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AGENDA NOTES

3rd CONFERENCE OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE

PARLIAMENT HOUSE ANNEXE

JULY 14-16, 1993

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
BUREAU OF PLANNING
NEW DELHI

Agenda Item No. IX

NATIONAL TB CONTROL PROGRAMME

1. Tuberculosis has been a major public health problem since decades and still continues to remain so. It is estimated that nearly 14 million active pulmonary TB cases exist in the country as on today of which 1/4th are sputum positive, or in other words infectious and responsible for spreading the infection in the community. Against the estimated total prevalence of 3 to 3.5 million sputum positive cases at this point of time around 1/3rd i.e. 1 million cases are new cases per year. Under the programme only 1.5 million TB cases (both sputum positive and sputum negative) are treated annually and 0.5 million deaths from TB are reported annually. It is also further known that the prevalence of TB is almost of the same order in both urban and rural areas.

2. National TB Control Programme was initiated following extensive field research by NTI, Bangalore and TRC Madras as centrally sponsored scheme on 50:50 sharing basis between the State and the Centre in 1962 by establishing district TB Centres, TB clinics, TB Hospitals covering a few districts which over a period of time has now been covering 390 districts in the country. In addition to the 390 districts, 18 centres, a large number of TB clinics and hospitals are also functioning where laboratory diagnostic support services and radiological facilities are available.

3. The objectives of the programme was to reduce suffering, disability and death from TB. However, over the last 30 years achievement under the National TB Control Programme are far short of the expectations. While

reasons for such shortfall were generally and specifically identified by two expert committees in 1975 and 1985, not much was done as a follow up to rectify them. While other National Health Programmes like NMEP, UIP, NLEP affected substantial organisational and strategy changes and improved their overall efficacy, National TB Control Programme did not make much headway largely for want of an appropriate strategy for reaching the peripheral areas and due to gross under-funding.

3)

4. *The programme was recently reviewed by a joint team from WHO and Government of India. Some of the important observations are -*

4

a) *Gross under-funding of the programme resulting in inadequate availability of drugs for treatment of detected cases.*

b) *Over-reliance on radiological diagnosis as against smear testing through microscopy resulting in concentration of cases diagnosed at the district TB centres and non-utilisation of the facilities available in the peripheral health institutions.*

c) *Ineffective and inadequate laboratory services leading to very low performance in case finding.*

d) *Poor case holding because of inappropriate perception of the people in the importance of completion of recommended course of treatment, time and cost factors involved in visiting the health institutions to obtain drugs, non-availability of drugs and lack of awareness and neglect of treatment following disappearnace of the symptoms.*

Issues involved are broadly :

1) *To involve the available health infrastructure in appreciation of the problem of TB and make available sputum microscopy facilities as close to the people as possible.*

2) *To improve the awareness amongst the people that TB is a fully*

curable disease and if recommended regimens are followed recovery is almost universal.

3) To make available supervised short course chemo-therapy of all smear positive cases as close to the people as possible and need for hospitalisation is minimal as domicillary treatment has been found to be highly effective. Hospitalisation should only be resorted to for seriously sick cases, emergency cases and complicated cases etc.

4) Funds that have been provided under the programme have been very inadequate. During the current financial year 35 crores have been provided whereas to treat one million sputum positive cases an annual outlay of the order of Rs.100 crores or more is required.

In the context of the above the Govt. of India has decided to formulate a revised National TB Control Programme and seek the assistance from World Bank to implement the same. A Task Force was constituted under the Chairmanship of DG, ICMR. The Task Force has prepared a Concept Paper and the same has been submitted and DGHS has been asked to prepare the detailed action plan document to seek the World Bank assistance. It has been decided that the project will be implemented in 5 States namely Kerala, West Bengal, Bihar, Gujarat and Himachal Pradesh and in the six metropolitan cities namely Delhi, Calcutta, Bombay, Madras, Hyderabad and Bangalore. As a part of advance action the revised TB Control Programme will be taken on pilot basis in one or part of the district or corporation areas selected for the implementation of the project.

Financial details, achievements under the programme are

given in the Annexures.

Council is requested to deliberate on the issues enlisted and suggest ways and means involve the existing health machinery to detect desired number of sputum positive cases in the community and to make available to them the recommended regimen of anti TB therapy to affect a cure rate of atleast 85 to 90 percent.

Financial Outlay & Expenditure Incurred During 7th Plan and Budget Provision Made for 1990-91 and 1991-92 - (For Supply of Anti-TB Drugs, Material and Equipments)

(Rupees in lakhs)

		Budget Provision	Actual Expenditure
During seventh Plan	(1985-86 - 1989-90)	6100.00	6176.00
-do-	(1990-91)	1500.00	1247.60
-do-	(1991-92)	1525.00	718.95
During Eighth Plan	(1992-93)	2900.00	2495.90
	(1993-94)	3500.00	-

Target laid down Under 20 Point Programme during Seventh Plan, Plan Holiday and Eighth Plan

Duration	Target for detection of cases (lacs)	Achieve-ment (lacs & %)	Target for sputum Exam. (lacs)	Achieve-ment (lacs & %)
7th Plan	74.50	76.09(103%)	170.00	116.47 (69%)
1990-91	16.50	16.68(104%)	34.00	23.88 (77.33%)
1991-92	16.75	9.57(57%)	34.00	19.53 (57%)
1992-93	17.5	14.75(84%)	34.00	26.56 (78%)
1993-94	18.0	-	34.00	-

Annexure 'A'

STATEMENT SHOWING THE TOTAL NUMBER OF DISTRICTS, DISTRICT TB CENTRES AND TB CLINICS IN THE COUNTRY AS ON 31.12.1992.

S.No.	Name of State/ U.T.	No. of Districts	No. of Distt. TB Centres	Total No.of other T.B. Clinics
1.	Andhra Pr.	23	23	25
2.	Arunachal Pr.	12	5	-
3.	Assam	18	11	9
4.	Bihar	42	32	25
5.	Goa	1	1	4
6.	Gujarat	19	19	4
7.	Haryana	12	11	4
8.	Himachal Pr.	12	11	7
9.	Jammu & Kashmir	14	10	4
10.	Karnataka	30	20	6
11.	Kerala	14	12	9
12.	Madhya Pr.	45	45	5
13.	Maharashtra	30	30	19
14.	Manipur	8	3	-
15.	Meghalaya	7	2	1
16.	Mizoram	3	2	1
17.	Nagaland	7	2	1
18.	Orissa	13	13	4
19.	Punjab	12	12	4
20.	Rajasthan	27	27	2
21.	Sikkim	4	3	3
22.	Tamilnadu	21	16	40
23.	Tripura	3	3	-
24.	Uttar Pr.	56	56	20
25.	West Bengal	17	16	116
26.	A&N Islands	2	1	-
27.	Chandigarh	1	1	1
28.	D&N Haveli	1	1	-
29.	Daman & Diu	2	1	-
30.	Delhi	1	1	13
31.	Lakashdweep	1	-	-
32.	Pondicherry	1	1	4
TOTAL		459	390	331

Annexure-'B'

STATEMENT SHOWING THE TOTAL NUMBER OF DISTRICTS, TB BEDS AND NO. OF DISTRICTS HAVING 10 OR LESS THAN 10 BEDS AND DISTRICT HAVING NO TB BEDS IN THE COUNTRY AS ON 31.12.1992

