Homoeopathy concerning steps for involvement of ISM practitioners in primary health care, family welfare, role of ISM in national programmes, maintenance of drug standards, research and quality of drugs as well as medicinal plants are important and must receive the serious attention of all those concerned with promotion of health care.

The Council has made very important recommendations regarding implementation of

the national programmes of malaria, leprosy, blindness and TB in the field of communicable diseases. The emergence of Kala Azar and Japanese Encephalitis has received due attention of the Council and need for providing the low endemic districts with Multi-drug therapy for control of leprosy has been recognized. We must also see that the cured leprosy patients are rehabilitated. Involvement of private practitioners in the national TB programme and research on TB by medical colleges is a very relevant recommendation. The need for mobilization of resources for control of blindness including health education has been taken note of. The threat of AIDS is very real and the recommendation of the Council-for ensuring complete safety of blood transfusion services and drug control have to be implemented very quickly.

We have also to take steps to ensure that food adulteration is prevented and the machinery for prevention of food adulteration as well as testing laboratories must be strengthened. The Council's recommendation to examine the restructuring of the drug control set up with special reference to the setting up of national drugs control authority is timely and I hope that the recommendation of this group will be available very short time.

The Council has made very important recommendations regarding medical education. It has recommended that unqualified persons should not be allowed to practice and that Central and State Governments should invoke penal provisions to stop practice by unqualified persons. The Council has also rightly emphasized the need for strengthening the reorientation of medical education scheme. The question of compulsory service in rural areas for medical graduates has been debated. The Council has emphasized, and rightly so, the need for continuing medical education for medical and Para-medical personnel. This is an area which has not received in the past the attention due to it and the Council's recommendation would provide necessary the requisite guidelines for the preparation of a suitable plan of action.

The National Health Policy was formulated in 1983 and it fixed the targets to be achieved by the year "2000. The recommendation of the Council that in order to effectively implement the National Health Policy and to achieve the goal of health, sufficient resources should be allocated is timely in the context of the Eighth Five Year Plan. The Ministry of Health & Family Welfare strongly endorse the recommendation of the Council that at least 7 per cent of the total Plan allocation should go to health and family welfare sector, I hope Planning Commission will take note of this recommendation by the Council which consists of representative; from all the States.

Friends, the discussions in the Council have highlighted some important issues which are common to the whole health sector. The most important of these issues are first, as I have mentioned the need for additional resources. The second issue relates to creation of a mechanism for ensuring inter-sectoral coordination with other health-related ministries and departments like education, social welfare, chemicals, sanitation and water supply. The third is the need for a proper management information system which implies building up of an appropriate data base and its constant updating in a proper form. Related to this is the need for evolving and strengthening a suitable system of monitoring and evaluation so that

the feed back on performance is available quickly. Finally the importance of health education has been emphasized time and again during the discussions in the context of practically every health programme. Preventive and promotive health is the most inexpensive shortcut to good health. Health education must be the bed rock on which every programme has built up; the emphasis on curative aspects alone will not enable us to reach the goal of Health for All.

Friends, over these three days, we have had a detailed and thorough discussion." We have benefited immensely from the exchange of ideas. A large number of important decisions have come from these deliberations which will provide guidance to my Ministry as also to the State Governments. This has been possible only because of the commitment you all have in promoting the health of our people. It is because of this deep commitment that we can face the challenges before us with confidence. I am very grateful to my colleagues here for their cooperation, for their sense of purpose and objective outlook and for their concrete and practical suggestion and ideas.

While closing the second conference of the Central Council for Health and Family Welfare, I would like to thank all and each one of you personally for your co-operation, which has made this meeting of the Council a great success.

Thank you once again and I wish you a safe journey home.

