CHAPTER 5

HUMAN AND SOCIAL DEVELOPMENT

5.1 FOOD AND NUTRITION SECURITY

Initiatives to improve nutritional status of the population during the last five decades include:

- ✉ Increasing food production- building buffer stocks
- ✉ Improving food distribution- building up the Public Distribution System (PDS)
- ✉ Improving household food security through
  - ⇔ Improving purchasing power
  - ⇔ Food for work programme
  - ⇔ Direct or indirect food subsidy
- ✉ Food supplementation to address special needs of the vulnerable groups-Integrated Child Development Services (ICDS), Mid-Day Meals
- ✉ Nutrition education especially through Food and Nutrition Board (FNB) and ICDS
- ✉ Efforts of the health sector to tackle
  - ⇔ Adverse health consequences of undernutrition
  - ⇔ Adverse effects of infection and unwanted fertility on the nutritional status
  - ⇔ Micronutrient deficiencies and their health consequences

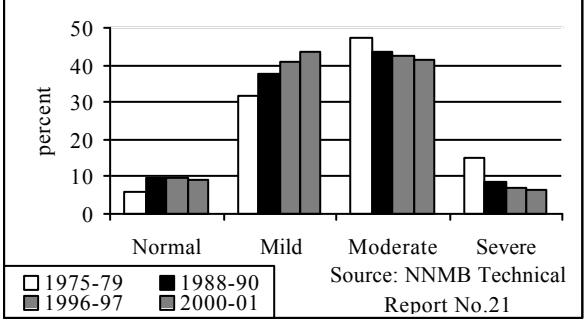
1. Recognising the importance of optimal nutrition for health and human development, India adopted multi-sectoral, multi-pronged strategy to combat major public health problems of chronic energy deficiency(CED), iodine deficiency disorders, Vitamin A deficiency and anaemia due to iron and folate deficiency and to improve nutritional status of the population. Constitution of India (Article 47) states that "the State shall regard raising the level of nutrition and standard of living of its people and improvement in public health among its primary duties".

Table-5.1.1 Prevalence (%) of Nutritional Deficiency Signs: Preschool Children

Nutritional Deficiency Signs	1975-79	2000-01
Odema	0.4	0.0
Marasmus	1.3	0.2
Angular Stomatitis	5.7	1.4

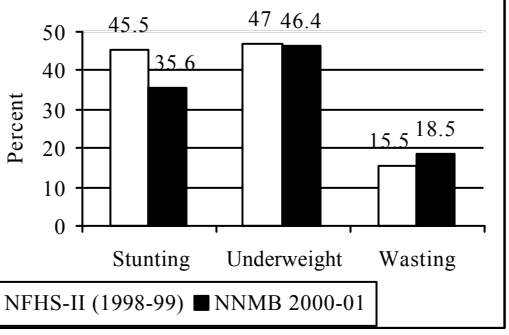
Successive Five Year Plans laid down the policies and strategies for achieving these goals. As a result of these interventions, there has been reduction in severe grades

Figure-5.1.1 Distribution (%) of 1-5 years Children by Nutritional Status (Gomez Classification)



Source: NNMB Technical Report No.21

Figure-5.1.2 Children (<3 years) with moderate undernutrition



of under-nutrition in children and some improvement in nutritional status of all segments of population. Kwashiorkor, marasmus, pellagra, lathyrism, beriberi and blindness due to severe Vitamin-A deficiency have become rare. Over the last three decades, there had been sustained reduction in nutrition deficiency signs and severe CED in preschool children (Table-5.1.1, Figures- 5.1.1&5.1.2). However, there has not been any decline in mild and moderate under-nutrition and anaemia. Changing life style and dietary habits have led to increased prevalence of obesity and associated non-communicable diseases especially among affluent segments of the population . In the new century, the country will have to gear itself to prevent and combat the dual problems of under- and over-nutrition. As the country enters the era of dual burden of under-and over-nutrition and their adverse consequences there is a need for a paradigm shift from :

- household food security and freedom from hunger to nutrition security for the family and the individual;
- untargeted supplementation to vulnerable groups to screening of all the persons from these groups, identification of those with various grades of undernutrition and appropriate management;
- lack of focused interventions for prevention of over-nutrition to the promotion of appropriate lifestyles and dietary intakes for the prevention and management of over-nutrition and obesity

With well targeted, multi sectoral and comprehensive interventions of

- ✉ increasing food production, effective processing and distribution,
- ✉ improvement in purchasing power ,
- ✉ nutrition and heath education generating awareness
- ✉ ensuring optimum utilisation of well targeted interventions for prevention, detection and management of macro and micronutrient deficiencies

it may be possible to achieve the goals set in the Health, Population and Nutrition policies.

Table-5.1.2 Average daily Percapita dietary intake

	Calorie (kal)		Protein (g)		Fat (g)	
	Rural	Urban	Rural	Urban	Rural	Urban
1972-73	2266	2107	62	56	24	36
1983	2221	2089	62	57	27	37
1993-94	2153	2071	60.2	57.2	31.4	42
1999-2000	2149	2156	59.1	58.5	36.1	49.6
Source: NSSO						

Dietary Intake

2. Dietary intake is an important determinant of nutritional status of the population. Poverty and lack of purchasing power have been identified as the two major factors responsible for the low dietary intake in India. The concern over the economic factors resulting in chronic under-nutrition led to the use of calorie intake as the basis of estimating poverty. The National Sample Survey Organisation (NSSO) monitors expenditure on foodstuffs as a part of consumption expenditure. Data from these surveys (Table-5.1.2) indicate that over the last three decades the overall calorie and protein intake in rural areas has shown a small decline; dietary intake in urban areas has remained unaltered. However, when the data is analysed by income (Table-5.1.3), the calorie intake

Table-5.1.3 Average Per Capita Calorie Intake by Expenditure Classes

Expenditure Classes	Rural			Urban		
	1972-73	19977-78	1993-94	1972-73	19977-78	1993-94
Lower 30%	1504	1630	1678	1579	1701	1682
Middle 40%	2170	2296	2119	2154	2438	2111
Top 30%	3161	3190	2672	2572	2979	2405

has shown a small increase in both urban and rural poor and a decline among the urban and rural rich. In the urban areas, the variation in intake over the years is much smaller. In spite of the fact that calorie intake has not increased, there is a rise in obesity mainly because of changes in life style and consequent reduction in energy expenditure. Over the last three decades, there has been a substantial increase in the fat intake in both rural and urban areas. In view of adverse nutrition (obesity) and health (non communicable diseases) implications of increased fat intake especially among the affluent group, this has to be curtailed through appropriate nutrition education. In view of the known massive interstate differences in the dietary intake and nutritional status, it is important to analyse the state-wise data on intake and nutritional status and modify the interventions programmes to cope with the problems.

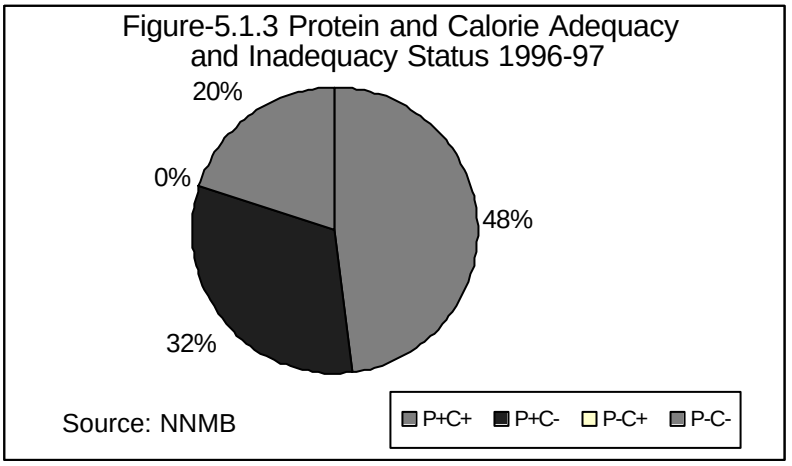
Table-5.1.4 Percapita Private Final Consumption Expenditure at 1993-94 prices in Rs.

	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
Cereals	900.86	908.87	907.48	966.27	855.43	898.00	894.34
Pulses	134.61	139.94	122.59	138.34	124.59	136.85	116.95
Sugar & Gur	226.29	211.57	215.95	254.57	228.81	251.62	268.79
Oil & Oilseeds	260.43	239.79	252.08	288.20	211.65	337.09	268.20
Fruits & Veg.	702.24	743.25	742.94	729.53	783.95	837.35	861.69
Potato & Other tubers	69.69	67.47	70.40	83.67	66.56	78.46	75.97
Milk & milk products	522.94	537.33	587.82	621.78	651.48	668.94	752.62
Meat, egg & fish	243.96	257.14	263.46	275.57	273.45	285.82	291.91

Source: Computed from National Accounts Statistics, CSO

3. Data from CSO (Table-5.1.4) indicates that during the nineties, the average per capita consumption expenditure on cereals has remained more or less constant but expenditure on pulses has declined in 1999-2000. However there is a considerable increase in the consumption of vegetables and fruits and milk and milk products. This is an

Figure-5.1.3 Protein and Calorie Adequacy and Inadequacy Status 1996-97



Source: NNMB

encouraging trend suggesting that the people are aware of the need for dietary diversification in order to meet the nutritional needs (macro, micro and phyto –nutrients) and are making efforts to diversify their dietary intake. It is important that this trend is accelerated by improving access to the vegetables, fruits, diary products at affordable cost through out the year in urban and rural areas in all states, because this trend towards dietary diversification is the first step towards sustainable food based intervention for prevention of macro and micronutrient deficiencies.

4. National Nutrition Monitoring Bureau (NNMB) is the only agency that collects information on dietary intake and nutritional status at the same time from the same house holds. Data from NNMB also shows that over the last three decades there has not been any substantial change in dietary intake. Analysis of data from NNMB on distribution of households according to protein-energy adequacy status is presented in Figure-5.1.3. About 48 per cent of the households consumed more than adequate amount of both proteins and calories, while 20 per cent of households consumed inadequate amounts of both the nutrients. With increasing access to cooking gas, piped water supply, labour-saving gadgets and transport, there has been a substantial reduction in the physical activity pattern and energy expenditure, especially in the middle and upper income groups. Data from NNMB repeat surveys indicate that there has been some reduction in under-nutrition and some increase in obesity over the last two decades (Figure-5.1.4). Data from NFHS has shown that among women in reproductive age, 35.8% are under-nourished and 10.6% are overweight. It is obvious that India currently faces the problem of both under-nutrition and over-nutrition and associated health hazards.

Figure-5.1.4 Nutritional Status of Adult Males

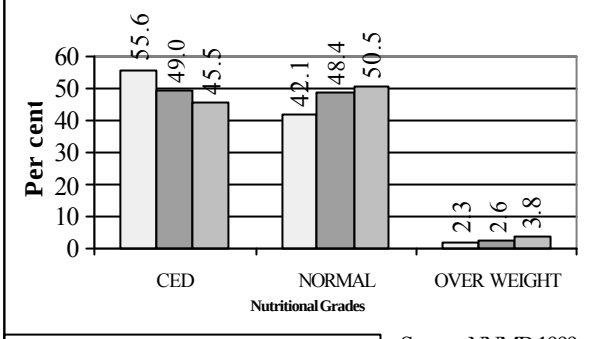
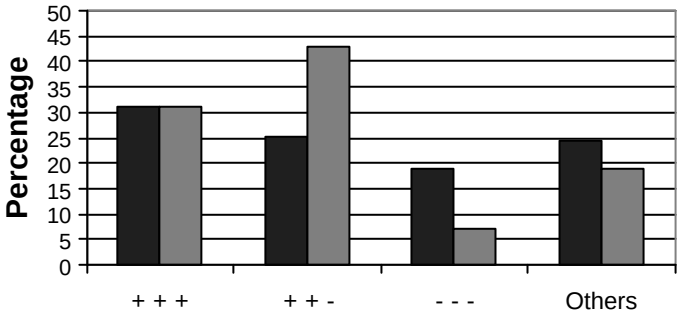


Figure 5.1.5 Comparison of Energy Adequate Status of Preschool Chidren and Adults



Dietary Intake	Adult Male	Adult Female	Preschool Children
+ + +	Adequate	Adequate	Adequate
+ + -	Adequate	Adequate	Inadequate
- - -	Inadequate	Inadequate	Inadequate

Intrafamilial Distribution of Food

5. NNMB is the only source for information on dietary intake of individuals in the family. Data on intake of different foodstuffs

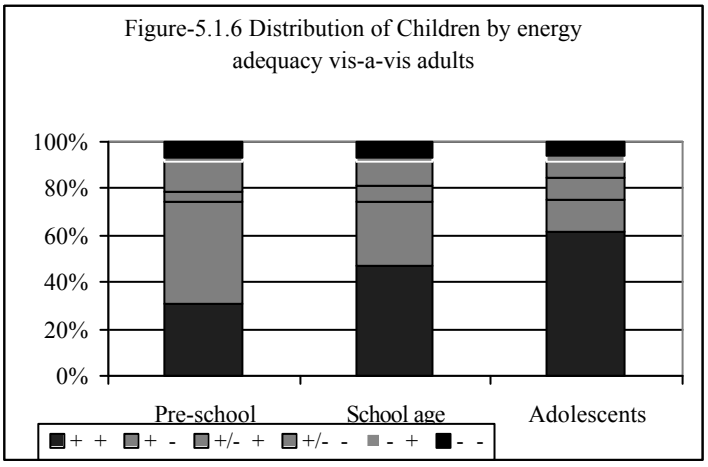
and nutrients by different age groups is given in Annexure 5.1.1. Time trends in intra familial distribution of food (Figure-5.1.5) indicate that while the proportion of families where both the adults and preschool children have adequate food has remained at about 30% over the last 20 years, the proportion of families with inadequate intake has come down substantially.

6. However the proportion of families where the pre-school children receive inadequate intake while adults have adequate intake has nearly doubled. Data from NNMB survey 2000-01 indicating intra-familial protein calorie adequacy is shown in Table-5.1.5. Only a third of children in the 1-3 years age group have adequate intake of both calorie and protein. The proportion with adequate protein-calorie intake from the family pot increases with increase in age. Data on energy adequacy status from NNMB also shows a similar picture (Figure-5.1.6). In 42.9% of the households, the energy intake of preschool children was inadequate even though the adults, both males and females, had adequate energy intake. This proportion steadily declines to 13.2% with the increase in age. This data clearly indicates that one of the major reasons for prevalence of undernutrition in young children is perhaps the inability of these children to consume enough food from the family meal rather than poverty. Nutrition education to the family that young children have a very low stomach capacity and in order to ensure that they get adequate energy and proteins it is important to feed them once in four hours or even more often may go a long way in reducing the prevalence of under nutrition in young children. Simultaneously efforts should be made to improve dietary intake in pregnant and lactating women so that their needs are met.

Table-5.1.5 Distribution (%) according to Protein-Calorieadequacy

	P+C+	P+C-	P-C-	P-C+
1-3 years	31.5	46.9	21.6	
4-6 years	28.6	62.5	8.9	
7-9 years	31	62	7	
10-12 years boys	31.9	59.3	8.9	
10-12 years girls	36.8	53.4	9.8	
13-15 years boys	43.9	46	10.1	
13-15 years girls	47.8	47	5.2	
16-17 years boys	56.8	12.2	25.7	5.3
16-17 years girls	71.6	5.7	16.4	6.3
Adult males sedentary	79.7	12.8	6.9	0.6
NPNL Sedentary	87.8	5.8	5.1	1.3
PW sedentary	69.7	9	15.4	5.9
Lact. Sedentary	67.2	6	16.5	10.3

Figure-5.1.6 Distribution of Children by energy adequacy vis-a-vis adults



Note: First sign indicate the adequacy status of adults (both males & females)

7. Mean energy consumption vis-à-vis RDI is given in Table-5.1.6. Mean consumption of energy is lower among females; however because of their smaller stature the RDA is met by nearly 90% of sedentary non pregnant and non lactating women; however as dietary intake is not higher in pregnant and lactating women less than 70% of the pregnant and lactating women meet their dietary requirement. Mean energy consumption, as percentage of RDI is the least among the preschool children. This is in spite of the fact that the RDI for preschool children forms a very small proportion (on an average 1300 Kcal/day) of the family's total intake of around 11000 Kcal/day (assuming a family size of 5).

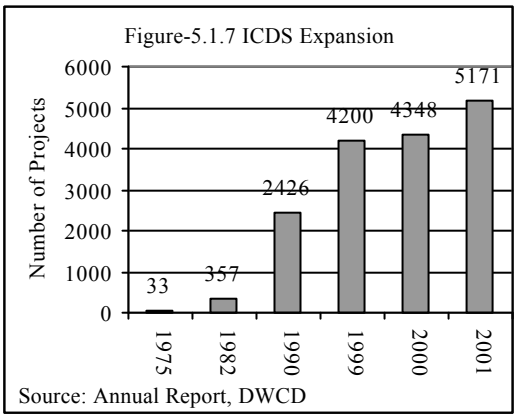
It would, therefore, appear that it is not economic deprivation or poverty that is a major factor responsible for inadequate dietary intake in children but lack of knowledge on child feeding, child rearing and child caring practices. There is an urgent need to improve health and nutrition education so that these adverse trends in preschool children's intake are reversed.

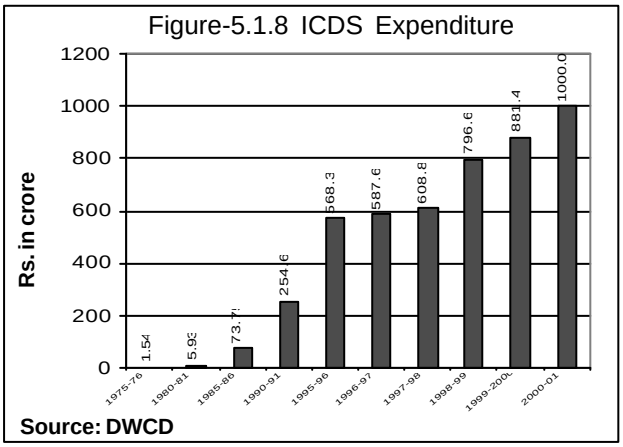
Table-5.1.6 Mean Energy Consumption- Children / Adolescents and Adults

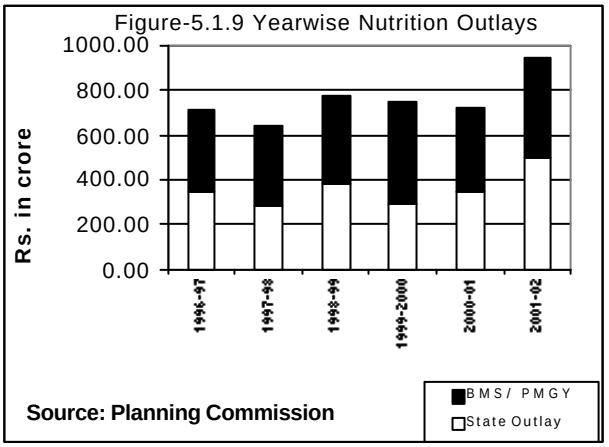
Age Group	Males			Females		
	Kcals	RDI	RDI %	Kcals	RDI	RDI %
Pre-school	889	1357	65.5	897	1351	66.4
School Age	1464	1929	75.9	1409	1876	75.1
Adolescents	2065	2441	84.6	1670	1823	91.6
Adults	2226	2425	91.8	1923	1874	102.6

Integrated Child Development Scheme

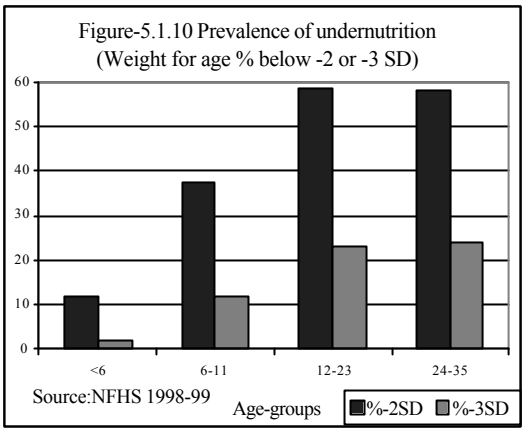
8. The nutrition component of ICDS, perhaps the largest of all the food supplementation programmes in the world, was initiated in 1975 to improve the nutritional status of preschool children and pregnant and lactating women. The initial geographic focus was on drought-prone areas and blocks with a significant proportion of scheduled caste and scheduled tribe population. In 1975, 33 blocks were covered under ICDS. Over the last two decades the ICDS coverage has progressively increased. As of March 2002, 5652 projects have been sanctioned; there are more than 5 lakh anganwadis in the country. The number of persons covered under ICDS rose from 5.7 million children 0-6 years of age and 1.2 million mothers in 1985 to 31.5 million children and 6.0 million mothers up to March 2002.

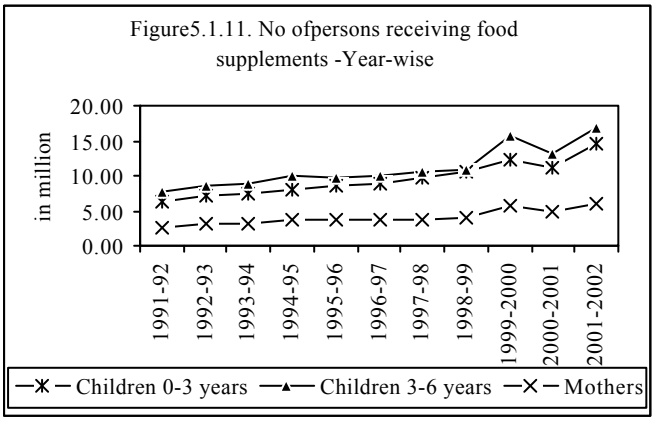






9. The central government bears the infrastructure and manpower cost of the ICDS programme. The state governments are responsible for funding the nutrition component. In addition, CARE, World Food Programme and other agencies provide food supplements in some selected blocks of some states. While over the last three decades there has been a steep increase in the number of ICDS blocks (Figure-5.1.7) and the flow of funds from the center (Figure-5.1.8), the states' own contribution has not shown any increase (Figure-5.1.9). In an attempt to cover larger number of persons, some of the states like Assam have started providing food grains instead of cooked or ready to eat food under the ICDS, as this would cut down cooking and operational costs. In an effort to augment the funds available for supplementary nutrition during the Ninth Plan period, nutrition was included as one of the components for funding under the Additional Central Assistance (ACA) that was given under Basic Minimum Services (BMS) during the first three years of the Ninth Plan and under PMGY in the last two years. In view of the fact that there is a steep increase in the undernutrition rate in the 6-36 months age group because these children do not get adequate food from the family pot (Figure-5.1.10), an attempt is being made under PMGY to provide take home food supplements (roasted and powdered mixture of cereals, pulses and oilseeds) to all the below poverty line families with children between 6 to 36 months, so that the mix could be fed to the children three to four times a day and this could substantially reduce the onset of undernutrition. The Department of Women and Child Development was releasing the funds for the nutrition component of the PMGY in the first two years viz., 2000-01 and 2001-02. From 1st April 2002, the Planning Commission has taken over the release of the funds under all components of the PMGY. Available data from the Department of WCD indicate that after the introduction of the take home food supplements under the nutrition component of PMGY there has not been a steep increase in the number of children in the 6-36 month age group receiving food supplements (Figure-5.1.11).





10. Some of the available data indicate that in many states:

- there was difficulty in procuring locally available take-home food supplements;
- relatively expensive ready-to-eat food, and not cereal-pulse-oilseed mix was provided
- the funds provided under the nutrition component of PMGY were not treated as an additionality but were substituted for state's own Plan funds for nutrition (annexure -5.1.2)

Detailed analysis of plan outlays indicated that

- ✉ only two of the major states viz., Andhra Pradesh and Tamil Nadu have provided more outlay for nutrition in 2001-02 as compared to 2000-01.
- ✉ in Kerala, J&K, Nagaland, Rajasthan and Tripura, the outlay provided is less than the funds earmarked for nutrition under PMGY.
- ✉ many states like Arunachal Pradesh, Assam, Bihar, Himachal Pradesh, Manipur, Meghalaya, Mizoram and Sikkim have kept their state plan outlay for nutrition at the same level as that provided under PMGY.

11. There is another problem with the fund allocation under nutrition component of PMGY. Under the formula used for allocation of funds under PMGY, the special category states with only 6% of the country's population get 30% of the funds under PMGY. The populous states with high poverty, under-nutrition rates get relatively small amounts under the nutrition component of PMGY and are unable to address the issue of reduction in under-nutrition (Figure-5.1.12). The special category states get 30% allocation and have more funds under PMGY than what is required to cover all children in the 6-36 moths age group in BPL families. In view of the fact that there are substantial gaps in providing nutrition supplements under the ICDS programme and that under-nutrition is wide spread, it was decided to allow the states with surplus funds under PMGY to utilize it to ensure better coverage of pregnant and lactating women as well as to ensure that children with Grade III & IV malnutrition get double ration of supplements as specified under ICDS. The scheme is being continued in the current financial year with increased allocation (Rs.2800 crore) of which 15% is earmarked for the nutrition component. The progress in utilization of funds under PMGY and the usefulness of the strategy of providing take-home food supplements to prevent undernutrition in 6-36 months old children will be reviewed.

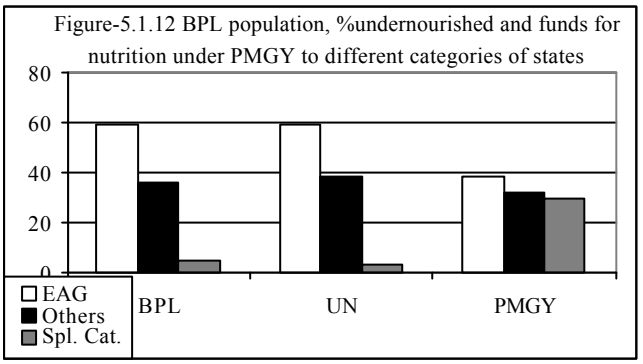


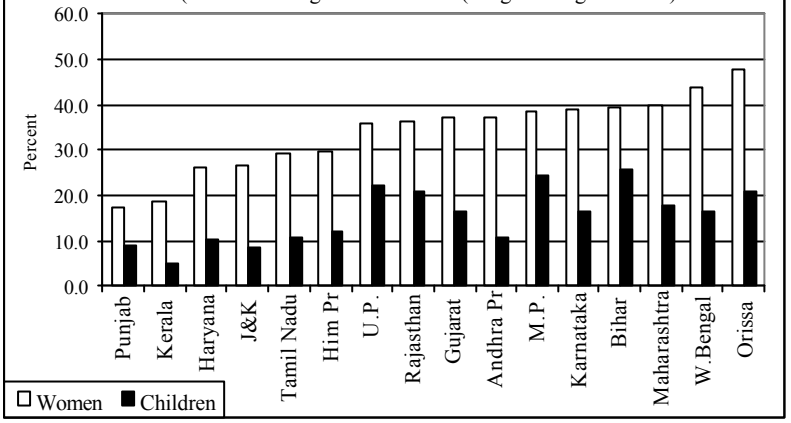
Figure-5.1.12 BPL population, %undernourished and funds for nutrition under PMGY to different categories of states

12. The guidelines laid down for the nutrition component of PMGY emphasise that all infants and children should be weighed at least once in three months to detect those who are under-nourished so that focused health and nutrition interventions could be undertaken. Even though growth monitoring is an essential component of ICDS, it has not been operationalised. In view of this the special category states are not able to utilize the funds available under PMGY for achieving rapid reduction in the severe grades of under nutrition in children and pregnant and lactating women.

Inter-state variations in Nutritional Status

13. NFHS provides state wise estimates of undernutrtion in women which clearly indicates that there are wide interstate variation in the nutritional status. The proportion of women with CED (BMI below 18.5kg/m^2) varies from 10.7 percent in Arunachal Pradesh to 48

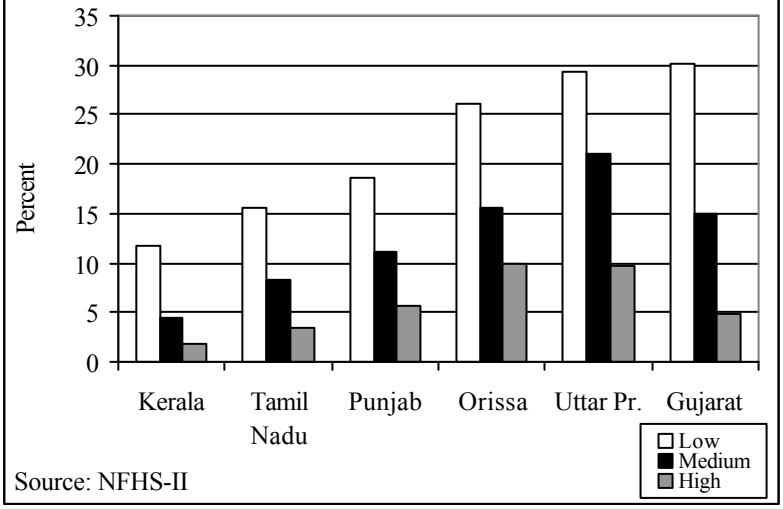
Figure 5.1.13. Prevalence of undernutrition in Women (BMI < 18.5 kg/m^2 & Children (weight for age < 3 SD)



percent in in Orissa and that of children severely under weight (-3SD) from 4.2 percent in Sikkim to 25.5 in Bihar (Figure-5.1.13). Punjab has the lowest levels of undernutrition in women and Kerala has the lowest levels of under nutrition in children. Prevalence of undernutrition in adult women is highest in Orissa, and highest levels of undenutrition in children have been reported from Bihar. Inspite of relatively higher levels of undernutrition in women the under-nutrition rates in children in Andhra Pradesh and Tamil Nadu are low. The relatively well organized food supplementation through ICDS may be the reason for the relatively lower prevalence of under-nutrition in children in spite of high under-nutrition rates in women in Tamil Nadu and Gujarat. In Kerala under-nutrition rates in children is very low in spite of very low investment in ICDS food supplementation, perhaps because of the appropriate infant and child feeding habits and better access to health care for children. It is essential that analysis of beneficial and adverse factors that account for the observed variation in nutritional status in different states is done and appropriate state specific intervention programmes drawn up and implemented. If this were done it may be possible to achieve substantial improvement in nutritional status even with all the current financial constraints. Available data on demographic and health indices of the population indicate that there are substantial inter-district differences in these indices. It is possible that a similar situation may exist in respect to nutritional status. As a part of the ongoing efforts at convergence, Department of Women and Child Development has collaborated with the Department of Family Welfare in conducting the Rapid House Hold Survey so that district wise information on macro and micronutrient nutritional status in children will become available by next year.

14. Data from NFHS also showed that there are substantial variations within the state among different income groups (Figure-5.1.14). In all the states, the proportion of undernourished children decreased with increase in income. However in spite of the lower per capita income Kerala and Tamil Nadu have lesser proportion of severely under nourished children; in states like Punjab, in spite of higher percapita income, the undernutrition rates in children

Figure-5.1.14 Nutritional Status of Children by Income



Source: NFHS-II

is higher. The proportion of children severely underweight even in the highest income group in Orissa (9.9%) and Uttar Pradesh (9.7%) are comparable with that of the lowest income group in Kerala (11.8%). Perhaps this is because of more equitable distribution of food within the state and within the family and also better access to health care. Gujarat provides the maximum funds under Plan for Nutrition but has a high proportion of children with weight below –3SD in the lowest income group. The flow of funds for nutrition to Orissa also, especially to the KBK districts, is quite high but this has not resulted in improved nutritional status of children. These data suggest that mere improvement in economic status or allocation of funds for food supplementation programmes may not result in improvement in nutritional status. It is important to identify factors responsible for higher prevalence of undernutrition and rectify them. Simultaneously efforts should be directed to identify the undernourished children through weighment, utilize the funds available to provide food supplements to them and give them needed health care.

Improving Nutritional Status of Adolescents

15. Projections made by the Technical Group on Population Projections indicate that the number of adolescents (in the 10-19 age group) will increase from 200 million in 1996 to 215.3 million in 2016. Adolescents, who are undergoing rapid growth and development, are one of the nutritionally vulnerable groups who have not received the attention they deserve. Data from NFHS–II indicate that the median age at marriage of girls in India is 16 years and 61 per cent of all girls were married before the age of 18. The mean age at first birth is 19.2. Under-nutrition, anaemia and poor ante-natal care inevitably lead not only to increased maternal morbidity but also to higher incidence of low birth weight and peri-natal mortality. Poor childrearing practices of these girls will add to infant morbidity and under-nutrition, thus perpetuating the intergenerational cycle of under- nutrition. Appropriate education, nutrition and health interventions, delay in age at marriage, optimum health and nutrition interventions during pregnancy are some of the inter-sectoral initiatives to break this vicious cycle. The Department of Women and Child Development has launched Kishori Shakti Yojana (2000) but the coverage (just two adolescents per block) is very low under this scheme.

16. In order to improve the nutritional status of adolescents, Prime Minister in his Independence day address in 2001 stated that food grains will be provided to combat under-nutrition in adolescent girls and pregnant and lactating women. A pilot project has been initiated to operationalise the announcement of the Prime Minister. The project, initially for a period of two years, is taken up in two of the backward districts in each of the major states and most populous district (excluding the capital district) in the remaining smaller states/Union Territories. The funds for 2002-03 has been given as additional central assistance to the states so that they can provide food grains through TPDS totally free of cost to the families of identified under-nourished persons. The programme is operationalised through the Department of Women and Child Development in the centre and in the states.

17. There is thus a shift of focus from providing cooked food at anganwadi to take home food supplementation in some schemes. Undoubtedly the take-home food supplements provided will be shared with the family but that would add to household food security; nutrition education to the community and family to provide food based on needs and careful monitoring of the undernourished individual will go a long way to ensure that the person

does get due share from the food supplements provided. This shift may free Anganwadi worker and helper from the routine time consuming task of cooking, feeding and cleaning. They can concentrate on important aspects of screening children/women for under-nutrition, nutrition education and pre-school education of 3-6 year old children as envisaged under ICDS scheme.

National Nutrition Mission

18. Prime Minister in his Independence Day Speech on 15th August, 2001 announced

- ✉ setting up of the National Nutrition Mission.
- ✉ providing Foodgrains at subsidized rates to adolescents girls and expectant and nursing mothers belonging to Below Poverty Line (BPL) families;

The National Nutrition Mission has the following objectives:

- ✉ reduction in under nutrition
- ✉ reduction/elimination of micronutrient deficiencies - iron, iodine and Vit A
- ✉ reduction in chronic energy deficiency

In addition the Mission would co-ordinate and monitor

- ✉ implementation of National Nutrition Policy;
- ✉ strengthening of existing programmes- ICDS and Mid Day Meal
- ✉ Nutrition education and IEC
- ✉ R&D
- ✉ relief in natural calamities.

19. National Nutrition Mission will be supervised by the National Nutrition Council headed by the PM as envisaged in the National Nutrition Policy.

Monitoring and Evaluation

20. NNMB established by ICMR is the only source of data on time trends in dietary intake and nutritional status of individuals but it covers only ten states. The Food and Nutrition Board of the Department of Women and Child Development conducted a nutrition survey in 1993-94 in 187 districts, the report of which was published in 1998. This was a one-time effort and the sample covered was not derived from a representative sample of the district. The NFHS has undertaken height and weight measurement in a representative sample of children and women and gives information on nutritional status of these groups at the state-level at two time points, 1992-93 and 1998-99. Every five years, the National Sample Survey Organisation (NSSO) collects and reports information on expenditure on food at the family level in representative sample population all over the country. The NSSO does not provide information on dietary consumption at the family and individual level and does not assess nutritional status.

21. Both ICDS and the health functionaries regularly file monthly progress report on nutrition status. However, there are lacunae and delays in the collection, reporting, collation and analysis of data. Monthly progress reports are not utilised for district level monitoring and midcourse correction of ongoing programmes. As part of efforts to monitor the nutritional component of the PMGY initiative, the Planning Commission has drawn up, in collaboration with the Department of Women and Child Development, a proforma for assessment and reporting of the nutritional status of under-six children. This has been incorporated as a part of the monthly ICDS reporting format. The state/central Departments of Women and Child Developments are to monitor the improvement in terms of

- ✉ enrolement of children in the 6-36 months age group;
- ✉ percentage of children who received complementary food by six months;
- ✉ nutritional status of children in the 6-36 months age group;
- ✉ fund allocation for nutrition and utilisation of funds provided.

22. At present, there is no data at the district level on prevalence of under-nutrition. As a part of the Rapid Household Survey under the Reproductive and Child Health programme, the Departments of Family Welfare and Women and Child Development with assistance from World Bank and UNICEF are currently carrying out a household survey which will provide district-wise information on the nutritional status of children which can be used to take up decentralized district based nutrition interventions.

Intersectoral Coordination

23. Department of Women and Child Development and Department of Family Welfare are the two major departments which have programmes aimed at improving nutritional status of women and children. There are ongoing efforts to improve convergence of services between these two departments. As a part of this effort it is envisaged that the anganwadi worker will:

- ✉ assist in reporting of births and deaths and the identification of pregnant women;
- ✉ will weigh neonates as soon as possible after delivery in home deliveries and refer neonates with weight below 2.2 kg to centres where a paediatrician is available;
- ✉ administer massive dose Vitamin A under the supervision of ANM to children between 18-36 months of age (18 months, 24 months, 30 months and 36 months) in April (pre-summer) and October (pre-winter)
- ✉ monitor and improve continued intake of iron folate medication in pregnant women;
- ✉ identify undernourished pregnant and lactating women and pre-school children and ensure that they get priority in food supplementation programmes under the ICDS and appropriate health care;
- ✉ promote cultivation of adequate quantities of green leafy vegetables, herbs and condiments in coordination with the PRIs and agricultural extension workers and ensuring that these are supplied to anganwadis on a regular basis to improve micro-nutrient content of food supplements.

- ✉ assist the ANM in organising health check ups of women and children and immunisation in the anganwadi;
- ✉ act as depot holder for iron and folic acids tablets, ORS, condoms and disposable delivery kit;
- ✉ help in organising emergency referral ; she will be provided with a list indicating the nearest facility to which women and children could be referred.

Annexure 5.1.1.

	Dietary Intake										
	Intake of foodstuffs (g/day)						Nutrient Intake per day				
	Cereal	Pulses	Leafy Veg	Milk Prod-ucts	Fats & Oils	Sugar & Jaggery	Protein (g)	Fat (g)	Energy (Kcal)	Iron (mg)	Vit. A (mg)
1-3 years	116	12	6	72	5	11	19.5	12.1	729	5.3	106
4-6 years	180	18	9	51	7	12	28.2	15.0	1066	8.1	127
7-9 years	225	19	12	48	8	13	34.0	16.9	1294	10.3	148
10-12 years											
Boys	267	21	15	48	9	14	40.4	19.9	1524	12.2	168
Girls	258	23	14	47	8	14	39.4	18.9	1500	12.1	174
13-15 years											
Boys	319	25	15	58	11	16	48.8	24.7	1856	15.4	196
Girls	302	24	16	50	10	14	43.7	21.0	1689	12.9	180
16-17 years											
Boys	379	29	16	51	11	15	54.7	25.6	2114	16.7	183
Girls	332	25	17	53	10	15	49.1	24.2	1856	15.3	213
>= 18 years Males											
Sedentary	186	34	46	97	12	15	58.7	34.4	2225	17.5	242
Moderate	433	30	19	54	12	15	61.0	27.3	2371	18.7	234
>= 18 years Females											
Sedentary											
NPNL	346	26	18	67	12	16	48.2	27.6	1878	14.1	220
Pregnant	353	28	15	77	12	17	49.7	25.9	1933	14.0	227
Lactating	392	28	18	65	13	13	50.3	25.9	2028	14.6	212
Moderate NPNL	347	28	16	51	11	15	52.0	22.4	2020	16.2	189

Annexure 5.1.2

Year-wise allocation for Supplementary Nutrition by the State Governments

(Rs. In crores)

		2000-01		2001-02		
Sl. No.	**State Name**	**State Plan**	**PMGY**	**State Plan**	**PMGY**	
1	Andhra Pradesh	52.81	21.31	95.60	28.41	^
2	Arunachal Pradesh	19.51	10.23	**11.46**	**11.46**	
3	Assam	56.94	26.94	**30.17**	**30.17**	
4	Bihar	76.01	43.09	**36.87**	**36.87**	
5	Chattisgarh			28.23	7.29	
6	Goa	0.62	0.12	0.80	0.13	^
7	Gujarat	139.22	9.72	132.50	10.88	
8	Haryana	6.02	2.52	4.50	2.82	
9	Himachal Pradesh	19.99	10.59	**9.80**	**9.80**	
10	Jammu & Kashmir	33.99	25.74	**10.00**	**13.50**	
11	Jharkhand			N.A.	11.39	
12	Karnataka	58.61	11.27	48.26	21.47	
13	Kerala	10.66	10.36	**0.35**	**11.61**	
14	Madhya Pradesh	68.32	17.07	42.00	19.22	
15	Maharashtra	72.34	14.87	49.33	19.79	
16	Manipur	15.57	7.28	**8.16**	**8.16**	
17	Meghalaya	12.24	6.09	**6.82**	**6.82**	
18	Mizoram	10.21	6.06	**6.27**	**6.27**	
19	Nagaland	12.34	6.17	**6.67**	**6.79**	
20	Orissa	69.57	14.78	26.96	16.56	
21	Punjab	15.06	6.06	7.79	6.79	
22	Rajasthan	40.15	14.46	**30.00**	**35.59**	
23	Sikkim	8.43	4.22	**5.70**	**5.70**	
24	Tamil Nadu	109.59	15.72	128.02	17.60	^
25	Tripura	16.34	7.62	**11.68**	**13.61**	
26	Uttar Pradesh	116.11	52.34	81.54	56.51	
27	Uttaranchal				2.11	
28	West Bengal	122.64	25.17	76.00	28.20	
29	A & N Islands	3.08	1.54	2.20	1.73	
30	Chandigarh	1.41	0.68	0.95	0.77	
31	Dadra & Nagar Haveli	0.87	0.20	0.62	0.22	
32	Daman & Diu	0.44	0.16	0.46	0.18	
33	Delhi	26.83	1.66	34.30	1.86	^
34	Lakshadweep	0.55	0.27	0.59	0.30	^
35	Pondicherry	7.18	0.72	6.74	1.92	
	All India	1203.65	375.03	941.34	452.49	

^: States which have provided increased outlay in 2001-02 than 2000-01

5.2 ELEMENTARY EDUCATION, LITERACY AND ADULT EDUCATION

The Constitution of India envisages provision of free and compulsory education for all children up to the age of fourteen. In the early stages of planning, it was expected that achievement of economic growth would be the primary means for the achievement of economic and social well-being including universal basic education. This strategy, however, did not yield the expected results. Further, the development experience of various nations overtime has led to the conviction that literacy and education have a direct role in human development and are instrumental in facilitating other achievements including economic prosperity. The Ninth Plan treated education as the most crucial investment in human development. The nation is firmly committed to provide Education for All, the priority being free and compulsory elementary education, coverage of children with special needs, eradication of illiteracy, vocationalisation, women's education and the special focus on the education of socially disadvantaged sections.

Elementary Education

2. The National Policy of Education (NPE), which was announced in 1986 and reviewed in 1992 created the framework for providing basic education for all with a concrete plan of action. The progress towards Universal Elementary Education(UEE) since then has been significant. The literacy rate in the last decade (1991-2001) has shown the highest jump of 13.15% since 1951 and increased from 52.21% to 65.37%. Female Literacy likewise registered an increase of 14.87% from 39.29% in 1991 to 54.16% in 2001. Concerted efforts have resulted in manifold increase in the number of institutions, teachers and students. During the period 1950-51 to 1999-2000 the number of primary schools increased more than 3 times from 2.10 lakh in 1950-51 to 6.42 lakh in 1999-2000 whereas the number of upper primary schools increased 15 times, from 13600 in 1950-51 to 1.98 lakh in 1999-2000. Total enrolment at primary stage increased 5.91 times between 1950-51 to 1999-2000 while the increase at upper primary level was more than 13 times. The total number of teachers increased from 6.24 lakh in 1950-51 to 32.17 lakh in 1999-2000, registering an increase of more than five times. Since 1993, the situation with regard to access in primary stage has improved considerably because of the interventions of Centrally Sponsored Schemes like Operation Blackboard, District Primary Education Programme, Non-Formal Education, Education Guarantee Scheme and the efforts of state governments. However, we are still at a considerable distance from the goal of Education for All. This requires detailed grass-root planning in the medium-term.

3. To realize the goal of UEE, Sarva Shiksha Abhiyan(SSA) was launched towards the end of the Ninth Plan i.e. year 2001-02. This is the first programme for UEE covering the entire country and aims at achieving this objective through a time-bound integrated approach to be implemented in Mission mode in partnership with states. The approach is community-owned and the Village education plans prepared in consultation with Panchayati Raj Institutions will form the basis of district elementary education plans. There will be focus on districts having low female literacy among Scheduled Castes and Scheduled Tribes and other children in difficult circumstances.

Review of Annual Plan 2001-02

4. As against the approved outlay of Rs.3800 crore for Schemes of Elementary Education during 2001-02, the actual expenditure was Rs.3569.16 crore which represents 93.92% of approved outlay. Annexure-I gives the scheme-wise allocation for 2001-02 and 2002-03 and the actual expenditure for 2001-02 for Elementary Education. The financial performance of two major schemes i.e. District Primary Education Programme (DPEP) and Mid-Day Meal (MDM) during the year 2001-02 has been fairly good. For District Primary Education Programme, an amount of Rs.1199.35 crore was spent against the approved outlay of Rs.1100 crore. Similarly for National Programme of Nutritional Support for Primary Education, the expenditure at Rs.1030.27 crore exceeded the approved outlay of Rs.930.00 crore. However, whereas states like Himachal Pradesh, Kerala, Madhya Pradesh and Karnataka were able to lift 95.7%, 92.9%, 87.8% and 86.6% of foodgrains respectively under Mid-Day Meal Scheme, some states such as Arunachal Pradesh, Jharkhand and Delhi lifted only 12.78%, 30.33% and 33.98% respectively.

5. There was, however, a major shortfall in expenditure under the Scheme Non-Formal Education where the level of expenditure was only Rs.83.23 crore as against approved outlay of Rs.400.00 crore as the scheme was still under the process of being formulated. The scheme has now been merged with Sarva Shiksha Abhiyan (SSA). The expenditure in Shiksha Karmi Scheme in Rajasthan was only Rs.10.00 crore against the plan provision of Rs.30.00 crore. The lack of interest and the financial and administrative problems faced by the state led to non-contribution of their share under the Scheme. Despite 50% funding from DFID, the Govt. of Rajasthan could not contribute the balance share under Shiksha Karmi. No expenditure could be made under the Scheme 'National Programme for Women's education', as the scheme did not take off. The scheme has since been renamed as "National Programme for Education of Girls at the Elementary Level" and has been made a component of SSA.

Annual Plan 2002-03

6. An outlay of Rs.4667.00 crore has been approved for the Annual Plan 2002-03 for Elementary Education. This includes a provision of Rs.1550.00 crore for Externally-Aided Projects. An exercise on Zero-Based Budgeting carried out by Planning Commission in consultation with the Department of Elementary Education & Literacy has concluded that amongst the schemes funded by domestic-budgetary support, the schemes namely Teacher Education, Mid-day Meal and Kasturba Gandhi Swantantra Vidyalaya will retain their identity, while all other ongoing schemes would be merged with Sarva Shiksha Abhiyan. Externally-Aided projects on elementary education, namely Shiksha Karmi, Lok Jumbish, DPEP and Janshala, though permitted to keep their separate identities will be shown under the umbrella of SSA. Thus, SSA is expected to absorb most of the existing programmes within its overall framework with the district as the unit of programme implementation. To make the approach totally holistic and convergent efforts would be made to dovetail programme implementation at district level with all other deparments. SSA also aims at systematic mobilisation of the community and creation of effective system of decentralized decision-making.

Adult Education

7. The National Literacy Mission has the basic objective of making literacy fundamental for everyone in the country specially women. It aims at sustaining threshold level of 75% by 2005. The mission seeks to provide meaningful opportunity for life long learning to adults and focus on residual illiteracy. Out of total 598 districts in the country, 574 districts have been covered under literacy programmes. The continuing education programme has begun in 120 districts; post-literacy programmes are ongoing in 294 districts while total literacy campaigns are on in 160 districts. There is special focus on the promotion of literacy among women; scheduled castes/tribes and backward classes. The Jan Shiksha Sansthans have expanded their outreach and are also catering to the rural segment by offering around 250 vocational training courses. The first phase of basic literacy instruction and the second phase of consolidation, remediation and skill-upgradation form two pivotal strategies of adult literacy within the broad perspective of programmes currently being implemented by the National Literacy Mission.

8. The National Literacy Mission has recognized the potential of NGOs in furthering its programmes and schemes. Given the major role envisaged for NGOs, they are now allowed to receive funds from Zilla Saksharta Samitis and actually run continuing education centers to enhance the participation of NGOs in the literacy movement.

Review of Annual Plan 2001-02

9. As against the approved outlay of Rs.200 crore for Adult Education for the year 2001-02, the actual expenditure was Rs.174 crore i.e. 87% of the total outlay. The scheme of Continuing Education alone was allocated Rs.108.50 crore i.e. 54.25% of total approved outlay against which the expenditure incurred was Rs.95.64 crore. There was 100% utilization of the approved outlay of Rs.25.00 crore for the Scheme of Shramik Vidyapeeth. This scheme is an unconventional programme of Non-Formal Adult and Continuing Education implemented primarily in urban and industrial areas. The basic objective of the scheme is to improve the occupational skill and technical knowledge of workers for enhancing their efficiency and increasing productive ability. The funding ratio of the adult literacy programmes between the Centre and the State Governments is 2:1 with the exception of the districts under the tribal sub-plan where the ratio is 4:1. Implementing agencies are now allowed to incur expenditure on basic literacy activities during the post-literacy phase.

Annual Plan 2002-03

10. The approved annual plan outlay for adult-education is Rs.233 crore for 2002-03. The scheme of continuing Education for Neo-literates alone accounts for Rs.145 crore i.e. 62.23% of total approved outlay. An amount of Rs.25 crore each has been allocated for the scheme of Jan Shiksha Sansthan and Literacy Campaign and Operation Restoration. The Adult Education programme and the SSA would go hand in hand to achieve full literacy and facilitate a wider process of community development and empowerment.

Annexure 5.2.1

Elementary Education
Scheme-wise Plan Outlay (2001-02, 2002-03) & Expenditure (2001-02)

(Rs. In crores)

Sl. No.	Name of the Scheme	2001-02 Approved Outlay	2001-02 Actual Expenditure	2002-03 Approved Outlay
1	Operation Blackboard	520.00	497.97	65.00
2	Teacher Education	220.00	172.82	207.00
3	Non Formal Education	400.00	83.23	2.00
4	National Council of Teacher Education	6.00	4.50	5.00
5	Bal Bhawan Society	4.00	3.50	4.50
6	National Programme of Nutritional Support to Primary Education	930.00	1030.27	1175.00
7	Sarva Shiksha Abhiyan	500.00	499.77	1650.00
8	National Programme for Women's Edu.	10.00	0.00	
9	Kasturba Gandhi Swantantrata Vidyalaya			8.50
A.	Sub-Total (Other than EAP)	2590.00	2292.06	3117.00
	Externally Aided Projects			
1	Shiksha Karmi	30.00	10.00	40.00
2	Lok Jumbish	59.00	50.00	60.00
3	Mahila Samakhya	11.00	7.75	20.00
4	District Primary Education Programme	1100.00	1199.35	1380.00
5	Joint GOI-UN Programme for Primary Edn.	10.00	10.00	20.00
6.	Sarva Shiksha Abhiyan – Externally Aided Component			30.00
B.	Sub-Total(EAP)	1210.00	1277.10	1550.00
	Total Elementary Education	**3800.00**	**3569.16**	**4667.00**

5.3 SECONDARY AND VOCATIONAL EDUCATION

SECONDARY EDUCATION

Secondary education serves as a bridge between elementary and higher education and prepares young persons between the age group of 14-18 for entry into higher education.

2. Children's population at the secondary and senior secondary level (age-group 14-18) as projected in 1996-97 by NSSO has been estimated at 9.66 crore. As against this the enrolment figures shows that only 2.70 crore were attending secondary schools. Thus 2/3rd of the eligible population remains out of the secondary school system. The number of secondary schools in India increased from 7.4 thousand in 1950-51 to 116.8 thousand in 1999-2000. However, this number is not adequate to accommodate the out of school children and the growing number of upper primary school pass outs. The impact of recent initiatives undertaken for Universalisation of Elementary Education is resulting in increased demand for expansion of secondary education.

3. While there has been an increase in the number of schools established, the spread of secondary schools has been uneven. There is disparity due to geographical reasons, rural urban divide and differing socio-economic status of various States/UTs.

4. The enrolment at the secondary level has increased to 28 million (1999) from 1.5 million in 1950-51. Of these, 62.2% were boys and 37.8% were girls. There is a significant gender gap in secondary education. This gender gap is expected to be narrowed down with greater stress on secondary education for all.

5. The number of secondary teachers has increased from 1.27 lakhs in 1950-51 to 17.2 lakhs in 1999-2000. The teacher pupil ratio has also increased from 1:21 in 1950-51 to 1.33 in 1999-2000. With the exception of States in the Eastern Region most teachers (90% or more) in secondary/higher secondary schools were trained, as per data of the same year.

6. In the Ninth Plan, the focus has been on reducing disparities, renewal of curricula with emphasis on vocationalization and employment oriented courses, expansion and diversification of the open learning system, reorganization of teacher training and the greater use of information and communication technology. Hostel facilities for girls, integrated education for the disabled, free education for girls etc. have been some of the issues in the secondary Education sector that received attention.

Review of the Annual Plan 2001-02

7. In the light of the above objectives, Centrally sponsored schemes as well as institutional programmes continued to be implemented in the last year of the Ninth Plan. An allocation of Rs.643.70 crores was made for the Secondary Education sector in the Annual Plan 2001-02 against which an expenditure of Rs.615.39 crores has been incurred.

8. During the year under review, under the Secondary Education sector, different schemes as well as Institutional Programmes continued to be implemented. Presently, the

Central intervention in the Secondary Education is at two levels, by creation and establishment of apex national level institutions and secondly through the Centrally-sponsored schemes An allocation of Rs.643.70 crores was made for the Secondary Education Sector in the year 2001-02..

9. In the year under review, the Centrally-sponsored schemes continued to be implemented addressing the issues relating to access and equity with focus on increasing girls' participation in education by providing hostel and other facilities, quality improvement of school education, information and communication technologies, integrated/inclusive education for disabled and vocational education.

10. The major Centrally-sponsored schemes in Secondary Education under implementation in 2001-02 were:

(a) The schemes for strengthening of Boarding and Hostel facilities for girls is meant to increase girls enrolment in schools. The MHRD revised assistance to NGOs (in 2001-02) which are running these hostels.

(b) Under the scheme, environmental-orientation, assistance is given to NGOs for preparation of textbooks and innovative programmes on environmental education which could be included in the curricula

(c) In the last year of the Ninth Plan, the MHRD with Cabinet approval revised the scheme Computer Literacy and Studies in Schools(CLASS). Each State and U.T will now formulate a Computer Education Plan programme for IT education in schools

(d) The Centrally-sponsored scheme' viz., the Education Technology Programme which utilizes audio/visual medium under the Satellite Instructional Television Experiment provides radio and Colour TVs to primary schools for qualitative education

(e) For imparting Yoga education in schools, financial assistance is provided to States, U.Ts. and N.G.Os for training of teachers and infrastructure

(f) For improvement of science education in schools, a Centrally-sponsored scheme is operational under which 100% assistance is provided to States and U.Ts. for provision of science kits, setting up of science laboratories and training of science teachers. The scheme also funds participation of Indian students at the school level in International Science Olympiads

(g) With a view to institutionalize population education in schools, the National Population Education Project has been in operation with the assistance from the United Nations Fund for Population Activities(UNFPA).

(h) For Strengthening of culture and values in schools, NGOs are given assistance under this Centrally-sponsored scheme to propagate art & culture.

(i) During the year under review, the Centrally-sponsored scheme 'Integrated Education for Disabled Children. Under the scheme, 100% assistance is provided to States/U.Ts. and NGOs for components like educational Aids,& equipment for education of Children with special needs and salaries for special teachers.

11. Details of the activities undertaken by the Central Institutes in the year under review are as follows:

- In the light of National Curriculum Framework of School Education, the **NCERT** continued to prepare syllabuses, textbooks and other instructional materials for different school subjects.

- There has been a substantial increase in the quantum and quality of the academic activities of the **Central Board of Secondary Education(**CBSE). The focus of these activities was in Curriculum Development, Pedagogical Support, Teacher Empowerment, Progress and Development of supplementary textual materials. CBSE conducted Group Mathematics Olympiad Examinations to discover talent and excellence in Mathematics.

- In the field of distance education, the **National Open School** which is the largest open school in system with an annual enrolment of 2 lakh approximately continues to operate through its 10 Regional Centres and 1700 accredited institutions. The NOS has taken the initiative of launching the Open Basic Education Programme(OBE) as an alternative programme for neoliterates and school dropouts. The innovative On Demand Examination system was operationalised last year in 5 Centres for class VIII level under the OBE programme.

- The **Central Tibetan School Administration** continues to run 79 schools for Tibetan children in the country. The schools are affiliated to various all-India Boards.

- Both **Kendriya Vidyalayas** and **Navodaya Vidyalayas** have decided to open 76 and 100 new schools respectively and strengthen the existing schools by providing required infrastructure, buildings, laboratories etc.

Annual Plan 2002-03

12. The current financial plan is the first year of the Tenth Plan. An outlay of Rs.719 crores under Annual Plan 2002-03 is for the Secondary Education Sector. The key issues during the Tenth Plan would be a greater focus on improving access, reducing disparities by emphasizing upon the Common School System; renewal of curricula with emphasis on Vocationalisation and employment oriented courses; expansion and diversification of the Open Learning System; reorganization of teacher training and greater use of new information and communication technologies, particularly computers.

13. As part of the Zero-Based Budgeting Exercise undertaken by the Planning Commission with Ministry of Finance and the MHRD, to bring in greater effectiveness in implementation and more focus, the Centrally-Sponsored and Central Sector Schemes have been grouped under broad heads

Access & Equity

14. The impact of recent initiatives taken for UEE is resulting in increased demand for expansion of secondary education. The Department of Secondary and Higher Education has proposed a new scheme called Access & Equity for the Tenth Plan. Rs.20 crores has

been allocated under the scheme for the annual plan 2002-03. Opening of new schools, expansion of capacity of the existing schools including double shifts, upgradation of upper primary schools in backward, unserved and underserved areas, as also expansion and diversification of open schooling and distance education are envisaged under the new CSS. Of the many options being considered during the Tenth Plan to increase access is Kendriya Vidyalaya Sangathan establishing schools in partnership with voluntary agencies under its umbrella. It is proposed to set up 150 Kendriya Vidyalayas (fully funded by the Government) in addition to the present level of 854 Kendriya Vidyalayas in the country. In the Tenth Plan it is proposed to set up Jawahar Navodaya Vidyalayas(JNVs) in the remaining districts of the country. At present there are 462 schools in as many districts. These pace setting residential schools catering to classes VI to XII, provide quality education to talented children from rural areas on the basis of common admission test. An outlay of Rs 85 crores for Kendriya Vidyalayas and Rs.360 crores for Navodaya Vidyalayas has been allocated under Annual Plan 2002-03. Another option is to provide a one time grant/seed money to reputed schools like those run by R.K. Mission, the Jesuits, DAV and other reputed societies, trusts and not-fot-profit organizations to set up more schools. Together, these two options will lead to the establishment of more secondary schools in the backward, unserved and underserved schools.

15. The existing scheme of strengthening of boarding and hostel facilities for girls under which assistance has been enhanced in the year 2001-02 will now be merged under the above new CSS called 'Access & Equity'. Strengthening of this girls' hostel will help in increasing the enrolment and thereby reducing the gender gap.

Quality Improvement in Schools

16. A new Scheme, Quality Improvement in Schools, will comprise the centrally sponsored schemes, viz., Promotion of Sciences Laboratories, Environmental Orientation to School Education, Promotion of Yoga and the central sector schemes, Population Education Project; International Mathematics/Science Olympiad. During the year 2001-02, States were provided assistance for purchase of science kits and science books for schools and for upgradation of science laboratories and training of science and maths teachers. Secondary school students participated in the international science Olympiads. For environment orientation, the State Governments and Voluntary Agencies are given assistance for conducting experimental and innovative programmes aimed at promoting integration of educational programmes in schools with local environmental conditions. Similarly, the States and U.Ts. are provided assistance for expenditure on training of Yoga teachers. With the help from the UNFPA, a population education project is being conducted in schools. It is being implemented by the NCERT. The State Governments would develop training modules for in-service training of teachers and provide infrastructure and research inputs for "Quality improvement in schools". An outlay of Rs 26 crores under the Annual Plan has been allocated for the merged scheme 'Quality improvement in schools'.

Information and Communication Technologies(ICT)

17. Information and Communication Technologies(ICT) will comprise the reworked centrally sponsored schemes, Computer Literacy & Studies in Schools (CLASS) and Educational Technology(ET). Keeping in view the current demand for IT and computerization, a major thrust in the Tenth Plan is to be given to this scheme and seeks

to familiarize students with information technology. The State Governments would prepare Computer Education Plans(CEP). The components of the merged scheme "ICT in Schools" would include (a) funding support for CEPs (b) strengthening and reorientation of staff of SIETs (c) Digitisation of SIETs' video and audio cassettes on the basis of need assessment and in partnership with NGOs (d) web/internet based education to be managed by the SIETs and (e) production of video and audio cassettes after assessing the demand. An outlay of Rs 111 crores has been allocated for the ICT scheme during the Annual Plan 2002-03.

Integrated Education for Disabled Children (IEDC

18. Integrated Education for Disabled Children (IEDC) is being implemented in 25 States and 4 U.Ts through over 41,600 schools benefiting more than 1,33,000 disabled children. Under the scheme, financial assistance on 100% basis is given to State Governments and NGOs towards facilities extended to disabled children such as books, uniforms, transport allowance, escort allowance etc. The scheme will be retained as individual scheme to generate greater sensitization towards the problems of disabled children. An outlay of Rs.35 crores has been allocated for the above scheme under Annual Plan 2002-03.

19. Apart from Kendriya Vidyalaya Sangathan and the Navodaya Vidyalaya Samithi, whose the NCERT and the NOS are the main apex level institutions in the Secondary Education Sector. The NCERT has launched 7th all-India Educational Survey in the current year 2002-03. During the current year, the textural materials based on the revised syllabuses are being prepared in all the subject-areas for classes VI, IX and XI.

Vocational Education In Secondary Schools

20. Vocationalisation of Secondary Education is a Centrally-sponsored scheme being implemented since 1988 to the State Governments in the formal sector and NGOs in the informal sector. The main objectives of the scheme are to enhance the individual employability, reduce the mismatch between demand and supply of skilled manpower and provide an alternative for those pursuing higher education without interest or purpose. The scheme is implemented by the State Governments at +2 stage of 10+2 scheme through approximately 6728 schools spread all over the country. More than 150 courses are offered in 6 major disciplines. Agriculture, Business and Commerce, Engineering and Technology, Health and Para Medical, home Sciences and Humanities.

21. As against the target laid down in the revised education policy of diverting 25% of senior secondary students to the vocation stream by year 2000, only 10% of students are at present opting for the vocational stream. The scheme of Vocationalisation of education has not gone down well with the stake-holders due to logistic and academic constraints that require streamlining of the courses. and establishment of strong industry – institution linkages.

22. The scheme has been evaluated a number of times. In the Tenth Five Year Plan, the scheme is proposed to be recast incorporating competency based flexible and modular vocational courses in schools; credit transfer system with provision for multi-point entry/exit; linkages between vocational courses at +2 level and courses at university level; linkages with industries through signing of Memorandum of Understanding, designing/continuous

updating of courses, development of curriculum, training of faculty/students and certification of the courses; charging fees and redesigned courses on self-financing basis; compulsory apprenticeship training facility; the placement of vocational pass-outs for apprenticeship; close association of local Business and Industry in need analysis and for conducting district vocational surveys before launching of any vocational courses in schools; mandatory facilities for running vocational courses for Kendriya and Navodaya Vidyalaya schools; special and in the Tenth Plan, it is proposed to recast the scheme treatment to persons with disabilities and appropriate attention to their needs and integration while designing and launching of vocational courses; financial assistance to States for creating testing and certification systems in co-operation with user bodies and professional associations; and reactivation of AICTE's vocational education board for providing technical support to the school system and for establishing linkages with other technical institutions.

23. There is an urgent need to cater to the Class VIII pass-outs whose numbers will swell with success of the UEE and SSA initiatives. In addition, there should be a focus on convergence of schemes like the SSA, adult education, vocational education schemes at schools, it is, Polytechnics, Community Colleges for optimal utilization of skill training facilities and a more targeted approach on placement in jobs.

24. An outlay of Rs.50 crores has been allocated under the Annual Plan 2002-03 for the vocational education schemes at secondary stage.

5.4 HIGHER & TECHNICAL EDUCATION

Higher Education

The Higher Education system has witnessed phenomenal expansion during the recent years. There are now 193 Universities, 47 Deemed to be Universities and nearly 12,342 colleges including 1500 women colleges in addition to the unrecognized institutions in the Higher Education Sector.

2. The issues of access and equity are central to the university/higher education system. The university system provides access to only 5.75% of the estimated population in the 18-24 age group. (As per the latest data available pertaining to the year 1999-2000, out of a total estimated population of 1345 lakhs in the age group 18-24, only 77.33 lakh were enrolled in colleges and universities). We have to increase students enrolment in the higher education system. In addition, the enrolment of disadvantaged sections have to be catered to and the regional disparities have to be reduced. It has been estimated that out of a total of 11594 colleges only 4683 are rural colleges.

3. The Ninth Plan reiterated the objectives/policy directions of National Policy for Education of 1986 and its Programme of Action of 1992. Broadly the 9th Plan emphasized on the steps to increase the access of Higher Education and adopted strategies to improve the quality of the Higher Education and the efficiency of the institutions of Higher Education System:-

Review of Annual Plan 2001-02

4. An outlay of Rs.575.00 crores was allocated for the University and Higher Education sector in the year 2001-02 against which an expenditure of Rs.544.73 crores was incurred.

5. The University Grants Commission continued to serve as a coordinating body between the Union and State Governments and the institutions of higher learning. At present, there are 17 Central Universities, 116 State Universities which are provided with development and maintenance Grants by the UGC.

6. In the year under review, the 51 Academic Staff Colleges(ASCs)s in various universities made efforts to enhance the provisional development of teachers by conducting orientation and refresher courses and seminars. 216 orientation programmes and 793 refresher courses were allocated to the ASCs, Universities and Institutions.

7. For the promotion of excellence in quality in Higher Education, the UGC has identified 5 Universities and accorded them the status of universities with potential for excellence last year. These universities are, viz., University of Madras, Jawaharlal Nehru University, University of Hyderabad, University of Pune and Jadavpur University.

In the pursuit of excellence, the UGC also provided financial assistance to autonomous colleges. Autonomous status was conferred to 8 institutions in the year under review.

8. Under the special assistance programme(SAP) the COSIP and COHSSIP, the UGC strengthened the department of humanities, basic sciences and social sciences in selected universities which have potential for advanced academic work. In its effort to promote research, the UGC and its regional offices continue to assist universities and colleges to undertake intensive and in-depth studies in specific subject areas.

Distance Education and IGNOU

9**.** At present there are 9 State Open Universities (apart from IGNOU) and 64 Correspondence Course Institutes in conventional Universities which provide distance education. However, out of a total of 77.33 lakh students enrolled in universities and colleges, only about 10.09 lakhs are enrolled in distance universities and colleges. IGNOU has steadily increased its activities. In January 2000, IGNOU launched the transmission of Gyan Darshan – a 24-hour educational TV channel. IGNOU has also launched its academic programme in the neighbouring Gulf countries and also in Maldives, Mauritius, Seychelles, Nepal, Sri Lanka and Vietnam.

10. In the year 2001, the Government constituted a 'Committee on Promotion of Indian Education Abroad(COPIEA) to promote Indian education abroad and to regulate the operations of foreign educational institutions in India to safeguard the larger national interests and the interests of the Indian students.

11. The Social Science Research Institutions outside the university system, viz., ICSSR, ICHR, ICPR, etc. continue to undertake research on current political, social and economic issues.

Annual Plan 2002-03

12. Under the Annual Plan 2002-03, which is the first year of the Tenth Plan, an amount of Rs.615 crores has been allocated for University and Higher Education sector. The key issue in the Tenth Plan is to raise the enrolment of the population in the age group (18-23) in Higher Education from the present 6% to 10% by the end of the Tenth Plan period. The focus and strategies would be on increasing access; quality; adoption of state specific strategies; liberalisation of the higher education system; relevance including curriculum, vocationalisation, networking and information technology; distance education; convergence of formal, non-formal, distance and IT education institutions; increased private participation in establishing and running of colleges, etc.

University Grants Commission

13. Out of a total allocation of Rs.615.00 crores mentioned above, an outlay Rs.516.75 crores has been allocated for the University Grants Commission under Annual Plan 2002-03.. The UGC will continue with its on-going effort to increase the access of Higher Education and would encourage women's enrolment. The stress will be on setting up study Centres/Cells for women's studies and provision of day-care facilities for the children of university and college employees. To ensure effective implementation of the reservation policy for SC/ST community, the Commission will provide financial assistance to SC/ST Cells which have been set up in Universities. At present 107 Cells are in operation. During the current year, the on-going efforts at networking among Universities and colleges and within campuses will be strengthened through LAN/WAN/INFLIBNET. In addition, the assistance given to computer departments to increase computer literacy in universities and colleges by the UGC will be stepped up. More and more colleges would be provided this assistance. In pursuit of excellence, the science & Humanities Departments in selected Universities which have a potential will be strengthened by grants. The introduction of PG courses in Engineering & Technology in selected Universities will give fillip to research & development. The proposals for these courses are screened by the Expert Committee of the UGC and are forwarded to the AICTE for approval.

Indira Gandhi National Open University

14. With its 46 Regional Centres and 691 Study Centres, IGNOU will continue tis efforts to expand Distance Education so as to increase the access to Higher Education. The telecast of IGNOU programme on the Gyan Darshan TV Channel has been increased to 24-hour transmission each day. IGNOU will continue its efforts in the North-east Region where it is playing an important role in imparting Teacher Training. Through its multi-media strategy, supported by counselling sessions at its study centers throughout the country and teleconferencing, more and more students will be enrolled. The total number of students registered with IGNOU at the end of 2001 was 3,04,681. During the current year, the courses and programmes of IGNOU shall be expanded so as to bring more flexibility in university-level education. During the Annual Plan 2002-03, an outlay of Rs.67 crores has been allocated for IGNOU.

Technical Education

15. The Technical Education system in the country covers courses and programmes in engineering, technology, management, architecture, town planning, and pharmacy. The sector has played an important role in the economic and technological development of the country.

16. Consequent upon the National Education Policy of 1986 which reorganized the Technical Management Education, a number of initiatives were taken. The Ninth Plan focused on four thrust areas such as (a) sustaining and consolidating the infrastructure and further expanding the scope of such infrastructure (b) strengthening systems of management and governance at all levels, networking between institutions and developing effective linkages (c) introducing new and innovative schemes which shall enhance the vibrancy of the system and help it conform to emerging demands of industrial growth in terms of new technologies and (d) expand the base of research amongst technical institutions.

Review of 2001-02

17. An outlay of Rs.575.00 crores was allocated for the schemes of Technical Education in the year 2001-02 against which an expenditure of Rs.552.08 crores was incurred.

18. During the year under review, a large number of engineering colleges and other technical institutes were established across the country with the approval of the All India Council for Technical Education (AICTE), mainly by mobilization of private initiatives. As in the past, the institutions of national importance/excellence like IIMs, IISc, Bangalore and other Central institutes namely ISM, SPA, NIFFT, NTTIE, IIITM, TTTIs, NERIST, SLIET, etc .provided instructional training to make available high quality trained manpower in the field of Technical Education, University of Roorkee has been declared as IIT, Roorkee. Some of the RECs are being accorded the Status of Deemed to be University.

19. The scheme of community polytechnics continue to contribute substantially by transferring techno-economic advances in technical education and appropriate technologies to the rural masses. The World Bank aided Third Technician Education Project continued to be implemented to improve the quality of Polytechnic pass-outs in the North-Eastern States, J & K and A & N Islands.

20. A large number of central technical institutes benefited when they upgraded their infrastructure facilities (including laboratories) and by development of their R&D basis under the MODROB scheme of the AICTE.

Annual Plan 2002-03

21. An outlay of Rs.650 crores has been allocated for the schemes of Technical Education under Annual Plan 2002-03. The major share of the outlay is for the IITs with an outlay of Rs.140 crores. The IIMs are mainly now self-financing with an outlay of Rs.25 crores in the year 2002-03

- The AICTE with an allocation of Rs.100 crores will continue its efforts in upgradilng and regulation the standard of technical education in the country. To expand the purview of the National Technical Manpower Information System(NTMIS), new disciplines will be brought within its fold like pharmacy, catering technology, etc.

- To meet the emerging need of quality manpower in information technology and related areas, an outlay of Rs. 30 crores has been allocated for the National Programme of HRD in IT launched last year. To overhaul the entire system of post-graduate education, the Ministry has accepted most of the recommendations of Rama Rao Committee and these are being implemented from the academic year 2002-03.

- For supporting new and emerging technology areas, an outlay of Rs. 5 crores has been allocated during the current year. These include the National Programme for Earthquake Engineering.

- To upgrade the quality of technical education in I.I.Ts., R.E.Cs., other Engineering Colleges, Polytechnics by providing equipment, funds for new courses and networking the institutions for on-line exchange of information and teaching-learning material, a new programme, viz., Technical Education Quality Improvement Programme(TEQIP) launched this year with World Bank assistance. An outlay of Rs.50 crores has been allocated for the programme in the Annual Plan 2002-03.

Promotion of Languages

22. During the Ninth Plan period, all the languages listed in Schedule VIII of the Constitution were promoted and developed through a variety of Central initiatives.

Review of 2001-02

23. An outlay of Rs.104.30 crores was allocated for the schemes of Languages in 2001-02.

24. The Kendriya Hindi Sansthan continued its efforts in developing latest methodologies of Hindi language teaching and training of Hindi teachers in non-Hindi speaking areas. During the year under review, the implementation of the scheme of appointment and training of Hindi teachers in non-Hindi speaking States/U.Ts. continued. The Central Hindi Directorate continued its work of preparing bilingual, trilingual and multilingual dictionaries. Further, Hindi-Persian, Hindi-Indonesian, Hindi-Sinhalese Dictionaries are under publication. More than 335 lakh persons have been enrolled for learning Hindi through the correspondence courses of the Directorate.