S. No.	Name of State/ U.T.	No.of Distts.	No.of TB Beds	No.of Distt. with 10 or less than 10 Beds.	Distt. having no TB Beds.
1.	Andhra Pr.	23	2579	-	2
2.	Arunachal Pr.	12	202	6	-
3.	Assam	18	809	7	3
4.	Bihar	42	2109	27	-
5.	Goa	1	260	-	-
6.	Gujarat	19	3563	-	-
7.	Haryana	12	410	3	-
8.	Himachal Pr.	12	743	1	4
9.	Jammu & Kash.	14	655	3	8
10.	Karnataka	30	3545	-	1
11.	Kerala	14	2283	-	1
12.	Madhya Pr.	45	1986	13	7
13.	Maharashtra	30	8207	-	2
14.	Manipur	8	145	2	4
15.	Meghalaya	7	254	-	2
16.	Mizoram	3	95	1	-
17.	Nagaland	7	100	-	5
18.	Orissa	13	901	2	-
19.	Punjab	12	921	1	1
20.	Rajasthan	27	2018	4	1
21.	Sikkim	4	100	3	-
22.	Tamilndau	21	3620	-	-
23.	Tripura	3	60	-	2
24.	Uttar Pr.	56	3437	9	13
25.	West Bengal	17	6433	-	-
26.	A&N Islands	2	67	-	-
27.	Chandigarh	1	10	1	-
28.	D&N Haveli	1	4	-	1
29.	Daman & Diu	2	10	2	-
30.	Delhi	1	1607	-	-
31.	Lakshdweep	1	-	-	-
32.	Pondicherry	1	188	-	-
TOTAL		459	47321	85	57

Annexure C

STATEMENT SHOWING PROVISIONAL ACHIEVEMENT IN RESPECT OF DETECTION OF NEW T.B.CASES DURING 1992-93

NATIONAL T.B.CONTROL PROGRAMME
(D.G.H.S.)

S.No.	States/Union Teritories	Annual Target	Achievement 1992-93	% Achievement.
1.	Andhra Pr.	90,400	65,517	72
2.	Arunachal Pr.	2,800	2,998	107
3.	Assam	39,100	17,975	46
4.	Bihar	1,98,640	183	99
5.	Goa	3,800	3,498	92
6.	Gujarat	1,48,200	1,58,228	107
7.	Haryana	31,200	31,058	100
8.	Himachal Pr.	18,960	17,008	90
9.	Jammu & Kash.	16,200	3,655	23
10.	Karnataka	85,200	65,653	78
11.	Kerala	46,600	27,275	59
12.	Madhya Pr.	1,22,800	52,473	43
13.	Maharashtra	2,36,500	2,34,147	99
14.	Manipur	4,200	2,603	62
15.	Meghalaya	2,600	2,426	93
16.	Mizoram	1,000	827	83
17.	Nagaland	1,800	1,354	75
18.	Orissa	41,300	28,367	69
19.	Punjab	43,400	44,764	103
20.	Rajasthan	46,360	33,557	72
21.	Sikkim	1,600	4,351	272
22.	Tamilnadu	1,18,940	99,034	83
23.	Tripura	2,100	2,163	103
24.	Uttar Pradesh	2,97,500	2,56,861	86
25.	West Bengal	93,200	51,113	55
26.	A & N Islands	400	440	110
27.	Chandigarh	2,600	1,723	66
28.	D & N Haveli	320	265	83
29.	Daman & Diu	260	581	223
30.	Delhi	47,200	64,028	136
31.	Lakshdweep	220	167	76
32.	Pondicherry	4,600	4,863	106
TOTAL:		17,50,00	14,75,155	84

Annexure - D

STATEMENT SHOWING PROVISIONAL ACHIEVEMENT IN RESPECT OF CONDUCTION OF SPUTUM EXAMINATION DURING 1992-93

NATIONAL T.B.CONTROL PROGRAMME
(D.G.H.S.)

S.No.	States/Union Teritories	Annual Target	Achievement 1992-93	% Achieve ment.
1.	Andhra Pr.	2,52,600	1,84,765	73
2.	Arunachal Pr.	6,750	7,610	113
3.	Assam	87,600	8,226	9
4.	Bihar	3,76,200	3,41,779	90
5.	Goa	4,500	14,997	333
6.	Gujarat	1,53,500	2,65,577	173
7.	Haryana	60,000	49,720	78
8.	Himachal Pr.	46,200	50,150	109
9.	Jammu & Kash.	51,600	10,900	21
10.	Karnataka	1,85,000	1,69,585	92
11.	Kerala	1,07,400	37,789	35
12.	Madhya Pr.	2,90,500	1,17,433	40
13.	Maharashtra	2,76,900	3,39,063	122
14.	Manipur	9,300	4,134	44
15.	Meghalaya	7,200	1,152	16
16.	Mizoram	3,000	3,254	108
17.	Nagaland	5,100	1,376	27
18.	Orissa	1,90,200	1,22,232	64
19.	Punjab	85,000	1,12,461	132
20.	Rajasthan	1,40,400	64,228	46
21.	Sikkim	4,500	2,657	59
22.	Tamilnadu	2,41,800	1,11,482	47
23.	Tripura	8,400	5,865	70
24.	Uttar Pradesh	5,75,000	5,13,951	90
25.	West Bengal	2,14,200	26,672	12
26.	A & N Islands	1.200	2,452	204
27.	Chandigarh	600	430	72
28.	D & N Haveli	500	265	53
29.	Daman & Diu	600	1,313	219
30.	Delhi	1,200	76,683	6390
31.	Lakshdweep	1,000	231	23
32.	Pondicherry	7,800	8,764	112
TOTAL:		33,95,848	26,55,820	78

RAJYA SABHA

DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE ON HUMAN RESOURCE DEVELOPMENT

FOURTH REPORT

ON

NATIONAL HEALTH PROGRAMMES OF THE DEPARTMENT OF HEALTH (MINISTRY OF HEALTH & FAMILY WELFARE)

(Presented to the Rajya Sabha on the 21st December, 1993)
(Laid in Lok Sabha on the 21st December, 1993)

RAJYA SABHA SECRETARIAT
NEW DELHI

DECEMBER, 1993/AGRAHAYANA, 1915 (SAKA)

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16/1/97

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COMPOSITION OF THE DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE ON HUMAN RESOURCE DEVELOPMENT

(1993-94)

1. Shri Ram Naresh Yadav—*Chairman*

MEMBERS

RAJYA SABHA

2. Prof. Saurin Bhattacharya
3. Shrimati Renuka Chowdhury
4. Dr. Jinendra Kumar Jain
5. Miss Saroj Khaparde
6. Shri V. Hanumantha Rao
* 7. Vacant
8. Shri Md. Salim
9. Shri Pravat Kumar Samantaray
10. Prof. I.G. Sanadi
11. Shri Ashoke Kumar Sen
12. Shri Vishnu Kant Shastri
13. Shri P. Upendra
14. Shri Ranjan Prasad Yadav

LOK SABHA

15. Dr. Viswanathan Kanithi
16. Dr. V. Rajeshwaran
17. Prof. (Smt.) Savithri Lakshmanan
18. Shri Mani Shankar Aiyar
19. Dr. Vasant Niwrutti Pawar
20. Prof. P.J. Kurien
21. Shri Subash Chandra Nayak
22. Shri Bapu Hari Chaure
23. Shri Z.M. Kahandole
24. Shri Datta Meghe
25. Shri Ishwarbhai Khodabhai Chavda
26. Shri K. Thulasiah Vandayar
27. Shri Aslam Sher Khan
28. Shri Inder Jit
29. Dr. Ramesh Chand Tomar
30. Shri Chinmayanand Swami
31. Shri Dau Dayal Joshi
32. Prof. K. Venkatagiri Gowda
33. Dr. K.D. Jeswani

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*Vacancy caused due to expiry of Shri T. Chandrasekhar Reddy on 15-9-1993.