MINISTRY OF HEALTH AND FAMILY WELFARE

New Delhi, the 6th January, 1988

Constitution of Central Council of Health and Family Welfare

S.O. 21(E).—In exercise of the powers conferred by article 263 of the Constitution and in supersession of the notification of the Government of India in the erstwhile Ministry of Health N. F. 6-1/51-P, dated the 9th August, 1952, the President hereby constitutes the Central Council of Health and Family Welfare and defines the nature of duties to be performed by it and its organization and procedure as follows, namely.—

1. Organization of the Council:

(i) The Council shall consist of—

- | | |
|---|---------------------------------|
| a) Union Minister for Health and Family Welfare | Chairman |
| b) The Union Minister of
The Union Deputy
Minister in the Ministry of health and family welfare | Vice-Chairman
Person |
| c) Member, Planning Commission | Member |
| d) Ministers in charge of the | Members |
| a. Ministries of Health and Family Welfare, | |
| b. Medical Education and Public Health | |
| c. in the States Union territories with | |
| d. Legislatures. | |
| e) A representative each of the | Members |
| a. <i>Demn</i> Admn. Dadra Nagar Haveli, | |
| b. Chandigarh, A&N Islands, | |
| c. Daman & Diu and Lakshadweep. | |
| f) MEMBERS OF PARLIAMENT | Members |
| i. Dr. V. Rajeshwaran | Lok Sabha |
| ii. Kum. Kamla Kumari | Lok Sabha |
| iii. Kum. Sushila Tiria | Rajya Sabha |
| iv. Kum. Sayeeda Khatun | Rajya Sabha |
| v. Non-Officials. | |
| (h) Representatives from Health and Family Welfare Sectors | |

MEMBERS

1. President, Indian Medical Association, (Ex-officio capacity).
2. President, Family Planning Association of India, Bombay (Ex-officio capacity).
3. President, Indian Council of Child Welfare, New Delhi (Ex-officio capacity).

4. Chairperson, Central Social Welfare Board, New Delhi (Ex-officio).
5. The President, Federation of Indian Chambers of Commerce and Industry, New Delhi (Ex-officio).
6. Director General, Indian Council of Medical Research, New Delhi (Ex-officio capacity).
7. The President, All India Organization of Employers, New Delhi (Ex-officio capacity).

Eminent Individuals

Members

1. Dr. Raj Arole, Society of Comprehensive Health Project in India, Jamkhed Maharashtra.
2. Dr. C. Gopalan of the Nutrition Foundation.
3. Shri Harish Khanna, Executive Director, Family Planning Foundation, New Delhi.
4. Dr. P. Siva Reddy, Adviser (Ophthalmology), State of Andhra Pradesh.
5. Smt. Verna W. Ingti, Chairperson, Meghalaya State Social Welfare Board.
6. Dr. Lalit Nath—A specialist in Community Medicine.
7. Dr. Banoo Coyaji, supld, K.E.M. Hospital, Sardor Mudaliar Road, Rasta Pcth, Pune (Maharashtra)
8. Shri S. P. Mittal, Chairman, Indian Association of Parliamentarians for population and Development.

(B) OFFICIALS

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

- (v) The expenditure involved will be met from within the sanctioned budget grant for the purpose.
- (vi) Expert and technical advisers to the Central Government and State Governments shall not be members of the Council and shall not have any right to vote when any decision is taken by it but shall, if so required by the Council, be in attendance at its meetings.
- (vii) The Council shall have a Secretariat staff consisting of a Secretary and such officers' and officials a.; the Chairman may, with the approval of the Central Government think fit to appoint.

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

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

- a. to consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects, such as the provision, of remedial promotive and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research ;
- b. To make proposals for legislation in fields of activity relating to medical and public health and family welfare matters, laying down the pattern of development for the country as a whole.
- c. To examine the whole field of possible co operation on a wide basis in regard to inter-State quarantine during times of festivals, out-break of clinic diseases and serious calamities search earth -quakes and famines and to a common program action.
- d. To make recommendations to the Central Government regarding distribution of available grants used for Health and Family Welfare present to the States and to review periodically the work accomplished in different area rough the utilization of these grants in a and.
- e. To establish on organization of organizations invested with appropriate function it's for promoting and maintaining cooperation between the Central and State Health and Family Welfare administrations.