25. The Central Institute of Indian Languages, Mysore has been playing an effective role in training teachers in modern Indian languages by conducting research in areas of language pedagogy and technology. In order to bring about improvement in the standards of teaching and learning of English, the Government give financial assistance to Regional Institutes of English and the English Language Teaching Institutes in different States.

26. The Rashtriya Sanskrit Sansthan conducted 13 courses of various levels in 8 Vidyapeethas and 21 Maha Vidyalayas in the country. An International World Sanskrit Conference was convened in April, 2001 in which scholars all over the world were invited.

Annual Plan 2002-03

27. An outlay of Rs.114 crores has been allocated under Annual Plan 2002-03 for the scheme of languages. As per the recommendations of the Core Committee on Zero-Based Budgeting various schemes relating to institutions of languages have been merged together. The MHRD has merged the programmes of (a) appointment of Urdu teachers (b) modernization of madarasa education and the (c) area intensive programme for educational minorities into one scheme called 'The Rashtriya Alpsankhyak Shiksha Abhiyan'(National Minorities Education Programme) with an outlay of Rs. 31.50 crores under the Annual Plan 2002-03.

BOOK PROMOTION AND COPYRIGHT

Review of Annual Plan 2001-02

28. With a view to promote book reading habit among the masses, especially children and youth, the Government of India dedicated the year 2001-02 as the Year of Books. The Year of Books commenced from 23 April, 2001 and culminated on 23 April 2002, which is also celebrated as World Book and Copyright Day. The National Book Trust, India (NBT) is the nodal agency for implementing various programmes and activities related to Year of Books. All the State Government and U.Ts., Members of Parliament and Educational Institutions etc. were addressed to undertake suitable programmes/activities to spread the message of Year of Books. The Department of Posts, brought out a special postal stamp on Year of Books.

29. The book promotion activities of the Department were carried out mostly through the National Book Trust (NBT). The trust organized a number of book fairs and exhibitions to encourage and inculcate reading habit among the people. The NBT organized the 15th New Delhi World Book Fair at New Delhi in the month January, 2001 - February, 2002.

30. During the year, Government took active steps for strengthening enforcement of Copy Right Law in the country. The Copy Right Office registered 1475 works during the last financial year. India participated in the World Intellectual Property Organisation(WIPO) by hosting various seminars and symposiums on intellectual property rights.

Annual Plan 2002-03

31. An outlay of Rs.12 crores has been allocated under the Annual Plan 2002-03 for Book Promotion and Copy Right activities which includes an allocation of Rs.6.70 crores for the National Book Trust. Through the NBT, the Department will provide financial assistance to a number of voluntary agencies for book promotional activities. During the year, the National Agency for International Standard Book Numbering (ISBN) system will continue to allot ISBNs to Indian Publishers. The ISBN is a 10 digit number which replaces the handling of long bibliography descriptive records. It is an essential instrument in present day book trade.

Scholarships

32. The National Scholarship scheme and the Scholarships for talented children from rural areas will be implemented in the year 2002-03 with the respective outlay of Rs.5 crores and 3 crores each. The number and the rates of scholarship have been upwardly revised. These schemes will continue to be implemented through the State and UT administration.

Planning and Administration

33. An outlay of Rs.7 crores has been allocated under Annual Plan 2002-03. In this sector, there are mainly Central Sector Schemes involving grants to UNESCO, NIEPA, and to the AUROVILLE management. A Centrally sponsored scheme for strengthening of statistical machinery at State level has been launched with an outlay of Rs.1 crore during the year 2002-03.

34. The Annexure 5.4.I gives details of outlay/expenditure of the schemes of Department of Elementary Education and Literacy and Department of Secondary and Higher Education, MHRD (Central Sector) in the years 2001-02 and 2002-03.

Annexure 5.4.1

Outlay/expenditure of the schemes of Department of Elementary Education, MHRD – Central Sector

(Rs. in crore)

Sl. No.	Scheme/Programme	Ninth Plan (1997-2002) Approved outlay	2000-2001 Actual Expendi-ture	2001-2002		2002-03 approved outlay
				Approved outlay	Fun*-ds certified as on 31-3-2002	
1	**2**	**3**	**4**	**5**	**6**	**7**
A1	Elementary Education	16369.59	3117.39	3800.00	3569.16	4667.00
2	Adult Education	630.39	108.16	200.00	174.00	233.00
	TOTAL (A) – Diptt. of Elementary Education and Literacy	16999.98	322.55	4000.00	3743.16	4900.00
B1	Secondary Education	2603.49	554.08	643.70	615.39	719.00
2	University & Higher Education	2500.00	497.55	575.00	544.73	615.00
3	Language Development	324.45	73.00	104.30	86.75	114.00
4	Scholarships	25.32	0.65	3.00	0.05	8.00
5	Book Promotion	16.25	3.51	12.00	13.74	12.00
6	Planning & Admn	65.38	6.44	7.00	4.18	7.00
7	Techl. Education	2373.51	494.00	575.00	552.08	650.00
	TOTAL (B) – Deptt. of Secondary & Higher Education	7908.40	1629.23	1920.00	1816.92	2125.00
	GRAND TOTAL (A + B)	**24908.38**	**4854.78**	**5920.00**	**5560.08**	**7025.00**

5.5 YOUTH AFFAIRS & SPORTS

Youth Affairs

The Youth of India representing one third of our population, constitute a vital and vibrant human resource. The Planning Commission has supported several programmes of Department of Youth Affairs & Sports to channelise the energy of the youth into constructive work and to inculcate in them noble and patriotic values. These programmes stress promotion & upgradation of necessary life skills amongst the youth through vocational training besides creating employment opportunities for them besides getting them involved in nation building activities.

Review of the Ninth Plan (1997-2002) and Annual Plan (2001-02):

2. During the Ninth Five Year Plan an amount of Rs.826.08 crore was provided by the Planning Commission of which Rs.679.02 crores (anticipated) was spent during Plan period. As against the allocation of Rs. 225 crores for the year 2001-02, the Department incurred an expenditure of Rs. 171.81 crores.

3. During the year 2001-02 Nehru Yuva Kendra Sangathan which has 500 Nehru Yuva Kendras across the country organized 2632 vocational training programmes to update and improve the vocational skills of the rural youth to supplement their income; 837 awareness generation programmes of 5 day duration each addressing immediate problems and issues of local and social importance, 471 work camps to provide experience in project planning and management and to improve the organisational skills of the youth club members. For supervision, monitoring and Guidance, NYKS has Regional Offices for every 10-15 NYKs and 18 Zonal Offices covering all the States and UTs. It has wide network of trained NSVs numbering about 5000. It has also 6.4 million rural youth volunteers enrolled through 200,000 village level youth clubs.‘ In addition to its regular programme, NYKS was associated with Rashtriya Yuva yatras, Mega work Camps, workshop on the theme ‘ Role of Youth in Disaster Management’, Swarnajayanti Gram Swarojgar Yojana, Tobacco Cessation Activities, Village Talk AIDS, Cultural Exchange Programmes etc. During the period under report NYKS organized a two day National seminar on vision Statement on Youth 2020 at Deen Dayal Upadhyaya Parishar, Bhopal. The objective of the Seminar was to discuss the vision for the young men and women in India until 2020 and to pioritize major goals to be achieved by the year 2020 A.D.

4. NYKS is also implementing a pilot project i.e. National Reconstruction Corps (NRC). The primary objective of the NRC are to provide an opportunity to youth to work for and with the community, understand the problem of real life and utilize their skills and knowledge in solving the social problems. The NRC scheme is being implemented in selected 120 districts in the country. The Youth Coordinators of concerned district are assisted by one project officer and 100 volunteers. These volunteers are engaged in various developmental activities at the grassroots level. Schemes of various agencies like Ministry of Rural development, Ministry of Non -Conventional Energy, Ministry of health, Forest, HRD, Urban Employment and Poverty alleviation, Tribal Affairs with special focus on Self Help group (SHG) formation are being implemented with the active cooperation of volunteers.

Thrust Area and objectives of the Tenth Plan

5. Adolescent youth in the age group of 10 to 19 years numbered 230 million, accounting for 22.8 per cent of the population. It is proposed to target this segment of the youth population through specific intervention strategies, that will focus on youth and power, gender justice, youth health and responsible living. The major thrust will be on involving the youth in the process of national planning and development and make them the focal point of development strategy by providing proper educational and training opportunities, access to information on employment opportunities including entrepreneurial guidance and financial credit, proper platforms for developing qualities of leadership, tolerance and open mindedness, patriotism, etc. The Ministry of Youth Affairs and Sports will play a pro-active and catalytic role in exploring and identifying employment opportunities for the youth incoordination with other ministries and departments so as to optimally utilize the investments in various youth-related schemes. Efforts will be made for networking between government and NGO sectors.

Action Plan 2002-03

6. Major expansion of the NYK and NSS with emphasis on vocational training and employment promotion will be **lynchpin** of youth programme in the Tenth Plan. Expansion of NYKS to cover all the districts and mobilising and empowering the youth by strengthening the youth club movement to cover at least 50 percent of the six lakh villages will also be undertaken. The Youth Development Centers (YDCs) will be expanded to achieve the ultimate objective of one youth development center in each of the 5,000 blocks of the country. The YDCs are to be made centers of information for youth and eventually Information Technology (IT) centers. More youth clubs, which have been the focal point of youth activities, will be established so as to provide a platform for young people to raise issues concerning them.

7. All categories of youths, including rural youth will be given an opportunity to participate in various schemes like the National Cadet Corps (NCC), NSS, Scouts and Guides and (NRC). The Rajiv Gandhi National Institute for Youth Development will be provided additional resources in terms of both manpower and material equipment with a view to transforming it into a national center for information, documentation, research & training.

8. Adolescents have very special and distinct needs. It is essential to invest in them as they are the future of the country. The most important issues regarding the adolescents are health, nutrition, education (both formal and non formal), vocation, recreation and sports, child labour, children in difficult situations, alcohol and drug abuse. All adolescents need to be educated, about matters like safe motherhood, reproductive health rights, sexuality and sexual responsibility, age of marriage, and first pregnancy, family size, health care, hygiene, immunization, HIV/AIDS prevention, the importance of education, particularly of girls, drug and alcohol abuse. They should also have some legal literacy and be made aware of vocational opportunities and career planning. A special scheme for adolescents will be launched in the Xth Plan.

SPORTS

Review of Annual Plan 2001-02

9. 'Sports' is integral to all round development of human personality. Outstanding achievements in sports add to our national prestige. Sports promotion is primarily the responsibility of the various National sports federations, which are autonomous. The role of the Government is to create the infrastructure and promote capacity building for broad-basing sports as well as for achieving excellence in various competitive events at the National and International levels. In order to bring about a radical change in the country's efforts to develop excellence in sports, the Government has evolved a new National Sports Policy during the period under report. Sports Authority of India (SAI), over a period of time has expanded its operations to promote broad basing of sports. The amalgamation of the elite academic institutions like National Institute of Sports, Patiala and the Laxmibai National College of Physical Education gave the SAI an opportunity to play a wider role. The total workforce of SAI is 3800 which includes 1600 coaches. An outlay of Rs.472.61 crore provided for sports during Ninth Plan against an expenditure of Rs 558.50 crore. For the Tenth Plan an amount of Rs. 932.36 crore provided for the Sports and Rs. 177.67 crore for the Annual Plan 2002-03.

Thrust Areas and Objectives of the Tenth Plan

10. There is an immediate need to create a network of basic sports infrastructure throughout the country. What is even more important is to provide access to these facilities. Modern equipment and training facilities at par with those available in developed countries would be provided to sportspersons to enable them to compete in international events. Efforts will be made to improve coaching skills and raise them to international standards. Emphasis will be laid on basic as well as applied research in sports-related fields. A drug free environment will be created by designing effective checks to eliminate drug abuse. Except a few popular sports, which attract private sponsorship, the majority of sports activities are devoid of any career opportunities for sportspersons. Hence, there is a need to have definite incentives for sportspersons in the form of job reservation and awards.

11. Corporate houses will be asked to adopt particular disciplines as well as sportspersons for long term development. A National Sports Development Fund has been created with 100 percent income tax exemption for donors.

12. High priority will be given to the promotion of sports in schools and rural areas. Panchayats and youth and sports clubs will be mobilized to promote sports culture in the country. Sports disciplines will be pritorised on the basis of proven potential, popularity and performance and greater emphasis will be given to junior and sub-junior levels. The mass media will be mobilized for fostering sports culture in the country. New programmes such as setting up of sports state academy, promoting recreational sports and adventure sports will be taken up.

13. Adequate sports infrastructure will be created in schools and colleges. All urban bodies should earmark open spaces for playgrounds whenever new colonies are being developed. Conversion of playing fields into housing/commercial complexes must be prohibited.

14. Municipalities and municipal corporations should also contribute to the development of sports by ensuring the maintenance of playgrounds /stadia/ and swimming pools by

involving a larger number of youth in sports activities, besides supplying the required quality of sports equipment. They must also organize competitions for all the Asian Games disciplines, particularly those which are popular at the local and state level.

15. In order to provide talented sportspersons with good quality equipment, the domestic sports industry should be given incentives for manufacturing equipment of international standards. Till that time, good quality equipment needs to be imported. Sports federations, state governments as well as private and public sector organisations would have to be fully involved in the formulation and implementation of the Plan. However, such a short-term Plan must have a long-term perspective of broad basing the sports with a view to achieving physical fitness for all and promoting excellence through spotting and nurturing talent.

NEW INITIATIVES

Adolescent

16. Adolescent youth in the age group of 10 to 19 years numbered 230 million, accounting for 22.8 per cent of the population. It is proposed to target this segment of the youth population through specific intervention strategies, that will focus on youth and power, gender justice, youth health and responsible living.

17. The major thrust will be on involving the youth in the process of national planning and development and make them the focal point of development strategy by providing proper educational and training opportunities, access to information on employment opportunities including entrepreneurial guidance and financial credit, proper platforms for developing qualities of leadership, tolerance and open mindedness, patriotism, etc. The Ministry will also play an active advocacy role in promoting gender justice by making the youth aware about their significance in the Indian context. Efforts will be made for networking between government and NGO sectors

State Sports Academy

18. The objective of the new scheme is to select best available potential in sports in the age group of 10-13 years and groom them over a period of time to achieve excellence at the national and international levels. It is proposed to set up a State Sports Academy in every State.

Scheme of DOPE Test

19. The scheme aims at prevention of drug abuse in sports by providing adequate facilities for dope test, creating awareness amongst athletes, parents, coaches, doctors, scientists & sports governing bodies. It will provide for educational programmes, establishment of accredited dope control laboratory and provision for dealing with drug offenders.

Annual Plan 2002-03

20. An outlay of Rs.1825.00 crores has been provided for the Ministry of Youth Affairs and Sports for the Tenth Plan and Rs. 285.00 crores for the Annual Plan 2002-03. For Youth Welfare Rs.690.64 crores for the Tenth Plan and Rs 106.98 crores for the Annual Plan 2002-03 and for sports sector Rs 1132.36 crores for Tenth Plan and Rs. 177.67 crores for the Annual Plan. Similarly, Rs. 2.00 crores is kept for Modernization and computerization of office during Tenth Plan and Rs. 0.35 crore for the Annual Plan.

5.6. HEALTH

Improvement in the health status of the population has been one of the major thrust areas for the social development programmes of the country. This was to be achieved through improving the access to and utilization of Health, Family Welfare and Nutrition services with special focus on under served and under privileged segments of population. Over the last five decades, India has built up vast health infrastructure and manpower at primary, secondary and tertiary care in Government, voluntary and private sectors. The population has become aware of the benefits of health related technologies for prevention, early diagnosis, effective treatment as well as rehabilitation for a wide variety of illnesses and accesses available services. Technological advancement and improvement in access to health care technologies which were relatively inexpensive and easy to implement, had resulted in steep decline in mortality between 1950 and 1990. The extent of access and utilization of health care varied substantially between states, districts and different segments of society; this to a large extent, is responsible for substantial differences between states in health indices of the population.

2 During the 90s, the mortality rates plateaued; country entered an era of dual disease burden. On one side there are communicable diseases which have become more difficult to combat due to insecticide resistance among vectors, resistance to antibiotics in many bacteria and emergence of new diseases such as HIV for which there is no therapy; on the other side increasing longevity and the changes in life style have resulted in the increasing prevalence of non-communicable diseases. Under nutrition and micro nutrient deficiencies and associated health problems coexist with increasing prevalence of obesity and life style related non communicable diseases. Unlike the earlier era, the technologies for diagnosis and therapy are becoming increasingly complex and are expensive. Increasing awareness about the potential of the newer health care technologies and rising expectations of the population have widened the gap between what is possible and what the the individual, institution or the country could afford. As the country undergoes demographic and epidemiological transition, it is likely that larger investments in health will be needed even to maintain the current health status, because the technology required for tackling resistant infections and non-communicable diseases are expensive and this will inevitably lead to escalating health care costs.

Current problems faced by the health care services include:

- ☞ persistent gaps in manpower and infrastructure in govt. sector especially at the primary health care level, in remote rural, tribal and urban slum areas where health care needs are greatest;

- ☞ sub-optimal functioning of the infrastructure; poor referral services;

- ☞ plethora of hospitals in Govt., voluntary and private sector not having appropriate manpower, diagnostic and therapeutic services and drugs;

- ☞ massive interstate/ inter district / urban-rural differences in performance as assessed by health and demographic indices; availability and utilisation of services are poorest in the most needy remote rural areas in states/districts;

- ☞ sub optimal intersectoral coordination;

- ☞ increasing dual disease burden of communicable and non-communicable diseases because of ongoing demographic, lifestyle and environmental transitions;

- ☞ technological advances which widen the spectrum of possible interventions;

- ☞ increasing awareness and expectations of the population regarding health care services; and

- ☞ escalating costs of health care, ever widening gaps between what is possible and what the individual or the country can afford.

HEALTH SYSTEMS REFORMS

3. Faced with the problems of a sub-optimally functioning health care system and providing adequate investment for improving health, Ninth Plan emphasized the need for :

- ☞ reviewing the changing health scenario and assessing response of the public, voluntary and private sector health care providers as well as the population themselves to the changing situation;

- ☞ reorganizing health systems so that they become efficient and effective; and

- ☞ introducing health system reforms which ensure access to public health programmes free of cost to all and enable the population to obtain essential health care at affordable cost.

4. The suggested health system reforms broadly fall into three categories : structural and functional aimed at improving efficiency, financial aimed at improving the resources available and governance related aimed at improving transparency and accountability . It was envisaged that the public sector will play the lead role in health systems reform. The following were the major thrust areas suggested in the Ninth Plan.

Structural and Functional Reforms Aimed at Improving Efficiency:

- ☞ Reorganisation and restructuring of existing health care infrastructure including the infrastructure for delivering ISM&H services at primary, secondary and tertiary care levels , so that they have the responsibility of serving population residing in a well defined area and have appropriate referral linkages with each other.

- ☞ Human resource development to meet growing health care needs – adequate in number, with appropriate skills and attitudes.

- ☞ Skill upgradation of health care providers through CME and redeployment of the existing health manpower so that they can take care of the existing and emerging health problems at primary, secondary and tertiary care levels.

- ☞ Horizontal integration of current vertical programmes including supplies, monitoring, IEC, training and administrative arrangements; formation of a single health and family welfare society at state and district levels .

- ☞ Fully functional accurate reporting system which provides data on births, deaths, diseases and data pertaining to ongoing programme through service channels, within existing infrastructure; monitoring and evaluation of these reports and appropriate midcourse corrections to be done at district level;

- ☞ Building up an effective system of disease surveillance and response at district, state and national level within and as a part of existing health services;

- ☞ Building up efficient and effective logistic system for supply of drug, vaccines and, consumables based on the need and utilisation.

Financial Reforms:

- ☞ Continued commitment to provide essential primary health care, emergency life saving services, services under the National Disease Control Programmes and the National Family Welfare Programme totally free of cost to individuals based on their needs and not on their ability to pay

- ☞ Evolve, test and implement suitable strategies for levying user charges for health care services from people above poverty line, while providing free service to people below poverty line; utilise the collected funds locally to improve quality of care.

- ☞ Evolve and implement a mechanism to ensure sustainability of ongoing govt. funded health and family welfare programmes especially those with substantial external assistance.

- ☞ Working out cost of diagnostics and therapeutic procedures for major and minor ailments in different levels of care and setting cost of care norms.

Governance Related

- ☞ Introduce a range of comprehensive regulations prescribing minimum requirements of qualified staff, conditions for carrying out specialized interventions and a set of established procedures for quality assurance.

- ☞ Evolving standard protocols for care for various illnesses; at primary, secondary and tertiary care settings – public sector hospitals, medical colleges, professional associations to play a major role in this exercise.

- ☞ Quality assurance and redressal mechanism such as Consumer Protection Act and Citizens' Charter for hospitals are to be set up.

- ☞ Appropriate delegation of powers to Panchayati Raj Institutions (PRIs) so that the problems of absenteeism and poor performance can be sorted out locally and primary health care personnel function as an effective team.

- ☞ Involvement of the Panchayati Raj Institutions in the planning and monitoring ongoing programmes and taking timely corrections for optimal utilisation of services.

5. During the last five years both the centre and the state Govts have taken several step to implement these recommendations. On the whole, the content and pace of the implementation has been suboptimal. The lessons learnt, progress achieved so far, and current status are summarised in the following pages.

Structural and Functional Reforms

6. The Health care system consists of:

- ☞ primary, secondary and tertiary care institutions, manned by medical and paramedical personnel;

- ☞ medical colleges and paraprofessional training institutions to train the needed manpower and give the required academic input;

- ☞ programme managers managing ongoing programmes at central, state and district levels; and

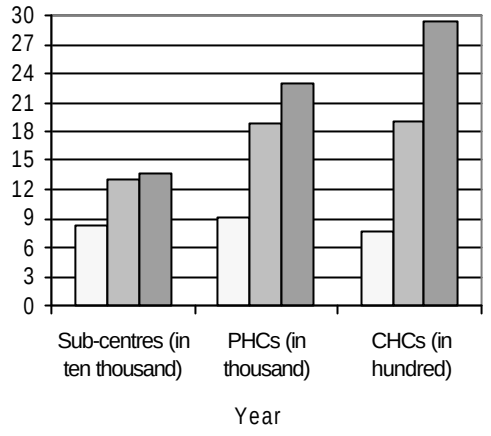
- ☞ health management information system consisting of a two-way system of data collection, collation, analysis and response.

So far the interaction between these components of the system had been sub-optimal. In spite of the plethora of primary, secondary and tertiary care institutions and medical college hospitals there are no well organised referral linkages between the primary, secondary and tertiary care institutions in the same locality. The programme managers and teachers in medical colleges do not link with institutions in any of the three tiers; essential linkages between structure and function are not in place (Annexure –5.6.1). Logistics of supply and HMIS are not operational in most states. Efforts are being made to reorganise health system, build up essential linkages between different components of the system so that there will be substantial improvement in functional status (Annexure –5.6.2).

Primary health care

7. The primary health care infrastructure provides the first level of contact between the population and health care providers. Realising its importance in the delivery of health services, the centre, states and several government related agencies simultaneously started creating primary health care infrastructure and manpower. This has resulted in substantial amount of duplication of the infrastructure and manpower. The government funded primary health care institutions include:

Figure 5.6.1 - Growth of SCs, PHCs and CHCs



Source: IAMR,

- the rural, modern medicine primary health care infrastructure created by the states (Figure 5.6.1) consisting of:

-Subcentres	138044	(1/ 4579 population)
-Primary Health centres	22928	(1/27364 population)
-Community Health centers	3077	(1/214000 population)

- subdivisional/Taluk hospitals/speciality hospitals (estimated to be about 2000)
- 5435 rural family welfare centres, 871 urban health posts, 1083 urban family welfare centres, 550 district post partum centres and 1012 sub-district postpartum centres funded by the Department of Family Welfare.
- 22,104 dispensaries, 2862 hospitals under the Dept of ISM&H.
- urban health services provided by municipalities.
- health care for central government employees provided by Central Government Health Scheme (CGHS).
- hospitals and dispensaries of Railways, Defence and similar large departments providing the health care to their staff.
- medical infrastructure of PSUs and large industries.
- Employee's State Insurance Scheme (ESIS) hospitals and dispensaries providing health care to employees of industries.
- all hospitals - even those providing secondary or tertiary care also provide primary health care services to rural and urban population

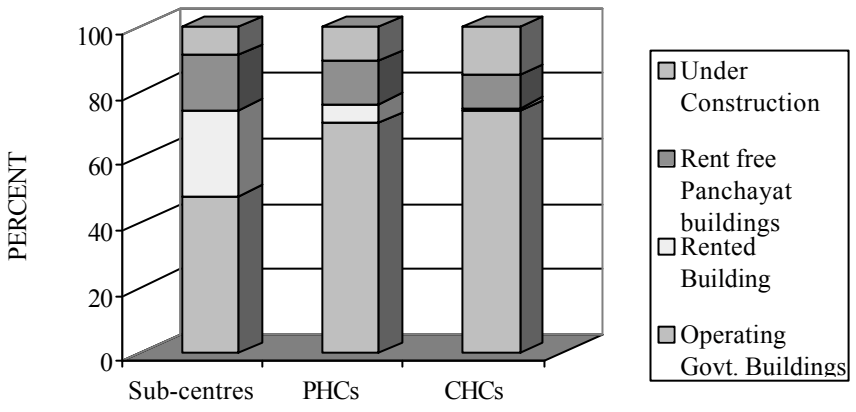
Table – 5.6.1 Health care infrastructure			
	Required	**In position**	**Gap**
Subcentres	134108	138044	8181*
PHCs	22349	22928	1714*
CHCs	5587	3077	2562
Modern medicine		**ISM&H**	
Hospitals	**Dispensaries**	**Hospitals**	**Dispensaries**
15188	25911	2991	23028

*: Some states have a deficiency in the number of health centers required, while some have an excess

More than three-fourths of the medical practitioners work in the private sector and majority of them cater to the primary health care needs of the population.

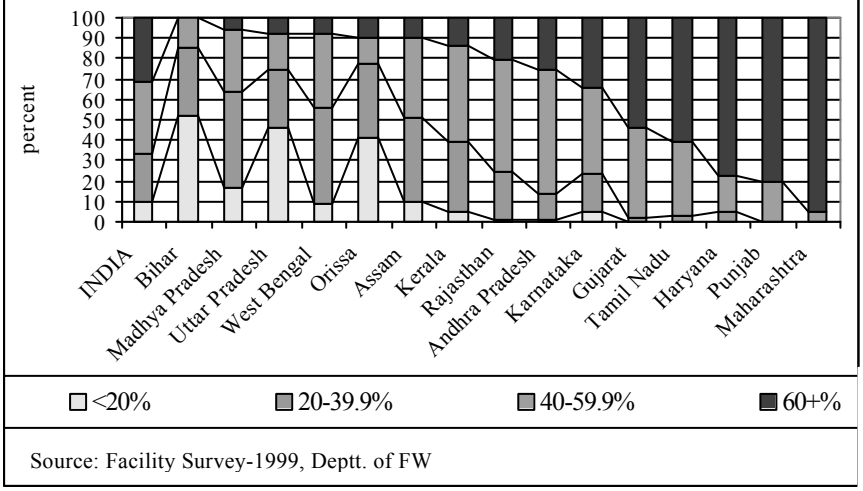
8. By the end of the Seventh Plan, most of the states had completed setting up of subcentres and primary health centers required to meet the norms for 1991 population (Table-5.6.1). Majority of them are located in their own building and cannot be shifted out. (Figure – 5.6.2) Some states have more than required number of PHCs and sub-centres, while in some there are gaps. Ignoring the surplus, the total number required to fill the existing gaps in states deficient in the required number of SCs, PHCs and CHCs were indicated as goals to be achieved during the Ninth Plan. Very little progress has been made in achieving these goals. Therefore the goals for the Tenth Plan continue to be filling these gaps (Annexure- 5.6.3). Almost all the gaps can be filled by appropriate reorganization of the existing infrastructure .

Fig 5.6.2. Construction of Buildings



SOURCE: RHS BULLETIN, JUNE 2000

Figure-5.6.3 Percentage Distribution of PHCs having all Critical Inputs



Source: Facility Survey-1999, Deptt. of FW

Many of the existing subcentres, PHCs and CHCs lack essential

physical infrastructure, manpower and consumables(Figure 5.6.3). Correcting these within available resources will be the priority during the coming years.

Situation regarding manpower position in these institutions is indicated in Table 5.6.2 and Annexure 5.6.4. It is obvious that the gaps in the manpower in critical posts could be completely corrected through redeployment of the exiting manpower after appropriate reorientation and skill upgradation.

Table-5.6.2 Health Manpower in Primary Health Care Centres

	Required(R)	**Sanctioned(S)**	**In Position(P)**	**Gaps**	
				R-P	S-P
Drs. In PHCs	22349	29702	22506	157#	7196
Specialists in CHCs	22348	6579	3741	18607	2838
MMPWs in SCs	134108	87504	73327	60781	14177
Lab techs in PHCs	27936	15865	12709	15227	3156
Specialists in PPCs	3100				
Malaria			**Leprosy**		
Male health workers	Sanctioned	In position	Regular	Contractual	
	39720	34580	17072	2632	
Lab technicians	7103	6026	1079	76	
				# : surplus	

9. The ongoing and proposed re structuring and redeployment at each level is indicated below.

At Sub-centre Level:

- The Department of Family Welfare has taken over the funding of all the 1.34 lakh ANMs in the sub-centres as per the 1991 requirement.

- Efforts are underway to fill vacancies in the posts of male multi-purpose workers (MMPW) by training and redeploying the large number of uni-purpose male workers with insufficient workload employed in various centrally sponsored disease control programmes(TB, Malaria, Leprosy, RCH) (Table-5.6.2)

At PHC Level

- There is more than adequate number of doctors to man every PHC. The major task is to ensure that they are available where they are posted. No additional recruitment is required in any of the states.

- Dispensaries and block level PHCs without specialists should be merged or recategorised as PHCs. Doctors in RFWC will be redeployed to cover the vacancies in

sanctioned posts in the PHCs. *West Bengal* has decided that doctors in the PHCs with no in-patient facilities will be posted in Block level PHCs. Staff from functional block level PHCs will visit PHCs with outdoor facilities and provide essential primary health care on rotational basis.

- ☞ Part time or contractual staff including those provided under the national disease control programmes and family welfare programme are being utilised to fill the gaps in manpower as and when required e.g. *Madhaya Pradesh*

- ☞ Mobile clinic approach can be utilized to access remote areas e.g. *Orissa, Rajasthan, Delhi slums*, *Maharashtra* (Tribal areas); these are expensive to run and maintain.

- ☞ ISM&H doctors are being posted in remote PHCs to provide essential primary health care e.g. *Gujarat. Kerala* and *Tamil Nadu* are posting ISM&H doctors in PHCs to provide complementary system of care.

- ☞ Uni-purpose workers in National Programmes are being trained and redeployed as multipurpose workers in the general health system in some states.

- ☞ Existing staff with varying qualifications are trained and used for filling the gaps; e.g. *Orissa* is training the pharmacists to be redeployed as lab technicians; they may not have appropriate skills and the effect of such a redeployment has to be assessed .

- ☞ Redeployment of staff for correcting the mismatch between expertise and infrastructure/ equipment; e.g. lab technician/microscope.

At CHC/FRU Level:

- ☞ All sub-district institutions with specialists are being recategorised as CHC/FRU under the three tier rural primary health care system; this will fill the apparent gaps in number of CHCs/FRUs.

- ☞ The staff of the post partum centers are being integrated into theFRUs/CHCs, thereby providing specialist manpower especially of obstetricians and pediatricians, to make FRUs functional.

- ☞ Development of appropriate two-way referral systems utilising information technology (IT) tools to improve communication, consultation and referral right from primary care to tertiary care level.

- ☞ GIS mapping of all government health facilities is being attempted and will be used for reorganization and restructuring of the infrastructure.

Urban Health Care

10. Nearly 30% of India's population lives in the urban areas; 27% of this population lives in urban slums. Recent estimates from the Planning Commission suggest that in some states poverty in urban areas is greater than in rural areas. There is need to develop sustainable health care delivery and financing system to improve the health outcomes,

particularly for the urban poor. *Delhi* and *Chennai* have developed a system of mapping out the existing health infrastructure and manpower and to link them effectively. *Delhi* has developed a GIS system for providing information regarding availability of health care in the vicinity .

Secondary Health Care

11. The secondary health care infrastructure at the district hospitals and urban hospitals is currently also taking care of the primary health care needs of the population in the city/ town in which they are located. This inevitably leads to overcrowding and under utilisation of the specialized services. Strengthening secondary health care services was an identified priority in the Ninth Plan. In addition to the funds they get from the state plan, seven states have taken World Bank loans to initiate projects to build up FRUs/district hospitals. The aim of these projects is to:

- strengthen FRUs to take care of referrals from PHCs/SCs;
- strengthen district hospitals so that they can effectively care for referrals;
- strengthen the referral system and rationalize care at each level to:
  - enable patients to get care near their residence;
  - ensure optimal utilisation of facilities at PHCs/ CHCs; and
  - reduce overcrowding at the district and tertiary care level.

12. The states have initiated construction works and procurement of equipments. They have reported increased availability of ambulances and drugs, improvement in quality of services following training to health care providers, reduction in vacancies and mismatches in health personnel/infrastructure and improvement in hospital waste management, disease surveillance and response systems. All these states have attempted to levy user charges for diagnostic and therapeutic services from people above the poverty line. Some states have been unable to ensure that the collected charges are retained for use in the same institution and this problem need be speedily resolved.

Tertiary Health Care

13. Over the last two decades a majority of the tertiary care institutions in the governmental sector have been facing a resource crunch and have not been able to obtain funds for equipment maintenance, replacement of obsolete equipments, supply of consumables and upgrading the infrastructure to meet the rapidly growing demand for increasingly complex diagnostic and therapeutic modalities. There is a need to optimise facilities available in tertiary care institutions, enhance the quality of services and strengthen linkages with secondary care institutions. Overcrowding in tertiary care hospitals and underutilization of expert care due to the lack of a two way referral system with primary and secondary care levels requires correction. To meet some of the recurring costs and to improve the quality of services in tertiary health care institutions the Ninth Plan suggested levying user charges and establishing pay clinics/pay cabins.

14. Some states have provided land, water and electricity at a lower cost to private entrepreneurs setting up tertiary care/superspeciality institutions on the condition that they provide outpatient and inpatient care free of cost for people below the poverty line. In an

effort to augment the availability of tertiary care, several states (e.g. *Rajasthan* and *Himachal Pradesh*) are trying out innovative schemes to give greater autonomy to government institutions, allowing them to generate resources and utilise them locally. Most states have not yet fully documented the extent and impact of their efforts in this direction. Available data suggest that *Kerala, Punjab* and *Haryana* have cost recovery ratios of around 10 per cent and more than 80 per cent of the fees for public facility care were paid by the richest 40 per cent of the population both in the urban and rural areas. This may be because this section uses the services more or the quality of care provided to those who pay may be better than to those who are exempt from paying. A review of the existing cost recovery system in states has shown that:

- an appropriate institutional framework for reviewing user charges has not yet been established;
- the level of cost recovery is minimal due to the low structure of fees and inadequate collection mechanisms;
- mechanisms for identifying and exempting the poor from user charges are ill defined; and
- funds collected are not retained at the point of collection in many states.

15. One of the major recommendations of the Ninth Plan was that a Technical Appraisal Committee should be constituted in all major government institutions to assess and prioritise the essential requirements for strengthening and up grading of facilities keeping in mind the funds available. This has not been fully operationlised in any state though some states have taken steps to improve the autonomy of these institutions. It is important to implement this recommendation, improve autonomy and encourage decentralised planning.

Human Resource Development for Health

- Setting up University of Health Sciences (UHS) to improve uniformity in the entry standards, appropriate curricula and examination for medical, dental, pharmacy and nursing colleges and paraprofessional training institutions. So far *Andhra Pradesh* (AP), *Tamil Nadu*, *Karnataka*, *Punjab* and *Maharashtra* have set up University of health sciences. Several states are in the process of setting up UHS.
- Skill upgradation of all health care providers through CME and reorientation and if necessary redeployment of the existing health manpower, so that they can take care of the existing and emerging health problems at primary, secondary and tertiary care levels.
- Training of all medical and para-medical personnel for all National Programmes and promote team approach. *Kerala* is considering providing continuing medical education not only to in-service personnel, but to all practitioners, perhaps on a self-financing basis.
- Mainstreaming of the ISM&H personnel so that they can participate in providing essential primary health care, assist in improving coverage under the National Disease Control

programmes *(Himachal*); provide complementary system of care.e.g. *Kerala, Himachal Pradesh* and *Orissa.*

- Creation of a specialist cadre at CHC level; besides their own speciality, they are trained to manage all national programmes. As and when the medical officers get selected to various posts , they will get appropriate in service orientation training ; for example when clinicans become programme managers they will get trained in programme management ; PSM specialist getting posted as programme manager will get exposure to clinical problems pertaining to the programme.
- Most states have formed a single health and family welfare society at district and state level. Some (*Orissa)* have taken steps to initiate a health strategy, whereby focus was shifted from project funding to sector funding.
- *Gujarat* is considering creation of a cadre of bio-medical engineers to oversee the maintenance of equipments in all the government hospitals of the state.
- *Andhra Pradesh* has launched a massive training programme to train all medical personnel to identify and refer cases of HIV/ AIDS

Improving Referral and Communication Linkages

- Building up a fully functional, accurate Health Management Information System (HMIS) utilising currently available IT tools; this real time communication link will send data on births, deaths, diseases, request for drugs, diagnostics and equipment and status of ongoing programmes through service channels within existing infrastructure and manpower and funding; it will also facilitate decentralized district based planning, implementation and monitoring;
- Development of appropriate two-way referral systems through introduction of a family folder, child health card and ANC card etc. to facilitate accurate record keeping, referral and reporting e.g. *Pondicherry* has introduced family folders, *Tamil-Nadu* has woman held ANC card.
- *Kerala* and *Orissa* have established a disease surveillance system, through which data is collected regularly (weekly/ monthly) from Government and private practitioners; the data is analyzed at district level and appropriate response initiated.

Use of information technology (IT)

16. IT tools can be used to improve communication, consultation and referral right from primary care to tertiary care level; currently efforts are underway to develop:

- Tele-linkages between PHCs and FRUs;
- tele-linkages between FRUs, district hospitals and tertiary care institutions; and,
- Telemedicine consultation between tertiary/ super-speciality care institutions in different regions.

17. Some of the major ongoing initiatives are:

West Bengal- Telemedicine linkages between Habra Hospital and School of Tropical Medicine; a pilot project connecting Bankura Medical College, North Bengal Medical College and SSKM Hospital; Government of India has entered into partnership with a leading NGO in establishing telemedicine for cardiac care.

Maharashtra- Pilot project on telemedicine linkage between three PHCs at Wagholi, Paud and Chakan provided by <Doctoranywhere.com> in collaboration with Tata Council for Community Initiatives. The service uses Internet based technology to connect the PHCs with medical specialists.

Orissa- Every village is being provided with telephone linkages and connected to blocks where Internet facility is available. Information is available on the net at block level PHCs about where a particular specialist would be available for an emergency care.

NEC- In view of distances, difficulty in terrain and lack of all types of infrastructure, this region requires better connectivity through the use of information technology. The S&T Division NEC proposed video conferencing linkages among the health care centers in the Northeast and with selected institutions outside the state. It has been suggested that the proposal should have three components:

- ☞ High tech expensive video conferencing and tele-linkages with tertiary care institutions;
- ☞ Internet based communication between district hospitals and tertiary care centers;
- ☞ Telephonic communication linkages between villages, subcentres, primary health centers, CHCs and district hospitals.

Uttaranchal- The state is building up tele-linkages among the primary health care centers; 10% of villages are already connected under the SIP project.

Andhra Pradesh Tele-counseling, an interactive voice response system, with a common toll-free number all over the state has been established to counsel patients of HIV/AIDS.

Public-Private Sector Collaboration:

18. Some of the ongoing initiative includes:

- ☞ contractual appointment of the health care personnel and hiring of private practitioners for providing services in the PHCs have been attempted in order to fill the gaps e.g. *Madhya Pradesh*;
- ☞ part time hiring of general practitioners and specialists to visit and provide health care in PHCs/CHCs in under-served areas e. g., *Madhya Pradesh*;
- ☞ NGOs providing rural health care by adopting PHCs e.g. *Karnataka*;

- ☞ state and central governments, PSUs reimburse cost of medical care provided by recognized private health care providers/institutions;

- ☞ involving NGOs/private sector practitioners in the National Programmes e.g. utilizing the services of NGOs, and not for profit institutions in the leprosy eradication programme, involvement of private practitioners/institutions in the blindness control programme and the HIV/AIDS control programme e.g. *Delhi*;

- ☞ private sector individuals/institutions/industry e.g. Tata Steel Company provide health care to the population living in a defined area;

- ☞ private super-specialty, tertiary/secondary care hospitals are given land, water and electricity etc. at a concessional rate and permission for duty-free import of equipment with the understanding that they will provide in-patient/out-patient services to poor patients free of charge. The experience has been varied with several problems being reported e.g. *Kerala, Rajasthan, West Bengal;*

- ☞ private practitioners provide information for disease surveillance in some districts in *Kerala;*

- ☞ private agencies have been engaged for support services like kitchen, laundry, cleaning and security. e.g. *West Bengal, Utranchal, Gujarat*; and,

- ☞ states are inviting private sector to set-up medical colleges e.g. *West Bengal.*

Community Participation

19. Increased community involvement in public health and family welfare programmes is being encouraged by many states Some of the major initiatives are:

*West Bengal***-** A Pilot project is being taken up under SIP, which is funded by EC, where in women from self help groups are being trained as Honorary Health Workers (HHWs) to assist the community in accessing services under Family Welfare and National Disease Control Programmes. Each HHW is to cover 200 households and the sponsoring organization is paid a performance-based incentive on a graded basis.

Nagaland- encouraging public participation in all health care services at the grassroots (SC) level; it is called "Communitisation" of health institutions. Through this, health sector financing is being done involving public, as well as private practitioners. A Village Health Committee and a Common Health Sub-centre Committee have been constituted to look after the overall health needs of the village, including the functioning of the sub-centre.

The state has also published a Citizens' Charter, with the aim of:

- ☞ Augmenting all health units to deliver basic health care services to the community;

- ☞ Ensuring supply of essential drugs and equipments;

- ☞ Emphasizing implementation of National Disease Control and family Welfare programmes; and

- ☞ Increasing the accountability of service providers in rendering efficient services.

Andhra Pradesh has launched a "Convergence Community Action" (CCA), involving all self-help groups to generate awareness about AIDS/STD in the community.

Governance Related reforms

20. Efforts are under way to bring about quality assurance and accountability in health care services. Assessment of the quality of health care is often thought to be a value judgment but there are determinants and ingredients of quality, which can be measured. These include assessment of infrastructure and manpower, processes such as diagnosis and treatment or outcome such as case fatality, disability and patient satisfaction. Health care quality evaluation includes safety, effectiveness and timeliness of interventions. It must also include assessment of the performance of the system in terms of meeting the changing needs of the population to stay healthy and learn to live with illness and disability. In recent years, there has been increasing public concern over the quality of health care both because of increasing awareness of the population and the mushrooming of health care institutions particularly in the private sector.

Introduction of Quality Control System in India will:

- prevent overuse, under-use, abuse and misuse of facilities;
- improves effectiveness and efficiency;
- help make positive outcomes more likely;
- help the effective and responsible use of resources;
- minimise barriers to appropriate care at different levels by matching the levels of care to the level of need;
- bring accountability into the health system; and
- ensures that optimum use is made of every rupee invested.

21. During 1990s, some initiatives were taken to address issues relating to quality of care such as, inclusion of the Consumer Protection Act. Some states have attempted to provide a legal framework for the functioning of private health care institutions on the lines of the Bombay Nursing Home Registration Act 1949. These legislative measures have so far not been effectively implemented partly because of the lack of objective criteria for defining 'quality of care' and the fear that enforcing such regulations may increase the cost of care. Several states are attempting to introduce some quality control concepts and tools into health care in order to ensure that:

- ☞ the population and the system benefit from defined and institutionalized norms, accountability and responsibility;

- ☞ the Tenth Plan goals are achieved and health indices of the population improve; and

- ☞ health care is made affordable for individuals and the country as a whole.

22. Many states are setting norms for posting of medical personnel in rural areas, and ensuring transparency in these so as to bring about accountability regarding presence and performance of health care providers.

West Bengal has demarcated the state into three zones, and has provided for posting of medical officers in these zones for a fixed period. The state has 'District Health and Family Welfare Samiti', so that various committees and societies do not act at cross-purposes. All public health functions are controlled by the CMOH. A system performance assessed on the basis of grading in an objective assessment criteria has been developed to identify the performance of different categories of employees; based on performance the employees are rewarded or punished. All the donor partners supporting the state health department are brought under a donor partners coordination committee headed by the chief secretary to improve coordination.

Kerala is proposing creation of a cadre system of specialists to fill the existing vacancies.

Uttaranchal: Special incentives are being given to doctors posted in remote areas with difficult terrain. Tour programmes of the ANMs are fixed in advance and MCH clinics are conducted on fixed days, and immunization days are also fixed. Sectoral and block level meetings are held every month. The deputy CMO pays surprise visits to these meetings whenever he can.

*Nagaland***:** the medical officer of every PHC is directed to visit every sub-centre once a month. The ANM is required to live there**,** and her tour is fixed in advance. She has a list of hospitals where different specialists are available, so that she can direct the people appropriately in an emergency. A booklet listing all the villages under each PHC/subcentre is available with the Village Health Committee. In case the service providers are absent from their duties, their salaries are deducted and used for up gradation of health care services there.

*Andhra Pradesh***:** a transparent policy for posting of personnel based on merit and on grading given through the performance monitoring system has been finalized. Medical and Paramedical personnel serving in remote rural and tribal areas are given special incentives. A remote sensing technique has been used for identifying areas with high musquitogenic conditions and initiating interventions to control mosquito breeding. District population stabilization societies are formed, and authority and funds were devolved to local levels. Service centers for sterilization were increased and refurbished; and surgeons trained in improved techniques. Output based performance indicators have been finalized and reporting frequency fixed. An attempt has been made to link performance with individual career advancement. It has been reported that this resulted in improving good antenatal care and immunization and has improved antenatal care and institutional delivery and reduced birth rate.

Uttar Pradesh is planning to give special incentives to doctors willing to work in rural areas,e.g. giving urban houses for their families, creation of a specialists' cadre etc. MBBS doctors will have to serve in the rural areas for a specified period before being eligible for an urban posting.

Financial Reforms

23. During the 1990s, it was recognized that, given the increasing awareness and expectations of the people, and the escalating costs of health care, the policy of providing health care services to people in government institutions free of cost could not continue. The Ninth Plan envisaged that major public health priorities such as essential primary health care, emergency life saving services, services under the disease control and family welfare programmes will be provided free of cost for all. The Ninth Plan advocated that the Centre and the state governments should work out appropriate norms for levying user charges on people above the poverty line for other services and hospitalisation and evolve mechanisms for collection and utilisation of funds. Currently there is no single source of information on the expenditure incurred on health care by the central and state governments institutions and individuals. It is imperative that a system of National Health Accounting, reflecting total expenditure on health is established. This will enable periodic review and appropriate policy decisions regarding modalities for ensuring optimal utilisation of the current investment in the health sector and also future investments to meet public health needs.

24. Given India's size and the fact that health is a state subject, it is important to examine inter-state differences in spending patterns. While the central government provides funds to the states under centrally sponsored schemes based on uniform norms, per capita expenditure in states vary depending upon the prevalence of diseases and utilisation of funds allocated. If these are taken into account, the central government expenditure does not show much variation between states. It is important that each state undertakes a detailed analysis of the current situation, identify critical points where appropriate interventions would enable the population below poverty line (BPL) to utilise subsidised government health services while providing affordable health care to other segments of the population. The Planning Commission provided additional central assistance to the Kerala government for an experimental model in a district hospital where different segments of the population above the poverty line (APL) pay for health care and the hospital meets the costs of care of BPL (lowest 20 per cent) population through a system of cross-subsidy.

25. With increasing awareness, people are willing to spend on health care. However, there is, at present, no mechanisms by which they can pay a part of their income, throughout their working life, so that the cost of health care or hospitalisation can be met without severe financial crisis. Health insurance in the government and private sector covers less than 10 per cent of the population, mostly from upper income group, government or industrial employees. There is need to explore mechanisms for providing near-universal coverage of the population for meeting the cost of hospitalisation and continuous care for chronic disease.

Financial reforms are aimed to address:

- ☞ equity in access to health care based on needs ;
- ☞ devising a targeting mechanism by which people below poverty line have ready access to subsidised health services to meet essential health care needs; while those from above the poverty line pay for the services both in government and private care facilities.

26. There is an urgent need to evolve, implement and evaluate an appropriate scheme for health financing for different income groups. Health finance options may include health insurance for individuals, institutions, industries and social insurance for BPL families. Health insurance has been suggested as a mechanism for reducing the adverse economic consequences of hospitalization and for chronic ailments requiring expensive and continuous care. Global and Indian experiences with health insurance/health maintenance organisations should be reviewed and suitable models replicated. In order to encourage healthy lifestyles, a yearly 'no claim bonus'/adjustment of the premium could be made on the basis of previous year's hospitalisation cost reimbursed by the insurance scheme.

The insurance schemes in India can be categorized into four broad groups: mandatory, voluntary, employer based and NGO based. Up to ten per cent of Indian population is covered by some form of health insurance. To address the needs of the larger segments of informal sector and self-employed workers some innovative schemes have been developed. Some of these are listed below.

*Ambikpur Health Association, Orissa***-** The scheme provides free outpatient care and limited hospitalization to about 75,000 individuals on a voluntary basis. The scheme has innovative features, like screening at the time of enrolment to avoid adverse selection of participants. However, premiums cover only 1-2 per cent outreach costs of the programme.
*Mallur Milk Co-operative, Karnataka***-** The scheme covers a population of about 7,000 spread across three villages; it provides preventive and curative health care (both out-patient and in-patient) to all eligible community members. Participation is mandatory. Income from endowment fund covers all expenses.
*Sewagram, Maharashtra***-** Free primary care, referrals, and hospitalization for chronic conditions are provided to a population of over 14,000 spread across 12 villages (75 % mandatory attendance within a participating village). Sliding scale premiums are employed to promoted equity.
*Meloj Milk Co-operative, Gujarat***-** Out-patients consultation, discounted drugs, and diagnostic services are provided by the Aga Khan Foundation. Enrolment is mandatory for all co-op members.
*SEWA, Gujarat***-** is a scheme for informal sector with two options-annual premium ranging between Rs85-400 or fixed deposit between Rs.1000-4800. Benefits include hospitalization charges between Rs.2000-10000, house assets Rs.5000-20000 and accidental death compensation of Rs.40000.

27. Some of the state Governments have also taken steps to formulate social insurance for meeting the essential hospitalization costs for people below poverty line . Some stases who have taken major initiatives in this aspect are:

*Kerala***-**State has proposed a Health Insurance Scheme for meeting hospitalization cost in BPL families.

Arogya Nidhi, Delhi—a government funded health insurance scheme is being implemented in Delhi for tertiary care. The state plans to initiate a pilot project on health insurance for people below the poverty line for secondary care in government institutions.

Andhra Pradesh-A health insurance scheme is implemented wherein a cover of Rs 20,000 towards hospitalization charges for a period of five years is assured for the acceptor of sterilization and his/ her two children, subject to a maximum of Rs. 4000 per year

Madhya Pradesh was in the process of launching a Community Health Insurance Scheme. *Himachal Pradesh* is planning to provide insurance cover to 100% families.

28. All these efforts have to be monitored and those which are feasible and cost effective replicated .

PREVENTION AND MANAGEMENT OF COMMUNICABLE DISEASES

29. Available limited data suggests that even though mortality associated with communicable diseases has to some extent been reduced, the morbidity continues to be very high. Deteriorating urban and rural sanitation, poor liquid and solid waste management and overcrowding have contributed to the increasing prevalence of communicable diseases. Increasing attention is urgently needed for prevention through effective implementation of infection control measures. All the ongoing National Disease Control Programmes initiated in the Ninth Plan are being continued. Modalities to improve delivery of services pertaining to these programmes through the existing health services are being worked out. Local accountability and intersectoral co-ordination should be improved through the involvement of PRIs. Evaluation and operational research to rectify problems in implementation and improving efficiency are receiving due attention.

Ninth Plan strategies for improving communicable disease control programmes

- ☞ Rectification of identified defects in design and delivery of diseases control programme.
- ☞ Filling critical gaps in infrastructure and manpower.
- ☞ Making service delivery responsive to user needs.
- ☞ Ensuring that health care providers have the necessary skills and support, including referral facilities and supplies.
- ☞ Improving community awareness, participation and effective utilisation of available services.
- ☞ Use of PRIs in improving community participation and monitoring implementation of programmes.

National Vector Borne Disease Control Programme

Malaria

30. The National Malaria Control Programme, the first centrally sponsored programme, was initiated in 1953. The National Anti Malaria Programme currently deals with malaria, filaria, kala-azar, Japanese encephalitis and dengue. To tackle high mobidity and mortality associated with malaria (particularly of falciparum malaria) 100 per cent central assistance under the NAMP is being provided to the northeastern states since 1994. Financial assistance was also obtained from the World Bank for the Enhanced Malaria Control Programme (EMCP) to cover 100 predominantly P. falciparum malaria endemic and tribal dominated districts. In other areas, the NAMP continues to be implemented as a centrally sponsored scheme on a 50:50 cost-sharing basis between the Centre and states.

Ninth Plan strategy for Malaria	Strategies for vector control:	Target for 2002
☞ early diagnosis and prompt treatment ☞ selective vector control and personal protection; ☞ prediction, early detection and effective response to outbreaks; and ☞ IEC	☞ Indoor spraying in areas where API is over 2 with appropriate insecticide ☞ Anti-larval measures in urban areas ☞ Introduction of medicated mosquito nets ☞ Use of larvivorous fishes and biolarvicides	☞ ABER (Annual Blood Examination Rate) of over 10% ☞ API (Annual Parasite Incidence) of less than 0.5% ☞ 25% reduction in morbidity and mortality due to malaria

31. The Ninth Plan strategies and goal for the NAMP are given in text box. Performance under the programme and utilization of funds (Table-5.6.3) were sub-optimal during the first three years and then improved.

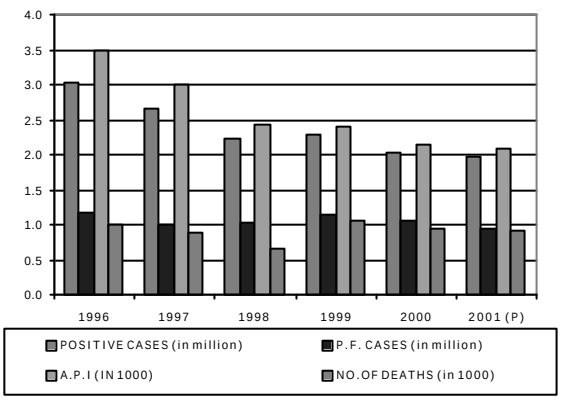
Table5.6.3 – NAMP-Outlays and Expenditure (Rs. Lakhs)

YEAR	OUTLAY	EXPD./RE
9TH PLAN	103000.00	
1997-98	20000.00	14276.00
1998-99	29700.00	16371.00
1999-00	25000.00	17601.00
2000-01	25500.00	18832.00
2001-02	22500.00	23400.00*
2002-03	23500.00	

Source: Department of Health
* Anticipated Expd.

However, the Ninth Plan goals for reduction in API and morbidity has not been achieved (Figure 5.6.4).

Figure 5.6.4 - National Anti Malaria Programme



Source : NAMP, Deptt of Health

Kala Azar

32. After a reported increase in the number of cases and deaths due to kala-azar between 1989-91 periods, an intensive programme for containment of kala azar was

Strategy for control of infection	Goals for Kala-azar
☞ interruption of transmission through insectide spraying with DDT; and ☞ early diagnosis and treatment of kala-azar cases ☞ The Central Government provides the insecticides and anti kala azar drugs ☞ the state governments meet the expenses involved in the diagnosis and treatment of cases and insecticide spraying operations	☞ Prevention of deaths due to kala azar by 2004 with annual reduction of at least 25 per cent ☞ Zero level incidence by 2007 with annual reduction of at least 20 per cent using 2001 as the base year ☞ Elimination of kala azar by 2010 (NHP 2002)

launched in 1992. During the Ninth Plan period, insecticide-spraying operations were often delayed and inadequate, and outreach of diagnostic and curative services were poor. Therefore, there was no massive decline in reported cases and deaths due to kala azar during the Ninth Plan (Table-5.6.4). Ninth Plan strategy and goal for kala azar control are indicated in text box.

Table –5.6.4 Cases and Deaths due to Kala-azar

Year	Bihar		West Bengal		Country	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
1997	15948	251	1450	3	17429	255
1998	12229	215	1113	6	13577	226
1999	11627	277	1091	6	12869	297
2000 (P)	12909	130	1244	11	14753	150

Source: Department of Health, 2001, P-Provisional

Dengue/Japanese Encephalitis (JE)

33. Periodic dengue outbreaks occur in many parts of India, in both rural and urban areas. Mortality is usually low but may be high in cases of dengue shock syndrome and dengue haemorrhagic fever (DHF). The reported total cases and deaths due to dengue/Japanese encephalitis during the Ninth Plan are given in (Table –5.6.5). The reported deaths are low perhaps because of the difficulty in diagnosis of cases.

Table-5.6.5 Cases and Deaths due to Japanese Encephalitis and Dengue/DHF

	JE		DENGUE/DHF	
Year	Cases	Deaths	Cases	Deaths
1997	2516	632	1177	36
1998	2120	507	707	18
1999	3428	680	944	17
2000 (P)	2313	535	605	7

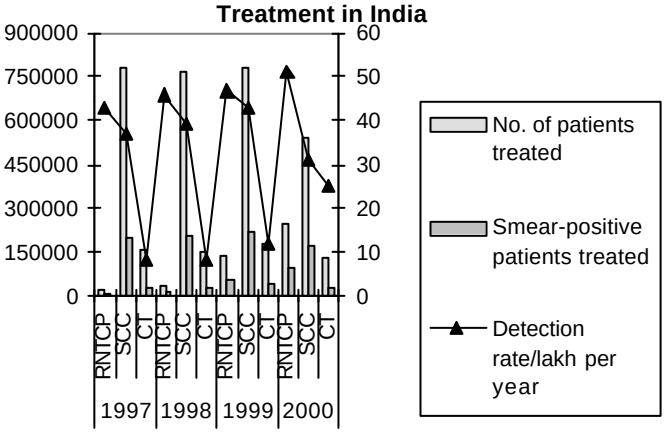
Source: Department of Health, 2001

Revised National Tuberculosis Control Programme (RNTCP)

34. The estimated prevalence of tuberculosis is 1.4 per cent, and sputum positive TB prevalence is estimated to be in the range of 4/1000 to 5/1000. The National Tuberculosis Control Programme was initiated in 1962 as a centrally sponsored scheme. The short course chemotherapy, which shortened the duration of treatment to nine months, was begun in selected districts in 1983. In spite of the availability of effective chemotherapy, there has not been any decline in the morbidity or mortality due to TB because of low case detection, case holding and cure rates. The programme was reviewed in 1992 and a Revised National Tuberculosis Control Programme (RNTCP) was drawn up. The full-scale initiation of RNTCP actually began in late 1998.

35. The performance during the Ninth Plan is given in Figure 5.6.5. The coverage of population under the programme increased from 89 million in 1998-99 to around 365 million in 2000-01. In order to improve coverage, increased participation of NGOs and private practitioners is being taken up.

Figure-5.6.5 Tuberculosis Detection and Treatment in India



Source: RNTCP, Department of Health

36. It is now recognized that there are inherent problems in ensuring compliance with long-term drug therapy for any chronic disease. In order to improve compliance with the long duration drug therapy the RNTCP envisaged the use of Directly Observed Treatment with Short Course Chemotherapy (DOTS). It is essential that the utility, acceptability and sustainability of the DOTS strategy is evaluated and if necessary mid-course corrections carried out. Outlays and utilization of funds are given in Table 5.6.6.

Table -5.6.6 Outlays/Expenditure for RNTCP (Rs. In Lakhs)

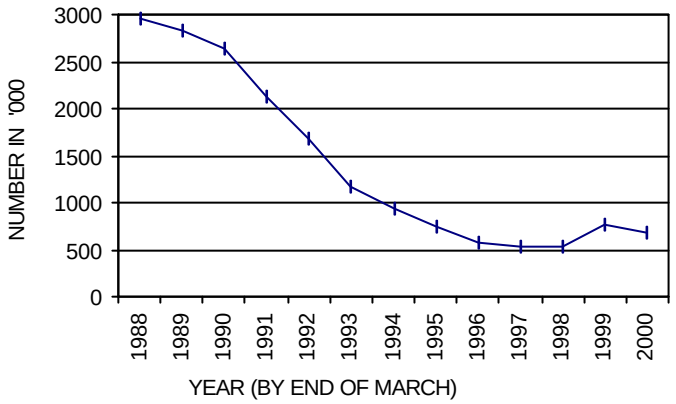
YEAR	OUTLAY	Expd./RE
9TH PLAN	45000.00	
1997-98	9000.00	3131.00
1998-99	12500.00	6888.00
1999-00	10500.00	8754.00
2000-01	12500.00	10875.00
2001-02	13600.00	13200.00*
2002-03	11500.00	

Source: Department of Health
* Anticipated Expd.

National Leprosy Eradication Programme (NLEP)

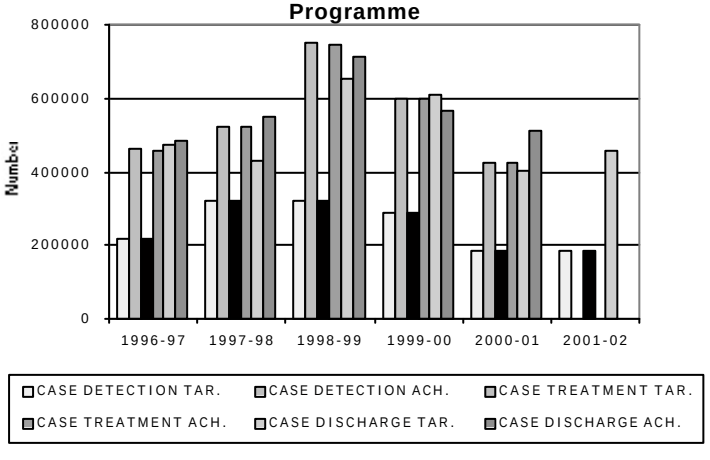
37. The NLEP was launched in 1983 as a 100 per cent funded centrally sponsored scheme with the goal of arresting disease transmission and bringing down the prevalence of leprosy to one in 10,000 by 2000. With the availability of multi-drug therapy (MDT), it became possible to cure leprosy cases within a relatively short period of six to 24 months. Over the years there has been a substantial decline in the prevalence of leprosy from 57/10,000 in 1981 to 5/10,000 in the year 2000 (Figure 5.6.6).

Figure 5.6.6- Prevalence of Leprosy Cases (1988-2000)



Source: NLEP, Department of Health, 2001

Figure 5.6.7 National Leprosy Eradication Programme



Source : NLEP, Department of Health, 2001

38. The performance of the NLEP during the Ninth Plan is shown in Figure 5.6.7. The department of health has initiated steps for the phased integration of the vertical programme within the general health services by training health care personnel in the detection and management of leprosy cases, making MDT available at all health facilities, improving disability and ulcer care and strengthening of monitoring and supervision. The outlays and utilization of funds during the Ninth Plan period is shown in Table 5.6.7.

Table-5.6.7 Outlays and expenditure for NLEP (Rs. in crore)		
YEAR	**OUTLAY**	**EXPD. /RE**
9TH PLAN	301.00	
1997-98	75.00	79.56
1998-99	79.00	78.03
1999-00	85.00	82.05
2000-01	74.00	73.86
2001-02	75.00	75.00*
2002-03	75.00	
Source: Department of Health, 2001 * Anticipated Expd.		

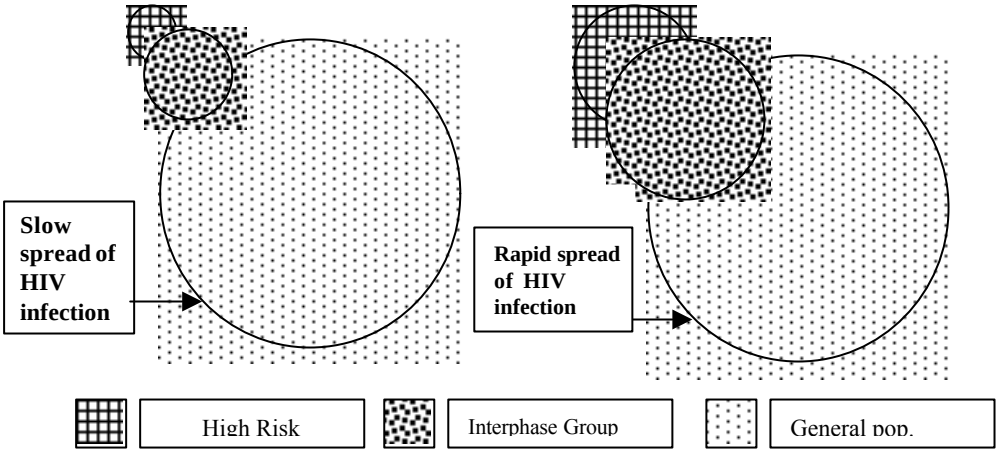
39. As of 2001, the estimated prevalence rate of leprosy is 4.3 in 10,000. Elimination level (PR < 1/ 10,000) has been achieved in Nagaland, Haryana, Punjab, Mizoram, Tripura, Himachal Pradesh, Meghalaya, Sikkim, Jammu and Kashmir, Rajasthan, Manipur and Assam. States that are close to achieving elimination (1-2/ 10,000) include Gujarat, Kerala, Arunachal Pradesh, Lakshadweep. Leprosy is now endemic mainly in the states of Bihar, Uttar Pradesh, Orissa, West Bengal, Madhya Pradesh, Jharkhand and Chattisgarh. The Modified Leprosy Elimination Campaign (MLEC), aimed at the detection of unidentified cases, was taken up first in Tamil Nadu in 1997 and then extended to Maharashtra, Orissa, Gujarat, the Jammu division of Jammu and Kashmir and Daman and Diu during 1997-98. It was subsequently extended to all districts during 1998-99.

40. Even though infection due to Leprosy bacillus is cured by MDT, the patients continue to suffer from neurological sequelae and deformities. The focus has to shift to helping these persons. So far 210 district leprosy societies have been provided funds for conducting disability/ulcer care management training. Gujarat mobilised experienced surgeons from all over the country to undertake reconstructive surgery in different district hospitals so that patients get treatment near their residence. The impact and cost effectiveness of these initiatives need to be assessed.

National AIDS Control Programme

41. The load of HIV infection in the community depends upon the prevalence of infection in three groups of population – the high-risk group, the interphase group and the low risk group. The high risk group (HRG) is a relatively small group . Soon after the introduction of infection in the community, there is a steep rise in prevalence of infection in this group because they are frequently exposed to the risk of infection. The inter-phase group consists mainly of men and women who have multiple sex partners. They form the link through which infection spreads to the vast low risk group of the general population. The general population (low risk group) acquires HIV infection from spouses who have multiple sex partners. The size of the three groups and the extent of the interphase group between them determine magnitude of the HIV infection in any country or community. Global epidemiological data on HIV infection indicate that soon after the introduction of the infection in the community seropositivity rates are low. In the next phase the infection spreads to susceptible persons in vulnerable groups resulting in steep rise in seropositivity rates. Finally in the third phase the seropositivity rates plateau when the number of persons who get infected is similar to the numbers who die of HIV infection. The steepness of the slope and the rapidity with which plateau is reached are determined by the proportion of susceptible at-risk persons in the community and the effective use of prophylactic measures by the risk groups (Figure-5.6.8).

Figure 5.6.8 – Spread of HIV infection in population



42. The estimated number of HIV infected person rose from one to two million in 1991, to 3.5 million in 1998 and 3.9 million in 2000. More than 50 per cent of infected persons are women and children. Every year, approximately 30,000 deliveries in India occur among sero-positive women and between 6,000 to 8,000 infants are peri-natally infected with HIV. At present, the number of AIDS patients in the country is small. However, over the next decade, persons who got infected in the 1980s and 1990s will develop AIDS, resulting in a steep increase in the number of AIDS patients.

43. India has the distinction of initiating national sero surveillance in 1986 to define the magnitude and dimension of HIV infection in the silent phase of the HIV epidemic long before AIDS cases were reported. Currently, HIV infection in the general population is seen in all states both in the urban and rural areas. Some of the projections made by the National AIDS Control Organisation (NACO) suggest that HIV infection in India may reach the plateau by 2010.

44. A National AIDS Control Programme (NACP) Phase I was launched in 1992 with World Bank assistance and was completed in 1999. Phase II of the programme, with funding from World Bank, Department for International Development (DFID) and United States Agency for International Development (USAID) is currently under way AIDS Phase II programme focuses on:

- ☞ reducing HIV transmission among the poor and marginalised high risk group population by targeted intervention,
- ☞ reducing the spread of HIV among the general population by reducing blood-based transmission;
- ☞ promotion of IEC, voluntary testing and counselling;
- ☞ developing capacity for community-based low cost care for people living with HIV/ AIDs;

- ☞ strengthening implementation capacity at the national, state and panchayat level through appropriate arrangements and increasing timely access to reliable information;

- ☞ forging inter-sectoral linkages between public, private and voluntary sectors.

Capacity building

- ☞ Awareness generation among all segments of population through Family Health Awareness campaigns
- ☞ Focussed attention and counselling to adolescents, sex workers, drug users , migrant labourers etc
- ☞ Improvement in the quality of and access to condoms including social marketing .
- ☞ Hospital infection control and waste management to reduce accidental spread of infection in health care settings.
- ☞ Clinical trials on chemotherapy to prevent mother to child transmission
- ☞ Establishment of behavioural surveillance

Infrastructure set up by NACO

Modernisation and strengthening of

- ☞ 815 blood banks
- ☞ 504 STD clinics in district hospitals

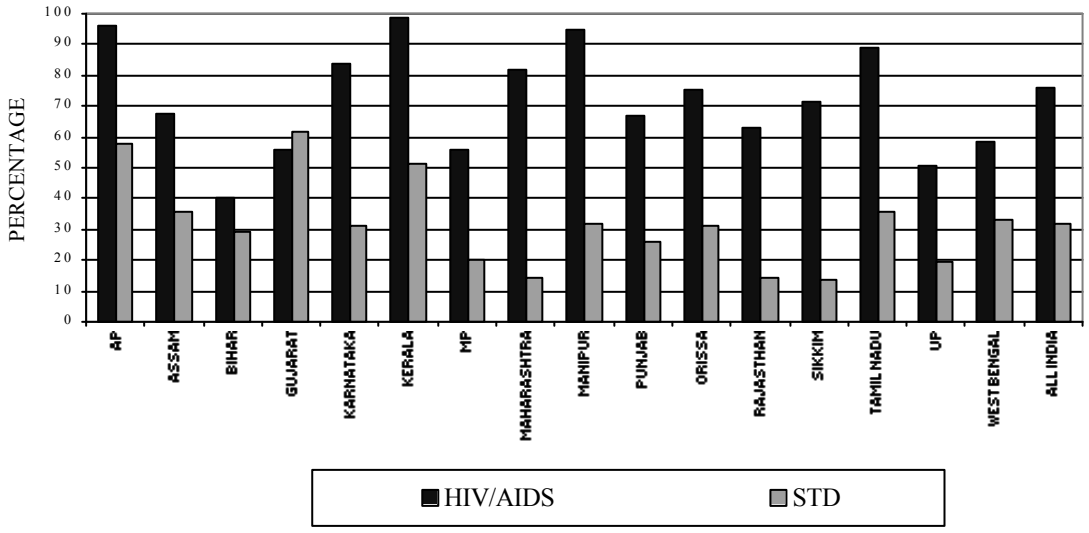
Establishment of

- ☞ 40 blood component separation facilities,
- ☞ 142 voluntary blood testing centre;
- ☞ 320 sentinel sites for monitoring time trends in the prevalence of HIV infection
- ☞ 570 sites for targeted intervention for prevention and management of HIV infection in high risk groups
- ☞ low cost community-based care for people living with HIV/AIDS

All these efforts are being monitored.

45. The recently concluded behavioural survey and the NFHS have shown that over two-third of the population knows about HIV infection. There are considerable urban-rural and

Figure 5.6.9 - Proportion of Respondents who had Ever Heard of HIV/AIDS and STD



SOURCE : NACO, Department of Health

inter-state differences. Awareness about STD was much lower than that about HIV infection (Figure-5.6.9). The outlays and expenditure on National AIDS Control Programme during the Ninth Plan is given in Table 5.6.8.

46. Monitoring of processes and impact evaluation of ongoing interventions and sentinel surveillance (serological, STD/ behavioural) to monitor time trends in the HIV epidemic would receive adequate attention. In addtion to these efforts, following encouraging results in initial pilot studies on use of perinatal anti retroviral therapy, programme aimed at reducing mother to child transmission is being taken up. Department of Health has been the nodal point of interventions which included not only the traditional activities of the health sector such as prevention, detection, counselling and management, but also areas such as legislation, rehabilitation of infected persons and their families.

Table 5.6.8
AIDS Control Programme (Rs lakh)

YEAR	OUTLAY	EXPENDITURE
9TH PLAN	76000.00	
1997-98	10000.00	12100.00
1998-99	11100.00	9936.00
1999-00	14000.00	13525.00
2000-01	14500.00	17330.00
2001-02	21000.00	23500.00*
2002-03	22500.00	

Source: Department of Health
* Anticipated Expd.

47. HIV is a multifaceted problem affecting all segments of society. Until now the Department of Health has been the nodal point of interventions which included not only the traditional activities of the health sector such as prevention, detection, counselling and management, but also areas such as legislation, rehabilitation of infected persons and their families. During the Tenth Plan period, it is expected that each Department should handle HIV infection related issues in their respective sectors. For instance, the Ministry of Labour should look into the prevention of discrimination at the work place. Voluntary organisations may be best suited for providing hospices for AIDS patients who do not have anyone to look after them and orphanages may have to take care of children who have lost their parents due to AIDS. If each sector plays its role, the country should be able to look after the needs of HIV infected persons and their families without any adverse effect on other programmes.

PREVENTION & MANAGEMENT OF NON-COMMUNICABLE DISEASES

48. During the Ninth Plan, programmes for control of non-communicable diseases included the National Programme for the Control of Blindness (centrally sponsored scheme) and the National Cancer Control Programme (central sector scheme). During the 1990s, several pilot projects such as the national mental health programme, the diabetes control programme, cardiovascular disease control programme, prevention of deafness and hearing impairment, oral health programme and medical rehabilitation were initiated as central sector pilot projects. After completion of the pilot phase, these programmes have been merged with the Central Institutes dealing with these problems.