34. Dr. Mahadeepak Singh Shakya
35. Dr. G.L. Kanaujia
**36. Shri Anna Joshi
37. Shri Braja Kishore Tripathy
38. Shri Rambadan
39. Shrimati Malini Bhattacharya
40. Shri Ram Chandra Dome
41. Shri Brahma Nand Mandal
42. Prof. Ummareddy Venkateswarlu
43. Shri Suraj Mandal
44. Shri Kanshi Ram

SECRETARIAT

Smt. Vanaja N. Sarna, Director
Shri Ram Krishan, Under Secretary
Shri Rohtas, Committee Officer

**Nominated w.e.f. 26-8-1993 in the vacancy caused by the resignation of Shri Chandrajeet Yadav w.e.f. 13-3-1993.

PRINTE

INTRODUCTION

I, the Chairman of the Department-related Parliamentary Standing Committee on Human Resource Development, having been authorised by the Committee to present the Report on its behalf, do hereby present the Fourth Report of the Committee on the National Health Programmes of the Department of Health (Ministry of Health & Family Welfare).

The Committee considered various documents and papers received from the Department of Health and also heard its Secretary and other officials to elicit further information at its meetings held on the 10th & 11th June, 1993.

The details of the working, targets, achievements, allocations and expenditure regarding major National Health Programmes of the Department *viz.* National Malaria Eradication Programme; Kala-azar; National Filaria Control Programme; National Leprosy Eradication Programme; National Programme for Control of Blindness and National AIDS Control Programme were discussed by the Committee and have been included in the Report.

The Committee considered and adopted the Report at its sitting held on the 16th December, 1993.

RAM NARESH YADAV
Chairman
Department-Related Parliamentary Standing Committee on Human Resource Development

NEW DELHI;
16th *December,* 1993

25 *Agrahayana,* 1915 *(Saka)*

An Overview

1. 'Health is Wealth' is a well-known proverb and it is an axiomatic fact that only healthy citizens can make a nation prosperous and healthy. Health plays a vital role in the making of a nation great and strong. Development and maintenance of good health is not only a personal or an individual effort but a Welfare State also plays a very important role in it.

2. It is expressly mentioned in our Constitution in Article 47, which relates to the Directive Principles of State Policy, that 'The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health among its primary duties...' The improvement of health and nutrition on national basis is the responsibility of the Central Council of Health. Since the inception of planning process in 1952, various health programmes have been introduced in the country. In pursuance of its commitment, Government also formulated a national Policy on Health in 1983.

3. But, the dimensions that health problems have acquired in our country are really complex and alarming. Majority of diseases people suffer from are poverty-related, while some have their origin in the utter lack of cleanliness and awareness or consciousness towards health. Rapid increase in environmental pollution, increasing population, cropping up of new diseases like AIDS and cancer are some of the challenges that the nation is facing today. To fight on all these fronts simultaneously is, of course, a formidable task, particularly when the resources at hand are limited.

4. As per World Bank estimates, in India only 1.3% of the Gross Domestic Product is spent on health which is perhaps the lowest amongst the developing countries. It is flabbergasting to further note that the allocation has shown a gradual diminishing trend in the successive Five Year Plans. For instance, 3.3% of the total outlay in the First Five Year Plan has come down to a dismal 2.74% during the Eighth Five Year Plan. In the face of the financial constraints foreign assistance was sought. Some traditional diseases like Leprosy, Tuberculosis, Malaria, Blindness, etc. still persist affecting the majority of our population. In such a situation, it is to be seen if Government's commitment to attain the goal of health for all by 2000 A.D. could possibly be fulfilled.

5. World Bank assistance to the scale of 100 to 200 million dollars per year has been cleared for Health sector throughout the Eighth Five Year Plan. The first project taken up under this project is the AIDS Control Programme. Assistance is also expected for Leprosy and Blindness Control Programmes.

6. In an effort to fight the menace of major diseases Government is implementing various National Health Programmes. The Committee had detailed deliberations on some of them namely; National Malaria Eradication Programme; Kala-azar; National Filaria Control Programme; National Leprosy Eradication Programme; National Programme for Control of Blindness and the National AIDS Control Programme.

I. National Malaria Eradication Programme

7. It is estimated that at the time of country's Independence in 1947, there were over 75 million malaria cases and about one million deaths had occured due to it. For its control, a national strategy was formulated in the year 1953. DDT proved to be a very effective insecticide and a great success was achieved in controlling this disesase. Encouraged by this initial success, the National Malaria Control was renamed as 'National Malaria Eradication Programme' in the year 1958. By the year 1965, the incidence of malaria witnessed a downward trend, with nil mortality rate which was, in itself, a great achievement. But this success was short-lived as in the mid-seventies recurrence of malaria was visible. There was a sharp increase in the number of reported malaria cases to the tune of 6.47 million per year. The strategy was revised once again named Modified Plan of Operation (MPO) with the objective of elimination of mortality rate, effective control of malaria and maintaining the gains achieved so far in its eradication. The objectives were sought to be achieved by prompt case- detection through active and passive surveillance and vector control by residual insecticidal spraying.

8. Since 1984, the incidence of malaria has stabilized at around 2 million cases per year. It is reported that during the year 1991, there were 1.81 million positive cases of malaria and around 400 deaths. During the year 1992, there were approximately 1.4 million reported malaria cases. Though tribals constitute only 8% of the total population, yet they account for over 30% of the malaria cases and 60% of the deaths on account of P. Falciparum. Similarly, there was a sharp increase in the number of cases detected in urban slums from 1,39,057 in 1989 to 2,11,890 in 1991. Studies and surveys conducted in this regard have shown the presence of resistance to DDT and a combination of anti-malaria insecticides.

9. There are Seven States in the country namely, Madhya Pradesh, Andhra Pradesh, Bihar, Gujarat, Maharashtra, Orissa and Rajasthan which are more vulnerable and most of the malaria deaths have occured there. According to the Annual Report of the Ministry of Health & Family Welfare for the year 1992-93, Malaria cases during the last five years indicated that in the year 1988, there have been 1.85 million cases with 0.68 million P. Falciparum cases and 209 deaths. In 1989, there were 2.05 malaria cases with 0.76 million P. Falciparum cases and 268 deaths, in 1990 out of the 2.02 million malaria cases there have been 0.75 million P. Falciparum cases with 353 deaths, in 1991 out of 2.11 million malaria cases there were 0.91 million P. Falciparum cases with 421 deaths and in 1992, there were 1.42 million cases with 0.45 million P. Falciparum cases and 246 deaths.

10. The National Malaria Eradication Programme is being implemented as a centrally sponsored category-II on a 50:50 cost sharing basis between the States and the Central Government. Under this Programme, the Central Government meets the cost of entire quantity of DDT and partially of BHC and Malathion, antimalaria drugs like Chloroquine, Primaquine and Pyrenthamine, etc. The State Governments are expected to meet the expenditure on staff and other operational costs for successful implementation of the Programme.