3. Procedure of the Council:—

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

- a) The Council meet at least. once in every year;
- b) It shall meet it such t'ime and place as the Chairman may appoint in this behalf;
- c) Five members (including this Chairman) shall form the quorum for meeting of the Council ;

- d) The Chairman and, in his absence vice-chairman |vice-chair *m* or such member as may be designated by the Chairman in this behalf from amount the members referred to in clause(d) of sub-paragraph (i) of paragraph 1 shall preside at the meeting ,
- e) All questions which may come up before the Council at a meeting shall be decided by a majority of votes of the members (including the Chairman) present a» the meeting;
- f) In case of equality of votes, the person presiding shall have a second or casting vote:
- g) The Council shall observe in the conduct of its business such other procedure as it may with the approval of the Central Government, lay down from time to time.

CONFERENCE OF THE CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE, 1st TO 3rd FEBRUARY, 1989

Venue: Vigyan Bhavan, New Delhi.

REVISED PROGRAMME

Wednesday February 1, 1989 Inaugural Session--Venue: Commission Room 'H'

- 11 AM to 11:30 A.M. -Welcome Address By Shri R. Srinivasan, Secretary Ministry of Health and Family Welfare.
- Inaugural Address by Miss Sarej Khapale. Union Minister of State Health and Family Welfare
- Remarks by Prof. P.N. Srivastava, Member Planning Commission.
- Address by Shri S.G. Pitreda, Adviser to PM on Technology Missions.
- Family Welfare Awards for 1987-88.
- Vote of Thanks by Dr. O.K. Vishwakarma. Director General of Health Services.
- 11.30 A.M. to 11.45.A.M. —TEA in the lounge.
- 11.45 AM. to 11.55 A.M. —Presentation on MEDLARS by Dr. (Mrs.) S.L. Chinnappa.
- 11.55 A.M. to 12.10 P.M. —Presentation on Immunization—National Study in Quality Evaluation of Family Welfare Services at P.H.C.level.
- 12.10 P.M. to 1.30 P.M. —Discussion on the Agenda Items,
- 1.30 P.M. to 2.30 P.M. —LUNCH in the Annexe.
- 2.30 P.M. to 4.00 P.M. — Discussion (continues)
- 4.00 P.M. to 4.15 P.M. —TEA in the Lounge.
- 4.15 P.M. to 6.00 P.M. —Discussion (continues); and Formation of Working Group.

Thursday, February 2, 1989

- 9.00 A.M. to 11.00 A.M. —**Venue: To be announced.**
- 11.00 A.M. to 11.15 A.M. —Working Group Discussions.
- 11.15 A.M. to 1.00 P.M. —TEA in the Lounge.
- 1.00 P.M. to 2.30 P.M. —Working Group Discussions (continue)
- 2.30 P.M. to 4.00 P.M. —LUNCH BREAK
- 4.00 P.M. to 4.15 P.M. —Working Group Discussions (continue)
- 4.15 P.M. to 5.00 P.M. —TEA in the Lounge.
- Formulation/finalization of Working Group Reports

Friday, February 3, 1989

- 9.30 AM. to 11.00 A.M. —**Venue: Commission Room 'H'**
- Presentation of Reports of Working Groups and adoption of recommendations.
- 11.00 A.M. to 11.15 A.M. —TEA in the Lounge.

11.15 A.M. to 1.15 P.M.

—Presentation of Reports of Working
Groups and adoption of
Recommendation (continue)

1.15 P.M. to 1.30 P.M.

—Concluding Remarks by Miss Saroj
Khaparde, Union Minister of State for
Health and Family Welfare.

1.30 P.M.

—LUNCH in the Annexe.

**MEMBERS PRESENT AT THE 2ND CONFERENCE OF CENTRAL
COUNCIL OF HEALTH AND FAMILY WELFARE**

Miss Saroj Khaparde, Union Minister of State for Health & Family Welfare.	Chair-person
Prof. P. N. Srivastava Member (Health), Planning Commission.	Member
Miss Komoli Mosang, Minister for Health & F. W. Arunachal Pradesh.	Member
Shri Anirudda Singha Choudhury, Minister for Health & F. W. Assam.	Member
Shri Dilkeshwar Ram, Minister for Health & F. W., Bihar.	Member
Shri Haji Sheikh Hassan Haroon, Minister for Health & F. W., Goa.	Member
Shri Vallabh Bhai Patel, Minister for Health & F. W., Gujarat.	Member
Smt. Kamla Verma, Minister for Health & F. W., Haryana.	Member
Shri Kaul Singh Thakur, Minister for Health & F. W., Himachal Pradesh.	Member
Shri R. S. Chib, Minister for Health & F. W. Jammu & Kashmir.	Member
Shri A. C. Shanmugha Das, Minister for Health & F. W., Kerala.	Member
Shri R. A. "Siddiqui", Minister for Health & F.W., Madhya Pradesh.	Member
Smt. Rajani Satav, Minister of State (Health), Maharashtra.	Member

