

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

**(RESOLUTIONS)
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DIRECTORATE GENERAL OF HEALTH SERVICES
(BUREAU OF PLANNING)

GOVERNMENT OF INDIA

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INAUGURAL SESSION

**WELCOME ADDRESS BY SHRI K.K. BAKSI,
SECRETARY, HEALTH**

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

I welcome you all to the Sixth Conference of the Central Council of Health & Family Welfare.

The fact that Primary Health Care forms a vital component of the Agenda for Governance clearly indicates the Government's concern for the health sector. The Council being the Apex Advisory Body, we look for guidance and directions from the Council for making the health care system meet the emerging challenges/problem areas that need to be addressed on priority. The need to improve the efficiency and effectiveness of the basic health delivery system so that the poor, particularly in the rural areas, gain adequate, prompt and timely access to the health care facilities is of utmost importance. Though over the years we have built up an impressive rural health infrastructure consisting of Sub-Centres, Primary Health Centres and Community Health Centres, however, due to various reasons the functioning of these centres leaves much to be desired. One of the major problems is the chronic absenteeism and non-availability of qualified professionals, para-medics and other health functionaries.

Similarly, with the rapid urbanization underway, specific efforts have to be made to provide health care services in urban areas. The unabated migration of population to the metros and other major cities has resulted in the proliferation of urban slums with inadequate access to basic facilities. This is yet another area that needs to be looked into urgently as the deteriorating health and hygiene conditions are resulting in the outbreaks of epidemics like Dengue, Cholera, Gastroenteritis etc. with increasing frequency.

The persistence of wide inter and intra State disparities in terms of availability of medical resources and health infrastructure needs to be minimised. For bridging these gaps, alongside strengthening the public sector, there is need to coopt private medical services also and bring their resources into the main stream of public health care delivery with adequate regulations to ensure adherence to minimum standards. Steps are required to enhance the level of their effectiveness and greater participation in the delivery of diagnostic and curative services and in the implementation of various national health programmes.

Intensification of efforts in the implementation of the National Disease Control Programmes, formulation of strategies for early prevention of life style related diseases through organised health education campaigns, provision of safety nets for ensuring the continued protection of the vulnerable groups namely women and children, geriatric groups and the socially and economically backward sections and strengthening of partnerships with Non-Governmental Organisations (NGOs) for enabling them to play a more active role in the health care delivery; and finally and most importantly, the active involvement of the community are all highly crucial areas. These and other issues have been addressed in the Agenda Notes and the Draft National Health Policy. We keenly look forward for your views and further guidance in helping us strengthen our initiatives.

It is indeed my pleasure to welcome you all once again to the Sixth Conference of the Central Council of Health & Family Welfare. I do hope your stay in Delhi will be pleasant and memorable.

**INAUGURAL ADDRESS BY SHRI K.C. PANT,
DEPUTY CHAIRMAN, PLANNING COMMISSION**

I am very glad to be in your midst at the Sixth Conference of the Central Council for Health and Family Welfare. This is a momentous occasion. We will be reviewing the progress achieved in the last five decades and discuss the lessons learnt. Based on these, we will recommend future policies, draw up strategies and set goals to be achieved in the first decade of new millennium.

Health

India is a pioneer in health service planning. Over the last five decades massive infrastructure manned by a large number of medical and paramedical persons has been created by the Government, voluntary and private sectors to provide primary, secondary and tertiary level health care services to urban and rural population. We can truly feel proud of the steep decline in the Crude Death Rate from 25.1 in 1951 to 9.0 in 1996. Life expectancy rose from 32 years in 1947 to 61.1 years in 1991-96.

In spite of these achievements, however, India ranks as low as 138th among the 174 countries in terms of the Human Development Index, which includes health as one of the indicators. The morbidity due to common communicable and nutrition related diseases continues to be high. Morbidity due to non-communicable diseases is showing a progressive increase because of increasing longevity and alterations in life style. We must address these areas of concern and rapidly improve the health status of the population.

First, let us look at Primary health care

India perhaps has the largest primary health care network manned by professionals and paraprofessionals. However, there are substantial differences between the states and between districts in the same state in the availability and utilisation of the health care services and health indices of the population. It is a matter of concern that the gaps in functional infrastructure are widest in the districts where the health care needs are greatest and private sector health care services are not readily available. The emphasis in the coming years should be to optimise the coverage and quality of care by identifying and rectifying the critical gaps in existing infrastructure, manpower, equipment, essential diagnostic reagents and drugs. Efforts will have to be directed to improve functional efficiency of the health care system through training and deployment of health manpower with requisite professional competence, and skill upgradation of all categories of health personnel, through structured continuing education.

Every major programme spends considerable part of the funds available on IEC activities using all media of communication. It is important to review all the ongoing IEC activities, make them reliable and relevant and avoid unnecessary duplication. Optimum use may be made of the ongoing advances in information technology to improve quality and reduce cost of the training and IEC programmes.

With the 73 rd and 74th Constitutional amendments, the Nagar Palikas and Panchayati Raj Institutions, are becoming operational in many States. It is important to involve these institutions in local planning and monitoring making use of available local and community resources, and co-ordinating programmes of related sectors such as sanitation, safe drinking water and women and child development, so that optimal benefit from all these programmes become available to the community and the vulnerable segments receive the attention that they need.

Nearly 30% of India's population lives in urban areas. In many towns and cities the health status of urban slum dwellers is worse than that of the rural population. There is either non-availability or substantial under-utilisation of available primary care facilities along with an over-crowding at secondary and tertiary care centres. This problem should be sorted out by appropriate re-organisation and restructuring of existing institutions and re-deployment of existing manpower. These should be linked with existing secondary and tertiary care institutions in the same geographically delineated areas for referral.

Secondary and tertiary care

At secondary and tertiary care level, there is an ever-widening gap between what is possible and what is affordable either for the individual or for the country. The majority of these institutions in the governmental sector lack adequate manpower and facilities to meet the rapidly growing demand for increasingly complex diagnostic and therapeutic modalities. Development and utilisation of appropriate technologies for diagnosis and management of patients at all levels are an essential pre requisite for improvement in the quality of health services without unnecessary escalation in cost of health care.

Several States have started levying user charges for the diagnostic and curative services offered in secondary and tertiary care institutions from people above the poverty line, to meet some of the recurring costs in providing such services. Some of the States are also taking up experimental projects of establishment of pay clinics/pay cabins for generating funds required by the institutions. Necessary amendments are being made to enable these hospitals to retain the funds generated by these activities so that they could be utilised to improve quality of services available. If found successful it might also be possible to use the income from pay clinics as cross subsidy for treatment of patients below the poverty line.

Let us now take up the problems posed by the ongoing demographic transition. India's planners recognised the necessity of attaining population stabilization and in 1952; India became the first country to adopt a National Family Planning Programme.

Over the years, improvement in the quality and coverage of health care has resulted in rapid decline in the death rate; decline in birth rate was less steep. As a result average annual growth rate of population during the last three decades has been over 2%. In the nineties, the decline in birth rate is steeper and the population growth rate has fallen below 2%. However, in the next few decades the population will continue to grow inspite of the decline in the birth rate because of the large and growing reproductive age group in the population. At present 20% of the population growth is due to unmet needs for contraception and another 20% due to high wanted fertility rate due to prevailing high infant mortality. These wanted but unmet needs exist in all segments of the population irrespective of religion, caste, education and income status. The Reproductive and Child Health (RCH) Programme should strive to meet all these felt needs, achieve rapid decline in birth rates and enable the country to achieve replacement level of fertility by 2011. The country's medium and long term efforts should be focussed on bringing about an accelerated convergence of ongoing demographic, socio-economic, educational and information technology transitions, enable the increasingly literate and aware families to achieve their reproductive goals, and the country to achieve rapid population stabilisation, sustainable development and improvement in the quality of life.

Interstate differences in fertility and mortality

There are massive inter state differences in birth rate, infant mortality rate, population growth rate and the time by which the replacement level of fertility is likely to be achieved. The five states of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar and Orissa, which constituted 44% of India's population in 1996, will contribute 55% of the population growth during the period 1996 to 2016. By 2016, nearly 50% of India's population will live in these five states. These states have been facing severe resource constraints, and have been performing poorly both in the social and economic sectors. Continued high population growth commensurate economic development, growth in employment potential and social sector programmes would further aggravate the situation. Energetic steps will have to be taken to avert this dangerous build-up, which will affect not just the people living in these States, but the whole country.

There is a small ray of encouragement.

Analysis of 1991 Census data as well as the district surveys commissioned by the Department of Family Welfare have clearly shown that even in poorly performing states, many districts are doing well. Infant mortality rates in Almora and birth rate in Kanpur-urban district are lower than the national levels. These successes should be replicated in other districts; simultaneously all districts should strive for incremental improvement in performance so that the over all performance of the state improves.

Planning Commission has implemented the recommendation of the NDC Committee on Population and has provided additional assistance to poorly performing districts. However, apart from funds, additional capacity building and monitoring assistance would be required to improve performance. In view of the interdistrict variation in vital indices, the FW Programme has embarked on community need assessment at PHC level and plans to meet these needs by improving access to comprehensive high quality health care services to women and children through the RCH (Reproductive & Child Health) programme.

Population projections and Family Welfare Programme

If the RCH programme caters felt needs for health, nutrition and contraceptive care, it will be possible to rapidly achieve replacement level of fertility and steep reduction in under nutrition and IMR, It is imperative that we take effective steps to achieve rapid population stabilisation, reduction in morbidity and mortality, sustainable development and improvement in the quality of life.

As the size of the under 15 years population is reduced as a result of the ongoing demographic transition, the opportunity should be utilised to improve quality and coverage of immunisation, health and nutrition services and improving access to education and skill development.

Family Welfare Programme is not the sole responsibility of Department of Family Welfare, Inter-sectoral coordination between Departments with allied programmes such Department of Health, ISM&H, Women and Child Development, Human Resource Development would enable sustainable improvement in coverage. Departments such as Railways, Defence can provide RCH services for their employees and their families. The Tripartite Committee meetings provide a mechanism for increasing participation of industry, labour leaders and self help groups in improving access to RCH services. After nearly two decades, the Family Welfare Programme is currently getting visible support from opinion leaders and the society. States like Rajasthan have implemented the legislation that elected representatives should set an example by adhering to small family norm. It is imperative to utilise all the favourable factors and transform the Family Welfare Programme into a people's programme.

Disease Control Programmes

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

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

In order to prevent delays in release of funds and improve monitoring, many of the on-going national programmes have created state or district level societies. In order to improve effective integrated functioning, it might be preferable to utilise a single health and family welfare society at state or district level. This step would also promote delivery of integrated health and family welfare services at and below district level. Efforts should be made to integrate the existing vertical programmes at district level and ensure that primary health care institutions will provide comprehensive health and family welfare services to the population.

Tribal Health

Tribal population is not homogenous, there are massive differences in health status of tribals in North Eastern States and tribal population in States like Orissa. Tribal population outside North Eastern States have higher disease burden. The factors that contribute to increased disease burden in these communities include poverty and consequent under nutrition; poor environmental sanitation, poor hygiene and lack of safe drinking water, leading to increased morbidity from water and vector-borne infections; lack of access to health care facilities resulting in increased severity and/or duration of illness; social barriers preventing utilisation of available health care services.

During the Ninth Plan period norms for establishment and staffing pattern of Sub Centres and PHCs will be specifically relaxed in the tribal areas taking into account the difficulty in terrain and problems in health care delivery. Implementation of all ongoing programmes will be intensified and closely monitored in these areas. NMEP provides

100% assistance in the North Eastern States and to tribal districts in other States. Specific projects are being evolved to meet the requirements for RCH care of the tribal population in the States such as MP, Bihar and Orissa. Planning Commission has provided additional central assistance for addressing special needs of KBK districts of Orissa and in the North Eastern States.

Health Insurance

Surveys carried out by NSSO indicate that high cost of hospitalisation is one of the factors leading to indebtedness especially among low and middle-income group population. Health insurance to meet the cost of hospitalisation for major illness will ensure that health care costs do not become a major financial burden or cause of indebtedness among these patients or their families. Over the last two decades several health insurance schemes have been introduced. There are individual, family and group insurance schemes for health care, senior citizens insurance and insurance for specific diseases. The experience gained in the implementation of these schemes will provide useful inputs for planning health insurance schemes. The premium of health insurance may have to be adjusted on the basis of health status of the person and age of the person and his/her family at the time of entry into health insurance. Yearly 'no claim bonus'/adjustment of the premium could be made on the basis of previous years hospitalisation cost reimbursed by the insurance scheme. This would be a mechanism through which the health education messages regarding the importance of remaining healthy through optimum utilisation of the preventive and promotive services as well as adopting a healthy life style get reinforced by economic incentives. Guidelines regarding what are the services for which reimbursement of treatment cost will be borne by the insurance company may have to be discussed, drawn up and implemented. Appropriate mechanisms through which the insurance premiums for the people below the poverty line are to be met will have to be evolved, tested and implemented.

Disaster, Accident and Trauma Services

Disasters, manmade and natural, keep happening in the country. The earthquake in UP is the most recent natural disaster faced by the country. Prediction and prevention of disasters might be difficult. However, disaster risk assessment and preparedness for disaster management are feasible and will go a long way in reducing deaths and suffering. Technological advances in the last twenty years have made it possible to substantially reduce mortality, morbidity and disability due to disasters, accidents, trauma and poisoning. This area requires increasing attention.

Efforts will have to be made to improve the availability and utilisation of the emergency care services at all levels of health care. Adequate training to medical and paramedical staff in emergency management at each level of care, provision of transport facilities for transfer of patients and suitable strengthening of emergency and casualty services in tertiary care centres so that they could handle the workload should be initiated. Rehabilitation services for those who have residual disabilities also will have to be strengthened. Steps to improve public awareness about available services and where and how to access them will also be taken up so that the population can fully utilise available services.

Hospital Infection Control and Waste Management

Increasing incidence of hospital-acquired infections and accidental infection in health care providers and waste disposers, renders it imperative that efforts are made to improve infection control and waste management through utilisation of appropriate, affordable technology at all levels of health care. During the Ninth plan period, infection control and waste management in all health care institutions should receive due attention and adequate funding.

ISM & H

There are over 6 lakh of ISM&H practitioners in the country. Many of them work in remote rural and urban slum areas. They are close to the community not only in the geographical sense but in terms of cultural and social ethos; hence these systems have wide acceptance among all segments of the population. They should be optimally utilised to improve access to health care, and the potential of ISM&H drugs and therapeutic modalities should be recognized. There is a need to create herbal farms in the public, private and joint sector to ensure that the essential plants and herbs of appropriate quality are produced in adequate quantity to meet the growing demand, and the cost of drugs is maintained at affordable levels. R&D programmes will have to be strengthened with a focus on development and testing of formulations especially for those illnesses for which there is no effective remedy in the modern system of medicine. Formulations found useful should be patented.

I had shared with you our thoughts and concerns on some of the major areas in Family Welfare, Health and ISM&H Sectors. You have before you an extensive agenda starting with the consideration of the draft National Health Policy. I am sure that over the next two days you will have excellent in-depth discussions and evolve recommendations on policy, strategies and programmes which will enable the country to achieve substantial improvement in health and demographic indices in the very first decade of the new millennium.

**PRESIDENTIAL ADDRESS BY
SHRI DALIT EZHILMALAI, UNION MINISTER OF STATE
(INDEPENDENT CHARGE), HEALTH & FAMILY WELFARE
AND CHAIRMAN, CENTRAL COUNCIL
OF HEALTH & FAMILY WELFARE**

Deputy Chairman, Planning Commission, State Health Ministers, Members of the Consultative Committee of Parliament, Health Secretaries, other senior officials of the Centre and State Governments and the State Directors General of Health Services, eminent experts nominated to the Council and friends.

I deem it a pleasure to welcome you to the Sixth Conference of the Central Council of Health & Family Welfare. I am happy that many eminent persons in the Health, Family Welfare and traditional systems of medicine are present here to attend this Conference of the Apex Advisory Body on Health Care. I am extremely grateful to the Deputy Chairman, Planning Commission for responding to my request to be present with us and agreeing to inaugurate this Conference. It no doubt, signifies his deep concern for the health sector. We all greatly appreciate his presence here with us today.

At the outset, I must thank all the States/UTs for their active participation in the 5 Regional Conferences of the States/UTs Health Ministers held during June-November, 1998 and the valuable suggestions made by them during the discussions in those Conferences. The Regional Conferences have greatly helped us to understand the various problems in the implementation of the health care programmes at the grass-root level. We have attempted to incorporate some of the suggestions made by State Governments in the Draft National Health Policy. I request you to give your considered views on the draft policy.

I would like to briefly present an overview of the developments in the health sector. We have made significant progress in expanding the Health Care Delivery System and reducing the burden of diseases to some extent. Most significant has been the eradication of guineaworm in the country. This was achieved due to the diligence and single minded efforts of our field officers and doctors to whom I take this opportunity to warmly congratulate. The guineaworm eradication is also the finest example of what an intersectoral coordination can achieve.