National Cancer Control Programme (NCCP)

49. It is estimated that there are two to 2.5 million cases of cancer in India, with 700,000 new cases being detected every year. About two-thirds of the cases are in an advanced stage at the time of detection and 300,000 to 350,000 cancer patients die each year. The most frequent cancers among Indian males are those of the mouth/oropharynx, oesophagus, stomach and the lower respiratory tract. In women, cancers of the cervix, breast, mouth/ oropharynx and oesophagus are common. Tobacco-related cancers (especially cancer of oral cavity, lung and cancer cervix) form more than 50 per cent of the overall cancer burden in the country.

The objectives of the National Cancer Control Programme are:

- ☞ primary prevention of cancers by health education through the government and NGOs;
- ☞ early detection and diagnosis of cancers especially cancer cervix, breast and oropharyngeal cancers;
- ☞ developing and strengthening of existing cancer treatment facilities;
- ☞ increasing access to palliative care in the terminal stage of cancer.

50. The Cancer Control Programme was initiated in 1975-76 as a central sector project. It was renamed as the National Cancer Control Programme (NCCP) in 1985. The programme provides funds to 17 Regional Cancer Centres (RCCs) established for diagnosis, treatment and follow up of cancer patients; they undertake surveys of mortality and morbidity due to cancer, training of medical and paramedical personnel in cancer care and preventive measures with emphasis on health education and research. NCCP provided funds for the purchase of equipment (cobalt unit, mammography unit) and for development of oncology wings in Government Medical Colleges/voluntary organizations. The District Cancer Control Programme aimed at promoting health education, early detection of cancer and pain relief was initiated in 1990-91. The progress in ongoing efforts for cancer prevention, early detection and management has been very slow. Ninth Plan allocation, anticipated expenditure and outlay for the year 2002-03 are given in Table 5.6.9.

Table-5.6.9 NationalCancer Control Programme

(Rs. In crores)

Ninth Plan		Outlay
Allocation	Expenditure	2002-03
190.00	198.14	61.00

51. Even today majority of cancers are detected in stage 3 and 4 when curative treatment is not possible. Efforts should be through health education to improve awareness of the population regarding need to seek medical care early. Simultaneously efforts should be made through CME to sensitise and upgrade the skills of health care providers in the primary, secondary and tertiary institutions so that they can take up the responsibility of:

- ☞ health education for cancer prevention;
- ☞ early diagnosis and management according to standard treatment protocols at appropriate institutions; and
- ☞ referral of cancer patients with complications.

National Programme for Control of Blindness (NPCB)

52. Survey carried out by the ICMR in the 1970s had shown that prevalence of blindness was 1.4 per cent and cataract accounted for over 80 per cent of blindness. The National Programme for Control of Blindness was initiated in 1976 with the objective of providing comprehensive eye care services at primary, secondary and tertiary care level. The progress in the programme was very slow and a survey in 1986-89 showed that prevalence of blindness was unchanged.

53. Prevalence of blindness was higher in Andhra Pradesh, Uttar Pradesh, Tamil Nadu, Orissa, Madhaya Pradesh, Maharashtra, Rajasthan, and Jammu and Kashmir, than the overall National prevalence (Table-5.6.10). In 1994, World Bank assistance was obtained for NPCB in seven of the eight states. Domestic budgetary support was provided to implement the project in Jammu and Kashmir.

Tabl 5.6.10 Prevalence of blindness

Category	Prevalence(%)	States
Low	< 1	Punjab, Himachal Pradesh, Delhi, West Bengal, and NE states
Medium	1 to 1.49	Gujarat, Haryana, Kerala, Bihar, Karnataka, Andhra Pradesh and Assam
High	1.5 to 1.99	Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh
Very high	≥ 2	Madhaya Pradesh, Rajasthan and J & K

54. In 1994, World Bank assistance was obtained for NPCB in seven of the eight states. Domestic budgetary support was provided to implement the project in Jammu and Kashmir. The major objectives of the programme were:

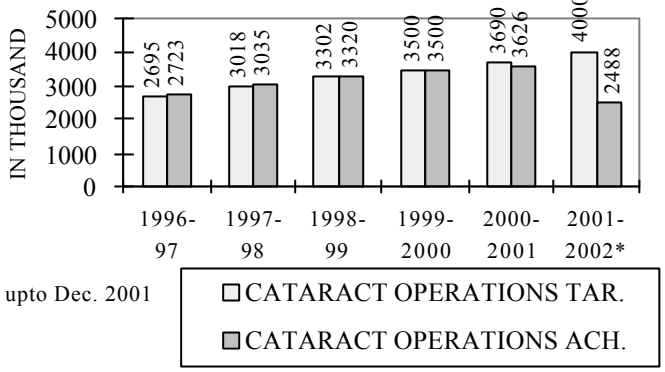
- to improve the quality of cataract surgery and clear the backlog of cataract by performing 11 million operations over a seven-year period;

- to strengthen the country's capacity to provide high volume, high-quality, low-cost eye care by upgrading the knowledge and skills of eye care personnel and improving access to service delivery through government, voluntary and private sector collaboration; and

- to increase eye care coverage among the underprivileged section of the population including women, urban slum dwellers and tribals.

55. The review of the World Bank assisted project in 2000 showed that even though infrastructure and manpower has been provided, performance both in fixed facilities and in camps have been far below the norms. Most of the district hospitals did not achieve the goal of 700-cataract surgeries/ surgeon/year; many mobile units did not achieve the goal of 1500 cataract surgery per year. As a result only 8.15 million cataract surgeries (the target was 11 million) could be done and cataract prevalence could not be reduced to 0.3 per cent.

Figure-5.6.10 Blindness Control Programme All India



Source : Departt of Health

Table-5.6.11 NPCB- Outlays and Expenditures

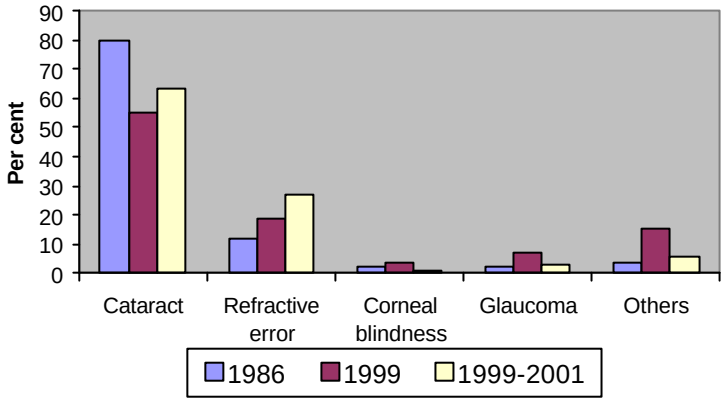
(Rs. In Lakhs)

Year	Outlays	Expenditure
9TH PLAN	44800.00	
1997-98	7000.00	5806.00
1998-99	7500.00	7285.00
1999-00	8500.00	8373.00
2000-01	11000.00	10941.00
2001-02	14000.00	14000.00*
2002-03	8600.00	

Source: Department of Health
* Anticipated Expd.

56. The performance during the Ninth Plan is given in Figure 5.6.10 Outlays and expenditure under the NPCB is shown in Table 5.6.11. The programme was revised to cover the entire country and It was recommended that district level action plan should be prepared using resource mapping, which is one of the most powerful tool in micro planning.

5.6.11 Main Causes of Blindness



MICRO-PLANNING AT THE DISTRICT LEVEL	
Steps	**Required Actions**
Listing of blind persons, particularly those who are blind in both eyes	▪ All persons aged 50 years and above should be enumerated ▪ Screening by especially trained health staff, NGOs, Panchayat member or a volunteers ▪ Confirmed blind cases be entered in the village blind register for computation
Mapping of eye care infrastructure	▪ Plot all fixed facilities: Government, voluntary or private sector
Target setting	▪ Cataract surgeries: 600/100,000 population over 3 years ▪ Allocate targets to each facility as per norms: 1 eye surgeon=700 cataract surgeries per year

	1 eye bed=50 surgeries per year -Distribute target to facilities by linking villages, distance to be covered -Blockwise target to ensure coverage of all villages -Gender: to ensure >50 % coverage in women -Social class: Minimum 40 % belonging to SC/ST and minority groups -Economic criterion: 60 % of persons covered are BPL
Options for surgical services	▪ Surgeries must be conducted in air conditioned, dust free, and sterile operation theatrtes ▪ Technical options: -operations performed by IOL surgery -operations be performed by conventional surgery in the absence of a trained surgeon
Assesment of resources assessories	▪ Materials-drugs and consumables, sutures, IOLs, spectacles, eye ointments, ophthalmic drops, injections, surgical ▪ Manpower-eye surgeons, ophthalmic assistance, trained nurses, volunteers, counselors ▪ Financial-Avaialability of funds as per guidelines
Monitoring for quality control	▪ Periodic reviews by the DBCS to assess progress in each block by individual provider unit ▪ Concurrent monitoring of individuals and organizations to assess the validity of reported data regarding follow-up, spectacles given and patient satisfaction

57. Recent survey (1999-2001) carried out in 15 districts of the country indicated that prevalence of blindness (Visual Acuity < 6/60) has come down to 1.08 as compared to earlier figure of 1.4 per cent but this is substantially higher than the goal of reducing the prevalence to 0.3 per cent by the year 2000. Prevalence of blindness in 50+ populations was estimated to be 8.3 per cent. Among the emerging causes of blindness, diabetic retinopathy and glaucoma need special attention. Twenty per cent of the diabetics (2 % of India's population is expected to be diabetic) have diabetic retinopathy. Over the last three decades there has been change in causes of blindness. The main causes of blindness in the 50+ populations are shown in the Figure 5.6.11. The programme has therefore been reoriented to cover the wider spectrum of ocular problems.

Mental Health

58. Mental health care has three major aspects, restoration of health in mentally ill, early detection and prompt treatment of 'at risk' individuals and promotion of mental health in normal persons. In India, mental health services are being provided through:

☞ dedicated mental hospitals

Magnitude of Mental Health Problems

It is estimated that:

☞ ten million people are affected by serious mental disorders.

☞ 20-30 million people have neurosis or psychosomatic disorders.

☞ 0.5 and 1 per cent of all children have mental retardation.

- ☞ as part of general health system
- ☞ Mental health programme with outreach services.

59. Incorporating mental health as a part of general health system and providing mental health care in general hospitals has helped in reducing the stigma associated with mental illness, legal restrictions on admission and treatment and facilitated early detection of physical problems. Most importantly, it ensured that the family was involved in the care. Encouraged by the success in this effort, many states embarked on the development of district psychiatric units. Some states like Kerala and Tamil Nadu have a district psychiatric unit in all districts. Though others lag behind in this respect, the concept of mental health care provided as an integral part of health care system has been accepted and implemented by all states.

60. Currently, 50 per cent of the medical colleges have a psychiatry department. It is estimated that there is one psychiatry bed per 30,000 population. There are 20,000 beds in mental hospitals and 2,000 to3, 000 psychiatric beds in general and teaching hospitals. However, in spite of all these facilities, even now less than 10 per cent of the mentally ill persons have access to appropriate care; prevention of mental illness and promotion of mental health remain of distant dreams.

61. During the Eighth Plan, the National Institute of Mental Health and Neuro Sciences (NIMHANS) developed and implemented a district mental health care model in the Bellary district of Karnataka with the objective of:

- ☞ providing sustainable basic mental health services to the community and to integrate these services with health services;
- ☞ early detection and prompt treatment of patients with mental illness;
- ☞ providing domiciliary mental health care;
- ☞ community education to reduce the stigma attached to mental illness; and
- ☞ treatment and rehabilitation of patients with mental illnesses.

62. During the Ninth Plan, the programme was expanded to 22 districts in 20 states. It was envisaged that psychiatric care would be possible in all health care facilities by providing district-based training in essential mental health care to all health professionals. A district mental health team was to provide referral support and supervision of the mental health programme. Simple, accurate records of work done were maintained by the health care providers. The progress in these districts has not yet been evaluated. It is expected that states would progressively improve access to mental health care services at the primary and secondary care levels and cover all districts in a phased manner. Psychiatry departments in medical colleges would play a lead role in the operationalisation and monitoring of the programme in the district in which they are located and form synergistic links with other ongoing related programmes. In the current year the programme is being expanded to cover newer districts

Accident and Trauma Services

63. Increasing mechanisation in agriculture and industry, induction of semi-skilled and unskilled workers in various operations, and rapid increase in vehicular traffic have resulted in an increase in morbidity, mortality and disability due to accident and trauma. Technological advances in the last two decades have made it possible to substantially reduce mortality, morbidity and disability due to accidents, trauma and poisoning. At present there is no organized comprehensive trauma care service either at the centre or in the state. During the Ninth Plan facilities for the management of accident and trauma care have been strengthened in several hospitals but these have not been linked into an effective multidisciplinary trauma care system. A conceptual model of such a system for Delhi has been prepared.

NINTH PLAN INITIATIVES

Disease Surveillance

64. The Department of Health initiated a pilot project on disease surveillance coordinated by the National Institute of Communicable Diseases in 1997. Initially the project involved strengthening laboratories and setting up a disease surveillance system in 20 districts, and was expanded to cover 100 districts by 2002. Many states have not been able to utilise the funds released or carry out the programme as envisaged. The major disease control programmes continue to have their own vertical surveillance system; of these, only the polio surveillance has a good track record. There is as yet no organised effort to integrate all the ongoing surveillance under various disease control programmes into a single programme for disease surveillance. Common epidemic-prone diseases are still not being monitored locally and reported to district officers for analysis and response.

65. Private sector provides over 75 per cent of curative care for common illnesses, however, data from private health providers is not yet included in any disease surveillance system. In the eighties ICMR funded a research project in Tamil Nadu North Arcot District (NADHI), in which private and government sector practitioners participated. The Kerala government has replicated this model in three districts. The state government proposes to expand this programme to other districts in the Tenth Plan. Efforts will be made to integrate ongoing vertical disease surveillance programme under the National Programme on Disease Surveillance and ensure that surveillance is linked to response at district level.

Infection Control and Waste Management in Health Care Settings

66. There has been increasing concern over the incidence of hospital-acquired infections and accidental infection in health care providers and waste disposers. One of the major new initiatives during the Ninth Plan was improvement of infection control and waste management through appropriate, affordable technology at all levels of health care. In November 1998, the Department of Health has constituted National Hospital Waste Management Committee under the chairmanship of the Secretary, Health, to coordinate and guide policy and programme initiatives in the field. A pilot project was initiated in 11 institutions with assistance from the department. Hospital infection control and waste management is also being taken up as a component of all World Bank-assisted secondary health system projects. Guidelines on hospital waste management were prepared and

circulated to states and union territories in November 2000 for their comments. Some states are providiing funds under the PMGY for infection control and waste management in primary health care institutions. Hospital infection control and waste management should be incorporated as an essential routine activity in all health care institutions at all levels of care during the coming years.

Horizontal Integration of Vertical Programmes

67. Initially, when sufficient infrastructure and manpower were not available for the management of major health problems, several vertical programmes like the NMEP and NLEP were initiated. Over the years,the three-tier health care infrastructure has been established. The Ninth Plan envisaged that efforts should be made to integrate the existing vertical programmes at the district level and ensure that primary health care institutions provide comprehensive health and family welfare services. The pace of horizontal integration has been very slow and uneven. During the Ninth Plan, attempts were made to:

- integrate the activities related to training and IEC under different vertical programmes;
- coordinate the activities for prevention and management of STD/reproductive tract infections (RTI) under the RCH and AIDS control programmes;
- improve coordination between ongoing HIV and TB control programmes; and
- provide leprosy services through the primary health care infrastructure.

68. Some states like Orissa and Himachal Pradesh have formed a single health and family welfare society at the state and district level for implementing all health and family welfare programmes. In some states, middle-level public health programme managers, who are currently heading the vertical programmes at the district-level, are being given the additional task of ensuring coordination and implementation of the integrated health and family welfare programme at primary health care institutions in defined blocks. Their involvement is also expected to operationalise disease surveillance and response mechanism at the district level. The National Health Policy 2002 (NHP2002) envisages a progressive convergence of all health and family welfare programmes under a single field of administration beginning at the district and below-district levels for funding, implementation and monitoring the entire gamut of public health activities.

Health Management Information System (HMIS)

69. HMIS is an essential management tool for effective functioning of the health system. During the Eighth Plan the Central Bureau of Health Intelligence and the state Bureaus of Health Intelligence developed a HMIS system. Under this system, district-level information on morbidity as reported by the government primary health care institutions is sent through National Informatics district computer network. Though some states responded initially, the system has never been fully operationalised. As a result there is no system through which reliable data on morbidity in different districts/ states could be collected and analysed and used for decentralized district based planning. So far, no effort have been made to use the currently available IT tools to build up a comprehensive HMIS and use it to improve efficiency and functional status of the health system. Concrete efforts are required to ensure that effective two way management information system is built up through out the country; all data pertaining to health and family welfare programmes are collected,

collated and reported from all districts and utilized to improve functional status and efficiency of the health system. This real time communication link would provide data on births, deaths, diseases, request for drugs, diagnostics and equipment and status of ongoing programmes through service channels within existing infrastructure, manpower and funding.

Information, Education, Communication and Motivation (IEC&M)

70. An aware and informed population, actively participating in programmes aimed at promoting health, preventing illness, accessing health care at appropriate level is an essential prerequisite for improvement in health status of the country. Health education, which is the major tool for achieving this objective, had received a lot of attention in the 1950s and 1960s. During the development of various centrally sponsored vertical programmes for disease control, family welfare proggramme and state's efforts to build up state specific programme, health education efforts got fragmented. Currently, health education efforts are mostly limited to information provided through mass media and health functionaries on Family Welfare services and disease control programmes. This has resulted in improved awareness of the population who accessed these programmes. However, active participatory health education aimed at motivating the population on life style changes and preventive and promotive health care programmes have not received due attention. Lack of readily available information at household and community level on where to go and whom to access for various health problems continue to remain a major barrier for seeking appropriate care. Health education under various vertical programmes should be integrated, so that health personnel at each level of care provide comprehensive IEC to the population. PRIs and NGOs should be involved in health promotion/education and IEC&M.

Drugs – production, quality and supply

71. Nearly one-third of the health budget at the centre and in the states is spent on providing drugs free of cost in all public health facilities. However, adequate stock of good quality drugs is not available in many of these institutions, and health benefits from treatment are sub optimal. Some of the factors responsible for this include:

- lack of a uniform essential drug list;
- poor quality control;
- problems in the procurement and supply of drugs; and
- the absence of treatment protocols for common diseases leading to unnecessary and irrational drug prescriptions.
- poor compliance with the prescribed regimen due to lack of awareness and counselling.

72. During the Ninth Plan, several state governments (e.g. Tamil Nadu, Delhi and Orissa) have introduced an essential drug programme with the following components:

- development of a drug policy;
- preparation of an essential drug list;
- establishing a quality control and assurance system;

- ☞ pooled procurement system and improvement in logistics of drug supply;
- ☞ improvement in the availability of safe and effective drugs;
- ☞ preparation of standard treatment guidelines and dissemination of information; and
- ☞ providing information about treatment to patients to improve compliance.

During the current year beginning should be made to:

- ☞ cover all states with expanded and strengthened essential drug programme
- ☞ adopt an online computer inventory control programme for the procurement and supply of drugs;
- ☞ establish a system to monitor cost, quality, availability and use of drugs;
- ☞ monitoring of all aspects of drug use including adverse drug reaction.

73. India has a large pool of technically skilled manpower and research infrastructure in both government and private sector laboratories. The Indian pharmaceutical industry has the ability to develop and commercialise chemical processes for a variety of drugs at low cost. However, financial problems and fragmentation of capacities makes production of some bulk drugs uneconomical; this has prevented Indian industry from achieving its full potential, both in the domestic and international market. The existence of nearly 20,000 manufacturing units and poor quality control have led to spurious and poor quality drugs reaching the market. The revised National Drug Policy 2001 had suggested remedial measures. The limit for foreign direct investment in the pharmaceutical sector was increased from 51 per cent to 74 per cent. Several products reserved for production in the public sector were de-reserved. Industrial licensing for all bulk drugs has been abolished except in the case of those produced by the use of recombinant DNA technology and bulk drugs requiring *in-vivo* use of nucleic acids as the active principles.

HEALTH SYSTEMS RESEARCH AND BIO-MEDICAL RESEARCH

74. ICMR is the nodal agency for biomedical health system research in India. Biomedical and health systems research is currently funded by several agencies including the ICMR, the Deparments of Biotechnology, Department of Science and Technology, the Council of Scientific and Industrial Research (CSIR) and the Ministry of Health and Family Welfare. Bio-medical and health systems research is being carried out by research institutions, universities, medical colleges and health service providers.

75. During the Ninth Plan, the major focus was on basic, applied and operational research for improving the quality, coverage, and efficiency of health services. The thrust areas of research included communicable diseases, improvement of the health and nutritional status of women and children and improving contraceptive acceptance and continuation rates. In communicable diseases, research has focused on development of indigenous immuno-diagnostics, improved drug regimens to combat emerging drug resistance among microbes, alternative strategies for vector control to combat increasing insecticide resistance and testing innovative disease control strategies through increased community participation. The major research areas relating to non-communicable diseases included early detection of cervical cancer in women and oral cancer in both sexes, anti-tobacco education, lifestyle modification to reduce the rising morbidity due to hypertension and cardiovascular diseases, documenting the health problems associated with lifestyle changes and increased longevity.

HEALTH SECTOR OUTLAY

76. The health sector is funded by the centre , states and externally assisted projects (in both the Centre and the states).

Externally assisted projects

77. Externally assisted projects initially focused on rural primary health care e.g. India Population Project (IPP) (I to IV, VI & VII) and later also covered urban primary health care (IPP V, VIII). During the 1990s, externally assisted projects for strengthening secondary care institutions were taken up in seven states. The tertiary care institutions have not received much funding from externally-assisted projects, except for individual institutions like Sanjay Gandhi Institute of Medical Education and Research (from Japan).

78. It has been reported that externally assisted projects introduce a project framework, management structures, parameters of expenditure, unit costs and institutional arrangements for monitoring which are very different from the ones already in place under national and state level programmes. The service providers who have worked in the externally assisted projects become de-motivated after the project is completed because similar parameters of expenditure may not be sustainable. It has also been reported that improvement in facilities and equipment through externally assisted projects have not resulted in improved performance. For example, despite the construction of a large number of sub-centres and staff quarters' occupancy remained low and deliveries in these institutions did not go up. States have not been able to provide adequate funds for maintenance of these infrastructure and equipment procured under the EAPs. These aspects and the issue of sustainability of the projects after they are completed need be looked into at the time of deciding areas/schemes for external assistance in the health sector. The mechanisms for repayment of loans when the EAP is in the form of loans is another aspect that has to be considered before EAPs in health sector are initiated.

State Government

79. The state governments provide funds for primary, secondary; tertiary care institutions (including medical colleges and their associated hospitals). State governments also receive funds from centrally sponsored disease control programmes and family welfare programme. Health was one of the priority sectors for which funds were provided during the Ninth Plan as additional central assistance under PMGY. These funds were to be utilised for meeting the essential requirements for operationalising rural primary health care. The ongoing and proposed externally assisted projects provide additional resources.

80. The state-wise outlay and expenditure in the Ninth Plan is shown in Annexure 5.6.5

Central Sector

Funds from the central sector are being utilised for supporting:

- ☞ medical education institutions of excellence;
- ☞ training institution for nurses;
- ☞ vaccine production institutes and special centres for specific diseases;

- ☞ Central Government Health Schemes;
- ☞ emergency relief measures and
- ☞ pilot central sector projects either to demonstrate the feasibility of disease control or for working out strategies for health care.

81. In addition to the domestic budgetary support, external funds have also been obtained for several centrally sponsored disease control programmes. The outlay and expenditure in the Ninth Plan is shown in Annexure 5.6.6

Zero Based Budgeting-2001

82. In November-December 2001 the Planning Commission and the Department of Health had reviewed all the ongoing Ninth Plan schemes/ programmes and undertaken a zero-based budgeting exercise. In the Ninth Plan, there were a total of 91 schemes (22 centrally sponsored schemes and 69 central sector schemes). Of these 45 are being retained, one is being transferred to the states, 38 are being merged into 14 schemes and seven are being weeded out. A total of 59 schemes, with a Ninth Plan outlay of Rs. 5,088.19 crore are continuing during Tenth Plan. The summary of the zero-based budgeting exercise is given in Table 5.6.12. Scheme wise outlays and expenditure during the Ninth Plan period is indicated in Annexure 5.6.5. Department of Health has been provided an outlay of Rs.1550 crores in the Annual Plan 2002-03.

Table 5.6.12

Zero Based Budgeting (Rs. In crores) Exercise 2001
Centrally Sponsored Schemes & Central Sector Schemes

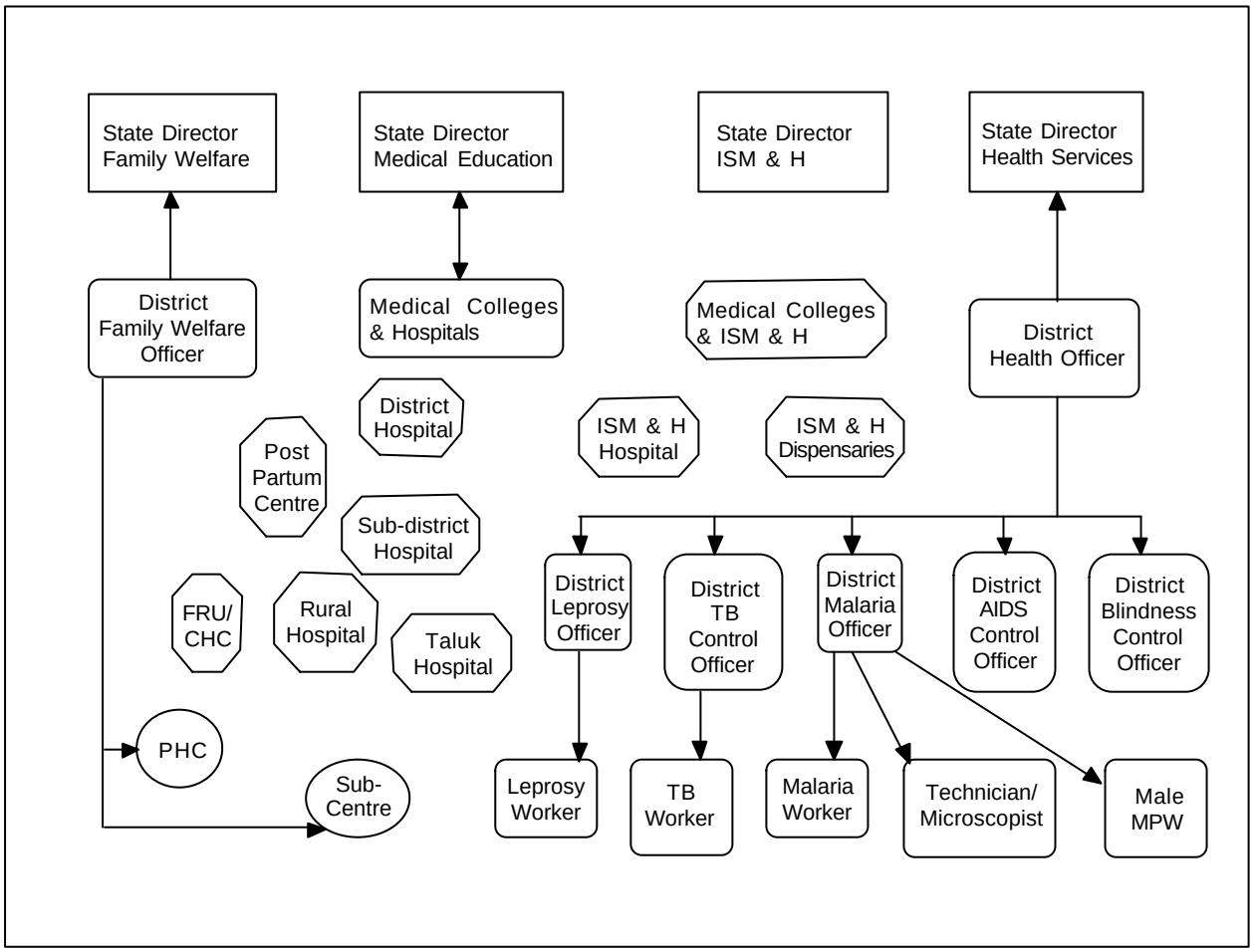
Ninth Plan

Schemes to be	Central sector			Centrally Sponsored		
	No. of Schemes	Outlay	Anticipated Expenditure	No. of Schemes	Outlay	Anticipated Expenditure
Retained	39	995.24	968.39	6	1,984.00	2,055.94
Merged	8/24	766.45	850.73	6/14	1,342.50	1,202.59
Transferred to states	1	4.00	1.88	NIL	NIL	NIL
Weeded out/dropped	5	22.00	5.69	2	4.00	2.98
Total Ninth Plan schemes	69	1787.69	1826.69	22	3,330.50	3,261.51
Continued in Tenth Plan	47	1,761.69	1819.12	12.00	3,326.50	3,258.53

Annexure - 5.6.1

ORGANISATION CHART - I

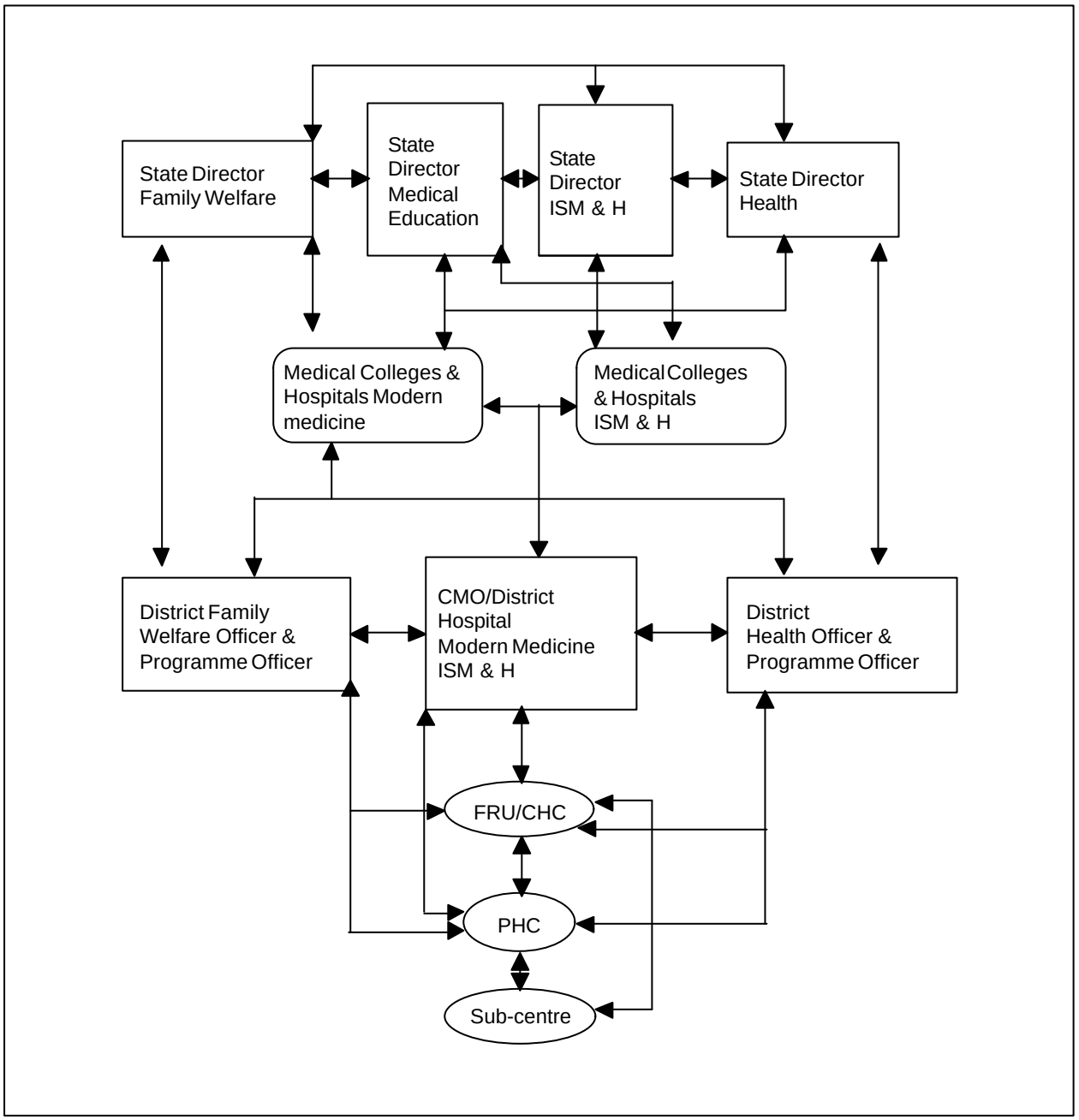
CURRENT STATUS OF HEALTH CARE INFRASTRUCTURE



Annexure - 5.6.2

ORGANISATION CHART - II

PROPOSED REORGANISATION AND LINKAGES



ANNEXURE - 5.6.3

STATE WISE/SYSTEM WISE NO OF HOSPITALS AND DISPENSARIES UNDER MODERN SYSTEM AND ISM & H

	STATES/ UTs	RURAL HEALTH CARE INFRASTRUCTURE									DISPENSARIES**			HOSPITALS**				Urban Family Welfare Centres**		Post Partum Centres**	
		Sub centres			Primary Health Centres			Community Health Centres			Modern System of Medicine @		ISM & H @@	Modern System of Medicine @		ISM & H @@					
		Reqd. 1991	In Position	Goal for the 10th Plan	Reqd. 1991	In Position	Goal for the 10th Plan	Reqd. 1991	In Position	Goal for the 10th Plan	DISPENSARIES	Beds	DISPENSARIES	HOSPITALS	Beds	HOSPITALS	Beds	UFWC	Health Posts	District Level	Sub-district Level
1	ANDHRA PRADESH	10242	10568	*	1707	1386	321	427	219	208	134	0	1930	3133	69778	22	1249	131	-	28	55
2	ARUNACHAL PRADESH	220	273	*	37	65	*	9	20	*	11	0	46	-	-	1	15	6	-	-	1
3	ASSAM	4356	5109	*	726	610	116	181	100	81	325	42	409	268	12661	6	260	10	-	11	30
4	BIHAR	11547	10332	1215	1961	1642	319	490	87	403	427	96	831	328	29090	14	1385	42	-	37	54
5	CHHATISGARH	4692	3818	874	704	545	159	176	150	26											
6	GOA	138	172	*	23	19	4	6	5	1	33	0	115	105	3848	6	245	-	-	4	-
7	GUJARAT	6168	7274	*	1028	1044	*	257	253	4	7255	9289	583	2528	63417	55	2476	113	28	33	55
8	HARYANA	2482	2299	183	414	402	12	103	64	39	130	126	454	80	7230	7	850	19	16	13	20
9	HIMACHAL PRADESH	973	2069	*	162	302	*	40	65	*	173	169	1081	63	5463	18	355	89	-	11	22
10	JAMMU & KASHMIR	1176	1700	*	196	337	*	49	53	*	610	0	445	67	8202	4	235	12	-	11	6
11	JHARKHAND	4278	4462	*	676	561	115	169	47	122											
12	KARNATAKA	6431	8143	*	1072	1676	*	268	249	19	797	1163	642	293	38479	178	8400	87	-	39	64
13	KERALA	4325	5094	*	721	944	*	180	105	75	53	164	3523	2107	97840	182	4031	-	-	22	60
14	MADHYA PRADESH	7430	8835	*	1316	1193	123	329	229	100	256	2	2363	363	18141	47	1810	63	99	47	75
15	MAHARASHTRA	10533	9725	808	1756	1768	*	439	351	88	8143	1622	486	3115	78920	160	18618	74	278	52	69
16	MANIPUR	344	420	*	57	69	*	14	16	*	42	0	10	17	1626	3	75	2	-	3	1
17	MEGHALAYA	464	413	51	77	85	*	19	13	6	21	0	5	9	1828	0	0	1	-	3	1
18	MIZORAM	122	346	*	20	58	*	5	9	*	13	130	2	12	1021	0	0	1	-	2	4
19	NAGALAND	325	302	23	54	46	8	14	9	5	17	68	2	29	1158	0	0	-	-	1	1
20	ORISSA	6374	5927	447	1062	1352	*	265	157	108	1197	282	1104	273	11980	13	473	10	8	19	60
21	PUNJAB	2858	2852	6	476	484	*	119	105	14	1469	5503	629	220	14921	17	956	23	64	19	35
22	RAJASTHAN	7484	9926	*	1247	1674	*	312	263	49	268	134	3689	219	21387	102	1631	61	90	35	100
23	SIKKIM	85	147	*	14	24	*	4	2	2	147	0	2	1	300	0	0	1	-	1	2
24	TAMILNADU	7424	8682	*	1237	1436	*	309	72	237	512	278	396	408	48780	229	2187	65	100	32	87
25	TRIPURA	579	539	40	96	58	38	24	11	13	612	0	96	29	1866	2	30	9	-	1	3
26	UTARANCHAL	1764	1609	155	265	257	8	66	30	36											

Contd....

ANNEXURE - 5.6.3 Contd.....

	STATES/ UTs	RURAL HEALTH CARE INFRASTRUCTURE									DISPENSARIES**			HOSPITALS**							
		Sub centres			Primary Health Centres			Community Health Centres			Modern System of Medicine @		ISM & H @@	Modern System of Medicine @		ISM & H @@		Urban Family Welfare Centres**		Post Partum Centres**	
	1991	Reqd. Position	In the 10th	Goal for 1991	Reqd. Position	In the 10th	Goal for 1991	Reqd. Position	In the 10th	Goal for ARIES	DISPENS	Beds ARIES	DISPENS TALS	HOSPI	Beds TALS	HOSPI	Beds	UFWC Posts	Health Level	District district	Sub-district
28	WEST BENGAL	10356	8126	2230	1726	1262	464	431	99	332	571	0	1153	399	53732	19	1007	111	-	27	55
29	ANDAMAN & NICOBAR ISLANDS	45	100	*	7	18	*	2	4	*	138	0	7	10	901	0	0	-	-	1	-
30	CHANDIGARH	13	13	0	2	0	2	1	1	0	33	0	9	1	500	3	185	3	10	2	-
31	DADRA & NAGAR HAVELI	40	36	4	7	6	1	2	1	1	3	6	2	3	115	2	0	-	-	-	-
32	DAMAN & DIU	12	21	*	2	3	*	1	1	0	28	0	1	3	150	1	5	-	-	-	-
33	DELHI	190	42	148	32	8	24	8		8	490	0	236	77	19345	17	1322	69	28	9	5
34	LAKSHADWEEP	7	14	*	1	4	*		3	*	0	0	6	2	70	0	0	-	-	-	-
35	PONDICHERRY	58	80	*	10	39	*	3	4	*	12	0	21	29	3136	0	0	-	-	3	-
36	CGHS	-	-		-	-	-	-	-	-	241	-	79	-	-	1	25	-	-	-	-
37	CENTRAL RESEARCH COUNCILS		-		-	-	-	-	-	-	-	-	85	-	-	39	930	-	-	-	-
38	M/o RAILWAY	-	-		-	-	-	-	-	-	-	-	162	-	-	0	0	-	-	-	-
39	M/o LABOUR	-	-		-	-	-	-	-	-	-	-	157	-	-	0	0	-	-	-	-
40	M/o COAL	-	-		-	-	-	-	-	-	-	-	28	-	-	0	0	-	-	-	-
	TOTAL	**134108**	**138044**	**8181**	**22349**	**22928**	**1714**	**5587**	**3077**	**2562**	**25911**	**24803**	**23028**	**14926**	**663163**	**2991**	**60251**	**1083**	**871**	**538**	**1012**

* INDICATES SURPLUS INFRASTRUCTURE, INFORMATION AVAILABLE AS ON AUG.2002; @ FOR THE PERIOD 1.1.1998; @@ FOR 1.4.1999; ** INFORMATION AVAILABLE FOR UNDIVIDED BIHAR, MP & UP

NOTE :- - = NIL INFORMATION.

SOURCE: HEALTH INFORMATION OF INDIA, ISM&H IN INDIA AND D/O FAMILY WELFARE; FIGURES ARE PROVISIONAL

Annexure - 5.6.4

MANPOWER REQUIREMENT IN RURAL PRIMARY HEALTH CARE INSTITUTIONS

Category of manpower	Requirement for Census 1991	In position as on 30.06.2000	Number sanctioned	Gap 2-3	Vacant 2-4
1	2	3	4	5	6
Specialists	22348	3741	6579	18607	15769
(4/CHC)					
Doctors at PHCs	22349	25506	29702	3157*	7353*
(1/PHC)					
Block Extension Educator/ Health Educator	22349	5508	6534	16841	15815
(1/PHC)					
Pharmacist	27936	21077	22871	6859	5065
(1/CHC+1/PHC)					
Lab. Technician	27936	12709	15865	15227	12071
(1/CHC+1/PHC)					
X-ray Technician/					
Radiographer	5587	1768	2137	3819	3450
(1/CHC)					
Nurse Midwife	61458	17673	22672	43785	38786
(7/CHC+1/PHC)					
Health Assistant (M)	22349	22265	26427	84	4078*
(1/PHC)					
Health Assistant (FM)	22349	19426	22479	2923	130*
(1/PHC)					
Health Worker (M)	134108	73327	87504	60781	46604
(1/SC)					
Health Worker (FM)	156457	134086	144012	22371	12445
(1/SC+1/PHC)					
TOTAL	**525226**	**337086**	**386782**	**191297**	**138444**

* indicates surplus

Source :- RHS Bulletin, June, 2000 (Ministry of Health & FW)

Annexure - 5.6.5

OUTLAY FOR HEALTH IN THE STATES & UNION TERRITORIES

Rs. Lakhs

STATES	9th Plan	1997-98		1998-99		1999-2000	2000-01	2001-02
	OUTLAY HEALTH	OUTLAY HEALTH	Act. Expd. HEALTH	OUTLAY HEALTH	Act. Expd. HEALTH	OUTLAY HEALTH	OUTLAY HEALTH	OUTLAY HEALTH
ANDHRA PRADESH	63052.00	13937.00	12366.00	20046.00	19865.00	28033.00	27749.95	33223.02
ARUNACHAL PRADESH	33502.00	3149.00	1782.00	3520.00	1814.00	2947.00	2068.93	2476.01
ASSAM	38410.00	6561.00	6223.00	7191.00	6887.00	7741.00	7439.00	12580.00
BIHAR	83200.00	7245.00	4950.00	12177.00	6902.00	12768.00	9891.01	10078.21
GOA	8122.00	1082.00	1032.00	772.00	1069.00	1646.00	1423.00	1649.00
GUJARAT	83225.00	22093.00	17180.00	23550.00	17179.00	25100.00	26000.00	21000.00
HARYANA	35134.00	3882.00	4493.00	5946.00	4126.00	5327.00	5648.00	6595.00
HIMACHAL PRADESH	31765.00	5544.00	6535.00	8965.70	8164.00	10555.00	9685.09	12014.86
J & K	110029.00	7450.00	6989.00	11385.51	8244.00	11974.00	10595.17	11628.32
KARNATAKA	110000.00	18359.00	21914.00	19544.30	22909.00	22774.00	22558.11	26879.60
KERALA	30940.00	6096.00	5828.00	6200.00	7343.00	6400.00	6335.00	5553.00
MADHYA PRADESH	56787.00	9331.00	7031.00	17351.47	14524.00	13524.00	11217.62	13462.62
MAHARASHTRA	91823.00	17391.00	13811.00	22993.00	16224.00	27798.00	30485.85	39128.91
MANIPUR	3600.00	630.00	540.00	809.35	809.00	1080.00	1250.00	1486.00
MEGHALAYA	14000.00	2430.00	1790.00	2430.00	2360.00	3079.00	3300.00	3200.00
MIZORAM	11201.00	1651.00	1651.00	1816.00	1785.00	2286.00	2562.00	2542.00
NAGALAND	10631.00	2506.00	2480.00	2128.00	2022.00	2128.00	1577.00	1283.00
ORISSA	41606.00	4104.00	5198.00	7526.21	7042.00	13208.00	8405.05	14915.16
PUNJAB	51159.00	9938.00	3187.00	16352.00	8374.00	18319.00	19187.00	17465.57
RAJASTHAN	77060.00	13919.00	12339.00	15289.00	10991.00	17262.00	9914.94	12366.30
SIKKIM	8000.00	857.00	757.00	814.00	1914.00	1559.00	1200.00	1373.50
TAMILNADU	78052.00	8909.00	11005.00	11650.93	12843.00	12426.00	12724.42	18084.16
TRIPURA	8559.00	1371.00	1091.00	1407.92	1448.00	1355.00	1442.46	1879.18
UTTAR PRADESH	118500.00	17312.00	15609.00	40551.00	10862.00	42816.00	30200.00	37278.00
WEST BENGAL	97864.00	20633.00	3322.00	19286.00	7811.00	23502.00	32176.00	42931.24
TOTAL STATES	**1296221.00**	**206380.00**	**169103.00**	**279702.39**	**203511.00**	**315607.00**	**295035.60**	**351072.66**
U T s								
A & N ISLANDS	7741.00	1559.00	1831.59	1895.00	2055.29	2000.00	1900.00	1900.00
CHANDIGARH	17065.00	3617.00	3748.90	3548.30	3297.61	3483.00	3717.00	3947.25
D & N HAVELI	514.00	219.00	148.87	252.70	189.82	280.00	217.80	234.80
DAMAN & DIU	887.00	133.00	165.96	173.00	186.91	136.00	150.10	165.00
DELHI	110140.00	15240.50	12684.15	19700.00	13994.62	27345.00	26642.00	34121.00
LAKSHADWEEP	817.46	233.85	267.78	333.00	323.61	229.03	281.45	211.46
PONDICHERRY	10000.00	1630.00	1546.97	2370.00	1921.30	2720.00	2720.00	3160.54
TOTAL UTs	**147164.46**	**22632.35**	**20394.22**	**28272.00**	**21969.16**	**36193.03**	**35628.35**	**43740.05**
GRAND TOTAL	**1443385.46**	**229012.35**	**189497.22**	**307974.39**	**225480.16**	**351800.03**	**330663.95**	**394812.71**
(STATES & UTs)								
CHHATISGARH								**6024.66**
JHARKHAND								
UTTARANCHAL								**5972.00**
GRAND TOTAL (states & UTs) Incl 3 states								**406809.37**

Annexure-5.6.6

OUTLAYS FOR DEPARTMENT OF HEALTH

Rs. Crores

Sl. No.		Name of the Schemes / Institution	9th Plan Allocation	9th Plan Anticipated Expenditure	2002-03 Outlay
9th Plan	**10th Plan**				
		CENTRALLY SPONSORED SCHEMES			
		Control of communicable Diseases:			
1 & 2	1	National Vector Borne Diseases Control Programme (Malaria, Kala-Azar, Filaria, Dengue and J.E.)	1000.00	954.95	235.00
3	2	National Leprosy Eradication Programme.	301.00	388.48	75.00
4	3	National Tuberculosis Control Programme.	450.00	462.73	115.00
5	4	National AIDS Control Programme including Blood Safety Measures and National S.T.D. Control Programme	760.00	745.26	225.00
6		National Guinea Worm Eradication Prog.	2.00	1.29	
7	5	Disease Surveillance Programme	25.00	20.32	10.00
8	6	Hospital Waste Management	2.00	1.79	5.00
		Strengthening of Drug & Food Administration & Control Capacity Building			
9	7	Assistance to States for Capacity Building (drug Quality)	20.00	29.00	20.00
10	8	Capacity Building for drug & PFA	20.00	1.00	1.30
11		Strengthening of State Drug Analytical Laboratories	5.00	5.10	
12		Strengthening of State Drug Control organisations including improvement of their information system and strengthening of enforcement and supporting staff	5.00		
13		Financial Assistance to the States for Strenghening their food testing laboratories	5.00	0.80	
14		Setting up of District Food Inspection Units in the States/UTs including Management Information System		3.16	
		Control/Containment of Non-communicable Diseases:			
15	9	National Programme for Control of Blindness	448.00	464.79	86.00
16 & 17	10	National Cancer Control Programme	190.00	198.14	61.00
18 & 19	11	National Iodine Deficiency Disorders Control Programme.	18.00	14.75	7.00
20	12	National Mental Health Programme	28.00	20.39	30.00
21	13	Drug De-addiction Programme including assistance to States	20.00	26.51	7.00
		Other Programmes			
22	14	UNDP Pilot Initiatives for Community Health		2.50	4.80
					882.10
		Central Sector Schemes:			
		Control of Communicable Diseases:			
1	1	i) National Institute of Communicable Diseases, Delhi (ongoing activities including Guineaworm & Yaws Eradication)	23.00	22.40	12.00
2		ii) Strengthening of Institute	3.70	3.69	
3	2	National Institute of Tuberculosis, Bangalore	1.50	3.78	2.00
4	3	Lala Ram Sarup Institute of T.B. and allied diseases, Mehrauli, Delhi	30.00	27.60	10.00
5	4	Central Leprosy Training & Research Institute Chengalpattu (Tamil Nadu) Regional Institute of Training, Research & Treatment under Leprosy Control Programme:	5.00	3.57	1.00
6	5	(a) R.L.T.R.I., Aska (Orissa)	2.00	0.56	0.40
7	6	(b) R.L.T.R.I., Raipur (M.P.)	2.50	0.71	0.20
8	7	(c) R.L.T.R.I., Gauripur (W.B.)	5.00	4.65	1.50
9	8	B.C.G. Vaccine Laboratory, Guindy, Chennai	5.00	5.80	5.00
10	9	Pasteur Institute of India, Coonoor	5.00	13.10	7.00

Annexure-5.6.6 continu...

Rs. Crores

Sl. No.		Name of the Schemes / Institution	9th Plan Allocation	9th Plan Anticipated Expenditure	2002-03 Outlay
9th Plan	10th Plan				
11	10	Central Research Institute, Kasauli	20.00	21.83	5.00
					44.10
		Hospitals and Dispensaries:			
12	11	Central Government Health Scheme	40.00	47.66	20.00
13	12	Central Institute of Psychiatry, Ranchi	16.00	17.00	8.00
14 & 15	13	All India Institute of Speech & Hearing Mysore, Mysore	8.00	15.21	7.00
16 & 17	14	All India Institute of Physical Medicine & Rehabilitation, Mumbai	15.00	6.71	2.70
18	15	Health Sector Disaster preparedness and Management	3.00	3.00	6.00
19	16	Safdarjung Hospital, New Delhi	103.00	96.36	65.00
20	17	Dr. R.M.L. Hospital, New Delhi	45.00	70.07	25.00
21	18	Institute for Human Behaviour & Allied Sciences, Shahdara, Delhi	10.00	3.00	1.00
					134.70
		Medical Education, Training & Research:			
		(a) Medical Education:			
22 to 25	19	All India Institute of Medical Sciences & Its Allied Departments, New Delhi	340.00	382.47	105.00
26	20	P.G.I.M.E.R., Chandigarh	175.00	162.00	25.00
27	21	J.I.P.M.E.R., Pondicherry	70.00	52.05	15.00
28	22	Lady Harding Medical College & Smt. S.K. Hospital, New Delhi	65.00	30.59	10.00
29	23	Kalawati Saran Childrens Hospital, New Delhi	56.00	49.92	6.00
30	24	Indira Gandhi Institute of Health & Medical Sciences for North East			
		Region at Shilong.	85.00	59.50	60.00
31	25	Kasturba Health Society, Wardha	25.00	38.28	10.00
32	26	V.P. Chest Institute, Delhi	5.00	11.28	8.00
33 & 34	27	i) All India Institute of Hygiene & Public Health, Calcutta	15.00	6.82	3.00
35	28	ii) Serologist & Chemical Examiner to the Government of India, Calcutta	1.25	1.23	0.50
36	29	National Medical Library, New Delhi	15.00	25.12	8.00
37	30	National Academy of Medical Sciences, New Delhi	1.60	1.55	0.50
38	31	National Board of Examinations, New Delhi	0.50	0.77	0.20
39	32	Medical Council of India, New Delhi	3.90	2.78	1.00
40	33	Education Commission of Health Sciences	2.00	0.00	5.00
41	34	N.I.M.H.A.N.S., Bangalore	60.00	80.40	24.00
		(b) Nursing Education:			
42	35	Indian Nursing Councils		0.50	0.40
43 to 47	36	Strengthening/adding seats to existing schools of Nursing	4.50	8.05	20.00
48	37	R.A.K. College of Nursing, New Delhi	3.50	1.53	3.00
49	38	Lady Reading Health School		0.25	0.30
		(c) Research:			
50 to 55	39	Indian Council of Medical Research, New Delhi	263.00	333.37	110.00
		Other Programmes:			
56	40	National Institute of Biological, NOIDA (U.P.)	70.00	63.54	20.00
57	41	Health Education	6.00	3.97	2.20
58	42	Health Intelligence (& Health Accounts)	1.25	1.44	1.90
59	43	Port Health Authority (Including setting up of offices at 8 newly created international airport)	2.00	2.12	1.60
60	44	Strengthening of D.G.H.S.	3.99	7.87	2.00
61	45	Strengthening of (Deptt. under) Ministry			3.00

Annexure-5.6.6 continu...

Rs. Crores

Sl. No.		Name of the Schemes / Institution	9th Plan Allocation	9th Plan Anticipated Expenditure	2002-03 Outlay
9th Plan	10th Plan				
62	46	Prevention of Food Adulteration	20.00	12.63	8.00
63 & 64	47	Central Drug Standard & Control Orgn.	40.00	23.68	15.00
					53.70
		NEW INITIATIVES DURING 10TH PLAN			
	48	**CENTRALLY SPONSORED SCHEMES**			20.00
	49	**CENTRAL SECTOR SCHEMES:**			0.50
					20.50
					1550.00
		SCHEMES THAT ARE EITHER TRANSFERRED OR DROPPED			
65		Rural Health Training Centre, Najafgarh	4.00	1.78	
66		Tejpur Mental Hospital			
67		Assistance to Voluntary Organisations			
		(a) Improvement of Medical Services	10.00	1.08	
		(b) Special Health Scheme for rural areas			
68		Continuing Education of Model Teachers	1.00	0.93	
69		Training of Medical Officers of C.H.S. Cadre	0.50	0.42	
		Total	**5118.19**	**5280.49**	

5.7 FAMILY WELFARE

India, the second most populous country in the world having a meagre 2.4% of the world's surface area sustains 16.7% of the world's population. Realising the inevitable high population growth during the initial phases of demographic transition and the need to accelerate the pace of the transition, India became the first country in the world to formulate a National Family Planning Programme in 1952, with the objective of "reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy". The First Five Year Plan stated "The main appeal for family planning is based on considerations of health and welfare of the family. Family limitation or spacing of children is necessary and desirable in order to secure better health for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form part of the public health programme". Thus the key elements of health care to women and children and provision of contraceptive services have been the focus of India's health services right from the time of India's independence. Successive Five Year Plans have been providing the policy framework and funding for planned development of nationwide health care infrastructure and manpower to deliver these services. The centrally sponsored and 100% centrally funded Family Welfare Programme provides the States additional infrastructure, manpower and consumables needed for improving health status of women and children and to meet all the felt needs for fertility regulation.

2 Demographic transition is an universal phenomenon. During initial phases of transition population growth is inevitable. The technological advances and improved quality and coverage of health care resulted in a rapid fall in Crude Death Rate (CDR) from 25.1 in 1951 to 9.8 in 1991. In contrast, the decline in Crude Birth Rate (CBR) has been less steep, from 40.8 in 1951 to 29.5 in 1991. As a result, the annual exponential population growth rate has been over 2% in the period between 1971-1991. The pace of demographic transition in India has been relatively slow but steady. Census 1991 showed after three decades the population growth rate declined below 2%. In order to give a new thrust and dynamism to the Family Welfare Programme and achieve a more rapid decline in birthrate, death rate and population growth rate in the last decade of the century, the National Development Council (NDC) set up a Sub-Committee on Population and endorsed its recommendations in 1993. During the Ninth Plan period, the Department of Family Welfare implemented the recommendations of the NDC Sub Committee.

3 Currently some of the major areas of concern include:

- ☞ the massive inter-state differences in fertility and mortality; fertility and mortality rates are high in the most populous states, where nearly half the country's population lives.
- ☞ gaps in infrastructure, manpower and equipment and mismatch between infrastructure and manpower in primary health centres (PHCs)/community health centres (CHCs); lack of referral services;
- ☞ slow decline in mortality during the 1990s; the goals set for mortality and fertility in the Ninth Plan will not be achieved;
- ☞ there has been no decline in the maternal mortality ratios over the last three decades, while neonatal and infant mortality rates have plateaued during the 1990s;

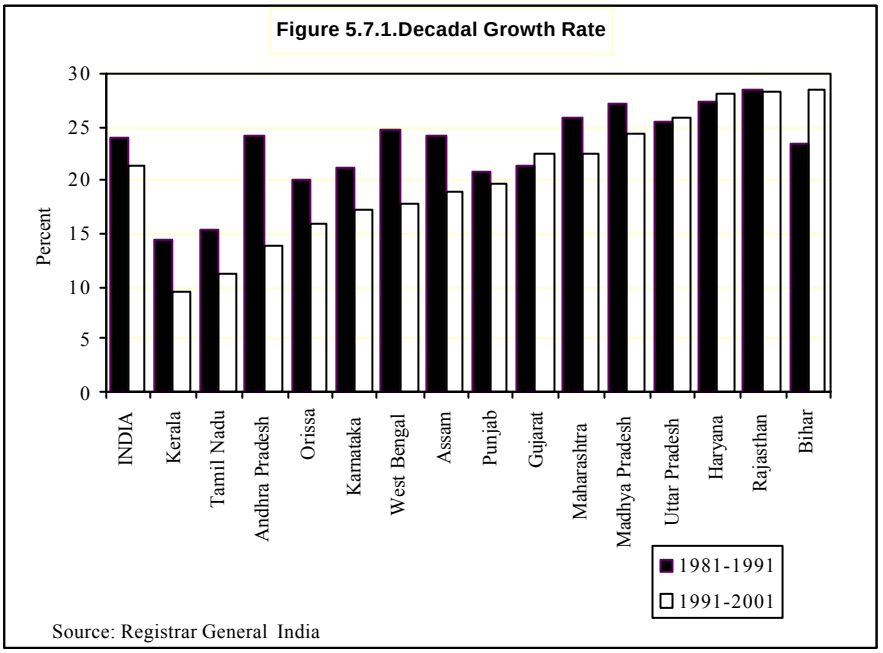
- ☞ the routine service coverage has declined, perhaps because of the emphasis on campaign mode operations for individual components of the programme;
- ☞ in spite of the emphasis on training to improve skills for the delivery of integrated reproductive and child health (RCH) services, the progress in in-service training has been very slow and the anticipated improvement in the content and quality of care has not taken place;
- ☞ evaluation studies have shown that the coverage under immunisation is not universal even in the best performing states while coverage rates are very low in states like Bihar; elimination of polio is yet to be achieved;
- ☞ the logistics of drug supply has improved in some states but remains poor in populous states;
- ☞ decentralised district-based planning, monitoring and mid-course correction utilising the locally generated service data and Civil Registration has not yet been operationalised .

These problems are being addressed expeditiously so that the goals set in the National Population Policy and the Approach Paper to the Tenth Plan could be achieved within the time frame.

Census 2001

4 Census 2001 recorded that the population of the country was 1027 million-15 million more than the population projected for 2001 by the Technical Group on Population Projections. The decadal growth during 1991-2001 was 21.34% (decadal growth in 1981-91 was 23.86%). Andhra Pradesh has shown an impressive fall in growth rate by over 10 percentage points within a short span of a decade during nineties. The growth rate in Bihar has shown an upward swing during 1991-2001; the growth rates in Rajasthan, UP and MP are now at a level where Kerala and Tamil Nadu were 40 years ago (Figure 5.7.1).

Figure 5.7.1.Decadal Growth Rate



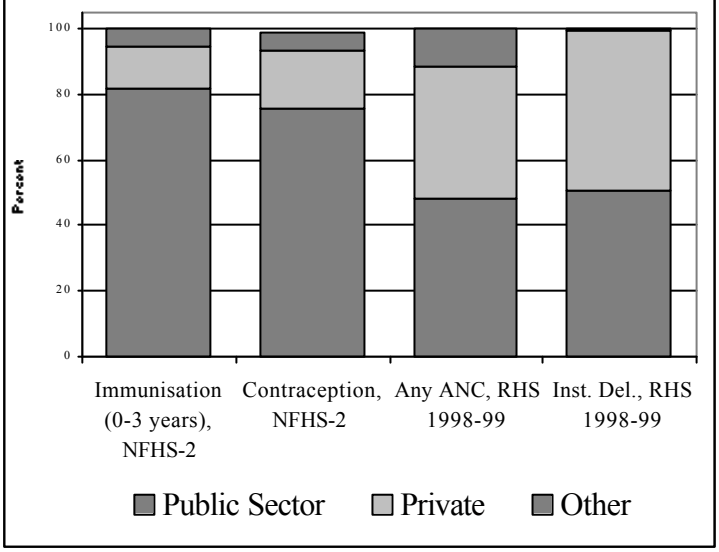
Source: Registrar General India

PROGRESS ACHIEVED DURING THE NINTH PLAN

5 During the Ninth Plan period the Dept. of Family Welfare has implemented the recommendations of the NDC Sub committee on Population; the centrally defined methods specific targets for family planning were abolished; emphasis shifted to decentralized planning at district level, based on community needs assessment and implementation of programmes aimed at fulfillment of these needs. A massive pulse polio campaign was taken up to eliminate polio from the country. The Department of Family Welfare set up a Consultative Committee to suggest appropriate restructuring and revision of norms for infrastructure funded by the states and the Center and has initiated implementation of the recommendations. Monitoring and evaluation have become part and parcel of the Family Welfare Programmes and the data is used for midcourse corrections The National Population Policy was formulated and the National Commission on Population was constituted in 2000.

6 Review of the FW programme has shown that Governmental network provides most of the MCH and contraceptive care (NFHS 1998-99). However, the utilization of public facilities is low when it is for ambulatory care for management of minor ailments. (Figure 5.7.2)

Figure-5.7.2 Source of MCH & FP Care



7 In view of the massive inter-state and inter-district differences in demographic indices in the availability and access to family welfare services, the Department of Family Welfare during the Ninth Plan embarked on decentralized district based area specific need assessment and programmes for fulfilling the needs (CNA approach). RCH programme was aimed at providing integrated good quality maternal, child health and contraceptive care. It was expected that these initiatives would lead to substantial improvement in the coverage and quality of services. The Department of Family Welfare was given additional outlay to enable them to provide adequate financial inputs to the states so that they can implement the programme as envisaged. Goals for the Ninth Plan were projected on the basis of these assumptions.

8 The health systems in the states required longer time to adapt to decentralised planning and RCH programme implementation. In an attempt to improve coverage under specific components of the RCH programme, some states embarked on campaign mode operations, which took their toll on routine services. Efforts to eliminate polio by the winter of 2000 through massive pulse polio campaign also had some adverse effect on routine immunisation delivery services. As a result of all these it is unlikely that Ninth Plan goals for CBR, Couple Protection Rate, Maternal Mortality Ratio and Infant Mortality Rate will be achieved (Annexure 5.7.1). However, the country is likely to achieve elimination of polio by 2004.

9 Independent surveys have shown that several states have achieved goals set for some aspect of the RCH programme during the Ninth Plan, demonstrating that these can be achieved with in the existing infrastructure, manpower and inputs. For instance :

- ☞ Andhra Pradesh, Punjab, West Bengal and Maharashtra have shown substantial decline in birth rates; the latter three states are likely to achieve replacement level of fertility, ahead of the projection made.

- ☞ Punjab has achieved couple protection rate and use of spacing methods far ahead of all other states

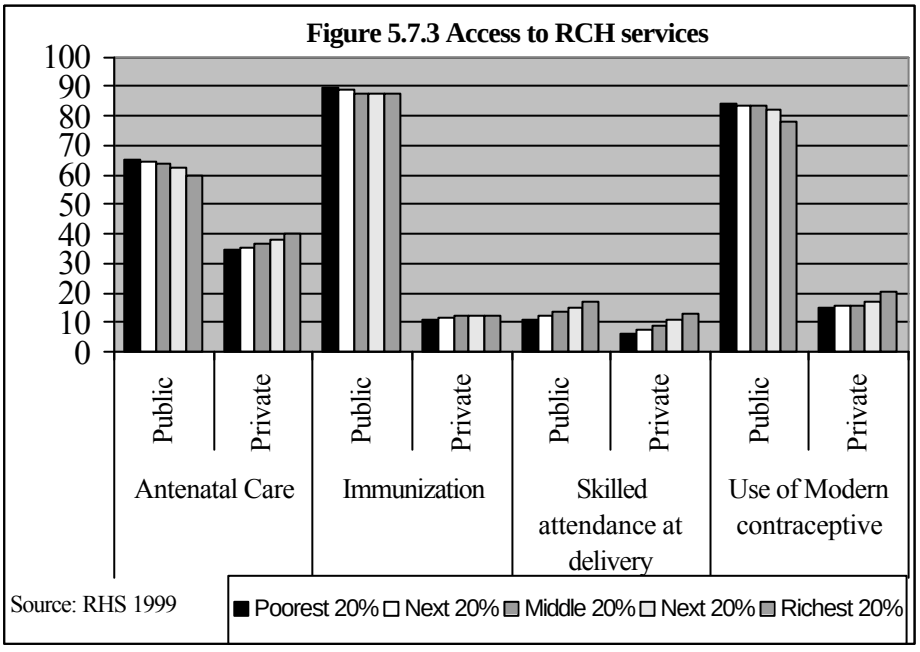
- ☞ In Tamil Nadu and Andhra Pradesh there has been substantial increase in institutional deliveries

- ☞ Kerala, Maharastra, Punjab and Tamil Nadu improved immunization coverage

- ☞ Tamil Nadu and Andhra Pradesh had achieved improvement in coverage and quality of Antenatal care

10 Analysis of data from service reports as well as surveys (NFHS 1&2 and RHS) have shown that in spite of the fact that family welfare services are being provided free of cost to all, there are substantial differences between income groups in accessing these services in public and private facilities (Figure 5.7.3). There were clear urban rural differences in the pattern of utilization of services. Evidence of gender bias existed in almost all states ranging from differences in contraceptive acceptance, care given to girl child during illness to adverse sex ratio at birth. During the Tenth Plan period, Family Welfare Programme will provide equitable access to these services to all irrespective of place of residence, socio-economic status and gender.

Figure 5.7.3 Access to RCH services



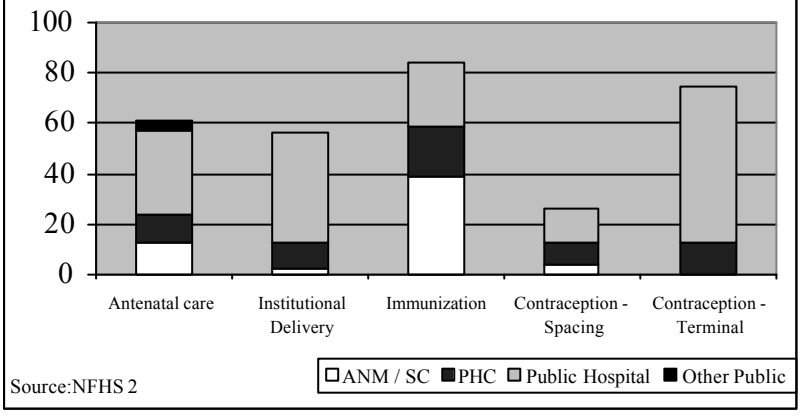
11 Irrespective of income group the pattern of access to specific services were similar. In all income groups: Nearly 90% of those getting immunized; Over 80% of those who accepted contraception; and over 60% of those who had antenatal care used public

facilities. In sharp contrast all income groups sought private practitioners for ambulatory care for minor ailments. This perhaps reflects the people's perception about the quality and availability of services in public facility.

12 Analyses of pattern of utilization of public health facilities for RCH care shows (Figure 5.7.4) :

- ☞ Over 40% of the immunization is given by the ANM and about 20% in provided at the PHC
- ☞ ANM provides only 10% of antenatal care; PHC provides another 10%
- ☞ Larger hospitals account for most of the antenatal care ,institutional delivery and terminal methods of contraception

Figure 5.7.4 Use of Public Health Facilities for RCH services



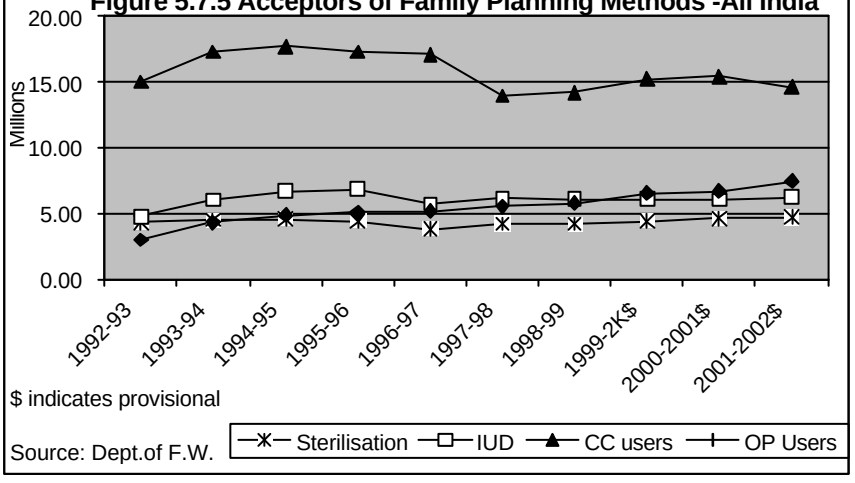
Source:NFHS 2

People's perception of the quality & availability of services in public is perhaps reflected through this. It is important to provide training to ANM's for undertaking appropriate antenatal screening of all women. Special efforts will be made during the next few years to improve access to all components of RCH care and ensure that all unmet needs for family welfare services are met.

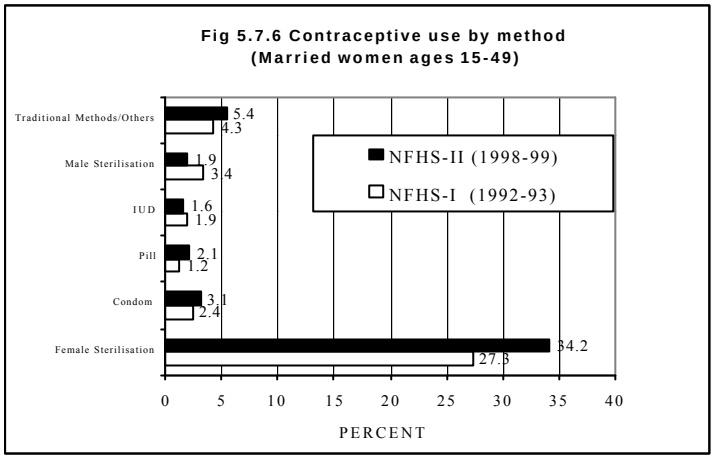
PREVENTION OF UNWANTED PREGNANCY

13 Data from service reports of Department of Family Welfare indicates that following an initial dip in the first two years of the Ninth Plan period, the acceptance of contraception improved. However throughout the Ninth plan period the reported numbers of new acceptors were lower than the reported levels in 1995-96 (Figure 5.7.5). This could partly be due to the fact that from 1996-97 the department of family welfare did not lay down method specification targets for

Figure 5.7.5 Acceptors of Family Planning Methods -All India

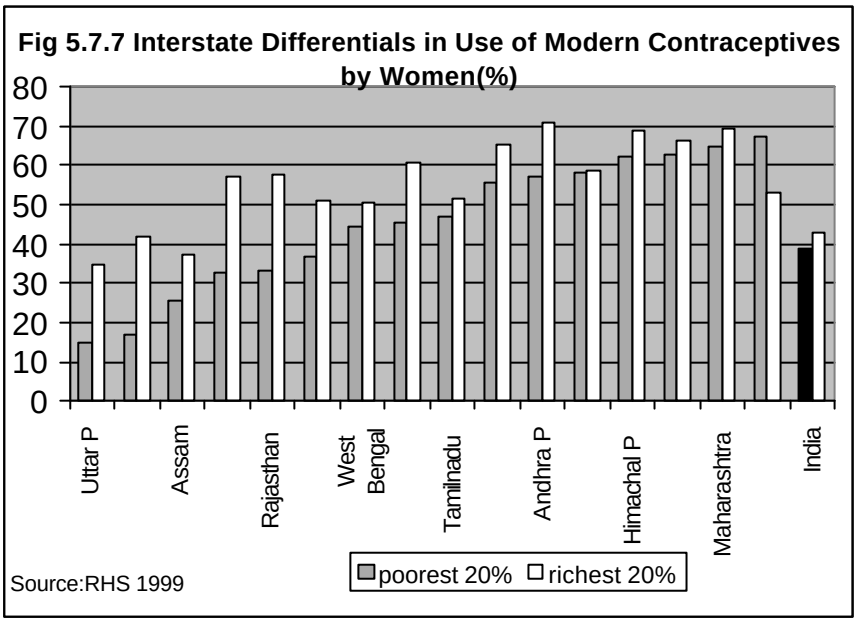


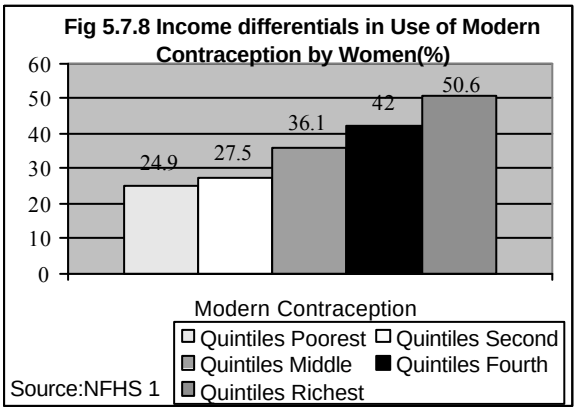
Source: Dept.of F.W.

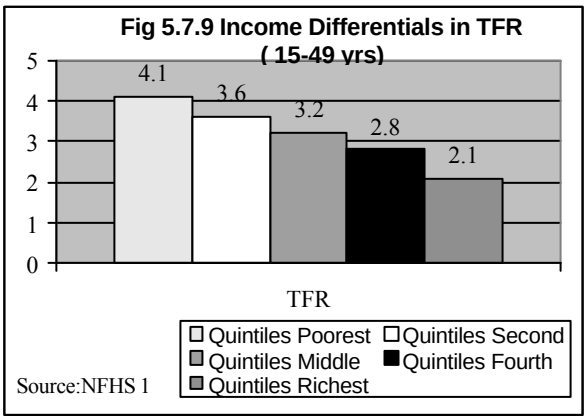


contraception and hence, the workers did not strive to achieve the goals. This could also be partly due to the fact that over reporting has declined. Data from NFHS I and II clearly indicate that over the 1990s there has not been a decline in acceptance of contraception except IUD (Figure5.7.6). This is in line with the decline in birth rate reported in SRS.