11. During his oral evidence tendered before the Committee, the Secretary, Department of Health, informed that malaria has taken an endemic turn because of the fact that the health infrastructure in the most affected States is extremely weak. The Deptt. has also realised that the tribal and hilly areas where malaria infection cases are high, have to be dealt with on a different footing from the rest of the country. Fifty per cent share of the States has to be reviewed and the

Central Government is thinking to have the central scheme implemented by taking assistance from World Bank to fight this menance. Keeping this in view, it is proposed to intensify the efforts for the full containment of malaria during the Eighth Five Year Plan. Accordingly, major attention is proposed to be given to the tribal sub-plan areas of Seven States of Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Orissa and Rajasthan, the urban population and population living in the project areas and rest of the country. This control strategy is a balanced mixture of preventive and curative measures for elective spraying for vector control, larviciding and source reduction in urban areas and early detection and treatment.

12. During his oral evidence tendered before the Committee, the Secretary, Department of Health, informed that they had achieved a great initial success in controlling malaria, but when the incidence reached a figure of 1,00,000 in the entire country in the seventies, they had a rebound and the incidence rose to about 6.5 million. Thereafter, the programme was started in 1977 and they were able to bring this figure down to 2 million in 1984. After that, this figure has more or less ramained stable. It means there has been no further improvement after 1984. This was due to a very high level of infection in the tribal areas of North-East. The migrant labour force from these areas going to different parts of the country also contributes to the spread of Malaria. A lot of on going construction activities contribute to the cause of stagnation of water and pollute environment leading to breeding of mosquitoes, hence the incidence of malaria.

13. The Committee was informed that for this purpose, a sum of Rs. 86 corres was spent during the year 1991-92. In 1992-93, Rs. 65 crores were allocated for malaria control programme which also included other vector diseases like Kala-azar and Filaria. Now, this amount has been increased to Rs. 87 crores for procuring insecticides, larvicides and drugs. For the year 1993-94, a sum of Rs. 110 crores has been allotted. It is also proposed to provide 100% Central assistance to the North Eastern States and the tribal sub-plan areas. For the tribal areas, it is also proposed to mobilise resources from the World Bank as well.

14. The Committee was informed that there was mainly three reasons for the resurgence of malaria, namely:—

(i) Administrative reasons—complacency shown by the administration after getting some initial success.

(ii) Technical reasons—

(a) Mosquitoes became immune to many insecticides and the insecticides which were very effective in the past became ineffective;

(b) the parasites have been irresistable to certain drugs;

(c) New drugs were tried out which also contributed in non-effectiveness of the programme to some extent.

(iii) Financial reasons—The programme was integrated into the Primary Health Centres after getting initial success in the sixties. The Primary Health Centres being very busy in their own programmes, could not provide attention and time which was very necessary for controlling malaria. Even financial allocation required for filling up the posts which were available in the sub-centres for eradication of malaria remained unfilled; the supply of PLO, etc. was not available because of financial constraints. All these factors contributed to the failure of the programme. Even financial allocations were reduced.

Kala-Azar

15. Kala-azar is another deadly disease which has become a serious Public Health Problem in Bihar and West Bengal. It is observed that after its resurgence in Bihar in early 70s, the disease has spread over from 4 districts to adjoining areas and now 30 districts in Bihar and 9 districts in West Bengal are the most affected. This estimate is based on cases reported in Government hospitals only. Some cases go to private practitioners and thus remain unreported. The disease is on the increase and has assumed serious dimensions in the above two States.

16. According to the estimates, there were 14079 Kala-azar cases in the year 1986 with 47 deaths and in West-Bengal there were 3718 cases with 25 deaths in the same year. There has been a rapid increase both in its incidence as well as deaths in Bihar. In the year 1989, there were 30903 cases with 477 deaths in Bihar and 3575 cases with 20 deaths in West Bengal. In the year 1992 there were 66959 Kala-azar cases in Bihar with 1266 deaths (provisional upto October). So there has been alarming increase, both in the incidence and the death cases in Bihar which requires immediate remedial steps.

17. Organised control measures have been initiated to control Kala-azar. Upto 1990-91, financial assistance for its control was being provided by the Central Government out of the NMEP budget provisions. However, separate funds amounting to Rs. 4.06 crores were made available during 1990-91 for control of this disease in Bihar and West Bengal.

18. The Committee was informed that in order to check the menace, efforts are being made for interruption of transmission, for reducing vector population by undertaking indoor residual insecticidal spray twice annually. Early diagnosis and treatment of Kala-azar cases and providing health education for community awareness, are also being undertaken in this connection.

19. The Committee was also informed that in view of the financial constraints, the Central Government decided to meet the total cost of medicines and insecticides for Kala-azar control in Bihar. Under the district action plan development, State Governments have agreed to deploy exclusive infrastructure for Kala-azar control and adequate material with strict supervision, monitoring and evaluation. The concept of making different functionaries at various levels responsible and accountable for success of the programme is likely to make a good impact on reduction of the incidence of Kala-azar.

20. The Central Government is providing insecticides and imported anti Kala-azar drug i.e. Pentamidine Isothionate to the West Bengal Government. The Central Government has also provided assistance to the Bihar Government in cash and kind during the last two years i.e. in 1990-91 and 1991-92, to the tune of Rs. 389.49 and Rs. 1535.99, respectively.

21. A budget provision of Rs. 1500.00 lakhs has been made to provide material assistance for Kala-azar control. However, in view of the seriousness of the problem, commitment of the Central Government to ensure availability of material for effective control, a Revised Estimates for Rs. 2376.55 lakh has been proposed to meet the cost of insecticides and anti Kala-azar drugs.

22. In addition UNICEF assistance of Rs. 15.55 lakh had been provided for 1990-91 to the State Governments for public information, education, communication activities and orientation training of medical professionals. UNICEF is providing assistance on continuing basis directly to the State Government of Bihar. Material assistance including the insecticides, DDT and the imported drug Pentamidine Isothionate is also provided.

National Filaria Control Programme

23. Filaria, like Malaria is also a deadly disease which has become a major health problem in our country. The disease has been prevalent throughout India except the States of Jammu & Kashmir, Punjab, Himachal Pradesh, Mizoram, Meghalaya, Tripura, Manipur, Rajasthan, Arunachal Pradesh, Delhi, Chandigarh, Haryana, Sikkim & Nagaland. Present estimates indicate that about 389 million people are living in 175 endemic districts of which about 103 million are living in urban areas and the rest in rural areas.

24. In order to control this disease, the National Filaria Control Programme was taken up in the year 1955 with the following action plan:—

(i) Delimitation of the problem in hither-to unsurveyed area;

(ii) Control in Urban Areas through:

a) Recurrent anti-larval measures; and
b) Antiparasitic measures.

25. For this purpose about 206 Central Units, 27 Survey Units and 195 Clinics are working in the country. About 43.43 million people in urban areas are being protected through anti-larval measures by 206 control units and 195 clinics are giving treatment with Diethy/Uarbanarine to clinical cases and microfilaria.

26. During the course of his oral evidence tendered before the Committee, the Secretary, Department of Health informed that efforts made in this connection have shown remarkable results. It is observed that about 73 per cent of the towns in microfilaria rate and about 69 per cent of towns in the disease rates where control measures are in operation for more than five years, have shown marked reduction in the filaria cases.

Monitoring

27. The Programme is being monitored by the Directorate of Malaria Eradication Programme and this organisation has got a good number of people spread all over the country. In addition to this, there are about 17 Regional Directors of Health posted in different States.

Observations/recommendations

28. The Committee is unhappy to note the sense of complacency shown by Government in eradication and control of malaria, resulting in resurgence of malaria cases, especially after achieving initial success to a great extent during the fifties and the sixties.

29. The Committee feels that assistance of World Bank be obtained expeditiously and new methods and technology should be used for the purpose.