While a measure of success has been achieved in reaching the goals set out in the National Health Policy, 1983, there have been short falls in some areas. The life expectancy at birth at 72 years and male literacy rate at 93.6% in Kerala are quite high as compared to some States like Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh.

The Infant Mortality Rate of 12 per 1000 in Kerala is less than a fourth of the all India estimate of 72 and less than one sixth of the rate of Madhya Pradesh and Orissa. While Crude Death Rate (per thousand) in respect of Madhya Pradesh, Orissa, Uttar Pradesh and Bihar are 11.0, 10.7, 10.3 and 10.0 respectively, the same for Kerala, Maharashtra, Haryana and Punjab have been 6.2, 7.3, 8.0 and 7.4. Even within these parameters there exist large variations between rural and urban areas, gender disparities and wide gaps between the needs and availability of health infrastructure. One of the major challenges to be met is to reduce disparities and bring about a modicum of uniformity among the States, within sub-districts. It is, therefore, necessary to design strategies and policies keeping in view the area requirements, different from the current practice of uniform policy design for implementation throughout the country.

The crude birth rate is still hovering around 2% per annum, implying an addition of 18 million births every year. If not checked this is likely to cross the one billion mark by the year 2001, according to present trends. This is, by far, our biggest challenge today. Although the Central and State Governments have been implementing a number of large programmes of controlling the population and for promoting the mother and child care, experience so far indicates that the decline in fertility rate has not been substantial in the States of Bihar, Uttar Pradesh, Madhya Pradesh and Rajasthan. It is time for us to consider whether these areas require a different strategy and programmes. Immunization Programmes have great impact in the overall strategy for control of population. All the State Governments and Administration of Union Territories have achieved considerable success in the Pulse Polio Immunization Programme. During the Pulse Polio Programme organised in 1998 over 13 crore children were administered the oral Polio dose. This is an achievement we can all be proud of. The special drive under Pulse Polio Immunization Programme made in the States of Bihar, Rajasthan and Orissa last month was also a great success. The School Health Check-up Programme, aimed at reaching out to our child population has been yet another success. However, there is no room for complacency as the nature of problems is continual. Therefore, we have to achieve total coverage by Immunization Programmes and School Health Checkup Programmes on a continuing basis by institutionalizing these programmes.

Communicable diseases still account for the maximum number of deaths in India. It is estimated that about 14 million people are suffering from active tuberculosis of which about 3 to 3.5 million are highly infectious sputum positive cases. About 0.5 million people die of the disease every year. The pilot test of revised strategy for combating TB popularly known as Directly Observed Treatment Short Course (DOTS) has been encouraging and it is now being expanded to 102 districts of the country covering a population of 270 million in a phased manner. At present more than 90 million population are being covered under DOTS and within the next two months India will be the second largest country in the world implementing DOTS. In the current year alone, the revised programme is likely to treat more than a lakh patient, prevent several lakh people from being infected with TB and save more than 15,000 lives.

With the implementation of the Modified Plan of Operations in 1977 under the National Malaria Eradication Programme, it has been possible to contain the annual incidence of malaria between 2 to 3 million. For sustained and intensified Anti-Malaria Activities, seven North Eastern States are being provided 100% Central Assistance since December, 1994 as against 50% Central shares under the programme. Further, an Enhanced Malaria Control Project with World Bank support and having an outlay of Rs.891 crores is being implemented since 30th September, 1997 covering 100 districts in seven Peninsular States namely, Andhra Pradesh, Bihar, Madhya Pradesh, Maharashtra, Gujarat, Orissa and Rajasthan and 19 towns/cities in the States of Karnataka, Tamil nadu and West Bengal to supplement ongoing activities for Malaria Control with a mix of interventions. Although the incidence of Malaria has shown a downward trend during 1998 as compared to 1997, there should not be any let up on the part of the State Governments with regard to their efforts in fighting this disease.

A National Dengue Control Programme on a 50:50 cost sharing basis between the Centre and the States is under formulation for prevention and control of dengue outbreaks keeping in view the outbreaks that occurred in some parts of the country in recent years. The States Governments may consider implementation of the National Dengue Control Programme within the existing framework of National Malaria Eradication Programme.

I am happy to state that the National Leprosy Eradication Programme was rated high in all the Regional Conferences of State Health Ministers. It has been possible to reduce the burden of leprosy remarkably. About 8.07 million patients have been declared cured due to the Multi Drug Therapy till March, 1998. A total of 4.54 lakh new hidden cases were detected through search by Special Campaigns in 25 States/UTs during the year 1997-98. We had all hoped for elimination of leprosy by the year 2000. While this can be achieved in some States in some others, this may take longer.

There has been an increase in the number of HIV infected individuals and at the end of 1998, a total of over 82 thousand HIV cases were detected out of about 3.5 million cases screened. The estimated HIV infections in the country are about 3 to 5 million. The infection has now percolated from high risk groups to low risk groups/ areas and from urban to rural areas. The total numbers of reported AIDS cases upto December, 1998 were 6693. The experience over the years has shown that inspite of launching Information, Education and Communication (IEC) campaigns, the impact on behavioural changes leading to the disease prevention and control has not been as expected due to social factors.

It is felt that until there is a strong advocacy specially at the political level, our messages may not reach the needy.

Under the National AIDS Control Programme since 1992, 815 blood banks are being provided financial assistance with a loan of Rs.222.6 crores availed from the World Bank. 378 blood banks have been provided equipment for modernisation and the remaining would be provided equipment shortly. 154 zonal blood testing centres are functioning which provide linkage to all blood banks. In order to correct the mis-match between demand and supply of blood, 40 blood component facilities are being established throughout the country so as to have optimal use of the available blood. The Blood Transfusion Councils have been set up at National and State levels inter-alia to co-ordinate the supply of safe blood and blood products and phase out professional blood donors in a time bound manner.

Under the National Programme for Control of Blindness, the objective is to reduce prevalence levels from 1.4% to 0.5% by the year 2005. A special thrust is being given to reduce cataract blindness which accounts for 80% of total blindness in the country. While the number of cataract operations have gone up from 24 lakhs in 1995-96 to nearly 33 lakhs, it is important that focus shifts away from outdoor camps to institutional surgery, from conventional to IOL surgery and accord high priority to the two important aspects of quality and follow-up. I am happy to inform you that from 1999-2000 onwards, the comprehensive eye camp programme being implemented in the World Bank assisted States will be extended to cover the whole country.

Due to the epidemiological transition which is taking place in the country, there is now a marked increase in the incidence of Non-Communicable Diseases such as Cardiovascular ailments, Cancer, Diabetes, Nutritional Deficiency Diseases and Mental problems. Being life style related diseases, containment is dependent upon change in behaviour and attitudes towards health, at the individual and societal level. As life style diseases are highly resource intensive, the more cost effective strategy is to focus on intensifying educational campaigns for behavioural change.

The objectives of the National Iodine Deficiency Disorders Control Programme are to undertake service to assess the magnitude of the iodine deficiency disorders, supply of iodated salt in place of common salt; health education and publicity; re-surveys to assess the impact of iodated salt after 5 years and IDD monitoring.

During the Eighth plan period there was a substantial improvement in the production, quality and transport of iodised salt. The annual production of iodised salt has increased from 5 lakh tonnes in 1985-86 to 40 lakh tonnes in 1996-97. By mid-1995, a ban on the sale of non-iodised edible salt has been implemented fully or partially in all States/UTs except Kerala, Goa and Pondicherry. Currently, it is estimated that about 80% of all edible salt is iodised and the use of iodised salt at house hold level has increased significantly. However, the target of universal iodisation of salt is yet to be achieved.

During the Ninth Plan it is proposed to strengthen the IDD monitoring and to achieve the goal of compulsory iodisation of salt for human consumption. IDD monitoring will be carried out at the district level both for regular checking of iodated salt as well as urinary iodine excretion. IEC activities are also proposed to be stepped up. It is also proposed to bring down the incidence of IDD below 10% level by 2000 AD.

Mental Health ailments have also become a major public health problem in recent times. Epidemiological Surveys within the country have revealed that 10% of the general population is in need of psychiatric care. To evolve and test appropriate strategies for some of the Non-Communicable Diseases, pilot projects have also been taken up in respect of Oral Health, Cardio-Vascular Diseases, Diabetes, Prevention of Deafness and Hearing impairedness and Rehabilitation of the Mentally Disabled.

Through sustained training and building attitudinal capacity among hospital functionaries and users, in the public and private sector, there should be increased emphasis on the proper management of hospital waste. This needs a special mention in view of its potential to harm and increase the risk of infection to patients, doctors and health care workers besides all those who handle bio-medical wastes. The mandate of the Supreme Court and the rules promulgated by the Ministry of Environment and Forest related to bio-medical waste disposal cast on the Ministries of Health and Family Welfare at the federal and the State levels special responsibilities for ensuring that all hospitals and health facilities, be they in the Government or private sector, adhere and comply with the guidelines formulated by the Central Pollution Control Board.

Epidemiological Surveillance is a pre-requisite to modern, effective control and prevention of communicable diseases. It means understanding a disease as a dynamic process involving the ecology of the infectious agent, the host reservoir, the vectors and the environment as well as the complex mechanism involved in the causation of the disease and its spread. As most communicable diseases are preventable, establishing a good surveillance net work and early warning systems are essential. The existing surveillance system is inadequate and requires strengthening. Accordingly, a National

Disease Surveillance and Response System with adequate laboratory back-up with the National Institute of Communicable Diseases (NICD) as a nodal agency, has been initiated and will be expanded to cover the whole Country.

While we have built up an impressive rural health infrastructure the same for the urban areas is practically non-existent. As a direct result of urbanisation there is a rapid increase in the number of unplanned urban slums with inadequate access to basic health facilities, social infrastructure and services. The possibility of mobilising resources from industrial enterprises, private health care institutions and voluntary organisations need to be explored for providing basic health care services to the urban poor. Provision of appropriate drugs of good quality at affordable costs is essential for the success of disease control programmes. Equally important is to restrict, and if possible, eliminate the use of irrational drug formulation, detect and eliminate spurious drugs. A capacity building project for increasing the production of drugs, food, vaccines is at an advanced stage of formulation for seeking World Bank Assistance. This project, once approved, would go a long way in strengthening and enlarging the drugs and food testing laboratories at the National and State levels.

In view of the vast reservoir of medically qualified personnel, there does not appear to be any further need to increase the admission capacity of the existing medical colleges or starting any new medical colleges except in those areas where there are none. Likewise, with nearly half of the medical graduates taking to post graduation and a quarter for PG Diploma Courses, the country is producing more specialists in some disciplines than needed. There is an acute shortage of Dental Graduates and Post Graduates. Yet another area of imbalance is in the production of para-medics, particularly nursing personnel. The nurse population ratio in India has been unsatisfactory. As per information available there is considerable short fall of Para-medics such as ANM/MPW (F), Laboratory Technicians, Nurses/Mid-wives as also qualified medical personnel working in rural areas. A feasible strategy for posting of required health personnel would need to be evolved. So also efforts made by the State Governments in making rural services compulsory for government doctors, have yielded varying results. We need to ensure continuous availability of graduate doctors in rural areas for which an appropriate mechanism such as enforcement of compulsory rural service etc. should be built into the scheme of medical education. I am confident that all of you will take necessary steps to ensure that doctors after receiving subsidised medical education in Government institutions are actually made to serve for a few years, in the remote areas where large segments of our poor reside.

It is high time that we evolve a concrete policy towards the private health sector as it plays a dominant role in the providing of health care. The need to encourage the private sector and give it an enabling environment to develop multi-speciality hospitals and diagnostic centres has been recognised. However, medical care in the private sector has so far worked in isolation without being accountable to any regulation or even self-regulatory mechanism.

In the absence of such a mechanism there is a strong case for external regulations, particularly when the public is paying for the services. The draft National Health Policy, which is one of the items of agenda of this Conference, has spelt out various measures in this regard. I hope that the Conference will deliberate upon some of these issues and offer concrete suggestions.

Although we have established a separate Department of Indian Systems of Medicines and Homoeopathy, I am aware that the resource allocations are inadequate and participation of these systems in the existing National Health Care Programme is negligible. We must harness the vast manpower and material resources of our own systems to deliver health care to the common masses.

The Indian Systems of Medicines and Homoeopathy is confronted with historical challenges at this juncture. While there are well developed research councils and institutions at National level and a number of ISM&H Medical Colleges spread all over the country and a large number of physicians are available in both urban and rural areas, there are also serious weaknesses like lack of scientific validation and inadequate research and development support, substandard ISM Colleges leading to production of less skilled manpower, lack of standardisation of drugs and quality control, decreasing supply of raw material due to depletion in forest area and lack of proper education and information about the systems. Therefore, there is an urgent need to increase the capability of these systems by capitalising on their strengths and removing weaknesses. The ISM&H is also facing challenges from the modern system of medicine with its tremendous clout in resources, research and development, and its domination of market share. It is necessary that the ISM&H should adopt modern scientific and technological advancement to increase its capability. The Department of ISM&H has identified six strategic areas namely, improvement of standard of ISM education, research and development, standardisation of drugs/and quality control, preservation and promotion of medicinal plants, information, education and communication and effective participation of ISM&H treatment in the National Health Programmes during the Ninth Plan. I am sure; all these points will also be discussed in this Conference.

Once again I welcome you to this Conference and seek your co-operation in making this Conference a grand success.

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

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

At the end of the Inaugural Session of the Sixth Conference of Central Council of Health & Family Welfare, it is my privilege to extend a vote of thanks to the distinguished invitees, health policy makers, health administrators, experts and other eminent persons in the field of health and family welfare sector. The Council being the apex Advisory body will look for guidance and directions, from the Council, for making the health care system attuned to meet the requirements of the common man. Shri K. C. Pant, Hon'ble Dy. Chairman, Planning Commission is well known to all of us. In spite of his busy schedule of official preoccupations, he kindly agreed to join us here today and inaugurate this Conference. This is a clear indication of the concern he has for the Health and Family Welfare sector. The thoughts he has articulated in his Inaugural Address will greatly guide us in solving various health problems relating to health sector planning. On behalf of the Central Council of Health & Family Welfare and all other participants, I extend to you, Sir, a hearty vote of thanks.

The Hon'ble Minister of State for Health & Family Welfare has been a source of inspiration and guidance to all of us in the Ministry. But for his help and guidance, this Conference could not have been organised within such a short period. I extend to you, Sir, our sincere thanks, on my personal behalf, as well as on behalf of the Members of the Central Council of Health and Family Welfare.

We are aware of a number of problem areas which need to be addressed on a priority basis. This includes, as has been mentioned, the existence of wide inter and intra State disparities in terms of availability of medical resources and health infrastructure which needs to be minimised. Private medical services need to be brought into the mainstream of public health care delivery with adequate regulations to ensure adherence to minimum standards. Steps are required to enhance the level of their effectiveness and greater participation in the delivery of diagnostic and curative services and in the implementation of various national health programmes.

The Draft Health Policy which has been circulated has spelt out various measures and I am sure the deliberations of this Conference will bring out positive outcomes in this regard.

We are passing through an epidemiological transition, where apart from communicable diseases like tuberculosis, malaria, AIDS etc., we are faced with life style related diseases like cancer, cardio-vascular ailments, diabetes, blindness, etc. While it is imperative to intensify the efforts in the implementation of National Disease Control Programme, it is also necessary to evolve strategies for early prevention of life style related diseases. It needs to be done through organised health education campaigns aimed at informing the population including the children and young adults regarding the dangers of rich diets in saturated fats, salts and excess calories, absence of physical activities and addiction to tobacco and alcohol.

Most of the epidemics and outbreaks are preventable but this is dependant on establishing an effective surveillance network and having early warning symptoms capable of responding in time. The existing surveillance system requires strengthening. A National Disease surveillance system with necessary laboratory work up has been initiated in the Ninth Plan on a pilot basis with National Institute of Communicable Diseases as a nodal agency. It is proposed to be extended to cover the entire country in a phased manner. Further, there is a mismatch in the production of medical manpower in some disciplines and shortages in essential branches. Similar issues pertain to paramedics and nursing personnel. It is necessary that we consider these problems and evolve suitable solutions. To give protection to the vulnerable groups of children, adolescents, pregnant and lactating mothers and geriatric groups, supplementation of nutrition and nutritional education is necessary. Micro nutrient deficiencies mainly of iodine, iron and vitamin A have an adverse impact on the human resource development and their prevention strategies are simple and cost effective. Consumption of iodated salt is the best way to prevent mental and physical retardation in growing children and needs to be ensured by all concerned.

Lastly, the agenda notes circulated have raised a number of important issues including suggestions to mitigate people suffering, particularly of the underprivileged. I am sure that these issues will be discussed in this Conference and we are looking forward to the outcome of the deliberations. With these words, it is indeed my pleasure to once again extend hearty thanks to all of you.