14 At all India level there is very little difference in contraceptive prevalence between the richest and poorest quintile population. This perhaps is because over 80% of population access contraceptive services in government institutions where these services are readily available free of cost. There are substantial differences in contraceptive prevalence between states (Figure 5.7.7). In all states except Kerala acceptance of contraception was higher among the richest quintile as compared to the poorest quintile. In states like Himachal Pradesh, Tamil Nadu, Karnataka and Maharashtra there is no significant difference in contraceptive prevalence between lowest & highest income groups. Improved access to, and utilization of contraceptive services especially to



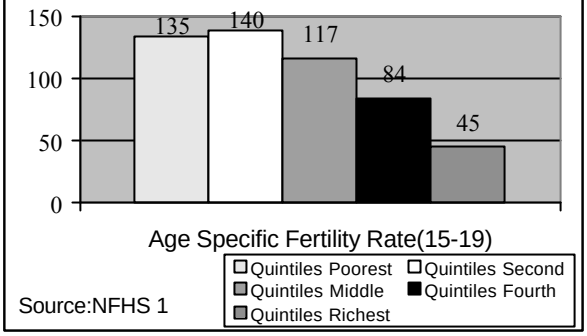




the poorer segments in the states of UP, Bihar, Assam, MP and Orissa is urgently needed in order to meet all the unmet needs for contraception and achieve substantial decline in fertility.

15 Data from RHS survey(1998-99) indicates that among women acceptance of contraception is higher and TFR lower with increasing income with highest quintile group having the highest CPR and lowest TFR. (Figure 5.7.8 & 5.7.9) There are substantial differences between income groups in age specific fertility in the 15-19 age group. Fertility is lowest among the richest quintile perhaps because of relatively later age of marriage (Figure 5.7.10).

Fig 5.7.10 Income Differentials in Age Specific Fertility Rate (15-19 yrs)



16 Age specific fertility in 15 – 19 yrs age group was higher among rural girls in all income groups. Both in urban and in rural areas age specific fertility in this age group was lower among the richest quintile. These differences could be perhaps due to delay in age at marriage (Figure 5.7.11).

Fig 5.7.11 Urban Rural Difference in Age Specific Fertility Rate (15- 19 yrs)

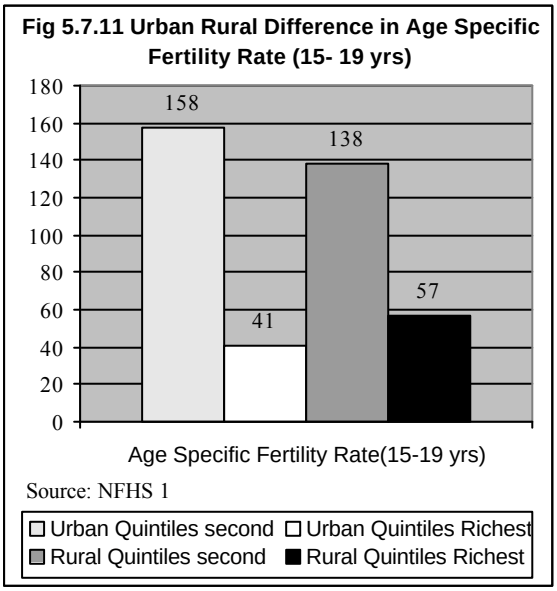
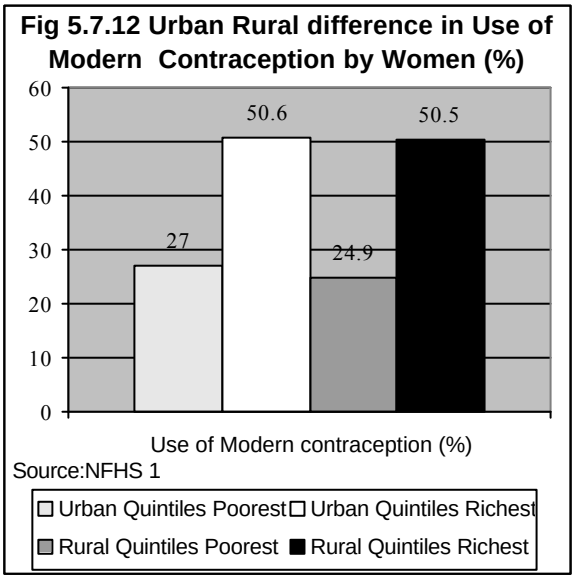


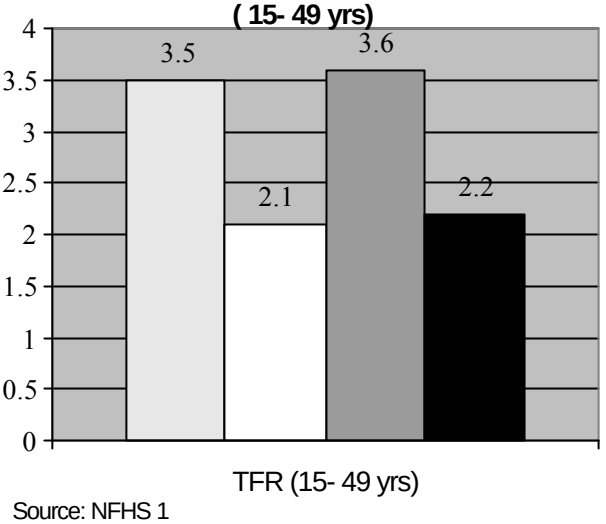
Fig 5.7.12 Urban Rural difference in Use of Modern Contraception by Women (%)



17 There are no significant differences in CPR between urban and rural women. Both in urban and in rural areas the highest quintile income group had CPR level nearly double that of the lowest quintile group. Improving access to good quality modern contraceptive care to women in all states in both urban and rural areas irrespective of economic status will enable the country to rapidly meet all unmet needs for contraception ,improve CPR and reduce birth rate(Figure 5.7.12).

18 The richest quintile group both in urban and rural areas have reached replacement level of fertility. TFR in the second lowest quintile is nearly double that of the highest quintile, with a small difference between urban and rural areas. It would appear that in spite of the fact that contraceptive care is available free of cost substantial proportion of poor do not access the services(Figure 5.7.13).

Fig 5.7.13 Urban Rural difference In TFR (15- 49 yrs)

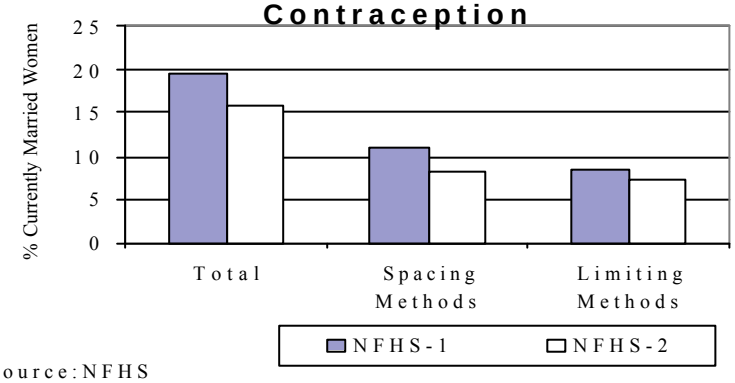


Source: NFHS 1

Unmet Needs for Contraception

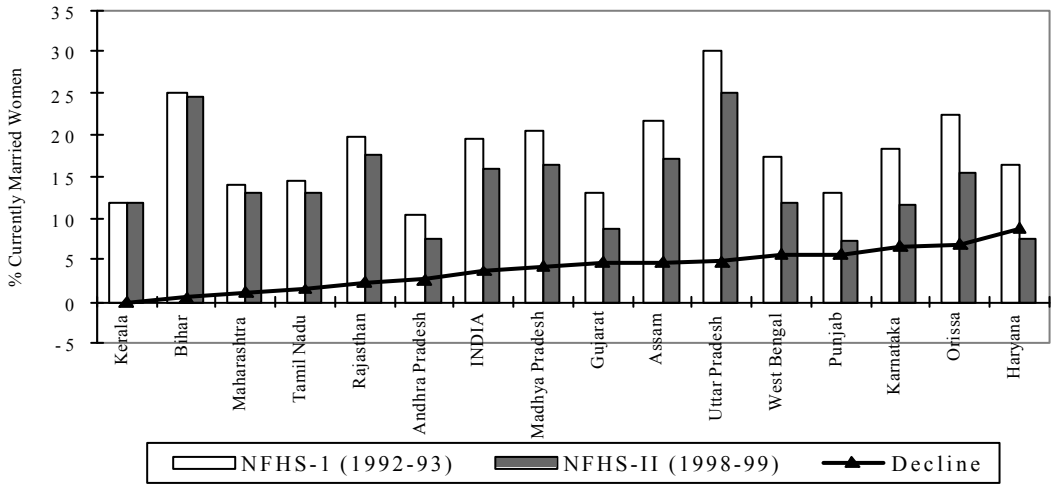
19 NFHS 1 and 2 (Figure 5.7.14) clearly indicate that there is still substantial unmet need for both terminal methods and spacing methods in all states. There are inter-state differences in the magnitude of unmet need for contraception (Figure 5.7.15.). It is imperative that all the unmet needs are fully met within the Tenth Plan period and a substantial reduction in unwanted pregnancy is achieved. Making a balanced presentation of advantages and disadvantages of methods, improving counselling, quality of services and follow up care

Fig 5.7.14 Unmet Need for Contraception



Source:NFHS

Fig 5.7.15 Unmet Need for Family Planning



will enable couples to make appropriate choices regarding contraception, increase couple protection rates and continuation rates and enable the country to achieve the goal of replacement level of fertility by 2010.

Monitoring Birth Order

Table 5.7.1 : Inter-district variations

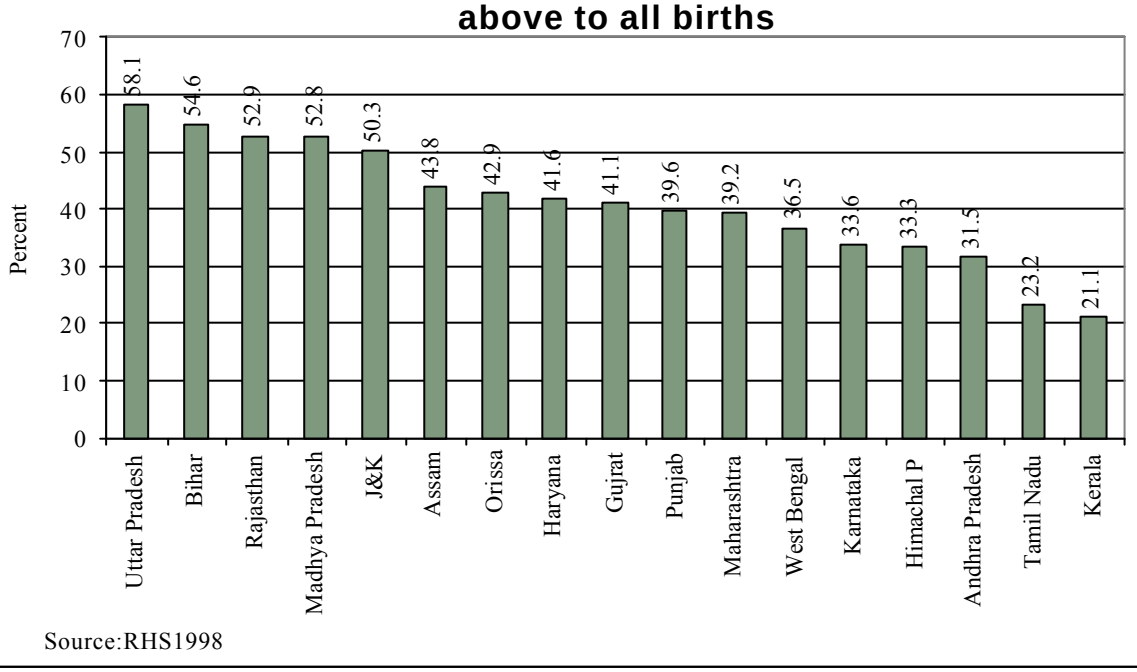
(Birth order three or more as percentage of total births**)**

<20%	27
20-40%	165
>40%	313

Source : RHS 1998-99

20 Monitoring reported birth order is an easy method of observing the progress towards achievement of replacement level of fertility. Currently, birth order of three or more account for nearly half of all births. There are massive inter-state and inter-district differences in the contribution of different birth orders (Table 5.7.1 and Figure 5.7.16). Based on this information, district-specific differential strategies can be evolved to improve contraceptive prevalence rates, increase inter-birth intervals and reduce higher order of births.

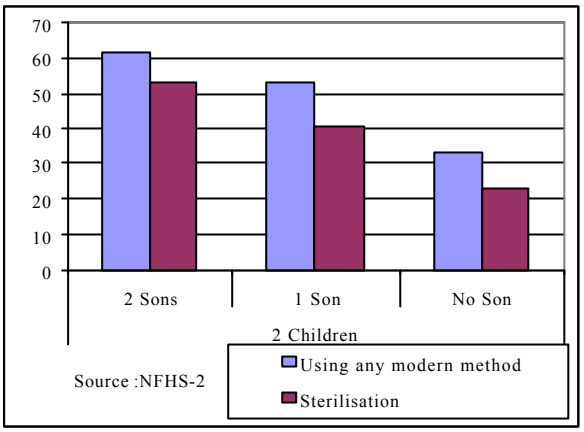
Fig 5.7.16 Contribution of births of order of three and above to all births

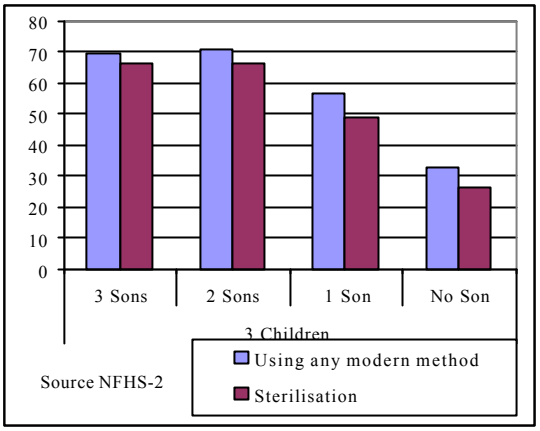


Gender–Bias and Acceptance of Contraception

21 Data from NFHS showed that the preference for a son influenced the acceptance of permanent as well as temporary methods of contraception (Figures 5.7.17 & 18). It is important that appropriate steps are taken by all concerned sectors to minimise and eliminate gender-bias which reduces contraceptive acceptance among those with girl children.

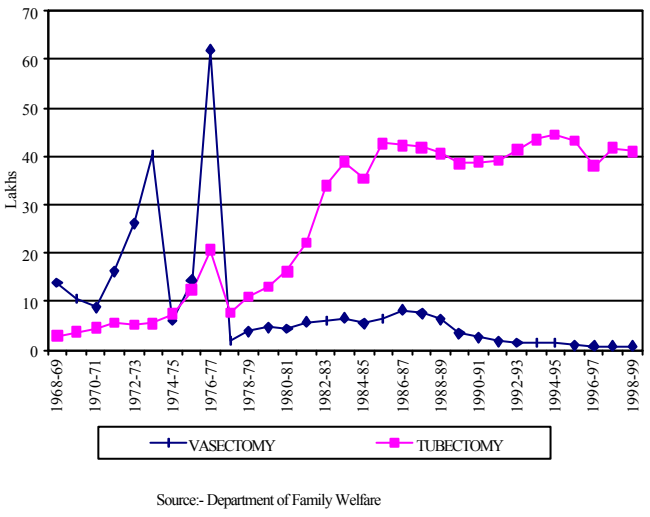
Fig 5.7.17 & 18 Acceptance of Family Planning by Number of Living Children & Their Sex





Men's Participation in Planned Parenthood

Fig 5.7.19 Acceptors of Vasectomy & Tubectomy

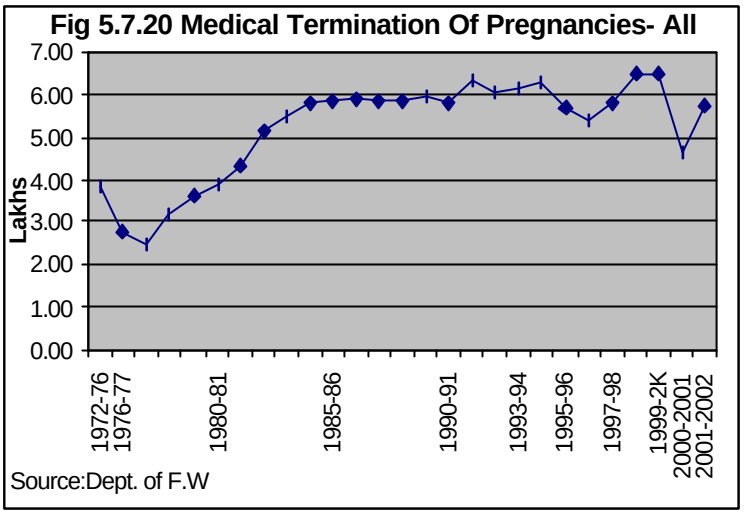


Source:- Department of Family Welfare

22 Men play an important role in determining education and employment status, age at marriage, family formation pattern, access to and utilisation of health and family welfare services for women and children. Their active co-operation is essential for the prevention and control of STI/RTI. In condom users, consistent and correct use is an essential pre-requisite for prevention of STI as well as pregnancy. Vasectomy was the most widely used terminal method of contraception in the 1960s and 1970s but since then there has been a steep decline in its use (Figure 5.7.19). It is essential that efforts to re-popularize vasectomy are intensified. Ample data exists to show that vasectomy is safer than tubectomy. Every effort will be made to repopularise vasectomy by improving access to vasectomy services. These services (conventional or no-scalpel) will be made readily available to all at convenient times as an outpatient procedure in all primary, secondary and tertiary care institutions. Follow up care will be provided to all taking into account the existing time constraints and the conveniences of men. Efforts will be made to seek men 's active participation in improving utilization of funds provided for emergency transport and ensuring that women and children reach appropriate centers where emergency services are available. Their cooperation will be sought in improving antenatal ,child health and immunization care as well as compliance with referrals. Over the next five years efforts will be made to ensure men's participation in every facet of planned parenthood activities

MANAGEMENT OF UNWANTED PREGNANCY

23 It is estimated that in 1998, about 9 per cent of maternal deaths were due to unsafe abortions. Available service data on MTPs indicate that following an initial rise in early 1980s, the number of reported MTP's hovered around 0.5 – 0.7 million in the 1990s (Figure 5.7.20). The estimated number of illegal induced abortions in the country is in the range of four to six million. There has not been any substantial decline in the estimated number of illegal abortions, reported morbidity due to illegal abortions or share of illegal abortions as the cause of maternal mortality. The management of unwanted pregnancy through early and safe MTP services as envisaged under the MTP Act is an important component of the ongoing RCH programme



24 During the Ninth Plan efforts were made to:

- improve access to family planning services and reduce the number of unwanted pregnancies;
- cater to the demand for MTP;
- improve access to safe abortion services by training physicians in MTP and recognising and strengthening institutions providing these safe abortion services; and
- decentralise registration of institutions to the district level.

25 In spite of these efforts, there has not been any increase in terms of coverage, number of MTPs reported and reduction in the number of women suffering adverse health consequences of illegal induced abortions. In order to reduce the morbidity due to induced abortion the following steps are being taken:

- reducing the number of pregnancies by fully meeting the felt but unmet needs for contraception;
- improving access to safe MTP services through:
  - ensuring the availability of MTP services in all institutions where there is a qualified gynaecologist and adequate infrastructure;
  - decentralising registration of MTP clinics to district level;
  - simplifying the regulations for reporting of MTP;

- ☞ training physicians working in well-equipped institutions in the government, private and voluntary sector in MTP so that they also can provide safe abortion services;
- ☞ providing manual vacuum aspiration (MVA) syringes in recognised MTP centers where there is a trained physician but no vacuum aspiration machine;
- ☞ using MVA for performing MTP in CHC / PHC , when a gynaecologist visits the CHCs/PHCs on a fixed day; and
- ☞ exploring the feasibility and safety of introducing non-surgical methods of MTP in medical college hospitals and extending the service in a phased manner to district hospitals.

➢ Ensuring that women do accept appropriate contraception at the time of MTP to prevent unwanted pregnancy requiring a repeat MTP.

MATERNAL HEALTH

26. The prevailing high rates of maternal morbidity and mortality have always been a source of concern, and antenatal and intrapartum care aimed at reducing these have been components of the National Family Welfare programme since its inception. Although data on state/district-specific maternal morbidity/mortality is not available, available figures from the SRS and the Survey of Causes of Death provide sufficient information on mortality rates and causes of death so that rational programmes could be evolved to combat major health problems in women. In the 1990s, the SRS and the NFHS1&2 provided independent data to assess the impact of ongoing programmes on maternal mortality. During the 1990s, there has not been any decline in MMR and more than 100,000 women continue to die each year due to pregnancy-related causes. (Table 5.7.2)

Table 5.7.2 : Maternal Mortality Ratio

	1992-93	1997	1998
RGI (Sample Registration. Scheme)	NA	408	407
National Family Health Surveys	424*	-	540*

*Differences are not statistically significant

Source : RGI & NFHS 1& 2

27 Data from SRS indicate that the major causes of maternal mortality continue to be unsafe abortions, antepartum and post-partum haemorrhage, anaemia, obstructed labour, hypertensive disorders and post-partum sepsis. There has been no major change in the causes of maternal mortality over years (Table 5.7.3). Increasing access to safe abortion services can prevent deaths due to abortion. Deaths due to anaemia, obstructed labour, hypertensive disorders and sepsis can be prevented by improving the access of essential obstetric care,universal screening for

Table 5.7.3:

Causes of maternal death (%)

Haemorrhage	30
Anaemia	19
Sepsis	16
Obstructed labor	10
Abortion	8
Toxemia	8
Others	8

Source: Survey of Causes of Death 1998

detection of obstetric problems, referral and timely treatment of complications of pregnancy, promoting institutional delivery and postnatal care. Emergency obstetric services will help saving lives of women with haemorrhage during pregnancy or complications during deliveries. The Ninth Plan envisaged universal screening of all pregnant women, identification of women with health problems, problems during pregnancy and appropriate management including referral to centers where appropriate care is available. This, however, has not been operationalised; highest priority will be accorded to operationalise this during the tenth plan.

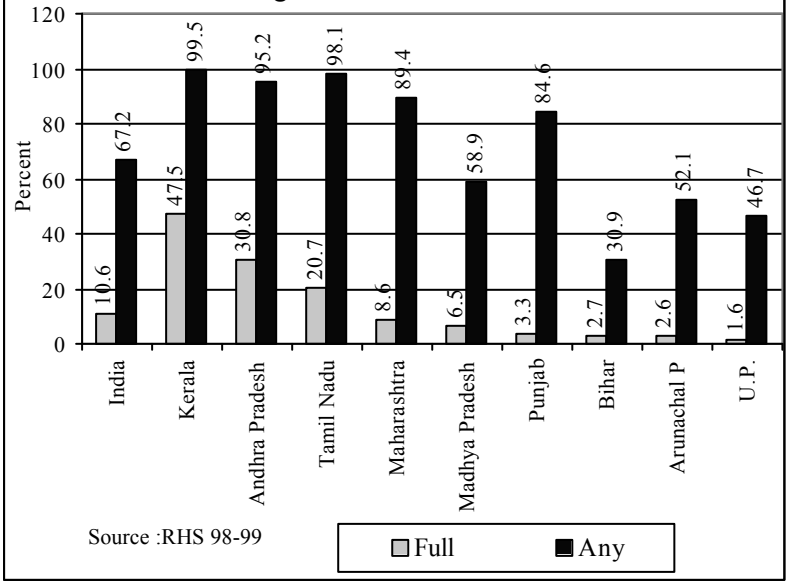
Antenatal Care

28 Under the RCH programmes, efforts were made to improve the coverage; content and quality of antenatal care in order to achieve substantial reduction in maternal and perinatal morbidity and mortality. Data from the rapid household Survey (RHS), 1998-1999 indicates that at the national level, 67.2 per cent pregnant women received at least one check-up but only 10.6 per cent had three antenatal checkups. Antenatal coverage in populous states with poor health indices such as Uttar Pradesh, Bihar and Madhya Pradesh are very low (Figure5.7.21). Antenatal coverage was good in almost all districts of Andhra Pradesh, Tamil Nadu and Kerala. Surprisingly, most districts in Punjab reported very low coverage. (Figure5.7.22)

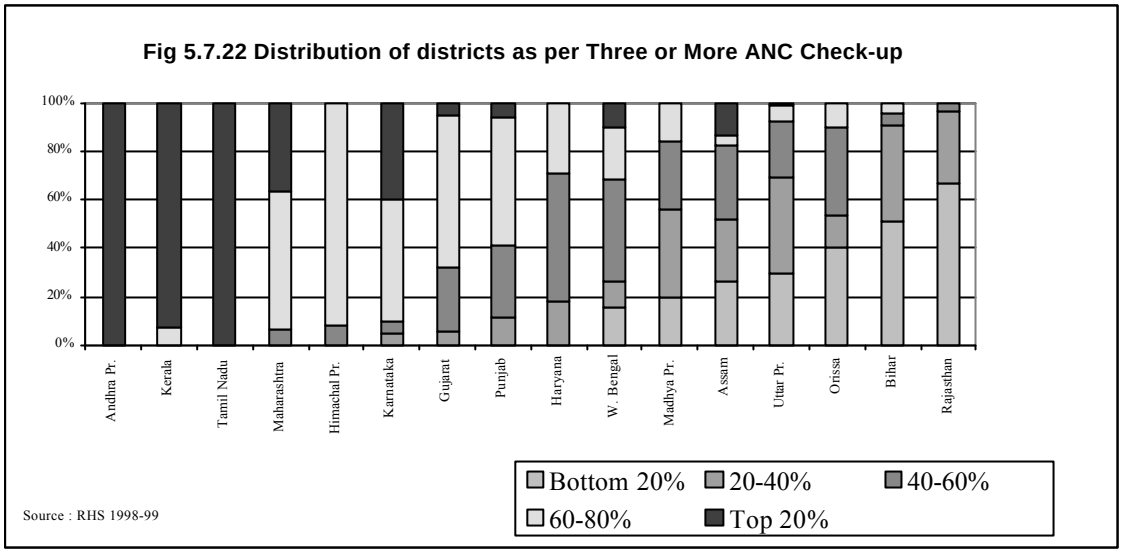
Antenatal Care

- Early registration of pregnancy (12 - 16 weeks).
- Minimum three ante-natal check-ups.
- Screening all pregnant women for major health, nutritional and obstetric problems.
- Identification of women with health problems/ complications, providing prompt and effective treatment including referral wherever required.
- Universal coverage of all pregnant women with TT immunisation.
- Screening for anaemia ; providing iron folic acid tablets for prevention of anemia; providing appropriate treatmentfor anemia.
- Advice on food, nutrition and rest.
- Promotion of institutional delivery / safe deliveries by trained personnel; advising institutional delivery for those with health / obstetric problems.

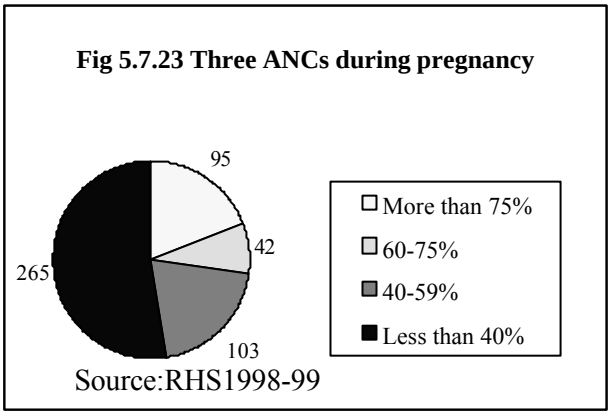
Fig 5.7.21 Antenatal Care



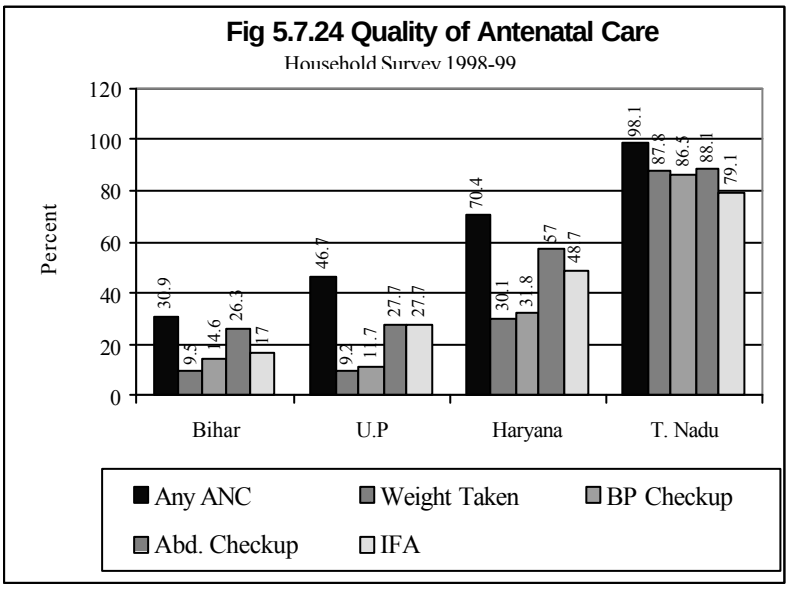
29 RHS data clearly indicates that only in 95 districts more than 75 per cent women had three antenatal visits during pregnancy. In as many as 265 districts, less than 40 per cent of the women had three antenatal visits



(Figure5.7.23). In Uttar Pradesh and Bihar, the content and quality of antenatal care was poor as compared to Haryana and Tamil Nadu Universal screening of pregnant women using appropriate antenatal care is essential for the detection of problems and risk factors during pregnancy and referral to appropriate facility for treatment. (Figure 5.7.24)



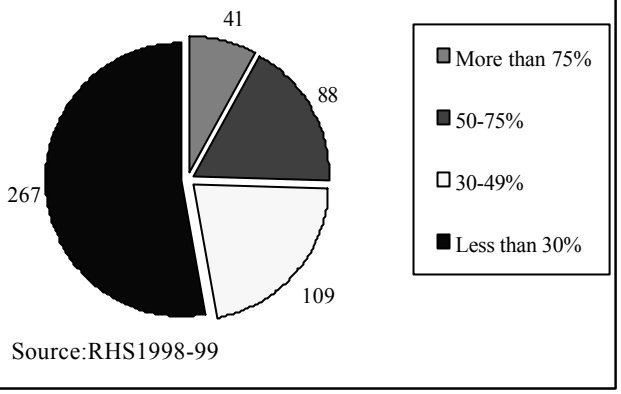
30 The problem of poor screening is aggravated by the fact that referral linkages for the management of problems are also poor in these states and, as a result, both maternal/perinatal morbidity and mortality continue to be high.



31 Anaemia is a major cause of maternal mortality in India. The Ninth Plan envisaged universal screening for anaemia in pregnant women and appropriate iron folate treatment. This is yet to be operationalised. In none of the states were services for anaemia included as a component of antenatal care.

RHS data indicated that less than 30 per cent pregnant women had taken iron folic acid tablets in 267 districts (Figure5.7.25). During the Tenth Plan, every effort will be made to fully operationalise the Ninth Plan strategy for prevention and management of anaemia.

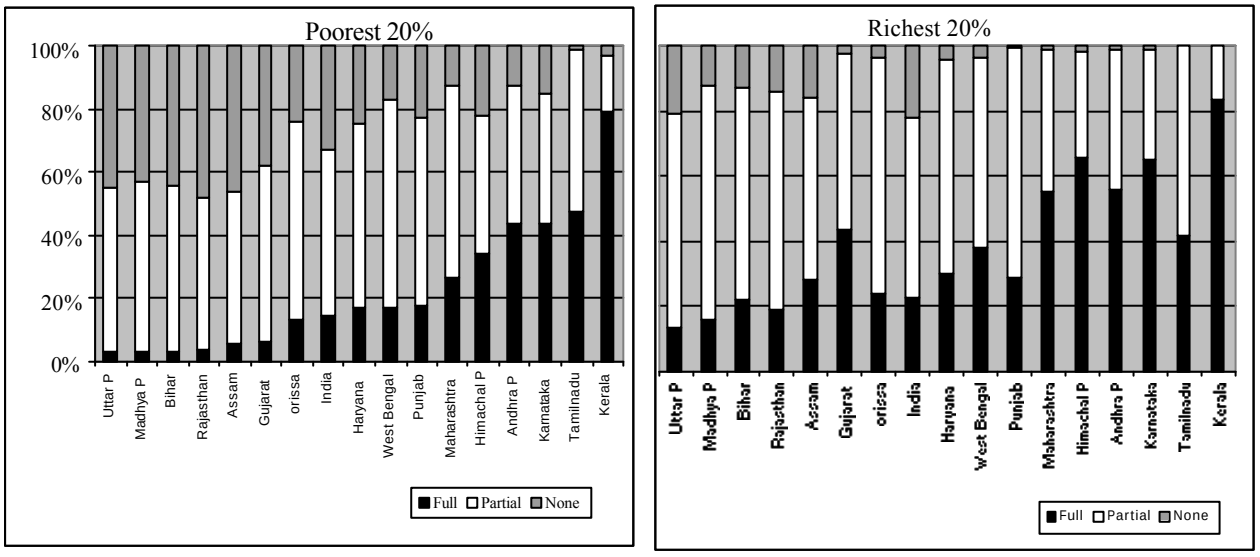
Fig 5.7.25 Consumption of IFA



Source:RHS1998-99

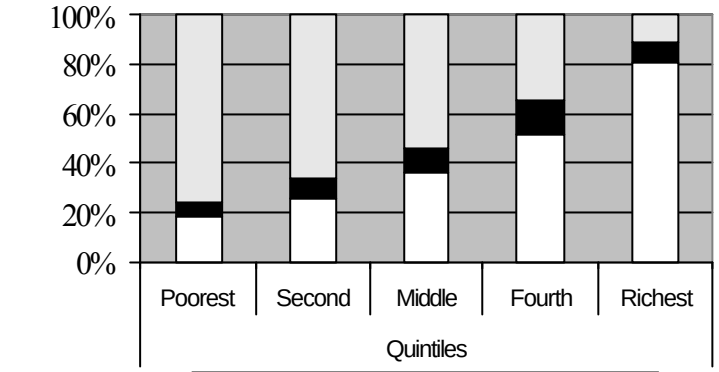
32. There are massive inter-state differences in percentage of women seeking antenatal care - Kerala where over 80% of both rich and poor seek antenatal care to UP where less than 15% of the richest get antenatal care. It is obvious that in states with poor health infrastructure and health indices (such as MP, UP, Rajasthan, Bihar) the richest group has lower antenatal care rate than the poorest quintile population in states like Kerala, Tamil Nadu, Karnataka and Andhra Pradesh. Efforts to improve availability of health care services in EAG states by making existing infrastructure and manpower fully functional are being taken up as a part of RCH programmes in these states(Figure5.7.26 & 5.7.27).

Fig 5.7.26 & 27 Interstate Differentials in Antenatal Care



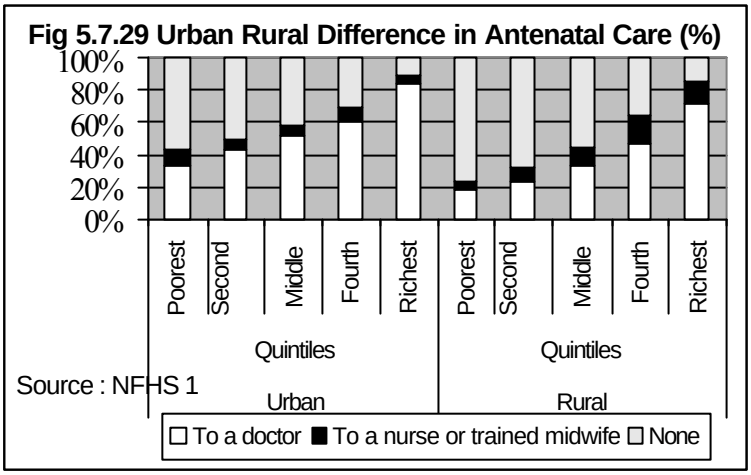
33. Over 80% of women from highest quintile have antenatal care under a doctor; in contrast only about 20% of the poorest have antenatal care with a doctor. In spite of the attempts through CSSM and RCH care to provide antenatal care through ANM/ nurses, very few women seek antenatal care with them (Figure5.7.28). This is mainly because the ANM/nurses do not have the equipments/skills to check B.P., Hb, Uterine size, and advice follow up care/referral. It is imperative that training of ANM/staff nurses in antenatal screening and identification is completed rapidly so that universal screening of all pregnant women and referral to appropriate facilities for care would be operationalised .

Fig 5.7.28 Income Differentials in Antenatal care(%)



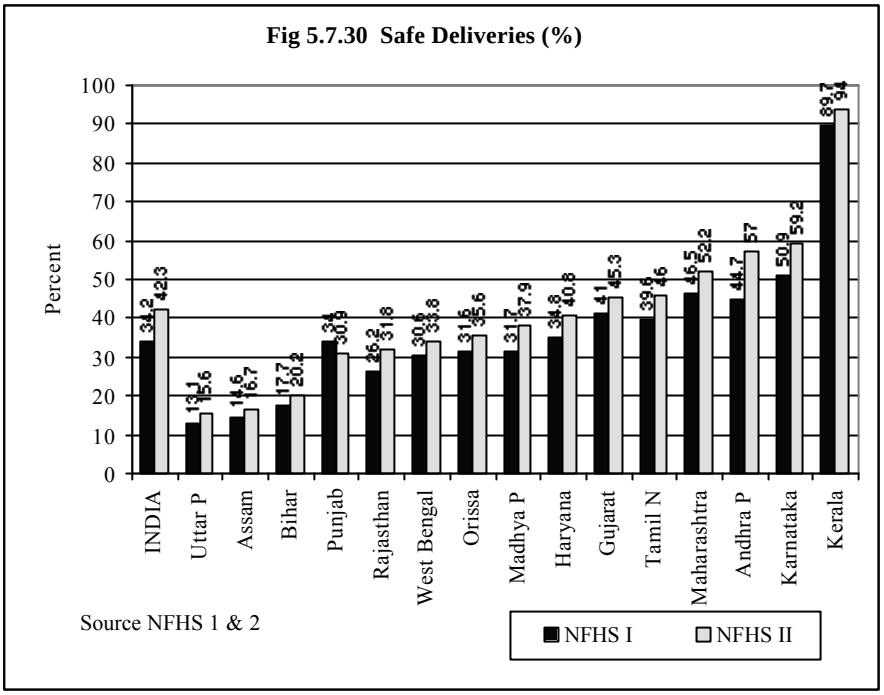
34. Access to antenatal care is lower in rural areas than in urban areas; both in urban and rural areas and in all income groups mostly ANC is done by a doctor. Nearly 60% of urban poor and 80% of rural poor do not access antenatal care. This is the segment of the population with highest prevalence of risk factors urgently requiring screening and appropriate management. (Figure5.7.29)

Fig 5.7.29 Urban Rural Difference in Antenatal Care (%)

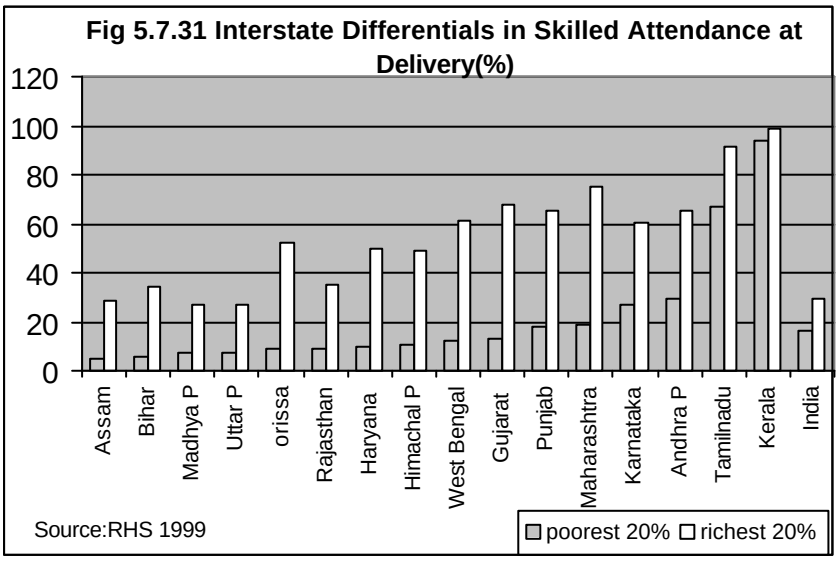


35. In order to provide the RCH services to people living in remote areas where the services at PHC/CHC level are not available, specialists from district hospitals/CHC are attending PHC/ CHCs on fixed days and provide needed care for women and children. Initially 102 districts were selected in 17 states i.e. Assam, Bihar, Chhatisgarh, Haryana, Jharkhand, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal, Arunachal Pradesh, manipur, Meghalaya, Mizoram, Sikkim and Tripura. During the last year 76 more districts have been covered. The impact of this effort in improving access to specialist care will be assessed. The CHC/FRU is the critical institution, which provides emergency obstetric care and plays a vital role in the referral system. The reported gaps in the number of CHCs/FRUs will be filled by appropriately reorganising the subdivisional hospitals, post-partum centres and block-level PHCs. The required number of core specialists will be posted through appropriate redeployment of the manpower especially from post partum centres ; wherever adequate number of specialists are not available even after this exercise, hiring them on a contractual or part-time basis can be considered. In order to strengthen the capability of CHCs/FRUs in antenatal and intrapartum care states can take up training of one of the staff nurses inCHC so that there is someone who has specialised in midwifery available to provide care. Over the next five years, efforts will be made to improve the Emergency Obstetric Care in all CHCs in a phased manner, by ensuring that these CHCs have well equipped operation theatre, access to banked blood, qualified obstetricians, paediatricians, anaesthetists.

Delivery Services



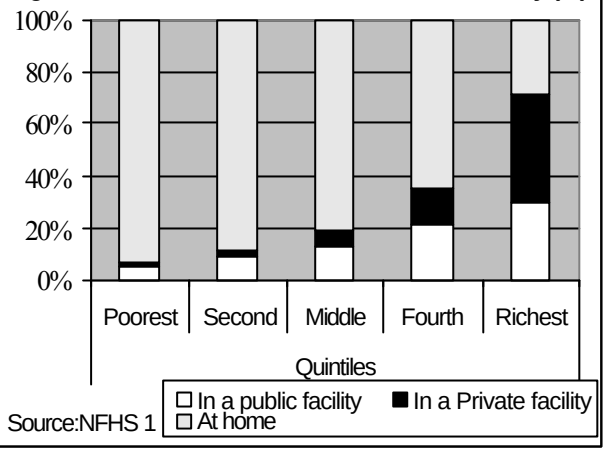
36. During the Ninth Plan, it was envisaged that efforts would be made to promote institutional deliveries both in the urban and rural areas. Simultaneously, in districts where a majority of the deliveries were taking place at home, efforts were made to train the traditional birth attendants (TBAs) through an intensive Dai Training Programme and to increase the availability of disposable delivery kits. The available data from the NFHS-1 and 2 and RHS-1998 suggest that there has been some improvement in institutional deliveries, especially in states like Tamil Nadu and Andhra Pradesh (Figure5.7.30) However, there are a large number of districts in many states where the situation with regard to safe deliveries is far from satisfactory.



37. There are massive differences between states in access to delivery care. In Kerala, irrespective of income all women seek and obtain skilled attendance at delivery. Tamily Nadu stands next to Kerala in this regard. However, in states like Assam, Bihar, Himachal Pradesh, UP, Orissa, Rajasthan, West Bengal, Haryana the richest 20th quintile have less access to skilled attendance at delivery as compared to the poorest in Kerala and Tamil Nadu (Figure 5.7.31).

38. Amongst the poorest groups less than 10% access public facility for delivery, while about 25% of the richest quintile access public sector for the delivery.(Figure 5.7.32) Poorer segments of population do not access private facilities perhaps due to economic constraints. Tamil Nadu has attempted to improve availability of delivery services in CHCs/

Fig 5.7.32 Income Differentials in Place of Delivery (%)



PHCs. Andhra Pradesh has come up with schemes to provide monetary assistance to women from BPL families if they access private facilities for delivery, which might at least in part be responsible for this substantial increase in institutional deliveries in AP.

39. It is surprising that even among the richest quintile population in whom financial barrier to safe institutional delivery does not exist, about a third deliver at home and 20% do not have deliveries conducted by a doctor or nurse. (Figure 5.7.33) Amongst the poorest quintile less than 10% have delivery in institutions conducted by a doctor or a nurse. Universal antenatal screening will enable identification of high-risk women (irrespective of income groups) who should be delivered in institutions by skilled persons without unduly inconveniencing the family and overloading institutions. This practice could result in substantial reduction in maternal and perinatal morbidity and mortality.

Fig 5.7.33 Income Differentials in Delivery Attendance (%)

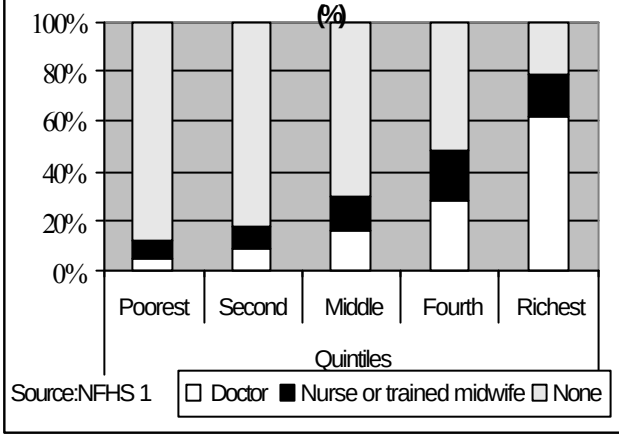
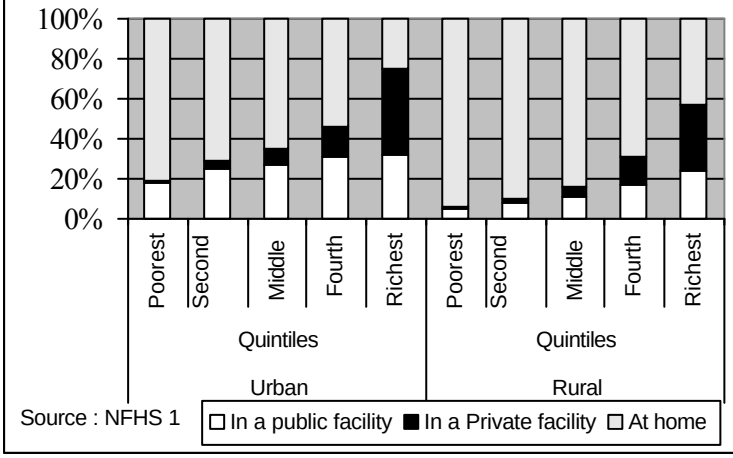


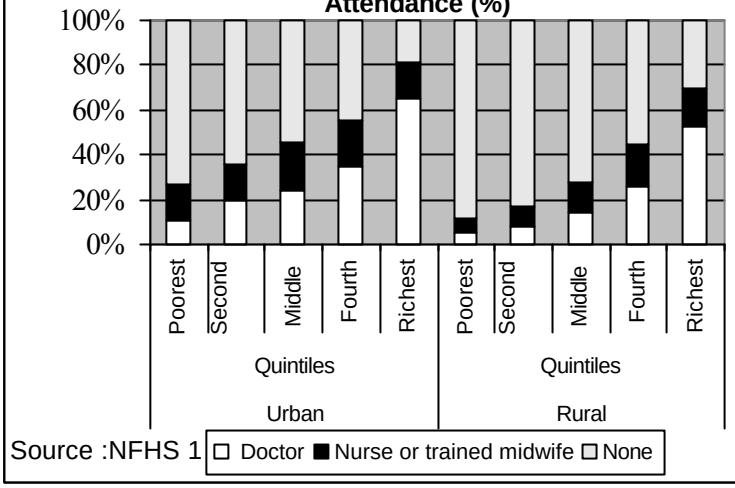
Fig 5.7.34 Urban Rural Difference in Place of Delivery (%)



40. Utilisation of public facility for delivery is poor both in urban and in rural areas. Less than 20% in urban and less than 10% in rural poor income group deliver in public facilities. Irrespective of income majority of rural and urban women deliver at home. In rural areas over 40% deliveries even in richest income group are at home. In the richest income group in urban areas nearly half deliver in private institutions (Figure 5.7.34).

41. In urban areas higher proportion of woman in each quintile group have access to skilled attendance for delivery (Figure 5.7.35). However, among the lowest quintile income group only about 25% of urban women and less than 10% of rural women had access to skilled person for delivery. The richest quintile group in urban and rural areas had deliveries attended by doctor. Irrespective of a urban or rural residence of income group, less than 20% of deliveries were conducted by nurses.

Fig 5.7.35 Urban Rural Difference in Delivery Attendance (%)



Source :NFHS 1

42. In order to improve delivery of services, all category "C" districts of Uttar Pradesh, Bihar, Madhya Pradesh, Orissa, Haryana, Rajasthan and all NE states are being provided with additional ANMs in 30% of sub-centres. In Delhi additional ANM's are being employed to provide skilled attendance at delivery for to slum areas. It is expected that with these interventions there will be a substantial increase in skilled attendance at delivery as well as institutional deliveries especially for recognized high-risk pregnant women. The Department of Family Welfare has launched a massive training programme of Traditional Birth Attendant (TBA) in districts where majority of deliveries occur at home. More than 11000 TBA/Dais have been trained in 166 districts during the year 2001-02.

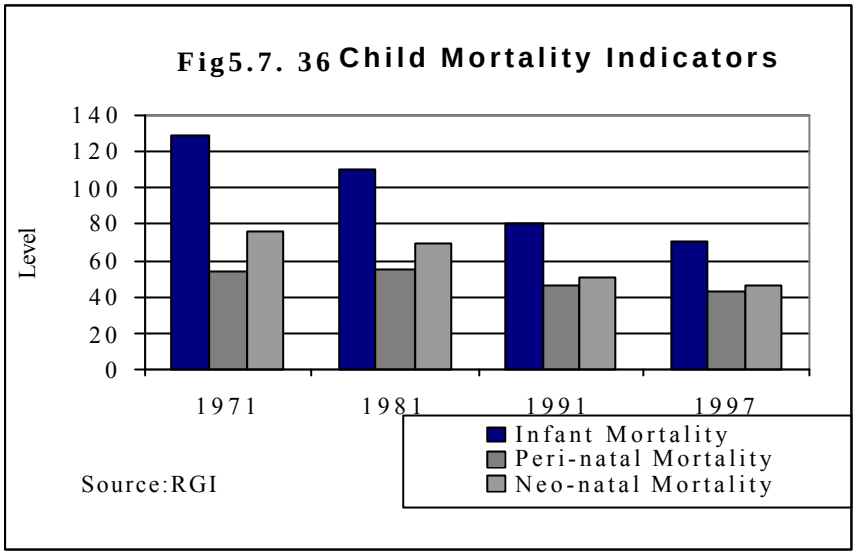
CHILD HEALTH

43 Infant and under-five mortality rates are excellent indicators of the health status of children. In India there is no system for collection and analysis of data on morbidity during childhood. In the absence of this, available mortality data and analysis of causes of death have been utilised for drawing up priority interventions for improving child health. Ongoing major intervention programmes in child health are shown in the text box.

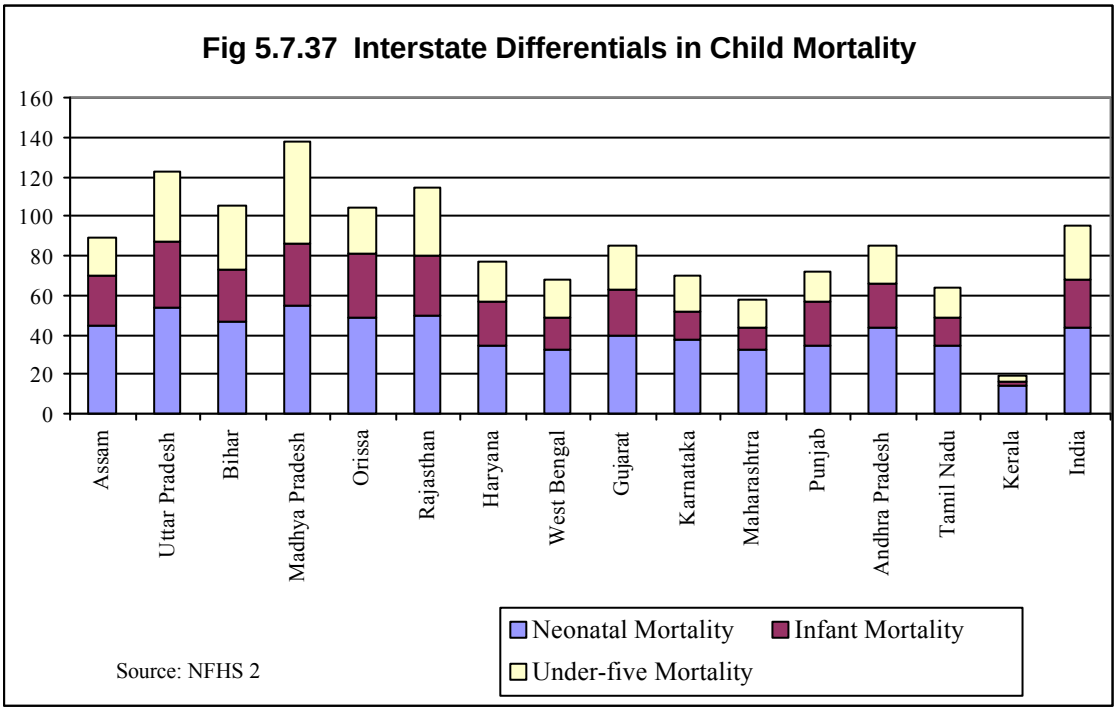
Components of child health care include :

- Essential newborn care
- Immunisation
- Nutrition:
  - exclusive breast-feeding for six months
  - timely introduction of complimentary feeding.
  - detection and management of growth faltering.
  - massive dose Vitamin-A supplementation.
  - iron supplementation, if needed.
- Early detection and appropriate management of:
  - acute respiratory infections;
  - diarrhoea.
  - other infections.

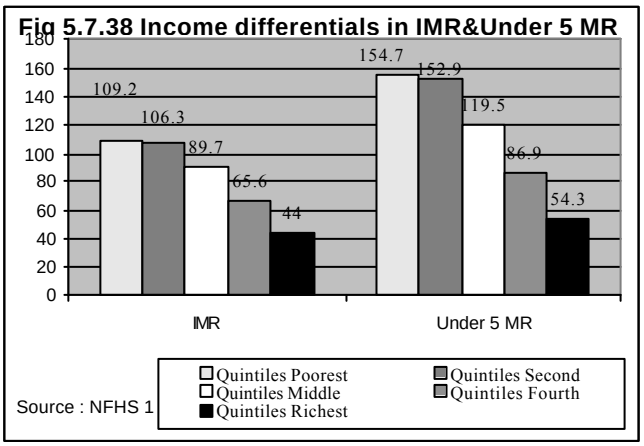
44. Improved access to immunisation, health care and nutrition programmes have resulted in substantial decline in IMR



between 1950-1990. However, it is a matter of concern that the decline in perinatal and neonatal mortality has been very slow (Figure 5.7.36). IMR has remained unaltered in the1990s. There are substantial differences between states in neonatal, infant and under- five mortality rates (Figure 5.7.37).

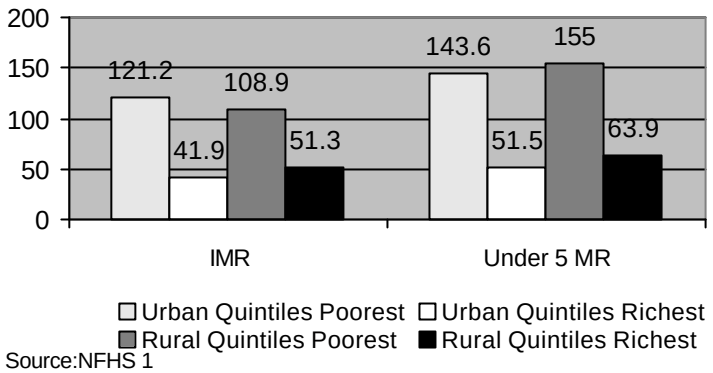


45. There are substantial differences in IMR & Under 5 MR between income groups (Figure 5.7.38). Infant mortality and under-five mortality rate among the lowest quintile population is nearly double that of the rates in highest quintile groups. This is perhaps due to better access to health care during infection and illness during childhood as well as better nutritional status.



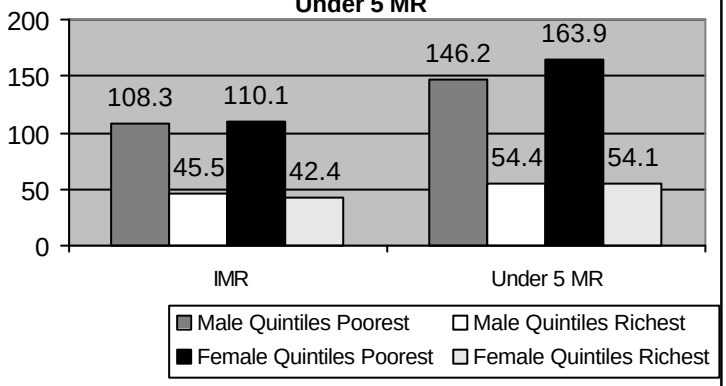
46. Both IMR and under-five mortality rate are lower in urban as compared to rural population (Figure 5.7.39). Within each area both IMR and under-five mortality rate in lower income quintile was twice that of the highest quintile. IMR in poorest urban quintile was higher than IMR in rural poorest quintile suggesting that urban slum dwellers have higher morbidity perhaps due to poor environmental sanitation, lack of access to safe drinking water as well as over crowding.

Fig 5.7.39 Urban Rural Differentials in IMR & Under 5 MR



Source:NFHS 1

Figure 5.7.40 Gender based differentials in IMR & Under 5 MR



Source:NFHS 1

47. Comparison of infant and under-five mortality rate in girls and boys indicate that even though there are no significant differences in mortality rates between them in the highest income groups under-five mortality rates in girls from poorer quintile are higher. Higher under-five mortality rates persist indicating gender bias in child rearing practices (Figure 5.7.40).

48. Over the last three decades there has not been any substantial change in the major causes of deaths during infancy and childhood. Diarrhoea is one of the leading causes of death among children. Most of these deaths are due to dehydration caused due to frequent passage of stools and can be prevented by the timely and adequate replacement of fluids. The Oral rehydration therapy was introduced in child health programme in 1986-87 in order to prevent such deaths. Health education aimed at the rapid recognition and appropriate management of diarrhoea has been a major component of the CSSM and RCH programs.

Table 5.7.4: Children with Diarrhoea

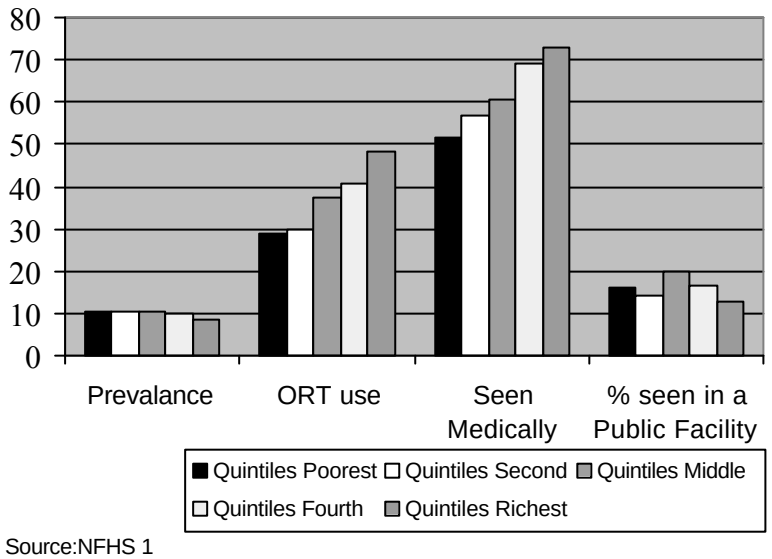
(Percentage treated with ORS)

Percent	Districts
>50	9
25-49	82
<25	413

Source: RHS 1998-99

49. The use of fluids available at home and oral rehydration solution (ORS) has resulted in a substantial decline in the mortality associated with diarrhoea, from an estimated one million to 1.5 million children every year prior to 1985 to 600,000 to 700,000 deaths in 1996. In order to further improve access to ORS, 150 packets of ORS are provided as part of the Drug Kit-A, two of which are supplied to all the sub-centres every year under the RCH programme. In addition, social marketing and supply of ORS through the public distribution system are being taken up in some states. However RHS data indicate that ORS was used in more than 50 per cent of cases of diarrhoea in only nine districts (Table 5.7.4). Improving access to and utilisation of home available fluids/ORS for the effective management of diarrhoea will receive priority attention during the Tenth Plan as an inexpensive and effective tool to reduce IMR /under-five mortality.

Figure 5.7.41 Income Differentials in Treatment of Diarrhoea

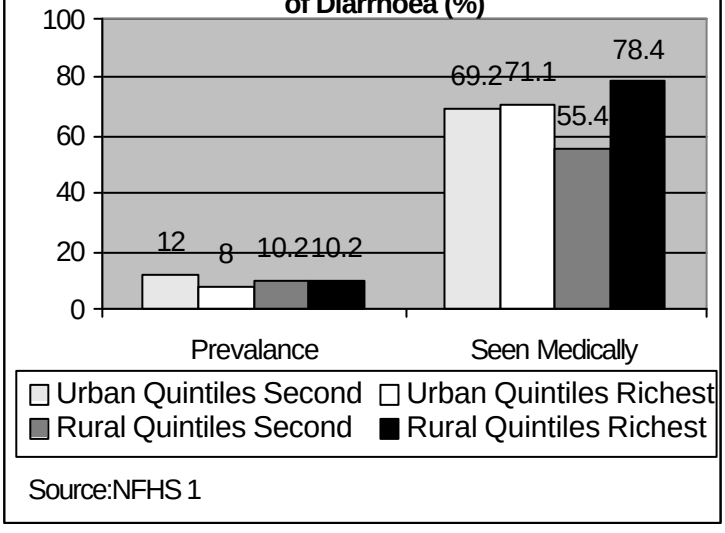


Source:NFHS 1

50. Prevalence in diarroheal diseases in children in all income groups are essentially similar (Figure 5.7.41). In higher income quintile however, parents got their children medically seen and used ORT more often. Inspite of the fact that prevention and management of diarrohea is a major child health intervention under the National Family Welfare Programme, less than 20% of parents in any income group utilised public facility for treatment of diarrhea. This situation requires immediate remedial measures.

51. Reported prevalence of diarrohea in highest income group in urban area is lower perhaps due to better sanitation and access to safe drinking water. Irrespective of income the urban parents sought medical advice. Rural poor did not access health personnel as often as the urban poor (Figure 5.7.42). Inspite of this the ORS use is quite low both in rural and urban areas. Over 60% of parents of children with diarrhoea are seen by medical persons,but less than 1/5th used ORT; CME on standard protocol for management of diarrohea to all

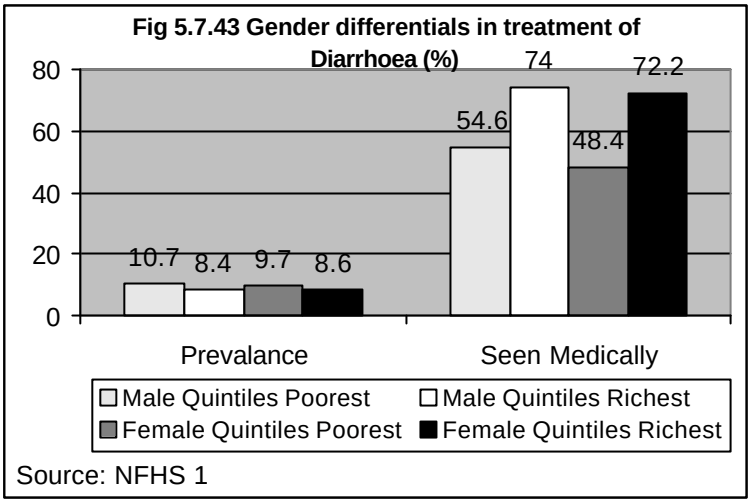
Figure 5.7.42 Urban Rural difference in Treatment of Diarrhoea (%)



Source:NFHS 1

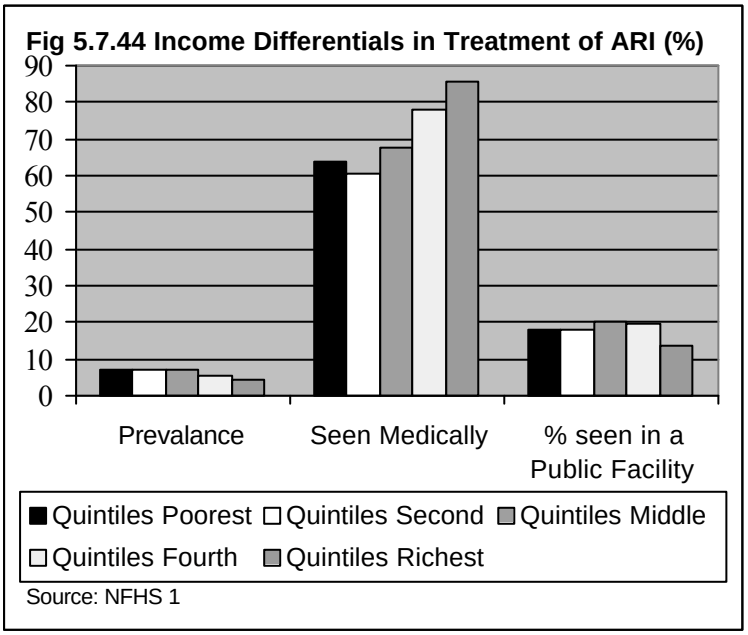
practitioners maybe urgently required to improve rational management of diarroheal diseases and achieve substantial reduction in mortality.

52. In the poorest income group lesser percentage of girl children with diarrohea received medical attention; however, such a trend was not obvious in the richest quintile population(Figure 5.7.43). The gender differential in recognition of illnesses and access to medical need has to be countered.



Acute Respiratory Infections

53. Pneumonia accounts for around 30 per cent of under five deaths in the country. Under the RCH programme, co-trimoxazole tablets are supplied to each sub-centre in the country as part of Drug Kit-A. Mothers and community members are being informed about the symptoms of ARI, which would require antibiotic treatment or referral. Training of health care personnel in the early diagnosis of ARI and appropriate treatment, including referral, as envisaged under the RCH programme has not yet been completed. This should receive immediate attention during the Tenth Plan period.



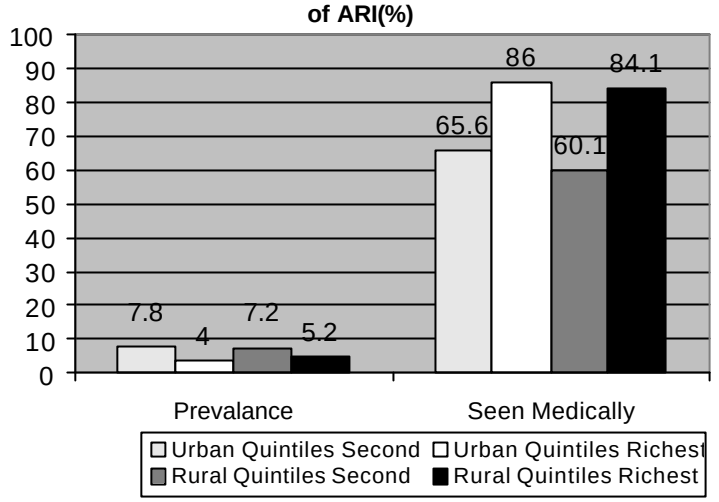
54. Prevalence of ARI was higher in children from lower income groups – perhaps due to overcrowding. Over 60% of parents from lowest quintile groups and 80% of parents from highest quintile groups sought medical aid. Irrespective of income group less than 20% went to government funded health facility (Figure 5.7.44); Majority had accessed private practitioners for treatment.

55. Prevalence of ARI is lower in higher income group both in rural and urban areas (Figure 5.7.45). Poor ventilation and over crowding is perhaps the most important factor responsible for higher prevalence of respiratory infections in poorest income groups Over

60% of rural and urban poor and over 80% of rural and urban rich took their children to health professionals. It is imperative that private practitioners along with government in service personnel have ready access to standardize treatment protocols for management of ARI so that there is substantial reduction in mortality due to ARI.

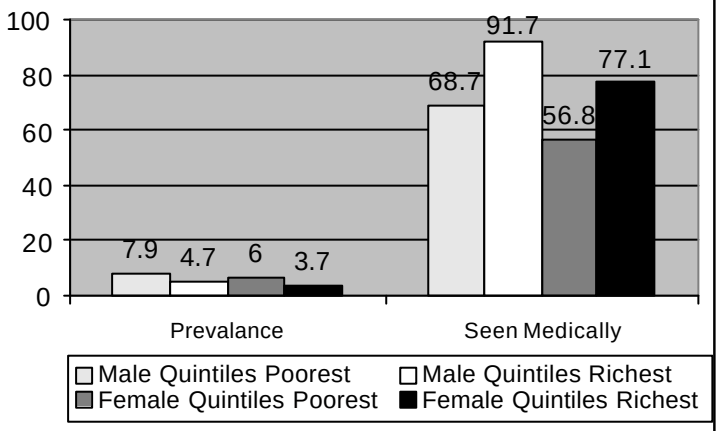
56. Both in the richest and the poorest income lower percent of girls with ARI received medical attention (Figure 5.7.46).

Fig 5.7.45 Urban Rural difference inTreatment of ARI(%)



Source : NFHS 1

Fig 5.7.46 Gender Differentials in Treatment of ARI (%)



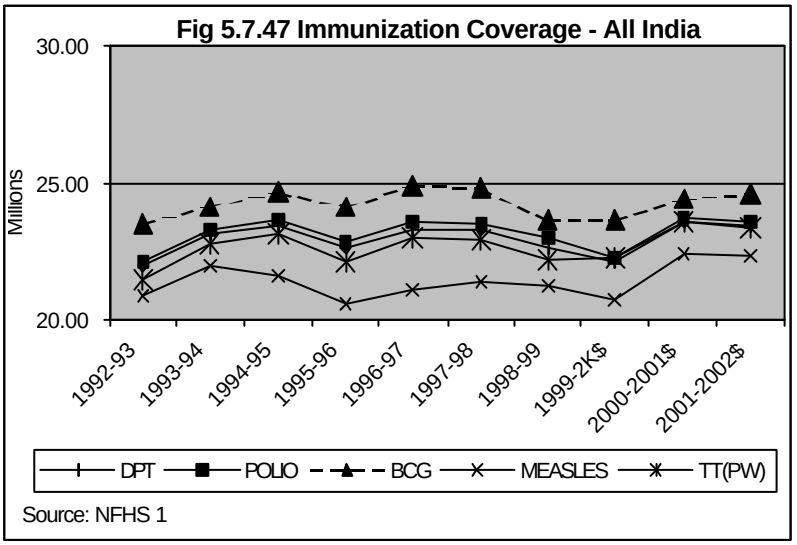
Source: NFHS 1

The fact that lesser percentage of girl children with ARI and diarrhea were taken to medical facility may be a manifestation of gender bias in the community and contribute to the observed higher rates of under-five mortality among girls especially those from poorer segments of the population.

IMMUNISATION

57. The Universal immunization program which was taken up in 1986 as a National Technology Mission, became a part of the Child Survival and Safe Motherhood (CSSM) programme in 1992 and the RCH programme in 1997. Under the programme, infants are immunised against tuberculosis, diphtheria, pertussis, poliomyelitis,

Fig 5.7.47 Immunization Coverage - All India



Source: NFHS 1

measles and tetanus. Coverage reported through service channels during the nineties is shown in Figure 5.7.47. The National Health Policy, 1983, set the goal of universal immunization against these six vaccine preventable diseases by 2000, this goal has not been achieved. However, reported cases of vaccine preventable diseases have declined over the same period (Figure 5.7.48).

Fig 5.7.48 Vaccine Preventable Diseases

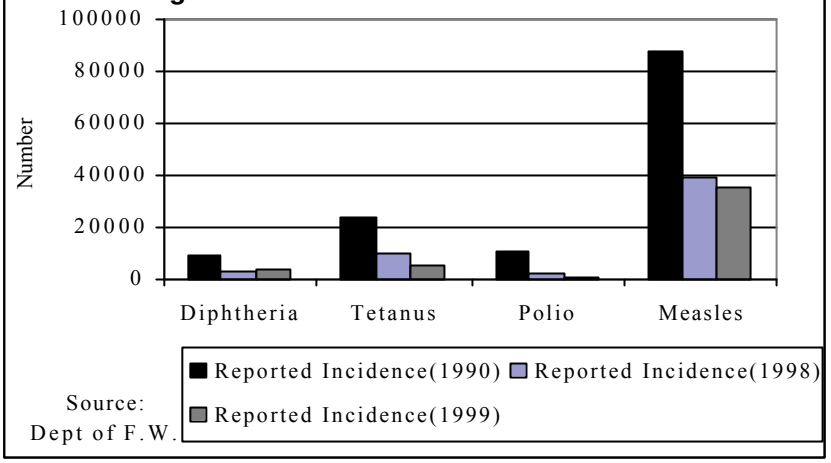
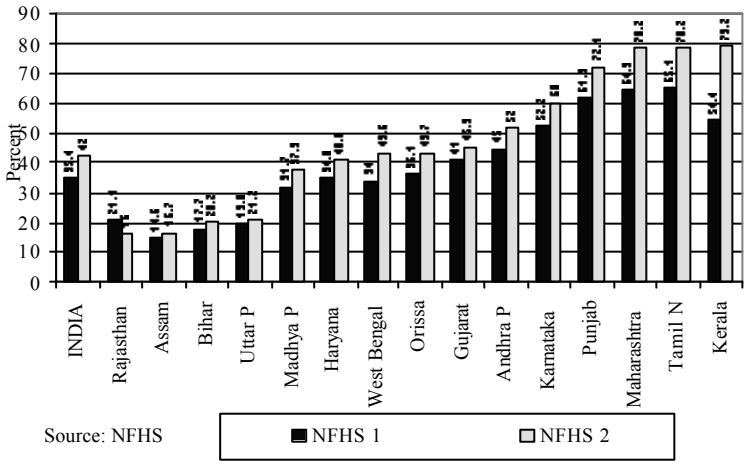


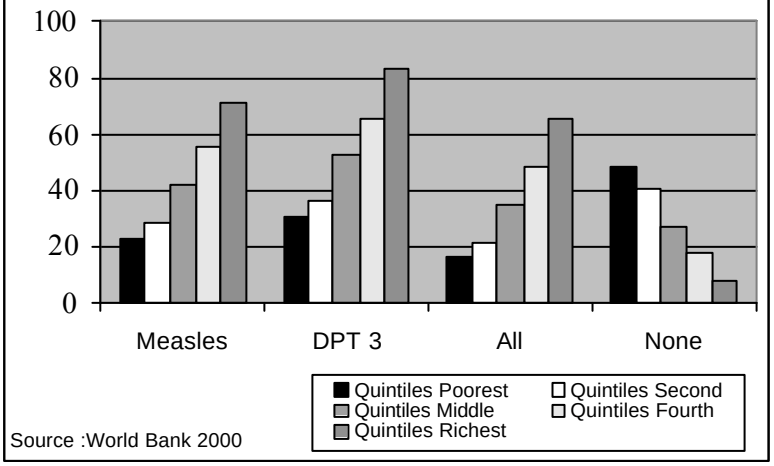
Fig 5.7.49 Children Fully Immunised (Percent)



58. Data from NFHS indicate that there has not been any decline in the immunisation coverage in the 1990s. However, none of the states have achieved coverage levels of over 80 per cent ; coverage level in states like Bihar Uttar Pradesh and Rajasthan were very low (Figure 5.7.49). The drop-out rates between the first, second and third doses of oral polio vaccine and DPT have been very high in most states. Lower coverage is reported for measles as compared to other vaccines. One of the main reasons for not achieving 100 per cent routine immunisation is the focus on campaign mode programmes in health and family welfare.