Shri I. Tompok Singh, Minister for Health & F. W., Manipur.	Member
Smt. Mayasalin War, Minister for Health & F. W., Meghalaya.	Member
Shri Niranjan Patnaik, Minister for Health & F. W., Orissa.	Member
Shri Raghunath Vishnoi, Minister for Health & F. W., Rajasthan.	Member
Shri Sanchaman Limboo, Minister for Health & F.W., Sikkim.	Member
Shri R.Ponnmudi alias Deivasigamani Minister for Health & F. W., Tamil Nadu.	Member
Shri Kashiram Reang, Minister for Health & F. W., Tripura.	Member
Shri Prasanta Kumar Sur, Minister for Health & F. W., West Bengal.	Member
Shri P, Kannan, Minister for Health & F.W., Pondhicherry.	Member
Shri K. Kandaswamy, Counsellor (Health), A&N Islands.	Member
Dr. V. Rajeshwaran, M.P., Lok Sabha.	Member
Kum. Sushila Tiria, M.P., Rajya Sabha.	Member
Kum. Sayeeda Khatun, M.P., Rajya Sabha.	Member
Dr. Raj Arole,	Member

Society of Comprehensive Health Project in India.

Dr. C. Gopalan, President, Nutrition Foundation of India.	Member
Sliri Harisii Khanna, Executive Director, Family Planning Foundation.	Member
Dr. P. Siva Reddy. Adviser (Ophthalmology) State of Andhra Pardesh.	Member
Dr. Lalit Nath. (Specialist in Community Medicine). Prof, and Head of Department of Social Preventive Medicine. A.I.I.M.S.. New Delhi.	Member
Dr. Banoo Coyaji. Superintendent, KEM Hospital. Pune.	Member
Shri S. P. Millal. Chairman Indian Association of Parliamentarians for Population and development	Member
Mrs. Amarjeet Kaur, Chairperson, Central Social Welfare Board.	Member
Smt. Avabai Wadia, President, Family Planning Association of India.	Member
Dr. A. S. Paintal. Director General, Indian Council of Medical Research.	Member

Dr. N. Satyanaravana,
President.
Indian Medical Association.

Member

Shri R. Srinivasan,
Secretary,
Ministry of Health and
Family Welfare.

Member

Dr. G. K. Vishwakarma.
Director General of Health Services.

Member

Shri R. K. Ahooja, Joint Secretary.
Department of Health.

Member-Secretary

ANNEXURE

ATTENDANCE AT THE WORKING GROUPS

(2nd FEBRUARY, 1989)

Working Group-I

Subject:—Family Welfare Programme including Mass Education and Media, Health Education, Involvement of Voluntary Organizations in Family Welfare Programme and Sex Determination Test.

Shti Prasanta Kumar Sur,
Health Minister, West Bengal.

Chairman

Shri R. S. Chib,
Health Minister, Jammu & Kashmir.

Co-chairman

Smt. Shantaben Y. Makwana,
Minister of State (Health).
Gujarat.

Member

Smt. Kamla Bhil,
Minister of State for Health,
Rajasthan.

Member

Smt. M. War,
Minister of State for health
Meghalaya

Member

Shri Vijay Ranchan.
Health Secretary,
Gujarat.

Shri B. B. Saxena,
Secretary (Medical),
Delhi Administration. Delhi.

Shri P. Raghavan.
Addl. Secretary,

Govt. of Kerala,
Health & F. W. Department.

Shri Lipokmeren Jamir,
Addl. Secretary (H&FW),
Nagaland.