**SUMMARY OF
THE PROCEEDINGS**

RESOLUTIONS

**Family Welfare Programme
and
Rural Health Infrastructure**

**PERFORMANCE OF FAMILY WELFARE
PROGRAMME - AN ANALYSIS**

The Council notes that the Department of Family Welfare implemented the Community Needs Assessment Approach (CNAA) (erstwhile target free approach), sought to involve the community and thus promoted the voluntary acceptance of a small family norm. It is a matter of great satisfaction that these efforts have contributed to the present trend of reduced birth rate as well as reduced rate of growth of population.

In this connection, the Council makes the following specific recommendations:-

1. The Council noted the difficulties encountered by State Governments in the flow of funds of family welfare programmes. The Council resolved to recommend that Government of India provides funds in the beginning of the year, with inbuilt flexibility for State Government to utilise these funds towards the implementation of family welfare programmes.
2. Among the different contraceptive methods, sterilization accounts for a major share in the family planning programme. However, sterilization is adopted by couples with at least two children. Therefore vigorous efforts are required to simultaneously promote birth spacing methods like IUD, OP and Conventional Contraceptives (CC). It was observed that most of the sterilization in various States is being done in camps. The Council urged the States that they must take necessary action to enhance institution based sterilisation.
3. Among the spacing methods, IUD has been found to be having much larger potential than the others. However, most of the States are not assessing the need of IUD acceptance and correspondingly are not achieving higher levels of performance; The States are urged to improve facilities in hospitals and other health care institutions, as for instance, to provide and maintain fixed hour services in each institution for IUD insertions. Regarding the performance of Oral Pills (OP) as a spacing method, present coverage is low, and should be augmented. The Council noted that the use of condoms in the country is not yet adequate and this option should be promoted vigorously, more so in view of the proliferating HIV cases in the country. Social marketing of condoms should be encouraged.
4. The Council urges the Central Government to explore the possibility of enhancing and increasing the number of contraceptive choices. Additionally, State Governments must ensure good quality of contraceptive services including the counselling of acceptors.

5. The Coimcil also noted the achievements of country in the reduction of the birth rate, total fertility rate and infant mortality rate. The Council urges that the States of Assam, Bihar, Madhya Pradesh, Orissa, Rajasthan and U.P. make special efforts in bringing down these indicators, in order to achieve a replacement level of birth rate of 21.
6. The Council urges all the States to expedite the preparation of need assessment for all districts and to regularly furnish monthly performance reports on time.
7. The Council noted the concerns expressed by States which have done well towards stabilizing population growth that their success in implementing this national agenda could lead to reduction in their representation in Parliament after 2001. The Council urged Government of India to address this issue.

**RURAL HEALTH CARE INFRASTRUCTURE DEVELOPMENT
BY STATES**

The Council noted that the gaps in health infrastructure and the inadequacy in the availability of skilled human resource are major constraints in the provision of primary health care.

The Council resolved that:-

- (i) State governments should ensure that a sizeable share of additional central assistance is utilized towards putting in place the required infrastructure for Primary Health Care, construction of buildings and provision of drugs and equipment;
- (ii) In view of the absence of trained health personnel in rural areas, the Council calls upon the States to decentralise authority for making contractual appointments of health professional and para-medical staff at the district level; and
- (iii) The Council requests the Planning Commission to earmark sufficient funds in the health sector under the Basic Minimum Services Programme, so that this earmarking is not diverted to other sectors.

**PROGRESS IN OPERATIONALISING REPRODUCTIVE
AND CHILD HEALTH (RCH) PROGRAMMES - NEW
INITIATIVES BY THE CENTRAL GOVERNMENT**

The Council appreciated the initiative taken by the Department of Family Welfare in launching this comprehensive programme of reproductive and child health. integrates all previous interventions towards reproductive health of both men and women and further, addresses itself to strengthening services provided through community participation and upgradation of first referral units towards comprehensive emergency obstetric and new born care as also improving out-reach services for the vulnerable population e.g. urban slums, tribal population and adolescents.

The Council noted the difficulties encountered by the State Governments in the implementation of the RCH Programme. State Governments urged that sufficient flexibility be built into the guidelines for RCH, so that State specific requirements may be taken care of, wherever necessary.

The Council was concerned about the slow pace of implementation of the various schemes under RCH Programme, and resolved that all the States should take immediate action to improve the pace of implementation.

**PROMOTION OF INSTITUTIONAL DELIVERIES AND
OPERATIONALIZING FRUS**

While reiterating the contribution of institutional deliveries and provision of emergency obstetric care at First Referral Units (FRUs), towards reducing maternal mortality and morbidity, the Council noted that the progress in this area has been slow and needs improvement. The Council, therefore, resolves that the State Governments should:-

- (i) Ascertain district wise gaps for individual PHC and CHC and deploy adequate number of trained medical personnel, and provide essential facilities namely, water, electricity, labour room, drugs and equipment, provisioned for under RCH Programme, in order to provide round the clock delivery services specially in the under served areas.
- (ii) Identify the gaps and accordingly, allocate resources made available under the RCH Programme in the identified FRUs to ensure availability of all the services under one roof namely emergency obstetric care, STI/RTI, MTP and sterilisation.
- (iii) Mobilise the community, through local IEC efforts, to promote the practice of institutional deliveries and prompt referral of high risk mothers.
- (iv) Promote the use of institutional facilities for safe deliveries in the rural areas.

VILLAGE HEALTH GUIDE SCHEME

The Council took note of the report submitted by the Committee under the Chairmanship of Shri P.K. Umashankar. The Council resolves that the Government of India may take an early decision on the recommendations of the Committee.

POLIO ERADICATION - STRENGTHENING MEASURES

The Council while appreciating the rapid progress made in the eradication of poliomyelitis resolves that all States should ensure:-

1. That 100% coverage of children below the age of 5 years with Oral Polio Vaccine during the Pulse Polio Immunisation days and the additional rounds. All states should ensure to make house to house visits to locate those children who have not been given the dose and ensure vaccinating such missed children.
2. That 100% outbreak response immunization for all Acute Flaccid Paralysis cases detected in the state is ensured.
3. That 100% collection of two stool specimens within 14 days of onset of paralysis of all cases of Acute Flaccid Paralysis.
4. That the ongoing routine immunization programme is strengthened to achieve 100% coverage with all antigens as per the national immunization schedule in order to prevent and control incidence of vaccine preventable diseases.
5. That all hospitals/health facilities provide immunization service at an easily accessible location and all doctors and other health functionaries should ensure vaccination of the children and pregnant women.
6. That supervision on the field level functionaries should be strengthened in order to improve coverage under the routine immunization programme.

Indian Systems of Medicine and Homoeopathy

HEALTH POLICY FOR ISM&H

The Indian Systems of Medicine and Homoeopathy portion of the Draft Health Policy was recommended for adoption of Working Group No. VI.

PERSPECTIVE PLAN FOR ISM&H

The Central Council of Health & Family Welfare resolves and enjoins upon State and Central Governments to keep the following issues in mind before planning/implementing any programme in the health sector:

1. The approach towards provision of health services should be one of system neutrality with all systems of medicine being treated equally.
2. The right to choose a system of medicine must not be decided by Central/State Authorities but must vest with the consumer of health services.
3. Bearing in mind the fact that the Indian Systems of Medicine have been providing health coverage for thousands of years, it is important to understand that ISM&H are just as effective for the promotion of health and prevention of diseases including common ailments as also in those diseases for which there is no cure in modern medicine.
4. Indian Systems of Medicine, which consist of Ayurveda, Unani, Homoeopathy, Naturopathy, Yoga and Siddha may be declared as National Systems of Medicine. In promoting and developing Indian Systems of Medicine & Homoeopathy, Central and State Governments should earmark atleast 20% of the funds allotted for health, ensure an ISM&H component in the National Health & Family Welfare Programmes, over a period of time, build-up necessary, primary, secondary and tertiary health care infrastructure and treat ISM&H medical and Para-medical staff, in all aspects on par with their modern medicine counterparts.
5. Each State Government/Union Territory will prepare a perspective plan for the development of ISM&H in the respective State with specific targets for development. Perspective plan should cover areas like, separate budget, separate Department/Directorate of Indian Systems of Medicine & Homoeopathy with a technically qualified person as Head of the Department, utilisation of services of ISM&H practitioners for health care delivery, ISM&H treatment facilities at block and district levels, role of NGO's, improvement in education, quality control of drugs, setting up of drug testing laboratories, enhancing availability of raw materials, research and development, information, education and communication, etc. The perspective plan should form the foundation for development of these systems for the next 15 years.

**EDUCATION AND TRAINING IN INDIAN SYSTEMS OF MEDICINE &
HOMOEOPATHY**

1. MINIMUM STANDARDS

The Central Council of Indian Medicine has circulated the rationalised and revised norms/standards of U.G. - ISM courses to all the State Governments for their views. The State Governments should expedite their views. Governments/ Institutions are required to follow the norms to improve the standard of institutions.

2. MUSHROOM GROWTH OF ISM&H COLLEGES

At present there are 172 colleges of Ayurveda, 37 colleges of Unani, 146 colleges of Homoeopathy, 2 colleges of Naturopathy and 2 Colleges of Siddha in the country. It has reached a saturation point in some States. It is necessary that the unbridled growth of sub-standard colleges be regulated. Considering the gravity of the situation the Conference resolves:

- (i) As a matter of policy State Governments should not recommend the setting up of any new college at least for a period of two years where already some colleges are in existence;
- (ii) The Universities also should not grant affiliation to new colleges in such States;
- (iii) The Universities/States are requested to prepare a master plan for education in ISM&H after assessing the need or otherwise for more institutions;
- (iv) In future no new college should be permitted to be set up without the prior permission of the Government of India;
- (v) The Directors of ISM&H of the concerned States should monitor the progress in term of improving the standards of the colleges regularly by holding at least two meetings in a year, with all the concerned with the development of ISM&H education.

3. SEPARATE ADMISSION TEST

In order to attract suitable candidates having interest in the ISM&H, there should be an entrance examination to be conducted separately for selection of students. There

should also be some condition stipulated to ensure that the students once selected do not abandon the course mid way. It would be desirable to start such an entrance test from the coming academic session. Alternatively, selection on merit list could also be followed.

4. ADMISSION QUALIFICATION

The minimum qualification for admission to the ISM&H colleges should be 10+2 with Biology Science group. The present admission qualification of BUMS course will continue till such time as text books are translated into English or 3 years whichever is earlier. The teaching of Sanskrit/Urdu/Persian/Tamil should form a part of the main course. The Pre-Tib course of BUMS needs to be abolished. However, scheme may be evolved whereby preference may be given to students having knowledge of Urdu for BUMS course and knowledge of Sanskrit for BAMS course.

5. POST-GRADUATE EDUCATION OF ISM&H

Post-Graduate teaching and training with appropriate infrastructure is essential to produce specialists, teachers, and researchers of ISM&H. The Department of ISM&H has a scheme for setting up PG Deptt. Assistance is provided for a plan period to support setting up the P.G.Departments. There is an urgent need to provide financial support to the P.G.Institutes both from the State Governments and the Central Government to strengthen the P.G. teaching programme.

It was further resolved that at least 20% of PG Colleges/Institutes be reserved for those States not having PG courses in the concerned subjects.

6. PROFESSIONAL UPGRADATION PROGRAMME (RE-ORIENTATION TRAINING)

There is a need for professional upgradation and, therefore, reorientation training programmes for in service teachers, physicians and private practitioners need to be organised in a big way by the State and Central Governments. State Governments should also support this and allocate adequate funds for these training programmes to make the programme a success.

CCIM/CC/Universities/States Government/Local Bodies should consider making such re-orientation training mandatory for all teachers/physicians. State Governments/Autonomous Bodies should sanction study/duty leave for this purpose.

7. PHARMACY/NURSING COURSES OF ISM&H

There is an acute shortage of Pharmacists, B.Pharma and Nursing personnel in ISM&H. Some of the State Governments/NGOs are running these courses. There is no uniform course for these professions nor is there any provision for recognising the qualification by way of a Pharma/Nursing Council arrangements are also required for registering these qualifications. Setting up of Pharmacy and Nursing training courses in existing ISM&H colleges during the 9th Five year Plan period be considered in addition to the setting up of Pharmacy Councils for ISM&H.

8. RESEARCH METHODOLOGY* MEDICAL STATISTICS IN U.G.&P.G. COURSES

Research and development has become essential for U.G. & P.G. courses of ISM&H. Presently U.G. teaching has no component of medical statistics and research methodology & information on latest development in ISM&H. It is, therefore, essential that the final professional course contents of BAMS/BSMS/BUM/BHMS should incorporate at least 10 marks for each subject on the R&D. Laboratory facilities need to be strengthened at U.G. colleges. R&D aspect of P.G. education, both in terms of equipment and manpower need strengthening. CCIM/CCH need to add the essential components in relevant syllabi.

9. ARRANGEMENT OF SEATS FOR FOREIGNERS/NRIs AS WELL AS STUDENTS FROM THOSE STATES WHERE THERE IS NO ISM& TEACHING INSTITUTIONS

There is growing demand from various foreign countries for graduate and post graduate level training for ISM&H. Presently there is no systematic arrangement to allocate seats in various UG & PG colleges. Therefore, arrangement should be made in colleges to impart training for foreign students, subject to the fulfillment of CCIM/CC norms. State Governments/ other National level Institutes may be requested to reserve some seats for this purpose in the various institutions.

National Institute of Ayurveda, Jaipur under Govt. of India should arrange 10 additional seats for foreign students at UG level. Similarly faculty of Ayurveda, BHU, IPGT&R, Jamnagar and NIA, Jaipur should allocate seats for M.D.(Ay.) students. Similar arrangement should be made in National Institute of Homoeopathy, Calcutta, Aligarh Muslim University for Unani students and Govt. Siddha college, Palamkottai.

For North-East States & Sikkim where there is no ISM Colleges independently seats are required in other States of the country. There is growing demand of such U.G. seats, therefore, State Govts. should volunteer some seats for the students of such States.

10. SEPARATE CADRE AND BETTER PAY-SCALES FOR ISM TEACHERS

Teaching requires special skill, experience and qualifications; therefore, the teaching cadre must be separated from the general cadre of dispensaries/hospitals. Post graduate qualifications have been made compulsory in Ayurveda teaching institutions. There is an urgent need to give better pay scales to the teachers of ISM&H colleges' equivalent to their allopathic counter-parts in various State Governments.

11. RESTART OF BAMS COURSE IN BANARAS HINDU UNIVERSITY

It is resolved that in addition to existing Post-Graduate faculties of Ayurveda, Under-Graduate courses of BAMS should be started in BHU.

STANDARDISATION OF DRUGS AND QUALITY CONTROL

1. The Council resolves to formulate a National Policy of ISM&H drugs.
2. The Council resolves to have separate drugs control system for ISM&H drugs at the Centre and State Government level. The State Governments should develop their own drug testing laboratories.
3. The Council resolves to appoint separate drug inspectors for ISM&H to have an effective quality control system on ISM&H drugs.
4. The Council resolves to complete the pharmacopoeial standards of ISM&H drugs before the end of 9th Five Year Plan to have quality control on ISM&H.
5. The Council resolves to formulate separate GMP for the drugs which contain metal and mineral especially mercury as the main ingredient.

ENHANCING AVAILABILITY OF RAW MATERIAL -MEDICINAL PLANTS

The Conference resolves to recommend that the Central Government/State/UT Govt. shall take immediate steps as follows:

- (i) State Departments of ISM&H should be identified as Nodal Department for proper planning, implementation, monitoring and coordination of activities relating to development of medicinal plants.
- (ii) State level Committees may also be set up by ISM&H Departments, which should have representatives of all concerned Departments in State/UTs. It is required for proper interaction and coordination for developmental works in the field of Medicinal Plants.
- (iii) To develop required mechanism and also to frame suitable rules/regulations or introduce legislation for procurement of data on consumption of medicinal herbs by drug manufacturing units and other local consumers.
- (iv) To establish large Medicinal Plant Gardens for growing of medicinal plants for demonstration purpose and also to augment the availability of these plants.
- (v) To initiate steps for growing of medicinal plants including trees in local forests areas by involving colleges of ISM&H in States/UTs.
- (vi) Ex-situ conservation through preservation of Germ plasm and propagation in other suitable agro-climatic areas;
- (vii) Introduction of exotic genera & species required for medicinal purposes in local areas;
- (viii) Cooperative/contract farming, making suitable fertile waste land available for the purpose, in suitable agro-climatic zones;
- (ix) Creation of centres for availability of plantation material and Germ Plasm of ISM&H Medicinal Plants;

- (x) To develop agro-techniques and tissue culture techniques for cultivation and propagation of important medicinal plants;
- (xi) To develop data-base system for compilation and dissemination of information on medicinal plants;
- (xii) To identify raw material items of animal/mineral origin which require specific steps for their development and also to initiate required developmental programmes.
- (xiii) State Governments should take action to set-up at least one complex comprising of medicinal plants garden, drug manufacturing pharmacy, drug testing laboratory and herbarium.
- (xiv) Arrangement should also be made to link up the cultivation of medicinal plants activity with assured marketing.
- (xv) To increase the awareness about the utility of medicinal plants, charts/booklets should be published and organisations be encouraged to organise workshop/ seminars.
- (xvi) ISM&H doctors should visit nearby schools to educate the students about the commercial and medicinal uses of medicinal plants.
- (xvii) Some of the State Governments like Himachal Pradesh have formulated State policy on medicinal plants keeping in view the scope of cultivation, propagation etc. This should be followed by all States/UTs.
- (xviii) The Central Government should set up a national level board for dealing with all aspects related to medicinal plants under the nodal Department of ISM&H.
- (xix) The growing demand of medicinal plants requires plantation and cultivation in larger areas other than agriculture land. Therefore, denuded forest land and other such lands should be utilised to establish "vanaspati vans" on larger areas. Department of Family Welfare, GOI has a scheme to support plantation of RCH related plants in such vanaspati vans. Proposals should be formulated and submitted by State Departments to D/o FW.
- (xx) Financial assistance be given to the State Governments and NGOs for cultivation of Medicinal Plants on large tracts of land.