59. Over 80% of children irrespective of income group received immunization from the government institutions. Access to immunization is provided free of cost to all. In spite of this immunization coverage under any vaccine was lower in poorer

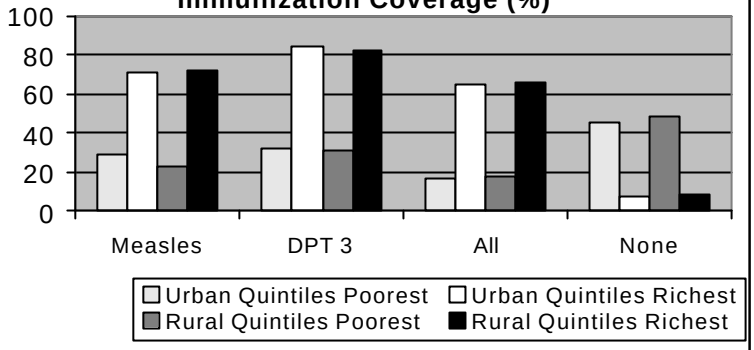
Fig 5.7.50 Income Differentials in Immunization Coverage (%)



income groups (Figure 5.7.50). Drop out between first, second and third doses of DPT and OPV are substantial. If this is prevented by appropriate follow up there will be substantial improvement in immunization coverage.

60. There are no urban rural differences in immunization coverage. The well structured rural health care system delivered immunization services inspite of problems in access. However, both in urban and rural areas the coverage under immunization was lower in the poorest quintile group (Figure 5.7.51).

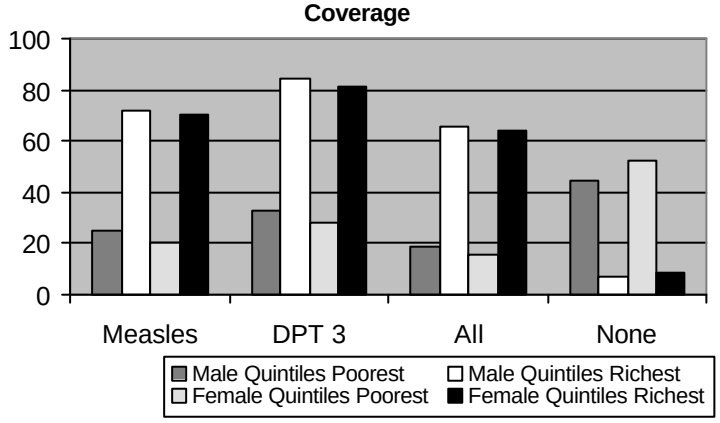
Fig 5.7.51 Urban Rural Differentials in Immunization Coverage (%)



Source: NFHS 1

61. Immunization coverage for any vaccine was slightly lower among girls especially those from poorer income groups and higher proportion of girls from lowest income quintile did not receive any immunization(Figure 5.7.52). Efforts to curtail gender bias in preventive care would be needed to counter this trend.

Fig 5.7. 52 Gender Differentials in Immunization Coverage



Source:NFHS 1

62. In view of the relatively low complete immunization by one year, special emphasis is being laid on strengthening routine Immunization activities so that the coverage of infants under six vaccine preventable diseases improves quickly. Support is also being provided to strengthening cold chain, injection safety and training. The Department of Family Welfare has introduced a pilot scheme of immunization of children against Hepatitis-B in the slum areas of 15 selected cities, where immunization coverage for 6 VPD is more than 80%. Several voluntary agencies are also providing Hepatitis B vaccination in selected urban areas.The progress in these efforts has to be monitored.

Pulse Polio Immunisation

63. Under the Pulse Polio initiative, launched in 1995-96, all children under five years of age are to be administered two doses of oral polio vaccine in December and January every year until polio is eliminated. Coverage under the programme has been reported to be over 90 per cent in all states, with over 120 million children taking the vaccine every year. However, it is a matter of concern that over the last five years coverage under

routine immunisation has not improved. There are sections of the population who escape both routine immunisation and the pulse polio immunisation. As a result, through there has been a substantial decline in the number of polio cases; this was not sufficient to enable the country to achieve zero polio incidences as yet.

64. Confirmed polio cases reported in the last four years is shown in Table 5.7.5. In 2002 the number of confirmed cases of polio has already exceeded those reported in 2001. Uttar pradesh and Bihar account for most of the reported cases Mop-up immunization is being undertaken following detection of wild poliovirus, including areas with clusters of polio compatible cases and in areas of continued poliovirus transmission. The sub-national immunisation days (SNID) and national immunisation days (NIDs) are being conducted using the combined fixed posts and house-to-house approach in all states. Special efforts are being made to achieve high routine and campaign coverage in under-served communities and remind families about the need for routine immunisation during the pulse polio immunisation campaigns.With improved routine immunization coverage and good coverage under pulse polio, it is expected that elimination of polio might be achieved by 2004.

Table 5.7.5 : No Of Polio Cases

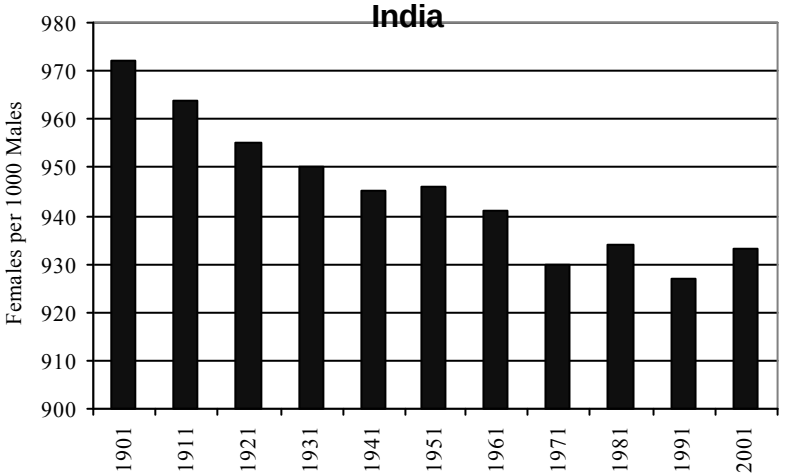
Year	No of cases of confirmed polio
1998	1931
1999	1126
2000	265
2001	268

Source:Dept. of F.W

Gender Bias

65. The reported decline in the sex ratio during the current century has been a cause for concern (Figure 5.7.53). The factors responsible for this continued decline are as yet not clearly identified. However, it is well recognised that the adverse sex ratio is a reflection of gender disparities. There is an urgent need to ensure that all sectors collect and report sex disaggregated data. This will help in monitoring for evidence of gender disparity. Continued collection, collation, analysis and reporting of sex disaggregated data from all social sectors will also provide a mechanism to monitor whether girls and women have equal access to these services.

Fig 5.7.53 Time Trends in Sex Ratio in India



Source: RGI

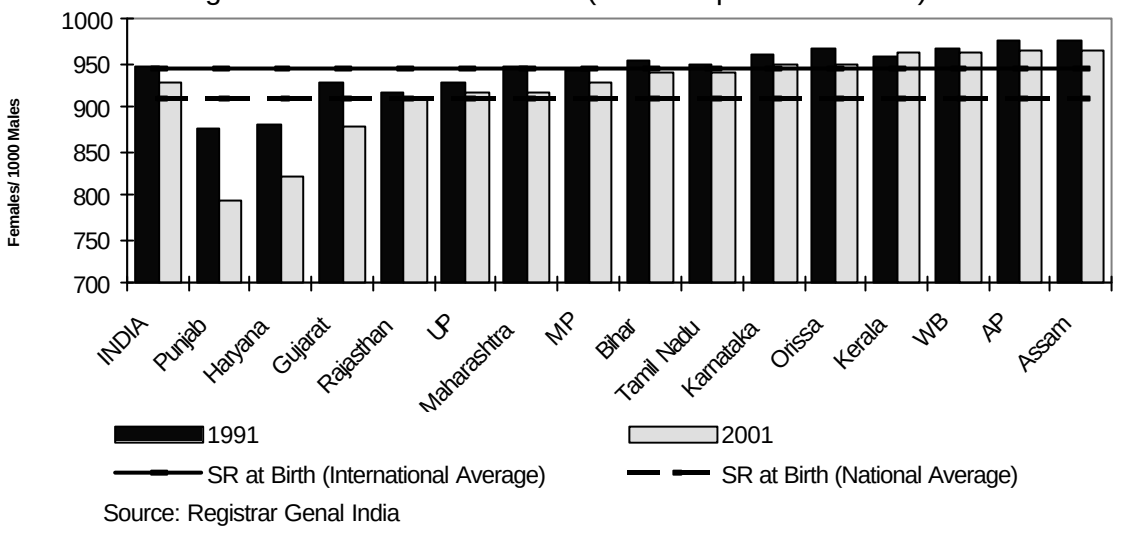
66. The census based estimates of sex ratio in the 0-6 age group show massive inter-state differences (Figure 5.7.54). In addition, data indicate that over the last three decades there has been a decline in the 0-6 sex ratio. (Table 5.7.6) There had been speculation as to whether female infanticide, sex determination tests and selective female foeticide are, at least in part responsible for this.

Table 5.7.6 : Child sex ratio (Femlaes/1000 Males)

Year	Urban	Rural	Total
1981	931	963	962
1991	935	947	945
2001	903	934	927

Source RGI

Fig 5.7.54 Sex ratio 0-6 Years (Females per 1000 Males)



Source: Registrar Genal India

67. Female infanticide is a cognizable offence. In order to prevent misuse of sex determination tests and sex selective abortions Prenatal Dianostic Technique Act enacted in 1994 and came into force from 1996. However very few cases have been registered under the act in spite of the anecdotal reports that these practices are widespread in some states not only in urban but also in rural areas. While considering a PIL Supreme Court has ordered the states to stringently implement the provision of the act and the centre to review the provisions under the PNDT act and make necessary modifications taking into account the current knowledge and technology available.

68. Under the PNDT act the states are registering all institutions having ultrasound machines and monitoring their use. Available reports from media and NGO's suggest that in most clandestine operations ultrasound examination for sex determination are carried out in the first trimester. The commonly used Ultrasound machines can detect sex of the fetus only in fourth month of pregnancy. Awareness generation among the public that ultrasound machines cannot detect sex of the foetus in first trimester may be required to reduce this fraudulent practice. Ultrasound can detect foetal sex in the second trimester but the second trimester MTP is is not an easy or safe procedure.Health education to the population clearly stating the dangers of second trimester abortion may reduce the sex selective second trimester abortions .

69. With the techniques like chorion villus biopsy it is possible to detect foetal sex in first trimester. Preconceptional determination of sex by invitro fertilization with Y

chromosome is possible. Currently these techniques are expensive and are not widely available. Legislation such as PNDT act is difficult to implement. Deterrent punitive measures under the act may reduce the abuse of technology for sex selective abortions.

70. Data presented elsewhere clearly shows that there are other manifestations of gender bias such as higher under 5 mortality rates among girls, parents seeking medical treatment for diarrhoea and respiratory infection were lower in girl children and acceptance of contraception among parents with two girls was half that of contraception among parents with two boys. In spite of these difficulties in implementation, the PNDT act is important step because it is an enabling health educational tool to achieve social transformation aimed at reducing the son preference. A comprehensive energetic IECM campaign to counter all these manifestations of gender bias has to be taken up.

Logistic Support

Ninth Plan Strategy
Improve uninterrupted supply of essential drugs, devices, vaccines and contraceptives, adequate in quantity and appropriate in quality.

71. Under the Family welfare program the central government procures and supplies drugs, equipment kits, contraceptives and vaccines to the states. While the drug kits are supplied at district level, vaccines and contraceptives are supplied at the state or regional level. The states have, so far, not created any specialised or dedicated system for receiving such supplies, storing them in acceptable conditions and distributing them. As a result, there are delays, deterioration in the quality and wastage of drugs. Supplies under the family welfare programme are to the tune of Rs. 500 crore and it is estimated that the losses due to deterioration and inefficiencies may be to the extent of 20 to 30 per cent.

72. The Department of Family Welfare, in collaboration with different external funding agencies working in different states, has formulated logistic projects for each of the major states. It envisaged that a specialised agency will be created in each state which will manage warehouses at the regional level for each cluster of five to eight districts. These warehouses will receive an indent from each hospital in the area and will ensure delivery of supplies within 15 days through a contracted transporter. To ensure efficiency, the state government agency will be paid only on the basis of a per centage of supplies it handles. The logistics project has already been initiated in some states. Currently efforts are underway to ensure that facilities which are being created, handle all the drugs/vaccine/ devices provided by the central government and state governments for all health care institutions. The progress of this programme and the problem encountered will be monitored and appropriate mid-course corrections instituted.

Private Sector Participation in RCH

73. Over 80 per cent of the practitioners of modern medicine and a higher proportion of the ISM&H practitioners work in the private sector. It is estimated that while the private sector provides more than three-fourths of all curative health care services, its contribution to maternal and child health and family planning services is less than one-third. The major limitations in private sector participation include:

- ☞ the focus till now has been mainly on curative services ;
- ☞ the quality of services is often variable; and
- ☞ the poorer sections of population cannot afford to pay for these services.

74. Under the RCH programme, several initiatives were taken to improve collaboration between the public and private sectors in providing family welfare services to the poorer sections, especially in the under-served areas. Efforts were made to increase the involvement of private medical practitioners in RCH care by providing them orientation training and ensuring that they have ready access to contraceptives, drugs and vaccines free of cost. The private sector has immense potential for improving the coverage and quality of RCH services. The challenge is to find ways to optimally utilise this potential.

Role of NGOs/Voluntary Organisations in the Family Welfare Programme

75. The National Population Policy 2000 envisages increasing role of NGOs/voluntary organisations in building up awareness about and advocacy for RCH interventions and also in improving community participation. Until recently, only a small number of NGOs were getting funding from the Department of Family Welfare, because a majority of them did not have adequate technical knowledge and the skills required. In an attempt to increase NGOs participation, the Department involved several well-established NGOs such as the Family Planning Association of India and Voluntary Health Association of India in selecting, training, assisting and monitoring of smaller, field-level NGOs for carrying out the following functions:

- ➢ advocacy for maternal child health interventions;
- ➢ promotion of small healthy family.
- ➢ improving community participation.
- ➢ counselling and motivating adolescents to delay the age at marriage, young couples to delay first pregnancy and couples with two children to limit their families by the use of appropriate contraceptive methods.
- ➢ act as a link between the community and health care providers.

76. Currently, the Department of Family Welfare funds 97 mother NGOs(larger NGOs looking after smaller ones) covering 412 districts and over 800 NGOs. These NGOs cover all districts in ten states. However, states with high fertility and mortality rates still have a large number of districts without any NGO presence.The state governments have also been trying to involve NGOs in providing services, or by adopting a PHC. The results have been mixed; these experiments need to be carefully monitored.

National Population Policy

77. The National Population Policy was drawn up by the Dept of Family Welfare and was approved by the cabinet in 2000. The immediate objective of the NPP2000 is to meet all the unmet need for contraception and health care for women and children. The medium term objective is to bring the total fertility rate to replacement level (TFR of 2.1) by 2010; the long-term objective of the Policy is to achieve population stabilization by 2045.

National Population Commission:

78. As envisaged in NPP National Commission on Population was constituted on 11th May 2000 under the Chairmanship of the Prime Minister of India. Deputy Chairman, Planning Commission is the Vice Chairman. The Commission has the mandate to

- ☞ review, monitor and give direction for implementation of the National Population Policy with the view to achieve the goals set in the Population Policy
- ☞ promote synergy between health, educational, environmental and developmental programmes so as to hasten population stabilization
- ☞ promote inter sectoral coordination in planning and implementation of the programmes through different sectors and agencies in center and the states.
- ☞ develop a vigourous peoples programme to support this national effort

79. The first meeting of National Commission on Population was held on 22nd July 2000. There were wide ranging discussions and useful suggestions for achieving the goal of population stabilization emerged. A Strategic Support Group consisting of secretaries of concerned sectoral ministries has been constituted as standing advisory group to the Commission. Nine Working Groups were constituted to look into specific aspects of implementation of the programmes aimed at achieving the targets set in NPP 2000 and their reports are being finalized.

Initiatives to Improve Performance in States with Poor Demographic Indices

80. Based on the demographic profile the country can be divided into three zones:

a) States that have achieved replacement level of fertility, i.e. a TFR of 2.1; The endeavour in these states should be to improve the quality of services

b) States which have made an effort and will achieve a TFR of 2.1 by 2010 where major effort will be to sustain the thrust

c) EAG states with high fertility and/or mortality; special efforts are being made to formulate programmes aimed at achieving socio-demographic goals set in the Population Policy.

81. The Empowered Action Group (EAG) constituted by the Department of Family Welfare in 2001 reviews the available infrastructure, performance of the health system and health indices and suggests steps for improving access to health care so that there is a rapid decline in fertility and mortality. This is an essential step if the ambitious goals for decline in fertility and mortality set in the National Population Policy are to be achieved because these states contribute to over 50 per cent of the country's mortality and fertility. The infrastructure in some states of this group (ex; Orissa, U.P. and Bihar) is functioning poorly; in Bihar over 70% of sub-centres are without ANMs. U.P. has taken some initiative and recently appointed 500 ANMs. ANMs are appointed as per the 1991 norms of one ANM per 5,000 population; but some sub-centres cater to a population of 12,000. In these places they have appointed an additional ANM. It is important to ensure that they are available in the place of posting and are fully functional. Efforts are being made to formulate

Table 5.7.7 Funds released for EAG States (Rs in Crores)

State	1999-2000	2000-2001	2001-2002
Bihar	182.02	208.63	156.16
Jharkhand			74.39
Madhya Pradesh	190.02	200.90	148.39
Chhatisgarh			59.74
Orissa	98.43	95.06	115.85
Rajasthan	136.02	185.11	189.75
Uttar Pradesh	335.97	370.46	385.42
Uttaranchal			42.05
Total - EAG States	942.46	1060.16	1171.75
Total - All India	2458.07	2790.11	3216.63

programmes aimed at achieving socio-demographic goals of the National Population Policy 2000, assist the state governments in achieving the goals set in their State Population Policy, devise ways for involvement of Voluntary Organizations, PRIs and expanding the scope of social marketing of contraceptives. . Information on funds released to the EAG states is as shown in Table 5.7.7.

82. The tribal population (except in the north-eastern states) faces immense problems in accessing essential health care services and have poor health indices. The Department of Family Welfare has already initiated several programmes focusing on meeting the health care needs of the tribal population. Special efforts will be made to address the health needs through area-specific programmes and increasing the involvement of NGOs and the tribal community in all activities.

83. The urban slum population has been shown to have poor maternal and child health indices. In many slums, immunisation coverage is very low and children are undernourished. The Department of Family Welfare and the Department of Health have been investing in improving urban primary health care infrastructure and ensuring that they are linked to existing secondary and tertiary care institutions. The India Population Project (IPP) V, VIII and Urban RCH Pilot Projects have built up the capacities of the urban health system in several cities. Efforts to rationalise urban health care and improve efficiency are underway so that reproductive care needs of urban population are fully met within the available infrastructure.

Monitoring and Evaluation

84. The NDC Sub-Committee on Population recommended creation of district-level databases on quality, coverage and impact indicators for monitoring the programme was implemented during the Ninth Plan period The following systems are being used for monitoring and evaluation of the Family Welfare Programme:

- Reports from state and implementation agencies.
- Sample Registration System and Population Census.
- Rapid Household Surveys.
- Large-scale surveys - NFHS, surveys by the NSSO and area-specific surveys by the Population Research Centres.
- Other specific surveys by national and international agencies.

85. The Department of Family Welfare has constituted regional evaluation teams which carry out regular verifications and validate the data on the acceptance of various contraceptives. These evaluation teams can be used to obtain vital data on failure rates, continuation rates and complications associated with different family planning methods. RHS data about the progress on programme interventions as well as its impact are being used to identify district-specific problems and rectify them. To assess the availability and the utilisation of facilities in various health institutions, facility surveys were conducted in 101 districts during 1998-99 and deficiencies found are being brought to the notice of the states and districts concerned. The format for monitoring the processs and quality indicators under the RCH programme have been developed and sent to all the states.

86. The substantial investments made in evaluation during the 1990s have increased awareness about the need for concurrent evaluation. Efforts are underway to consolidate the gain by putting in place a sustainable system of evaluation at the district level in the from of CRS and district surveys. Efforts are also being made to reduce duplication of efforts through appropriate intersectoral coordination . For instance as a part of the rapid household survey, district specific information on undernutrition and anemia rates in preschool children, anemia in adolescents are being collected.

Reorganisation of Family Welfare Infrastructure

87**.** When the Family Welfare Programme was initiated in the early 1970s the infrastructure for providing maternal and child health and family planning services was inadequate at the primary health care level, and sub-optimal in the secondary and tertiary care levels. In order to quickly improve the situation, the Department of Family Welfare created and funded post-partum centres, urban family welfare centres/ health post and provided additional staff to the then existing PHCs (block level PHC's). In addition, the ANMs in the sub-centres, created after the initiation of the Family Welfare Programme, were also funded by the Department. The Department of Family Welfare also created state and district level infrastructure for carrying out the programmes and setting up training institutions for pre/in-service training of personnel. All these activities were being funded through Plan funds.

88. Over the last three decades, there has been considerable expansion and strengthening of the health care infrastructure by the State. Family welfare services are now an integral part of services provided by primary, secondary and tertiary care institutions. The staff funded by the Department of Family Welfare under the scheme of rural family welfare centres and post partum centres are state health services personnel functioning as part of the state infrastructure. In view of this, the Ninth Plan recommended that the funding should be taken over by the state Department of Health. States have been given the responsibility of funding post partum centres and rural family welfare centres from 1 April 2002. There are over 5000 docters funded under RFWC who could be redeployed in

PHC'sagainst vacancies in PHC docters posts so that functional status of PHC's improves. Similarly over 3000 specialists currently working under the post partum programme could be redeployed against vacant posts in CHC/FRU's so that these institutions become fully functional and could deliver integrated RCH services.

89. Since ANMs are crucial for increasing the outreach of the programme, it is important to ensure that the posts of ANMs are filled and steps taken to ensure that they are available and perform the duties they are assigned. One of the major problems with respect to the ANMs is that while the Department of Family Welfare funded over 97,000 posts, about 40,000 were funded by the state (from non-Plan). The Ninth Plan recommended that this dichotomy in funding should be removed and all the ANMs, as per the norms for the 1991 population should be funded by the Department of Family Welfare. This has been done from 1 April 2002. It is expected that this would ensure that the states do employ the required number of ANMs, streamline their functioning and improve the coverage, content and quality of maternal and child health care.

Zero Based Budgeting

90. In the past, the Family Welfare Programme has been considered as a single centrally sponsored scheme. As a result, the heads of funding were functional viz. Personnel, Services, Supplies, Transport, Area Development etc. All ongoing programmes including maternal and child health and immunisation, received inputs from these functional heads. In the Ninth Plan, major projects like RCH, pulse polio immunisation and strengthening of routine immunisation were added as schemes with large outlays. The Planning Commission and the Department of Family Welfare carried out an exercise to rationalize the schemes. A revised scheme-wise listing was evolved where, schemes for strengthening of infrastructure, Area Development Project, Training, Research, programme related activities for contraception, immunisation, maternal health, Child Health and Nutrition were identified as specific schemes. After this, a zero based budgeting effort was taken up and schemes identified for convergence, weeding out and transfer to the states. The summary of the zero based budgeting exercise is given in the Table 5.7.8 .The scheme- wise outlays and anticipated expenditure during the Ninth Plan and outlays provided for 02-03 are given in Annexure-2

Table 5.7.8 : Zero Based Budgeting 2001.

Category	No. of Schemes	Outlay for Ninth Plan (Rs. crore)	Anticipated expenditure during Ninth Plan (Rs. Crore)
Schemes to be transferred to the states	3	2,080.00	2,198.00
Schemes to be merged and retained	11/40	7,640.20	7,398.39
Schemes to be weeded out	8	185.85	31.25
Schemes to be retained	43	5,213.95	4,961.33
Total	94	15,120.00	14,588.97
Total No. of schemes to be continued in the Tenth Plan	54	12,854.15	12,359.72

Yearwise outlay, R.E., and actual expenditure for the Ninth Plan is given in Table 5.7.9.

Table 5.7.9 : Outlays , RE and expenditure during the Ninth Plan

Year	B.E.	R.E.	Actual Expenditure
1997-98	1829.35	1829.35	1822.00
1998-99	2489.35	2253.00	2342.75
1999-2000	2920.00	3120.00	3099.76
2000-01	3520.00	3200.00	3090.11
2001-02	4210.00	3700.00	3596.63
Total	14968.70	14102.35	13951.25

The Deptt of Family welfare has been provided with an outlay of Rs.4930 crores for the year 2002-03.

Annexure 5.7.1

Indicator Target Year	Present Status	Goals			
		NHP-1983 2000	Ninth Plan 2002	Tenth Plan 2007	NPP 2000 2010
Crude Birth Rate	25.8 SRS(2000)	21	24	21	21
Total Fertility Rate	2.85 *	2.3	2.9	2.3	2.1
Couple Protection Rate (%)	46.2 Dept. of F.W.(2000)	60	51	65	Meet all needs
Maternal Mortality Ratio	540 *	Below 200	300	200	Below 100
Perinatal Mortality Rate	-	30-35	-	-	-
Neo natal Mortality Rate	43.4 *	-	35	26	-
Infant Mortality Rate	68 SRS(2000)	Below 60	56	45	Below 30
Under Five Mortality Rate	94.9*	-	-	-	-
% immunized against 6 VPD(%)	42 *	85	65	100	100
⇔ Measles	51*				
⇔ DPT	55*				
⇔ Polio	63*				
⇔ BCG	72*				
Ante-natal care(ANC)					
⇔ % at least 3 ANC	43.8 *	100	90	90	100
⇔ % received IFA for 3 or 4 months	47.5*			100	100
⇔ % received two doses of TT	66.8 *		95	100	100
Deliveries					
Institutional Deliveries(%)	33.6 *	-	35	80	80
Deliveries by trained health personnel & TBA (%)	42.3 *	100	45		100
Prevalence of low birth weight (%)	30 (Estimated)	10	-	-	-

* Source : NFHS – 2

Annexure 5.7.2

(Rs. Crore)

IX Plan	X Plan	Name of Scheme	Ninth Plan			Annual Plan 2002-03
			Approved Outlay	Sum of Annual Outlay	Ant. Expdt.	
1	2	3	4	5	6	7
	A	**INFRASTRUCTURE MAINTENANCE**	**6231.90**	**6654.85**	**7506.17**	**2303.00**
1		Rural Family Welfare Centres	1500.00	1600.00	1600.36	
2	1	Sub-Centres	2200.00	2346.00	2344.60	1809.00
3	2	Urban FW Services	250.00	307.00	305.69	122.00
4	3	Direction & Administration	671.90	541.00	465.25	200.00
5		Post Partum Centres	530.00	560.00	557.94	
6		Village Health Guides Scheme	50.00	40.00	39.70	
7	4	Logistics Improvement	80.00	51.85	4.84	10.00
	5	Contractual Services/ Consultancies	Included in RCH		Included in RCH	162.00
8		ANM (Part of Sub-Centres)				
9		Additional ANMs/PHNs/Lab. Technicians				
10		SM Consultant				
11		Aneasthetist				
12		Other Exp. (State/National level Consultants/Contingency)				
13		Arrears	950.00	1209.00	2187.79	
	B	**INFRASTRUCTURE DEVELOPMENT**	**1050.00**	**1202.35**	**915.76**	**364.20**
14	6	Area Projects (IPP Projects)	800.00	820.00	637.79	74.80
15	7	Social Marketing Area Projects		82.35	6.42	10.00
16	8	USAID Assisted Area Project	250.00	300.00	271.55	59.40
17	9	Other Externally Aided Infrastructure Development Projects				
18	10	EC Assisted SIP Project	Includred in RCH		Includred in RCH	220.00
	C	**TRANSPORT**	**150.00**	**250.50**	**250.65**	**113.00**
19	11	Maintainence of vehicle already available	150.00		250.65	98.00
20	12	Supply of Mopeds to ANMs				15.00

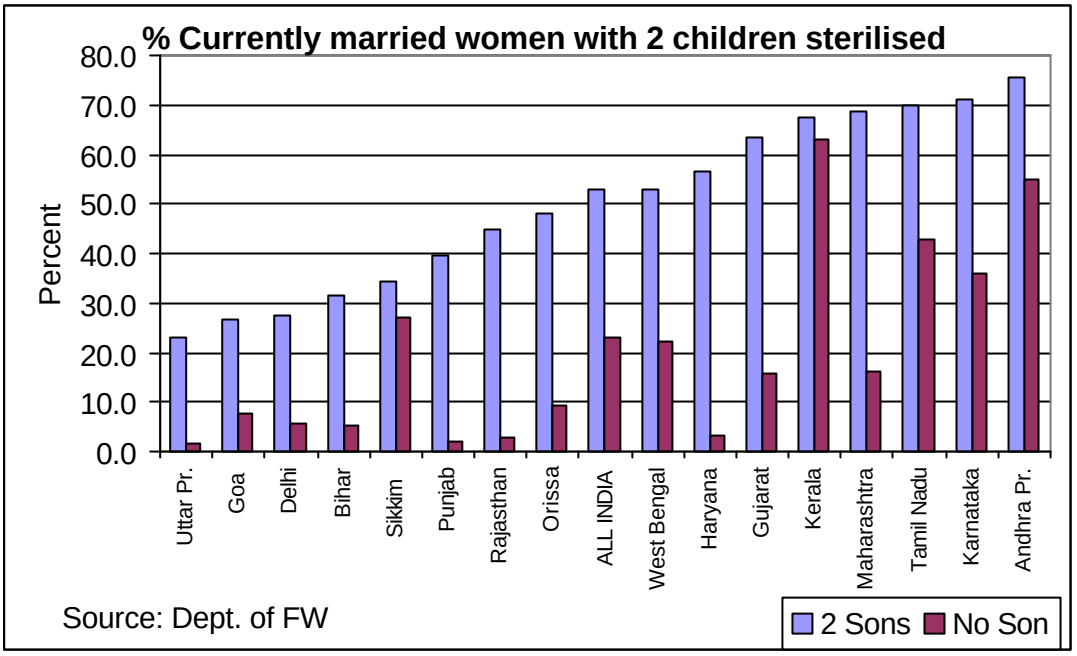
	D	**TRAINING**	**257.35**	**301.28**	**289.29**	**99.60**
21	13	Basic Training for ANM/LHVs	150.00	181.40	182.07	67.00
22	14	Maintenance & Strengthening of HFWTCs	40.00	48.06	46.94	14.00
23	15	Basic Training for MPWs Worker (Male)	35.00	37.90	35.76	10.00
24	16	Strenthening of Basic Training schools				2.00
25	17	F.W. Training and Res. Centre, Bombay	5.00	5.00	2.53	1.50
26	18	NIHFW, New Delhi	21.00	21.35	14.52	3.15
27	19	IIPS, Mumbai	5.70	6.90	6.83	1.70
28	20	Assistance to I.M.A.	0.65	0.67	0.64	0.25
	E	**RESEARCH**	**96.00**	**107.00**	**96.58**	**30.30**
29	21	Population Research Centres	35.00	33.00	22.47	8.00
30	22	CDRI, Lucknow	8.00	8.00	8.00	2.30
31	23	ICMR and IRR	53.00	66.00	66.11	20.00
32	24	Other Research Projects				0.00
	F	**CONTRACEPTION**	**1541.50**	**1578.70**	**1458.35**	**483.50**
	25	Free distribution of contraceptives	460.00	491.30	436.83	184.00
33		Conventional Contraceptives	265.00	310.00	286.20	
34		Oral Contraceptives	80.00	78.40	65.66	
35		IUD	115.00	102.90	84.97	-
36		New Methods				
	26	Social marketing of contraceptives	400.00	428.70	407.40	115.00
37		Conventional Contraceptives	400.00	360.85	339.04	
38		Oral Contraceptives		67.85	68.36	
	27	Sterilization	680.20	653.80	610.26	180.50
39		Sterilization Beds	8.60	8.60	8.79	
40		Sterilsation and IUD insertion	600.00	575.00	534.22	
41		Supply /Procurement of Laparascopes	70.00	68.00	66.75	
42		Recanalization	1.60	2.20	0.50	
43	28	Testing Facilities	1.30	1.90	1.24	0.50
	29	Role of Men in Planned Parenthood	-	3.00	2.62	3.50
44		No Scalpel Vasectomy		3.00	2.62	
45		Other Innovative Schemes *(Male Participation)*	-	-	-	-

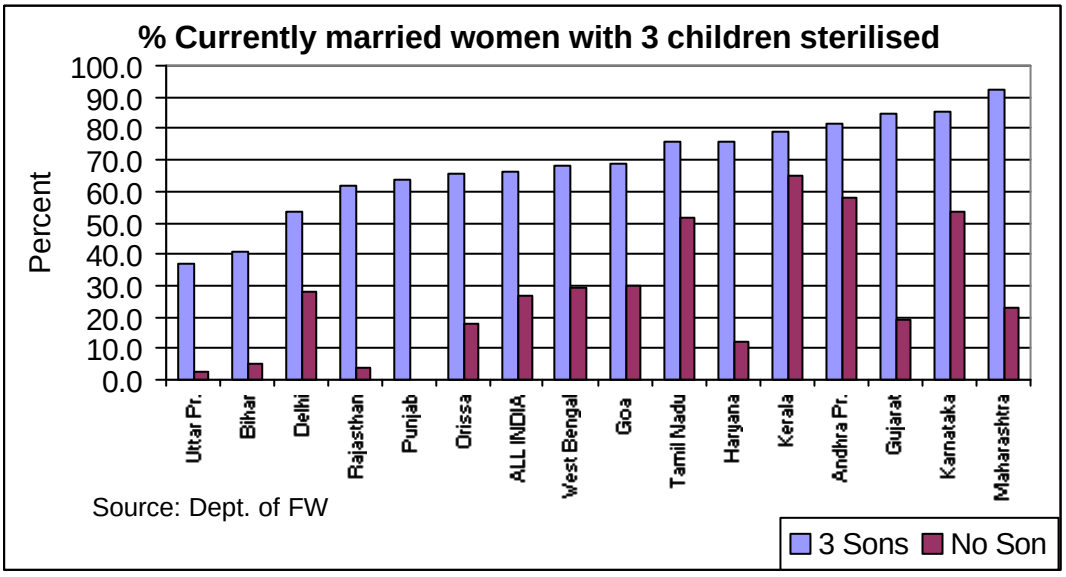
	G	**REPRODUCTIVE & CHILD HEALTH**	**5150.00**	**4423.30**	**3753.49**	**1174.20**
	30	Immunisation	-	-	-	226.00
46		Procurement of Vacccines for Routine Immunisation			Included in RCH	
47		Cold Chain				
		(a) Cold Chain Maintenance				
		(b) Cold Chain Equipment				
48		Surveillence against VPDs	Included			
49		Other Vaccines *(Hepatitis B)*	in RCH			
50	31	Routine Immunisation Strengthening				10.00
51	32	Pulse Polio				400.00
		(a) OPV				240.00
		(b) Operating cost				160.00
	33	Child Health				1.00
52		Essential New Born care *(Home based neonatal care)*	Included		Included	
53		Diarheal Diseases - Prevention/ Treatment	in RCH		in RCH	
54		ARI-Prevention/Treatment				
	34	NUTRITION	Included		Included	
55		Vitamin-A Programme	in RCH		in RCH	
56	35	Adolscent Health	Included in RCH		Included in RCH	3.00
	36	Maternal Health				254.00
57		Ante-natal care				
58		Nutritional Anaemia *(Anaemia Control & De-worming)*				
59		Home Delivery Care				
		(a) Community based midwives				
		(b) Dais Training	Included		Included	
60		Dais Kits *(Drugs, Kits & Equipments)*	in RCH		in RCH	
		(a) Drug Kits/FRU Drugs/PHC Drugs/ RTI Drugs				
		(b) MTP/RTI/STI Equipment/Kit/IUD Kit				
		(c) Equipment for Blood Storage & Lab. Equipment				
		(d) Needles & Syringes				
		(e) Neo-Natal Equipment				

61		Promoting Institutional Deliveries *(a) 24 Hour Delivery* *(b) Operationalising FRUs for Emergency Obs. & NN Care*	Included in RCH		Included in RCH	
62	37	MTP Services (Manual Vac. Aspirator for safe abortion)	Included in RCH		Included in RCH	1.20
63	38	RTI/ STI prevention and management	Included in RCH		Included in RCH	2.00
	39	Other RCH Interventions and services	Included in RCH		Included in RCH	122.00
64		Referral Transport				
65		Out reach Services				
66		RCH Camps				
67		Civil Works				
68		Research (In RCH Activities)				
69		MIS				
70		Expdt. At Headquarters				
71	40	NGOs and SCOVA	Included in RCH		Included in RCH	22.00
	41	Training				53.00
72		RCH Training	Included in RCH		Included in RCH	
73		Training of ISM&H				
74		Training of AWW				
75	42	Tribal Projects	Included in RCH	Included in RCH	Included in RCH	
76	43	Urban Slums Projects				5.00
77	44	District Projects				75.00
78	45	Other Projects under RCH				-
	H.	**OTHER FAMILY WELFARE PROGRAMMES**	**643.25**	**450.72**	**318.68**	**355.90**
79	46	Maternity Benefit Scheme	Transferred from M/o Rural Development	80.00	80.00	90.00
80	47	Information, Education and Communication	170.00	184.80	160.91	84.70
		Non-RCH				
		RCH				
81	48	Travel of Experts/Conferences / Meetings etc.	16.10	15.35	2.15	1.50
82	49	International Contribution	6.30	6.99	6.33	1.70
83	50	Empowered Action Group	265.00	30.00	30.00	50.00
84	51	Community Incentive Scheme		30.00	5.00	60.00

85	52	Family Welfare Link Health Insurance Plan		0.01	0.01	50.00
86	53	Policy Seminars		3.00	3.00	3.00
87	54	Other Initiatives		0.03	0.03	15.00
88		Strengthening of Rural Family Welfare Centres under National Human Development Initiative	Included in Sub-centres (scheme 2)	20.00	Included in Sub-centres (scheme 2)	
89		Other Offices under Direction & Administration	28.10	29.60	29.02	
90		ISM Institutions	7.00	5.02	1.39	
91		Regional Institute of MCH	0.75	0.60	0.31	
92		Hindustan Latex Limited	1.90	1.72	0.13	
93		Family Welfare Counsellor Scheme	1.00	1.00	0.00	
94		School Health Scheme	147.10	42.60	0.40	
	55	Additional RCH activities in the Tenth Plan				0.30
	56	Other New Initiatives				6.00
		GRAND TOTAL	**15120.00**	**14968.70**	**14588.97**	**4930.00**

Annexure 5.7.3





5.8 INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

INTRODUCTION

1. The umbrella term, Indian systems of medicine and homoeopathy (ISM&H), includes Ayurveda, Siddha, Unani, Homoeopathy and therapies such as Yoga and Naturopathy. Practitioners of ISM&H catered to all the health care needs of the people before modern medicine came to India in the twentieth century. Currently, there are over 680,000 registered ISM&H practitioners in the country; most of them work in the private sector. A major strength of ISM&H system is that it is accessible, acceptable and affordable.

2. India also has a vast network of governmental ISM&H healthcare institutions. There are 3005 hospitals with over 60,000 beds and over 23,000 dispensaries providing primary healthcare. Over 16,000 ISM&H practitioners qualify every year from 405 ISM&H colleges. The Department of ISM&H supports four research councils and provides research grants to a number of scientific institutions and universities for conducting clinical research, ethno-botanical surveys and pharmacopoeial and pharmocognostic studies on herbal drugs and medicinal plants. Pharmocopoeial Committees constituted by the Department are finalising standards for single simple formulations and will shortly take up the task of formulating standards for compound ISM formulations.

3. Despite all these efforts, the ISM&H have not realised their full potential because:

- existing ISM&H primary, secondary and tertiary healthcare institutions lack essential staff, infrastructure, diagnostic facilities and drugs.
- the potential of ISM&H drugs and therapeutic modalities has not been fully exploited.
- lack of quality control and good manufacturing practices have resulted in the use of spurious and substandard drugs.
- the quality of training of ISM&H practitioners has been below par. Many ISM&H colleges lack essential facilities, qualified teachers and hospitals for practical training. There is no system of Continuing Medical Education (CME) for periodic updating of knowledge and skills.
- the ISM&H practitioners are not involved in national disease control programmes or family welfare programme.
- Medicinal plants have been overexploited and, as a result, the cost of ISM&H drugs have increased and spurious products are getting into the market.

4. The National Health Policy (1983) visualised an important role for the ISM&H practitioners in the delivery of health services. In order to give focused attention to the development and optimal utilisation of this branch of medicine, a separate Department for ISM&H was set up in 1995. The Department is making efforts to ensure that ISM&H practitioners are brought into the mainstream so that they provide a complementary system of care along with practitioners of modern systems of medicine.

Healthcare Services

5. The Ninth Plan aimed at improving the quality of primary, secondary and tertiary care in ISM&H, with the Departments of ISM&H in the Centre and the states taking up several initiatives to improve the quality and coverage of these services at each level.

Primary Health Care

6. ISM&H practitioners provide primary healthcare to vulnerable sections of the population especially those living in urban slums and remote areas. Details of the number of ISM&H hospitals and dispensaries (as on 1 April 1999) are given in Annexure-5.8.1. In some states like West Bengal and Gujarat, ISM&H practitioners alone are posted in primary health centres (PHCs) in some remote rural and tribal areas. In Kerala, ISM&H practitioners provide a complementary system of care in the PHCs. It is important to ensure that the ISM&H dispensaries and hospitals are linked with PHC/urban health care centres so that they can have ready access to diagnostic and other facilities available in these institutions and, at the same time, patients can choose the system for treatment.

Secondary Health Care

7. A majority of existing ISM&H secondary hospitals function as separate institutions and do not have linkages with either primary ISM&H healthcare institutions or with secondary healthcare institutions in the modern system of medicine. Very often these institutions lack adequate diagnostic facilities, infrastructure and manpower. The Ninth Plan had envisaged initiation of a pilot project to test the feasibility and usefulness of posting ISM&H practitioners in district hospitals. Some states did attempt to provide ISM&H clinics in district hospitals but the experience in this area has been limited.

Infrastructure

Vast infrastructure has been created:

- Hospitals 3,005
- Beds 60,681
- Dispensaries 23,028

Problems:

- No organised referral system.
- They provide healthcare only to those who come to them.
- Each centre is isolated. They are not linked with other institutions in the area.
- No organised referral system.
- No linkage with existing modern system hospitals – hence they are unable to function optimally as a complementary system or utilise the diagnostic facilities available.

Tertiary Healthcare

8. All ISM&H colleges, private as well as public, have attached tertiary care hospitals. In addition, there are tertiary care and/or speciality centres attached to national institutes. Private /voluntary sector institutions also provide tertiary care in ISM&H. During the Ninth Plan, the Department of ISM&H provided funds to strengthen many of these institutions. One Unani speciality clinic was established in the Ram Manohar Lohia Hospital, Delhi and one Ayurvedic and one Homoeopathic unit was established in the Safdarjung Hospital, Delhi. The Department has also provided funds for establishing speciality clinics in the

National Institute of Mental Health and Allied Sciences (NIMHANS), Bangalore. These clinics are reported to have very good attendance. Department of ISM&H has obtained 'in principle' approval of the Planning Commission for schemes aimed at strengthening ISM&H hospitals and dispensaries and setting up ISM&H clinics in secondary and tertiary care institutions both in Central Government funded hospitals and in State Government funded hospitals.

Development of Human Resources for ISM&H

9. There has been a progressive increase in the number of practitioners graduating from ISM&H educational institutions during the last five decades. Currently there are 405 under graduate and 77 post graduate colleges in ISM&H (Table 5.8.1). But the quality of training these colleges impart is poor. A recent inspection of 160 colleges showed that:

- 44 per cent of them lack the required number of departments;

Table 5.8.1 Medical Education in ISM&H

System	Colleges Undergraduate	Postgraduate
Ayurveda	198	53
Unani	39	5
Siddha	2	2
Homoeopathy	166	17
Total	**405**	**77**
Admission capacity	16,845	821

Source: Department of ISM & H, 2001

Current Problems In Medical Education

- ☞ Students join ISM&H institutions through a common entrance examination; those who do not get admission in modern system of medicine opt for ISM&H colleges.
- ☞ The quality of teachers is poor and teaching aids are in short supply.
- ☞ Morale of ISM&H teachers and students is low.
- ☞ Present ISM&H syllabus and curriculum are inadequate. As a result, graduates do not have the knowledge, skills and confidence to practice ISM&H therapy.

- 89 per cent do not have the requisite number of teachers;
- 52 per cent lack required hospital beds;
- 79 per cent have less than 60 per cent bed occupancy;
- 91 per cent do not have adequate diagnostic equipment;
- 52 per cent of all colleges have a student/bed ratio, which is higher than the prescribed ratio of 1:3.

10. Not enough attention is paid to train the students to use ISM&H diagnostic and therapeutic modalities. As a result, these students lack confidence, knowledge and skills in using ISM&H therapeutic modalities and tend to practise the modern system of medicine in which they are not trained. Patients, therefore, do not get the benefit of ISM&H therapy in spite of accessing ISM&H practitioners.

11. Some of the steps which had been suggested to improve the situation are:

- introduce an entrance examination for ISM&H undergraduate courses with appropriate eligibility criteria to identify the potential and interest of students;

- ensure uniformity in the admission system in undergraduate and postgraduate courses;
- reorient the syllabus keeping in mind the potential for employment in industry and ISM&H services being offered through speciality clinics;
- strengthen existing national centres of excellence in collaboration with the Department of ISM&H;
- strengthen and mainstream at least one college for each system as a model of undergraduate/postgraduate college in each of the major states; and
- operationalise an appropriate and transparent accreditation system for educational institutes through Councils of ISM&H.

Quality Assurance in Education in ISM&H

12. The Indian Medicines Central Council Act, 1970 was enacted for the constitution of a Central Council of Indian Medicines, maintenance of a central register of Ayurveda, Siddha and Unani and related matters. The Central Council of Indian Medicine (CCIM) and the Central Council of Homoeopathy (CCH), constituted in 1970 and 1973 respectively, are responsible for :

- laying down and maintaining uniform standards of education for ISM&H courses, prescribing standards of professional conduct, etiquette and code of ethics for practitioners and
- advising the central government on matters relating to the recognition of appropriate qualifications of ISM&H.

13. They also work in coordination with state-level board/council to maintain standards in ISM&H medical institutions. In addition, they maintain central registers for Indian systems of medicine and homoeopathy respectively.

14. A review of the functioning of the Councils by the Department of ISM&H shows that the monitoring procedures and schedules are not adequate. The recommendations of the CCIM and CCH are often not acted upon. There is no legal framework and, consequently, no institutional mechanism available to lay down and enforce standards relating to yoga and naturopathy. The standards of education in these two disciplines are, therefore, the weakest.

15. A large number of colleges are being opened predominantly in the private sector, after obtaining permission from state governments and getting affiliated to universities. Between 1995 and 2000, the CCIM permitted setting up of 73 ayurveda Colleges, 11 homoeopathy colleges and three siddha colleges. This mushrooming of colleges has adversely affected the quality of ISM&H education. The problem was discussed in the Central Council for Health and Family Welfare 1997 and at the first conference of State Health Ministers in ISM&H in 1997. Suitable amendments may have to be made to the Indian Medicines Central Council Act, 1970 and the Homoeopathy Central Council Act, 1973 to ensure that new colleges comply with the prescribed guidelines.

16. Department of ISM&H is taking steps to reduce the proliferation of substandard medical colleges and check the deterioration in standards of teaching. Simultaneously, the Department of ISM&H is taking steps to ensure that the statutory councils perform the role assigned to them. Periodic inspection of all established ISM&H colleges is necessary to ensure that only those colleges which have the necessary infrastructure, manpower and facilities be allowed to continue operating. This is, undoubtedly, a difficult task but is necessary to improve the standards of ISM&H education. Department of ISM&H has proposed that selected UG/PG colleges will be appropriately strengthened so that quality of care and teaching improve.

Paraprofessionals in ISM&H

17. Currently there are no arrangements for providing a degree or diploma in IS&M pharmacy nor is it included as one of the options in the general pharmacist course. Similarly, there is no training for nursing in ISM&H. The department should take up these two matters so that ISM&H practitioners have the necessary support staff.

National Institutes in ISM&H

18. The Department of ISM&H has set up national institutes in each of the major disciplines which are meant to act as centres of excellence providing high quality patient care, teaching and research. While some of these institutes are well established and are functioning effectively, many are in the initial stages of operationalisation. The Department of ISM&H has obtained 'in principle' approval of a major scheme to strengthen these institutions so that these centres can play a pivotal role in improving teaching, training, patient care and research and patient care standards.

National Institutes Funded By The Central Government

- National Institute of Ayurveda, Jaipur
- National Institute of Unani Medicine, Banglore$
- National Institute of Homoeopathy, Calcutta
- National Institute of Naturopathy, Pune
- Morarji Desai National Institue of Yoga, New Delhi
- National Institute of Siddha, Chennai$
- Rashtriya Ayurveda Vidyapath, New Delhi

$ being established

Continuing Medical Education (CME) in ISM&H

19. Most of the Registered Practitioners of ISM&H (Table 5.8.2), are in the private sector; there is a need to periodically update their knowledge and skills through continuing medical education. During the Ninth Plan period, the Department of ISM&H started a scheme for re-orientation and in-service training. The scheme offered one month's course for teachers and physicians and a two months' course for ISM&H practitioners in specialised fields like *ksharasutra, panchakarma therapy*, dental

Table 5.8.2 - Registered Medical Practitioners In ISM&H

Ayurveda	4,27,504
Unani	42,445
Siddha	16,599
Naturopathy	429
Homoeopathy	1,94,147
Total	6,81,124

Source: Department of ISM&H, 2001

practices and in yoga. The response to this course has been poor because most practitioners felt that they cannot leave their practice for an extended period.

20. During the current year, efforts are being made to provide registered ISM&H practitioners with updated information about advances in their respective systems beginning with Government-employed ISM&H practitioners. The training material will be produced by the national institutes and the state ISM&H colleges with the help of experts. Optimal use will be made of advances in information technology to improve the outreach of the CME programme so that it does not disrupt their practice. Attempts will also be made to increase the involvement of ISM&H practitioners in counselling and improving the utilisation of services under the national health and family welfare programmes during the Plan period. The ISM&H practitioners will play an important role in:

- health education;
- drug distribution for national programmes;
- motivation and counselling in family welfare programmes;
- acting as depot holders for selected items such as condoms and oral rehydration therapy (ORT) packages;
- motivation for immunisation; and
- improvement in environmental sanitation through community efforts.

Preservation, Promotion and Cultivation of Medicinal Plants and Herbs

21. Over the last two decades there has been a steady increase in the demand for drugs used in ISM&H. However, the demand for good quality medicinal plants and herbs have not been met. The prices of several plants have increased sharply, making them unaffordable and some species of medicinal plants are also reported to be endangered because of increasing pressure on forests.

Medicinal Plants

Current Problems:-

- ☞ The demand for medicinal plants is growing; the trade in medicinal plants is secretive and exploitative.
- ☞ The profit motive is leading to unsustainable practices being employed. As a result, plant species are in danger of extinction.
- ☞ Quality of ingredients is poor, leading to poor quality of drugs.
- ☞ Cultivation has not been encouraged and most plants are uprooted from the wild.

22. The Planning Commission had constituted a Task Force on the Conservation, Cultivation, Sustainable Use and Legal Protection of Medicinal Plants. The Task Force recommended:

- establishment of medicinal plants conservation areas (MPCA), covering all ecosystems, forest types and sub types;
- ex-situ conservation of rare, endangered medicinal plants may be tried out in established gardens managed by the Departments of Agriculture, Horticulture or Forests;

- gene banks created by the Department of Biotechnology should store the germplasm of all medicinal plants;
- 'establishment of *Vanaspati vans*' in degraded forest areas;
- forest areas rich in medicinal plants should be identified, management plans formulated and sustainable harvesting encouraged under the Joint Forest Management System;
- technically qualified NGOs must be encouraged to take up the task of improving awareness and increasing availability of plant stock and involved in the promotion of agro-techniques for cultivation of medicinal plants;
- screening/testing/clinical evaluation of herbal products to be taken up and completed;
- drug testing laboratories for ISM&H products should be established with qualified staff;.
- establishment of a Traditional Knowledge Digital Library so that information on medicinal plants and their use in the country could be accessed readily.
- establishment of a Medicinal Plant Board for integrated development of the medicinal plants.

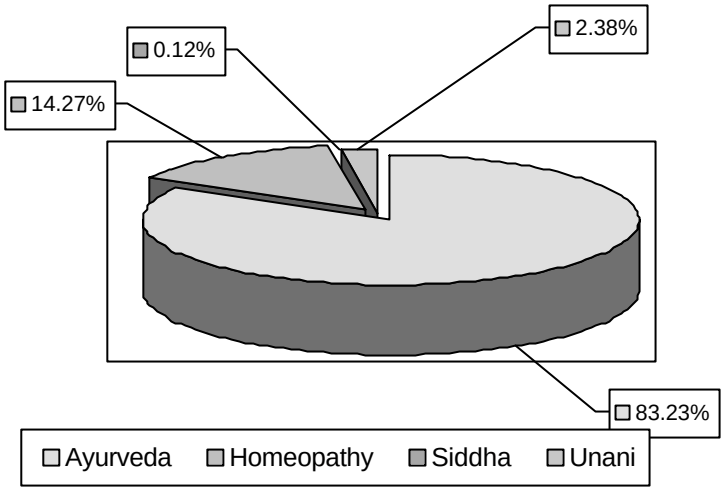
23. Many of the recommendations of the task force have been implemented. The Medicinal Plant Board has been established in the Department of ISM&H to look after all multi-sectoral issues relating to the development of medicinal plants. The Board is expected to formalise and organise the marketing of and trade in medicinal plants, coordinate efforts of all stakeholders in the sector and improve the awareness availability of herbal products. Twelve state governments have established State Medicinal Plant Boards. The ministries of Health and Family Welfare, Environment and Forest, Rural Development and Agriculture are promoting the cultivation of medicinal plants. Agro-techniques are being standardised for 28 plants identified for fast track cultivation. States have been requested to introduce measures to register cultivators and traders dealing with medicinal plants and to make the Forest Development Corporation the conduit for supply of medicinal plants to industry. The proposals to encourage R&D, support gene banks and support industry for the identification of export markets and market segmentation are under consideration.

24. The Department of ISM&H has initiated a scheme on a Traditional Knowledge Digital Library. Around 35,000 formulations described in 14 ancient texts relating to ayurveda are now entered in this library and can be accessed by all. This step will help ready access to traditional practices and prevent outsiders taking patents on them. The Department has established a Patent Cell to keep track of patents concerning ayurveda, siddha and unani drugs being filed in India and abroad. The cell will also provide professional and financial assistance to government and private ISM&H scientists for filing of patents. An Expert Group has been constituted for advising the Department with regard to patenting issues.

ISM&H Industry

25. The global market in herbal products in alternative systems of medicine is estimated to be $62 billion. India's share in this is very meagre. Even within the country the share of ISM&H products is only a modest Rs. 4,200 crore ; Ayurvedic drugs and formulations account for over 80% of the products (Figure 5.8.1).

Figure 5.8.1 - Market Share of drugs of difffernt systems of ISM&H



Source: Department of ISM&H, 2001

26. A survey of the current status of the ISM&H industry undertaken by the Department of ISM&H showed that it is divided into the large, medium, small and very small-scale sectors (Table 5.8.3). The small-scale sector is not pursuing good manufacturing practices. Patent proprietary medicines are being introduced through wide-scale licensing without checking their efficacy or quality. These medicines have become expensive. A number of products claiming to be ayurvedic medicines use large quantities of synthetic ingredients as excipients. Classical and *shastra* preparations are not getting due importance.

Table 5.8.3 - ISM&H Industry in India

- Rs.4, 200 crore industry (ayurveda accounts for Rs. 3,500 crore)
- 7,000 manufacturers of ayurvedic products
  - ⇔ Large (> Rs. 50 crore) 10
  - ⇔ Medium (Rs. 5-10 crore) 25
  - ⇔ Small (Rs. 1-5 crore) 965
  - ⇔ Very Small (<Rs. 1 crore) 6,000

Source: Deptt of ISM&H 2001

27. Through continuing CSS of drugs quality control the Department has taken steps to ensure good manufacturing practices and quality control of drugs through strengthening of drug testing laboratory in the State/UTs so that there is increasing confidence in ISM&H drugs and formulations, as a result of which their market will expand both within the country and abroad.

Table 5.8.4 - Licensed Pharmacies in India

Ayurveda	8,533
Unani	462
Siddha	385
Homoeopathy	613
Total	**9,992**

Source: Department of ISM&H, 2001

Quality Control of Drugs

28. There are a large number of ISM&H pharmacies in the country (Table 5.8.4) and many of them, especially smaller ones, do not adopt good manufacturing practices. The

Department of ISM&H has finalised and notified good manufacturing practices for ayurveda, siddha and unani drugs over the last two years.

Central Government's efforts to strengthen drug quality control

- ☞ Pharmacopoeial Laboratory for Indian Medicines, Ghaziabad and Homoeopathy Pharmacopoeial Laboratory, Ghaziabad are being strengthened.
- ☞ Appellate laboratories for drug testing and quality control are being identified.
- ☞ Preparation of drug formularies and Pharmacopoeias for ayurveda, siddha, unani and homoeopathy drugs are proceeding rapidly.
- ☞ The Department of ISM&H is assessing and training ISM&H drug industry personnel and drug inspecting staff in standardisation and quality control.

29. Setting up pharmacopoeial standards and strengthening of the drug control laboratories has been identified as a priority in the Ninth Plan. The Pharmacopoeial Laboratory of Indian System of Medicine (PLIM) and Homoeopathic Pharmacopoeial Laboratory (HPL) at Ghaziabad are the major ISM&H drug testing laboratories. However, ensuring quality control is still a major problem because of lack of adequate number of ISM&H testing laboratories. In order to address this problem, the Department has initiated a centrally-sponsored programme for strengthening of state drug testing laboratories and for improving good manufacturing practices in ISM&H pharmacies. However, complaints of poor quality of ingredients or adulteration and substitution of components used for preparation of ISM&H drugs and lack of confidence in the safety, efficacy and quality of the drugs persists, testing of complex ISM&H drugs is difficult. Drug testing laboratories at the state level are either inadequate or non-existent. State governments are not properly implementing licensing or quality testing requirements for the enforcement of Pharmacopoeial standards.

30. Department of ISM&H is making efforts to improve the quality control of drugs used in ISM&H by:

- completing all pharmacopoeial work by 2004;
- modernising state ISM&H pharmacies;
- motivating these pharmacies and the ISM&H industry to adopt good manufacturing practices;
- strengthening the central and state quality control laboratories and exploring the feasibility of utilising laboratories of the Central Council for Research in Ayurveda and Siddha (CCRAS) and chemistry and biochemistry laboratories of universities/college departments as well as existing drug testing laboratories in the modern system of medicine for testing and quality control of ISM&H drugs.
- implementing stringent drug quality control and strictly enforcing the provisions of the Drugs and Cosmetics Act (1940**)** and the Magic Remedies Prevention Act, 1954.
- Monitoring work relating to survey samples and statutory samples of ISM&H.

Neutraceuticals and Food Supplementation Products

31 Food supplements, cosmetics and toiletries and neutraceuticals are flooding the Indian market. It has been reported that they have export potential. These products contain not only plant-based materials, exotic plant ingredients but also synthetic chemicals. As all these products do not come under the category of either modern system or ISM&H drugs, they are not governed either by the Drugs and Cosmetic Act or the Prevention of Food Adulteration Act (1986), they enter the market without any quality control. It is important that these products are brought under the purview of Drugs and Cosmetic Act or the Prevention of Food Adulteration Act through suitable amendments of these acts and compliance with the act should be monitored carefully

Medical Tourism

32. There has been a resurgence of interest in traditional medicine in India and abroad, leading to an increased demand for specialised treatment available in ISM&H. A number of tourists are visiting Kerala for *panchakarma* treatment for rejuvenation, and treatment of neuro-muscular and orthopaedic disorders. Himachal Pradesh has initiated a scheme on health tourism by offering *panchakarma* in good hotels. During the Annual Plan 2002-03, opportunities in this area will be explored and catered to. At the same time appropriate transparent quality and cost of care norms will be set up and monitored to prevent exploitation of the clients.

Research and Development

33. During the current year, there will be focussed attention on R&D especially clinical trials on new drug formulations, clinical trial of promising drugs through strengthening of the Central Research Councils and coordination with other research agencies. Special emphasis on encouraging research aimed at improving ISM&H inputs in National Health Programmes has been laid. Clinical trials on testing of drugs traditionally used in illnesses and those used in tribal societies for safety and efficacy and research on developing new drug formulation may be conducted.

Some of the major problems in R&D in ISM&H include:

- ISM&H practitioners and researchers need training in research methodology.
- in spite of growing interest in Indian health systems, alternate and complementary medicine, none of the research done by research councils, industry and academic institutions has been published in scientific journals of national and international repute.
- research has not concentrated on areas where ISM&H has unique advantages such as prevention and management of lifestyle-related diseases, and diseases for which drugs are not available in the modern system;
- research work is not carried out in collaboration with modern hospitals where abundant clinical material is available.

34. There are four research councils in ISM&H: the Central Council for Research in Ayurveda and Siddha (CCRAS), the Central Council for Research in Unani Medicines

(CCRUM), the Central Council for Research in Yoga and Naturopathy (CCRYN) and the Central Council for Research in Homoeopathy (CCRH). These councils are the apex bodies for research in the various systems of medicine and are fully financed by the Government of India. They initiate, guide, develop and coordinate basic and applied research, medico-botanical surveys, research on cultivation of medicinal plants and pharmacognostical studies. These councils also conduct research programmes aimed at drug standardisation and clinical trials of new ISM&H drugs.

35. The following measures are being taken to improve R&D.

- Priority will be accorded for bio-medical research pertaining to drug development in specific areas where strength of ISM has already been established.
- Importance will be given to research on the fundamental principles of ISM&H.
- Emphasis will be laid on research in the preventive and promotive aspects of ISM especially lifestyle-related disorders.
- Medico-historical investigations of ISM&H will be continued.
- Promising and widely accepted practices and skills of traditional healers in rural and tribal areas will be identified and evaluated.

Involvement in National Progamme

36. The Department of ISM&H is associated with the RCH Programme of the Department of Family Welfare. Thirty institutes have been identified for providing training to ISM&H physicians in RCH and funds have been provided by Department of Family Welfare for inclusion of Ayurvedic and Unani drugs in the drug kit of ANM is being considered. Involvement in all other Central and State Health Sector Programmes e.g. Malaria, Tuberculosis control, diarrhoeal diseases control will have to be taken up in a phased manner.

National ISM&H Policy

37. Globally, there has been a revival of interest in a complementary system of healthcare especially in the prevention and management of chronic lifestyle-related non-communicable diseases and diseases for which there are no effective drugs in the modern system of medicine. India is currently undergoing demographic and lifestyle transition which will result in the increasing prevalence of non-communicable diseases and lifestyle related disorders. ISM&H, especially ayurveda, yoga and naturopathy, can play an important role in the prevention and management of these disorders. ISM&H practitioners can undertake the task of counselling and improving the coverage and continued use of drugs in national diseases control programmes and the family welfare programme.

38. The National ISM&H Policy approved by the Cabinet in October 2002 envisages that the following measures will enable ISM&H system achieves its full potential in providing healthcare:

- improving the quality of primary, secondary and tertiary care;
- mainstreaming ISM&H institutions and practitioners with modern systems of medicine so that people have access to a complementary system of care;
- strengthening ISM&H educational institutions so that students get adequate training, giving them confidence to practise their system and participate in national programmes;
- investing in continuing medical education;
- ensuring the conservation, preservation, promotion, cultivation, collection and processing of medicinal plants and herbs required to meet growing domestic demand for ISM&H drugs and the export potential;
- completing Pharmacopoeia of all the systems of ISM&H and drawing up a list of essential drugs and ensuring their availability;
- ensuring quality control of drugs and improving their availability at an affordable cost;
- investing in research and development (R&D) for the development of new drugs and formulations, undertaking clinical trials and patenting them; and
- undertaking clinical trials of promising drugs being in use, by appropriately strengthening Central Research Councils and coordinating their research with other research agencies such as Indian Council of Medical Research (ICMR), Delhi.

Zero Based Budgeting

39. The Planning Commission had directed all central ministries/departments to review the ongoing schemes using the zero-based budgeting methodology and to ascertain which of the ongoing schemes require continuation in the Tenth Plan. The Department of ISM&H also went through this exercise.

40. Since the Department started functioning only in 1995, most of the schemes had been initiated during the Ninth Plan. A majority of them relate to strengthening essential central institutions in medical education, healthcare, drug quality and research. All these schemes are, therefore, essential. It was found that there were a large number of small schemes and these were merged into broad programmes. Some of the centrally sponsored schemes had been misclassified as central sector schemes and this error has now been corrected. The outlays and expenditure under each of these during the Ninth Plan is summarised in Table-5.8.5.

Table 5.8.5 – Summary of Zero Based Budgeting Exercise –2001
Centrally Sponsored Schemes

Scheme	No. of schemes	Ninth Plan outlay (Rs. Lakh)	Ninth Plan – Sum of yearly outlays (Rs. Lakh)
Schemes to be retained	1	51	51
Schemes to be merged	3/8	5,992	8,047
Schemes to be weeded out	1	0	410
Total	4/10	6,043	8,508
Central Sector Schemes			
Schemes to be retained	1	480	680
Schemes to be merged	8/34	20,112	27,465
Total	9/35	20,592	28,145

Outlays and Expenditure:

42. The Department of ISM&H has been provided with an outlay of Rs. 15000.00 lakhs for the Annual Plan 2002-03. The outlay and expenditure for the Ninth Plan and Annual Plans 2002-03 are given in Table below.

Table 5.8.6 - Outlay and Expenditure

Rs. in Crores				
Ninth Plan (B.E.)	Ninth Plan (Actual)	2001-2002 (B.E.)	2001-2002 (Anti Expd.)	2002-2003 (B.E.)
266.35	292.26	120.00	80.69	150.00

Annexure 5.8.1

Hspitals And Dispensaries Under Indian Systems Of Medicine And Homoeopathy

SL.	NAME OF	AYURVEDA			UNANI			HOMOEOPATHY			OTHERS		
NO.	STATES/ UTs	Dispen saries	Hospitals	Beds	Dispen saries	Hospitals	Beds	Dispen saries	Hospitals	Beds	Dispen saries	Hospitals	Beds
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	Andhra Pradesh	1437	8	444	207	7	390	286	6	280	0	1	135
2	Arunachal Pradesh	4	1	15	1	-	-	41	-	-	0	0	0
3	Assam#	329	2	130	1	-	-	75	3	105	4	1	25
4	Bihar#	522	9	871	128	4	414	181	1	100	0	0	0
5	Delhi#	122	9	771	19	4	311	95	3	190	0	1*	50
6	Goa	59	6	245	-	-	-	56	-	-	0	0	0
7	Gujarat	539	45	1745	-	-	-	34	9	730	10	1	1
8	Haryana	414	6	840	20	1	10	20	-	-	0	0	0
9	HimachaPradesh	1064	16	330	3	-	-	14	-	-	0	2	25
10	J & K#	247	1	25	171	2	200	2	-	-	25	1	10
11	Karnataka	561	124	6132	45	11	202	25	25	1480	11	18	586
12	Kerala	759#	109	2561#	1#	-	-	2754	72	1440	9#	1#	30
13	Madhya Pradesh	2105	34	1160	56	1	60	202	12	590	0	0	0
14	Maharashtra#	463	73	11713	23	10	1400	-	77	5505	0	0	0
15	Manipur	-	-	-	-	-	-	9	1	10	1	2	65
16	Meghalaya	-	-	-	-	-	-	5	-	-	0	0	0
17	Mizoram	1	-	-	-	-	-	1	-	-	0	0	0
18	Nagaland	-	-	-	-	-	-	2	-	-	0	0	0
19	Orissa	527	8	323	9	-	-	503	5	150	65	0	0
20	Punjab#	489	11	771	35	-	-	105	6	185	0	0	0
21	Rajasthan	3486	90	1179	79	5	270	121	5	160	3	2	22
22	Sikkim	-	-	-	-	-	-	1	-	-	1	0	0
23	Tamilnadu	10	4	267	6	1	54	41	3	150	339	221	1716
24	Tripura	30	1	10	-	-	-	66	1	20	0	0	0
25	Uttar Pradesh#	713#	1671	9911	148#	136	1186	1378	36	399$	0	0	0
26	West Bengal#	254	3	215	-	2	110	899	14	682	0	0	0
27	A & N Islands	-	-	-	-	-	-	7	-	-	0	0	0
28	Chandigarh#	5	1	150	-	-	-	4	1	25	0	1	10

Contd....

SL.	NAME OF	AYURVEDA			UNANI			HOMOEOPATHY			OTHERS		
NO.	STATES/ UTs	Dispen saries	Hospitals	Beds	Dispen saries	Hospitals	Beds	Dispen saries	Hospitals	Beds	Dispen saries	Hospitals	Beds
1	2	3	4	5	6	7	8	9	10	11	12	13	14
29	D & N Haveli	1	1	-@	-	-	-	1	1	-@	0	0	0
30	Daman & Diu	1	1	5	-	-	-	-	-	-	0	0	0
31	Lakshadweep	4	-	-	-	-	-	2	-	-	0	0	0
32	Pondicherry	12	-	-	-	-	-	1	-	-	8	0	0
33	Cghs	31	1	25	9	-	-	34	-	-	5	0	0
34	CentralResearch	32	20	475	8	12	265	41	5	105	4	2	85
	Councils												
35	M/O RAILWAY	38	-	-	-	-	-	124	-	-	0	0	0
36	M/O LABOUR	129	-	-	1	-	-	25	-	-	2	0	0
37	M/O COAL	28	-	-	-	-	-	-	-	-	0	0	0
	Total	**14416**	**2258**	**40313**	**970**	**196**	**4872**	**7155**	**297**	**12836**	**487**	**254**	**2660**

Source: Department Of ISM&H, 1999

Note :- Institutions functional as on 1.4.1999;
- = Nil Information.
= Information for the current year has not been received. Hence repeated for the latest available year.
* = Information regarding Yoga Hospitals in Delhi is under clarification.
$ = Figures as on 1.4.98.
@ = No. of beds reported nil in under clarification
Figures are provisional

Annexure 5.8.2

Tenth Plan Outlays - Department of ISM&H

Rs. In Lakhs

Sl. No.	Name of the Scheme	Ninth Plan Outlay	9th Plan Sum of Year-wise Outlay	Anticipated Expenditure	2002-03 Outlay
1	2	3	4	5	6
	Centrally Sponsored Schemes				
A	Development Of Institutions	2920.00	4020.00	4279.48	1950.00
B	Hospitals And Dispensaries	490.00	402.00	73.72	750.00
C	Information, Education And Communiation (IEC)	51.00	51.00	0.00	300.00
D	Drugs Quality Control	2582.00	3700.00	3146.55	875.00
	Central Sector				
A	Strengthening Of Deptt. Of ISM&H	1650.00	2129.00	1964.61	515.00
B	Educational Institutions	5282.00	6693.00	4990.65	2615.00
C	Statutory Institutions	176.00	169.00	147.00	15.00
D	Research Councils (Intra And Extra Mural Research)	8391.00	10777.00	10661.94	2520.00
E	Hospitals And Dispensaries	71.00	292.00	314.80	276.00
F	Medicinal Plants	1765.00	3420.00	2215.56	2516.00
G	Strengthening Of Pharmacopoeial Laboratoraties	1082.00	1150.00	365.50	567.00
H	Information, Education And Communiation (IEC)	480.00	680.00	839.28	300.00
I	Other Programmes And Schemes	1595.00	2960.00	226.52	1801.00
	New Initiatives During The 10th Plan				-
	Grand Total	**26635.00**	**36443.00**	**29225.61**	**15000.00**

5.9 HOUSING, WATER SUPPLY AND CIVIC AMENITIES

5.9.1 WATER SUPPLY AND SANITATION

1. The Tenth Five Year Plan envisages provision of safe drinking water on a sustainable basis to every settlement in the country and to take all possible measures for rapid expansion and improvement of sanitation facilities in the urban as well as rural areas with local participation.

2. Whereas provision of safe drinking water and sanitation is a State subject and primary responsibilities of the State Governments, and more specifically the local bodies, the Central Government has been supplementing the efforts of the State Governments in the form of financial assistance and technical guidance since 1976-77 by implementing a large scale Centrally Sponsored Scheme of rural water supply, viz. "Accelerated Rural Water Supply Programme" (ARWSP), also known as "Rajiv Gandhi National Drinking Water Mission". Based on the reports received from the State Governments by the Drinking Water Mission, there were 19544 left over "Not Covered" (NC) and 165722 "Partially Covered" (PC) habitations as on 1.4.2001 out of a total of 1422664 identified habitations in rural areas. Besides, as many as 1.50 lakh habitations, which are reported to have been suffering from water quality problems, like excess fluoride, arsenic, salinity, iron etc, also need to be tackled. Thus, the task ahead is significantly large in terms of "No-source" villages/habitations, extent of quality and quantity problems of water supply to be tackled and more importantly the sustainability of the programme. As regards rural sanitation, a Re-structured Centrally Sponsored Scheme with involvement of local people and NGOs has been brought in force from April 1999.