30. The Committee recommends that State Governments should be asked to be more vigilant, prompt, to strengthen the infrastructure including adequate staff and to make it obligatory for the private practitioners to report all the cases to the authorities concerned. Malaria Research Centres should be provided requisite infrastructure and staff to act as watch-dogs.

31. The Committee observes that the allocations for Malaria are combined with the allocations for filaria and Kala-azar, which means that when there is an increase in filaria and Kala-azar part of allocations may be accordingly shifted to these areas, reducing the actual allocation for malaria. The Committee recommends separate allocations for all the three wings namely Malaria, Kala-azar and Filaria respectively. The Committee further observes that in view of all three diseases having common allocations , it is quite clear that there has been no actual

increase in funds for anti-malaria programme in spite of the fact that the number of malaria cases have not come down since 1984. Not only that, there has been an increase in malaria cases, particularly cases of Malaria falciparum in tribal areas and in urban slums. The fact that majority of deaths from malaria being in tribal areas (60% of total cases) was found shocking by Committee. It is recommended that the recently-cleared proposal of making malaria eradication programme in tribal and other malaria-prone areas where health service is weak a 100% centrally-sponsored Scheme should be immediately implemented. Regular monitoring must also be done through cooperation with State Governments and local bodies.

32. The Committee expresses its deep concern over the shortage of some effective and potent medicines to cure malaria particularly P. Falciparum and recommends that steps should be taken to ensure that the requisite medicines are easily available in all the Hospitals/Dispensaries and in the open market. Government should also supply such medicines under National Malaria Eradication Programme to all the States so that all the State Government Hospitals could have the medicine. Arrangements should also be made to supply these medicines through Mobile dispensaries in the areas most affected by Malaria. Regular spray in the affected areas should also be undertaken. Inpregnated bed nets duly dipped in synthetic chemicals which not only kill the mosquitoes but also acts a repellent be provided wherever possible.

33. As per the annual report (1992-93) of the Ministry of Health & Family Welfare, budget provisions and expenditure, both in cash and kind, is not adequate. Instead of increase, there has been decrease both in the allocations and the actual expenditure incurred on Filaria Eradication Programmes.

34. The Committee recommends that adequate funds, separate from the Malaria Eradication Programme, may be provided for control/Eradication of Filaria and Kala-azar.

35. The Committee also recommends that concerted efforts should be made to use new techniques and no laxity be shown in this regard. The Committee also recommends that both urban and rural areas be covered under Filaria Eradication Programme and awareness Programme should be given wide publicity through print and electronic media. Adequate supply of anti-filaria drugs in hospitals, dispensaries and in the open market be ensured apart from the usual spraying.

II. National Leprosy Eradication Programme

36. India has a very high rate of incidence of leprosy, which is widespread all over the country, and is one of the major health problems.

37. The magnitude of the disease can be judged by the fact that as per the Ministry's Annual Report (1992-93), out of 10 million cases of leprosy in the world, 2.5 million are estimated to be found in India. The prevalance rate of leprosy exists above 5 per 1000 population in 201 districts out of 468 districts and about 15% of the leprosy sufferers are children below 15 years of age.

38. The leprosy control Programme, which was in existence since 1955, was given priority and redesignated as National Leprosy Eradication Programme in 1983. It is one of the centrally sponsored Health Schemes financed 100% by the Central government and implemented through State governments.

39. During the course of his oral evidence tendered by the Secretary, Department of Health, the Committee was informed that the programme has been launched in 135 districts which are considered endemic i.e. where the prevalence rate is more than 5 per thousand. The Programme remains to be launched in 66 other districts which are in the same category. Then

there are 77 other districts which are moderately endemic i.e. having a prevalance rate of 2 to 5 per thousand. If these 143 districts are covered over and above 135 districts that are already covered then 95% of the leprosy patients will be covered.

40. The Committee was also informed that in the last 5-6 years, since the introduction of Multi-drug Therapy there has been a major breakthrough in bringing down the incidence of leprosy as out of estimated 4 million cases in 1981, the number has come down to 1.4 million by the end of february, 1993. Wherever the Multi-drug Therapy Programme has been in operation for more than 5 years, there is 80% reduction in incidence.

41. The Secretary of the Health department stated that the programme has produced dramatic results and it is expected that leprosy would be eliminated from the country by the turn of the century, i.e. when the prevalence rate will be below 1 per 10,000 population.

42. The Secretary of the department admitted that in an effort to cure more and more cases sufficient attention had not been paid to rehabilitation and reconstructive surgery and to help the patients lead a normal life after they are cured.

43. Therefore, it is very necessary to have centres of reconstructive surgery and rehabilitation and a sustained health eduction campaign to make people understand that the patients who are cured or have undergone treatment for the disease are absolutely safe and infection free.

44. The Committee was informed that under the programme of major reconstructive surgery there is no plan to create new institutions instead under the world Bank project institutes where reconstructive surgery is available will be revamped and provided with equipments and appliances free of cost.

45. These institutes will also be provided Rs. 2500/- for each major surgery and package of services which include full cost of operation service, OPD and total care of the patient. If an institute is not available within a district then the patient will be referred to any such institute established in a nearby district. In that case, the amount will be Rs. 2500/- plus the reimbursement of travel expenses of the patient.

46. It was informed that there are district Leprosy Officers in 105 districts in which Multi-drug Therapy Programme has been taken up and also there is one doctor for every 4-5 lakhs of population. To ensure that the programme reaches every village there are village level workers for every 20,000 population who are supposed to go around and find out the cases and see that the services reach them for their treatment.

47. The Secretary conceded that some posts of doctors are lying vacant in some districts and the State Governments have been urged to fill them up.

48. There are also District Leprosy Societies in all the districts where the programme has been taken-up. In the societies there are local representatives, members of Legislatures, panchayats etc. with whom various aspects of the programme are discussed.

49. As regard role of Voluntary organisations it was informed that out of about 285 voluntary organisations, 55 are receiving assistance from Central Government. The grants-in-aid are given under the Survey, Education and Treatment (S.E.T) Scheme and are released through the State Governments.

50. The performance of the voluntary organisations are being closely monitored by the Central Government and also by the State Governments themselves. However, the Secretary admitted that it is possible that some voluntary organisations may not be performing upto the expectations but by and large they are doing commendable work. It was also informed that there

are some international voluntary organisations also who have covered the entire districts and done extremely good work.

51. The NLEP is given high priority and for the Eighth Five Year Plan it has been allocated Rs. 140.00 crores as against actual expenditure of Rs. 40.00 crores during the Sixth Plan (1980-85) and Rs. 85.82 crores during Seventh Plan (1985-90). The expediture for the 8th Five Year Plan is constantly increasing on yearly basis from 17.58 crores in 1990-91, to 24.38 crores in 1990-91, and Rs. 35.00 crores as per revised estimates of 1992-93. The Budget estimates for 1993-94 is also Rs. 35.00 crores. In reply to query as to why the budget provision of Rs. 35 crores for 1993-94 has been kept at the same level as that of the last year, it was informed that after negotiations with the World Bank a loan of Rs. 332 crores, over a period of 6 years, for the expansion of the programme has been approved and the formal approval by the Board of World Bank is likely to come in June-July. This additional amount will substantially add to the financial resources for this programme.

52. The external aid component earlier was as meagre as Rs. 1.05 crores in 1990-91, Rs. 1.78 crores in 1991-92 and Rs. 1.10 crores in 1992-93. However, the aid has substantially increased to Rs. 11.00 crores in 1993-94 due to major contribution of Rs. 9.50 crores by the World Bank.

53. The evaluation of the programme was done in December, 1991 through 15 specially created teams of experts each, one of the members of which was International expert on leprosy.