RESEARCH & DEVELOPMENT

1. This Conference resolves that the State Governments may make provisions for research and development in Ayurveda, Homoeopathy, Unani and Siddha Systems and Yoga and Naturopathy. The Post-Graduate Institutes in ISM&H, the University Faculties good hospitals, treatment centres shall be identified for this purpose and financial assistance be provided.
2. The State Governments shall draw a list of institutions engaged in ISM&H research activities and publish the list from time to time.
3. The State Governments shall set up Research Boards for each of the ISM&H Systems with eminent personalities in respect of disciplines to give proper directions and guidance in ISM&H research.

INFORMATION, EDUCATION & COMMUNICATION

1. The Council resolves to recommend that each State/UT Government shall set up a separate IEC Cell on the pattern of the one set up by the Department of ISM&H in the Ministry of H&FW, Government of India for effectively popularising the various pathies under ISM&H and for creating awareness among the general masses about the strength of ISM&H.
2. The Council resolves to recommend that the State/UT Governments through their publicity Departments shall make use of the mass media for popularising ISM&H in their State.
3. The Council resolves to recommend that each State/UT Government shall earmark adequate separate budget for IEC activities for ISM&H.
4. The Council resolves to recommend that each State/UT Government shall provide the information with regard to the facilities available with them under ISM&H to the Mother NGOs who are implementing the IEC Scheme of the Department of ISM&H of the Government of India for passing on that information to the general public and would help such Mother NGOs in whatever way possible to popularise the said scheme.

INVOLVEMENT OF ISM&H PRACTITIONERS IN NATIONAL HEALTH & FAMILY WELFARE PROGRAMMES

- (i) The Council having taken note of the vast potential of ISM&H systems in treating various kinds of diseases of national importance resolves that these systems should be made an integral part of National Health Programmes, Family Welfare Programmes and RCH Programmes and primary health care.
- (ii) The Council resolves that JSM&H practitioners be involved in the programmes like Anganwadi schemes of the Department of Women and Child Development.
- (iii) The Council resolves to post at least one Physician of ISM&H in the existing PHC in every State and also to fill vacancies caused by non-availability of allopathic persons by ISM&H physicians.
- (iv) The Council resolves to start specialist treatment centres of ISM&H at the Taluk/ block level and introduce ISM&H wings in the existing State Government hospitals so that the benefits of these systems can be made available to the general public as per their choice. It was also resolved to set up Centres of excellence (hospital facilities) in the national Capital.
- (v) The Council resolves that the State Governments may also assist NGOs to set up specialist hospitals of ISM&H.
- (vi) The CGHS be extended to more places.
- (vii) Treatment taken in ISM&H hospitals should be recognised for medical reimbursement as in the case of Allopathy hospitals.
- (viii) Department of ISM&H should issue policy guidelines on the manner in which a component of ISM&H in the Ministry of H&FW is to be achieved viz. line of treatment etc.

Communicable Disease Control Programmes

COMMUNICABLE DISEASE CONTROL PROGRAMMES

Recognising that if the communicable diseases are not dealt with promptly and timely a situation will be precipitated which will adversely affect not only health of the country but also its economy. The Council resolved that the highest priority should be accorded to the public health programmes by the Centre and all the States.

The Council also observed that issues like decentralization of procedure, planning and monitoring of the programmes need to be looked into for initiation of locally feasible strategies so as to have more effective control over these communicable diseases. The Council also observed that for facilitating implementation of National Health Programmes, District Health Societies should be constituted because this could facilitate an integrated approach which is one of the important aspects in the implementation of these programmes. A common district society for various national health programmes may lead to such a holistic approach.

In view of the present status of the national health programmes for the control of communicable diseases, Council passed the following Resolutions:-

NATIONAL MALARIA ERADICATION PROGRAMME

Malaria has been one of the major public health problem in the country. Though the incidence of malaria has been contained between 2-3 million cases annually for more than a decade, occurrence of local and focal outbreaks from various parts of the country during the recent past has resulted in increase in malaria deaths. The situation has been aggravated due to massive developmental activities, fast urbanisation, population migration etc. Ongoing control measures may not fetch effective results until and unless area specific approach is adopted. The very first objective of programme i.e. elimination of malaria deaths needs to be given due consideration, especially in view of recent increase in malaria deaths. Therefore, the Council resolved the following:

1. PREVENTION OF DEATHS DUE TO MALARIA

The Council notes that elimination of deaths due to malaria is the first objective of the Modified Plan of Operation of the NMEP and due to a number of causes viz. the delay in the detection and treatment of malaria chloroquine resistance in *P.falciparum*, malaria outbreaks and population migration/aggregation of labour in development projects, there has been an increase in the number of malaria deaths in the country since 1994. The Council resolves that the states may orient their action plans for control of malaria keeping prevention of deaths as the first objective of the programme and accordingly prepare area specific action plans in respect of important components of control strategy. The emphasis should also be given to tackle with border malaria with the approach of inter-state and inter-country coordination for planning, implementation and monitoring of anti-malaria activities. The Council also realises that for the better compliance of the patients, anti-malarial like blister package will be useful, hence piloting may be done for finding out effectivity, operational feasibility etc. in some areas.

2. BYE-LAWS TO PREVENT MOSQUITOGENIC CONDITIONS

The Council reiterates its concern about the increasing incidence of malaria in urban areas and the number of outbreaks of dengue/DHF and notes that the mosquito breeding which leads to the spread of these diseases in the urban areas is largely man-made and legal provisions to prevent it would go a long way in containing their transmission and spread. Accordingly, the Council urges the States to formulate and enforce municipal bye-laws on the pattern of bye-laws already enforced in the Greater Mumbai Corporation which includes legal provisions to prevent mosquitogenic conditions leading to the spread of diseases like malaria, filariasis, Dengue/DHF. The Council has also noted that several state governments are already committed to formulating bye-laws in the towns under the EMCP being implemented with World Bank assistance.

On the same note Council resolves that in view of increasing incidence of malaria in the urban areas, urban malaria scheme should be extended to all the malarious towns having more than 40,0000 population.

3. BYE-LAWS ON MANDATORY LABOUR SCREENING IN PROJECT AREAS

The Council notes that population migrations and labour aggregation in project areas are important factors in determining high malaria transmission and in the introduction/spread of drug resistant P.falciparum malaria. Several focal outbreaks of malaria affecting local populations have occurred in development project/construction sites. To prevent such outbreaks, the Council resolves that all states should implement bye-laws on the pattern of Goa bye-laws to make the screening of labour populations in development project areas/construction sites a mandatory exercise on part of the concerned health services.

4. INADEQUATE/UNTIMELY RELEASE OF STATE FUNDS

The Council notes that malaria being seasonal disease, timely and adequate release of state funds to meet the operational cost of insecticides spraying in the proper season is most essential for interrupting transmission of the disease. Some of the states either do not release sufficient funds for meeting operational cost or are not releasing them in time for undertaking timely spray operations. The seven North-Eastern States which are covered under 100% central assistance need to utilise the funds for the purpose for which assistance is being provided. The Council resolves that the states may ensure that adequate funds are released and utilised in time for undertaking spray operations against malaria vectors. The members from North-Eastern States have expressed that the central assistance provided to the States are not being released to the programme in time. The Council also resolved that the seven North-Eastern States which are covered under 100% central assistance may explore the possibility of constituting district societies for facilitating the central cash release to the programme so as to avoid delay in release of funds. Council also resolves that uninterrupted supply of anti-malarial drugs should be ensured by the Union Government.

5. FILLING UP OF VACANCIES

For ensuring early detection and prompt treatment of malaria cases, the surveillance workers post should be filled up in all the states. The Council reiterates that all the vacancies of zonal entomologists and supporting staff in some of the states need to be filled up on a priority basis.

6. NATIONAL DENGUE CONTROL PROGRAMME

The Council resolves that in view of the recent outbreaks of Dengue in the various states and emerging dengue problem in the various parts of the country, there is need to have a continuous monitoring by establishing a National Dengue Control Programme on the pattern of National Malaria Eradication Programme. The proposal at the central level should immediately be considered and the Planning Commission may be requested to make budget provision for National Dengue Control Programme. All problem states should also propose to establish National Dengue Control Programme within the existing framework of National Malaria/Vector Borne Diseases Control Programme in the respective states.

7. SUPPLY OF INSECTICIDE

The Council observed that insecticide like BHC has been banned and DDT is being phased out. The alternative insecticides malathion and synthetic pyrethroides are decentralised items under the present pattern of the national programmes. In view of the same Council resolves that Central Government may explore the possibility of supplying these insecticides to the needy states based on technical criteria.

8. INTER-SECTORAL COORDINATION

The Malaria problem has been precipitated by various developmental projects being carried out by different sectors/departments. These sectors/departments are responsible for creating mosquito-genic condition and population migration which results into increase malaria transmission. Therefore all the sectors responsible for creation of such situation should have a provision of anti-malaria component. Under the programme due emphasis should be given for inter-sectoral coordination by involving the sectors responsible for creating malariogenic conditions and sectors which can play a role in malaria control for the effective containment of malaria situation.

9. USE OF ANTI-MALARIAL OF INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY (ISM&H)

The use of effective medicines of indigenous system is to be promoted. Therefore, the Council resolves that anti malarial drugs of ISM&H may be used where ever possible.

NATIONAL AIDS CONTROL PROGRAMME

Advocacy

1. That all states should formulate a strong advocacy programme for legislature members of Zilla Parishad Municipal Corporation, Panchayats, Community Opinion Leaders, Trade Union Leaders and all other elected representatives, for making them aware about the magnitude and socio-economic implication of HIV/ AIDS epidemic and their role in. the containment of the infection.
2. That all States should participate in nation-wide "Family Health Awareness Week" during the month 26th April to 1st May, 1999 by actively involving the community to increase the awareness on STDs including HIV as well as in early detection and prompt treatment of STDs. This pilot programme will later on be extended to all the districts to bring maximum involvement of community in awareness and STD prevention programme.

Inter-Sectoral Co-ordination

3. That all States should constitute a coordination committee under the chairmanship of Chief Secretary in order to make HIV/AIDS Prevention & Control Programme as one of their activities. Members of this Committee may be drawn from the Ministries/Departments like Tourism, Social Welfare, Education, Industry, Railways Surface Transport, Rural Development, Corporate Sectors, NGOs and elected representatives. Similar Committee should be constituted at the district level involving Panchayats Municipalities/Corporations.

Community Participation

4. That all States should evolve a mechanism for community participation by empowering Community Based Organisation (CBOs), NGOs, Panchayats and other organisations working with marginalised population like commercial sex workers, slum dwellers and other vulnerable groups related to HIV infection by their involvement in social marketing of condoms, referral of STD cases and home/community care of people living with HIV/AIDS (PLWHA).

Care & Support for PLWHA & Human Rights

5. That all States should develop a continue care programme for PLWHA which included family/community care and care at hospitals/health centres without discrimination.

All hospitals both in Government and private sectors should admit people living with HIV and AIDS (PLWHA) for medical care without any discrimination.

All states should ensure the protection of HIV human rights of PLWHA & their families by eliminating all form of discrimination on the basis of HIV/AIDS status, protecting and promoting privacy and confidentiality, addressing existing inequalities & prejudices in order to reduce vulnerability to HIV/AIDS, addressing specific issues in specific setting, work place, health care, treatment, care & support, social welfare, education travel and promoting voluntary testing.

HIV Testing

6. That all states should follow the HIV testing policy adopted by the NACO, which is based on the recommendations of the WHO, both in Government and private sectors.

National AIDS Prevention & Control Policy

7. That the Council adopts the National AIDS prevention and control policy, which has already been approved by the National AIDS Committee for the Effective containment of HIV infection all over the country.

Strengthening of the National AIDS Control Programme at District Level

8. It was resolved by members that all the States/UTs should consider to create a National AIDS Control Programme implementation unit at each district level for its proper supervision, monitoring and evaluation. It can be achieved either by strengthening the existing nodal units or creating new ones depending upon the availability of the resources.
9. That adequate attention should be paid to research related to HIV/AIDS particularly in the field of HIV vaccine, prevention of mother to child transmission and drugs for the management of HIV related illness.
10. The Council expresses its concern on the magnitude of the problem of tuberculosis in HIV infected individuals. The Council resolves that all out efforts should be made to bring convergence between these two national programmes for the early detection.
11. That the States/UTs should make concerted efforts to promote voluntary blood donation and screening of blood free from HIV, Hepatitis B, Malaria and Syphilis.

NATIONAL TUBERCULOSIS CONTROL PROGRAMME

1. The Council notes that, unless effectively controlled now, increasing disease burden and emergence of multi-drug resistant tuberculosis (MDRTB), will lead to a situation of unaffordable and unacceptable losses due to morbidity and mortality.
2. The Council recognises that the only way to control this emerging problem is through the Revised National Tuberculosis Programme (RNTCP) and building a system in which it ensures a cure rate of atleast 85%.
3. Therefore, the Council resolves that RNTCP should be implemented all over the country in a phased manner and ensure atleast 85% cure in all detected cases. The Council recommends extension of RNTCP to the entire country as quickly as possible.
4. The Council notes with satisfaction that support for 100% requirement of anti-TB drugs for the States/UTs is being provided by Central Government since 1997-98. While drugs for sputum positive cases are being supplied by the Central Government, cash assistance is being provided to the State Governments for procurement of drugs for sputum negative cases. However, the Council notes with concern that some State Governments are purchasing drugs as per the national programme guidelines. Therefore, the Council resolves that cash assistance be utilized by the states for purchasing only Tab INH, Tab Ethambutol and combination tablets of INH and Thiacetazone strictly as per these guidelines.
5. The Council notes that effective supervision and proper infrastructure are essential for the proper implementation of TB Programme.
6. The Council, therefore, resolves that States must ensure the following:
 - a) Establishment of District Tuberculosis Centres with proper buildings.
 - b) All DTCs should have full complement of staff including a full time DTO.
 - c) Fill up all existing and newly required posts- of laboratory technicians.

7. The Council recommends that the savings accruing to States because of 100% Central assistance for drugs be now used for providing infrastructure support to TB Control Programme.
8. Most of the vehicles supplied to the State Government have outlived their life. Since supervision is an essential component of TB Programme, the Council recommends that vehicles be provided by Central Government to all DTOs in a phased manner at the earliest.
9. To facilitate release of funds, the Council resolves that all State and UTs in the country should establish State Society at the State HQ. The State should also strengthen their management and supervisory capacity.
10. The Council is pleased to note that Central Government is imparting training to the State level officers and DTOs who are then imparting training to other category of staff in State/Districts. Since TB Control Programme involves intensive training, the Council resolves that frequent transfers of trained staff should not be undertaken. With a view to build up trained manpower in the State, it is essential that each State should have its own State TB Demonstration and Training Centre to build trained manpower.
11. Recognising the important role of private practitioners, the Council appeals to all of them to meet this challenge with the seriousness it deserves. The Council resolves that private public sector collaborative efforts be launched.
12. To all TB patients the Council appeals that they must ensure full treatment and full cure and not give up treatment in between. The Council also resolves that there should be a suitable national level awareness campaign.
13. The Council finally resolves that combating TB must become a top priority for the Central and State Governments and all out efforts be made in this direction.

NATIONAL LEPROSY ERADICATION PROGRAMME

The Council reviewed the programme and noted with appreciation the progress of implementation of National Leprosy Eradication Programme and passed the following Resolution to further strengthen the programme.