Shri P. Abbanna,
Addl. Secretary,
Govt. of Andhra Pradesh.

Smt. Rami Chhabra
Adviser (MM&C).

Convenor

Shri S. K. Alok,
Jt. Secretary.

Convenor

Dr. A. K. Gupta.
Hony. Jt. Secretary.
I. M. A.

Shri P. K. Ray,
Dy. Secy. West Bengal.

Dr. D. D. Nimawai.
Addl. DM&HS,
Rajasthan.

Dr. (Mrs.) Deborah Roy.
Dir. H. S. (FW&MCH etc)
Meghalaya.

Dr. B. N. Singh.
Addl. Director. Andhra Pradesh

Dr. V. M. Bedi. Reg. Director H&FW,
Himachal Pradesh

Dr. G. M. Dhar
Director F. W., MCH & Immunization,

Jammu & Kashmir.

Dr P K. Mukharjee,

Dir. F. W., Orissa

Dr. T. M. Rammesa,

Addl. Director.

Karnataka.

Shri J. K. Khanna.

Dy Director Health Services,

Punjab.

Dr. H. L. Batra,

Jt. DHS,

Chandigarh.

Dr. M. A. Owaisy,

Dy. Comm, (FW).

Min. of Health & F.W.

Dr. S. C. Dutt.

Reg. Director H&FW,

Ahmedabad.

Dr. G. Harpalani.

Reg. Director (H&FW),

Jaipur.

Dr. S. C. Rai.

Director F. W.,

Uttar Pradesh.

Smt. C. K. Gariyala.

Dir. of family Welfare,

Tamil Nadu.

Shri D. K. Bhatt,

Demograper,

Jammu & Kashmir.

Shri Mohammad Rafi,
Under Secretary,
Jammu & Kashmir.

Dr. Ghanshyam Sharina,
Director of H. S.,
Haryana.

Shri Shyam Lal Goyal,
Assistant Director (Demography),
D. H. S.,
Haryana.

Dr. B. Thangdailova,
Joint Director of H. S.,
Mizoram.

WORKING GROUP II

Subject:—MCH & Immunization, Primary Health Care including Minimum Needs Programme and School Health Services.

Sh. Niranjan Patnaik,
Health Minister,
Orissa. Chairman

Dr. (Smt.) Kamla Verma,
Health Minister,
Haryana. Co-chairperson

Dr. Lalit M. Nath, Member

Dr. R. S. Arole Member

Sh. P. K. Malhotra, Convenor
Jt. Secretary.

Dr. Harcharan Singh,
Adviser (H&FW),

Planning Commission.

Sh. V. G. Nigam,

Principal Secretary, Madhya Pradesh.

Dr. Jagdish C. Sobti,
Hon. Jt. Secretary,
Indian Medical Association.

Dr. Ali Baksh,
Spl. Secretary (H&MI-),
J&K.

Sh. Alok Perti,
Dy. Secretary,
Min. of Health & FW.

Smt. Lina Chakrabarti
Health Secretary,
West Bengal.

Smt. C. Narayanaswamy,
Secretary, Health & FW,
Orissa.

Sh. A. Bhattacharyya.
Dy. Secretary,
West Bengal.

Sh. S. Seetharaman,
Health Secretary,
Pondicherry.

R. Datta,
Chief Adviser &
Spl. Secretary (Health),
Tripura.

Dr. M. R. Chandrapure,
Director Health Services,

Maharashtra.

Dr. E. S. Rahavendra,
Director of Public Health,
Tamil Nadu.

Dr. Mohib Ahmed,
Director in Chief Health Services,
Bihar.

Dr N. A. Nath,
director,
Central Health Education Bureau,
Dte. G.H.S.

Dr. S. N. Sinha,
Regional Director, Health & FW,
Bihar.

Dr. H. V. Sakhrie,
Addl. Director, Health & FW,
Nagaland.

Dr. K. N. Srivastava,
Regional Director,
Uttar Pradesh.

Dr. S. C. Sharma,
Asst. Director General
Dte. G.H.S

Dr. U. K. Bhasin,
Dy. Director General,G.H.S.