Observations/recommendations

1. The reported data has been validated.
2. The progress of programme is slow in Uttar Pradesh, Madhya Pradesh, Bihar, Orissa and West Bengal.
3. A good number of posts of Medical Officers, Non-Medical Supervisors are vacant in some states. Such vacancies are 20% to 30% in Uttar Pradesh, Madhya Pradesh, Bihar and West Bengal.
4. There is need for further toning up of logistic arrangements i.e. drugs, vehicles and equipments.
5. Temporary Hospitalization wards are not being utilised to their capacity.
6. There is need to further tone-up the training activities.
7. M.D.T. has been found to be very effective.

54. The Committee appreciates the optimism of the Ministry that they will be able to eliminate leprosy from the country by the turn of the century and hopes that the Ministry will make all out efforts to achieve the target.

55. The Committee also hopes that the Ministry will learn lesson from their mistakes in Malaria Eradication Programme and will not repeat them in this programme and recommends that foolproof steps be taken not only for the elimination of the leprosy but also for rehabilitation of the people who are inflicted with the disease and the programme be continued with same vigour till leprosy is completely eradicated.

56. The Committee recommends that M.D.T. programme, which has produced dramatic results, be expanded to such an extent that all the districts of the country where the prevalence rate of leprosy is more than 2 per 1000 population and pockets of districts which have endemic leprosy, are brought under it immediately. The Committee also recommends that rural and backward areas which have endemic leprosy be given special attention.

57. The Committee expresses its deep anguish over the fact that Department has done almost nothing for so many years for the rehabilitation of the patients which virtually negates the objective of the programme. The Committee, therefore, recommends that rehabilitation and reconstructive surgery be given utmost priority and centres of reconstructive surgery and rehabilitation be opened in all the districts where prevalence rate is more than 2 per 1000 population.

58. The Committee takes strong exception to the approach of the Department to treat cases in which disease starts eating up fingers and nose, as burn put cases for whom nothing much can be done except rehabilitation to a limited extent.

59. The Committee is of the view that if the explanation of the Department is accepted no treatment is to be provided to the advance cases of AIDS and Cancer as they are not curable. The Committee feels that no case is a burn out case and every patient deserves the best treatment and rehabilitation even if he cannot be cured.

60. The Committee, therefore, recommends that for the so called burnt out cases more humanistic approach be adopted and they be provided best possible treatment and he kept in the hospitals as long as it is required.

61. The Committee also recommends that some scheme be formulated for the poor patients who are living on the river banks of religious places, begging on the streets or living in isolated places for whom even their families do not care and they may be provided food, clothing, shelter and all other medical attention.

62. The Committee is not convinced with the claim made by the Secretary during the course of his oral evidence that they have one doctor for every 4 to 5 lakhs of population and recommends that it should be ensured that there are doctors for every 4-5 lakhs of population and also recommends that Committee be informed of number of doctors in position in each district.

63. The Committee fails to understand the rationale for having District Leprosy Officers in 105 districts only when the programme has been launched in 135 districts. The Committee, therefore, recommends that post of District Leprosy Officers be immediately created in remaining 30 districts and also recommends that District Leprosy Officers be appointed in all the districts of the country, in phases, where the prevalence rate is more than 2 per 1000 population. The Committee is of the considered view that only doctors as District Leprosy Officer can properly monitor the progress of programme and recommends that only medical men be appointed as District Leprosy Officers.

64. The Committee also recommends that wherever the post of District Leprosy Officer is vacant it should be immediately filled up and it should also be ensured that posts of District Leprosy Officers are not kept vacant for long durations. In case it is not possible to fill up the post for some reasons the alternative arrangements be made.

65. The Committee feels that budget allocation of Rs. 35.00 crores for NLEP for the year 1993-94 is inadequate and it should have been increased substantially keeping in view the importance of the programme and rate of inflation, irrespective of the fact that World Bank grant worth Rs. 68 crores was expected to be released from August, 1994. In the course of oral evidence before the Committee, the Health Secretary said that refampicin, needed for both leprosy and tuberculosis, is now likely to be produced in the country from the basic stage. This would lead to the reduction of the cost of Refampicin, which is a costly drug now. The Committee thinks that instead of the price of drugs being primarily within the purview of the

Ministry of Chemicals and Fertilizers, Health Ministry be also involved in this particularly in the case of basic drugs needed for national programmes.

III. National Programme for Control of Blindness (NPCB)

66. Eye is the most beautiful and invaluable gift of nature. Without eyes world is nothing but darkness. India being the second most populous country in the world, has at present 14 per thousand cases of blindness. Government in its first effort to meet the backlog of blindness on a national scale, launched a National Programme for Trachorma Control in 1963. This Programme was subsequently merged into the National Programme for control of Visual impairment and prevention of blindness which was re-named in 1976 as National Programme for Control of Blindness (NPCB). This is 100% a Central Government sponsored scheme.

67. As per the evaluation of blindness done by All India Survey 1988-89, cataract is found to be responsible for 81% of blindness in India.

68. National Programme for Control of Blindness (NPCB) aims at providing intensive health education for eye care through the mass media and extension education methods; extension of ophthalmic services in rural areas through mobile units and eye camps and establishment of permanent infrastructure for eye care as an integral part of general health services. Government claims that it is engaged in the control of blindness since 1963 but the Committee is surprised to note the fluctuation in the funds released, expenditure incurred and actual cataract operations performed/proposed to be performed during the period 1985-94 as illustrated in the following statistics:—

Year	Amount released on the NPCB (in crores)	Expenditure incurred (in crores)	Cataract operations performed (in lakhs)
1985-86	6.16	6.76	12.24
1986-87	5.56	6.88	12.09
1987-88	6.05	8.50	12.09
1988-89	5.44	7.65	11.90
1989-90	5.70	9.82	10.70
1990-91	5.67	8.12	11.98
1991-92	9.70	9.70	15.13
1992-93	20.00		12.25
1993-94	25.00		(provisional till Feb. 1993)

69. The Committee finds no plausible reason to the variations in the above figures and therefore, recommends that there should not be any let up in the efforts to achieve the target of reducing the blindness from the present 14 per thousand to 3 per thousand by the turn of the century i.e. 2000 A.D.

70. The Secretary, Department of Health, Ministry of Health & Family Welfare, in his oral evidence tendered before the Committee, has stated that at least two million people are being added every year to the number of persons requiring cataract operations whereas the performance has been to the tune of 1.5 million operations per year. In other words at least 50,000 people are being added to the list of patients requiring cataract surgery every year.

71. The Committee takes it seriously that the achievement rate of cataract operations is declining steadily. For instance, in the year 1990-91, the percentage of achievement for cataract

operations was 92.53% but in the year 1991-92 it was only 73.47% and in 1992-93 it is expected still to go down as against the target of 20.00 lakhs, only 12.25 lakh operations have been performed till February, 1993. Therefore, this is a matter of great concern and anxiety.

72. The Committee strongly recommends that Government should find out the reasons of this fall in the cataract operations and devise some programmes so that more and more cataract operations can be performed at a greater speed and if not more, at least targets fixed should be achieved every year. The Committee also puts a word of caution that in its urge to achieve the targets, Government should ensure that no quacks are used in such operations and that the number of casualities should be eliminated completely. It should also be ensured that post-operations care should be given high priority and benefits given to the poor families undergoing such operations should reach them immediately such as grant of Rupees Sixty for spectacles and the like.

73. The Committee is surprised to find that no foolproof method has been adopted in calculating the cataract operations done by the private and non-Government organisations (NGOs) and recommends that supply of information to the PHC or CHO at the district level should be made mandatory for all such organisations engaged in the cataract operations.