1. The NLEP has shown substantial progress in reducing the leprosy case load in the country and most of the States will be able to achieve elimination of leprosy by the end of year 2000. Adequate provision therefore, should be made for consolidation of achievements and completion of unfinished task of elimination in the remaining States so that resurgence of the disease does not take place. The Council recommends continuation of vertical infrastructure in 5 major endemic States of Bihar, Orissa, UP, West Bengal and MP till the year 2005. The process of integration should be started in the remaining States/UTs so that the programme is integrated with general health care in the States/UTs which are able to achieve elimination by the year 2000. The District Leprosy Societies should be continued after integration for which nucleus staff with DLO be set up after integration till elimination of leprosy is maintained for 5 years.
2. Modified Leprosy Elimination Campaign should be implemented in 12 major States. For the remaining States/UTs training of general health care staff should be taken up extensively in all the districts with support of some IEC activities from State Headquarters and in all the districts.
3. A short formal training of Medical Officers and general health care staff on leprosy should be completed in all States/UTs before integration and this training should be linked with MLEC so that maximum number of staff undergo such training.
4. Encouragement to NGOs should be continued and SET grant-in-aid being given to voluntary organisations for Survey Education and Treatment activities should also be continued. Though the core activities for NGOs being given SET grant should continue to be case detection, treatment and health education, the total work performed for leprosy should be included as a criteria for assessing the overall performance of the NGO for the purpose of grant-in-aid.

5. The NGO centres which are being provided reimbursement facility for reconstructive surgery and supply of MCR Chappals should continue to be supported after 31st March 2000.
6. Present arrangement for supply of high quality anti leprosy drugs through WHO with longer life of 4 years duration may be continued.

**NATIONAL SURVEILLANCE PROGRAMME FOR
COMMUNICABLE DISEASES**

The Council welcomed the action taken for implementation of the Centrally Sponsored National Surveillance Programme for Communicable Diseases and expressed satisfaction that Rs.30 crores has been earmarked for this programme for the 9th Plan period, of which Rs.2.9 crores were released in 1997-98 and Rs.3.75 crores in 1998-99. However, the Council resolves that:-

- a. Keeping in view the importance of this programme, efforts should be made to cover all the districts in the country instead of restricting it to 100 districts in the 9th Plan period.
- b. If need be, financial assistance may be procured from an international funding agency like the World Bank for this purpose.

Non-Communicable Disease Control Programmes

**NATIONAL PROGRAMME FOR CONTROL OF
BLINDNESS**

1. The Council resolves that the States/UTs should take all possible measures to improve performance of cataract operations on patients of the bilaterally blind and other eye care services, both quantitatively and qualitatively, in Government fixed facilities viz. medical colleges and district hospitals. Optimal utilization of trained surgeons and infrastructure provided for IOL surgeries should also be ensured so that the poor and needy get access to the technologically superior system of correction. A minimum of 30% of cataract surgeries should be conducted with IOL implantation.
2. The Council resolves that follow up services should be adequate and timely provided to enable operated cases to gain maximum possible vision. Standard cataract surgery records and discharge slips should be made mandatory and maintained for each operated case on a mandatory basis.
3. The States/UTs should efficiently utilize funds provided by Government of India for implementing the programme. The States/UTs should forward Statements of expenditure and audit reports in time to enable Government of India to seek reimbursement from the World Bank.
4. The Council resolves that the State/UT should develop an effective system of monitoring and review of this important programme, with a view to ensuring restoration of eyesight and universal coverage of the poor, particularly the socially under privileged. For this, the States/UTs should post a full time State Programme Officer, preferably of the rank of Joint Director and requisite support staff as sanctioned under the NPCB.
5. The Council resolves that the States/UTs and respective District Blindness Control Societies should prepare a micro plan in each district to cover the target population. For this, house to house screening of population and maintenance of village-wise blind registers should be a mandatory prerequisite. The Micro

Plan will enable "mopping up" the backlog and also help expand the services to cover other equally important causes of blindness.

6. National Programme for Control of Blindness should be made a comprehensive eye care programme rather than a cataract centered programme. The States/UTs should expand activities like school eye screening for correction of refractive errors, eye donation and eye banking for reduction in corneal blindness, management of glaucoma and other eye disorders. Follow up of operated cases and provision of corrective glasses should also be emphasised.
7. The Council appreciates steps taken by Government of India to expand activities, > currently available only in 7 States under the World Bank assisted project, to the entire country. These activities include construction of dedicated eye operation theatres and eye wards at places where these are inadequate, training of eye surgeons in IOL surgery and supply of required ophthalmic equipment and consumables. With development of infrastructure, emphasis should shift from the eye camp approach to the fixed facility approach, in a gradual manner. However, screening camps to identify operable cases need to be organised and operable cases transported to fixed facility.
8. While the role of NGOs has been positive and widespread, there is need to make them more accountable by earmarking a geographic area and thereby ensuring that they not only organise camps for surgery but also the required follow up.
9. The States should take steps to phase out District Programme Managers, who have been appointed on contract basis. For ensuring long term sustainability of the programme, the States/UTs should identify a suitable officer to be incharge of blindness at the district level, so that the programme gets main streamed into the regular working of the Health Care system in the districts.
10. The Council resolves that screening of blind school children should be undertaken by a team of ophthalmic experts and those children, who can be restored vision, treated appropriately.

11. The Council notes that in some areas, particularly tribal areas, there have been cases of Keratomalacia due to Vitamin A deficiency. It is recommended that there should be provision for Vit A supplementation and treatment of those with signs of Vit. A deficiency, to prevent/ treat nutritional blindness.
12. The Council recommends that 2% of the budget allocated for the programme should be utilized on monitoring and concurrent evaluation, as per Planning Commission norms.

**NATIONAL IODINE DEFICIENCY DISORDERS CONTROL
PROGRAMME**

1. The Council recognises the fact that Iodine Deficiency Disorders (IDD) are one of the major public health problems in the country. It is estimated that about 200 million people are at the risk of IDD out of which 61 million population are having goitre and 8.8 million have various neurological disorders. The consumption of iodated salt is the most effective and cheapest method to control this problem. The country has generated production capacity of 112 lakh MT per annum for iodated salt against the requirement of 50 lakh MT per annum for direct human consumption.
2. The Council notes with concern that nutritional Iodine Deficiency directly affects the physical and mental development of human beings. Therefore it must be accorded high priority by providing appropriate funds to achieve the goal of bringing down the incidence of IDD below 10 per cent in the endemic districts by 2000 A.D. and also to control the problem in the entire country.
3. The Council also noted with concern that there are a few States/UTs which have yet to set up IDD control cells and IDD monitoring laboratories.
4. The Council resolves that :
 - i) All States/UTs should accord high priority to implement the National Iodine Deficiency Disorders Control Programme (NIDDCP) in order to improve the human resource development and also to bring down the prevalence of IDD below 10 per cent in endemic districts.
 - ii) The States which have not issued notification for ban on the sale of non-iodated salt for direct human consumption should do so immediately and ensure effective enforcement of the same.
 - iii) The States/UTs which have not yet set up IDD Control Cells in their respective States/UTs should do so without any further delay.
 - iv) The States/UTs should establish the IDD Monitoring Laboratory as sanctioned under the programme in their States for monitoring the iodine content of iodated salt and urinary iodine excretion.

- v) The States/UTs should take appropriate steps to provide iodated salt at reasonable price to all, through the Public Distribution System (PDS).
- vi) To popularise and promote the consumption of iodated salt, the Centre alongwith the States/UTs should intensify Information, Education and Communication (IEC) activities highlighting the importance and benefits of consumption of iodated salt in control of Iodine Deficiency Disorders (IDD).
- vii) The Staces/UTs should encourage installation of local salt iodation plants to eliminate the risk of loss of iodine content during transit.
- viii) To monitor the programme effectively, there is a need to develop trained manpower of both medical and paramedical personnel. The laboratory technical staff associated with IDD monitoring are to be trained suitably for monitoring the quality control of iodated salt and urinary iodine excretion.

NATIONAL CANCER CONTROL PROGRAMME

The Sixth Conference of CCH & FW observed that there are more than 2 million patients in the country and nearly 7 lakh new cases come up every year. The disease is associated with high morbidity and mortality. Therefore, there is a need to strengthen the measures for creating wide spread awareness, early detection and for terminal stage relief. Treatment facilities also require to be augmented and strengthened. The Council accordingly resolves that :-

1. Regional Cancer Centres should be provided regular and augmented financial assistance to augment and upgrade their treatment facilities.
2. The focus of the Cancer Control Programme should be on creation of wide spread awareness and early detection. Therefore, greater impetus should be given by the States/UTs to the implementation of the District Cancer Control Programme as per the notified scheme, and ensure its regular monitoring. States Medical Colleges may also be given greater responsibility in creating wide spread awareness.
3. Treatment of cancer is cost intensive, which limits its accessibility by the poor. Therefore, State/UTs may ensure that the provision of free service, which is to be a part of the conditions for grant-in-aid for setting up facilities like cobalt therapy units, is regularly and effectively monitored, to ensure strict compliance and to develop a referral system for this purpose.
4. Grants-in-aid are currently being provided by the Central Government under five schemes under the National Cancer Control Programme, based on the recommendation of the State/UTs. The State/UTs should monitor the proper utilisation of such funds and ensure that the utilisation certificates etc. are furnished on time.
5. It is universally acknowledged that consumption of tobacco products is a major preventable cause of cancer. Taking into consideration the critical need to initiate preventive measures against this dreaded disease, there is a need to have a comprehensive policy for discouraging the consumption of tobacco & tobacco based products in the country.

As a preliminary step the Council recommends the ban on all chewing tobacco products, like Gutka, at the earliest. Further Central Government could also consider levying a cess of 1% on the turn over of all tobacco based manufacturing units for taking up awareness activities and setting up counselling & treatment facilities.

6. Guidelines pertaining to all the schemes under the National Cancer Control Programme will be circulated to the States/UTs to facilitate them to formulate appropriate proposals.

NATIONAL MENTAL HEALTH PROGRAMME

The Central Council notes with concern that mental health problems are on the increase and that this has been neglected area so far. As mental health and physical health are both integral parts of health, mental health should be integrated with physical health. Accordingly,

1. The Council appreciated the efforts of the Ministry of Health in initiating pilot projects in the area of community mental health through the District Mental Health Programme in some States. It recommends that more State Governments should take advantage of the various training programmes initiated by the Centre to create more trained manpower at the periphery and at the grass root level, it also recommends that more States and UTs should actively participate in the District Mental Health Programme initiated by the Centre.
2. The Council resolved that if the District Mental Health Programme has to make any impact, atleast one District in each State and, in the larger States, one additional District for every 10 Districts should ideally be covered under this programme, in a phased manner. To achieve this objective, the Council recommends that higher budget allocation may be made for this programme.
3. It notes with concern that even though the Mental Health Act, 1987 is effective from 1st April, 1993, Mental Health Authorities have not been set up by some of the States/UTs. The Council, therefore, recommends that the States accord top most priority to setting up of Mental Health Authorities at State level so that mental health services are provided as per law.
4. The Council notes with concern that unhygienic and inhuman environment in some of the mental hospitals and recommends that the State Governments should see that mental hospitals adopt prescribed minimum standards of care for this purpose. Further, it also recommends that action be initiated to establish Day Care Hospitals, Half-way houses etc. for discharged mental patients with the active involvement of the Community.

5. In view of the increasing demand for psychiatric services in rural areas, the Council urges that the Medical Council of India examine and upgrade the training curriculum in psychiatry at the undergraduate level in medical colleges, if necessary by making it a compulsory subject.
6. The Council further recommends that more focused attention be paid for establishing counselling facilities for handling vulnerable categories or persons suffering from mental stress due to :-
 - (i) Poverty and destitution, dowry victims, victims of rape, assault or other forms of domestic violence.
 - (ii) Neuro-psychiatric problems of the aged, viz. Alzheimer's disease, Parkinson's disease, other dementias, depression in the elderly etc.
 - (iii) Child and adolescent psychiatric services arising from maladjustment in schools and colleges.
 - (iv) Victims of natural or man-made calamities and disasters.
7. IEC activities be undertaken in the field of mental illness and stress related to psychosomatic problems through print and electronic media to dispel myths, misconceptions about mental illness and create public awareness so that the stigma of mental illness is removed from society.
8. Centres as well as States & UTs have to establish effective monitoring and evaluation mechanisms for the mental health programme. Further, mental health cells need to be established with designated programme officers in the Directorate of Health Services at the Centre and the States.

**ROLE OF HEALTH SECTOR IN IMPLEMENTATION OF
PROGRAMMES FOR PERSONS WITH DISABILITIES
ACT OF 1995**

The nodal Ministry for implementation of the Disabilities Act is the Ministry of Social Justice & Empowerment. However, as there are a number of national programmes run by the Health Ministry which have a direct bearing on early detection and also prevention of disability, they need to be further strengthened and their role emphasized. These National Programmes are:-

1. Leprosy Eradication
2. Blindness Control
3. Iodine Deficiency Disorder
4. National Mental Health Programme
5. Universal Immunization Programme
6. Maternal & Child Health Programme
7. Pilot Project on Medical Rehabilitation

1. The Council recommends that institutions and bodies involved in research and investigation of causes, occurrences and early symptoms of Disabilities be further identified by the States and the Centre. Existing ones like the Indian Council of Medical Research, All India Institute of Physical Medicine and Rehabilitation, Mumbai, All India Institute of Speech & Hearing, Mysore and National Institute of Mental Health & Neuro Sciences, Bangalore need to be further strengthened.
2. The Council recommends that training programmes for medical, paramedical and field workers are accorded top priority and State Governments should take advantage of the existing Central schemes for this purpose.
3. IEC activities should include folk dance, stage dramas etc, in addition to involvement of media to create public awareness and remove prejudice surrounding some of the disabilities.
4. The Council recommends setting up of a Centre for Basic Rehabilitation Services in each State and in every district for people with disabilities.

5. The Council recommends establishment of a screening mechanism to identify high risk groups among school & pre school children in the States & UTs so that they can be detected and rehabilitated at an early stage.
6. The Council recommends setting up and providing special facilities for the disabled in Hospitals/Health Institutions such as special toilets, ramps in all health institutions, . to increase their access to medical facilities.
7. The Council reiterates the Resolution No. 8 of Fifth Conference of Central Council of Health & FW and resolves that every medical college should develop the Department of Physical Medicine and Rehabilitation. Before 2000 A.D. every State should have at least one medical college with a Department of Physical Medicine and Rehabilitation. While in 5 years serious attempt should be made to cover all the medical colleges, in a phased manner.
8. The Medical Council of India should re-circulate its mandatory recommendation, which should be made time bound for starting Department of Physical Medicine and Rehabilitation in all medical colleges (private and Government), in order to meet the requirement of the new curriculum for under-graduate medical education.
9. Facility for chronically disabled patients with health problems should be developed in each State.

DRUG QUALITY CONTROL

The Council Resolves that :-

1. The States/UTs should ensure that all information required from time to time in respect of drugs manufacturing units, enforcement activities, investigation etc. is promptly communicated to the Central Government within the stipulated time frame ' < as and when such information is requested.
2. The Central and State drug control organisations should be adequately equipped for monitoring Good Manufacturing and Laboratory Practices, which should be of uniform standard throughout the country. Capacity for drug testing needs to be correspondingly improved.
3. The States/UTs should encourage technical personnel engaged in manufacturing; and quality control of drugs to undergo frequent training in order to upgrade their skills so as to keep pace with changing requirements and rapid technological advances.
4. The working of the drug testing laboratories in the country needs to be extensively *audited* from time to time. Schemes may be evolved to undertake such technical audits jointly by State and Central drug control officials' alongwith external experts.
5. The States/UTs should lay greater emphasis on the rational use of drugs, keeping in view the guidelines incorporated in the National Essential Drugs List (NEDL), which have already been circulated to States/UTs.
6. The Council notes with concern the need for promoting research for development of new drugs for diseases which are of high priority and wide coverage (today or are likely to emerge in the future) in the country. Accordingly, it calls for atleast 3% of the turn over of the pharmaceutical industry to be invested in fostering basic research in these areas.

Agenda Item No. XXXV

PREVENTION OF FOOD ADULTERATION (PFA)

7. The Council resolves that there is a need to develop an efficient surveillance and rapid response system in the States/UTs to manage outbreaks like the dropsy which occurred last year. It also calls for greater and more effective monitoring of food products, including street foods, for increasing the number, of food samples tested each year particularly of products like milk and milk based products, edible oils, spices etc. and to ensure that the prescribed periodic reports are sent by States/UTs to the Centre on time. The Council also calls for the creation of a database on all Licensed Food Establishments by each States/UT as this is a critical input for policy formulation.

OTHER NON-COMMUNICABLE DISEASES AND TRAUMA

The Council takes notes of the growing incidence of non communicable diseases and the increasing double burden of diseases in the country. It was also noted that there are a number of health related problems which are an outcome of changes in life styles, a growing geriatric population, the stress and tension of modern life and trauma caused due to increased number of accident cases. Accordingly, the Council resolves as under:-

1. Since the incidence of diseases like Diabetes, CVD and Stroke is increasing every day, in addition to the pilot projects which have been initiated at the National level, there is a need to give greater thrust to preventive measures, since these initiatives would be much more cost effective than any curative regime. Hence both Centre and States/UTs should give due attention to promoting preventive measures.
2. Given the increasing number of trauma cases occurring in the country, leading to significant morbidity and mortality and colossal loss of man days, the Council recommends the formulation of a National Accident Prevention and Management Programme which will include setting up a smaller satellite trauma centres at National Highways linked to tertiary care hospitals. The Council also recommends that the manufacturers of motorcars/two wheelers should earmark some part of their profits towards accident prevention programmes. Helmets should also be made compulsory for all riders of two wheelers.