3. In so far as urban water supply is concerned, a modest Centrally Sponsored scheme viz., Accelerated Urban Water Supply Programme for small towns with population less than 20,000 (as per 1991 census) is under implementation by the Ministry of UD&PA since 1993-94. Similarly, a Centrally Sponsored Scheme of Urban Low Cost Sanitation for Liberation of Scavengers is also under implementation since 1990 with the primary objective of eliminating the obnoxious practice of manual handling of human excreta, through conversion of all the existing dry latrines into sanitary latrines. Under this scheme, "whole-town" approach is adopted and in the process, assistance is also provided for construction of new sanitary household/community latrines, where no toilet facility exists. Besides, the State Governments have also been putting in substantial plan allocations for urban water supply and sanitation schemes and significant institutional funding availed. However, the per capita unit costs of incremental water supply and modern underground sewerage schemes are very high and beyond the means of most of the urban local bodies/ State Governments in their current financial status. More innovative "User-Charges" and pricing principles, therefore, need to be adopted to enhance the financial viability of the Sector and permit resource mobilisation through institutional finance, market borrowing, private investment etc.

Review of Annual Plan 2001-2002

4. The Annual Plan 2001-2002 included an outlay of Rs. 8355.03 crore - Rs. 5972.23 crore in the State and UT Plans and Rs. 2382.80 crore in the Central Plan for water supply and sanitation sector. Against this, the likely expenditure during the year is Rs. 7948.74

crore -Rs. 5691.94 crore in the State and UT Plans and Rs. 2256.80 crore in the Central Plan. In addition, an amount of Rs 33.50 crore was also released under Non-lapsable Central Pool of Resources for North-Eastern States and Sikkim.

5. On the basis of reports, furnished by the State Governments to the Rajiv Gandhi National Drinking Water Mission, 43771 villages/habitations have been provided with safe drinking water supply facilities during 2001-2002, against a total target of 45526 villages/ habitations.

6. Under Centrally Sponsored Accelerated Urban Water Supply Programme (AUWSP), 660 projects costing Rs. 829.34 crore have been approved up to 2001-2002 including 85 projects costing Rs. 122.81 crore during 2001-2002. The Government of India has so far released an amount of Rs. 360.57 crore including Rs 95.00 crore during 2001-2002 and States have released a total amount of Rs. 244.09 crore. An expenditure of Rs. 391.38 crore has been reported to have been incurred so far on these schemes.

7. Under the Centrally Sponsored Scheme of "Low Cost Sanitation for Liberation of Scavengers", HUDCO sanctioned a total of 858 schemes covering 1476 towns after 1989-90 till March 31st 2002, costing Rs.1467.41 crore for conversion of 18.14 lakh individual dry latrines into sanitary latrines and construction of 18.58 lakh new individual sanitary latrines and 3966 community toilets in various States. The total cost of Rs.1467.41 crore of the sanctioned projects includes a component of Rs. 511.69 crore as the Central subsidy component, Rs.514.99 crore as HUDCO loan component and the balance Rs. 440.73 crore as beneficiaries' contribution. Against this, cumulative amounts of Rs.262.89 crore as subsidy and Rs. 314.79 crore as loan have been released up to March 31st, 2002. These include Rs.9.85 crore as subsidy and Rs. 32.08 crore as loan during 2001-2002. In so far as physical progress is concerned, 14.58 lakh household sanitary latrines and 2982 community toilets have been completed. Besides, 1.06 lakh conversion and 2.13 lakh new construction of household and 185 community toilets are in progress. In all, 37430 scavengers have been liberated and 387 towns declared scavenging-free.

Annual Plan 2002-2003

8. In keeping with the Tenth Plan objective, the Annual Plan 2002-2003 includes a large Plan Outlay under water supply and sanitation sector including Rs. 3299.10 crore under Central Plan as can be seen in Annexure 5.9.1

9. The scheme-wise break-up of the approved outlays under Central Plan and State-wise details of the State/UT plans are indicated in Annexure-5.9.2 and Annexure-5.9.3 respectively.

Rural Water Supply and Sanitation

10. For achieving the objective of providing safe drinking water supply to all rural habitations during the Tenth Five Year Plan (2002-07), the following prioritisation shall be adopted :

- Highest priority to be given to ensure that the remaining "Not Covered" habitations are provided with sustainable and stipulated supply of drinking water.

- Equally important would be to ensure that all the “Partially Covered” habitations having a supply level of less than 10 litres per capita per day (lpcd) as also those affected severely with water quality problem are fully covered with safe drinking water facilities on a sustainable basis.
- Thereafter other “Partially Covered” and Quality Affected habitations are to be covered.
- After providing drinking water supply facility to all rural habitations as per the existing data by 2004, the remaining period of the Tenth Plan would be utilized for consolidation, i.e., coverage of newly emerged habitations and those which have slipped back to “Partially Covered” or “ Not Covered” due to variety of reasons.
- Simultaneously action is needed to identify and tackle habitations where water quality problems have newly emerged.
- It should be ensured that SC/ST population and other poor/weaker sections are covered fully on a priority basis, by a systematic survey of all such identified habitations.

11. The stipulated norms of supply would be 40 lpcd of safe drinking water within a walking distance of 1.6 kms or elevation difference of 100 meters in hilly areas, to be relaxed as per field conditions applicable to arid, semi-arid, and hilly areas. At least one handpump/spot-source for every 250 persons is to be provided. Additional water in DDP areas for cattle to be provided, based on the cattle population. Cattle needs need not necessarily be met through piped water supply and could be made through RWH structures/spot-sources.

12. In the States where 40 lpcd has been achieved in all habitations, the next step is to raise the level to 55 lpcd. Population/distance/elevation norms for coverage may also be liberalized during the Tenth Plan in respect of States which have achieved full coverage as per the existing norms, subject to cost sharing by the beneficiaries.

13. The Annual Plan 2002-2003 envisages to cover 8417 “Not-Covered” and 60957 “partially-Covered” villages/habitations. State-wise details are shown in Annexure 5.9.4.

14. Rain Water Harvesting has been recognised as an important source of water, particularly in hilly regions of North-Eastern States, islands and water-stress areas. This will also help recharge the ground water aquifers and check the depleting ground water table, as also reduce severity of floods and quality problems of water, like fluoride, arsenic, salinity, etc. Concerted efforts, therefore, need to be made to construct rain water harvesting structures and conserve the rain water under/over the ground to help meet the water demand. Operation and maintenance of rural water supply is not satisfactory at present and therefore, is an area of concern and needs special attention with the involvement of community, particularly the women.

15. Rural Sanitation programme is now gaining momentum in several States. The type of facilities to be provided would be decided, based on the need and full participation and involvement of Gram-Panchayats, the people, particularly the women and the NGOs. The programme of construction of low-cost household sanitary latrines will continue to get emphasis with priority on conversion of dry latrines into sanitary ones. The concept of total environmental sanitation needs to be adopted. For success of the programme, it may be

necessary to ensure alternative delivery system also through “Rural Sanitary Marts”, a commercial enterprise with social objective, which apart from being a sales outlet, also serves as a counselling-centre as well as a service-centre.

Urban Water Supply and Sanitation

16. Due to rapid urbanisation and ever increasing population of the cities and towns, their demand for adequate drinking water supply and hygienic disposal of liquid and solid wastes is assuming greater importance year after year. The service levels of water supply in most of the cities and towns are far below the desired norms; in some cases, particularly the smaller towns, even below the rural norms and therefore, augmentation of water supply systems is necessary. While the coverage of urban population by protected water supply is estimated to be around 89%, this however, does not truly reflect the poor service levels and deprivation of the poor, particularly those living in slums. Similarly, in the case of urban sanitation, though about 60% of the population is reported to have access to sanitary excreta disposal facilities, only 30% have access to sewerage system mostly in a few big cities, and the balance 30% is covered with low-cost sanitary latrines. Even where sewered, the same are partial and without adequate treatment facilities in most of the cases. Slums are worst affected and mostly without basic environmental sanitation facilities.

17. In view of constraint on budgetary resources, it would be necessary, as envisaged in the Tenth Plan, that the Urban Water Supply and Sanitation Schemes should increasingly depend on institutional finance and the State budgetary support be provided adequately to meet the counterpart matching requirements of institutional finance. In so far as budgetary provisions are concerned, besides State Plan outlays, the Central Plan also includes an outlay of Rs. 143 crore under the Centrally Sponsored Accelerated Urban Water Supply Programme for Small Towns with population less than 20,000 (as per 1991 census). The Operation and Maintenance and Management of Urban Water Supply Schemes have not been given due attention and in most of the cases, the revenue generation is much less than the actual cost of Operation and Maintenance. This calls for an urgent revision of water tariff and improvement of billing and collection mechanism.

18. The coverage of urban population with sanitation facilities is rather slow. While sophisticated sewerage system and sewage-treatment facilities may be necessary in the case of metropolitan cities and a few important tourist/pilgrim centres and industrial cities/ towns, the low-cost sanitation approach may have to be adopted in all other cases due to constraints on financial resources and other competing demands. Waste-water-recycling after appropriate treatment for non-domestic uses in the water scarcity areas needs to be given due priority, if found techno-economically viable. This would save a large quantity of fresh water to be used for domestic purpose.

19. With a view to eradicate the most degrading practice of manual handling of night-soil completely in the country within a short time frame, the Centrally Sponsored scheme of urban low cost sanitation for liberation of scavengers has been accorded a high priority during the Tenth Plan. The Annual Plan 2002-2003 includes Rs. 30 crore for this scheme under the Central Plan. The Central legislation titled “The Employment of Manual Scavengers and Construction of dry Latrines (Prohibition) Act 1993” had already been passed by the Parliament and assented by the President in June, 1993. All the State Governments have been requested to adopt the Central legislation or enact State

legislation in line with the Central legislation. In addition to Uts, 17 States viz. Andhra Pradesh, Goa, Karnataka, Maharashtra, Tripura, West Bengal, Orissa, Punjab, Assam, Haryana, Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Tamil Nadu, Uttar Pradesh and Gujarat have already adopted this legislation. However, the Act is yet to be enforced strictly in these States.

Externally aided Water Supply and Sanitation Projects

20. The World Bank is assisting various States in Water Supply and Sanitation Programme in urban and rural areas. Currently 4 projects are under implementation. The disbursement budget estimate for 2002-2003 is about Rs. 148.561 crore. Apart from these projects, several projects are also being funded by other External support Agencies like ADB, JBIC, KFW, EEC, DIFD, DANIDA, Netherlands etc.

5.9.2 HOUSING

21. Housing is a basic necessity as well as an important economic activity, in that it is a part of the construction industry,. Construction activity accounts for more than 50 per cent of the development outlays. A study by the Indian Institute of Management, Ahmedabad, commissioned by HUDCO, to evaluate the impact of investment in the housing sector on GDP and employment, has found that the sector ranks third among the 14 major sectors in terms of the direct, indirect, and induced effect on all sectors of the economy.

22. The Housing and Habitat Policy, 1998 has specifically advocated that Government create a facilitating environment for growth of housing activity instead of taking on the task of housing itself. Housing is largely a private sector activity in both the rural and urban sectors. This is not to rule out the need for a high degree of involvement of the Government and its agencies in meeting the housing needs of the urban poor. The nature of this involvement – it may in some instances extend to house construction itself – is to be determined by the needs of a given situation.

23. The National Agenda of Governance also emphasised that housing activity would be an engine for substantial generation of employment, and all legal and administrative impediments that stand in the way of vigorous housing activity should be removed forthwith. What is undisputed is that governmental initiatives and its 'facilitating role' have a significant impact on the provision of housing and growth of the sector. These initiatives and interventions relate to legislations concerning ownership, transfers and development of land; stamp duty and registration laws; rent control legislation; tax policy particularly relating to housing loans; property and land tax laws; town planning law and its actual implementation, i.e., Comprehensive Development Plans, zoning regulations, land use change; and building bye-laws. It also covers urban development activities through parastatals and urban development authorities; sites and services schemes; slum policy; provision of urban infrastructure; urban transport policy and facilities; the institutions in the public sector relating to housing development and housing finance; and house construction in the public sector.

24. With the anticipated entry of FDI into the real estate sector, care has to be taken that the needs of the urban poor and marginalised sections are not ignored. Given the large number of activities impinging on housing directly and indirectly and the multiplicity of

agencies involved, designing a framework for orderly and dynamic growth in the housing sector in the Tenth Plan is a challenge to the planners.

25. The Working Group on Housing for the Tenth Plan has observed that around 90 per cent of housing shortage pertains to the weaker sections. There is a need to increase the supply of affordable housing to the economically weaker sections and the low income category through a proper programme of allocation of land, extension of funding assistance and provision of support services. The problem of the urban shelter-less and pavement dwellers has not been given the consideration that is necessary in a welfare or pro-poor State, as seen from the lack of progress in the Night Shelter Scheme. Regulation of building quality and its assurance, especially in areas prone to disasters is an issue whose urgency was reiterated after the earthquake in Gujarat in January 2000. Building designs also need to be gender sensitive and should accommodate the requirements of physically challenged population.

26. In order to increase the proportion of household savings in the housing sector, as well as to provide houses to those who cannot as yet afford to have their own houses, there is need to encourage the promotion of rental housing by the private sector, public sector, cooperatives and individuals. This requires legislative changes in the existing rent control laws, something on which which very little progress has been achieved.

27. Availability of land has been constrained by certain provisions contained in a variety of laws such as the Land Revenue Act, the Land Reforms Act, the Urban Land (Ceiling and Regulation) Act (ULCRA), the Town Planning Act and the Urban Development Acts. Each of them has, often through its provisions and equally through the manner in which they were implemented — created hurdles for legitimate transactions in land urgently required for expansion of the housing stock. The repeal of ULCRA was expected to ease the situation to some extent. This needs to be followed up by other changes whereby legally valid availability of land for urbanization is speeded up, and people are not driven to adoption of short-cuts to obtaining housing plots and other uses.

28. Balancing the liberal availability of land, with the demands of orderly growth with adequate provision of infrastructure is no easy task, and the ‘land sharks’ are invariably one step ahead of the authorities that enforce regulations and provide of amenities. This has led to the proliferation of ‘unauthorised layouts’ and ‘informal settlements’. The efficacy of town planning and urban development programmes lies in meeting the growing demand for housing in urban areas within the framework of the tenets of orderly growth. Public and private initiatives in various parts of the country have already demonstrated that, given the will and efficiency of implementation, it is possible to plan ahead and promote orderly growth. These efforts need to be made more widely known and replicated.

Institutional Financing of Housing

29. The substantial thrust on housing laid by Government through the facilitating measures including Reserve Bank of India (RBI) regulations relating to priority sector lending, fiscal concessions and budgetary incentives has started to bear fruit. Institutional credit disbursals have grown from Rs. 5,767 crore in 1997-98 to Rs. 12,626 crore in 2000-01. These disbursals are through the 28 Housing Finance Institutions (HFIs) under the ambit of the National Housing Bank (NHB).

HUDCO

30. HUDCO earmarks 55 per cent of its housing portfolio funds for the economically weaker sections (EWS) and low income groups (LIG), with differential interest rates, high loan component for lower cost units, and longer repayment period. Though its releases are somewhat less than sanctions, it is noteworthy that HUDCO has sanctioned 12.46 million urban housing units (till September, 2001) in both urban and rural areas. During 1998-2001, under the Additional 2 Million Housing programme, against a total target of 30 lakh housing units, HUDCO has supported 33.82 lakh units.

31. The other factor in HUDCO operations for the mass housing programmes is the dependence on State Government guarantees, which as noted elsewhere, disqualifies some states who have defaulted. Such states will need to take steps to fulfil their obligations under the guarantee. HUDCO is also a large player in retail lending for housing, and in two and a half years has sanctioned a total loan amount of Rs. 2,331 crore to 2,62,550 beneficiaries. HUDCO has been in the forefront of the Government's efforts to come to the aid of disaster-affected households, and has provided financial assistance for disaster rehabilitation housing to the tune of Rs. 2,360 crore for construction of over 4 million houses for earthquake, cyclone, and flood victims.

32. In order to undertake housing programmes for the poorer sections, states must create an environment favouring loan-based house construction for the EWS categories, and strengthen the state-level machinery for lending and loan recovery. EWS housing in urban areas has long remained a neglected area in relation to the demand, and without arrangements in place for credit support to this section, states will find it difficult to continue giving State guarantees to loans from HUDCO. To ensure recovery of loans, conferment of ownership rights in the name of the beneficiary family (jointly in the names of wife and husband) could be done only after the entire loan is recovered, till which time the house may be held on a rental basis. To augment housing supply for the poor, there is also need to enlarge private initiatives and public-private sector partnerships. While encouraging the development of new integrated townships through foreign direct investment/private entrepreneurship, there should be provision for earmarking a percentage of such housing for EWS/LIG households.

Cooperative Sector

33. The National Cooperative Housing Federation operates through 26 apex cooperative housing federations in the states. There are nearly 90,000 primary cooperative housing societies with 6.5 million individual members. Up to 31 March 2001, the apex federations have mobilised Rs. 6,407 crore from LIC, NHB, HUDCO commercial and cooperative banks etc., and disbursed loans of Rs 6,800 crore to housing cooperatives and individual members. This has led to the construction of approximately 2.13 million dwelling units (completed and under construction). Housing cooperatives have been given a target of construction of one lakh houses each year under the 2 million housing programme for the EWS/LIG, and they have been able to construct a total of 2.92 lakh units in the 1998-2001 period.

Strengthening of Housing Stock In Vulnerable Regions

34. About 54 per cent of India's land area is vulnerable to earthquakes, 8.4 per cent to cyclonic wind and storm surges, and 4.9 per cent of the area is vulnerable to flood damage. The Working Group on Housing has suggested a scheme for strengthening of the vulnerable house in the EWS and LIG category in 107 districts which face highest risk of damage because they are multi-hazard prone. According to an estimate, these houses can be strengthened and retrofitted at 10 per cent of the cost of construction of a new house on an average. What is equally important is to demonstrate retrofitting technologies relevant to the specific disaster-prone area.

35. The problem of housing slum-dwellers in decent surroundings is dealt with separately. In view of the growing problems of the housing sector, and particularly the urban poor, the following measures are necessary and should be implemented during the Tenth Plan period:

- The first priority in urban housing, particularly for the urban LIG and EWS, is the provision of land at affordable prices. Increased availability of developed land in urban areas through adoption of various innovative approaches like land bank for the poor and land assembly methods, vacant land tax and transferable development rights and simplification of sub-division regulations is called for.
- Unauthorised settlements have become a part of the urban scenario. They house a large number of people and there is ambivalence regarding regularisation of these settlements and extension of services to them. In many cities, they are not brought under the property tax net. Pragmatic solutions leading to security and extension of civic services are required. To prevent proliferation of such colonies, the land use and sub-division policies need to be streamlined, and their implementation rendered speedy and smooth without undue hassles to those in need of land for housing.
- The city planning provisions need to be tuned to the requirements of the weaker sections in urban areas through adoption of appropriate and affordable standards and norms, use of cluster housing and 'growing house' concepts.
- The feeling that urban planning ignores the needs of the urban poor, must be dispelled through effective action to meet these needs. The urban development authorities who acquire and develop large tracts of land for the growth of the cities, should reserve a major part of such land to meet the requirements of the EWS/LIG population. At present, there is little evidence that these authorities — who are often the sole organisation for development of serviced land — are providing the due share of land to the urban poor.
- Housing and economic activities have to go hand in hand with the provision of housing for the workers close to work places. There is need for coordinating the development of industrial areas and housing areas. Layouts should be mixed in nature with the urban poor - providers of services - being enabled to live and integrate with the rest of the community.

- Schemes such as the Two Million Housing scheme and the new scheme of housing with Central assistance for the slum population (Valmiki Ambedkar Awas Yojana or VAMBAY) should be used to provide immediate benefit to the most disadvantaged urban segments.
- HUDCO assistance is not available to several states which are unable or unwilling to stand guarantee for these loans. A solution has to be found so that the urban poor in these states do not find themselves at a disadvantage in comparison with other states where there is greater willingness to use HUDCO loans.
- Urban housing should mostly be based on savings and credit from HFIs. The workers of the informal sector and other urban poor including slum-dwellers are generally not served by these Institutions. At the same time, public institutions such as Housing Boards and Housing Co-operatives, have not been able to meet the needs of these sections. This will only increase the growth of unserviced housing and of slums. There is a need to make housing loans available to the EWS in the cities. Credit activity by state agencies and housing co-operatives need to be revived. HUDCO and the HFIs should be encouraged to finance self-help groups or groups who have the support of an NGO and who can be of assistance in loan recovery.

36. Costs of urban housing are likely to be higher in comparison with rural housing programmes because of the higher land costs standards of construction in urban areas. It is for this reason that a scheme such as VAMBAY, launched in the final year of the Ninth Plan, has a combination of subsidy and loan. Expectations of fully subsidised housing should be discouraged. An environment needs to be created to encourage housing programmes with credit to the extent that beneficiaries can afford.

Urban Transport

37. A good network of roads coupled with efficient mass urban transport system play a catalytic role in urban economic growth, with beneficial impact on the urban poor. Adequacy of transport network help to plan development in diversifying economic activities, production, expanding trade etc, contributing to per capita GDP. The only major programme in operation is the Delhi Mass Rapid Transit System (MRTS) with soft loan assistance from JBIC. The funds are made available to the DMRC (Delhi Metro Rail Corporation) as pass through assistance, which is included in the budget resources of the Ministry of Urban Development and Poverty Alleviation. The project is scheduled for completion in March, 2005. During the Annual Plan, 2001-02, Rupee one crore was kept as pass through assistance against which a provisional expenditure of Rs 783.35 is indicated. The equity provision made for 2001-02 was Rs 165 crores which is anticipated to be the expenditure also. For the Annual Plan (2002-03), while pass through assistance from JBIC is kept at Rupee one crore, a provision of Rs 172 crores has been provided as equity to DMRC.

Annexure - 5.9.1

Water Supply and Sanitation - Summary of Outlays/Expenditure

Rs Crore

Scheme	2000-2001 Actual Expenditure	2000-2001 Approved Outlay	2000-2001 Anticipated Expenditure	2002-2003 Approved Outlay
1	2	3	4	5
State & UT's Plans				
a) Rural Water Supply & Sanitation) b) Urban Water Supply & Sanitation)	5237.94#	5972.23$	5691.94	NA
Sub Total (State and UT's Plan)	**5237.94#**	**5972.23$**	**5691.94**	**NA**
Central Plan				
a) Ministry of Rural Areas & Employment				
1) Centrally Sponsored Accelerated Rural Water Supply Programme.	1896.55	2010.00	1975.00	2235.00
2) Centrally Sponsored Rural Sanitation Programme	130.85	150.00	135.00	165.00
b) Ministry of Urban Affairs & Employment				
1) Centrally Sponsored Accelerated Urban Water Supply Programme for small towns with population less than 20,000	64.00	95.00	95.00	143.00
2) Centrally Sponsored Urban Low-cost Sanitation Scheme for liberation of scavengers	29.62*	39.80*	19.80	29.80
3) Other Schemes	81.51	88.00	32.00	26.30
Sub-Total (Central Plan)	**2202.53**	**2382.80**	**2256.80**	**2599.10**
GRAND TOTAL	**7440.47**	**8355.03**	**7948.74**	**NA**

Note : (i) The above mentioned figures do not include the funds released under the Non-Lapsable Central Pool of Resources for NER and Sikkim.
(ii) * - Beside the above mentioned schemes, a Provision of Rs 0.20 crore is made every year for meeting establishment related expenditure under Water Supply & Sanitation.
(iii) # - Figure is excluding Chhattisgarh and Jharkhand.
(iv) $ - Figure is excluding Jharkhand.

Annexure 5.9.2

Water Supply and Sanitation - Central Plan Scheme wise outlay/Expenditure

Rs. Lakh

Sl. No.	Scheme	2000-2001 Actual Expenditure	2000-2001 Approved Outlay	2000-2001 Anticipated Expenditure	2002-2003 Approved Outlay
1	2	3	4	5	6
	Ministry of Rural Areas & Employment				
	Centrally Sponsored Accelerated				
1	Rural Water Supply Programme inclu. Rajiv Gandhi National Drinking Water Mission programme	189655	201000	197500	223500
2	Centrally Sponsored Rural Sanitation Programme	13085	15000	13500	16500
	Sub total (MoRAE)	202740	216000	211000	240000
	Ministry of Urban Affairs & Employment				
1	Public Health Engineering Training Programme	152	198	198	130
2	Monitoring & Management Information System				
3	Research & Development				
4	Equity to Urban Development and Urban Water Supply Finance Corporation/HUDCO (WS Share)	2000	2000	500	2000
5	Centrally Sponsored Urban Low-Cost Sanitation Scheme for Liberation of Scavengers	2962*	3980*	1980*	2980*
6	Pilot project on solid waste management near Airport in few selected city in the country.	0	500	500	500
7	Centrally Sponsored Accelerated Urban Water Supply Programme for small towns with population below 20,000 (as per 1991 Census)	6400	9500	9500	14300
8	Counterpart fund for external assistance to HUDCO from OECF(Japan)	0	0	0	0
9	Support to water supply scheme of major cities facing acute water shortage (Ganga Barage)	5999	6100	2000	0
10	Special new scheme for Water Supply	0	1	1	0
11	Special new scheme for Solid Waste Management and Sanitation	0	1	1	0
	Sub Total (MoUAE)	**17513**	**22280**	**14680**	**19910**
	Total	**220253**	**238280**	**225680**	**259910**

Note : (i) The above mentioned figures do not include the funds released under the Non-Lapsable Central Pool of Resources for NER and Sikkim

(ii) * - Beside the above mentioned schemes a Provision of Rs 0.20 crore is made every year for meeting establishment related expenditure under Water Supply & Sanitation.

Annexure 5.9.3

Outlay/Expenditure on Water Supply and Sanitation - States and Uts

Rs. Lakh

Sl No.	State/ UT	2000-2001 Anticipated Expenditure	2001-2002	
			Approved Outlay	Anticipated Expenditure
1	**2**	**3**	**4**	**5**
1	Andhra Pradesh	8964	22363.70	18264
2	Arunachal Pradesh	2674	2913.00	3005
3	Assam	6463	6754.00	6754
4	Bihar	2479	6185.02	6185
5	Chattisgarh	#	13504.30	13504
6	Goa	8662	8648.00	8648
7	Gujarat	86813	62594.00	62594
8	Haryana	7725	6500.00	10017
9	Himachal Pradesh	12137	12176.77	13027
10	Jammu & Kashmir	11003	13125.00	13125
11	Jharkhand	#	#	#
12	Karnataka	56152	61017.32	75741
13	Kerala	9000	13700.00	10000
14	Madhya Pradesh	13601	18589.00	18590
15	Maharashtra	60142	73455.39	73455
16	Manipur	2388	6125.00	4930
17	Meghalaya	3258	3340.00	2917
18	Mizoram	3004	2574.00	3151
19	Nagaland	2279	3901.00	3866
20	Orissa	8730	8737.88	9051
21	Punjab	6399	9580.10	9580
22	Rajasthan	26762	30274.01	26323
23	Sikkim	1522	1754.00	1818
24	Tamil Nadu	69937	72658.48	58550
25	Tripura	2704	2797.28	2797
26	Uttar Pradesh	27907	41836.00	23153
27	Uttranchal	18977	13425.00	13425
28	West Bengal	14467	20506.79	18420
29	A&N Islands	1700.71	2675.00	2675
30	D&N Haveli	309.98	301.60	301.6
31	Daman & Diu	257.24	175.00	175
32	Delhi	44765	52415.00	52415
33	Lakashadweep	245.87	238.40	238.4
34	Pondicherry	1691.27	1573.34	1689
35	Chandigarh	675	810.00	810
	Grand Total	**523794.07**	**597223.38**	**569194.00**

- Not Available

Annexure 5.9.4-Contd.

Status of Drinking Water Supply in Rural Habitations

Sl. No.	State/UT	Status as on 1. 4. 2001				Coverage during 2001-2002					
						Target			Acheivement		
		NC	PC	FC	Total	NC	PC	Total	NC	PC	Total
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
1	Andhra Pradesh	0	18583	51149	69732	0	2560	2560	0	2560	2560
2	Arunachal Pradesh	403	995	2900	4298	60	103	163	16	45	61
3	Assam	801	22314	47554	70669	623	3500	4123	151	2595	2746
4	Bihar	2	2	105336	105340	2	2	4	2	2	4
5	Chhathisgarh	402	817	49160	50379	402	817	1219	402	2653	3055
6	Goa	11	46	339	396	11	39	50	3	1	4
7	Gujarat	190	2235	27844	30269	100	400	500	94	458	552
8	Haryana #	0	193	6552	6745	0	193	193	0	592	592
9	Himachal Pradesh	1593	11658	32116	45367	900	950	1850	519	1406	1925
10	Jammu & Kashmir	2074	3688	5422	11184	600	400	1000	0	0	0
11	Jharkhand	497	119	99480	100096	421	100	521	0	0	0
12	Karnataka	10	21148	35524	56682	10	4990	5000	7	1626	1633
13	Kerala	805	6956	2002	9763	30	300	330	9	238	247
14	Madhya Pradesh	127	0	109362	109489	127	0	127	81	2284	2365
15	Maharashtra	2256	26120	57554	85930	500	2500	3000	161	2650	2811
16	Manipur	30	302	2459	2791	28	364	392	0	20	20
17	Meghalaya	549	920	7170	8639	240	200	440	85	25	110
18	Mizoram	0	525	386	911	0	206	206	0	63	63
19	Nagaland	393	596	536	1525	74	38	112	22	11	33
20	Orissa	34	119	113946	114099	34	101	135	22	78	100
21	Punjab	1792	3123	8534	13449	513	0	513	282	0	282
22	Rajasthan	6908	19545	67493	93946	3000	8000	11000	792	10111	10903
23	Sikkim	0	472	1207	1679	0	130	130	0	104	104
24	Tamil Nadu	0	4934	61697	66631	0	4934	4934	0	6865	6865
25	Tripura	287	711	6414	7412	287	370	657	0	260	260
26	Uttar Pradesh #	32	126	243475	243633	2	31	33	32	124	156
27	Uttaranchal	262	1188	29558	31008	164	288	452	87	119	206
28	West Bengal	0	17809	61227	79036	0	5750	5750	0	6078	6078
29	A & N Islands	0	141	363	504	0	50	50	0	9	9
30	D & N Haveli	46	243	227	516	15	24	39	8	5	13
31	Daman & Diu	0	0	32	32	0	0	0	0	0	0
32	Delhi	0	0	219	219	0	0	0	0	0	0
33	Lakashadweep	0	10	0	10	0	10	10	0	9	9
34	Pondicherry #	40	84	143	267	0	33	33	0	5	5
35	Chandigarh	0	0	18	18	0	0	0			
	TOTAL	**19544**	**165722**	**1237398**	**1422664**	**8143**	**37383**	**45526**	**2775**	**40996**	**43771**

Note:
- PC Targets fixed in respect of Haryana, UP and Pondicherry are for augmentation.
NC - Not Covered, PC - Partially Covered, FC - Fully Covered

Annexure 5.9.4 Contd..

Status of Drinking Water Supply in Rural Habitations

Sl. No.	State/UT	Status as on 1.4.2002				Target for 2002-2003		
		NC	PC	FC	Total	NC	PC	Total
1	**2**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
1	Andhra Pradesh	0	16023	53709	69732	0	8012	8012
2	Arunachal Pradesh	387	1043	2868	4298	327	446	773
3	Assam	650	22314	47705	70669	600	5000	5600
4	Bihar	0	2	105338	105340	0	0	0
5	Chhathisgarh	0	1843	48536	50379	0	0	0
6	Goa	8	46	342	396	0	4	4
7	Gujarat	96	2772	27401	30269	100	918	1018
8	Haryana #	0	0	6745	6745	0	48	48
9	Himachal Pradesh	1074	11658	32635	45367	693	5000	5693
10	Jammu & Kashmir	2074	3726	5384	11184	1074	1644	2718
11	Jharkhand	497	119	99480	100096	200	100	300
12	Karnataka	3	22090	34589	56682	3	7400	7403
13	Kerala	796	6954	2013	9763	400	2000	2400
14	Madhya Pradesh	46	0	109443	109489	0	0	0
15	Maharashtra	2095	26942	56893	85930	1000	11810	12810
16	Manipur	30	364	2397	2791	30	100	130
17	Meghalaya	464	920	7255	8639	180	200	380
18	Mizoram	0	553	358	911	0	180	180
19	Nagaland	371	637	517	1525	195	50	245
20	Orissa	12	119	113968	114099	12	49	61
21	Punjab	1510	3123	8816	13449	1510	1097	2607
22	Rajasthan	6116	19545	68285	93946	1895	9105	11000
23	Sikkim	0	472	1207	1679	0	130	130
24	Tamil Nadu	0	4934	61697	66631	0	0	0
25	Tripura	287	946	6179	7412	93	332	425
26	Uttar Pradesh #	0	1131	242502	243633	0	0	0
27	Uttaranchal	175	1175	29658	31008	34	500	534
28	West Bengal	0	17809	61227	79036	0	6650	6650
29	A & N Islands	0	141	363	504	0	46	46
30	D & N Haveli	38	243	235	516	31	110	141
31	Daman & Diu	0	1	31	32	0	0	0
32	Delhi	0	0	219	219	0	0	0
33	Lakashadweep	0	10	0	10	0	0	0
34	Pondicherry #	40	84	143	267	40	26	66
35	Chandigarh	0	0	18	18	0	0	0
	TOTAL	16769	167739	1238156	1422664	8417	60957	69374

Note:
- PC Targets fixed in respect of Haryana, UP and Pondicherry are for augmentation.
NC - Not Covered
PC - Partially Covered
FC - Fully Covered

5.10 EMPOWERMENT OF WOMEN AND DEVELOPMENT OF CHILDREN

INTRODUCTION

Women and Children who constitute 65.6 per cent of country's population and account for 673.80 million (projected) in 2001 occupy centre-stage in all human development efforts. To this effect, the Tenth Plan aims at empowering women through translating the recently adopted National Policy for Empowerment of Women (2001) into action and at ensuring 'survival, protection and development' of children through a Rights-based Approach. The Annual Plan for the year 2002-03 being the first year of the Tenth Plan is very much in tune with these very policies and programmes of the Tenth Plan.

Review of the Ninth Plan (1997-2002) and Annual Plan (2001-02)

2. Under the Central Sector, an outlay of Rs.1,650 crore was earmarked for Women and Child Development in the Annual Plan (2001-02). This includes Rs.4.00 crore for Food and Nutrition Board, which is part of the nodal Department of Women and Child Development. During the Ninth Five Year Plan, the total expenditure was Rs. 6249.60 crore which was much below the outlay of Rs. 7810.42 crore. While details of the year-wise and programme-wise outlays earmarked and the expenditure incurred under the Women and Child Development during Annual Plan (2001-02) are available at Annexure- 5.10.1, summary of the same along with the outlays and expenditure during the Ninth Plan (1997-2002) is given in the following Table 5.10.1

Table No. 5.10.1

Outlays and Expenditure under Women & Child Development Sector during Ninth Plan (1997-2002) and Annual Plan (2001-02)

(Rs. in crore)

Sl. No.	Name of the Schemes	Ninth Plan (1997-2002)		Annual Plan (2001-02)	
		Outlay	Actual	Outlay	Actual
1	2	3	4	5	6
I.	**Women and Child Development**	**7791.95**	**6240.97**	**1646.00**	**1640.41**
i)	Central Sector Schemes	990.22	578.90	168.50	161.15
ii)	Centrally Sponsored Schemes	6801.73	5662.07	1477.50	1479.26
II.	**Food and Nutrition Board**	**18.47**	**8.63**	**4.00**	**2.78**
	Total	**7810.42**	**6249.60**	**1650.00**	**1643.19**

3. Under the State sector, as Women and Child Development forms part of the 'Social Security and Welfare', no separate figures of either outlays or expenditure are available. However, the same are included in the outlays as part of Social Welfare as given in Annexure-5.13.2 under the Chapter 'Social Welfare'. A detailed programme-wise review of achievements under this sector during the Annual Plan (2001-02) and during the Ninth Plan (1997-2002) is given in the following paragraphs.

a) Empowerment of Women

4. The nodal Department of Women and Child Development responsible for empowering women formulates policies and programmes to supplement efforts of other line Ministries; implements a few innovative schemes; enacts legislations affecting women; and co-ordinates the efforts of both governmental and non-governmental organisations. Some of the important on-going interventions of the Department during the Ninth Plan are detailed below:

Empowering Strategies

5. The earlier programme of Indira Mahila Yojana (IMY) was recast and retitled as 'Swayamsidha' in 2001 to empower women by generating awareness and helping them to achieve economic strength through micro-level income-generation activities and establishing convergence of various basic services along with other social empowerment programmes. Out of the Ninth Plan outlay Rs. 165.00 crore and Annual Plan (2001-02) outlay of Rs. 19.50 crore, only Rs. 8.95 crore and Rs. 6.85 crore could be spent respectively because of late approvals/sanctions. Achievements under this programme include coverage of 650 blocks and 53,100 Women's Self Help Groups (SHGs) benefiting 9,29,250 women.

6. Another empowering intervention is 'Swa–Shakti Project', launched in 1998 for a period of 5 years (1998 – 2003) with the assistance from International Development Association and International Fund for Agricultural Development. Swa-Shakti is in operation in 57 districts of 9 States viz. Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Madhya Pradesh, Uttaranchal and Uttar Pradesh. Swa-Shakti aims to create an enabling environment for empowerment of women through setting up of women's SHGs and developing linkages between SHGs and lending institutions to ensure women's continued access to credit facilities for income generation activities. The outlay for Annual Plan (2001-02) was Rs. 15 crore and expenditure during the year was also Rs. 15 crore. Of the Ninth Plan outlay of Rs. 102.94 crore, the expenditure was Rs. 36 crore to set-up approximately 9,735 SHGs of which 5,451 were set up during the year 2001-02 with assistance of around 118 NGOs till the end of October 2001 .

Employment and Income Generation

7. With an ultimate objective of making women economically independent and self-reliant, a special thrust was being given to create more and more of employment-cum-income-generation opportunities during the Ninth Plan. Under the programme of 'Support for Training and Employment Programme (STEP)', which provides a comprehensive package of skill up-gradation through training, extension inputs, market linkages to poor and assetless women in the traditional sectors benefited 34,590 women during the year 2001-02 and 87,140 women during the Ninth Plan. Against the Annual Plan (2001-02) outlay of Rs. 18 crore, expenditure was Rs. 18.57 crore. Of the Ninth Plan outlay of Rs. 88.32 crore, expenditure was Rs. 76.84 crore. Since its inception in 1987 about 6,12,401 women have been covered under 133 projects launched in 19 States (Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Nagaland, Orissa, Sikkim, Tamil Nadu, Tripura, Uttaranchal, Uttar Pradesh and West Bengal). Nearly 60 per cent of the projects were in

the dairy sector. About 8,000 women's dairy cooperatives with a membership of 4 lakh have been organised throughout the country mainly through the initiative of State Cooperative Milk Federations.

8. Under the programme of Setting up of Training-cum-Production Centres for Women (popularly known as NORAD) 53,050 literate/semi-literate women were benefited during the year 2001-02 through extension of training in non-traditional trades (like electronics, watch assembling, computer programming, garment making, secretarialship, community health services, embroidery, weaving etc.) at the cost of Rs. 18.95 crore against an outlay of Rs. 18.00 crore, during the Annual Plan (2001-02) and Rs. 76.50 crore against an outlay of Rs. 88.98 crore, during the Ninth Plan. Another major programme of employment and training called Socio-Economic Programme (SEP) benefited about 2,900 women during Annual Plan (2001-02) and 3,100 women during Ninth Plan through a wide variety of income-generation activities undertaken by newly set up SEP Units - 58 during Annual Plan (2001-02) and 62 during Ninth Plan. While the Annual Plan (2001-02) expenditure under this programme was Rs. 1.25 crore against an outlay of Rs. 1 crore, the Ninth Plan expenditure was only Rs. 4.92 against an outlay of Rs. 26.42 crore. The scheme of Condensed Courses of Education & Vocational Training for Adult Women (CCE & VT) have benefited more than 9,000 women enrolled in 381 courses during 2001-02 using the full outlay of Rs. 2 crore and approximately 70,000 women enrolled in 2,805 courses conducted during the Ninth Plan spending Rs. 19.54 crore against the outlay of Rs. 45.60 crore by providing new avenues of employment through continuing education and vocational training.

Welfare and Support Services

9. Support services play an important role towards empowering women by way of reducing their burden of child-care and other employment-related problems. The programme of 'Hostels for Working Women (HWW)', launched in 1972-73, aims to promote greater mobility for working women through provision of safe and inexpensive accommodation. While Rs. 4.96 crore was spent out of the Annual Plan (2001-02) outlay of Rs. 9 crore to set up 21 new hostels benefiting 1,440 women, during the Ninth Plan Rs. 34.57 crore was spent out of an outlay of Rs. 51.25 crore to set up 102 new hostels to benefit 8,000 women. Since inception, 881 hostels with a sanctioned capacity of 62,308 women and 8,226 children in the attached 316 day care centres, have been sanctioned under the Scheme. To provide temporary shelter and rehabilitation to women and girls in distress, 60 new Short Stay Homes (SSH) for Women and Girls, benefiting about 1500 women were set up during the year 2001-02. Since inception, 271 SSHs have been operationalised, benefiting more than 6,700 women. While the expenditure incurred during Annual Plan (2001-02), was Rs. 5.32 crore of the outlay of Rs. 10 crore, the Ninth Plan expenditure was Rs. 25.53 crore of the outlay of Rs. 55.64 crore.

10. Under the scheme of Assistance to Voluntary Organisations for Education Work for Prevention of Atrocities on Women, Study Centres and Institutions of higher learning and Voluntary Organisations are given financial assistance for undertaking various activities of education work. The Scheme of General Grants-in-Aid to Voluntary Organisations through Central Social Welfare Board, which is a multi-faceted programme, extends financial assistance to voluntary organisations for rendering welfare services to women, children, aged and infirm, handicapped etc., and for conducting awareness generation campaigns

through various programmes. In addition, expenditure on activities like Field Counselling and Inspections, Evaluation and Statistics/Data Bank and Administration Expenditure of Central and State boards are also covered. Under the scheme of Grant-in-Aid for Research, Publication and Monitoring, 65 new research studies were taken up by the end of the Ninth Plan, of which 8 new studies were taken up during Annual Plan (2001-02). While Annual Plan (2001-02) expenditure was Rs. 0.63 crore, against an outlay of Rs. 1.51 crore, during the Ninth Plan, expenditure incurred was Rs. 2.43 crore out of the outlay of Rs. 2.95 crore.

Awareness Generation and Gender Sensitisation

11. Efforts continued during the Annual Plan (2001-02) to organise camps to conscientise rural women for exercising their rights and enhance their status in the family and society, sensitise government and non-government functionaries on women's issues. The Ninth Plan attached great importance to those efforts, which trigger changes in societal attitudes towards women and the girl child. Under the programme for Information and Mass Education, efforts continued to create public awareness through multi-media strategy on issues relating to women. While during Annual Plan (2001-02), Rs. 3.36 crore was spent against an outlay of Rs. 3.50 crore, during the Ninth Plan, the expenditure incurred was 8.7 crore against the outlay of Rs. 9.75 crore. An integrated media campaign projecting a positive image of both women and the girl child through electronic, print and film media is the most important component of the government's communication strategy. To sensitise planners, policy makers and the enforcement machinery, a countrywide gender ensitization programme has been launched since 1991. Special campaigns to combat atrocities against women have also been launched throughout the country in collaboration with the State Home Departments and NGOs.

Other Enabling Measures

12. Rashtriya Mahila Kosh (RMK), set up in 1993, addresses the credit needs of poor and assetless women in the Informal Sector. RMK has initiated a number of promotional measures for popularising the concept of micro financing, thrift credit, formation and stabilisation of Self-Help Groups (SHGs) and also enterprise development for poor women. Since inception, RMK has sanctioned credit worth Rs.109.73 crore benefiting 4.21 lakh women through 992 NGOs and disbursed Rs.82.38 crore up to February 2002, with a recovery rate of more than 90 per cent.

13. The National Commission for Women (NCW), a statutory body, set up in 1992, under National Commission Act of 1990, continued to pursue its mandated activities of safeguarding the rights and interests of women through review of legislations, and investigation into individual complaints/atrocities and remedial action. The Commission has accorded highest priority in securing speedy justice to women. The major objectives of NCW are to investigate, examine and review all matters relating to the Constitutional safeguards provided for women, review of both women-specific and women related legislations and suggest amendments wherever needed and to function as an surveillance agency and facilitate redressal of grievances. Out of the total 41 legislations having a direct bearing on women, the Commission reviewed and suggested remedial legislative measures in respect of 32 Acts. Of the Annual Plan (2001-02) outlay of Rs. 5 crore, Rs. 4.17 crore, was spent. The corresponding expenditure and outlay for the Ninth Plan are Rs. 16.17 crore and Rs. 16.25 crore, respectively.

Table 5.10.2

WOMEN'S COMPONENT PLAN : SOME FACTS & FIGURES

(Rs. in Crore)

Sl. No.	Name of Ministry/ Department	Ninth Plan Outlay	WCP	% (Col 4 to Col 3)
1	**2**	**3**	**4**	**5**
A.	**Women-Specific Nodal Department**			
	WCD	**7810.42**	**7810.42**	**100.0**
B.	**Women-related Ministries/Departments**			
1.	Health	5118.19	2581.25	50.4
2.	Family Welfare	15120.20	10541.26	69.7
3.	Indian Systems of Medicine & Homeopathy	266.35	133.18	50.0
4.	Education	20381.64	10212.44	50.1
5.	Labour	899.12	300.85	33.5
6.	Agriculture & Co-operation.	9153.82	349.96	3.8
7.	Rural Development	41833.87	17415.00	41.6
8.	Urban Employment & Poverty Alleviation	4931.22	403.60	8.2
9.	Social Justice & Empowerment	6608.13	814.81	13.2
10.	Tribal Affairs	*	60.00	*
11.	Science & Technology	1497.35`	7.50	0.5
12.	Information & Broadcasting	680.05	30.00	4.4
13.	Non-Conventional Energy Sources	2122.14	401.00	18.9
14.	Small-Scale & Agro-Related Industries	3786.85	868.93	23.0
15.	Youth Affairs & Sports	826.09	12.33	1.5
	Sub-Total – B	**113225.02**	**44132.11**	**39.0**
	Grand Total (A + B)	**121035.44**	**51942.53**	**42.9**

* Included in the Ministry of Social Justice & Empowerment.

The total Gross Budgetary Support (GBS) of all the Ministries and Departments for the Ninth Plan was Rs.203982 crore. WCP as a percentage of the total GBS of the GOI for the Ninth Plan works out to 25.5.

14. The year 2001 was celebrated as Women's Empowerment Year. During the year, various activities and programmes were taken up on different themes pertaining to women's social, political and economic empowerment. The Scheme for Women in Difficult Circumstances – 'Swadhar' has been designed with a flexible and innovative approach to cater to the requirement of women in distress. The Scheme aims to provide primary need of shelter, food, clothing and care to the marginalized women/girls living in difficult

circumstances, besides providing emotional support and counselling to such women and rehabilitating them socially and economically through education, awareness, skill up-gradation and personality development through behavioural training etc.

Women's Component Plan

15. During the Ninth Plan, a new strategy of Women's Component Plan (WCP) was brought into action as one of the important strategies by directing both the Centre and the State Governments to ensure that not less than 30 per cent of funds/benefits are earmarked in all the women-related sectors. Also, a special mechanism of inter-sectoral review was resorted to for ensuring flow of adequate funds/benefits to women from all the related sectors.

16. As per the available information, funds from 15 Ministries/Departments are flowing to women. Of these, 4 Ministries/Departments viz. Family Welfare, Health, Education and Indian System of Medicine and Homeopathy are contributing to women with as high as 50 to 70 per cent of their Gross Budgetary Support (GBS); Ministries of Labour and Rural Development contribute 30 to 50 per cent and the other Ministries/Departments less than 30 per cent of their GBS of the Ninth Plan. Accordingly, the total amount of resources that flowed to women during the Ninth Plan from the Women-specific Nodal Department and Women-related Ministries/Departments works out to Rs.51,942.53 crore which accounts for 42.9 per cent of GBS of those very same Ministries/Departments. However, the same will come down to 25.5 per cent if the total GBS of all the Central Ministries/Departments are taken into consideration. Details are given in the Table5.10.2. Further, the most striking feature in this entire exercise is to notice that there are Departments like Family Welfare accounting for as high as 70 per cent flow of its total budget for the good of women. Also, the review has brought forth a revealing factor that WCP has created lot of awareness and sensitisation amongst the planners, policy-makers, administrators to ensure that the funds/ benefits from other development sectors do not by-pass women.

17. Some of the important initiatives/achievements made during the Ninth Plan include - adoption of Women's Component Plan (1997) to ensure that benefits from other developmental sectors do not by-pass women; launching of 'Swa-Shakti' to create an enabling environment for empowerment of women through setting up of self-reliant SHGs (1998); instituting 'Stree Shakti Puraskars' (1999) to honour 5 distinguished women annually for their outstanding contribution to the upliftment and empowerment of women; setting up of a Task Force on Women under the Chairpersonship of Shri K.C.Pant, Deputy Chairman, Planning Commission to review the existing women-specific and women-related legislations and suggest enactment of new legislations or amendments, wherever necessary (2000); introducing Gender Budgeting to attain more effective targeting of public expenditure (2000-01); adopting a National Policy for Empowerment of Women to ensure gender justice, besides empowering women both socially and economically (2001); celebrating the Year '2001 as Women's Empowerment Year' to create awareness and conscientise women (2001); recasting of Indira Mahila Yojana as 'Swayamsidha', to empower women through a major strategy of converging the services available in all the women-related programmes besides organising women into SHGs for undertaking various entrepreneurial ventures; (2001); launching of 'Swadhar' to extend rehabilitation services for 'Women in Difficult Circumstances' (2001); introducing a Bill on Domestic Violence against Women (Prevention) to eliminate all forms of domestic violence against women and the girl child (2002).

b) Development of Children

18. Development of children has been accorded top priority in the country's development agenda, since they are the most vulnerable section of society and yet they hold key to our future development. Policies and programmes accordingly have been geared towards the holistic development of children through special initiatives in the areas of health, nutrition and education. To supplement these efforts, the nodal Department of Women and Child Development has been implementing various policies and programmes as discussed below.

19. Services for early childhood development continued to receive priority with a special focus on the girl child. Along with it, efforts to strengthen the on-going approach of converging the basic services of health, nutrition and pre-school education also continued towards promoting the holistic development of the young child through the programme of Integrated Child Development Services (ICDS) Scheme. It caters to the pre-school children below 6 years and expectant and nursing mothers with a package of 6 basic services viz. health check-ups, immunization, referral services, supplementary nutrition, pre-school education and health and nutrition education. The process of universalisation was expected to be completed by the end of the Ninth Plan by covering all the 5,652 ICDS projects spread all over the country benefiting 54.3 million children and 10.9 million expectant and nursing mothers. Against the Annual Plan (2001-02) outlay of Rs. 1,198 crore, the expenditure incurred was Rs. 1,224.43 crore. Of the Ninth Plan outlay of Rs. 4,980 crore, the expenditure was Rs. 4,556.86 crore benefiting 31.5 million children and 6 million expectant and nursing mothers through 4,608 ICDS Projects.

20. The World Bank-assisted ICDS (WB-ICDS) Programme which has been in operation since 1990-91, extends assistance for a few additional inputs like construction of Anganwadi buildings and Child Development Project Officers office-cum-godowns, on a selective basis, strengthening of training and communication, improved health facilities, income-generation activities etc. besides providing the normal ICDS package. While the WB-ICDS Project-I (1991-97) covered 301 ICDS projects in the States of Andhra Pradesh (110) and Orissa (191), the WB-ICDS Project II (1997-2000) would be covering 649 projects in the States of Bihar including Jharkhand (272) and Madhya Pradesh including Chhattisgarh (377). The WB-ICDS Project III (1998-2004) which was started in 1998-99, is expected to cover 1,003 projects in the States of Andhra Pradesh, Kerala, Tamil Nadu, Maharashtra, Rajasthan and Uttar Pradesh. The programme in Andhra Pradesh is being implemented as part of the total programme of Andhra Pradesh Economic Reconstruction Programme (APERP). Of the Annual Plan (2001-02) outlay of Rs. 220 crore, the expenditure incurred was Rs. 219.94 crore. Of the Ninth Plan outlay of Rs. 1,163.79 crore, the expenditure was Rs. 883.62 crore.

21. UDISHA is a special effort to strengthen the on-going ICDS Training Programme into a dynamic, responsive and comprehensive training-cum-human resource development programme. For the implementation of UDISHA, World Bank extends financial assistance to the extent of Rs.600.55 crore. The National Institute of Public Cooperation and Child Development, New Delhi with its nation-wide network of 4 Regional Centres at Bangalore, Guwahati, Indore and Lucknow; 43 Middle Level Training Centres (MLTCs) and 535 Anganwadi Workers Training Centres (AWTCs) is expected to implement UDISHA. While during the Ninth Plan, 2,304 Child Development Project Officers/Assistant Child Development Project Officers (CDPOs/ACDPOs), 4,993 Supervisors and 2.8 lakh Anganwadi Workers (AWWs) were trained under UDISHA, during Annual Plan (2001-02), 424 CDPOs, 1,210 Supervisors and 86 AWWs were trained. Against the Annual Plan

(2001-02) outlay of Rs. 40 crore, the expenditure incurred was Rs. 52.86 crore. Of the Ninth Plan outlay of Rs. 329.29 crore, the expenditure was Rs. 142.63 crore.

22. The on-going Scheme for the Adolescent Girls, viz. Kishori Shakti Yojana (KSY), launched to empower adolescent girls in preparation to their future productive and reproductive roles as confident individuals was in operation in 2,000 ICDS Blocks.

23. The Scheme of Balika Samriddhi Yojana was launched in 1997 to extend a post-delivery grant of Rs.500/- for the mother of the Girl Child belonging to the Below the Poverty Line (BPL) Group and annual scholarships of Rs.300/- for a girl child in Class I to Rs.1000/- for Class X. Of the Ninth Plan outlay of Rs. 390 crore, Rs. 176.64 crore was spent to cover about 3.5 million girl children, of which 0.27 million were covered during Annual Plan (2001-02). Of the Annual Plan outlay of Rs. 25 crore, the expenditure incurred was Rs. 13.04 crore.

24. The scheme of Crèches/Day-Care Centres for children of working/ailing mothers, being a non-expanding scheme, maintained the same level of 12,470 crèches benefiting 3.11 lakh children. However, to meet the growing demand for more crèches, a National Crèche Fund (NCF) was set up in 1994 with a corpus of Rs.19.90 crore received under Social Safety Net. The NCF extended financial assistance for the opening of crèches besides conversion of the existing Anganwadis into Anganwadi-cum-Crèches. Under the NCF, 3,114 crèches were added during the Ninth Plan benefiting about 0.79 lakh more children. Against the Annual Plan (2001-02) outlay of Rs. 7.45 crore, Rs. 7.6 crore was the expenditure. Of the Ninth Plan outlay of Rs. 36.05 crore, the expenditure incurred was Rs. 29.50 crore.

25. To sum up, some of the important initiatives/achievements during the Ninth Plan include launching of Balika Samriddhi Yojana to extend a special package to girl children belonging to families living below the poverty line to ensure that all girl children; introducing Kishori Shakti Yojana as an enriched version of the scheme for Adolescent Girls being implemented as part of ICDS to improve the nutritional and health status of girls in the age group of 11-18 years and equipping them with vocational skills for them to be gainfully engaged, (2000); extending Additional Central Assistance (ACA) of Rs.375 crore under Pradhan Mantri Gramodaya Yojana to fill the existing financial gaps for implementing Special Nutrition Programme of ICDS, (2001); accomplishing universalised ICDS by the end of the Ninth Plan to cover all the 5,652 Blocks/ Wards spread all over the country benefiting 54.3 million children and 10.9 million expectant and nursing mothers; (2001-02); enhancing the honorarium to Anganwadi Workers from Rs.500/- to Rs.1,000/- and to Anganwadi Helpers from Rs.260/- to Rs.500/- per month in recognition of the services being extended by the 2 grassroot level workers, (2002); drafting of a National Policy and Charter for Children to reiterate the cause of the children as enshrined in the Constitution and to seek the partnership of the community to protect children from violation of their rights, (2002); drafting of a Bill for setting up of a National Commission for Children to safeguard the Rights of Children (2002).

Impact of Policies and Programmes

26. The impact of various policies and programmes and the efforts put in by both governmental and non-governmental organizations over a period of time in empowering women and development of children, have brought forth a perceptible improvement in the status of women and children, as reflected in the following 21 selected Gender Development Indicators given in Table 5.10.3.

Table 5.10.3.

The 21 Selected Gender Development Indicators: 1981 to 2001

Sl. No.	Indicators	Women	Men	Total	Women	Men	Total
	1	2	3	4	5	6	7
Demography and Vital Statistics							
1	Population (in million in 1981 & 2001)	330.0	353.4	683.4	495.7	531.3	1027.0
2	Decennial Growth (1981 & 2001)*	24.93	24.41	24.66	21.79	20.93	21.34
3	Sex Ratio (1981 & 2001)**	934	-	-	933	-	-
4	Life Expectancy at Birth (1981-85 & 1996-1996-01)	55.7	55.4	-	65.3	62.3	-
5	Mean Age at Marriage (1981 & 1991)	18.3	23.3	-	19.5	23.9	-
Health and Family Welfare							
6	Birth Rate (1981 & 1999)	-	-	33.9	-	-	26.1
7	Death Rate (1981 & 1999)	12.7	12.4	12.5	8.3	9.0	8.7
8	Infant Mortality Rate (1988 & 1999)	93.0	96.0	94.5	70.8	69.8	70.0
9	Child Mortality Rate (1985 & 1997)	40.4	36.6	-	24.5	21.8	-
10	Maternal Mortality Rate (1980 & 1998)	468	-	-	407	-	-
Literacy and Education							
11	Literacy Rates (1981 & 2001)*	29.76	56.38	43.57	54.16	75.85	65.38
12	Gross Enrolment Ratio (1980-81 & 1999-2000)						
	- Classes I-V	64.1	95.8	80.5	85.2	104.1	94.9
	- Classes VI – VIII	28.6	54.3	41.9	49.7	67.2	58.8
13	Drop-out Rate (1980-81 & 1999-2000)*						
	- Classes I – V	62.5	56.2	58.7	42.3	38.7	40.3
	- Classes VI – VIII	79.4	68.0	72.7	58.0	52.0	54.6
Work and Employment							
14	Work Participation Rate (1981 & 2001)*	19.7	52.6	36.7	25.7	51.9	39.3
15	Organised Sector (No.in lakh in 1981& 1999)	27.93 (12.2 %)	200.52	228.45	48.29 (17.2%)	232.84	281.13
16	Public Sector (No. in lakh in 1981 & 1999)	14.99 (9.7 %)	139.85	154.84	28.11 (14.5%)	166.04	194.15
17	Government (No. in lakh in 1981 &1997)	11.9 (11%)	97.1	109.0	15.7 (14.6%)	91.7	107.4
Decision - Making							
18	Administration (No. in IAS & IPS in 1987 & 2000)	360 (5.4%)	6262	6622	645 (7.6%)	7815	8460

Sl. No.	Indicators	Women	Men	Total	Women	Men	Total
	1	2	3	4	5	6	7
19	PRIs (No. in lakh in 1995 & 2001)	318*** (33.5%)	630***	948***	725@ (26.6%)	1997	2722
20	Parliament (No. in 1998 & 2001)	59 (7.2%)	707	770	70 (8.5%)	750	820
21	Central Council of Ministers (1985 & 2001)	4 (10%)	36	40	8 (10.8%)	66	74

* Figures in per cent;
** Females per 1,000 males;
*** Refers to 1995 in respect of some states namely Gujarat, Haryana, Karnataka, Kerala, Madhya Pradesh, Punjab, Rajasthan, Tripura and West Bengal;
@ As on 18.10.2001.
Note:i) Figures in parentheses indicate the percentage to the total and year of the data in respective columns. Although, efforts were made to keep a common 'base' and common 'comparable year' but the same could not be kept up because of the limitations in the availability of data and other practical problems; ii) The years given in the parentheses refers to the Year of the Data in columns 3,4 &5 and 6,7 & 8 respectively.

Source: 1. Census of India, 1991; Census of India, 2001: Provisional Population Totals; and SRS Bulletins for respective years, Registrar General & Census Commissioner, GOI, New Delhi; 2. Selected Educational Statistics for respective years, Dept. of Education, Ministry of HRD, New Delhi; 3. Annual Report, 1999-2000, Deptts. of Elementary & Literacy and Secondary & Higher Education, Ministry of HRD, New Delhi; 4. Employment Exchange Statistics, DGE&T, Ministry of Labour, New Delhi; 5. Dept. of Personnel & Training, New Delhi; 6. Ministry of Rural Development, New Delhi; 7. Election Commission of India, New Delhi; 8. National Informatics Centre, Parliament House, New Delhi

Annual Plan (2002-03)

27. As part of the Zero Based Budgeting for the Tenth Plan, an in-depth exercise on the rationalization, through convergence, merging and weeding-out of the on-going schemes of Department of Women and Child Development, both for Central Sector and Centrally Sponsored Schemes has been carried out. Out of the 46 on-going schemes during the Ninth Plan (1997-02), only 25 schemes (20 CS and 5 CSS) will be retained in Tenth Plan (2002-07). Of these 25 schemes, 5 Schemes are new (2 CS and 3 CSS).

28. In the Annual Plan (2002-03), a total outlay of Rs.2,200 crore has been provided for Women and Child Development sector under the Central Sector. As stated earlier, Plan outlays for Women and Child Development under State Sector are included under the outlays for 'Social Welfare' (Annexure – 5.13.2 of Chapter on Social Welfare). While details of the programme-wise outlays earmarked under the Women and Child Development during Annual Plan (2002-03) are available at Annexure- 5.10.1, summary of the same along with the outlays earmarked for the Tenth Plan is given in Table –5.10.4:

Table – 5.10.4

Outlays under Women and Child Development Sector during Tenth Plan (2002-07) and Annual Plan (2002-03)

(Rs. in crore)

Sl. No.	Name of the Schemes	Tenth Plan (2002-07) outlay	Annual Plan (2002-03) outlay
1	2	3	4
I.	Women and Child Development	13670.00	2198.00
i)	Central Sector Schemes	1148.22	156.18
ii)	Centrally Sponsored Schemes	12521.78	2041.82
II.	Food and Nutrition Board	110.00	2.00
i)	Central Sector Schemes	10.00	2.00
ii)	Centrally Sponsored Schemes	100.00	0.00
	Total	**13780.00**	**2200.00**

29. In line with the approach, strategies and priorities of the Tenth Five Year Plan (2002-07), Annual Plan (2002-03) being the first year of the Tenth Plan, accords high priority to empowerment of women and development of children. While the various women-related line Ministries continued to implement their policies and programmes related to women and children, the nodal Department of Women and Child Development will supplement their efforts to create an enabling environment with requisite policies and programmes; extending legislative support; and setting up of exclusive institutional mechanisms at various levels with adequate financial and manpower support as elaborated below:

a) Empowerment of Women

30. In the context of having a laid down National Policy, approach to the Tenth Plan for empowering women is something very distinct from the earlier Plans as it stands now on a strong Platform for Action with definite goals, targets and time-frame. Further, as the process of empowering women initiated during the Ninth Plan is expected to continue through and beyond the Tenth Plan, there can be no better approach for the Tenth Plan than translating the recently adopted National Policy for Empowerment of Women (2001) into action through -

- Creating an environment through positive economic and social policies for development of women to enable them to realize their full potential;
- Allowing the de-jure and de-facto enjoyment of all human rights and fundamental freedom by women on equal basis with men in all spheres-political, economic, social, cultural and civil;
- Providing equal access to participation and decision-making for women in social, political and economic life of the nation;

- Ensuring equal access to women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office etc.;
- Strengthening legal systems aimed at elimination of all forms of discrimination against women;
- Changing societal attitudes and community practices by active participation and involvement of both men and women;
- Mainstreaming a gender perspective in the development process;
- Eliminating discrimination and all forms of violence against women and the girl child; and
- Building and strengthening partnerships with civil society, particularly women's organisations.

31. The major strategy proposed to be adopted in the Tenth Plan and Annual Plan (2002-03) will be – Social Empowerment and Economic Empowerment with a special thrust on Gender Justice. To improve the socio-economic status of women and child, Gender Justice will receive special priority to ensure elimination of all types of discrimination – as prescribed in the Policy. Also, the implementation of the Ninth Plan strategy of Women's Component Plan will be further intensified to ensure better flow of funds to women from other developmental sectors. To this effect, Plans of Action, both at the national and state levels will be prepared.

32. The Annual Plan (2002-03) will initiate the process of preparing the Plans of Action, both at central and state levels, which will clearly specify - i) the measurable goals to be achieved along with the time targets, preferably in consonance with the time frame set by the other women-related National Policies; ii) commitment of resources; iii) earmarking of the benefits under WCP; iv) fixing up of responsibilities for implementation of Action Points; and v) structure and mechanism to ensure effective review, monitoring, and impact of all the related policies, Plans of Action and programmes in raising the status of women, the adolescent girls and the girl children at par with their counterparts. Besides, the Annual Plan (2002-03) reaffirms the major strategy of mainstreaming gender perspectives in all sectoral policies and programmes and plans of action to achieve the ultimate goal of eliminating gender discrimination and creating an enabling environment of gender justice which would encourage women and girls to act as catalysts, participants and recipients. Further, where there are gaps, women-specific interventions will be undertaken to bridge the same

33. Further, the Plan will continue the process of organising women into Self-Help Groups (SHGs) which started during Ninth Plan to provide permanent aid for articulating their needs and contributing their perspectives to development. Experience has already shown that these Groups have been very effective institutions at grassroot level in facilitating access to women, be it financial or services or for information.

34. Effective convergence of available services, resources, manpower, infrastructure, etc. in all the women-related sectors, viz. health, nutrition, education, employment, media, environment, safe drinking water, adult/functional literacy, gainful employment either wage

or self-employment, sanitation, knowledge and information about integrated management of childhood diseases; counselling to safe motherhood practices, nutrition, welfare services, Science and Technology, small and medium industrial sectors/industries, micro-credit, will be carried out to optimise the impact;

35. To reinforce the on-going process of empowering women, the Annual Plan will use, along the lines of the Tenth Plan, a sector-specific 3-fold strategy for empowering women through - i) Social Empowerment, ii) Economic Empowerment, and iii) Gender Justice, as discussed in the following paragraphs.

i) Social Empowerment

36. The Annual Plan (2002-03) will create an enabling environment by adopting various affirmative and other developmental policies and programmes for empowering women through facilitating their access to education, primary health care and family welfare, employment opportunities towards attaining self-reliance so as to realise their full potential.

37. In line with the commitments of the Tenth Plan, the present strategy of supplementing health care and nutrition services through Pradhan Mantri Gramodaya Yojana (PMGY) to fill the critical gaps in the existing primary health care infrastructure and services will continue, thus facilitating easy and equal access to all basic minimum services during the Annual Plan. Recognising the critical link between the health and nutritional status of women, mothers and girl children, the Plan commits to tackle both macro and micro-nutrient deficiencies through nutrition supplementary feeding programmes with necessary support services like health check-ups, immunisation, health and nutrition education and nutrition awareness etc.

38. Efforts to declare education as a 'Fundamental Right' and launching of a nation-wide innovative programme viz. Sarva Shiksha Abhiyan (SSA) clearly reflect the Government's concern and commitment to ensure that every citizen of this country is literate/educated. Through the specially targeted programme of SSA, efforts will be made to reach the un-reached Girl Child and to ensure that SSA achieves its commitment on schedule. Further, the progress made under female education will be consolidated and carried forward for achieving the set goal of `Education for Women's Equality' as advocated by the National Policy on Education, 1986 (revised in 1992). The Scheme of CCE&VT run by CSWB has been earmarked Rs.2 crore for the Annual Plan (2002-03). The 'Distance Education Programme' for women has been earmarked Rs. 0.55 crore for the Annual Plan (2002-03).

39. Steps are being initiated to provide easy and equal access to free education for women and girls at all levels and in the field of technical and vocational education and training in up-coming and job-oriented trades. Further, the support services through mid-day meals, hostels and incentives like free supply of uniforms, text-books, transport charges etc. will be expanded to increase enrolment/retention rates and reduce drop-out rates. The Plan will extend the existing network of regional vocational training centres to all the States and Women's Industrial Training Institutes and Women's Wings with General Industrial Training Institutes with residential facilities in all districts and sub-districts and provision of training in marketable trades.

40. Through a well-planned media strategy, the Plan will encourage media to foster women and the Girl Child; change the mind-set of the people and thus promote balanced portrayals of women and men. For the schemes of Information and Mass Media and Information Technology Rs. 6.00 crore and Rs. 0.50 crore have been earmarked respectively for the Plan year 2002-03. To encourage women's participation in the employment market Hostels for Working Women and Short Stay Homes for distressed women each earmarked Rs. 15 crore for the year 2002-03.

ii) Economic Empowerment

41. The Plan will ensure capacity-building through training and upgradation of skills; and provision of employment and income-generation activities with both 'forward' and 'backward' linkages with the ultimate objective of making all women economically independent and self-reliant. SHGs, which act as the agents of social change, development and empowerment of women, will continue to be encouraged. The on-going integrated women's empowerment programmes of Swa-Shakti and Swayamsidha will be expanded during the Annual Plan with outlays of Rs. 25 crore and Rs. 20 crore respectively with an ultimate objective of universalising the same through the already available grass-root level networking of SHGs. Besides, under various poverty alleviation programmes, viz. Swarnajayanti Gram Swarozgar Yojana, Swarna Jayanti Shahari Rozgar Yojana, Rashtriya Mahila Kosh (RMK), Support for Training and Employment Programme (STEP), Training-cum-Production Centres (NORAD) for Women etc., women will be encouraged to form SHGs to enhance their capabilities and earning capacities. The last three programmes RMK, STEP, and NORAD have been earmarked Rs. 1 crore, Rs. 25 crore and Rs. 25 crore respectively for the Annual Plan (2002-03).

42. Efforts will be continued to ensure that women in the Informal Sector who account for more than 90 per cent of the workforce are given special attention as they continued to be vulnerable with regard to their working conditions as they are denied even minimum or equal wages, leave aside other legislative and health safeguards. As the majority (89.5 per cent) of female workforce is concentrated in the agricultural sector, women in agriculture are doubly marginalized, first as women and second as landless farmers, as limitation of inheritance rights and other social practices deprive women from entitlement to land and other productive assets. Therefore, the Plan will make concerted efforts to ensure that reasonable benefits of training and extension in agriculture, its allied activities like horticulture, small animal husbandry, poultry, fisheries, etc. reach women. The issue of Joint *Pattas* for husband and wife under Social Forestry and Joint Forest Management is a case in point.

43. Efforts will be made to remove the existing cultural bias that women are good only in stereo-type/feminine jobs and encourage women to equip themselves with necessary professional/vocational skills and compete with men to make an entry into such areas. Further, the Plan will ensure that the employers fulfil their legal obligations towards their women workers in extending child care facilities, maternity benefits, special leave, protection from occupational hazards, allowing formation of women workers' associations/ unions, legal protection/aid etc.

44. The recast programme of IMY which aims at empowering women both socially and economically, now known as Swayamsidha will be further expanded in coverage during the

Plan. The micro-credit programme of RMK will be linked with the Groups formed under Swayamsidha for financing various employment-cum-income generation activities. Further, access to credit for women will be increased either through the establishment of new micro-credit mechanisms or strengthening of the existing credit institutions catering to women along with expansion of the limited coverage of RMK. There will also be efforts to equip all States/UTs with Women's Development Corporations to provide both 'forward' and `backward' linkages of credit and marketing facilities to women entrepreneurs, besides being catalysts. Further, the Annual Plan will try and expedite the earlier efforts of the Government to set up a 'Development Bank for Women Entrepreneurs' in the Small Scale and Tiny Sectors.

45. Appropriate steps will be taken to identify the traditional sectors that are shrinking due to advancement of technology, market shifts and changes in the economic policies. Efforts will be made to re-train and re-deploy women displaced from traditional sectors due to advancement of technology. Appropriate policies and programmes will be formulated to promote alternative opportunities for wage/self-employment in traditional sectors like *khadi* and village industries, handicrafts, handlooms, sericulture, small scale and cottage industries to absorb those displaced women.

46. Aforesaid steps will be supplemented with affirmative action to ensure at least 30 per cent of reservation for women in the Public Sector along with provisions for upward mobility. Special concessions and relaxations, like multiple entries, enhancement of upper age limit, etc. need to be extended to ensure adequate representation of women in services in the public sector.

iii) Gender Justice

47. The Annual Plan will make a beginning to eliminate all forms of gender discrimination and thus, allow women to enjoy not only the de-jure but also the de-facto rights and fundamental freedom at par with men in all spheres, viz. political, economic, social, civil, cultural etc. The Plan will take special measures to examine the declining sex ratio and initiate necessary action to achieve the balanced sex ratio. It will also try and ensure easy accessibility for women and the girl child to the basic minimum services through effective inter-sectoral coordination. The Plan will, therefore, strive to completely eradicate female foeticide and female infanticide through effective enforcement of both Indian Penal Code, 1860 and the Pre-Natal Diagnostic Technique (Regulation and Prevention of Misuse) Act, 1994 with most stringent measures of punishment.

48. Efforts will be made to eliminate discriminatory feeding practices towards Women and Girl child resulting in malnutrition and its related deficiencies and diseases amongst women, mothers and children, which has become a big threat to their development potential. Immediate steps will be taken to ensure that adequate provisions are made to reinforce the supplementary feeding services in all the 7.5 lakh Anganwadis, as per the prescribed norms, both in quality and quantity. Besides, efforts will also be made to ensure 'Food Security for All at House-hold Level' so that the existing discriminatory practices in food sharing can be avoided. The additional assistance being extended through PMGY and the services visualized under the Nutrition Mission Mode will be of great importance to rectify the existing inequalities and discriminatory feeding practices.

49. To foster holistic development of women, the Plan will attempt to eliminate discrimination against women and girls in respect of education and health and thereby create a favourable social environment where every individual strives to achieve his/her full potential. It will also initiate action to increase access to women and girls through special measures viz. provide free education, appoint more women teachers, create a gender-sensitive educational system, increase enrolment and retention rates through provision of hostels, mid-day meals and improve the quality of education to facilitate life-long learning as well as development of vocational/technical skills. Efforts will also be made to develop gender sensitive curricula at all levels of educational system in order to address sex stereotyping as one of the causes of the gender discrimination. Also special efforts will be made to increase easy access towards a comprehensive, affordable and quality health and nutrition care through widespread RCH and ICDS services. Also, measures will be adopted to take into account the reproductive rights of women to enable them to exercise their reproductive choices.