74. The Secretary, Department of Health informed the Committee that corneal blindness is not a major reason for blind nor a contributory factor. But, the Committee feels that there is a need to set up eye-banks in the country and therefore recommends that Government should persue, educate and encourage people through mass media to donate eyes voluntarily on a large scale. Simultaneously, Government should also develop adequate infrastructure and facilities in order to successfully procure the eye of each and every donor.

75. Voluntary Organisations play a significant role to make National Programme for Control of Blindness (NPCB), successful, especially in the field of Education, Prevention, Rehabilitation and Surgical services, etc. Government have been giving emphasis in the recent past to form District Blindness Control Societies in all the States and Union Territories which are to be registered under the Societies Registration Act of 1860, under the control of Deputy Commissioner/District Magistrate by involving voluntary organisations of the area and raising funds from local sources. In this connection, the District Ophthalmic Surgeon is the Member Secretary of the Society apart from the representatives of the local and voluntary organisations and as per the oral evidence tendered before the Committee by the Secretary, Deptt. of Health 174 such societies have been formed so far and are functioning.

76. The Committee feels that it is a very good step taken by Government in order to achieve targets fixed for cataract operations and making National Programme for Control of Blindness a success and recommends that a mechanism may be evolved to hold meetings of such societies at least once in three months and all concerned should be asked to attend the meetings and also monitor the cataract operations performed in their district invariably. The Committee also recommends that concerted efforts should be made to form such societies in all the remaining distircts all over the country as soon as possible.

77. As per the Annual Report of the Ministry of Health & Family Welfare for the year 1992-93 funds allocations under Eighth Plan for the National Programme for Control of Blindness has been fixed at rupees 120 crores apart from the foreign aid agreed upon between the Government of India and Government of Denmark which is Rupees 22.25 crores over a period of five years 1989-94 under phase-II, the funds for which are to be released in a phased manner depending upon the actual expenditure incurred by the various State Governments under the scheme. The Committee recommends that indigenous allocation may be

enhanced in order to achieve the targets fixed for National Programme for Control of Blindness apart from exploring funds from such foreign agencies.

National AIDS Control Programme

78. Acquired Immuno Deficiency Syndrome (AIDS) has emerged as one of the major public health problems in recent years. It is caused by human immuno deficiency virus (HIV). AIDS virus destroys the body's immune system i.e. strength to fight against disease. Hence the person becomes susceptible to all kinds of diseases and slowly and slowly goes down and dies. The virus spreads primarily through sexual intercourse, but can also be transmitted by sharing drug injecting needles, through transfusion of infected blood, and from infected mothers to their unborn and new born children.

79. According to the World Health Organisation (WHO) estimate, there are about one million people infected with HIV in India. HIV infection in the country has been reported from as many as 23 States/Union Territories of which Maharashtra, Tamil Nadu, Delhi and Manipur have the highest incidence.

80. The first HIV infection case in India was detected in Madras in 1986, in a survey conducted by the Indian Council of Medical Research (ICMR). Subsequently, the AIDS Control Programme was formulated in 1987, which has following components: (i) Surveillance; (ii) Safety of blood and blood products; and (iii) Health Education.

81. A separate wing known as AIDS Control Organisation has been established in the Ministry of Health & Family Welfare from September/October, 1992, in order to co-ordinate the programme effectively. Since AIDS has no cure as of now, the thrust of the whole programme is on creation of awareness through information, communication and education for promotion of safe practices including safe sex, use of sterilised/disposable needles, use of uninfected blood and blood products etc.

82. The Committee feels that proper and effective implementation of the National AIDS Control Programme is possible only when there exists essential infrastructure. In a country like India where a large number of population is illiterate, it is a challenging task to educate and arouse awareness to make them understand the causes of the disease and advise them on taking necessary precautions. In the absence of a vaccine, it is necessary to inform people as to how HIV is transmitted and educate them to protect themselves and their loved ones from the deadly disease. As the number of AIDS cases increase education aimed at preventing the syndrome becomes more important and imperative.

83. During the course of his oral evidence tendered before the Committee, the Secretary, Department of Health informed that efforts are being made to educate people in order to control Sexually Transmitted Disease (STD) because it is one of the major factors for transmission of HIV infection. There are 332 STD clinics spread all over the country. Efforts are also being made to impart training to rural doctors so that they can identify the symptoms and refer the persons suffering from the disease to STD clinics. Alarming and rapid increase in HIV positive cases in our country has necessiated utmost and precautionary measure in the field of AIDS control. The Committee, therefore, recommends that it should be made mandatory to carry out HIV tests of persons who undergo normal blood tests in hospitals. It will in this way be easier to detect and screen out the AIDS cases.

84. The Committee observes that services available in some of the STD clinics are not being properly utilised. The Committee recommends that efforts should be made to utilise the STD clinics fully for the treatment of the afflicted persons.

85. The Committee feels the need to launch a massive programme to promote public awareness and community support. So that myths and misconceptions about the disease could be obliterated. In this regard the Committee recommends that:—

(i) An advertisement campaign should be designed to reach large number of people with messages about prevention of AIDS. Television and radio spots may also be used.

(ii) Leaflets should be published for distribution in various public forums and in health care facilities. Such material must contain latest medical information, reach new target population, and should stress matters that survey results have indicated to be of special importance. This material may also be prepared in regional languages for distribution among local population.

(iii) Forums should be set up and workshops, classes and seminars should be organised from time to time in different areas to enable members of the general public to interact with the experts. This will allay the fears and wrong notions which exist in society about the disease.

(iv) Journalists and specialists should prepare articles to enhance readers' general knowledge and arouse awareness and understanding about AIDS.

(v) The programme should be designed not only to inform the target population about the disease but also to motivate them to act on information they already possess.

(vi) The programme should not rely entirely on printed and broadcast messages. Face to face education may also help people to clarify their misconceptions. More and more voluntary organisations may be encouraged to take up the challenging task of enlightening the people through the use of different media viz. drama, street plays, exhibitions and videos.

(vii) While educating people about the disease and its control, public sensibilities should be considered carefully in order to make the programme acceptable to them.

86. The Committee emphasises on the need to evolve broad AIDS Control Strategy covering all major aspects such as revamping of STD Control Programme, safe blood transfusion and streamlining infection control in hospitals. There should be a stricter enforcement of Screening of blood donors. Besides this, a responsible system of primary health care centres should also be established for providing psycho-social care to infected persons and to counter social ostracism against them.

87. The Committee also stresses the need to encourage extensive grass-root participation of general public and voluntary organisations in the AIDS prevention and control programme.

88. The indigenous systems of medicine contain a reservoir of wisdom which concerns public health. The Committee recommends that efforts may be made to revive and strengthen the traditional systems. Ayurveda and other indigenous systems of medicine may be encouraged to find treatment of the AIDS.

89. Neem is found in abundance in India. Many International investigations and research studies have proved beyond doubt that it is very effective and safe in the cure of deadly diseases like AIDS and Cancer, etc. Therefore, the Committee recommends that concerted efforts should be made to harness the use of Neem and its products in the cure of AIDS and cancer in addition to other such diseases. The Committee also recommends that more and more emphasis should be laid on research in this regard for which adequate funds should be provided.