Urban Health, Other Health Programmes and Health for Vulnerable Groups

ANTI TOBACCO MEASURES

The Council notes with concern that out of an estimated three million tobacco related deaths per annum in the world, about 0.8 deaths take place in India. The Council was aware that tobacco consumption is the single largest public health problem, which is completely preventable and avoidable.

The Council welcomes the decision of the Government to introduce a comprehensive Bill in the Parliament to prohibit advertisements and to provide for a regulation of trade, commerce, production, supply, storage and distribution of tobacco products. The Council further resolves that State Governments should discourage the consumption of tobacco through stringent measures namely:-

- (a) Prohibiting smoking/chewing tobacco in Government offices, public places and public transport services.
- (b) Discouraging the sale of tobacco products near educational institutions, hospitals and religious places.
- (c) Undertaking publicity about the harmful effects of tobacco products through mass media and school health programmes.
- (d) Wide scale celebration of "No Tobacco Day" including organising of rallies by students to project the harmful effects of tobacco consumption and the benefits of abstinence from tobacco products.
- (e) Setting up Tobacco cessation clinics to support those who seek to give up this addictive habit.

Awareness of the importance to change behaviour, the Council resolves that in addition to legislative measures, it is equally important to focus on Health Education and information dissemination. It is resolved that funds mobilised as taxes from tobacco manufacturers and trade be earmarked and utilised for a nation-wide campaign, interviews utilising mass media. The Council strongly recommends that there should be a ban on consumption of Gutka. State Governments should enact necessary legislation.

DRUG DE-ADDICTION PROGRAMME

1. The Conference noted with concern that the problem of Drug addiction continues unabated and the problem in North Eastern States and in certain Metropolitan cities is alarming.
2. The consequences of Drug addiction are severe, as it has gradually seeped into the very fabric of Indian society, particularly the youth, in terms of socio-economic implications and serious health hazards.
3. The Conference notes that the Ministry of Health and Family Welfare has initiated a number of measures to tackle the problem by providing assistance to the State Governments for strengthening their infrastructure to establish Drug De-addiction Centres in identified Medical College and District Hospitals. Special schemes have been worked out for North Eastern States for an integrated and coordinated approach.
4. The Conference, however, notes that despite the gravity of the problem, that State Government's matching contribution in terms of manpower and recurrent cost for running the Centres has been negligible. This has led to less than optimal utilization of the infrastructure and other facilities provided by the Central Government. The Conference, therefore, urges upon all State Governments to take the following immediate measures:-
 - i) In view of the urgency in tackling the problem, the State Governments need to give higher priority to the programme and create a separate budget head for the same.
 - ii) The State Governments may take immediate steps to revitalize the Centres where infrastructure has been created by the Central Government, by providing additional inputs required. The ultimate aim is to make these Centres self-reliant.
 - iii) Steps may be taken to integrate the Drug De-addiction Programme with other related health programmes such as T.B., STD, HIV/AIDS, RCH etc.

- IV) Intersectoral coordination with other Departments associated with the programme such as Ministry of Social Justice & Empowerment, Youth Affairs, Women & Child Development may be effected.
- v) Emphasis may be given to community based outreach programme through the existing health infrastructure. Empowerment of community leaders can be an important plank of the strategy.

Action should also be initiated for rehabilitation of the beneficiaries of the de-addiction programmes and also for preventing relapse of treated and cured addicts.

HOSPITAL WASTE MANAGEMENT

1. The State Government/ Union Territory Administration may make allocation of funds for providing and installing incinerators of equally effective alternative method for implementation of Bio-medical Waste (Management & Handling) Rules, 1998, if not already done;
2. The State Government/ Union Territory Administration may keep in view the above Rules while granting registration licensing of hospitals/ laboratories/ clinics in private sector. The State Government/ Union Territory Administration may set up standing mechanisms consisting of State Pollution Control Boards, Municipalities, Health Departments and hospitals far Hospital Waste Management;
3. The hospitals will be responsible for rendering the waste non-infectious and thereafter Municipalities will collect and dispose off the treated and disinfected medical waste;
4. The State Government should set up prescribed authorities as required by the above rules. The new rules have to be given wide publicity through media, advertisement, etc. The Central Government/ State Government/ Union Territory Administration may take necessary steps for creating awareness and dissemination of the Bio-medical Waste (Management & Handling) Rules, 1998 by using the media/ advertisement etc;
5. The Central Government may include the subject of Medical Waste Management in the curriculum of medical colleges as well as Nursing Colleges. Adequate emphasis has to be given on training, motivation and supervision of the hospital staff engaged in waste management;
6. The Central Government/ State Government/ Union Territories may introduce training programmes for imparting training to the medical and para-medical staff to make them responsible and aware of medical waste disposal;

7. The staff involved in the hospital waste management may be provided with adequate protection wears like gloves, aprons, masks and boots and they shall be immunized especially against Hepatitis B virus;
8. The Central Government/ State Government/ Union Territories may take up infection control and waste management in all the projects/ programmes where new health infrastructure is being created or existing infrastructure improved/ strengthened.

ENVIRONMENTAL HEALTH

The Council notes with concern that any ecological change (even as a result of major civil engineering undertakings) may result in sequence of events leading to eruption of epidemics. It therefore, recommends that attention needs to be focused on early definitive action so that such crisis in the form of epidemics is averted. It also recommends setting up of an Environment Impact Assessment Mechanism in the Ministry of Health through creation of Health Impact Assessment Cell in the Ministry.

It notes with concern that urban, semi-urban and rural sanitation standards continue to be low, resulting in outbreaks of dengue, malaria and other water borne disease like diarrhoea, hepatitis, cholera etc. Further more environmental pollution of water and soil has resulted in fluorsis, arsenic, lead and cadmium poisoning, contamination due to insecticides and pesticides. The number of cases, which had declined, has again shown an upward swing. There was also need to generate awareness about the toxicity of insecticides/ pesticides and also to promote the use of protective gear.

Health impact and environmental epidemiology relating to air, water and soil pollution need to be monitored and evaluated, particularly in the critically polluted areas in the country. There is an urgent need for effective coordination with other related Ministries such as the Ministry of Environment & Forests, Industry, Urban Affairs & Employment and Waste Resources, both at the Centre and the State levels. Coordination Committees at the State Level/ District level/ Mandal level need to be set up. The meetings of these Committees would be attended by Departments of Health, Rural Water Supply/ PWD, Housing, Public Health etc. and would review the plans for environment health, sanitation, and safe drinking water and for taking preventive action. There is need to increase trained manpower in the field of public health and create and identify more institutions" for imparting such training.

There is a need for involvement of local bodies like Panchayats and Nagar Palikas in the development programmes, including public health and sanitation, in the rural and urban areas in the country. Plans for health education, health awareness and community participation in environmental health and sanitation activities need to be developed by these bodies.

The Council recommends that a National Environmental Health Campaign for one week be undertaken throughout the country once a year on the lines of the Pulse Polio campaign. This campaign should be sponsored by the Central and State Governments and should involve all local bodies upto the gram panchayat level. Such a campaign would disseminate awareness about public health and disease prevention measures. Similarly, "Clean and Green" drives for specific areas should be undertaken on fixed days of every month for generating awareness about environment and its impact on health.

OCCUPATIONAL HEALTH

Promotion and protection of Health of the workers is to be looked upon as an economic necessity. It was resolved that the following actions be recommended.

1. Documentation of the magnitude and types of occupational health problems for initiation of appropriate interventions.
2. Continuous monitoring of safety of work environment and workers' health and workers health status both in the organised and unorganised sectors of industry and agriculture. The industrial workers be examined once in three months and DMHO entrusted with the task of obtaining the reports.
3. Special attention to health problems of clusters of unorganised workers e.g. weavers, brick kiln workers, beedi workers, hotel workers and automobile workshop workers, etc.
4. Creation of awareness and education of workers, farmers, employers etc.
5. Closer liaison between the Labour and Health Departments for promoting prevention.
6. Training programmes for ESIS, PHC, district hospital doctors, Para-medics.
7. Improve knowledge of toxicity and antidotes of pesticides and adequate stocking of antidotes of common poisoning cases at peripheral health facilities.
8. Strengthening of laboratory facilities for the diagnosis and management of occupation related morbidity.

REGULATORY MEASURES FOR PRIVATE NURSING HOME

The Central Government may frame norms and standards for ensuring proper health care for different categories of institutions in consultation with the State Governments for private hospital/ Nursing Homes/ Clinical establishments to be followed by all the State Governments. These norms shall prescribe the minimum standards of staff and infrastructure for all such institutions.

The State Government may enact laws to provide for compulsory registration of private hospitals, nursing homes and clinical establishments in order to ensure minimum facilities for different forms of treatment. It would also be necessary to regulate fees charged by the private health institutions. The laws could provide for compulsory exhibition of fees, qualification of doctors, equipment available, etc.

CITIZEN CHARTER FOR GOVERNMENT HOSPITALS

The Council resolves that a Citizens Charter for Hospitals may be implemented by the States/ Union Territories Governments for all health institutions and orientation of staff should also be undertaken.

URBAN HEALTH

In view of health problems faced by urban slum dwellers it was resolved that Urban Health Posts be established to provide basic health services to the urban slum population which would be supported on par with rural PHCs by Central/ State Governments. These Urban Health Posts will make available facilities for safe deliveries also. The RCH programmes may also be extended to urban slums.

HEALTH FOR VULNERABLE GROUPS

It was resolved that one third of the total PHCs be strengthened to provide for 24 hours service to women by hiring gynaecologists/ nurses on contract basis if necessary and further that ambulance services be provided under the RCH Programme.

It was resolved that a special scheme be introduced for promoting institutional deliveries targeting below poverty line families. The special package could cover transportation costs, compensation for loss of wages for the patient and attendant. The expenditure could be borne by the Central/ State Governments on a 50:50 basis.

It was resolved that a community Health Worker be appointed in ST habitation/ SC colonies from amongst the community and the services be paid for by the Community or honorarium paid through local panchayat/ community leadership group Training and setting up of these workers in the habitation/ colony will be at the Government cost.

MEDICAL EDUCATION

1. The Council resolves that the IMC Act be amended to provide for the requirement of essentiality certificate from State Government in the Act itself. Same amendment be made in the Dentists Act.
2. The Council resolves that the Central Government may continue to fix the upper ceiling of fee structure for merit and payment seats in private medical/ dental colleges. Also resolve that to maintain standards of medical education, adequate funds will be earmarked for improving facilities in medical/ dental colleges in State sectors. The desirability of increasing the fee structure for medical/ dental institutions for improving the facilities is also noted.
3. The Council resolves that the membership of Medical Council of India be further broad based by amending the IMC Act to provide that the State Government nominee on the Council would be the State Director Medical Education provided the DME is a registered medical practitioner and registered on the Indian Medical Register. The Vice Chancellors of Health Universities should also be on the Council provided they are medical practitioners. The number of members from State Universities prior to the establishment of the Health Universities would be maintained at that level by suitably amending the IMC Act. Similar changes be made in other Technical Councils of the Health Sector.
4. The Council resolves that service conditions, salary and all other relevant aspects of Medical/dental college teachers shall be covered under the IMC/ Dentists Act as in the AICTE Act.
5. The Council resolves that the syllabus of MBBS/BDS courses, preventive aspects of diseases and Medical Ethics must be included as mandatory subjects.
6. The Council resolves that the submission of applications for new medical institutes etc. and claim for subvention shall be submitted through the concerned State Government.
7. Council reiterates the Resolution passed in the 4th Conference of CCH&FW that the nursing staffing norms as recommended by the Health Manpower Production Committee be implemented by the States/U.Ts at least in phased manner.

The Council resolves that the quality of training imparted in the nursing and other paramedical education institutions be improved. Before opening additional schools and colleges of Nursing/ Paramedics, the existing institutions should be strengthened. The concerned technical Councils should enforce the standards laid down by them to improve the quality of training. Efforts may be made to train more M.Sc. nursing personnel to solve the problem of nursing teachers in the country. Periodic continuing education to be arranged to update the knowledge, skill and attitudes of nursing and other para medical personnel to improve the nursing care and para medical services. Nursing personnel be trained in speciality areas. Working conditions of nurses be improved. B.Sc. nursing course should be structured in such a way to have more hands on patient care on par with general nursing training programme. Necessary financial support should be extended by the State and the Centre.

8. The Council notes with concern the shortage of dentists and the need for improving the quality of Dental Care at the Primary Health Level. The Council therefore resolves that all State Governments must appoint dentists in Primary Health Centres. In all proposals to establish new dental colleges, the State Governments would certify that the dental care would form a part of the State's primary health care programme.
9. The Council also resolves that State Governments should take steps to create infrastructure in medical institutions for starting new speciality courses such as Geriatrics and Transfusion Medicine. For training teaching personnel, similar incentives as recommended for para clinical subjects should be introduced.
10. The Council also resolves that the Central Government and the UGC should provide for funding Health Universities.
11. The Council takes note of the shortage of medical specialists in the North Eastern States and recommends that a pool of PG seats be created exclusively for the medical students of the N.E. States.

CONTINUING MEDICAL EDUCATION (CME)

The Council takes note of the need for continuing medical education (CME) for general practitioners as well as specialists.

The Council notes that a large number of medical practitioners of allopathy have little access to advances in medicine and little opportunity to know about the advances in every aspect of medical theory and practice taking place all over the world. Therefore, it is imperative that the State Governments may take positive action to support seminars, workshops in order to give programmes of Continuing Medical Education extensive coverage.

The Council having taken note of above resolves that :-

1. The State Governments/U.Ts. may take initiative in the matter and promote continuing medical education amongst general practitioners and specialists by organising workshops, seminars, conferences in medical colleges, district level hospitals, PHCs, etc. particularly in area of Public Health. Participation in the CME programme should be made mandatory and the IMC Act be amended to provide for renewal of registration after every five years subject to minimum attendance of 150 hours in CME programme. Medical practitioners above 65 years of age would be exempted from the requirement of renewal of registration. The MCI would formulate guidelines for accreditation of CME programmes and the State Medical Councils would be the nodal authorities for accrediting CM Programmes. The State/ U.T. Governments may take assistance of IGNOU for encouraging distant mode of education amongst medical practitioners working in rural areas, PHCs, etc. The Council also emphasises that CME programmes should be designed to facilitate exposure to information technology particularly tele medicine.
2. The professional associations, medical colleges etc. may be encouraged to organise workshops. This could be taken up on self-financing basis. The Central/ State Governments could provide token financial assistance to professional associations, medical colleges for this purpose.

3. The need for continuing medical education is greater for General Duty Medical Officers whose services are available to a wide section of population as they treat a wide variety of diseases. It is, therefore, necessary that their skill and knowledge base is continuously upgraded especially in the area of Public Health.
4. Alongwith it, it may be necessary to provide for upgradation of skills of paramedical staff in order that they can provide minimum level of medical care.

**PAUCITY OF TEACHERS IN NON-CLINICAL SUBJECTS LIKE
ANATOMY, PHYSIOLOGY, BIOCHEMISTRY, MICRO-BIOLOGY,
FORENSIC MEDICINE AND COMMUNITY MEDICINE**

The Council takes note of the fact that there is shortage of teachers in non-clinical subjects like Anatomy, Physiology, Bio-chemistry, Community Medicine, Micro-Biology and Forensic Medicine in Medical Colleges in the country.

The Council resolves that to overcome the shortage of teachers in non-clinical specialities of Anatomy, Physiology, Biochemistry, Pharmacology and Microbiology, the State Governments/ U.Ts may consider starting post graduate courses in non-clinical subjects and some of the para clinical courses in their medical colleges and the students joining such courses may be given incentives in the form of scholarships, cash incentives hostel facilities and may consider appointing them to Government services upon obtaining admission provided they furnish a bond to serve the Government for a minimum period for ten years. There need not be any entrance test for these specialities but the candidates must fulfill the minimum eligibility conditions for obtaining admissions. The teachers may be paid special allowances for working in non-clinical departments. Time bound promotions may also be considered as an incentive.

The Council further resolves that the MCI's requirement of obtaining bank guarantee for starting of PG courses may be waived in the case of these specialities.

PARTICIPATORY MANAGEMENT BY THE COMMUNITY

The Council appreciates the action by the State Government of Kerala for handing over Primary Health Centres to the locally elected bodies and resolves that:

Every State Government may consider restructuring the public health services and ensure that PHC/Sub Centres are actively involved in the management of health care services. It is believed that such involvement will help in enhancing accountability, lend greater transparency and also sustainability. Further, devolution of resources to local bodies will also enable a more need based planning of health resources. This may be included in the National Health Policy.