Dr. Amarjeet Basur,
DADG (AR),

Die, G.H.S.

Sh. J. P. Mishra,
Under Secretary (RHS)
Min. of H & FW.

Dr. **Jotsna** Sokhey,
Asstt. Commissioner. Min. of H& FW.

Dr. K. B. banerjee,
Dy, Commissioner (MCH).

Dr. K. P. M. Prabhu,
Asst. Commissioner.

Dr. A. Bhardwaj.
Assti. Commissioner (trg),
Delhi.

Sh. T. **Dileep** Kumar,
Dy. Nursing Adviser, Min. of H & FW.

Dr. (Mrs.) K. Kehar.
Chief Medical Officer (RH).
Die. G.H.S.

Dr. D. C. Hazarika.
Director of Health Services.
Assam.

Dr. J. S. Nagra.
D.H.S.,
A & N Islands.

WORKING GROUP III

N.M.E..P. including Kala-Azar Control—N.L.E.P'. --TB Control—Control of Blindness-AIDS—Cancer Research including anti-tobacco measures - Control of Water-borne diseases.

1. Shri Kaul Singh Thakur. --Chairman
Health Minister.
Himachal Pradesh.
2. Shri Kashi Ram Reung. --Co-chairperson
Health Minister.
Tripura.
3. Shri R. A. Siddiqui. --Member
Health Minister,
Madhya Pradesh.
4. Ms. Sushila Tiria. --Member
Member of Parliament.
5. P. Siva Reddy, --Member
Andhra Pradesh.
6. Dr. N. Satyanarayan, --Member
President, I.M.A.
7. Shri P. Subramanyun,
Salt Commissioner
Jaipur.
8. Prof. Madan Mohan,
Adv. (Ophth.).Govt. of India.
9. Dr. Usha Luthra.
Addl. D.G. (ICMR).

10. Shri. K. Ramamurthy.
Addl. Chief. Secretary (Health)
Gujarat.
11. Shri Palai Mohandas.
Secretary (H&FW).
Kerala.
12. Ms. Neeru Nanda.
Secretary (Health).
Goa.
13. Shri M. S. Dayal.
Addl. Secretary (II)
Govt. of India
14. Shri R. Vasudevan.
Joint Secretary (V).
Govt. of India.
15. Dr. M. V. V. L. Narshima
Director. N.M.E.P.
Govt. of India.
16. Dr. J. L. Javare Gowda.
Director,
Health & Family Welfare
Karnataka.
17. Dr. T. Verahese,
D.D.G. (L),
Dte. G.H.S.
18. Dr. B. N. Mittal,
A.D.G. (L)
Dte. G.H.S.

- 19 Dr. N. K. Roy,
Regional Director.
Pune.
20. Dr. C. L. Malhotra.
Director of Health Service
Himachal Pradesh.
21. Dr. Sonali N. Sehgal.
Director, N.I.C.D.
Delhi.
22. Dr. P. C. Roy,
A.D.G. (D&CD),
Dtc. G.H.S.
23. Dr. A. Dutta,
Director of Health Services.
West Bengal
24. Dr. N. Choudhury,
Dy. Director, N.M.E.P.
Govt. of India.
25. Dr. (Mrs.) C. Valit,
A.D.G. (NCD)
Dtc. G.H.S.
26. Dr. B. T. Like,
A.D.G. (TB),
Die. G.H.S.
27. Dr. M. G. Muthu Kumarasamy,
Director of Medical Services & Family Welfare,
Tamil Nadu.
28. Dr. S. P. Bhattacharyya,
Director of Health Services,
Meghalaya.

29. Dr. Nganushi K. Ao
Addl. Director of Health & FW,
Nagaland.
30. Dr. Gurcharan Singh,
Regional Director,
Chandigarh.
31. Dr. J. P. Gupta
Regional Director
Srinagar
32. Dr. V. P. Gupta
Director of Health Services
Jammu
33. Dr. S. C. Bhalla
Director Medical & Health Service
Uttar Pradesh
34. Dr. V. P. Sharma
Director
Malaria Research Center,
Delhi.
35. Shri K. B. S. V. Rao,
Principal System Analyst.
National Information Centre.
Delhi.
36. Dr. D. N. Mandal,
C.M.O. (Ophth.),
Dtc. G.H.S.
37. Dr. Anand Helkar
Director of Health Service,
Goa.