90. While the Committee agrees that proper precautionary measures should be taken to check the spread of HIV infection which might lead to AIDS, the Committee recommends for an indigenous study of AIDS cases in the country, for proper assessment of its extent, instead of

relying on World Health Organisation report alone. The Committee fails to understand the reasons for the priority given to the anti-AIDS programme in the World Bank assisted scheme. While assistance is still to come for most of the other national programmes (e.g. Malaria Eradication Programme) and hardly any real increase in budgetary allocations has been made. The enormous quantum of World Bank assistance for the anti-AIDS programme seems to be totally lop-sided, to say the least. The Committee feels that instead of this lavishness, enhancement of allocation in basic health services like Anti-Malaria, Anti-Tuberculosis Programmes, etc. would also have pre-empted spread of AIDS.

MINUTES

MINUTES OF THE MEETING OF THE COMMITTEE ON HUMAN RESOURCE DEVELOPMENT

VII

*SEVENTH MEETING

The Department Related Parliamentary Standing Committee on Human Resource Development met at 11.00 A.M. on Thursday, the 10th June, 1993, in Committee Room 'A', Ground Floor, Parliament House Annexe, New Delhi.

PRESENT

1. Shri Ram Naresh Yadav — *Chairman*

RAJYA SABHA

2. Prof. Saurin Bhattacharya
3. Miss Saroj Khaparde
4. Shri Md. Salim
5. Shri Pravat Kumar Samantaray
6. Shri Vishnu Kant Shastri
7. Shri P. Upendra
8. Shri Ranjan Prasad Yadav

LOK SABHA

9. Dr. Viswanatham Kanithi
10. Dr. V. Rajeshwaran
11. Dr. Vasant Niwrutti Pawar
12. Shri Ishwarbhai Khodabhai Chavda
13. Dr. Ramesh Chand Tomar
14. Shri Dau Dayal Joshi
15. Dr. K.D. Jeswani
16. Dr. Mahadeepak Singh Shakya
17. Dr. G.L. Kanaujia
18. Shri Braja Kishore Tripathy
19. Shrimati Malini Bhattacharya
20. Shri Brahmanand Mandal
21. Shri Suraj Mandal

REPRESENTATIVES OF THE MINISTRY OF HEALTH & FAMILY WELFAPE (DEPARTMENT OF HEALTH)

Shri R.L. Misra, Secretary
Shri I. Chaudhari, Additional Secretary (Health)
Shri P.R. Das Gupta, Additional Secretary (AIDS)
Dr. A.K. Mukerjee, Director-General, Health Services
Shri T.K. Das, Joint Secretary
Shrimati S. Chandra, Joint Secretary
Shri Pawan Chopra, Joint Secretary

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*Minutes of I to VI meetings relate to matters not included in this report.

Shri I.S. Bist, Joint Secretary
Shri B.S. Lamba, Joint Secretary
Shrimati A.P. Ahluwalia, Financial Advisor & Jt. Secretary
Dr. C.H.S. Shastri, Advisor (ISM)
Dr. V.T. Augustus, Advisor (Homoeopathy)

SECRETARIAT

Shri R.C. Soperna, Deputy Secretary
Shri Om Prakash, Under Secretary
Shri A.K. Singh, Committee Officer

2. The Committee heard the Secretary (Health), Ministry of Health & Family Welfare regarding Annual Report for the year, 1992-93 concerning Department of Health.

The Committee adjourned at 1.25 P.M. and re-assembled at 4.00 P.M.

A verbatim record of the proceedings was kept.

3. The Committee then adjourned at 6.45 P.M. to meet again on the 11th June, 1993 at 11.00 A.M.

VIII

EIGHTH MEETING

The Department Related Parliamentary Standing Committee on Human Resource Development met at 11.00 A.M. on Friday, the 11th June, 1993, in Committee Room 'A', Ground Floor, Parliament House Annexe, New Delhi.

PRESENT

1. Shri Ram Naresh Yadav —— *Chairman*

RAJYA SABHA

2. Prof. Saurin Bhattacharya
3. Shrimati Renuka Chowdhury
4. Miss Saroj Khaparde
5. Shri Md. Salim
6. Shri Pravat Kumar Samantaray
7. Shri P. Upendra

LOK SABHA

8. Dr. Viswanatham Kanithi
9. Dr. Vasant Niwrutti Pawar
10. Dr. Ramesh Chand Tomar
11. Shri Dau Dayal Joshi
12. Dr. K.D. Jeswani
13. Dr. Mahadeepak Singh Shakya
14. Dr. G.L. Kanaujia
15. Shri Braja Kishore Tripathy
16. Shrimati Malini Bhattacharya
17. Shri Brahmanand Mandal
18. Shri Suraj Mandal

REPRESENTATIVES OF THE MINISTRY OF HEALTH & FAMILY WELFARE (DEPARTMENT OF HEALTH)

Shri R.L. Misra, Secretary
Shri I. Chaudhari, Additional Secretary (Health)
Shri P.R. Das Gupta, Additional Secretary (AIDS)
Dr. A.K. Mukerjee, Director-General, Health Services
Shri T.K. Das, Joint Secretary
Shrimati S. Chandra, Joint Secretary
Shri Pawan Chopra, Joint Secretary
Shri I.S. Bist, Joint Secretary
Shri B.S. Lamba, Joint Secretary
Shrimati A.P. Ahluwalia, Financial Advisor & Joint Secretary
Dr. C.H.S. Shastri, Advisor (ISM)
Dr. V.T. Augustus, Advisor (Homoeopathy)

SECRETARIAT

Shri R.C. Soperna, Deputy Secretary
Shri Om Prakash, Under Secretary
Shri A.K. Singh, Committee Officer

2. The Committee heard the Secretary (Health), Ministry of Health & Family Welfare regarding Annual Report for the year, 1992-93 concerning Department of Health.

A verbatim record of the proceedings was kept.

3. The Committee then adjourned at 2.25 P.M.

XXI

*TWENTY-FIRST MEETING

The Department-related Parliamentary Standing Committee on Human Resource Development met at 3.00 P.M. on Thursday, the 16th December, 1993 in Committee Room 'A', Ground Floor, Parliament House Annexe, New Delhi.

PRESENT

1. Shri Ram Naresh Yadav —— *Chairman*

RAJYA SABHA

2. Prof. Saurin Bhattacharya
3. Smt. Renuka Chowdhury
4. Shri Md. Salim
5. Prof. I.G. Sanadi

LOK SABHA

6. Prof. (Smt.) Savithri Lakshmanan
7. Shri Mani Shankar Aiyar
8. Dr. Vasant Niwrutti Pawar

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* Minutes of IX to XX meetings relate to matters not included in this report.

9. Shri Bapu Hari Chaure
10. Shri A. Thulasian Vandayar
11. Dr. G.L. Kanaujia
12. Shri Anna Joshi
13. Smt. Malini Bhattacharya
14. Shri Ram Chandra Dome

SECRETARIAT

Shri Ram Krishan, Under Secretary
Shri Rohtas, Committee Officer

2. The Committee considered and unanimously adopted the Draft Fourth Report with some modifications. The Committee decided to resent the Report in the Rajya Sabha and to day the same on the Table of Lok Sabha on Tuesday, the 1st December, 1993 and authorised the Chairman and in his absence *Shri Md. Salim and Prof. I.G. Sanadi* to present the Report in the Rajya Sabha and also authorised *Dr. Vasant Niwrutti Pawar and Shri Dau Dayal Joshi* to lay the Report on the Table of the Lok Sabha. The Committee decided to hold its next meetings at 3.00 P.M. on Monday, the 10th January, 1994 and at 11.00 A.M. on Tuesday, the 11th January, 1994 to take up for consideration the National Culture Policy, 1992.

3. The Committee then adjourned at 4.00 P.M.