Agenda Item No. XXXVI

**RIGHT TO PRACTICE MODERN SYSTEM OF MEDICINE AND
PRESCRIBE MODERN MEDICINE IN TERMS OF RULE 2(E)(E)
OF DRUG AND COSMETICS RULES, 1944**

The agenda item was debated upon.

OBLIGATORY SERVICE IN RURAL AREAS BY QUALIFIED MEDICAL GRADUATES FOR THREE YEARS

1. The Council notes that its earlier Resolutions specifying administrative measures for meeting the shortage of allopathic doctors in rural areas have been considered by the Central Government and the State Governments/ U.Ts.
2. The Council notes the fact that a good deal of imbalance between rural and urban areas in the provision of medical care services continues to persist.
3. The Council notes that the State/U. T. Governments were requested to place Medical Officers, Gynaecologists, Paediatricians, Physicians, Surgeons in the vacant posts in rural areas.
4. The Council having taken note of the above resolves that:-
 - (i) Decentralised recruitment be resorted to fill up vacancies and local bodies may be authorised by State Governments/U.Ts. to recruit doctors even on contract basis.
 - (ii) The State/U. T. Governments may consider adopting transfer policy as per their needs and also improve infrastructural facilities.
 - (iii) The State/ U.T.Governments may take action as per the resolution adopted at the Fifth Conference of CCH&FW held from 8th to 10th January, 1997 at New Delhi and consider reserving a minimum twenty five percent of post graduate seats for inservice Medical Officers who have put in minimum 3 years service in rural areas with a bond that they will serve Government atleast for five years after the completion of the PG course.
 - (iv) The State Governments/ U.Ts. may take steps to fill up vacancies of specialities in CCHCs, Medical Officers in PHCs by making rural services obligatory for atleast 3 years.

CONSTITUTION OF INDIAN MEDICAL & HEALTH SERVICES

The Council, having taken note of the assurances given by the Minister of State for Health & FW on the floor of Parliament to consider the subject of creation of Indian Medical & Health Services in consultation with members of the CCH&FW, felt that the matter requires in depth consideration by the State/U.Ts. The Council urges the State Governments and UT administration to convey their views on this issue urgently so that the Central Government is able to take a considered decision on the subject. The Council also recommends the development of in-service training courses of Health Management for middle and higher level health managers of State and Centre in different institutions.

National Health Policy

DRAFT HEALTH POLICY

The approach adopted by the Working Group was as follows:

- (i) to consider introductory chapter with a view to suggest gaps that need to be filled;
- (ii) clause by clause consideration of the Draft Policy;
- (iii) need to augment goals set out at the end of the Health Policy.

The Working Group deliberated the National Health Policy at great length and made the following critical observations and suggestions:-

- (1) The Policy right at the outset must indicate its strong commitment to Health for All and give an indication of the linkage with the last policy.

The approach must stress on decentralization for ensuring sustainability, higher accountability and intersectoral integration at the grass root level. Decentralization needs to be achieved by relying on the provisions of the 73rd and 74th Amendments so as to provide a more pro-active role to the people and the people's representatives.

The following points must be included more strongly;

- (2) Establishing a workable referral system.
- (3) Quality of care
- (4) A strong system of surveillance with emphasis on public health.
- (5) Involvement of the community and local bodies. For such a process, decentralization must focus upon developing capacity of the people's representatives and communities at large in matters related to health planning goals, etc.

- (6) The National Health Policy should have flexibility with the States and address local needs through the adoption of strategies like mobile clinics which have been found useful in some parts of the North East.
- (7) Utilization of information technology in enhancing the understanding of the people as well as providers.
- (8) Demystify medicine and develop in every State a cadre of persons capable of addressing the first line of community health/ public health needs at the primary level.
- (9) Manpower development in general and specialization in particular, should be need based. The policy of production of doctors, giving weightage to only some specialities, needs to be reviewed in order to ensure availability of all disciplines in equal measure. It was observed that in some states there was a surfeit of gynaecologists but very few anaesthetists.
- (10) Need to reassess the issues related to the deployment of manpower in primary health care institutions. While absenteeism of doctors in rural areas continues to be a problem, despite several incentives having been provided, there is need to have properly trained Para medics or medical personnel for traditional systems of medicine.
- (11) There is also need to focus more on strengthening communication facilities at PHCs' by way of telephones and transport for immediate referral of needy patients.
- (12) The Working Group felt that greater focus and importance should be given to the increasing role of traditional systems of medicine, particularly Ayurveda. To give a fillip to ISM and integrate it as an alternative system of medicine, it was felt that following initiatives, in specific terms, need to be considered:
 - Traditional/Indian medicines to be integrated in the National Health system and not to be used as an 'alternative'.

- Provide for practitioners of traditional systems of medicines in all PHCs/ CHCs. This will help overcome to some extent the difficulty being felt on account of absenteeism of doctors.
 - Formulate a policy on medical plants to ensure that they are not patented by Multi National Companies and also growing/ packaging them for export. It was felt that this comparative advantage that we were enjoying in this sector was, unlike in China, not being fully exploited due to low importance being accorded to it within the country. Therefore, to begin with, we need to increase the budgetary allocation to ISM preferably upto 20% of Health budget and also give it greater priority and role in our National Health system.
 - It would be necessary to improve the job opportunities and working conditions of not only the practitioners of ISM but also other para professionals such as Pharmacists, Nurses, Technicians etc. in order to attract people to take up study of alternative systems of medicines.
 - Finally, laying down of guidelines for the type and level of care that a practitioner of ISM can be permitted to provide while handling trauma or accident cases.
- (13) Issues related to ethics in Medical Research and organ transplant also need to be clearly brought out.
- (14) There was discussion regarding the efficacy of single doctor PHCs where absenteeism was highest due to and resulting in low patient turnover. It was suggested that the structure should be examined to arrive at the appropriate level/ population for placing a fully qualified and trained allopathy doctor.
- (15) It was unanimously felt that not only should greater stress be laid on exploiting information technology for health education but more importantly strengthen and evolve a format for a multi sectoral approach making the linkages between health and non health sectors stronger. In fact, it was felt that in view of the critical importance of non health sectors on health outcomes the issues related to multisectoral linkages should be indicated under a separate heading.

- (16) It was felt that while there was need for increasing the health budgets as a proportion to the total budget and redefining priorities so as to provide for a referral system, there was also a case for better targeting of Government services to the poor and needy. Even if the percentage of GDP or SDP to be assigned to health cannot be spelt out, the need to move towards a reasonable bench mark should be recognized in the Policy.
- (17) It was observed that in several State Governments, doctors were being permitted private practice, having adverse impact on patient care. It was, therefore, felt that the National Health Policy should make a clear mention of this issue, though it was a State subject. In addition to banning such practice, it was felt that priority be accorded for Hospital Advisory Committees to be constituted consisting of all stake holders as this could be one effective means of closely supervising the doctors and other health functionaries and ensuring better accountability.
- (18) There was need to sharply focus on the two issues that continue to plague the country's health system, urban bias and gender bias, making it quite inequitous. It was observed that in the collection and monitoring of programmes, coverage of women be ensured. Besides, there is also need to consider sensitizing and changing the mindset and orientation of health workers at all levels, to specific problems of women.
- (19) There was much discussion on the current system of drug procurement by Government of India creating enormous problems at State levels. Decentralization of drug procurement or constitution of a Committee at the Central Ministry level to monitor the supply of drugs and equipment for filling up gaps and taking corrective action for timely supply could be some solutions that the National Health Policy could consider spelling out.
- (20) Other observations made pertained to drafting, as well as specific programmatic interventions such as need for according higher focus on blood separation of components; involvement of community in the Malaria programme, greater stress for home and community based palliative care for cancer patients; broadening the immunization programme to include Hepatitis B and MMR;

Focussing on establishing day care centres for the mentally ill, greater attention to nutrition which could be detailed under a separate heading; an integrated drug policy etc.

- (21) Overall, it was observed that a stronger justification for a new National Health Policy, sustainability of delivery system, the persistence of regional imbalances, burgeoning private sector necessitating regulation and co-option so as to achieve the HFA goals etc. need to be brought more clearly, alongside spelling out the primary goals and aim of the Health Policy-equity and efficiency-i.e. is more being spent wisely and is it equitable.
- (22) It was also observed that the National Health Policy be set within the contextual frame work of wide socio economic disparities prevailing in the country and increasingly widening. Such a frame work would enable a more cost effective system of care using time tested, relevant and need based technology and not driven by costly technologies which may not be relevant and instead contribute to pushing up the cost of care.
- (23) Over reliance on expensive diagnostics is unaffordable for most people. While dependence on such expensive diagnostic techniques must be controlled and time tested techniques which have worked should not be abandoned.
- (24) There should be special mention of Population.
- (25) There should be emphasis on re-training of Government doctors who are to rise in the profession so that they are equipped to handle multifarious public health, financial administrative issues and are certainly not exposed to work that they are not familiar with.
- (26) Portion of Nutrition should form a separate heading.
- (27) Portion of Dental Health should be linked with non-communicable diseases.
- (28) Health Insurance and Health Finance should be clubbed.
- (29) Need to collect data of access by women and treatment of women should be emphasized.

- (30) Regional imbalances and intra-State disparities must be brought out more strongly with some strategies on how to reduce the disparity.
- (31) The need to identify proper technology for hospital waste management (incinerators etc.) should be recognized.
- (32) There should be District Level Planning Bodies to plan for the Health of the District along with their plan for economic and social development.
- (33) Decentralized local bodies should get support and guidance from the respective Health Departments and their performance reviewed by them from time to time.
- (34) The financial responsibility indicated in Para 11.2 should develop on all levels of the Government, not on the State only.
- (35) Issues relating to old aged people need to be focused. Specific steps for geriatric groups need elaboration.
- (36) IPP VI - Research in Andhra Pradesh - 80% expenditure on health in private sector.
- (37) On disabled persons one chapter to be incorporated. Recommendations of the Sub-Committee on disabled persons to be incorporated.

ANNEXURES

MINISTRY OF HEALTH AND FAMILY WELFARE
NOTIFICATION
New Delhi, the 6th April, 1999
CONSTITUTION OF CENTRAL COUNCIL OF HEALTH AND
FAMILY WELFARE

S.O. 232 (E).- In exercise of the powers conferred by article 263 of the Constitution and in supersession of this Ministry's notification No. Z. 16011/13/89-B.P., dated 20th January, 1993 published in the Gazette of India : Extraordinary Part-II Section 3 Sub Section (ii) dated 22 January, 1993, the President hereby constitutes the Central Council of Health and Family Welfare and defines the nature of duties to be performed by it and its organisation and procedure as follows, namely:-

1. Organisation of the Council :

(i) The Council shall consist of :-

- | | |
|--|----------------|
| (a) The Union Minister for Health
in the Ministry of Health and Family Welfare | :Chairman |
| (b) The Union Minister of State
in the Ministry of Health and Family Welfare | :Vice-Chairman |
| (c) Member, Planning Commission | :Member |
| (d) Ministers in charge of the
Ministry of Health and Family
Welfare, Medical Education and
Public Health in the States/Union
Territories with Legislatures. | :Members |
| (e) A representative each of the
DadarNagarHaveli, Chandigarh,
Andaman and Nicobar Islands,
Daman and Diu and Lakshadweep. | :Members |

- (f) **Members of Parliament** : Members
1. Dr. Vallabh Bhai Kathiria Lok Sabha
 2. Dr. (Ms.) C. Suguna Kumari Lok Sabha
 3. Smt. Malti Sharma Rajya Sabha
 4. Smt. Chandresh Kumari Rajya Sabha
- (g) **Non-Officials**
- (i) Representatives from Health and Family Welfare Sectors : Members
1. President, Indian Medical Association (ex-officio)
 2. President, Family Planning Association of India, Bombay, (ex-officio)
 3. President, Indian Council of Child Welfare, New Delhi, (ex-officio)
 4. Chairperson, Central Social Welfare Board, New Delhi, (ex-officio)
 5. The President, Federation of Indian Chambers of Commerce and Industry, New Delhi. (ex-officio)
 6. Director General, Indian Council of Medical Research, New Delhi, (ex-officio)
 7. The President, All India Organisation of Employers, New Delhi, (ex-officio)

(ii) Eminent Individuals : Members

1. Prof. V. Ramalingaswamy, Ex-DG, ICMR
X-29, Hauz Khas
New Delhi
2. Justice M.S. Janaitanan, Chairman Tamil Nadu State
Legal Services Authority Chennai
3. Shri Brahaspati Dev Triguna
143-A, Saraikale Khan, Nizammuddin East New Delhi-
110013
4. Shri Hakim Syed Khleefatullah 49, Bharathi
Salai Triplicane, Chennai - 600 005
5. Prof. Imarana Quadeer Centre
for Studies in
Community Health and Social Medicine JNU, New
Delhi
6. Dr. V.K.A. Kutty
President Association for Welfare of the Handicapped 17/194-A,
M-Square Complex Pavamani Road Calicut-673 001

(h) Officials

1. Secretary, Department of Health : Member
Ministry of Health & Family Welfare.
2. Secretary, Department of Family Welfare : Member
Ministry of Health & Family Welfare.

- | | | | |
|----|---|---|---------------------|
| 3. | Secretary, Department of Indian Systems of Medicine & Homoeopathy | : | Member |
| 4. | Secretary, Department of Education
Ministry of Human Resource Development. | : | Member |
| 5. | Secretary, Department of Women and Child Development. | : | Member |
| 6. | Director General of Health Services | : | Member |
| 7. | Deputy Director General of Health Services (Plg.) | : | Member
Secretary |

- (iii) Eminent Individuals at (g) (ii) 1 to 6 shall normally be members of the Council for a period of two years. The Members of Lok Sabha shall be Members of the Council so long as they are members of Lok Sabha or two years whichever is earlier.
- (iv) The Members of Rajya Sabha shall be Members of the Council so long as they are members of Rajya Sabha, or till 5th April, 2001, whichever is earlier.
- (v) 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 Supplementary Rule 190 and orders of the Government of India thereunder as issued from time to time.
- (vi) The expenditure involved will be met from within the sanctioned budget grant for the purpose.
- (vii) Expert and technical advisers to the Central Government and State Governments shall not be members of the Council and shall not have any right to vote when any decision is taken by it but shall, if so required by the Council, be in attendance at its meetings.
- (viii) The Council shall have a Secretarial staff consisting of a Secretary and such Officers and officials as the Chairman may, with the approval of the Central Government, think fit to appoint.

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

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

- (a) To consider and recommend broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects, such as the provision of remedial promotive and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research ;
- (b) To make 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 epidemics and serious calamities such as earth-quakes and famines and to draw up a common programme of action ;
- (d) To make recommendations to the Central Government regarding distribution of available grants-in-aid for Health and Family Welfare purposes to the States and to review periodically the work accomplished in different areas through the utilisation of these grants-in-aid; and
- (e) To establish any organisation or organisation invested with appropriate functions for promoting and maintaining co-operation between the Central and State Health and Family Welfare administration.

3. Procedure of the Council:-

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

- a) The Council shall meet at least once in every year;
- b) It shall meet at such time and place as the Chairman may appoint in this behalf;

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

(No. Z-16011/1/98-BP)
K. SUJATHA RAO, Jt. Secy.