WORKING GROUP IV

Subject:—Medical Education including ROME Scheme and National Health Policy.

Shri Anirudda Singha Choudhury — Chairman
Health Minister,
Assam,

Shri R. Poamndi Alias Deviasigamani — Co-chairman
Health Minister,
Tamil Nadu.

Dr. V. Rajeshwaran. — Member
M.P, Lok Sabha.

Shri R. K. Ahuja, — Convenor
Jt. Secy.

Dr. (Mrs.) Ira Ray, — Convenor
Addl. D.G. (M).

Dr. N. K. Grover,
Hony. General Secy. I.M.A.

Dr. A. K. N. Sinha,
President,
Medical Council of India
New Delhi.

Dr. P. S. **Jain**,
Secretary,
Medical Council of India,
New Delhi.

Dr. H. D. Tandon,
Adv. in Med. Education.

Dr. R. K. Gandhi,
President,
National Academy of Medical Sciences.

Dr. (Mrs.) B. K. Maini,
Executive Director,
National Board of Exam.

Dr. S. K. Lal,
Secretary,
National Academy of Med. Sciences.

Dr. L. Surya Nanayana.
Vice Chancellor,
A.P. University of Health Sciences,
Andhra Pradesh.

Shri P. K. Singh,
Secy. (Health).
Manipur.

Shri Arun Kumar,
Secy. Health,
Rajasthan.

Shri Raghbir Singh,
Secy. Health & Med Edu.
Haryana.

Dr. B. M. Rana,
Chief Medical Officer,
Daman & Diu.

Dr. V. P. Varshney
Director of Health Service,
Delhi Admn.

Mrs. R. K. Sood,
Nursing Adviser, D.G.H.S.

Dr. J. P. Gupta,
Director,
N.I.H.F.W.

Dr. N. Rajeevashetty,
Director of Med. Edu.
Karnataka.

Dr. Lalitha Anantha Subramaniam,
Director of Medical Education,
Tamil Nadu,

Dr. Lalengi Khiangte,
Director of Health Services, Mizoram.

Dr. G. Santhakumari
D.M.E.
Kerala.

Dr. F. Handa,
Director Research Medical Education,
Punjab.

Dr. N. K. Vaidya,
Dir. Medical Education,
Himachal Pradesh.

Dr. Sarla Varma,
Director Medical Education.
Uttar Pradesh.

Dr. A. Dutta,
Regional Director
Hyderabad (A.P.).

Dr. B. N, Barkakaty,
Reg. Director (H&FW)
Shilong

Shri: R Srinivasan,
U.S (ME).

WORKING GROUP V

Prevention of Food Adulteration Drugs, Standard Control including problem of Drug Abuse

1. Shri L. Tempok Singh, — Chairman
Health Minister,
Manipur.
2. Miss Komoli Mosang, — Co-chair person
Health Minister,
Arunachal Pradesh.
3. Mrs. Vineeta Rai, — Convenor
Joint Secretary.
4. Dr. D. Dutta,
Prof. & Head, Psychiatry,
A.I.I.M.S., New Delhi.
5. Dr. Prem K. Gupta,
Drugs Controller (India).
6. Shri S. N. Khandelwal,
Special Secretary, Medicines & Health,
Rajasthan.
7. Shri B.. B. Sharma,
Commissioner,
Food & Drugs Admn.,
Maharashtra.
8. Shri V. B. Desai,
Drug Controller,
Karnataka.
9. Dr. V. Perumai,
Drugs Controller,
Tamil Nadu.
10. Dr. P. Das Gupta,
D.D.C.(I),
Ministry of Health.

11. Smt. A. Kishore,
Under Secretary (D),
Ministry of Health.

12. Dr. H. C. Mishra.
Director of Health Services,
Orissa.

13. Dr. Ram Lai,
Jt. Director of Health Service,
Punjab.

14. Dr. N. Deb Burman,
Director of Health Services,
Tripura.