50. The Annual Plan will work out a strategy in close collaboration with the Ministry of Labour and other sectors with employment potential to ensure extension of employment opportunities to remove inequalities in employment – both in work and accessibility and thereby improve female make women's work more visible and their contribution recorded in the National Accounts. As one of the important measures to ensure gender justice, attempts will be made to ensure that value added by women in the Informal Sector as workers and producers is recognized through redefinition/re-interpretation of conventional concept of work and preparation of Satellite and National Accounts. Also, efforts will be made to extend/enforce both legislative and welfare measures, especially those of the minimum and equal wages for women to control/eradicate their exploitation in the informal sector besides improving the working conditions. Gender sensitising both administrative and enforcement machinery and ensuring that the rights and interests of women are taken care of, besides involving them in planning, implementation and monitoring of processes. Awareness Generation Projects for Rural and Poor Women (AGPRPW) run by Department of Women and Child Development has been allocated an outlay of Rs. 4.30 crore.

51. The Annual Plan will define the Women's Component Plan (WCP) clearly and identify the schemes under each Ministry/Department which should be covered under WCP and ensure adoption of such women-related mechanisms through which funds/benefits flow to women from these sectors. Immediate action will be initiated in tying up the 2 effective concepts of WCP and Gender Budgeting, and thus ensure both preventive and post-mortem action, in enabling women receive their rightful share from all the general developmental sectors. It is neither the quantum nor the share in total outlay that matters in empowering women. The most crucial issue is how to ensure that the funds already flowing from various developmental sectors are effectively converged, worth utilized and better monitored.

52. Action will be initiated for enacting new women–specific legislations and amending the existing ones, if necessary, based on the review made and recommendations already available to ensure gender justice. Besides, all the subordinate legislations to eliminate all gender discriminatory references will be reviewed.

53. Efforts will be to increase the number of women in decision-making at various levels both in administrative and political spheres, through affirmative discrimination, if necessary.

In this context, action will be initiated to legislate reservation of not less than 1/3 seats for women in the Parliament and in the State Legislative Assemblies and thus ensuring women in proportion to their numbers reach decision-making bodies so that their voices are heard.

54. Violence against women and the girl-child, both domestic and at work-place, is progressively increasing. As per the latest data (1999) published by the National Crime Records Bureau, New Delhi, the total number of crimes committed against women has risen from 1.21 lakh in 1997 to 1.36 lakh in 1999. Of the total 1.36 lakh crimes against women in 1999, torture claims the highest share of 32.3 per cent; followed by molestation (23.8 per cent); kidnapping and abduction (11.7 per cent); rape (11.4 per cent); sexual harassment (6.5 per cent); and dowry death (4.9 per cent); immoral traffic (6.9 per cent) and others (2.5 per cent). Therefore, to arrest the ever increasing violence against women and the Girl Child including the Adolescent girls, well-planned Programmes of Action will be prepared in consultation with all the concerned, especially the enforcement authorities. The scheme for women in difficult circumstances – Swadhar, initiated last year has been earmarked an outlay of Rs.15 crore to provide shelter, food, clothing and care to the marginalized women living in difficult circumstances. The National Commission for Women (NCW), in-charge of safeguarding rights and interest of women has been earmarked an outlay of Rs. 6 crore.

55. Realising the problem of in sufficient gender disaggregated data at the State/District level, immediate steps will be taken to expedite standardisation of the Gender Development Index. Thereafter gender segregated data will be collected at national, State and district levels; compiled/collated and analysed to assess the status of women at regular intervals with an ultimate objective of achieving equality at par with men. Thus, the Plan will initiate/ accelerate the process of societal reorientation toward creating a Gender-Just Society. Also, steps will be initiated to set up a National Resource Centre for Women with the responsibility of collecting gender disaggregate data from all women-related sectors and a token provision of Rs. 0.01 crore has been made for the purpose.

b) Development of Children

56. The Plan advocates a Rights-based Approach as proposed by the National Policy and Charter for Children (2002) and the two existing National Plans of Action for Children/Girl Child (1992) to ensure:

- 'Survival' of children, especially the girl child, by arresting the declining sex ratio and curbing its related problems of female foeticide and female infanticide;
- 'Protection' for all children and in particular those with special needs and problems and those in difficult circumstances through effective implementation of the existing child-related legislations; and
- 'Development' through effective implementation of policies and programmes in areas of health, immunisation, nutrition and education through the 3 nation-wide Programmes of RCH, ICDS, SSA and other related programmes.

57. ICDS will continue to be the mainstay for promoting the over-all development of the young children especially the Girl Child and the mothers all over the country. The Plan recognises while the early childhood up to 6 years are critical for the development of

children, the pre-natal to first three years are the most crucial and vulnerable period in the life for achievement of full human development potential and cumulative lifelong learning. The scope of the on-going approach to converge the basic services of health, nutrition and pre-school education to promote holistic development of the young child, as embodied in ICDS, will be further strengthened with community participation/community action to reach the un-reached, i.e., children below 3 years. Efforts will be made to expand/widen the scope of the development of children with necessary interventions related to empowerment of women, with a special focus on the girl child and the adolescent girl. To the existing package of health, nutrition, education, and awareness thereof being provided by KSY, counselling facilities will be added and vocational training and entrepreneurial skills will be strengthened.

58. Attempts will be made to achieve universal coverage expeditiously under the Universal Immunisation Programme, and to undertake area-specific micro-planning to meet their needs through high quality integrated Reproductive and Child Health services. Further, focussed interventions aimed at improving the nutritional status of children below 6 years with a special priority for children below 24 months through the on-going direct feeding programme of Special Nutrition Programme will be made. The Plan will operationalise universal screening of children to screen families living below the poverty line will be operationalised for macro and micro-nutrient deficiencies as the children from below 6 years are the 'risk group' and improve the dietary intake through a change in the feeding practices and intra-family food distribution.

59. The challenge in the field of child development is to achieve community participation and community contribution. Priority will be accorded to strengthen the knowledge, skills and capabilities of frontline workers, as mobilisers of convergent action. Thus, the major thrust will be to develop decentralised training strategies with innovative ground-based approaches. New approaches for mobilising assistance both in cash and kind for the sustenance of child development programmes will be experimented with community participation/contribution to ICDS. Also, efforts will be made to involve the corporate sector to adopt the ICDS projects and thus fulfil their societal obligations. The principles enunciated above, and the envisaged role of PRI/Urban Local Bodies will have major implications not only in planning but also in the control of the flow of funds for the programmes of child development.

60. The Annual Plan re-affirms the life-cycle approach for the betterment of the Adolescent/Girl Child. The Plan will concentrate its efforts to eliminate all forms of discrimination and violation of the rights of the Adolescent/Girl Child by undertaking strong legal measures including punitive ones. These include strict enforcement followed by the harmful practices of female foeticide/female infanticide, child marriage, child abuse, child labour, child prostitution etc. Also, special efforts will be made to use all types of mass media to re-orient the mind-set of people to perceive Girl Child as an asset.

61. Emerging out with 25 years of rich experience in the programmatic perspective, the task ahead for ICDS in the Tenth Plan will not only be that of feeding and teaching the young child, but that of adopting a synergistic approach to strengthen the capacity of care-givers and communities to provide physical and social environment for the young child in the family/community and at the AWCs. ICDS has already reached a stage, where it is essential not only to universalise its expansion, but also to enrich its contents. The

spectrum of ICDS services has broadened with interventions related to the empowerment of women and communities and convergence of sectoral services. This emerging profile of ICDS will rededicate itself to promoting early childhood care for survival, protection and development. Accordingly, the thrust areas under ICDS will be as under: - address the needs of urban poor; direct intervention to fight rampant under nutrition and malnutrition among children and women; conversion of Anganwadi Centres into Anganwadi-cum-Crèches; initiate Child Care facilities for women labourers working at construction sites; community involvement under ICDS; universalisation of KSY (Adolescent Girls' Scheme) as a component of ICDS Scheme; fostering innovation under ICDS to tackle the area/locality specific bottlenecks and problems under ICDS; a major advocacy, communication and social mobilization initiative linked to UDISHA to promote young child survival, protection and development with participation - especially that of the girl child; improving the quality of service delivery and management strengthening of basic infrastructural facility. For the scheme of training of ICDS functionaries an outlay of Rs. 72 crore for Annual Plan 2002-03 has been provided.

62. Special efforts will be made for an effective implementation of the National Nutrition Mission for which a token provision of Rs. 1 crore has been earmarked. Food and Nutrition Board attached to the nodal Department of Women and Child Development is expected to create nutritional awareness through its National Nutrition Policy and Nutrition Education, which has been earmarked an outlay of Rs. 2 crore, through the countrywide network of Field Agencies and also streamlined the otherwise isolated efforts of both Government and non-Governmental organisations through the existing coordination mechanism both at central and state levels.

63. Efforts will be made to ensure to enrol every child and to provide education otherwise to children who were never enrolled or dropped out before completing eight years of elementary schooling. There is an increasing need for support services like Crèches/Day Care Centres to for the children of working/ailing mothers, especially in the present day context where more and more women are joining the workforce both in the organised and unorganised sectors. Support services of crèche/day care services will be expanded during the year 2002-03. To help reduce the burden of working/ailing mothers and also of the girl child who is expected to bear the burden of sibling care, Rs. 12 crore has been earmarked for Crèches/Day Care Centres for Children of Working/Ailing Mothers.

64. The National Plans of Action both on Children and the Girl Child have very clearly defined the 'Children in Difficult Circumstances' as inclusive of street children, working children, child sex workers, child drug-addicts; children in conflict with law; children with disabilities; children with HIV/AIDS; children of HIV/AIDS patients; children whose parents are under custody; children affected by various disasters (natural and man-made); children affected by national and international conflicts, viz. political refugees, war victims, internally displaced and children whose families are in crisis; both social and economic including those belonging to broken families. While recognising the major gap that exists today in reaching the children belonging to these special groups who are in urgent need of care and protection, the Plan will initiate action to get the necessary in-depth studies conducted on priority basis to assess the size and magnitude of the problem and try to streamline and expand the on-going efforts both in the government and non-government sectors; and launch if necessary, new programmes to cover the hitherto unattended groups.

65. In addition to the Training of ICDS functionaries, National Institute of Public Co-operation and Child Development (NIPCCD) will continue to organise orientation/training courses for the representatives of both Governmental and Non-Governmental organisations engaged in planning and implementation of various programmes for the welfare and development of women and children. For this purpose, an amount of Rs. 6.00 crore has been earmarked for NIPCCD for Annual Plan (2002-03).

66. With a view to extend financial assistance to Below Poverty Line (BPL) families the scheme of Balika Samriddhi Yojana (BSY) launched in 1997 is under implementation providing post-delivery grants, annual scholarships usable for provision of text books-uniforms etc.

67. To protect children from all types of exploitation through strict enforcement of the Immoral Traffic (Prevention) Act, 1956; the Juvenile Justice (Care and Protection) Act, 2000, the Child Labour (Prohibition and Regulation) Act, 1986, the Hindu Succession Act, 1956, Indian Penal Code, 1860 and the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 action has been initiated to set up a National Commission for Children. A token provision of Rs. 0.20 crore has been made in the Annual Plan (2002-03).

Externally Aided Projects

68. Several projects undertaken for Women and Child Development receive external aid. They include: Setting up of Training-cum-Production Centres for Women (NORAD), World Bank ICDS programme (Multi-State ICDS Project, training of ICDS Functionaries – UDISHA, Rural Women's Development & Empowerment Project and CIDA-assisted Project for Himachal Pradesh. For the Annual Plan (2002-03) an outlay of Rs. 398.01 crore has been provided under EAP against the total aid of Rs. 236.50 crore received during 2001-02. A statement showing year-wise external aid spent during the Ninth Plan (1997-2002) is given in Annexure – 5.10.2. A summary of the external aid budgeted for the Tenth Plan (2002-07) and for Annual Plan (2002-03) is given in Table 5.10.5.

Table – 5.10.5

Outlays under Women and Child Development Sector during Tenth Plan (2002-07) and Annual Plan (2002-03)

(Rs. in Crore)

Sl. No.	Name of the Schemes	Tenth Plan (2002-07) outlay		Annual Plan (2002-03) outlay	
		Total	EAP	Total	EAP
	1	2	3	4	5
I.	**Women and Child Development**	**13670.00**	**1683.02**	**2198.00**	**398.01**
i)	Central Sector Schemes	1148.22	25.00	156.18	5.00
ii)	Centrally Sponsored Schemes	12521.78	1658.02	2041.82	393.01
II.	**Food and Nutrition Board**	**110.00**	-	**2.00**	-
i)	Central Sector Schemes	10.00	-	1.00	-
ii)	Centrally Sponsored Schemes	100.00	-	1.00	-
	Total	**13780.00**	**1683.02**	**2200.00**	**398.01**

Role of Voluntary Organisations

69. The voluntary organisations have been contributing significantly for the empowerment of women and development of children by creating awareness generation and gender sensitisation, formulating alternative models in the areas of credit, organising women into SHGs, self-employment, participatory rural appraisal etc. Grants in aid to voluntary organisation for the year 2002-03 has been earmarked at Rs. 6.61 crore.

Annexure 5.10.1

Plan outlays and expenditure - Women and Child Development Sector

(Rs. Crore)

Sl. No.	Name of the Scheme	Annual Plans			Sl. No.	Annual Plan (2002-03)	
		2000-01	2001-02			Name of the Scheme	B.E.
		Actuals	B.E.	Actuals			
1	2	3	4	5	6	7	8
I	**CENTRAL SECTOR SCHEMES**						
A	**Welfare & Development of Children**						
1.	Creches/Day Care Centres for Children children of working/ Ailing Mothers	4.50	7.45	7.60	1.	Creches/Day Care Centres for children of working/ Ailing Mothers	12.00
2.	National Creche Funds for Child Care Schemes	-	0.97	-		-	-
3.	Balsevika Training Programme	-	-	-			
4.	Training of ICDS Functionaries	19.94	40.00	52.86		Transferred to CSS	-
5.	National Institute of Public Co-operation & Child Development (NIPCCD)	1.85	2.50	2.20	2.	National Institute of Public Co-operation & Child Development (NIPCCD)	6.00
6.	Early Childhood Education	0.27	0.01	-			
7.	Balwadi Nutrition Programme (BNP)	0.07	0.01	-			
8.	National Commission for Children	-	1.00	-	3.	National Commission for Children	0.20
	Total - A	**26.63**	**51.94**	**62.66**			**18.20**
B.	**Welfare &Development of Women**						
9.	Hostels for Working Women	7.42	9.00	4.96	4.	Hostels for working Women	15.00
10.	Setting up of Training cum Production Centres for Women (NORAD)	13.89	18.00	18.95	5.	Setting up of Training cum Production Centres for Women (NORAD)	25.00
11.	Support to Training cum Employment Programme(STEP)	14.36	18.00	18.57	6.	Support to Training cum Employment Programme (STEP)	25.00
12.	National Commission for Women	3.50	5.00	4.17	7.	National Commission for Women	6.00
13.	National Credit Fund for Women (RMK)	-	1.00	-	8.	National Credit Fund for Women (RMK)	1.00
14.	Common Wealth Meeting	0.60	-	-			
15.	Strengthening of WD Bureau	-	-	-			
16.	Creation of Office of the Commissioner for Rights of Women	-	-	-			
17.	Mahila Samridhi Yojana(MSY)	15.95	8.00	7.34			
18.	Women Empowerment Project	-	0.01	-			

Annexure 5.10.1 contd..

(Rs. Crore)

Sl. No.	Name of the Scheme	Annual Plans			Sl. No.	Annual Plan (2002-03)	
		2000-01	2001-02			Name of the Scheme	
		Actuals	B.E.	Actuals			B.E.
1	2	3	4	5	6	7	8
19.	GIA to Voluntary Organisation through CSWB and strengthening of its Field Organisations	14.00	15.00	15.00	9.	Grant-in-aid to Central Social Welfare Board (i) General Grant-in-Aid (ii) Condensed Courses (iii) Awareness Projects (iv) Short Stay Homes	37.30 16.00 2.00 4.30 15.00
20.	Condensed Courses of Education and Vocational Training for Women	1.50	2.00	2.00			
21.	Awareness Generation Project for Rural and Poor Women	1.80	4.00	4.00			
22.	Education Work for Prevention of Atrocities Against Women	0.20	0.28	-			
23.	Short Stay Homes (SSH)	8.00	10.00	5.32			
24.	Socio-Economic Programme	1.00	1.00	1.25			
25.	Distance Education	1.41	0.50	0.50	10.	Distance Education	0.55
26.	National Resource Centre for Women (NRCW)	-	2.00	-			
27.	Women's Empowerment Year 2001	0.91	11.00	11.60			
28.	Scheme for Women in difficult circumstances (Swadhar)	-	6.00	0.08	11.	Scheme for Women in difficult circumstances (Swadhar)	15.00
	Total -B	**84.54**	**110.79**	**93.74**			**124.85**
C	**Grant-in-Aid and Other Schemes**						
29.	GIA to Research Publication & Monitoring	0.56	1.51	0.63	12.	Other Grant-in-Aid (i Research & Monitoring 5.00 ii Women & Child 1.50)	6.50
30.	Organisational Awareness in the field of Women and Child Development	0.20	0.25	0.27			
31.	Programme Monitoring & Evaluation Unit	-	-	-			
32.	Organisational Assistance to Voluntary Organisation	-	0.01	-			
33.	Information and Mass Media	1.75	3.50	3.36	13.	Information and Mass Media	6.00
34.	NEMA	-	-	-			
35.	Information Technology	0.46	0.50	0.49	14.	Information Technology	0.50
	Total - C	**2.97**	**5.77**	**4.75**			**13.00**
	Total - (A+B+C)	**114.14**	**168.50**	**161.15**			**156.05**

Annexure 5.10.1 contd..

(Rs. Crore)

Sl. No.	Name of the Scheme	Annual Plans			Sl. No.	Annual Plan (2002-03)	
		2000-01	2001-02			Name of the Scheme	B.E.
		Actuals	B.E.	Actuals			
1	2	3	4	5	6	7	8
D	**Food and Nutrition Board**						
36.	Research & Development	-	-	-		-	-
37.	Implementation of National Nutrition Policy	0.07	0.50	0.08	15.	Implementation of National Nutrition	2.00
38.	Fortification of Milk with Vitamin A	0.02	0.10	0.01			
39.	Capital Expenditure	-	0.40	0.01			
40.	Nutrition Education	1.84	3.00	2.68			
41.	Production of Nutritious Food	-	-	-		-	-
	Total - D	**1.93**	**4.00**	**2.78**			**2.00**
E	**New Schemes**						
	-	-	-	-	16.	CRÈME	0.01
	-	-	-	-	17.	National Resource Centre for Women	0.01
	Total - E						**0.02**
	Total - I (A to E)	**116.07**	**172.50**	**163.93**			**158.07**
II A	**CENTRALLY SPONSORED SCHEMES** **Welfare & Development of Children**						
42.	Integrated Child Development Services (ICDS)	1047.86	1198.00	1224.43	18.	Integrated Child Development Services (ICDS)	1635.44
43.	World Bank Assisted ICDS Projects	140.01	220.00	219.94	19.	World Bank Assisted ICDS Projects	288.48
	-	-	-	-	20.	Training of ICDS Functionaries	72.00
44.	Balika Samriddhi Yojana	20.97	25.00	13.04	-	Balika Samriddhi Yojana (To be transferred to States) awaiting NDC's approval)	-
	Total - A	**1208.84**	**1443.00**	**1457.41**			**1995.92**
B	**Welfare & Development of Women**						
45.	Integrated Women's Empowerment Programme (Swayamsidha)	2.10	19.50	6.85	21.	Integrated Women's Empowerment Programme (Swayamsidha)	20.00
46.	Rural Women's Development and Empowerment Project (Swa-shakti)	8.00	15.00	15.00	22.	Rural Women's Development and Empowerment Project (Swa-shakti)	25.00
	Total - B	**10.10**	**34.50**	**21.85**			**45.00**
	Total - A + B	**1218.94**	**1477.50**	**1479.26**			**2040.92**

Annexure 5.10.1 contd..

(Rs. Crore)

Sl. No.	Name of the Scheme	Annual Plans			Sl. No.	Annual Plan (2002-03)	
		2000-01 Actuals	2001-02 B.E.	2001-02 Actuals		Name of the Scheme	B.E.
1	2	3	4	5	6	7	8
	New Schemes						
	-	-	-	-	23.	National Nutrition Mission	1.00
	-	-	-	-	24.	CIDA Assisted Programme for Himachal Pradesh	0.01
					25.	ICDS IV	-
	Total - C						**1.01**
	Total - II (A to C)	**1218.94**	**1477.50**	**1479.26**			**2041.93**
	Grand Total I + II	**1335.01**	**1650.00**	**1643.19**			**2200.00**

Note: 10% of the total outlay of the Department is earmarked for North Eastern States.

Annexure 5.10.2

Women & Child Development

Foreign aid routed through budget during Ninth Plan (1997-2002)

Sl. No.	Name of the Programme	Funding Agency	2000-01		Annual Plans 2001-02		2001-02		2002-03	
			Actual		BE		RE		BE	
			EAP	Total	EAP	Total	EAP	Total	EAP	Total
1	2	3	4	5	6	7	8	9	10	11
	Central Sector Schemes									
	Welfare and Development of Children									
1.	Training of ICDS Functionaries	UNICEF & WORLD BANK	14.16	19.94	28.00	40.00	49.00	70.00	50.40	72.00
2.	National Institute of Public Cooperation and children Development (NIPCCD)	UNICEF	-	1.85	-	2.50	-	2.50	-	6.00
3.	Setting up of Employment and income Generation Training cum Production Centres for Women (NORAD)	NORAD	5.00	13.89	5.00	18.00	10.00	23.00	5.00	25.00
4.	Rural Women's Development and Empowerment Project	IDA & IFAD	7.00	8.00	13.50	15.00	13.50	15.00	25.00	25.00
5.	Women Empowerment Project	UNIFPA	-	-	0.01	0.01	0.01	0.01	Weeded-out	
	Centrally Sponsored Schemes									
6.	World Bank Assisted ICDS Project	IDA & WB	98.01	140.01	154.00	220.00	154.00	220.00	201.86	288.37
	Food and Nutrition Board									
7.	Nutrition Education	UNICEF	0.50	1.84	0.50	3.00	0.50	3.00	Merged and renamed as 'Implementation of National Nutrition Policy and Nutrition Education'	
8.	Implementation of National Nutrition Policy	UNICEF	-	0.07	-	0.50	-	0.50		
	Total		**124.67**	**185.60**	**201.01**	**299.01**	**227.01**	**334.01**	**282.26**	**416.37**

5.11 EMPOWERMENT OF THE SOCIALLY DISADVANTAGED GROUPS

INTRODUCTION

Empowerment of the Socially Disadvantaged Groups viz. the Scheduled Castes (SCs), the Other Backward Classes (OBCs) and the Minorities was of high priority. In fact, this is part of the Constitutional commitment, to raise their status on par with that of the rest of society. They constitute a sizeable percentage of the country's population i.e. - SCs accounting for 179.7 million representing 17.5% and Minorities at 188.9 million representing 18.4% of the population in 2001 (projected in the absence of Census data, on the basis of trend of the decennial growth rate), and the population of OBCs, as estimated by the Mandal Commission in 1993, constitutes 52% of country's total population with a possibility of double counting of certain communities of SCs and Minorities as OBCs. Despite the various welfare and developmental efforts brought in so far, these disadvantaged groups continue to lag behind the rest of the society due to their socio-economic backwardness.

Review of the Ninth Plan (1997-2002) and Annual Plan (2001-02)

2. The year 2001-02 being the terminal year of the Ninth Five Year Plan (1997-02), special efforts were made to fulfil the Ninth Plan commitment of empowering the Socially Disadvantaged Groups. The Ninth Five-year Plan earmarked a total outlay of Rs.4985.05 crore for the Backward Classes Sector at the Centre, in the budget of the Ministry of Social Justice and Empowerment (M/SJ&E). Of this, an amount of Rs. 992.00 crore was earmarked for the Annual Plan 2001-02, with Rs. 581.00 crore for both Central and Centrally Sponsored Schemes and Rs. 411.00 crore as Special Central Assistance (SCA) for Special Component Plan (SCP). Actual expenditure amounted to Rs. 4016.75 crore during the Ninth Plan period, reflecting 80.6% utilization.

3. In the State sector, an amount of Rs.9689.15 crore for Ninth Plan was allocated against which Rs. 9179.90 crore is estimated to have been spent, reflecting effective use of 94.7% of the total allocation. While the scheme-wise outlays and expenditure at the Central level for the Backward Classes during Ninth Plan and Annual Plan 2001-02 are given at Annexure 5.11.1, the details of the outlays and expenditure in the State sector for the same period are given at Annexure 5.11.2.

Table 5.11.1

Outlays and expenditure for welfare and development of Backward Classes during Ninth Plan 1997-02 and Annual Plan 2001-02

(Rs. in crore)

Sl. No.	Name of the Schemes	Ninth Plan (1997-02)		Annual Plan (2001-2002)	
		Outlay	Actual	BE	Actual
1.	**Welfare & Dev. of SCs**	**4156.50**	**3569.84**	**872.28**	**807.82**
i)	Central Sector	651.56	400.32	66.51	80.45
ii)	CSS	1411.99	1160.88	394.77	274.86
iii)	SCA to SCP	2092.95	2008.64	411.00	452.51
2.	**Welfare of OBCs**	**621.45**	**290.08**	**79.36**	**55.40**
i)	Central Sector	430.75	199.60	21.85	4.59
ii)	CSS	190.70	90.48	57.51	50.81
3.	**Welfare of Minorities**	**207.10**	**156.83**	**40.36**	**21.30**
i)	Central Sector	207.10	156.83	40.36	21.30
ii)	CSS	-	-	-	-
	Total (1+2+3)	**4985.05**	**4016.75**	**992.00**	**884.52**

EDUCATIONAL DEVELOPMENT

Scheduled Castes (SCs)

4. Education being the most effective instrument for empowering the disadvantaged, the Ninth Plan attempted to achieve the same through universalisation of primary education amongst the educationally backward communities of SCs, OBCs and Minorities with a special focus on low-literacy pockets. To this effect, the strategy has been to support and motivate the students through provision of scholarships, hostel facilities, free books and special coaching etc.

5. To promote higher education amongst SCs, Post-Matric Scholarships are awarded to all the eligible SC students to pursue graduate and post-graduate courses in recognized institutions within the country with some additional benefits to persons with disabilities amongst SCs. Although the Ninth Plan benefited 15 lakh SC students annually at Post-Matric level and above, an evaluation study on the scheme conducted by the Ministry revealed that the SC students in some States are facing hardships due to non-payment of scholarships in time, as the State Governments could not meet the committed liability under the scheme.

6. The Scheme of 'Pre-Matric Scholarships for the Children of those engaged in Unclean Occupations' was implemented exclusively to motivate the children of scavengers, sweepers and tanners to enrol and pursue education and also to control school drop-out rates amongst them. The ultimate objective of the scheme is to wean away these children from the clutches of traditional inhuman occupation of manual scavenging. Actual expenditure of Rs. 36 crore exceeded the approved outlay of Rs. 30 crore during the Plan

period. The Ninth Plan physical achievement exceeded the target of 16.91 lakh by reaching 2.28 lakh more beneficiaries. Correspondingly, special provisions for students with disabilities were also introduced keeping in line with the provisions of the Persons with Disabilities Act, 1995.

7. To reduce the present high drop-out rates and increase the retention rates amongst SCs, a major support service is provided in the form of hostel facilities for SC boys and girls studying in middle, secondary and higher secondary schools, colleges and universities. The Central Assistance to the scheme has been declining, as the State Governments are not able to provide the required matching share under these schemes. During the Ninth Plan 354 girls' hostels and 388 boys' hostels were constructed benefiting 25,196 SC girls and 17,244 SC boys, at the cost of Rs. 118.1 crore. Evaluation of the implementation of the scheme of hostels for SC boys and girls indicate that the functioning of the same requires continuous and close monitoring in order to check the deficiencies noticed such as late receipts of the proposal from the State, inadequate reporting of progress of construction, States inability to provide full matching share, poor maintenance and facilities of the hostels which are some of the impediments in implementation of the scheme requiring rectification. Effective involvement of NGOs needs to be encouraged so as to optimize the implementation of the scheme of the hostels for SC boys and girls.

8. Another support service is the scheme of 'Book-Banks for SC Students' that supplies textbooks to SC students for pursuing Medical, Engineering, Veterinary, Agricultural, Polytechnic, Chartered Accountancy, Business Administration, Bio-Sciences and Law Courses etc. costing Rs. 10.61 crore benefiting about 1,15,300 SC students during the Ninth Plan period. Provision has also been made for Braille Books to promote educational development amongst the visually disabled SC students. The other educational developmental programmes include - 'Special Educational Development Programme for SC Girls belonging to very Low Literacy Level districts' and 'Upgradation of Merit of SC Students'. Introduced in 1996-97, the former Scheme is being implemented by the Zilla Parishad of the concerned districts. It aims to establish special residential schools for SC Girls who are the first generation learners in low-literacy pockets where the traditions and environment are not conducive to learning. The scheme covers 48 districts spread over Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, where the literacy of SC girls was less than 2 per cent as per the 1981 Census. However, during the Ninth Plan, financial assistance was provided for only 104 schools as against the target of 140 schools. The scheme of 'Up-gradation of Merit of SC Students' aims to provide remedial and special coaching to SC students studying in classes IX to XII. Beneficiaries during the Ninth Plan period totalled 3,755 SC students costing Rs. 4.72 crore. The Scheme had limited success in spite of full assistance, due to lack of interest on the part of States/UTs.

9. Coaching and Allied Scheme for SC students which aims to improve the knowledge and aptitude by providing special coaching to them through Pre-Examination Training Centres (PETCs) was revised during the Ninth Plan for funding on per unit-cost basis. Universities and private institutions receive 100 per cent Central Assistance on contractual basis, while State-owned PETCs receive the Central Assistance to the extent of 50 per cent of the contractual amount. The scheme which was common for both SC and ST students upto the year 2000, is operated now exclusively for SC students. So far, 48,500 SC/ST students have been benefited with an expenditure of Rs. 11.09 crore during the Ninth Plan.

Other Backward Classes (OBCs)

10. For educational development of OBCs, new initiatives were undertaken during the Ninth Plan to provide Pre-Matric and Post-Matric and other higher education scholarships and hostels facilities. Besides, students belonging to the OBCs were also allowed to enjoy the existing hostel facilities meant for SC boys and girls. For OBC students to participate effectively in the competitive examinations, Pre-Examination Coaching Centres were also set up in the Ninth Plan.

11. Provision of Pre and Post-Matric Scholarships for OBC Students is intended to promote higher education amongst OBCs by supporting financially poor OBC students studying at pre-Matric and Post-Matric classes including Ph.D degrees. The States of Andhra Pradesh, Assam, Bihar, Goa, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Manipur, Sikkim, Tripura, and Uttar Pradesh have so far availed of both the schemes. However, so far only States of Himachal Pradesh, Maharashtra, and Uttaranchal could avail the scheme of Post-Matric Scholarships. During the Ninth Plan 5,74,566 OBC students received the Post-Matric scholarships and 12,62,372 were awarded Pre-Matric scholarships.

12. The provision of Hostels for OBC Boys and Girls, being one of the major support services, aims to reduce the high drop-out rate at middle/higher including university level education amongst OBCs through provision of accommodation for students in an academic environment. The State Governments of Andhra Pradesh, Bihar, Jharkhand, Karnataka, Madhya Pradesh, Manipur, Rajasthan, Sikkim, Tripura, Tamil Nadu and Uttar Pradesh have implemented this scheme, benefiting 11,470 students.

13. The Pre-Examination Coaching Centres for OBCs is implemented to provide special coaching and training for OBC candidates to enable them to succeed in various competitive examinations. The Scheme has benefited 2,480 students during the Ninth Plan period. The programme of Assistance to Voluntary Organisations for the Welfare of OBCs was launched in the Ninth Plan in order to involve the voluntary sector for improving educational and economic conditions of OBCs. So far, 305 voluntary organizations were assisted with an expenditure of Rs.7.07 crore during the Ninth Plan. An allocation of Rs. 1.50 crore was made for the same in the Annual Plan 2001-02.

Minorities

14. For Minorities, provision of educational facilities is vital as large sections amongst them continue to be educationally backward. Improvement in literacy levels, upgradation of quality of education and its relevance to the emerging employment opportunities are crucial to their development. Maulana Azad Education Foundation set up in 1992-93 provides for remedial coaching, construction and expansion of schools/residential schools/colleges/ polytechnics/ hostels mainly for girls and purchase of machinery/equipment for laboratories and for setting up/strengthening vocational/technical training centres for women. Against a provision of Rs. 100 crore as a 'Corpus Fund' for the Foundation Rs. 70 crore has been made available by the end of the Ninth Plan. The interest accrued on the Corpus is utilised to finance activities related to educational empowerment of Minorities.

15. The scheme of Pre-Examination Coaching for Weaker Sections based on economic criteria is extended to improve their performance in competitive examinations for various job opportunities. Against a provision of Rs.12.00 crore for the Ninth Plan, a sum of Rs.11.29 crore was spent for funding 417 Institutions to train 30,310 students. In the Annual Plan 2001-02 an amount of Rs. 3.00 crore was earmarked for this scheme.

ECONOMIC DEVELOPMENT

Scheduled Castes (SCs)

16. For economic development of SCs, the financial institutions set up exclusively for the purpose both at the national and the state levels, such as National Scheduled Castes and Scheduled Tribes Finance and Development Corporation (NSFDC) and State SC Development Corporations (SCDCs) continued to function as catalytic agents for financing, facilitating and mobilizing funds for promoting employment and income-generating activities amongst the SCs living below the poverty line. While Rs. 10 crore was budgeted for the NSFDC, the SCDs were provided with an allocation of Rs. 23 crore during 2001-02. Skill and entrepreneurial training was also imparted to unemployed SC youths through reputed training institutions. Micro-credit scheme has also been taken up since 2000-01 for funding Self-Help Groups for small loans. NSFDC's performance has gained momentum over the years. The Corporation has so far sanctioned 2,759 schemes, which on completion would benefit 3,43,517 SC beneficiaries to take up various income-generating activities. At present, SCDCs are functioning in 25 States/UTs, benefiting around 14.88 lakh SCs during the Ninth Plan period.

17. The National Safai Karamcharis Finance and Development Corporation (NSKFDC) was set up in January 1997, for promoting economic development/self-employment amongst the scavenging communities. NSKFDC has since been acting as an apex institution for channelising funds through the State Channelising Agencies (SCAs). Concessional financial assistance is provided for establishment of viable income-generation activities as alternative to scavenging. Under the Micro-Credit Scheme, Self-Help Groups (SHGs) were formed amongst the target group by SCAs/NGOs and small loans to a maximum of Rs.10,000 per beneficiary provided for undertaking income-generation activities. Financial assistance is also extended to Co-operatives formed by a group of 25 scavengers for setting up of Sanitary Marts production-cum-trading-cum-service centres and for conversion of dry latrines into wet ones. During the Ninth Plan 33,725 beneficiaries were covered with financial support of Rs.81.75 crore extended as equity to NSKFDC. An amount of Rs. 25.00 crore was budgeted for NSKFDC in 2001-02.

Other Backward Classes (OBCs)

18. Towards the economic development of OBCs, the National Backward Classes Finance and Development Corporation (NBCFDC) set up in 1992 to promote self-employment among the poorest of OBCs living below double the poverty line. It provides soft loans through the State Channelising Agencies and also arranges technical, entrepreneurial and managerial training amongst the individuals or groups belonging to OBCs. The Corporation has disbursed term loans of Rs.614.08 crore to assist 3,74,754 beneficiaries during the Ninth Plan. A micro-credit scheme has also been introduced to extend credit facilities to the target groups for small business especially for women

beneficiaries through SCAs as well as NGOs. It has also launched a new scheme viz. 'SWARNIMA' that provides loan up to 1.00 lakh to finance self-employment activities for OBC women living below poverty line. Incidentally, this scheme stands out with outstanding recovery rates of 86% in 1999-2000, 87% in 2000-01 and 89% in 2001-02. A budgeting support of Rs. 16.84 crore was extended to NBCFDC during the Annual Plan 2001-02.

Minorities

19. The National Minorities Development and Finance Corporation (NMDFC) set up in 1994-95 to promote income-generating activities amongst the poor minority community continued to provide soft loans and organize training programmes, especially for the craftsmen engaged in traditional occupations and trade. The scheme of 'micro-financing' has also been introduced in 1998-99 and the same is being implemented directly through NGOs and SHGs benefiting 81,695 Minorities during the Ninth Plan period. The NMDFC received a budgetary provision of Rs. 15.26 crore for the Annual Plan 2001-02.

Financial Institutions - Evaluation

20. A critical assessment (Oct. 2000) of the working of all these Corporations revealed that all of these Corporations are heavily dependent upon government assistance and therefore, do not qualify as functional Corporations. Generally, the Corporations are expected to become self-reliant over a period of 2-3 years of their establishment. Instead, these organizations are becoming more and more dependent upon the Government and demanding a hike in the Authorised Share Capital from time to time, which reflects bad financial health and habit. Further, these corporations have maintained a recovery rate as poor as 30% to 50%. In sharp contrast, a similar organization like Rashtriya Mahila Kosh (RMK), which extends credit to poor and assetless women in the informal sector, could achieve a recovery rate as high as 95% to 98% and become self-sufficient by raising the original corpus of Rs.31.00 crore in 1993 to Rs.48.06 crore within a period of five years. This calls for a critical study of the working of all these six Corporations immediately with a major objective of introducing necessary reforms, both business and managerial, so that they can fulfill their objectives they were set out to accomplish.

Social Justice

21. To abolish the practice of untouchability and curb the high incidence of crimes and atrocities against SCs, efforts were made through effective implementation of the Protection of Civil Rights (PCR) Act, 1955 and the Scheduled Castes and the Scheduled Tribes (Prevention of Atrocities) Act, 1989 with the help of 36 Special Courts under PCR Act 1955 and 113 Special Courts under SC and ST (POA) Act 1989. Financial assistance is provided to the State in the ratio of 50:50 (100% to UT Administration) for strengthening the enforcement of judicial machinery, publicity and for the relief and rehabilitation of the affected person.

22. Towards total eradication of manual scavenging, the National Scheme of Liberation and Rehabilitation of Scavengers and their Dependents was modified in 1998 to accommodate revised norms and involve NGOs in the efforts made for identification, liberation and rehabilitation of scavengers. Although, complete elimination of the practice of

manual scavenging could not be achieved by the end of the Ninth Plan (2002) as targeted, yet around 3.84 lakh out of the 6.53 lakh identified scavengers were rehabilitated, while 1.47 lakh were trained for alternative vocations. An amount of Rs.236.02 crore was spent under the scheme in the Ninth Plan. The tardy progress made in the National Scheme of Liberation and Rehabilitation of Scavengers also correspond to non-utilisation of funds allocated for this crucial area of concern. Evidently against the budgetary provision of Rs. 75 crore made for this scheme for the year 2001-02 only Rs. 9.2 crore could be spent despite bringing revision in this scheme – such as introduction of Sanitary Marts and involvement of volunteer agencies. This calls for rigorous and intensive efforts of all the concerned to work with war footing efforts specially as regards identification and rehabilitation of scavengers and conversion of dry latrines into wet latrines to accomplish the commitment of totally eliminating the practice of manual scavenging by 2007.

Implementation of Special strategies of SCP and SCA to SCP for SCs

23. For the economic development of SCs, special strategy of Special Component Plan (SCP) for SCs has been in operation to ensure flow of funds in proportion to the population of SCs from all other developmental sectors. So far, only 14 Central Ministries/Departments and 27 States/UTs have been earmarking funds under the Scheme. As for the Central Ministries' share, Rs.1646.02 crore was earmarked under SCP during first three years of the Ninth Plan. For the last two years, no information on any substantial SCP component is available from the Ministry. However, during the same period, 27 States/UTs have earmarked Rs.42308.97 crore reflecting 12.20% of the entire State budget.

24. SCA to SCP is a Central scheme under which cent per cent grant is extended to States as an additive to strengthen the efforts of the States to fill the critical gaps in the family based income-generating activities. During the Ninth Plan period, 110.75 lakh SC families were assisted under the programme out of targeted 130.52 lakh, reflecting a shortfall of 15%. As for financial commitment, Rs.2004.67 crore was actually released as SCA to SCP during the Ninth Plan period against an outlay of Rs.2092.95 crore reflecting 96% achievement. But, actual utilization of funds during the same period were only Rs. 1456.91 crore, which is about only 70% of the outlay indicating that more efforts are needed to improve the implementation of SCP at the Central level in order to achieve the Plan target.

Annual Plan 2002-03

25. With a view to optimising and containing the growth of Government expenditure and to deploy the scarce resources in a more cost-effective manner, the number of ongoing schemes of the Ninth Plan has been brought down from 31 to 13 in the Tenth Five Year Plan and subsequent Annual Plans through a special exercise of Zero-Based Budgeting. Towards empowering the Socially Disadvantaged Groups of SCs, OBCs and Minorities, an outlay of Rs. 1080.00 crore for the Central Sector and Centrally Sponsored Schemes, including Rs.379.00 crore as Special Central Assistance for Special Component Plan for SCs has been provided in the Annual Plan 2002-03. While details of the programme-wise outlay earmarked under Socially Disadvantaged Groups during the Tenth Plan (2002-07) and Annual Plan (2002-03) are available at Annexure 5.11.1, summary of the same is given in the following Table 5.11. 2.

TABLE 5.11.2

Outlays for welfare and development of Backward Classes during Tenth Plan 2002-07 and Annual Plan 2002-03

(Rs. in crore)

Sl. No.	Name of the Schemes	Tenth Plan 2002-07 Outlay	Annual Plan 2002-03 BE
1.	**Welfare & Dev. of SCs**	**5786.00**	**964.10**
i)	Central Sector	402.60	61.60
ii)	CSS	3070.00	523.50
iii)	SCA to SCP	2313.40	379.00
2.	**Welfare of OBCs**	**450.00**	**76.50**
i)	Central Sector	116.35	17.50
ii)	CSS	333.65	59.00
3.	**Welfare of Minorities**	**290.00**	**39.40**
i)	Central Sector	188.10	39.40
ii)	CSS	101.90	-
	Total (1+2+3)	**6526.00**	**1080.00**

26. Annual Plan (2002-03) being the first year of the Tenth Five Year Plan, it initiates the Tenth Plan approach into practice. Empowerment of the Disadvantaged Groups initiated during the Ninth Plan, has had an impact on their involvement in the development process, even though not to the expected extent. Hence, the thrust and strategy during the Annual Plan 2002-03 would be directed to accelerate the process of empowerment of these weaker sections in an intensive manner so that ultimate objective to bring the status of these socially disadvantaged groups raised to that of the rest of the society. Any improvement in their socio-economic conditions as well as growth would be possible through a multi-pronged strategy of removing the existing disparities on the one hand and strengthening the current development plans and programmes on the other. For this, adequate priority will be accorded to programmes catering to the educational and economic development. The on-going programmes would be strengthened / expanded, along with initiating new measures so as to accelerate their all-round development. This would be keeping in view the persistent skewed distribution of income, wealth and the social inequity surrounding them. The policy focus will be necessarily tuned towards ensuring equitable distribution and growth with social justice. Accordingly, the strategy arrived at is three-pronged.

- **Social Empowerment** : through removing all the persisting inequalities, disparities and other problems besides providing easy access to basic minimum services. Education being the key factor for social development, the same will be given top priority. The intent would be an enabling environment for their welfare and development.

- **Economic Empowerment** : through promotion of employment-cum-income generation activities. The ultimate objective must be to make them economically independent and self-reliant.

- **Social Justice** : through eliminating all types of discrimination against them with the strength of legislative support, affirmative action, awareness generation / conscientisation, and requisite change in the mind-set of people.

SOCIAL EMPOWERMENT

Scheduled Castes

27. With an ultimate objective of reducing the existing gap between SCs and the general population, efforts are being made to arrest the school drop-out rates and improve enrolment and retention rates through provision of scholarships, hostel facilities and other educational aids. To pursue higher studies, Post-Matric Scholarships are awarded to eligible students towards payment of tuition and other expenses. An outlay of Rs.273 crore has been earmarked for SC students for the Plan year which is 71% more than the last year's Plan expenditure. Under the Scheme of Pre-Matric Scholarships for the children of those engaged in unclean occupations, efforts will be made to exceed last year's coverage of 4.5 lakh beneficiaries at the cost of Rs.14.50 crore. For professional courses, text books are supplied through the Scheme of Book Banks for SC students for which a provision of Rs.2 crore has been made for 2002-03. As support service, devised to check the high drop-out rates among the SC students in the middle, higher secondary schools, colleges and universities, Central Assistance is provided on matching basis to States and 100% assistance to UTs for construction of hostel buildings. The Plan provides for Rs. 45 crore for construction of Girls and Boys Hostels. Other educational programmes in operation include "Upgradation of Merit of SC Students and Research & Training" for which outlays of Rs.42 crore and Rs. 0.50 crore, respectively have been allocated for the year 2002-03.

28. In addition to the above, a few more educational programmes will be in operation for the benefit of SCs. They include Coaching Centres for Allied Services / Public Sector openings (plan provision of Rs.10 crore), Special Education Development Programmes for SC Girl students in low-literacy areas; and other Educational programmes being implemented through the voluntary organisations. Along with the general education, vocational education/training will also be encouraged/extended to SC students so as to enable them to enhance their technical and productive capabilities in those vocations that have direct relevance to their local needs and market demands. Other than financing formal educational programmes, the Plan also supports social education programmes under Ambedkar Foundation through national/regional seminars, workshops, and symposium with an outlay of Rs. 1 crore for the year 2002-03.

Other Backward Classes

29. The new interventions launched during the Ninth Plan for improving the educational status of OBCs will be continued with much larger coverage to improve the accessibility to the otherwise educationally backward OBCs. To promote educational development amongst the OBCs an allocation to the tune of Rs.42.5 crore has been made for Annual Plan 2002-03 for extending Pre and Post Matric Scholarships as a Centrally Sponsored Scheme. The other educational programme viz., the Hostel Facilities for OBC Boys and Girls is also supported with an outlay of Rs.16.50 crore. The sole Central Sector Scheme of Pre-examination Coaching Centres for OBCs has been earmarked with an outlay of Rs.1.65 crore. Besides, Grant-in-Aid to the tune of Rs. 3.85 crore has been earmarked for the NGOs to undertake welfare activities for OBCs.

Minorities

30. Minorities who constitute a sizeable population and contribute to the country's development process will be given priority through a comprehensive approach focusing their educational development and economic upliftment. Special attention will be given to traditional Artisans who play an important role in preserving their heritage of art and culture through their contribution in economic as well as social arena. As the crucial drawback in the development of Minorities, especially that of the Muslims, primarily lies in their educational backwardness, special efforts will be made to accomplish their social development through promotion of education, especially amongst their women and girl children by modernizing and mainstreaming their existing traditional educational institutions such as the Madarsas, by adopting syllabi being followed in the regular education system. There are two major schemes for educational development aimed at social empowerment and eventually economic empowerment of the Minorities. One is merit-based scholarships provided for students belonging to Minorities with a plan provision of Rs.15.40 crore. The other scheme supports pre-examination coaching centres for weaker sections run on the basis of economic criteria. Special attention will be accorded towards strengthening of the Maulana Azad Education Foundation which is working for the promotion of the educational development especially amongst the educationally backward Minorities. To this effect a provision of Rs. 30.00 crore has been envisaged to achieve complete funding of Rs. 100.00 crore to the Corpus of the Foundation.

ECONOMIC EMPOWERMENT

Scheduled Castes

31. For economic upliftment of SCs, suitable activities will be identified and prioritised that can provide sustainable income. Recognising their traditional ability and skills in the agriculture production, efforts will be made to improve their productivity abilities through skill and technology upgradation, along with provision of land ownership with community irrigation facilities. All poverty alleviation programmes will be revitalised and expanded to make stronger impact on the economic conditions of SCs living at the margin of all developmental efforts. The Financial Institutions working exclusively for the economic empowerment of SCs (NSFDC & SCDCs) will be geared to function as catalytic agents for economic development. For this purpose, functioning of the Apex Corporations will be reviewed and reformed and strengthened with professional expertise in marketing and business management so that they are able to undertake and accomplish projects for SCs and other members of the weaker sections and contribute effectively towards their upliftment without being a drain on limited financial resources of the government.

32. There are two Central Sector Schemes, each providing funds to two Apex level organisations - National SC Finance Development Corporation (NSFDC) and National Safai Karamchari Finance and Development Corporation (NSKFDC) with provisions of Rs.15.10 crore and Rs.20.00 crore respectively. Two other Centrally Sponsored schemes are currently under operation. One, Coaching and Allied Scheme for SC students with an outlay of Rs.10.00 crore that provides coaching facilities through pre-examination training centres and private institutions/universities to enable them compete in civil services and other competitive examinations and thereby improve SC representation in various Governmental, semi-Governmental organisations. Under the other Scheme, namely, the

Scheduled Castes Development Corporations (SCDCs), eligible SC families are identified and motivated to undertake economic development schemes/projects by extending credit support and financial assistance for margin money with an aim to promote self-employment and income-generating activities through entrepreneurship. An outlay Rs. 25.00 crore has been earmarked for SCDCs in the Annual Plan 2002-03.

Other Backward Classes

33. The OBCs besides being engaged in the primary sector also depend upon a broad spectrum of economic activities. Efforts will be made to encourage the allied activities engaged in by OBCs, through skill upgradation, capacity building, training, market linkages, credit support etc. Also, as the majority of OBCs depend upon agriculture, OBC farmers will be encouraged and supported to adopt innovative land based activities to improve productivity and make a serious dent on the incidence of poverty in this community.

34. Some of the OBC communities, especially those living in rural areas, depend upon the traditional occupation/artisanship weaving which are languishing in the worst forms of social and economic backwardness. Efforts will be made to encourage occupational mobility for those OBCs, by providing facilities for appropriate educational and vocational training in modern and up-coming technologies, supplemented with financial and other assistance to enable them to start new ventures.

35. To achieve the above mentioned objective, the National Backward Classes Finance and Development Corporation (NBCFDC) set up in 1992 to assist OBCs in a wide range of income-generating activities through both wage and self-employment ventures in the areas of agriculture and its allied activities viz., dairying, fisheries, animal husbandry, traditional and other artisan occupations, small scale and cottage industries, transport services, small business and petty shops etc. will further be strengthened during 2002-03. A provision of Rs.12.00 crore has been made for NBCFDC for the year 2002-03.

Minorities

36. Priority will be given to upgradation of technology especially in the much needed handloom sector to increase value-addition by extending appropriate support in terms of vocational training in modern technologies, skill upgradation, credit facilities etc. In fact, special efforts will be made to encourage export-oriented handicrafts in view of expanding foreign market and the National Minority Finance Development Corporation (NMFDC) will be encouraged to extend financial and other technical support. The authorized share capital of NMFDC has already been raised from Rs. 300.00 crore to Rs. 500.00 crore to benefit the Minorities. Also, to preserve their traditional skills, they will be encouraged to form into SHGs/Cooperatives for which financial assistance will be extended along with credit and marketing services. In the Annual Plan 2002-03, Rs. 20.00 crore outlay has been provided for NMFDC.

Social Justice

37. Efforts will be made to strengthen and revitalize all the four statutory Commissions viz. National Commission for SCs and STs (1992), National Commission for OBCs (1993), National Commission for Minorities (1992) and National Commission for Safai Karamcharis

(1994) and make them more effective in safeguarding rights and interests of these Groups and thus ensure them social justice. In this pursuit eradication of manual scavenging, elimination of atrocities against the disadvantaged groups will be given priority attention.

38. As the inhuman practice of manual scavenging continues to be a matter of national concern, the Tenth Plan will embark upon a nation-wide programme to work out alternative strategies for conversion of all the existing dry latrines into wet ones on a Mission Mode Approach and thus bring forth total eradication of manual scavenging on a time-bound basis by 2007. To this effect, Annual Plan will, in tune with the Tenth Plan strategy, emphasize preparation of State-specific Plans of Action to initiate time-bound programmes in respect of - conversion of dry latrines into wet ones; identification of scavengers; weaning them away from this profession and rehabilitating them with training and alternative jobs; follow-up of the rehabilitated persons; and effective co-ordination between the Welfare Departments of the States and the Local Bodies. In these national endeavours, the National Commission for Safai Karamcharis will take the lead. In the Annual Plan 2002-03 an outlay of Rs. 80.00 crore for the National Scheme of Liberation and Rehabilitation of Scavengers has been earmarked for this purpose.

39. The on-going special efforts will continue to ensure effective implementation of the two special legislations viz., the Protection of Civil Rights (PCR) Act 1955 and the SCs / STs (Prevention of Atrocities) Act, 1989 and thus prevent the increasing problems of social discrimination, exploitation, untouchability and violence against SCs, OBCs and Minorities including sexual exploitation of women and the girl children belonging to these Groups. In addition, there are four National Commissions to safeguard the rights and interests of SCs, OBCs and Minorities and Safai Karamcharis through a constant vigil and enforcement machinery along with efforts of NGOs. Measures will also be undertaken to set up adequate number of well functioning Special/Mobile Courts in each district to provide on-the-spot speedy settlement and redressal of grievances. An outlay of Rs. 32.00 crore has been provided for implementation of PCR Act.

Special Strategies of SCP and SCA to SCP for SCs.

40. Special endeavour will be made to reinforce the implementation of both the mechanisms viz. SCP for SCs and SCA to SCP which was launched specially in support of social justice to ensure that adequate funds flow for the development of SCs through various sources. Taking note of the implementation of these mechanisms becoming routinised, a Central Tripartite Committee set up in the Planning Commission in 1999 will continue to monitor towards more effective implementation of these two mechanisms. In this context, the State Governments, which are yet to set up State Tripartite Committees, will initiate action for setting up of these Committees and start the detailed reviews with regard to earmarking funds under SCP and also the utilization of SCA to SCP.

41. While the nodal Ministry of Social Justice and Empowerment will keep a close vigil on the utilisation of these special funds, reviews at the Centre both by the CSSTC and the National Commission for SCs will continue on a regular basis to assess the effectiveness of these instruments in supplementing/complementing the efforts of the nodal Ministry in empowering these Disadvantaged Groups economically.

APPENDIX - 5.11.1

SCHEME-WISE BREAK-UP OF PLAN OUTLAYS AND EXPENDITURE BACKWARD CLASSES SECTOR (SCs, OBCs & Minorities)

(Rs. in Crore)

Sl. No.	Name of the Scheme	NINTH PLAN (1997-02)		ANNUAL PLAN (2001-02)		Sl. No.	Name of the Scheme	Tenth Plan (2002-07) Outlay	Annual Plan (2002-03) B.E.
		Outlay	Act. Expdr.	B. E.	Act. Expdr.				
1	2	3	4	5	6	7	8	9	10
I.	**CENTRAL SECTOR SCHEMES (CS)**								
1	Special Central Assistance (SCA) to Special Component Plan (SCP)	2092.95	2008.64	411.00	452.51	**1**	**Special Central Assistance (SCA) to Special Component Plan (SCP)**	2313.40	379.00
2	National SC and ST Finance and # Development Corporation (NSFDC)	241.23	156.23	10.00	25.00				
3	National Safai Karamachari Finance and Development Corporation (NSKFDC)	81.75	81.75	25.00	25.00	**2**	**National Finance Development** Corporations for Weaker Sections	478.20	67.10
4	National BC Finance and Development Corporation (NBCFDC)	400.00	191.50	16.84	0.00				
5	National Minorities Development and Finance Corportion (NMDFC)	111.00	92.26	15.26	15.26				
6	Grant-in-Aid to Non Governmental Organisations (NGOs) for SCs	118.03	105.12	30.00	29.00	**3**	**GIA to NGOs for SCs, OBCs & Research &Training**	193.85	29.35
7	Research and Training for Scheduled Castes	2.85	1.61	0.50	0.30				
8	Grant-in-Aid to NGOs for OBCs	10.00	7.07	3.50	3.8				
9	Special Educational Development Programmes for Girls belonging to SC low Literacy Areas	7.70	1.61	0.01	0.15	—	—	—	
10	Dr. B.R.Ambedkar Foundation	200.00	54.00	1.00	1.00	**4**	**Dr. B.R.Ambedkar Foundation**	5.00	1.00
11	Strengthening of BC Bureau	0.75	0.00	0.00	0.00		**—**	-	
12	Equity participation in State BC Corporations	10.00	0.00	0.01	0.00		**—**	**-**	
13	Preparation of Multi-Sectoral Plan for Minority Concentration Districts	14.10	0.53	0.10	0.00		**—**	**-**	
14	Grant-in-Aid to Maulana Azad Education Foundation	70.00	52.75	22.00	3.00	**-**	**Grant-in-Aid to Maulana Azad Education Foundation**	30.00	*****
	Total - I	**3360.36**	**2753.07**	**535.22**	**555.02**		**Total**	**3020.45**	**476.45**
II.	**CENTRALLY SPONSORED SCHEMES (CSS)**								
15	Post-Matric Scholarships for SC Students	614.16	457.29	159.77	159.28	**5**	**Post-Matric Scholarships & Book Banks for SC Students**	1558.00	275.00
16	Book Banks Scheme for SC Students #	12.00	10.61	2.50	2.99				
17	Pre-Matric Scholarships for Children of those families engaged in Unclean Occupations	30.00	36.25	12.00	10.04	**6**	**Pre-Matric Scholarships for Children of those families engaged in Unclean Occupations**	87.00	14.50
18	Hostels for SC Boys	52.05	64.97	20.00	19.94				
19	Hostels for SC Girls	45.00	53.13	20.00	19.35	**7**	**Hostels for SC, OBC and Weaker Sections**	347.00	61.50
20	Hostels for OBC Boys and Girls	49.90	20.76	15.00	11.45				
21	Scheduled Caste Development # Corporations (SCDCs)	180.00	173.63	23.00	21.00	**8**	**Scheduled Caste Development Corporations (SCDCs)**	150.00	25.00
22	Coaching & Allied Scheme for SCs	16.71	11.09	10.00	2.00				
23	Pre-examination Coaching for OBCs	10.00	1.03	1.50	0.79	**9**	**Coaching & Allied Scheme for SCs, OBCs & Other Weaker Sections**	97.55	15.65
24	Pre-examination Coaching for Weaker Sections based on economic criteria	12.00	11.29	3.00	3.04				

APPENDIX - 5.11.1 contin.....

(Rs. in Crore)

Sl. No.	Name of the Scheme	NINTH PLAN (1997-02)		ANNUAL PLAN (2001-02)		Sl. No.	Name of the Scheme	Tenth Plan (2002-07) Outlay	Annual Plan (2002-03) B.E.
		Outlay	Act. Expdr.	B. E.	Act. Expdr.				
1	2	3	4	5	6	7	8	9	10
25	Up-gradation of Merit of SC Students #	5.26	4.72	42.50	1.00	**10**	**Up-gradation of Merit of SC Students**	346.50	42.00
26	Implementation of PCR Act,1955 & # SC/ST (POA) Act, 1989	121.81	113.17	30.00	30.06	**11**	**Implementation of PCR Act, 1955 & SC/ST (POA) Act, 1989**	170.00	32.00
27	National Scheme of Liberation & Rehabilitation of Scavengers & their Dependents	335.00	236.02	75.00	9.20	**12**	**National Scheme of Liberation & Rehabilitation of Scavengers & their Dependents**	460.00	80.00
28	Post-Matric Scholarships for OBCs	49.90	40.57	42.50	39.36	**13**	**Merit based Scholarships for OBC and Minority Students**	289.50	42.49
29	Pre-Matric Scholarships for OBCs	49.90	29.15				**i. Pre and Post Matric Scholarships for OBC and Minority Students**		
30	Mobile Schools,Shelter etc. for Nomadic Tribes	1.00	0.00	0.00	0.00		**ii. Merit based Scholarships for OBC Students**		0.01
31	Residential Schools for OBC Boys and Girls	40.00	0.00	0.01	0.00		**iii. Merit based Scholarships for Minority Students**		15.40
	Total - II	**1624.69**	**1263.68**	**456.78**	**329.50**		**Total**	**3505.55**	**603.55**
	GRAND TOTAL - I+II	**4985.05**	**4016.75**	**992.00**	**884.52**		**GRAND TOTAL**	**6526.00**	**1080.00**

* Spill-over of the total Corpus of Rs.100 crore to be paid to the Foundation and the scheme to be weeded-out during 2002-03.

\# Outlay and Expenditure under these schemes were common for SCs & STs up to the Annual Plan 1999-2000 under M/SJ & E.

Annexure-5.11.2

PLAN OUTLAYS AND EXPENDITURE - BACKWARD CLASSES WELFARE (SCs,STs,OBCs & MINORITIES) - STATES/UTs.

(Rs.in lakh)

Sl. No.	Name of States	Agreed Outlay IX Plan (1997-02)	Likely Exp. IX Plan (1997-02)	Actual Exp. 1997-98	Actual Exp. 1998-99	Actual Exp. 1999-00	Actual Exp. 2000-01	Outlay 2001-02	Revised Outlay 2001-02
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Andhra Pradesh	124059.0	95983.0	12271.0	27546.0	14049.0	12965.0	29151.9	29152.0
2	Assam	17917.0	12689.0	2031.0	3767.0	2649.0	1713.0	2529.0	2529.0
3	Bihar	46800.0	9526.0	3294.0	2804.0	1161.0	690.0	1577.0	1577.0
4	Chhattisgarh							3226.1	3226.0
5	Goa	450.0	268.0	38.0	29.0	63.0	75.0	63.0	63.0
6	Gujarat	108080.0	111775.0	14446.0	14446.0	28864.0	26921.0	30300.0	27098.0
7	Haryana	8026.0	3855.0	699.0	536.0	552.0	668.0	700.0	1400.0
8	Himachal Pradesh	3134.0	2850.0	608.0	671.0	612.0	624.0	323.0	335.0
9	Jammu & Kashmir	2998.0	3225.0	688.0	1047.0	480.0	485.0	525.0	525.0
10	Jharkhand *								
11	Karnataka	80000.0	120617.0	19768.0	21997.0	26029.0	20818.0	23898.0	32005.0
12	Kerala	64090.0	50977.0	11404.0	12695.0	5878.0	9000.0	11900.0	12000.0
13	Madhya Pradesh	63556.0	54395.0	13668.0	15769.0	12245.0	5829.0	6313.0	6884.0
14	Maharashtra	110127.0	106479.0	16170.0	21447.0	25564.0	22233.0	21064.9	21065.0
15	Manipur	4315.0	3396.0	314.0	852.0	1081.0	728.0	421.0	421.0
16	Meghalaya	50.0	47.0	8.0	7.0	12.0	10.0	10.0	10.0
17	Orissa	44475.0	48294.0	9143.0	12463.0	12837.0	10990.0	2956.9	2861.0
18	Punjab	47736.0	23045.0	7980.0	2328.0	1622.0	6445.0	4669.6	4670.0
19	Rajasthan	29205.0	20592.0	4431.0	5925.0	5835.0	4229.0	160.0	172.0
20	Sikkim	1500.0	1146.0	132.0	307.0	89.0	173.0	470.0	445.0
21	Tamil Nadu	100000.0	85464.0	15960.0	17568.0	15845.0	17447.0	27098.0	18644.0
22	Tripura	9480.0	10651.0	2182.0	2513.0	1969.0	2220.0	1767.0	1767.0
23	Uttar Pradesh	75550.0	109565.0	23828.0	22016.0	22621.0	22920.0	24360.0	18180.0
24	Uttaranchal						2927.0	987.0	987.0
25	West Bengal	17232.0	27928.0	3805.0	4641.0	5774.0	7580.0	7546.0	6128.0
A.	**Total (States)**	**958780.0**	**902767.0**	**162868.0**	**191374.0**	**185831.0**	**177690.0**	**202016.4**	**192144.0**
1	A&N Islands	210.0	281.5	24.9	37.1	73.5	76.0	70.0	70.0
2	Chandigarh	490.8	377.3	101.6	63.7	62.4	73.7	76.0	76.0
3	D&N Haveli	5.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0
4	Daman& Diu	104.5	94.7	24.8	15.7	18.0	18.2	18.0	18.0
5	Delhi	6825.0	4237.6	446.2	213.8	511.4	666.2	2400.0	2400.0
6	Pondicherry	2500.0	3390.9	371.0	583.5	761.5	871.2	1000.7	803.7
B.	Total (U.Ts)	10135.3	8383.1	969.6	913.8	1426.8	1705.2	3564.7	3367.7
	Grand Total (A+B)	**968915.3**	**917990.1**	**163537.6**	**192287.8**	**187257.8**	**179395.2**	**205581.1**	**195511.7**

* Finalisation not yet.

5.12 TRIBAL DEVELOPMENT

INTRODUCTION

Scheduled Tribes (STs), who live in isolation, lag behind the rest of the society due to their socio-economic backwardness. According to the 1991 Census, they account for 67.76 million and represent 8.08 per cent of country's total population. Of these, 1.32 million (1.95 per cent) belong to Primitive Tribal Groups (PTGs) whose conditions are even worse than those of the rest of the tribals. In the absence of 2001 Census data, population of STs has been estimated to have reached 88.8 million by 2001 (projected on the basis of the trend of the decadal growth rates of STs), representing 8.6 per cent of country's total population.

Review of Ninth Plan (1997-2002) and Annual Plan (2001-02)

2. The Annual Plan (2001-02), being the last year of the Ninth Five Year Plan (1997-2002), continued with the process of empowering STs with social justice. Accordingly, all efforts were geared to create an enabling environment conducive to a better quality of life for the tribals. To this effect, a total outlay of Rs. 3174.13 crore (Table - 1) was earmarked for the development of the Tribals in the budget of the Ministry of Tribal Affairs (M/TA) for the Ninth Plan. Of this, an amount of Rs.1040 crore was earmarked for the Annual Plan (2001-02) which included Rs. 240 crore for Central and Centrally Sponsored Schemes, Rs. 500 crore as Special Central Assistance (SCA) for Tribal Sub-Plan (TSP), and Rs. 300 crore as Grant-in-Aid (GIA) under Article 275(1) of the Constitution for promoting the welfare of the Scheduled Tribes or to improve the administration of the Scheduled Areas. The Plan expenditure, during the Ninth Plan for this sector is likely to be Rs. 3091.32 crore reflecting 97.4 per cent utilisation.

Table -5.12.1

Outlays and expenditure for the welfare and development of Scheduled Tribes during Ninth Plan (1997-2002) and Annual Plan (2001-02)

Rs. in crore

Sl. No.	Name of the Schemes	Ninth Plan (1997-02)		Annual Plan (2001-2002)	
		Outlay	Actual	Outlay	Actual
(1)	(2)	(3)	(4)	(5)	(6)
I.	Central Sector Schemes (CS)	270.07	232.91	117.50	47.77
II.	Centrally Sponsored Schemes (CSS)	144.06	181.95	122.50	47.98
III.	Special Central Assistance (SCA) to TSP	2010.00	2009.61	500.00	500.00
IV.	GIA under Art. 275(I) of the Constitution	750.00	666.85	300.00	225.56
	Total	**3174.13**	**3091.32**	**1040.00**	**821.31**

3. In the State Sector, as already indicated in the Chapter on 'Empowerment of Socially Disadvantaged Groups', a common outlay of Rs. 9689.15 crore for the Ninth Plan was allocated for implementing various socio-economic development programmes for all the four socially disadvantaged groups viz (SCs/STs/OBCs/Minorities). The scheme-wise outlays and expenditure for the Tribals at the centre during the Ninth Plan and Annual Plans are given at Annexure-I and details of the outlays and expenditure in the State sector at Annexure II of the Chapter on 'Empowerment of Socially Disadvantaged Groups'.

Implementation of TSP and SCA to TSP

4. The Tribal Sub-Plan was launched to directly foster tribal development. It stipulates that funds of the centre and states should be quantified on the population-proportion basis with budgetary mechanisms to ensure accountability, non-divertability and utilisation for the welfare and development of STs. SCA to TSP is being extended to strengthen the efforts of the states by filling the critical gaps under the family-based income generation projects catering to those living below poverty line. The SCA was enhanced from Rs. 1250.00 crore in the Eighth Plan to Rs. 2010.00 crore in the Ninth Plan, indicating an increase of 60.8 per cent to benefit as many as 67.50 lakh ST families living below the poverty line.

5. While the flow to TSP at the central level stood at 5.85 per cent with 25 Ministries/ Departments contributing to it, the same stood at 7.52 per cent at the state level with only 23 States/UTs contributing to it. This would indicate that earmarking of funds under TSP by the Central Ministries/Departments and by States/UTs unfortunately has not been up to the expected level.

Grant-in-Aid under Article 275(1) of the Constitution

6. In contrast to the earlier practice of releasing lump-sum funds under this provision to individual states, releases from the year 2001-02 are being made against specific developmental works/projects identified by the State Governments or to raise the level of administration of the Scheduled Areas to that of the rest of the State. Against an outlay of Rs. 750 crore earmarked for the Ninth Plan, the actual expenditure was Rs. 666.85 crore reflecting 88.9 per cent utilisation. For the Annual Plan (2001-02) the outlay was Rs. 300 crore representing 44 per cent of the total Ninth Plan outlay. The actual expenditure of Rs. 225 crore fell short by 25 per cent due to State Governments' failure to utilise earmarked funds on time.

7. While the nodal Ministry of Tribal Affairs (carved out of the then Ministry of Social Justice & Empowerment in 1999) implements ST specific innovative programmes, ST-related line-Ministries/Departments implement general development policies and programmes through TSP, as per the details given in the following paragraphs.

Education and Literacy

8. The special commitment of the National Policy on Education (1986) to improve the educational status of STs continues to be the major strength behind the interventions and incentives launched to improve the accessibility of the tribals to education in the far-flung remote and isolated areas. Over the years efforts to universalise primary education continued, aided by multiple support services. One such educational programme is 'Sarva

Shiksha Abhiyan'. This is a unique programme where parents/guardians are required to participate in the activities of the schools. Involvement of the parents enhances effectiveness of the programme as it ensures that the benefits reach the target group. As a support service, the National Programme of Nutritional Support to Primary Education extends Mid-Day Meals to increase retention rates. In the field of higher and technical education, special provisions such as reservation of seats, relaxation in minimum qualifying percentages, remedial coaching and scholarships are extended by the Department of Secondary and Higher Education. Similar concessions are also given to ST students for improving their skills in the up-coming/modern trades, which have better employability.

Health and Family Welfare

9. To improve tribal health, National Health Policy (1983) categorically emphasises the urgent need for early detection and treatment of endemic and other diseases specific to tribals. Keeping in view the fact that most of the tribal habitations are concentrated in far-flung areas, forestland, hills and remote villages, the population coverage norms for setting up of Sub-centre, Primary Health Centre (PHC), Community Health Centre (CHC) and appointment of Multipurpose Workers have been relaxed. Also, the State Governments have been advised to introduce schemes for compulsory annual medical examination of the rural population. Under these schemes, Mobile Health Check-up Teams are deputed to villages according to a schedule drawn-up annually and in case of need for further investigation and treatment, tribal patients are entitled to avail of free facilities in Government and Referral hospitals. To reach the health-care services to STs especially those living in the most backward remote areas, 52 districts in 13 States (Andhra Pradesh-6, Bihar-6, Gujarat-3, Kerala-5, Madhya Pradesh-4, Maharashtra-6, Manipur-4, Orissa-8, Rajasthan-2, Tamil Nadu-2, Tripura-4, Uttar Pradesh-1 and West Bengal-1) have been identified by the Central Planning Committee. The State Governments are also to take special steps to check deaths of children due to malnutrition, epidemics etc. in the district identified by the Central Planning Committee, particularly during summer/monsoon seasons. This further entails the state governments to establish adequate number of Sub-centres, PHCs and CHCs by virtue of norms relaxed for these centres in tribal areas. Besides, deployment of medical and para-medical personnel as per the staffing pattern; stocking of essential medicines/drugs as per requirement, regular field visits by medical as well as para-medical personnel, provision of Mobile Health Units whereever feasible, spraying of DDT and chlorination of wells etc. have also been receiving focussed attention over the years. Among other programmes, the National Malaria Eradication Programme and Programmes to control Filaria, Japanese Encephalitis and Kala-azar were also implemented by States/UTs with 50 per cent central assistance for spraying insecticides, supply of Anti-Malaria drugs etc. in tribal areas. In order to address the problem of high incidence of Leprosy amongst tribals, National Leprosy Eradication programme was implemented with 100 per cent assistance for detection and treatment of leprosy cases of Tribal Population. In the same vein, National Tuberculosis Control Programme was also implemented with 100 per cent Central Assistance for supply of anti-TB drugs, equipment etc. in Tribal areas.

10. A new Scheme for PTGs and Nomadic Groups called 'Medical care for Remote and Marginalized and Nomadic Communities' was also launched during the Ninth Plan with an approved outlay of Rs. 5 crore. Under this Scheme, the following projects were taken up towards - i) Prevention and control of Hepatitis 'B' infection amongst the PTGs of Andaman & Nicobar Islands; ii) Intervention for hereditary common haemolytic disorders amongst

tribals of Sundergarh district in Orissa; iii) Intervention programme for Cholera and Parasiptism, Vitamin 'A' deficiency disorders amongst some PTGs of Orissa; iv) Intervention programme for Nutritional Anaemia and Haemoglobin apathies amongst primitive tribal population in India.

11. The programme of Reproductive and Child Health (RCH) which takes care of the maternal and child health needs, also made some special provisions for those living in remote areas where the existing services at PHC level are under-utilized. A scheme for holding special camps has been initiated during the year 2000-01. The scheme is being implemented in 102 districts in 8 health-wise weak States and 7 North-Eastern States. The coverage of the scheme is expected to be extended to some more districts in the coming years.

Labour and Employment

12. To help the educated ST job seekers, the Scheme of 'Coaching-cum-Guidance Centres for Scheduled Castes and Scheduled Tribes' has been implemented through 22 Coaching-cum-Guidance Centres spread all over the country. To facilitate recruitment of STs against reserved vacancies in various Central Government Ministries/Departments, another scheme namely 'Special Coaching Scheme' was implemented for STs registered with the employment exchanges to enable them to appear in Competitive Examinations/ Selection Tests.

Rural Development

13. Among the employment generating programmes, 50 per cent of benefits of integrated programme of Swarnajayanti Gram Swarozgar Yojana (SGSY) were earmarked for SCs/ STs and 7.49 lakh ST swarozgaris accounting for 13.2 per cent of the total number of swarozgaris benefited during the Ninth Plan. Under the Jawahar Gram Samriddhi Yojana (JGSY), which provides wage employment, 22.5 per cent of Plan allocations were earmarked for STs/SCs. During the Ninth Plan, 2,201.41 lakh man-days were provided for STs accounting for 15.9 per cent of total employment generated by the scheme. Under the Employment Assurance Scheme (EAS), which is open to all rural poor including STs, 3,082.94 lakh man-days were provided for STs which accounted for 20.8 per cent of the total employment created by the scheme during the Ninth Plan. The two schemes of JGSY and EAS were merged into a mega scheme of Sampoorna Grameen Rozgar Yojana (SGRY) with effect from 1 April 2002. The scheme of SGRY focussed on generation of wage employment, creation of durable rural assets and infrastructure and provision of food security to the rural poor.