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

- | | | |
|----|---|----------|
| 1. | Shri Dalit Ezhilmalai
Union Minister of State
for Health & FW | Chairman |
|----|---|----------|

**Ministers Incharge of Ministries of Health & FW, Medical Education
and Public Health in the State/UTs with Legislatures.**

- | | | |
|----|--|--------|
| 2. | Dr. N. Janardhan Reddy
Minister, Health, Medical & FW
Andhra Pradesh | Member |
| 3. | Dr. Kamala K. Kalita
Minister, Health & FW
Assam | Member |
| 4. | Shri Mahavir Prasad
Minister, Health, Medical
Education, FW
Bihar | Member |
| 5. | Dr. A.K. Walia
Minister for Health, Delhi | Member |
| 6. | Shri J.P. Nadda
Minister for Health,
Himachal Pradesh | Member |
| 7. | Shri Gobind Ram Sharma
MOS for Health, J&K | Member |
| 8. | Shri Ashok Bhatt
Minister for Health & FW
Gujarat | Member |

9.	Dr. H.C. Mahadevappa Minister for Health & FW Karnataka	Member
10.	Dr. M. Shankar Naik Minister for Medical Education Karnataka	Member
11.	Shri A.C. Shanmukha Das Minister for Health & Sports Kerala.	Member
12.	Dr. D.S. Ahar Minister for Health, Maharashtra.	Member
13.	Shri Moring Makunga Minister for Health, Manipur	Member
14.	Dr. Donkumar Roy Minister for Health, Meghalaya	Member
15.	Shri Neiba Ndang Minister, Health & FW, Nagaland	Member
16.	Shri Niranjan Patnaik Minister for Health & FW & Energy, Orissa	Member
17.	Shri Indira Mayaram Minister for Family Welfare, Rajasthan	Member
18.	Shri Rajendra Chowdhary MOS, Health, Rajasthan	Member
19.	Dr. D.P. Kharel Minister of Health & FW, Sikkim	Member
20.	Shri Ramapati Shastri Minister for Health & FW, U.P.	Member

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|-----|--|--------|
| 21. | Shri Partha De
Minister for Health &FW,
West Bengal | Member |
| 22. | Smt. Minati Ghosh
Minister of State for Health & FW,
West Bengal | Member |

Representatives from UTs

- | | | |
|-----|--|--------|
| 23. | Dr. R.S. Sandhu
Director, Health Services
Chandigarh. | Member |
| 24. | Dr. L.N. Patra
MCH Officer,
Dadra & Nagar Haveli | Member |
| 25. | Dr. S.S. Vaishya
DMHS, Daman & Diu | Member |
| 26. | Shri Ramesh Chandra
Principal Secretary, Health & FW,
Delhi. | Member |

Non-Officials

- | | | |
|-----|--|--------|
| 27. | Dr. Nina Puri

President, Family Planning
Association of India,
Mumbai | Member |
|-----|--|--------|

Eminent Individuals

- | | | |
|-----|----------------------------------|--------|
| 28. | Shri Hakim Syed
Khaleefatulla | Member |
| 29. | Shri Brahaspati Dev Triguna | Member |

30. Dr. V.K.A. Kutty
President, Association for
Welfare of the Handicapped. Member

31. Prof. V. Ramalingaswami
Ex-DG, ICMR Member

Officials

32. Shri K.K. Baksi
Secretary, Health Member

33. Shri Y.N. Chatturvedi
Secretary, Family Welfare Member

34. Smt. Shanta Shastri
Secretary, ISM&H Member

35. Dr. S.P. Agarwal
Director General of Health Services. Member

36. Dr. R.L. Malhotra
Dy. Director General (Planning)
Dte. G.H.S. Member

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

STATE GOVERNMENTS

Andhra Pradesh

1. Smt. R. Chatterjee
Secretary, Health, Medical & F.W.
2. Shri CBS Venkataramana Commissioner, Family Welfare
3. Dr. P.Rama Rao Director, Health
4. Shri K.Janaki Reddy Drug Controller
5. Dr. C. Chandrasena
Addl. Director (Medical Education)
6. Dr. P.V. Raj
Addl. Director (Ayurveda)
7. Dr. Hamid Ali Siddique
Superintendent, ISM & H

Arunachal Pradesh

1. Shri G. Koyu
Secretary, Health & F.W.
2. Dr. G. Yomcha
Director, Health Services

Assam

1. Shri Viren Dutta Secretary, Health
2. Dr. S.N. Thakuria Director, Health Services
3. Dr.AC. Borah
Director, Medical Education
4. Dr. B.C. Kro
Director, Health Services
5. Shri P. J. Gogoi
Govt. Analyst,
Regional Drug Testing Laboratory.

Bihar

1. ShriA. K. Choudhury
Commissioner & Secretary,
Health, Medical Education and F. W.
2. Dr.A.R.C. Sinha
Director, Health Services

Delhi

1. Dr. Jeevan Jha
Director, Health Services
2. Dr. (Smt.) Santosh Chadah
Director, Family Welfare
3. Dr. Kiran Dambalkar
CMO & DDHS

Gujarat

1. Shri Ashok Bhatia
Principal Secretary
2. Shri. S. K. Verma
Addl. Chief Secretary (F.W).
3. Shri Subodh Adeshara
Commissioner
4. Dr. N.D. Ghasura
Director RCH & State F.W. Officer
5. Dr. B.P. Thaker
Director, ISM & H

Goa

1. Shri Rakesh Mehta
Secretary, Health
2. Shri Albano Couto
Adviser
3. Dr. A. Salelkar
Director, Health Services

Haryana

1. Dr. P.L. Jindal
Director General Health Services
2. Smt. Komal Anand
FCHM
3. Dr. Paramjit Singh
Director, Ayurveda
4. Dr. B.K. Prinja
Deputy Director

Himachal Pradesh

1. Dr. Sukhram Chauhan
Director, Health & Family Welfare
2. Dr. Suresh Kumar
Officer on Special Duty
Deptt. of ISM & H
3. Shri O.P. Verma
OSD to Health Minister
4. Dr. Rakesh Pandit
Senior Specialist
Directorate of ISM

Jammu & Kashmir

1. Dr. V.P. Gupta
Special Secretary
Health & Medical Education
2. Dr. Shahida Aga
Director, Health Services
3. Dr. K.L. Sharma
Director, ISM
4. Dr. R.K. Goel
Director, Health Services

Karnataka

1. ShriA. Sengupta
Secretary, Health & F.W.
2. Shri K. Jothiramalingam
Secretary, Medical Education

3. Shri S. Subramanya
Additional Secretary, Health & F.W.
4. Dr. G.V. Nagaraj
Project Director (RCH)
5. Shri R. Ananda Rajashekar
Drug Controller
6. Dr. M.T. Hemareddy
Director, Health Services
7. Dr. S.M. Angadi
Director, ISM
8. Prof. K.P. Puthuraya
Dy. Director, Medical Education

Kerala

1. Shri V. Vijayachandran
Secretary, Health & F.W.
2. Dr. V.K. Rajan
Director, Health Services
3. Dr. P.K. Bondriya
Joint Director, DISM

Madhya Pradesh

1. Shri Anshu Vaish
Secretary, Health & F.W
2. Dr. Y.R. Sharma
Director, Health & F.W.

Maharashtra

1. Shri T.C. Benjamin
Secretary, Medical Education

2. Ms. Ranjana Sinha
Secretary & Commissioner (F.W.)
3. Dr. Subhash Salunke
Director, Health Services
4. Dr. V.L. Deshpande
DMER

Manipur

1. Shri D.S. Poonia
Secretary, Health
2. Dr. M. Amusena Singh
Addl. Director, Health
3. Dr. S. Robei Singh
Addl. Director, F.W.

Meghalaya

1. Shri K.V. Eapen
Secretary, Health & F.W.
2. Dr. I. Blah
Director of Health Services (MCH & FW)
3. Dr. N. Nongplish
Director of Health Services

Mizoram

- I. Dr. C. Thanchamliana
Asstt. Director
F.W. Deptt.

Nagaland

1. Shri V. Sakhrie
Secretary, Health & F.W.
2. Dr. K. Tali
Joint DMS
3. Dr. S. Aier
Project Director, NSACS
4. Dr. Seyiekietuo
Dy. Director (F.W).
5. Dr. Kepelhusis
Joint DMS

Orissa

1. Ms Meena Gupta
Secretary, Health & F.W.
2. Dr. Jhasketan Sahu
Director, Health Services
3. Dr. S. M. Hassan
Director, Family Welfare
4. Shri N.P.Das
Director ISM &H

Punjab

1. Shri Rajesh Chhabra
Principal Secretary, Health
2. Dr. Joginder Singh
Dy. Director, Health

Rajasthan

1. Shri Ram Lubhaya
Secretary, Medical, Health & RW.
2. Dr. N. M. Singhvi
Director, RW.
3. Dr. G.S.Gahlot
Director (PH)
4. Dr. Akilesh Bhargava
OSD
5. Shri Ramesh K. Jain
Project Director Cum Dy. Secretary

Sikkim

1. ShriD. Dadul
Commissioner & Secretary Health &RW.
2. Dr. T. R. Gyatso
Principal Director, Health Services

Tamil Nadu

1. Shri K.Allaudin
Special Secretary, Health & F. W.
2. Ms. Sheela Rani Chunkath,
Commissioner MCH & Welfare
3. Dr. R. Ayyathurai
Director, Public Health
4. Dr. V. Subramanian
Joint Director, ISM & H

Uttar Pradesh

1. Shri V. K. Dewan
Principal Secretary
Medical, Health & F.W.
2. Shri Navtej Singh
Secretary, Health
3. Shri Lov Verma
Secretary, Medical, Health & F. W.
4. Dr. H.C.Vaish
Director General, Medical and Health
5. Dr. Bachchi Lal
Director General, National Programme
6. Dr. Rakha Goswami
Addl. Director,
Ayurvedic & Unani Deptt.

West Bengal

1. Shri N. K. S. Jhala
Principal Secretary, Health & F. W.
2. Shri Trilochan Singh
Special Secretary, Health & F. W.
3. Dr. Somnath N Chatterjee
Director, Health Services
4. Prof. (Dr.) S. K. Bandopadhyay
Director, Medical Education

Government Organisations, Autonomous Institutions and Others

1. Dr. Prema Ramachandran
Adviser (Health)
Planning Commission
2. Dr. Prem Agarwal
Secretary General
Indian Medical Association
3. Dr. (Mrs.) S. Kantha
Vice Chancellor
Rajiv Gandhi University of Health Sciences Bangalore
4. Dr. P. V. Venugopal
Dy. Chairman,
FICCI, Health Committee
5. Dr. Ketan Desai
President,
Medical Council of India
6. Prof. B.N.Singh
Principal NH Medical College
(Homoeopathic Department)
U.P.
7. Dr. Arjun Das
Prof. & Head (ENT),
Govt. Medical College, Chandigarh
8. Dr. G.Ramakrishna
Prof. (Homoeo)
Indian Medicines Homoeopathy Deptt.,
Andhra Pradesh

9. Dr. V. K. Srivastava
Prof. Pharmacology
Medical College
Meerut
10. Dr. P. C. Banerjee
Red Cross
11. Shri Pramod
Managing Director
Indian Medicines Pharmaceuticals
Corporation Ltd.

Ministry of Health & Family Welfare

1. Smt. Shailaja Chandra
Addl. Secretary & Project Director NACO
2. Shri J. V. R. Prasada Rao
Addl. Secretary
3. Smt. Renu Sahni Dhar
Joint Secretary
4. Ms. Sujata Rao
Joint Secretary
5. Shri Deepak Gupta
Joint Secretary
6. Smt. Sunila Basant
Joint Secretary
7. Shri P. Bhargava
Joint Secretary
8. Ms. Meenakshi Datta Ghosh
Joint Secretary
9. Shri Vijay Singh
Joint Secretary and Financial Adviser

10. Shri J. Thakur
Chief Controller of Accounts
11. Dr. V. B. Gupta
Dy. Commissioner
12. Dr. (Smt.) Lalrinthuangel
Dy. Commissioner
13. Dr. Ashok Kumar
Dy. Commissioner
14. Shri P. K. Saha
Chief Director
15. Shri R. M. Bhattacharya
Director
16. Shri Vineet Chowdhry
Director (ME)
17. Shri Babu Lal
Director (ID)
18. Shri K. V. Rao
Director
19. Shri S. K. Das
Director (D)
20. Shri V. K. Punni
Director (SSM)
21. Shri S. C. Srivastava
Director (Policy)
22. Dr. Prem Kishore
Director (ISM & H)
23. Dr. Mohd. Khalid Siddique
Director (ISM & H)

24. Dr. R. U. Ahmad
Director (ISM & H)
25. Dr. D. P. Rastogi
Director (ISM & H)
26. Shri T. Jena
Director (CHS)
27. Shri B. L. Meena
Director (ISM & H)
28. Shri Kanwar. R. Singh
Director (ISM & H)
29. Shri O. S. Veerwal
Director (ISM & H)
30. Shri Vikramaditya
Director (ISM & H)
31. Shri Naresh Kumar
Director (ISM & H)
32. Dr. S. K. Sharma
Adviser Ayurveda (ISM & H)
33. Dr. Ravindra Singh
Joint Director (DC)
34. Shri A. K. Mehra
Joint Director
35. Shri Nagendra Nath Sinha
Dy. Secretary
36. Shri K. P. Unnikrishnan
Dy. Secretary
37. Dr. S. Sarkar
Asstt. Commissioner

38. Dr. V. K. Behal
Asstt. Commissioner
39. Dr. N. Namshum
Assistant Commissioner
40. Dr. (Smt.) Praveena Goel
Assistant Commissioner
41. Dr. S. Malhotra
Assistant Commissioner
42. Dr. Aliya Aman
Dy. Adviser (U)
43. Shri S. P. Singh
Dy. Adviser (Homoeopahty)
44. Shri M. L. Sharma
Dy. Adviser (Ayurveda)
45. Shri S. Madhavan
Dy. Adviser (Drugs)
46. Shri M.A. Kumar
Assistant Adviser (ISM & H)
47. Dr. G. P. Garg
Chief Chemist (ISM &H)
48. Sushama Rath
U.S. (ID)

Directorate General of Health Services

1. Dr. Ira Ray
Addl. D.G.
2. Dr. R. K. Srivastava
Addl. D.G.

3. Dr. O. N. Krishna
Addl. D.G.
4. Dr. Sarajit Sehgal
Addl. D.G.
5. Shri Ashwani Kumar
DCG(I)
6. Dr. N. S. Dharamshaktu
DDG (Lep)
7. Dr. V. K. Manchanda
DDG (RHS)
8. Dr. Sangeeta Khanna
DDG (G)
9. Prof. A. S. Bais
DDG (M)
10. Dr. G. R. Khatri
DDG (TB)
11. Dr. (Smt.) R. Jose
DDG (O)
12. Dr. Shiv Lal
Director (NAMP)
13. Dr. P. L. Joshi
Joint Director (Tech.), NACO
14. Smt. Neelam Kapoor
Joint Director, NACO
15. Dr. (Mrs.) T. Bhasin
Director, CHEB
16. Dr. A. K. Seth
Director, CBHI

17. Dr. Jotna Sokhey
Director, NICD
18. Dr. Y. N. Rao
Officer on Special Duty
19. Shri P. Das Gupta
DCG (I)
20. Dr. B. K. Tiwari
Adviser, Nutrition
21. Shri D. Amarnath
Addl. Economic Adviser
22. Dr. D. Bachani
ADG (O)
23. Shri P. C. Das
CMO, CHEB
24. Shri T. Dileep Kumar
Nursing Adviser
25. Dr. G. S. Sonal
Dy. Director, NMEP
26. Shri B. N. Tiwari
Statistical Officer, Bureau of Planning
27. Shri G. R. C. Menon
Consultant, Bureau of Planning
28. Shri N. C. Gupta
PO (AV) (CHEB)
29. Dr. A. Ghose
MHI (AC)

**SIXTH CONFERENCE OF THE CENTRAL COUNCIL OF
HEALTH AND FAMILY WELFARE
Vigyan Bhawan Annexe, New Delhi
8-10 April, 1999**

PROGRAMME

Thursday the 8th April, 1999

Inaugural Session

9.00 hrs. to 10.00 hrs.	:	Registration
10.00 hrs. to 10.10 hrs	:	Welcome by Secretary (Health)
10.10 hrs. to 10.25 hrs	:	Address by Hon'ble Union Minister State for Health and Family Welfare and Chairman
10.25 hrs. to 10.45 hrs	:	Inaugural Address including lighting of lamp by Hon'ble Deputy Chairman, Planning Commission
10.45 hrs. to 10.55 hrs	:	Vote of Thanks by Director General of Health Services
10.55 hrs. to 11.15 hrs.	:	Tea
11.15 hrs. to 13.30 hrs.	:	Plenary Session- Address by State Health Ministers and others members of the CCH&FW
13.30 hrs. to 14.30 hrs	:	Lunch

14.30 hrs. to 16.00 hrs.	:	Plenary Session- Address by State Health Ministers and others members of the CCH & FW-continued
16.00 hrs. to 16.20 hrs.	:	Tea
16.20 hrs. to 18.00 hrs.	:	Plenary Session- Address by State Health Ministers and others members of the CCH&FW-continued
18.00 hrs.	:	Announcement of the Constitution of Working Group and their venue for 9th April, 1999

Friday the 9th April, 1999

9.30 hrs. to 9.40 hrs. Department	:	Address by Secretary, of Health
9.40 hrs. to 9.50 hrs. Department	:	Address by Secretary, of Family Welfare
9.50 hrs. to 10.00 hrs. Department	:	Address by Secretary, of ISM&H
10.00 hrs. to 10.10 hrs. Working Groups	:	Sub-Division into
10.10 hrs. to 11.40 hrs. Discussions	:	Working Group
11.40 hrs. to 12.00 hrs.	:	Tea
12.00 hrs. to 13.30 hrs. Discussions	:	Working Group (continued)
13.30 hrs. to 14.30 hrs.	:	Lunch

14.30 hrs. to 16.00 hrs.	:	Working Group Discussions (continued)
16.00 hrs. to 16.20 hrs.	:	Tea
16.20 hrs. to 18.00 hrs.	:	Working Group Discussions & Finalisation of Reports
20.00 hrs.	:	Dinner to be hosted by Hon'ble Union Minister of State for Health & Family Welfare

Saturday the 10th April, 1999

10.10 hrs. to 11.30 hrs.	:	Presentation of reports of Working Group and Discussion thereon
11.30 hrs. to 11.50 hrs.	:	Tea
11.50 hrs. to 12.50 hrs.	:	Adoption of Final Resolutions/ Recommendations
12.50 hrs. to 13.30 hrs.	:	Concluding Remarks by Shri Dalit Ezhilmalai, Union Minister of State for Health & Family Welfare
13.30 hrs.	:	Lunch