14. To meet the housing needs of STs, about 60 per cent of the total allocation under the Indira Awas Yojana, was earmarked for STs and SCs together. During the Ninth Plan, a total of 7.68 lakh dwelling units were constructed for STs, which accounts for 20.3 per cent of the total houses constructed under the scheme. Similarly, under the Accelerated Rural Water Supply Programme, 10 per cent of total funds was earmarked for STs. During the Ninth Plan, a total of about 119 lakh (9 per cent) STs were benefited under the programme. Under the Central Rural Sanitation Programme, sanitary latrines are provided to the rural population and 20 per cent of total funds are earmarked for providing subsidy to the individual households of STs (and SCs) living below Poverty Line. During the Ninth Plan as many as 3.1 lakh (6.4 per cent) sanitary latrines were provided to STs.

15. Under the National Old Age Pension Scheme, 23.7 lakh STs were covered during the Ninth Plan, which accounted for 7.4 per cent of the total beneficiaries. During this period while 1 lakh ST families benefited under the National Family Benefit Scheme, accounting for 10.2 per cent of the total, 4 lakh ST women also benefited under National Maternity Benefit Scheme, accounting for 7.4 per cent of the total.

Urban Development

16. Under the Urban Self-Employment Programme of Swarna Jayanti Shahari Rozgar Yojana, financial assistance is extended to STs for various small-scale entrepreneurial ventures. (For details Chapter on 'Empowerment of Socially Disadvantaged Groups' may be referred to).

Women and Child Development

17. To take care of the women and children including those belonging to these Groups, the nation-wide programme of Integrated Child Development Services (ICDS) continued to provide the much needed nutritional and health inputs/services for the benefit of tribal children, adolescent girls and expectant and nursing mothers living in the tribal areas through ST specific ICDS projects with relaxed norms. Of the total 5652 ICDS projects expected to be operationalized in the country by the end of the Ninth Plan, 758 (13.4 per cent) are Tribal Projects where a package of 6 services viz. health check-ups; immunisation; supplementary feeding; referral services; non-formal pre-school education and health and nutrition education are being extended to 4.77 million children and 0.96 million mothers. The concept of Mini-Anganwadis introduced in the tribal areas during the Ninth Plan is another measure to ensure ICDS services reach the tribal women and children.

Tribal Affairs

18. The nodal Ministry of Tribal Affairs laid greater emphasis in the Ninth Plan on the educational development of STs, implementing multiple support schemes. The scheme of 'Post-Matric Scholarships' (PMS), provision of Hostels and Ashram Schools continued to be major centrally sponsored schemes operational to promote higher education among STs. However, progress of the scheme has become very slow. Under the PMS, approximately 5.31 lakh students were benefited during the Ninth Plan. For the scheme of 'Hostels for ST Girls and Boys' the Central assistance to the scheme has been declining due to inability of the states to provide their share under these schemes. Evaluation of the scheme by the Ministry revealed inadequate performance of the states in service maintenance and management of the hostels. During the Ninth Plan 289 ST students hostels benefiting 10,649 girls and 317 hostels accommodating 13,958 boys and 294 Ashram Schools to accommodate 14,310 students in all were constructed. A review of the functioning of the Ashram Schools has revealed that some of the schools are very badly maintained and deprived of even the basic facilities. The scheme of Educational Complexes in low literacy pockets was launched with a specific objective of promoting education amongst ST girls. In addition, coaching facilities are being extended to ST students through Pre-Examination Coaching Centres to enable them to compete with others in various competitive examinations. To impart vocational training to ST students to increase their employability, 235 VTCs were established during the Ninth Plan.

19. In the sphere of economic development, the National Scheduled Castes and Scheduled Tribes Finance and Development Corporation (NSFDC) continued to function as a catalytic agent for financing, facilitating and mobilizing funds from various sources for promoting economic development activities of STs living below 'double the poverty' line through 47 State Channelising Agencies, of which 19 were working exclusively for STs. In order to give focussed attention to STs, the NSFDC was bifurcated, to set up an exclusive Corporation for STs in April 2001 with an authorized share capital of Rs. 500.00 crore. Through the combined Corporation of NSFDC, 934 income-generation projects were initiated for the benefit of 38,436 STs with the State ST Development Corporations (STDCs) functioning as the channelising agencies.

20. Another national level organisation i.e. the Tribal Cooperative Marketing Development Federation of India Ltd. (TRIFED) continued to offer remunerative prices for the Minor Forest Produce (MFP) collected and the surplus agricultural items produced by the tribals, eliminating the possibility of exploitation by the middlemen. Further, Grant-in-Aid to STDCs was provided to strengthen the share capital base of the corporatoin in order to help it increase the volume of procurement of MFP from tribals at remunerative prices and facilitate construction of ware houses/go-downs; establishment of processing industries and promotion of research and development activities of the 16 Corporations.

21. The scheme for the Development of Primitive Groups was launched in the Ninth Plan (1998-99) for the development of 75 Primitive Tribal Groups (PTGs) with population strength of 13.6 lakhs and spread over 15 States/UTs. The scheme aims at alleviating the conditions of PTGs who are still leading a precarious and fragile life and some of who are even on the verge of extinction due to hunger, diseases and ill health. Hundred per cent Central Assistance was given to States/UTs and also to NGOs for implementing an integrated action plan incorporating supply of safe drinking water, food and nutrition security, health coverage, educational facilities etc., keeping in view local needs and constraints. During the Ninth Plan 1,234 grain banks were set up in tribal villages for storage of food grains as safety net against starvation deaths of STs and also for improving nutritional standards amongst the children. In order to promote voluntary action in the tribal areas, especially in the remote and far-flung areas, 893 socio-economic development projects undertaken by the Voluntary Organizations were supported.

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Plan outlay

22. Total budgeted outlay for 2002-03 is Rs. 1090.00 crore consisting of Rs. 500.00 crore (45.8 per cent) as Special Central Assistance to TSP, Rs. 300.00 crore (27.5 per cent) as Grants-in-Aid under Article 275(1) of the Constitution, Rs. 261.00 core (23.9 per cent) for Central and Centrally Sponsored Schemes and Rs. 29.00 crore as a lump sum provision for the North Eastern Region. Further, for effective implementation of the on-going schemes/programmes, the core committee on ZBB has carried out an extensive exercise to rationalise the currently operational schemes. Accordingly, the number of schemes for the STs has come down to 14 from the earlier 25 schemes. The scheme-wise distribution (Central and Centrally Sponsored) of the Plan outlay is appended, a summary of the same is given in the following Table: 5.12.2

Table - 5.12.2

Outlays for the welfare and development of Scheduled Tribes during Tenth Plan (2002-2007) and Annual Plan (2002-03)

Rs. in crore

Sl. No.	Name of the Schemes	Tenth Plan (2002-07) Outlay	Annual Plan (2002-03) Outlay
(1)	(2)	(3)	(4)
I.	Central Sector Schemes (CS)	924.64	158.90*
II.	Centrally Sponsored Schemes (CSS)	829.36	131.10*
III.	Special Central Assistance (SCA) to TSP	2500.00	500.00
IV.	GIA under Art. 275(I) of the Constitution	1500.00	300.00
	Total	**5754.00**	**1090.00**

***** Includes the NER provision of Rs.29.00 crore

Approach

23. Efforts made through various developmental decades, have brought forth improvement in the socio-economic status of the tribals. However, the progress still falls short of mainstreaming the tribals with the rest of the society as the gap in their socio-economic status continues. As the tribals grapple with these tragic consequences, a small clutch of bureaucratic programmes could do little to resist the precipitous pauperisation, exploitation and disintegration of tribal communities. As a result of this, the tribals continue to suffer and bear with a number of 'Un-resolved Issues' and 'Persisting Problems', which require immediate attention of the Government. The following paragraphs explain the seriousness of some of the Un-resolved Issues and Persisting Problems.

24. As the 'Un-resolved Issues and the Persisting Problems' pose a serious challenge to the development of Tribals, the major approach of the Tenth Plan and the Annual Plan (2002-03) being the first year of the Tenth Plan, will be to 'Resolve the Unresolved Issues' and 'Solve the Persisting Problems' through:

· Protecting the tribals from land alienation and the related problems of indebtedness and exploitation. Steps will be taken for effective enforcement of existing legal measures along with provisions made under the Fifth and Sixth Schedule of the Constitution. In addition, efforts will also be made to persuade all the concerned State Governments to bring forth necessary amendments in their existing laws and regulations concerning tribal land to ensure - **i)** total ban on transfer of tribal land to non-tribals; **ii)** stringent penal provisions for non-tribal persons found in possession of tribal land once restored; **iii)** land alienation laws to cover non-Scheduled Areas; **iv)** effective machinery for quick disposal of cases and restoration of land possession; **v)** strengthening of traditional tribal Panchayats/ councils with adequate legal awareness and legal aid provisions; **vi)** constitution of committees with tribal representatives to review the projects involving land alienation where it becomes inevitable, and the resultant rehabilitation of the tribals, thus affected; and **vii)** awareness generation and legal aid for implementation of legal provisions concerning land alienation.

- Protecting the tribals from indebtedness and exploitation. Efforts will be made to improve the economic status of the tribals through employment and income-generation activities in addition to enforcing all available facilitatory legal measures. To wean the tribals away from shifting cultivation, economic alternatives are being devised in the form of region-based employment generation programmes, in addition to providing fair price and assuring rightful collection and gainful disposal of MFP and other produce. Since agriculture is the main source of livelihood of tribals, efforts will be made to boost agricultural production in tribal areas through effective operationalisation of the National Water Policy and improve the extension of irrigation facilities.

- Expediting the final pronouncement of the 'National Policy for Rehabilitation of the Displaced Persons' with a special focus on the displaced tribals, giving appropriate compensation and ensuring no further deterioration in the living conditions.

- Promoting tribal participation in forest centred activities and thereby stimulating the tribal economy without alienating tribals from the forest. The Plan will initiate development of Forest Villages by ensuring access to basic services so that these villages can reap the benefits of developmental activities.

- Expanding the on-going schemes further with effective involvement of voluntary organisations. Those tribal groups, whose primary occupation includes hunting, shifting cultivation, art and craft, wage labour and agriculture are in a precarious state, and also on the verge of extinction in spite of generous funding from Government of India. Their special situation calls for more focussed attention and sensitivity while designing Plan programmes for their betterment. Efforts are being made to design schemes keeping in view the specific needs of each tribe and its environment in addition to providing basic necessities like food nutrition, safe drinking water, education and health care. An outlay of Rs. 20.00 crore has been earmarked for the development of the PTGs for 2002-03 against an actual spending of Rs. 5.14 crore during the previous Plan year.

- Strengthening of the grass-root democratic institutions viz. PRIs and Gram Sabhas.

25. As tribals today do not have access to the basic pre-requisites of life, viz. food and nutrition, safe drinking water, education, health care and productive assets, due to their physical isolation and social and economic weakness, tribal women and children bear the brunt of deprivation and consequential hazards of backwardness. Accordingly, all the concerned Ministries/Departments will be effectively involved to give a boost to the on-going programmes with a special focus on the Scheduled/Tribal areas and tribal population, as per the details given below:

- In line with the Tenth Plan strategy, the Annual Plan gives a high priority to improve the educational status of the STs through improving school enrolment and arresting drop-out rates. The operational programmes include provision of Post Matric Scholarships, Hostels, residential schools and coaching schemes. Post Matric Scholarships are awarded to eligible students for payment of tuition, and other expenses to pursue higher studies. An outlay of Rs. 66.00 crore has been earmarked for ST students for the Plan year. For professional courses textbooks are supplied through the scheme of Book Banks for ST students. The Annual Plan (2002-03) has made a provision of Rs. 1.5 crore for the purpose. As a support service devised to check the high drop-out rates among the ST students at Middle level, Higher Secondary Schools, Colleges and Universities, Central Assistance is provided on

matching basis (50:50) to States and 100 per cent assistance for UTs for construction of hostel buildings. The Annual Plan provides for Rs. 13.00 crore and Rs.11.00 crore for construction of Girls & Boys Hostels respectively. In addition an outlay of Rs.14 crore has been provided in the plan to set up Ashram Schools in TSP areas. Under Coaching and Allied Scheme, free coaching facilities are provided to ST candidates through pre-examination training centres and private institutions/Universities to enable them compete in Civil Services and other competitive examinations and ultimately to improve STs representation in various Governmental, semi Governmental organisations. An outlay of Rs. 1.5 crore has been earmarked for the Annual Plan for the purpose. In addition to the above, some more educational programmes are in operation; they include 'Up-gradation of Merit of ST students, Provision of Research and Training for STs, both of which are Centrally Sponsored Schemes with an outlay of Rs. 1 crore and Rs. 8 crore respectively for the Plan period. Among the Central Sector Schemes are setting up of educational complexes in low literacy pockets, Vocational Training Centres and organised social programmes. For these three above-mentioned Schemes the Plan provides for Rs. 8 crore, Rs. 12 crore and Rs. 1 crore respectively.

- Health and survival being the fundamental requirement, special strategies with preventive-cum-remedial measures will be made specially focusing on tribal areas viz. forest villages and the tribals, specially the PTGs who are subjected to high risk, in addition to extending organised services for the treatment of endemic diseases.

- Food and Nutrition Security is of vital importance for survival as well as for good health of the Tribals, especially that of PTGs as some of them are on the verge of extinction due to hunger, starvation and malnutrition. Therefore, special efforts will be made to reach the programmes of Special Nutrition Programme (SNP) through ICDS, for children below 6 years, expectant and nursing mothers, Mid-Day Meal (MDM) for school-going children and Targeted Public Distribution System (TPDS) to strengthen the household food security to the tribals living in far-flung remote areas and especially PTGs. The Plan aims to ensure food security for the most vulnerable PTGs and tribals living in the forest villages by linking 'Food for Work' and other income-generation activities and establishing Village Grain Banks (VGBs). An outlay of Rs. 20.00 crore has been earmarked for for VGBs for the Plan year, which indicates a ten-fold increase from the outlay and expenditure for 2001-02. The main objective of the scheme is to provide a safeguard against non-availability of food grains in remote tribal areas and making provision for availability of food grains during the natural calamities – drought, cyclone etc.

- The two Apex level National Organisations viz. i) National Scheduled Tribes Finance Development Corporations (NSTFDC); and ii) Tribal Cooperative Marketing Development Federation of India Ltd. (TRIFED) will continue to play an important role in the promotion of income-generation activities. These Corporations in alliance with the State Finance and Development Corporations are expected to work as catalytic agents besides extending both forward and backward linkages of credit and market facilities to the micro-level agencies to improve the economic status of the STs. The TRIFED, set up in 1987, aims to provide marketing assistance and remunerative prices to STs for MFP collected by them and surplus agriculture produce and protect them from exploitative private traders and middlemen. The Central Government extends funds as contribution to the share capital of TRIFED and also for Price Support operations. The authorised share capital of TRIFED is Rs. 100 crore and the

paid-up capital is Rs. 99.98 crore. Outlay for investment in TRIFED and Price Support for the Annual Plan (2002-03) has been fixed at Rs. 6.01 crore. In addition, an outlay of Rs. 14 crore has been earmarked as Grant-in-Aid to State Tribal Development Cooperative Corporation (STDCCs) for MFP. Special efforts will be made in collaboration with the Department of Rural Development to provide employment and income-generation opportunities, especially to those living below the Poverty Line either through wage or self-employment by linking micro-credit both for self-employment ventures and consumption credit, when no work opportunities are available.

- To protect the indigenous knowledge of tribals of medicines and medicinal plants acquired through the generations, the Plan will initiate action on priority basis for providing legal and institutional framework to acknowledge the Intellectual Property Rights of tribals to such resources and knowledge and give them legal recognition and protection of their ownership rights.

- The Protection of Civil Rights (PCR) Act, 1955 and the SC and ST (Prevention of Atrocities) Act, 1989 are the two important legal instruments to prevent/curb persistent problems of social discrimination and atrocities against these disadvantaged groups. The SC & ST (POA) Act, 1989, provides for special courts/mobile courts for on the spot speedy trials and disposal of cases promptly. To ensure effective implementation of these Acts, a Centrally Sponsored Scheme is under implementation, for strengthening the administrative machinery, judiciary and publicity for the relief and rehabilitation of the affected persons. In the Annual Plan (2002-03), Rs. 32 crore has been earmarked for the implementation of PCR Act, 1955 and SC/ ST (POA) Act, 1989.

Implementation of Special Strategies of TSP and SCA to TSP

26. Implementation of the special strategies of the TSP for STs and the SCA to TSP has been receiving special attention, since their inception, as these are affective instruments to ensure proportionate flow of funds for STs from the other general development sectors. The special strategies of TSP are being implemented only by 25 Ministries/Departments, at the Centre. As per the available information, 25 Ministries/Departments and 23 States/UTs reported earmarking Rs. 1440.40 crore (4.2 per cent of the total divisible outlay) in 2000-01 and Rs. 4158.30 crore (7.5 per cent) under TSP in 2001-02. Further, to supplement the efforts of States/UTs towards economic development of STs, SCA is extended to fill the critical gaps in their TSP, especially through funding/supporting ST families below the poverty line to take up various income generation and self-employment projects. In the Annual Plan (2002-03), Rs. 500.00 crore has been provided as SCA to TSP to supplement the efforts made in the poverty alleviation programmes in the sectors of agriculture, horticulture, animal husbandry, forestry, co-operatives, fisheries, village & small-scale industries etc. The outlay has remained unchanged for two consecutive years.

27. In addition to TSP, exclusive Grant-in-Aid under Article 275(1) of the Constitution is extended to the States towards improving the administration level in the Scheduled Areas and also to meet the cost on special projects meant for welfare and development of the tribals. To accelerate the efforts in improving the situations in the Scheduled Areas and also to give added boost to the special activities taken up for the welfare and development of the tribals, Grant-in-Aid under Article 275(1) to the tune Rs. 300 crore has been

earmarked for the Annual Plan (2002-03), same as in the previous year 2001-02. It may be noted that the combined outlay earmarked for SCA to TSP and GIA under Article 275(1) of the Constitution constitute 73.4 per cent of the total outlay of the Ministry of Tribal Affairs.

28. The Plan recognises the need for a separate Personnel Policy for Tribal Areas to ensure that all the concerned officials handling welfare/development work of STs, should undergo, mandatory sensitisation training programmes to develop expertise on the subject and function more effectively.

29. Given the importance of women in tribal society special efforts will be made to empower tribal women through legal provisions for their protection as well as in respect of property rights, affirmative action in responsible decision-making positions, economic upliftment and directing population proportion at benefit flow from women related initiatives.

Voluntary Action

30. In view of the obvious limits of bureaucratic efforts, the coming years will increasingly witness participation of voluntary organisations in social economical upliftment of the tribals, which will facilitate their integration with the mainstream and counter social unrest. Voluntary Organisations which have been playing a vital role in delivering services at the grass-root level are being encouraged not only to supplement the government's efforts to extend various welfare and developmental services to these socially disadvantaged groups, but also to assist both the government and the target groups to fight against the social and economic exploitation inflicted upon these groups. These organisations with their local base and informal approach are in a better position to operate at the micro level and address the unresolved issues by implementing the plan programmes more effectively and efficiently. Accordingly, in the Annual Plan (2002-03), an amount of Rs. 30 crore has been earmarked for the NGOs as 'Grant-in-Aid' to extend various welfare and developmental services to the STs especially for the PTGs. The outlay is the same as the previous year's but it is not indicative of inadequate thrust since the approved outlay is nearly a third of entire Ninth Plan outlay (Rs. 92 crore). Sponsored activities will include a wide spectrum of services viz., Residential and Ashram Schools, Hostels, Medical Units, Computer Training Units, shorthand and typing training units, balwadis/crèches, libraries and audio-visual units etc. The grant is generally restricted to 90 per cent of the total approved cost of the project and the balance of 10 per cent is to be borne by the grantee organisation.

Annexure 5.12.1

Ministry of Tribal Affairs

SCHEME-WISE BREAK-UP OF ANNUAL PLANS (2000-03) - OUTLAY/EXPENDITURE OF MINISTRY OF TRIBAL AFFAIRS

(Rs.in crore)

Sl. No.	Name of the Scheme	ANNUAL PLAN			Sl. No.	ANNUAL PLAN (2002-03)	
		2000-01	2001-02			Name of the Scheme (Final out come of ZBB)	Outlay
		Actual	BE	Actual			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
I.	**CENTRAL SECTOR SCHEMES (CS)**						
1	Grant-in-Aid to NGOs for STs	21.88	30.00	23.80	1	Grant-in-Aid to NGOs for Coaching ST Students for Competitive Exams.	32.00
2	Special incentives to NGOs performing exemplary tasks.	0.00	0.00	0.00			
3	Vocational Training Centres in Tribal Areas	2.54	12.00	2.33	2	Vocational Training Centres in Tribal Areas	12.00
4	Educational Complexes in low Literacy Pockets	1.47	7.50	2.50	3	Educational Complexes in low Literacy Pockets	8.00
5	Investment in TRIFED	0.00	1.00	0.00	4	Investment in TRIFED and Price support	6.01
6	Price support to TRIFED	4.00	4.00	0.00			
7	Grant-in-Aid to STDCs for MFP	8.42	14.00	11.71	5	Grant-in-Aid to STDCs forMFP	14.00
8	Village Grain Banks	3.15	2.00	2.00	6	Village Grain Banks	20.00
9	Development of Primitive Tribal Groups (PTGs)	10.71	16.00	5.14	7	Development of Primitive Tribal Groups (PTGs)	20.00
10	National ST Finance & Development Corporation	0.00	30.00	0.19	8	National ST Finance & Development Corporation and GIA to State ST Dev. & Finance Corporations	32.00
13	Information and Mass Education	0.00	1.00	0.10		—	-
14	Organisation of Tribal Festivals	0.00					
15	Exchange of visits by Tribals	0.00					
16	Rehabilitation of Tribal Villages of Protected Areas	0.00	0.00	0.00		—	—
	Total - I	**52.17**	**117.50**	**47.77**			**144.01**
II.	**CENTRALLY SPONSORED SCHEMES (CSS)**						
17	Post-Matric Scholarships (PMS) for ST Students	63.10	71.60	27.70	9	Scheme of PMS, Book Banks and Upgradation of Merit of ST Students	68.49
18	Book Banks Scheme for ST Students	0.00	0.90	0.37			
19	Upgradation of merit of ST Students	0.00	0.40	0.25			

Annexure 5.12.1(Concld)

(Rs.in crore)

Sl. No.	Name of the Scheme	ANNUAL PLAN			Sl. No.	ANNUAL PLAN (2002-03)	
		2000-01	2001-02			Name of the Scheme (Final out come of ZBB)	Outlay
		Actual	BE	Actual			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
20	Coaching and Allied Scheme for ST Students *	0.00	1.40	0.22		—	-
21	Hostels for ST girls	2.34	13.00	6.70	10	Scheme of Hostels for ST Students	24.00
22	Hostels for ST boys	2.51	10.80	7.45			
23	Ashram Schools in TSP Areas	0.00	14.00	4.40	11	Ashram Schools in TSP Areas	14.00
24	Research and Training for STs	1.25	7.80	0.70	12	Research & Mass Education, Tribal Festivals and Others	10.50
25	G.I.A. to State ST & Finance Devp. Corporations (STDCs) **	2.41	2.60	0.19		—	-
	—	—	—	—		Lump-sum provision for North East Region	29.00
	Total - II	**71.61**	**122.50**	**47.98**			**145.99**
	TOTAL - I+II	**123.78**	**240.00**	**95.53**			**290.00**
III.	**Special Central Assistance (SCA) to Tribal Sub-Plan (TSP)**	**400.00**	**500.00**	**500.00**		**Special Central Assistance (SCA) to Tribal Sub-Plan (TSP)**	**500.00**
IV.	**G.I.A. under Art.275(I) of the Constitution**	**191.29**	**300.00**	**225.56**		**G.I.A. under Art.275(I) of the Constitution**	**300.00**
	GRAND TOTAL (I+II+III+IV)	**715.07**	**1040.00**	**821.31**			**1090.00**

Annexure 5.12.2

Plan Outlays And Expenditure - Backward Classes Welfare (SCs,STs,OBCs & Minorities) - States/UTs.

Rs.in lakh

Sl. No.	Name of States	Agreed Outlay IX Plan (1997-02)	Likely Exp. IX Plan (1997-02)	Actual Exp. (1997-98)	Actual Exp. (1998-99)	Actual Exp. (1999-00)	Actual Exp. (2000-01)	Outlays (2001-02)	Revised Outlay (2001-02)
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Andhra Pradesh	124059.0	95983.0	12271.0	27546.0	14049.0	12965.0	29151.9	29152.0
2	Assam	17917.0	12689.0	2031.0	3767.0	2649.0	1713.0	2529.0	2529.0
3	Bihar	46800.0	9526.0	3294.0	2804.0	1161.0	690.0	1577.0	1577.0
4	Chhattisgarh							3226.1	3226.0
5	Goa	450.0	268.0	38.0	29.0	63.0	75.0	63.0	63.0
6	Gujarat	108080.0	111775.0	14446.0	14446.0	28864.0	26921.0	30300.0	27098.0
7	Haryana	8026.0	3855.0	699.0	536.0	552.0	668.0	700.0	1400.0
8	Himachal Pradesh	3134.0	2850.0	608.0	671.0	612.0	624.0	323.0	335.0
9	Jammu & Kashmir	2998.0	3225.0	688.0	1047.0	480.0	485.0	525.0	525.0
10	Jharkhand *								
11	Karnataka	80000.0	120617.0	19768.0	21997.0	26029.0	20818.0	23898.0	32005.0
12	Kerala	64090.0	50977.0	11404.0	12695.0	5878.0	9000.0	11900.0	12000.0
13	Madhya Pradesh	63556.0	54395.0	13668.0	15769.0	12245.0	5829.0	6313.0	6884.0
14	Maharashtra	110127.0	106479.0	16170.0	21447.0	25564.0	22233.0	21064.9	21065.0
15	Manipur	4315.0	3396.0	314.0	852.0	1081.0	728.0	421.0	421.0
16	Meghalaya	50.0	47.0	8.0	7.0	12.0	10.0	10.0	10.0
17	Orissa	44475.0	48294.0	9143.0	12463.0	12837.0	10990.0	2956.9	2861.0
18	Punjab	47736.0	23045.0	7980.0	2328.0	1622.0	6445.0	4669.6	4670.0
19	Rajasthan	29205.0	20592.0	4431.0	5925.0	5835.0	4229.0	160.0	172.0
20	Sikkim	1500.0	1146.0	132.0	307.0	89.0	173.0	470.0	445.0
21	Tamil Nadu	100000.0	85464.0	15960.0	17568.0	15845.0	17447.0	27098.0	18644.0
22	Tripura	9480.0	10651.0	2182.0	2513.0	1969.0	2220.0	1767.0	1767.0
23	Uttar Pradesh	75550.0	109565.0	23828.0	22016.0	22621.0	22920.0	24360.0	18180.0
24	Uttaranchal						2927.0	987.0	987.0
25	West Bengal	17232.0	27928.0	3805.0	4641.0	5774.0	7580.0	7546.0	6128.0
A.	**Total (States)**	**958780.0**	**902767.0**	**162868.0**	**191374.0**	**185831.0**	**177690.0**	**202016.4**	**192144.0**
1	A&N Islands	210.0	281.5	24.9	37.1	73.5	76.0	70.0	70.0
2	Chandigarh	490.8	377.3	101.6	63.7	62.4	73.7	76.0	76.0
3	D&N Haveli	5.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0
4	Daman& Diu	104.5	94.7	24.8	15.7	18.0	18.2	18.0	18.0
5	Delhi	6825.0	4237.6	446.2	213.8	511.4	666.2	2400.0	2400.0
6	Pondicherry	2500.0	3390.9	371.0	583.5	761.5	871.2	1000.7	803.7
B.	**Total (U.Ts)**	**10135.3**	**8383.1**	**969.6**	**913.8**	**1426.8**	**1705.2**	**3564.7**	**3367.7**
	Grand Total (A+B)	**968915.3**	**917990.1**	**163537.6**	**192287.8**	**187257.8**	**179395.2**	**205581.1**	**195511.7**

* Finalisation not yet.

5.13 SOCIAL WELFARE

INTRODUCTION

It is well acknowledged fact that the fast paced economic and industrial growth in the country in the past few decades, with increasing trends in the rural-urban migration, has had significant but detrimental impact on the socio-economic development of the more marginalised, vulnerable and disadvantaged sections of society. This has manifested in problems like poverty, destitution, slum and pavement dwellers, which are straining the limits of civic amenities. The breakdown of strong societal and joint family bonds, which hitherto provided the basic support systems for these groups too have rendered them helpless and exposed to the vagaries of economic and social changes. All these factors have forced these groups either into social deviance, maladjustment or into destitution, beggary etc. In the absence of any other support mechanism, the State has to take upon itself the responsibility for the welfare, care and protection of these groups.

2. The Social Welfare Groups, include - Persons with Disabilities, viz., loco- motor, visual, hearing, speech and mental disabilities; the Social Deviants who come in conflict with law viz., juvenile delinquents/vagrants, drug addicts, alcoholics, sex workers, beggars etc; and the Other Disadvantaged viz., the Older Persons, children in distress such as Street Children, orphaned/abandoned children etc. Except for the Disabled and the Aged who are head counted in the population Census, no authentic data exist with regard to the magnitude of size of other groups except for occasional surveys and micro studies. In the absence of the Census 2001, the disabled (barring the mentally disabled) are estimated at 20.54 million or about 2.0 percent of the total country's population. The Aged (60+)account for at 70.6 million (2001 Census) or 6.9 per cent of the country's population .

Review of Annual Plan 2001-02

3. An outlay Rs.343.80 crore was provided for the Social Welfare Sector in the Annual Plan (2001-02) under the Central Sector (in the budget of the nodal Ministry of Social Justice and Empowerment) consisting of Rs.263.80 crore for the implementation of the policies, programmes and schemes for the Disabled and Rs.80.00 crore for Social Defence and the Other Disadvantaged. In addition, an amount of Rs.1297.47 crore was provided in the State Sector for the welfare and development of these groups.

4. The three fold strategy of the Ninth Plan specific to each individual group viz-i) Empowering the Persons with Disabilities ii) Reforming the Social Deviants and iii) Caring for the Other Disadvantaged was continued during the Annual Plan 2001-02 through a multi- collaborative and inter -sectoral coordinated efforts of the nodal Ministry of Social Justice and Empowerment along with concerned partner Ministries/ Departments. In this, they were ably guided and supported by the ground breaking legislation and policies enacted /adopted for these Groups notably the Persons with Disabilities(Equal Opportunities, Protection of Rights and Full Participation) Act 1995, (PWD Act, 1995) the Juvenile Justice (Care and Protection of Children) Act 2000 and National Policy on the Older Persons, 1999. While the general development sectors fulfilled their responsibility towards these Groups through reaching basic facilities such as health, nutrition, education, poverty alleviation, employment etc, the nodal Ministry of Social Justice and Empowerment continued to complement and supplement the efforts of these sectors with its own specific

innovative programmes for all the three target groups. The progress achieved in the Annual Plan 2001-02 by the Ministry of Social Justice and Empowerment is summed up in the following paragraphs.

Welfare and development of the persons with disabilities

5. The major thrust of the Ninth Plan of making as many disabled as possible active, self reliant and productive members of the society was continued in the Annual Plan 2001-02 with the backing and strength of the PWD Act, 1995. This Act encompasses a wide range of provisions to deal effectively with the multi dimensional problems and needs of the disabled starting right from prevention and early detection of disabilities to curative, rehabilitative and developmental measures including right to free education of the disabled child, enhanced employment opportunities, reservation to the extent of 3% in government jobs and poverty alleviation programs. The Act is being further amended to strengthen the existing provisions and introduce novel features such as affirmative action, social security, barrier free environment and above all advocating a multi-collaborative approach by assigning responsibilities to the concerned Ministries/ Departments for implementation of the provisions of the Act.

6. To provide a holistic package of services for the Disabled, the premier apex level seven National Institutes (NIs) viz, National Institute for the Visually Handicapped(Dehra Dun); National Institute for the Orthopaedically Handicapped (Kolkata); National Institute for the Hearing Handicapped (Mumbai); the National Institute for the Mentally Handicapped (Secundrabad); and the National Institute for Multiple Disabilities (shortly coming up at Chennai) along with the two apex level institutions of Institute of Physically Handicapped, New Delhi and the National Institute of Rehabilitation, Training and Research, Cuttack continued to work in their specialised sectors. They offered specialised courses to train professionals, research and community awareness activities, fitment and rehabilitation camps. Through their outreach services these Institutes also undertook programs for prevention and early identification of disabilities. These Institutes cumulatively have provided 319 thousand units of rehabilitative services during the year 2001-02. An outlay of Rs. 103.83 crore was provided for the National Institutes during the Ninth Plan as against which Rs. 59.08 crore was spent. In the Annual Plan 2001-02, a sum of Rs. 15.44 crore was spent as against an outlay of Rs.17.70 crore. To effectively supplement the efforts of the National Institutes and act as their extended arm at the regional level, the five Composite Regional Centres (CRCs) (at Srinagar, Lucknow, Sundernagar, Bhopal and Guwahati) were made functional in 2000-01. Besides, the four Regional Rehabilitation Centres (RRCs) for the spinal injured (at Jabalpur, Mohali, Bareilly and Cuttack) have also started providing technical support and referral services in temporary accommodations pending their building constructions. So far, the CRCs services benefited 22,000 persons, while over 5000 persons have been benefited/covered by RRCs. The Indian Spinal Injury Centre (ISIC), New Delhi provided comprehensive rehabilitation management services to the persons with spinal cord injuries which included surgical interventions, physical, psycho-social and vocational rehabilitation. The total bed occupancy of ISIC in 2001-02 was 18607 (till December 2001). The Centre also provided free OPD treatment during 2001-02 to about 1967 persons. The outlay provided during the Ninth Plan was Rs.23.28 crore while the expenditure incurred was Rs.15.06 crore. During the Annual Plan 2001-02 , Rs.2.07 crore was spent as against an outlay of Rs. 2.25 crore.

7. The Rehabilitation Council of India, New Delhi, is responsible for regulating training, policies and programmes for various categories of professionals in the area of disabilities. It also maintains the Central Rehabilitation Register for all professionals/ personnel and promotes research in rehabilitation and specialised education. By the end of March 2002, the Council developed 80 short term and long term training programs to meet the manpower programmes for 16 categories of rehabilitation professionals and gave recognition to 144 institutions to run courses at different levels. Other programmes undertaken by RCI included a national programme of orientation of medical officers working in Primary Health Centres in disability management. It also launched special Education B.Ed course through distance mode. An outlay of Rs. 26.41 crore was provided during Ninth Plan for this scheme as against which Rs.12.01 crore was spent, while in the Annual Plan 2001-02 an amount of Rs.2.40 crore was the expenditure as against an outlay of Rs. 3.00 crore.

8. The Artificial Limbs Manufacturing Corporation (ALIMCO) manufactured over 21 lakh aids and appliances in the Ninth Plan of which about 9 lakh was manufactured during the year 2001-02. It also distributed aids and appliance to about 50,000 beneficiaries in that year. The Corporation performed remarkably well during 2001-02, with a quantum increase in production and capacity utilisation from 41% in 1997-98 to 130 % in 2001-02. This is also reflected in the record turnover of Rs. 35 crore (projected) during the 2001-02 compared to Rs. 23.55 crore in 1999-2000. Special achievements in Annual Plan 2001-02 include : four Auxiliary Production Centres in Bhubaneswar, Jabalpur, Rajpura (Punjab) and Bangalore to increase production and sale of wheel chairs and tri-wheelers to the orthopaedically disabled, became functional from July 2001; a modern prosthetic and orhtotic centre and state of art metal assembly shop was set up; new products such as polypropylene based prosthetic lower limbs, electric hand walking stick and hand propelled tri-cycle / wheel chair too were developed. An expenditure of Rs.17.60 crore was incurred by the Corporation in the Ninth Plan as against an outlay of Rs.28.20 crore provided. In the Annual Plan an amount of Rs. 5.40 crore was spent as against an outlay of Rs. 6.00 crore. Under the scheme 'Assistance to Persons with Disabilities for Purchase/Fitting of Aids and Appliances(ADIP)', financial assistance was provided to agencies (such as NGOs. NIs, ALIMCO etc) for assisting the disabled persons in procuring durable, sophisticated and scientifically manufactured aids and appliances. An amount of Rs. 109.78 crore was provided for this scheme in the Ninth Plan while the expenditure was Rs. 133.80 crore. During 2001-02, 140 implementing agencies were assisted for this purpose with an expenditure of Rs.43.44 crore as against Rs. 47.28 crore outlay provided.

9. The National Handicapped Finance Development Corporation (NHFDC), provided concessional loans to the disabled with annual income of less than Rs.1 lakh per annum in the urban areas and Rs. 80000 per annum in the rural areas for income generation activities. Under its micro-financing scheme the Corporation assisted individual beneficiaries and Self Help Groups. During the year 2001-02, the Corporation sanctioned release of Rs.9.15 crore covering 2047 beneficiaries of which Rs.8.11 crore have been disbursed benefiting 1793 disabled persons. Till date, 9,755 disabled persons have benefited during the Ninth Plan. NHFDC also provided loans to Parents' Associations of mentally retarded persons to set up income generating activities for these groups. An outlay of Rs. 226.40 crore was provided for this Corporation in the Ninth Plan while the expenditure was Rs. 51.30 crore. During the Annual Plan 2001-02 an outlay of Rs.13.00 crore was provided. However, no expenditure was incurred from this outlay, as the Corporation utilised its own internal resources.

10. With the objective of reaching the unreached viz the rural disabled, the National Programme for Rehabilitation of Persons with Disabilities (NPRPD) had by the end of March 2002, financially assisted 82 districts towards local capacity building for the much needed rehabilitation structure right from the panchayat level upwards. This programme is now transferred to the State Sector. An expenditure of Rs.104.13 crore was incurred on this Scheme during the Ninth Plan as against an outlay of Rs. 94.05 crore provided. In the Annual Plan 2001-02 an amount of Rs. 43.61 crore was provided /spent.

11. To help the disabled in securing gainful employment, the centrally sponsored scheme of Special Employment Exchanges or Special Cells in regular employment exchanges continued its efforts to place disabled in jobs. At present there are 41 Special Cells and 40 Special Employment Exchanges in the country. The number of disabled job seekers in 2001-02 on live registers of all the Employment Exchanges and Cells in the country was 98,200 and placement was 1800 (January to June 2000). An amount of Rs. 3.61 crore was spent on this scheme in the Ninth Plan as against an outlay of Rs. 5.00 crore. In the Annual Plan 2001-02, an amount of Rs. 1.54 crore was spent as against an outlay of Rs. 1.60 crore. This Scheme is now slated for transfer to the State Sector.

12. With a view to promote voluntary action and enlarge the scope and delivery of services the four on-going schemes of-assistance to voluntary organizations for disabled persons; rehabilitation of leprosy-cured persons; persons with cerebral palsy and mental retardation; and starting special schools for handicapped children were merged into one single Umbrella scheme 'Promote Voluntary Action for Persons with Disabilities' in 1998, with innovative inputs like providing legal aid, recreation, research etc. An amount of Rs. 201.80 crore was provided for this scheme in the Ninth Plan while the expenditure was Rs. 232.99 crore. During 2001-02 about 549 organisations were assisted with Rs. 60.86 crore to benefit 52681 persons. More than 350 special schools and 140 vocational training centres are being run under this scheme.

13. To cater to the much neglected field of mental disability, the National Trust for the Welfare of the Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities, Delhi set up in December, 1999, is implementing an Umbrella Scheme called 'Reach and Relief Scheme for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities' that provides for long term and permanent state institutions, day care centres, augmentation of home visits, etc. So far, 165 Local level Committees under the chairpersonship of the district magistrate have been formed to advocate the needs and rights of disabled persons. Also, 228 organisations, including 11 parents' associations have been registered to work in the field of mental disabilities. To facilitate the activities to be taken up by the Trust, a Corpus Fund of Rs.100 crore was instituted.

14. In addition to the above, a number of other measures were also taken with regard to research and development of appropriate and innovative technological appliances for the disabled under the aegis of the Science and Technology in Mission Mode. Over 30 aids and appliances were developed such as plastic aspheric lens, myo-electric hand control system and motorised joystick operated wheel chair.

15. The Ministry took special steps to ensure that the provisions of the PWD Act 1995 were implemented effectively, through review and monitoring of the implementation of the

Act. These measures included- i) Review of the implementation of the Act by the Statutory Committees viz. Central Co-ordination Committee and the Central Executive Committee; ii)Monitoring the progress of various provisions of the Act not only at the Centre but also in the States/UTs by a Group of Secretaries with the representatives of 51 Central Ministries/ Departments; iii) Notification in June 2001 of the identified posts suitable for the disabled, based on the recommendations of the Report of the Expert Committee; iv) Standing Committee of Secretaries constituted under the Chairpersonship of the Cabinet Secretary to provide an additional institutional mechanism for continuous review of compliance by Ministries/Departments / public sector undertakings regarding reservations for persons with disabilities.

REFORMING THE SOCIAL DEVIANTS

Juvenile Maladjustment

16. To deal with the growing problem of juvenile maladjustment, and to make it more child friendly with well laid out welfare-cum-rehabilitative services for children in conflict with law, the Juvenile Justice Act 1986 was repealed by the Juvenile Justice (Care and Protection of Children) Act, 2000 (JJ Act, 2000). This Act has been enforced in the entire country except Jammu and Kashmir. As per the Act, the State Governments are required to set up Juvenile Justice Boards and Child Welfare Committees in every district. To ensure speedy implementation of the provisions of the Act, the Ministry notified Model Rules under the Act in June 2001and also advised the States to adopt these rules or frame their own. The Ministry is also implementing the scheme of Juvenile Social Maladjustment now called 'A Programme for Juvenile Justice', wherein assistance is being provided to the extent of 50% of the expenditure to the State Governments to establish and maintain the mandatory homes for neglected and delinquent Juveniles. As on March 2002, 290 Juvenile Homes, 287 Observation Homes, 35 Special Homes and 50 After-Care Homes were established for care and rehabilitation of juveniles. In addition, 202 Juvenile Courts and 260 Juvenile Welfare Courts were set up across the country. During the Ninth Plan an amount of Rs.52.58 crore was spent on this programme as against an outlay of Rs.41.24 crore. In 2001-02 as against an outlay of Rs.12.50 crore, Rs.15.37 crore was spent.

17. The special campaign of National Initiative for Child Protection (NICP) initiated by the Ministry through the National Institute of Social Defence and CHILDLINE Foundation continued to provide the links with allied systems such as police, health care providers, judiciary, education, etc for child protection and rehabilitation.

Prevention of Drug / Alcohol Abuse

18. To control the menace of drug and alcohol abuse, the Ministry is implementing the Scheme of Prevention of Alcoholism and Substance (Drugs) Abuse through a comprehensive package of awareness generation services, identification of addicts, referral service and setting up of treatment and rehabilitation centres. During 2001-02, assistance was provided to 359 non- governmental organisations to run 442 centres (of which 88 were drug counselling and assistance centres and 354 were treatment cum rehabilitation centres). The number of alcohol and drug addicts registered in these organizations was about 3.00 lakh of whom about 1.60 lakh were detoxified. The National Centre for Drug Abuse Prevention (NC-DAP) set up in 1998, developed and conducted training programs

for various categories of service providers. To decentralise training requirements and cater to the regional requirements, the five Regional Resource and Training Centres set up in Chennai, Pune, Delhi and two in Kolkata undertook a number of training programs in their regions providing training to various levels of functionaries, upgrading information and data base and networking in the field of drug demand reduction, in addition to developing training manuals in areas including prevention and management of drug abuse and HIV/ AIDS etc. Special collaborative projects were undertaken with the international agencies of International Labour Organisation and United Nations International Drug Control Programme (UNDCP) which included 'Community Wide Demand Reduction in India' wherein more than 1000 service providers were trained in different parts of the country; 'Community Wide Demand Reduction in the North East', with a view to check the high incidence of drug abuse in that area, especially injecting drug use. To assess the magnitude, nature and pattern of drug abuse in the country, a National Survey on Drug Abuse is being conducted by the Ministry in collaboration with UNDCP .Preliminary data on the dimensions of the problem and the target groups most affected has been compiled and the same is being processed. Against the total Ninth Plan outlay of Rs.80 crore, a sum of Rs.88.84 crore was spent during the Plan to support the community-based voluntary action, training and other rehabilitation facilities for alcohol and drug demand reduction while in the Annual plan 2001-02 the outlay/ expenditure was Rs 22.50 crore.

The Other Disadvantaged

19. The Annual Plan 2001-02 followed the Ninth Plan policy of ensuring the well being of the Aged through extending support of financial security, health, shelter, etc. To tackle the growing problem of street children the strategy included preventive measures with welfare and developmental support services like the ICDS, education, health feeding programs etc.

Care of the Older Persons

20. The National Policy on Older Persons (NPOP) adopted in 1999, formed the basis for the welfare and care of Older Persons by initiating action in the crucial areas of, health care and nutrition, shelter, education, training, research and dissemination of information, and supplemental care and protection provided by the family and above all financial security including pension support. A National Council for Older Persons was set up along with the Draft Plan of Action demarcating clearly the responsibilities of partner Ministries/ Departments mandated under the Policy. To provide secretarial services to the Council, an agency called Aadhar was set up at the centre and Zilla Aadhars at the district level. Since its constitution in December 1999, the process of appointment of Zila Aadhars members in nearly 530 districts was completed. These members provide vital support to the aged in solving their problems.

21. Financial assistance was provided to NGOs under the 'Integrated Programme for Older Persons' for establishing and running old age homes, day care centres, mobile medicare units as well as non-institutional services to the senior citizens. During 2001-02 about 525 such projects were supported through 350 organisations. In the Ninth Plan an amount of Rs.51.66 crore was spent while the outlay provided was Rs.56.42 crore. An outlay of Rs.15.00 crore was provided in the Annual Plan 2001-02 while the expenditure was Rs.14.61 crore. Taking into account the growing concern for old age social and income security especially in the unorganised sector the Report on ' Old Age Social and Income

Security (OASIS)' was commissioned. This report is now under the consideration of a Group of Ministers under the Chairpersonship of Deputy Chairman, Planning Commission.

Street Children

22. With the objective of weaning away the street children from a life of deprivation and vagrancy and rehabilitating them, the Ministry is implementing the scheme of 'An Integrated Programme for Street Children' with a wide range of initiatives like 24 hour drop in shelters, night shelters, nutrition, health care, sanitation, hygiene, safe drinking water, education, recreational facilities and protection against abuse and exploitation. Currently, 190 organisations are operating in 22 States benefiting 1.58 lakh street children. During the Ninth Plan the expenditure incurred was Rs.31.78 crore as against the outlay of Rs.32.98 crore. An amount of Rs. 8.06 crore was spent on this scheme during Annual Plan 2001-02 against an outlay of Rs.12.00 crore. The special initiative of the CHILDLINE service, a toll free telephone(1098) service available to children in distress responds to the emergency needs of the children and provides referral service. This facility is now operating in 34 cities, and has received over 10.00 lakh calls from children/concerned adults as on March 2002.

Adoption of Children

23. To offer permanent rehabilitation through adoption, to orphaned, abandoned and destitute children, efforts were made to place as many children as possible in both in-country and inter-country adoptions. During the year 2001 about 3197 children were placed in adoption of which 1297 were inter country and 1900 within country. The Central Resource Adoption Agency(CARA) which regulates and monitors adoption of Indian children abroad is in the process of issuing revised guidelines for both in-country and inter-country adoptions. It has also taken up skill building amongst social workers vested with the responsibility of the welfare and rehabilitation of orphaned children. During the Ninth Plan an outlay of Rs.3.26 crore was provided for CARA and Rs. 9.00 crore for Shishu Greha for promoting in country adoptions, while the expenditure was Rs.2.28 crore and Rs.7.47 crore respectively. During the Annual Plan 2001-02 an expenditure of Rs.1.10 crore was incurred by CARA as against an outlay of Rs.2.00 crore, while Rs.2.00 crore was spent under the scheme of Shishu Greha against an outlay of Rs.5 crore during 2001-02.

National Institute of Social Defence (NISD)

24. The newly autonomous NISD apart from its on going activities of documentation, research training programs etc further enlarged the scope of its activities to undertake new tasks like review of policies and programs in the field of social defence; anticipate and diagnose social defence problems; develop and promote voluntary action ; activities for child protection in collaboration with NICP and CHILDLINE; programs to train care givers in the field of aged etc. In the field of prevention of alcohol and drug abuse, the special cell NC-DAP continued to provide intensive training courses and capacity building of service providers. An amount of Rs. 5.60 crore was provided for NISD during the Ninth Plan, against which Rs.6.68 crore was spent. During the Annual Plan 2001-02, Rs. 2.12 crore was spent as compared to the outlay of Rs. 3.00 crore.

Annual Plan (2002 – 03)

25. The Tenth Plan will continue the three-pronged strategy of – **i**) Empowering the Disabled; ii) Reforming the Social Deviants; and iii) Caring for the Other Disadvantaged with a special focus on convergence of the existing services in all related welfare and development sectors so as to attain maximum beneficiary coverage in the areas of preventive, curative, rehabilitation, welfare and development for all the target groups. In this context the nodal Ministry of Social Justice and Empowerment will be ably supported by the other general development sectors to reach services and facilities to these target groups. The Annual Plan 2002-03 ,being the first year of the Tenth Plan, will initiate the approach and the policy thrusts and programmes to be undertaken in the course of the next five years.

Financial Outlay

26. The total outlay for the Annual Plan 2002-03 is Rs.330.00 crore consisting of Rs.232.50 crore for the welfare of the disabled (excluding additionally Rs.20 crore for the National Trust for the Mentally Retarded) and remaining Rs.97.50 crore for social defence and the other disadvantaged. To optimise the use of available resources and achieve synergy and convergence in functioning, the number of on-going schemes in the Social Welfare Sector was brought down from 39 during the Ninth Plan to 16 in the Tenth Five Year Plan through the special exercise of Zero-Based Budgeting (ZBB) involving merging, weeding out, and transferring of schemes to the State Sector, non plan etc. The scheme-wise expenditure at the Centre for the Social Welfare Sector during Annual Plan 2000-01, outlay and expenditure for the terminal year of the Ninth Plan, 2001-02 and the outlay for Annual Plan 2002-03 - the first year of the Tenth Plan (as per the final outcome of the ZBB exercise) are given at Annexure 5.13.1. The details of the outlays and expenditure in the State Sector are given at Annexure 5.13.2. Table 5.13.1 summarises the outlay and expenditure in the Ninth Plan (1997-2002) and the Annual Plan (2001-02) as well as the outlay approved for the Tenth Plan (2002-07) and the Annual Plan (2002-03).

Table 5.13.1

Social Welfare-Plan Outlays and Expenditure

(Rs.in crore)

	Ninth Plan (1997-2002)		Annual Plan (2001-02)		Tenth Plan (2002-07)	Annual Plan 2002-03 BE
	Outlay	**Actual**	**BE**	**Actual**	**Outlay**	**Outlay**
I. Ministry of Social Justice & Empowerment	1208.95	1020.39	343.80	309.37	2004.00	330.00
II. States/UTs	3344.42	3674.88	1297.47	1217.97	7250.49	1312.20
Total I+II	**4553.37**	**4695.27**	**1641.27**	**1527.34**	**9254.49**	**1642.20****

** Excludes Rs.20 crore as additional Corpus Fund to be paid to the National Trust for Mentally Retarded during 2002-03.

27. The following paragraphs gives the details of the various schemes being implemented by the nodal Ministry of Social Justice and Empowerment in the Annual Plan 2002-03.

I). Empowering the Persons with Disabilities

28. The Annual Plan 2002-03, in line with the commitment of the Tenth Plan will seek to empower as many disabled as possible to become active, self reliant and productive contributors to the national economy with the strength and support of the provisions of the PWD Act, 1995. In this context the underlying tenet of multi-sectoral collaborative effort and responsibilities laid down in the Act, will receive an added thrust through formulation of detailed guidelines and rules by partner Ministries/Departments for implementation of provisions of the Act. Further to ensure adequate fund availability, steps will be initiated to introduce a component plan for the disabled in the budget of these Ministries/ Departments to ensure that the funds/ benefits mandated under the PWD Act 1995, flow to the disabled.

29. In accordance with the ZBB exercise a clutch of schemes were suitably merged under the umbrella scheme of 'Implementation of the PWD Act.1995'. These include the RRCs and CRCs, S&T Mission Mode etc. An outlay of Rs. 33.50 crore has been provided for this umbrella scheme in 2002-03(including spill over requirement of Rs.1.00 crore for the Office of the Chief Commissioner for Disabilities, during 2002-03).

30. To meet the requirements of the needy areas and groups especially the rural unreached , the outreach services providing a composite package of treatment, rehabilitation, training etc of the national and regional network institutional mechanism viz, the seven National Institutes, the four Regional Rehabilitation Centres and the five CRCs along with ISIC will suitably be enhanced and expanded. For this purpose the seven NIs have been provided an outlay of Rs.28.00 crore, in the Annual Plan 2002-03, while the ISIC has been allotted Rs.4.00crore. (the RRCs and the CRCs form part of the schemes under the umbrella scheme of 'Implementation of the PWD Act', 1995).

31. To enhance functional mobility and accessibility to the disabled, the production and distribution of suitable aids and appliances will be stepped up. In this context ALIMCO will produce assistive devices to benefit 40,500 beneficiaries during 2002-03 for which an outlay of Rs.4.00 crore has been provided. To ensure widespread distribution of aids and appliances the ADIP scheme will receive Rs.55.00 crore benefiting 2.15 lakh persons.

32. As training and manpower requirements in the field of disability is a priority concern special measures will be taken by the Rehabilitation Council of India (RCI) to ensure quality of service in these areas through enforcement of uniform standards for rehabilitation professionals and developing training courses. In the year 2002-03, RCI will be provided with Rs.4.00 crore for this purpose. To upgrade skills as well as professional manpower especially at the higher levels of rehabilitation for the disabled, including Post graduate level training, a College of Rehabilitation Sciences is being set up for which an amount Rs.6.03 crores has been provided in the Annual Plan 2002-03.

33. Job placement being one of the more important avenues of employment for the disabled , efforts will be made to generate more jobs for them, through effective identification and filling up of reserved posts up to 3 per cent of the vacancies in the Government and Public Sector Undertakings through Special Employment Exchanges/

Special Cells in the Regular Employment Exchanges. This scheme is slated for transfer to the State Sector along with an outlay of Rs.3.60 crore and at present is awaiting NDC approval.

34. Economic empowerment through income generating and self employment opportunities for the disabled will be specially encouraged by various concessional and micro financing schemes of NHFDC. In this context the formation of SHGs will be specially encouraged to enable taking up of viable income generating activities. The Annual Plan 2002-03 has earmarked Rs15.00 crore for the Corporation.

35. The Voluntary Sector have traditionally played an important role in delivery of community based services to the disabled . The umbrella scheme of 'Promote Voluntary Action for Persons with Disability' will be supported to widen its operations to the unreached areas and also introduce new innovative components in their services. For this purpose an outlay of Rs.72.00 crore has been provided for this scheme. It is expected that over 500 NGOs will be assisted for this purpose.

36. Recognising the special problems faced by the mentally disabled, and the need to expand the activities for their welfare, development and protection, the Corpus of the 'National Trust for the Welfare of the Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities' will be further enhanced from Rs.100 crore to Rs. 120 crore. Accordingly a sum of Rs.20 crore has been provided as additional Corpus for the Trust in 2002-03.

II). Reforming the Social Deviants

37. Recognising that social deviants such as juvenile delinquents , alcohol and drug addicts are victims of circumstances and situational compulsions rather than habitual criminals engaged in organised crime, the Annual Plan 2002-03 advocates reform and rehabilitation of these social deviants in a humane rather than a punitive environment , with a view to transforming today's social deviants into tomorrow's responsible citizens.

Juvenile Social Maladjustment

38. The thrust will on the effective implementation of the Juvenile Justice (Care and Protection of Children) Act 2000 with its objective of rehabilitating the juveniles in a child-friendly positive environment by utilizing the network of institutional and non-institutional facilities. For this purpose, rigorous steps will be taken to ensure that minimum standards and quality of life are maintained in the mandatory institutions set up under the Act. The role of voluntary organisations will also be suitably expanded to promote non institutional care for these children. The scheme of 'Programme of Juvenile Justice' under which M/ SJE shares the cost with the States for maintaining the mandatory home for the juveniles has been provided with an outlay of Rs.16.00 crore to assist 30,000 juvenile inmates in mandatory homes.

Alcoholism and Drug Abuse Reduction

39. The integrated and comprehensive community based approach to curb the growing problems of alcoholism and drug abuse in the country will be strengthened and expanded

to reach needy areas like the rural areas and North East and the high risk groups like street children, commercial sex workers, truck drivers etc. This will involve intensive awareness generation and preventive education, counselling, treatment, de-addiction and rehabilitation of addicts. Training of service providers will be stepped up through the efforts of the NC- DAP and the Regional Training Centres. An outlay of Rs.28.50 crore has been earmarked to be used for prevention of alcohol and drug abuse. About 3.2 lakh addicts are expected to benefit from the programme during 2002-03.

III). Caring for the Other Disadvantaged

40. The Other Disadvantaged includes the Aged and the orphaned, abandoned, destitute and street children, neglected children, who in the wake of declining family support systems and other socio-economic circumstances are left helpless and necessarily require the support of the and protection of the State.

Care of the Older Persons.

41. To fulfil the commitments of the National Policy on Older Persons for providing health, shelter, work therapy, vocational training, recreation, protection of life etc special emphasis will be placed on expanding the on-going programmes of old age homes, day care centres, mobile medicare units and medicare centres being implemented under the scheme of 'Integrated Programme for Older Persons'. During the Annual Plan 2002-03 an amount of Rs.20.30 crore is being provided for this scheme to support around 260 voluntary organisations and benefit 70,000 persons. To help the aged to solve their own problems , the services of the 'Zilla Aadhars' and HELPLINE will be extended to all the districts in the country.

Welfare of Children in Difficult Circumstances

42. To tackle the growing problem of children in difficult circumstances(street children, orphaned abandoned, destitute children etc.) who are most vulnerable to abuse and exploitation, the Annual Plan 2002-03 seeks to expand and strengthen the Integrated Programme for Street Children focussing on preventive and rehabilitative aspects with necessary provisions for health, nutrition, shelter, vocational training and education etc. for all-round development of these children. To provide complete rehabilitation for orphaned and destitute children in adoptive families, efforts will be made under the scheme of Shishu Griha to place larger number of these children in adoption within the country. An amount of Rs.19.00 crore has been provided during the plan for the scheme of 'Welfare of Children in Difficult Circumstances' which includes the schemes for Street Children as well as Shishu Griha.

43. A special scheme will also be initiated during the Annual Plan 2002-03 for ' Welfare of Children in Need of Care and Protection.' The objective of this scheme is to cater to child workers and potential child workers(such as street children, children of pavement dwellers, migrants, sex workers, destitute children etc.) and provide opportunities to them to facilitate their entry into main stream education through non formal education, bridge education, vocational training etc. An amount of Rs.5 crore has been provided for this scheme during the Annual Plan 2002-03.

44. The programme of National Initiative for Child Protection (NICP) will continue work to create child-friendly systems in agencies like police, health, judiciary, education to enable the street children access basic facilities like health, transport, labour etc. CHILDLINE services which receive calls for help from children in distress will be adequately strengthened with appropriate inter-linkages.

Adoption of children

45. To provide permanent homes to the orphaned children, the Central Adoption Resource Agency (CARA) will upgrade its facilities for research and documentation so that information about children available for adoption can be easily ascertained. As a follow-up in the post adoption period, monitoring and evaluation mechanism of CARA and the Indian Embassies abroad will be strengthened to update records, organize home visits and computerized documentation facilities. The scheme is to be transferred to non-plan from 2003-04 after meeting the spill over requirements of Rs.2 crores in Annual Plan 2002-03.

National Institute of Social Defence

46. The Annual Plan will seek to strengthen the newly autonomous National Institute of Social Defence professionally, technically and financially, to enable it to broaden its activities in the field of social defence and for the other disadvantaged groups. The Institute will revive its earlier activities of training and manpower development of social defence personnel, especially in the areas of community-based services for juvenile justice, prison welfare, prison administration, child adoption, children in need of care and protection, prevention of drug-abuse, welfare of senior citizens and other emerging social problems. For this purpose an outlay of Rs. 4.00 crore is being provided for the Institute in the Annual Plan 2002-03.

47. Realising that most of the social welfare programme are best implemented by the voluntary organisations as they are in close contact with the target groups, the Annual Plan 2002-03 will seek to identify and encourage NGOs with good performance track record and motivate them to work in the needy and rural areas.

Annexure 5.13.1

Scheme-Wise Break-Up of Annual Plans (2000-03) Outlay/Expenditure of Ministry of Social Justice and Empowerment (Disabled, Social Defence & Other Disadvantaged Groups

(Rs.in crore)

Sl. No.	Name of the Scheme	ANNUAL PLAN			Sl. No.	ANNUAL PLAN (2002-03)	
		2000-01	2001-02			Name of the Scheme (Final out come of ZBB)	Outlay
		Actual	BE	Actual			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	**CENTRAL SECTOR SCHEMES (CS)**						
A	**WELFARE OF THE DISABLED**						
1	National Institute of Visually Handicapped, Dehradun Scheme for Funding to National Institutes	2.60	2.50	2.84			
2	National Inst. of Orthopaedically Handicapped, Kolkatta	1.12	2.50	1.55			
3	National Institute for the Hearing Handicapped, Mumbai.	2.63	2.90	2.61			
4	National Institute for the Mentally Handicapped, Secunderabad	3.32	3.30	3.49	1.	Scheme for Funding to National Institutes	32.00
5	National Institute of Rehabilitation, Training & Research, Cuttack	3.60	4.00	3.60			
6	Institute of the Physically Handicapped, New Delhi	1.35	1.50	1.35			
7	National Institute for the Multiple Handicapped, Chennai	0.00	1.00	0.00			
8.	National Institute of Social Defence, New Delhi	2.02	3.00	2.12			
9.	Artificial Limbs Manufacturing Corporation,Kanpur	0.00	6.00	5.40	2.	Artificial Limb Manufg. Corporation,Kanpur	4.00
10.	Scheme of Assistance to Disabled Persons for Purchasing /Fitting of Aids & Appliances	29.01	47.28	43.44	3.	Scheme of Assistance to Disabled Person for Purchasing / Fitting of Aids & Appliances	55.00
11.	Assistance to Vol. Organisations for the Disabled						
12.	Assistance to Vol. Organisations for Rehabilitation of Leprosy Cured Persons	62.12	65.00	60.86	4.	Scheme to Promote Voluntary Action for Persons with Disabilities	72.00
13.	Assistance to Vol. Organisations for Persons with Cerebral Palsy and Mental Retardation						
14.	Assistance to Vol. Organisations for Establishment of Special Schools						
15.	Indian Spinal Injury Centre	2.30	2.25	2.07	5.	Indian Spinal Injury Centre	4.00
16.	Rehabilitation Council of India	3.75	3.00	2.40	6.	Rehabilitation Council of India	4.00
17.	National Trust for Persons with Mental Retardation	44.00	42.00	51.00	-	National Trust for Persons with Mental Retardation	1.00*

* Rs. 1 crore as spill over of the Ninth Plan Corpus of Rs. 100 crore. Also Excludes Rs. 20 crore to the paid as additional Corpus to the National Trust and the scheme to be weeded out during the year 2002-03 itself.

Annexure 5.13.1 contd.

(Rs.in crore)

Sl. No.	Name of the Scheme	ANNUAL PLAN			Sl. No.	ANNUAL PLAN (2002-03)	
		2000-01	2001-02			Name of the Scheme (Final out come of ZBB)	Outlay
		Actual	BE	Actual			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
18	National Handicapped Finance and Development Corporation	0.00	13.00	0.00	7	National Handicapped Finance and Development Corporation (NHFDC)	15.00
19.	National Rehabilitation Programme for the Disabled	55.52	43.61	43.61		—	—
20.	Implementation of the Persons with Disabilities (PWD) Act, 1995	4.01	13.75	8.70	8.	Implementation of the Persons With Disabilities (PWD) Act,1995.	32.50
21.	Six Regional Composite Resource Centres	0.00	0.00	0.00			
22.	Science & Technology Projects In Mission Mode	0.30	3.00	1.04			
23.	Office of the Chief Commissioner for Persons with Disabilities	0.27	1.00	0.73	-	Office of the Chief Commissioner for Persons with Disabilities (Spill-over only for 2002-03)	1.00
24.	Support to children with Disabilities (An UNDP funded Scheme)	0.18	1.61	0.93	9.	Support to children with Disabilities (An UNDP funded Scheme)	2.37
	Total (A)	**218.10**	**262.20**	**237.74**			**222.87**
B.	**New Scheme**	**—**	**—**	**—**	**10.**	**College of Rehabilitation Sciences**	**6.03**
	Total (A+B)	**218.10**	**262.20**	**237.74**			**228.90**
C.	**SOCIAL DEFENCE AND OTHER DISADVANTAGED GROUPS**						
25.	Education work for Prohibition and Drug Abuse	20.64	22.50	22.50	11.	Assistance to Vol. Orgns. For providing Social Def. Services including Prevention of Alcoholism & Drug Abuse	28.50
26.	Assistance to Vol. Orgns. for providing Social Def. Services	2.76	4.00	2.48			
27.	Central Adoption Resource Agency (CARA)	0.47	2.00	1.10	—	Central Adoption Resource Agency (Spill-over only for 2002-03)	2.00
28.	Integrated Programme for Street Children	7.24	12.00	8.06	12.	Grant-in-aid for Welfare of Children in Difficult circumstances	19.00
29.	Assistance to Homes for Infant and Young Children for Promoting In-country Adoption	1.88	5.00	2.00			
30.	Assistance to Vol. Orgns. for Programmes related to Aged.	12.36	15.00	14.61	13.	Assistance to Vol. Orgns. for Programmes related to Aged.	20.30

Annexure 5.13.1 contd.

(Rs.in crore)

Sl. No.	Name of the Scheme	ANNUAL PLAN			Sl. No.	ANNUAL PLAN (2002-03)	
		2000-01	2001-02			Name of the Scheme (Final out come of ZBB)	Outlay
		Actual	BE	Actual			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
31.	Grant in aid for Research Studies and Publications	0.27	0.50	0.47	14.	Grant in aid for Research, Information and Other Miscellenous	6.70
32.	Information and Mass Education Cell	3.95	5.00	3.50			
33.	Miscellaneous Scheme	0.00	1.50	0.00			
34.	Scheme for Beggary Prevention	0.00	0.00	0.00			
35.	Assistance to all India Vol. Orgns. In the field of Social Welfare	0.00	0.00	0.00		—	—
36.	Grant in aid to School of Social Work	0.00	0.00	0.00			
	Total (C)	**49.57**	**67.50**	**54.72**			**76.50**
D.	**New Scheme**	-	-	-	15.	Scheme for Welfare of Working Children & Children in Need of Care and Protection	5.00
	Total (C+D)	**49.57**	**67.50**	**54.72**			**81.50**
	TOTAL - I (A to D)	**267.67**	**329.70**	**292.46**			**310.40**
II.	**CENTRALLY SPONSORED SCHEMES (CSS)**						
A.	**WELFARE OF THE DISABLED**						
37.	Employment of the Handicapped	0.97	1.60	1.54	-	Employment of the Handicapped (Awaiting NDC's approval)	3.60
38.	Regional Rehabilitation Centres	0.00	0.00	0.00		—	—
	Total (A)	**0.97**	**1.60**	**1.54**			**3.60**
B.	**SOCIAL DEFENCE AND OTHER DISADVANTAGED GROUPS**						
39.	Scheme for Prevention and Control of Juvenile Social Maladjustment	10.50	12.50	15.37	16.	Scheme for Prevention and Control of Juvenile Social Maladjustment	16.00
	Total (B)	**10.50**	**12.50**	**15.37**			**16.00**
	TOTAL - II (A+B)	**11.47**	**14.10**	**16.91**			**19.60**
	GRAND TOTAL - I + II	**279.14**	**343.80**	**309.37**			**330.00**

Note - 10% of the total outlay of the Ministry is earmarked for North Eastern States.

Annexure 5.13.2

Plan Outlay And Expenditure - Social Welfare(Women & Child Development, Welfare of Disabled and Social Defence) - State/Uts.

(Rs. Crore)

Sl. No.	Name of State/ Union Territories	Annual Plans			
		(2000-01)	(2001-02)		(2002-03)
		Actual	BE	Actual	BE
1	2	3	4	5	6
	STATES				
1	Andhra Pradesh	37.45	42.27	42.27	68.32
2	Arunachal Pradesh	1.52	1.56	1.76	6.00
3	Assam	3.25	3.10	3.10	0.00
4	Bihar	1.72	1.33	0.30	10.76
5	Chhattisgarh		5.00	5.00	19.25
6	Goa	3.22	4.61	4.61	34.50
7	Gujarat	0.00	53.50	47.85	54.26
8	Haryana	298.39	324.52	320.27	326.47
9	Himachal Pradesh	24.76	23.16	23.16	29.97
10	Jammu & Kashmir	15.69	16.98	16.98	22.66
11	Jharkhand		224.73	224.73	37.95
12	Karnataka	61.80	70.98	51.27	55.44
13	Kerala	4.00	6.55	3.50	22.00
14	Madhya Pradesh	12.97	14.04	14.09	15.62
15	Maharashtra	10.62	14.59	14.59	12.08
16	Manipur	0.53	3.82	2.95	7.33
17	Meghalaya	1.67	2.00	2.36	5.50
18	Mizoram	3.54	3.20	3.40	4.84
19	Nagaland	0.34	0.59	0.59	5.26
20	Orissa	18.88	15.48	8.12	46.44
21	Punjab	33.36	153.60	153.60	165.77
22	Rajasthan	7.64	19.43	19.73	20.66
3	Sikkim	2.31	2.30	2.61	3.70
24	Tamil Nadu	47.63	64.38	44.40	45.02
25	Tripura	6.38	3.86	8.48	13.14
26	Uttar Pradesh	80.63	81.86	70.13	118.38
27	Uttranchal	3.00	12.70	12.70	10.45
28	West Bengal	49.49	72.11	58.56	76.17
	TOTAL (States)	**730.79**	**1242.25**	**1161.11**	**1237.94**
	UNION TERRITORIES				
1	A & N Islands	0.94	1.25	1.25	1.90
2	Chandigarh	0.65	0.73	0.47	2.16
3	Dadra & Nagar Haveli	0.07	0.09	0.09	0.24
4	Daman & Diu	0.05	0.07	0.07	0.12
5	Delhi	28.68	38.50	38.50	51.60
6	Lakshadweep	0.24	0.24	0.17	0.44
7	Pondicherry	14.45	14.34	16.31	17.80
	TOTAL (UTs)	**45.08**	**55.22**	**56.86**	**74.26**
	GRAND TOTAL	**775.87**	**1297.47**	**1217.97**	**1312.20**

5.14 EMPLOYMENT, LABOUR WELFARE AND SOCIAL SECURITY (INCLUDING SKILL DEVELOPMENT)

The planning process attempts to create conditions for improvement in labour productivity and for provision of social security to supplement the operations of labour market. The resources are directed through the Plan programme towards skill formation and development, exchange of information on job opportunities, monitoring of working conditions, creation of industrial harmony through an infrastructure for healthy industrial relations and insurance against disease and unemployment for the workers and their families. The achievements of these desirable objectives in the areas of labour and labour welfare are determined primarily by the kind of labour market that exists.

2. A significant proportion of workers presently are earning below the subsistence wages. The slow down in the rate of population growth and increasing participation of the younger age-group in education are likely to moderate the growth of labour force and, to that extent, the pressure on the need for employment creation is reduced. However, considering the existing situations, one of the objectives of the Tenth Plan is to bring about a qualitative change in the structure and pattern of employment in terms of promoting growth of good quality work opportunities.

3. The situation of surplus labour, coupled with the employment of most of the workers in the unorganized segment of the economy has given rise to unhealthy social practices like bonded labour, child labour and adverse working conditions faced by the migrant labour. During the Ninth Plan period, elimination of these undesirable practices and aspects such as ensuring workers safety and social security, looking after labour welfare and providing the necessary support measures for sorting out problem relating to employment of both men and women workers in different sectors had received priority attention and the same effort would continue during the Tenth Five Year Plan.

Employment

4. In pursuance of the Prime Minister's announcement to the nation that the Government is committed to 'create ten crore employment opportunities over a period of ten years', the Planning Commission was entrusted with the responsibility of giving shape to this vision. To this end, the Planning Commission constituted a Task Force on Employment Opportunities in January 1999 under the Chairpersonship of Dr. Montek Singh Ahluwalia, the then Member, Planning Commission. The Task Force submitted its report in July 2001. However, in order to address the issues of under-employment through appropriate policy interventions at the sectoral and regional levels, Planning Commission constituted the Special Group on Targeting Ten Million Employment Opportunities per year under the Chairpersonship of Dr. S.P. Gupta, Member, Planning Commission. The Special Group has submitted its report in May 2002.

5. The Special Group examined the past and present situation of employment and unemployment of the country and also regional dimensions of the problem of unemployment. The group has also made projections of Labour Force and Work

Opportunities for the Tenth Plan (2002-07) by using Current Daily Status (CDS). Alternative scenario to increase employment generation with little changes in policies is also given. The Group has observed that if the employment elasticities observed in the past continue, even the rate of growth of 8% per annum will not be sufficient to achieve the Tenth Five Year plan target of providing gainful high quality employment to the addition to the labour force. The Group has, therefore, suggested restructuring of sectoral growth profile in favour of more labour intensive sectors.

6. The Special Group has recommended encouragement to growth in labour intensive sectors such as agriculture, food processing, small and medium enterprises, Khadi and Village Industries, construction and services sectors including health, nutrition and education, etc.

7. The difference in the magnitude of unemployment is considerable if CDS and UPSS bases are compared. As per CDS concept, about 26.58 million person years are estimated as unemployed on an average working day in the year 1999-2000(NSSO 55th round). Incidence of unemployment on CDS basis in 1993-94 (50th round) was estimated at 6%. Compared to 2.2% unemployment rate on Usual Principal and Subsidiary Status (UPSS) basis in 1999-2000, incidence of unemployment on CDS basis at 7.3% in 1999-2000.

8. Concept of Usual Principal Status (UPS) has been used in 8th Plan. Concept of Usual Principal and Subsidiary Status (UPSS) has been used in 9th Plan. However, UPSS has been seen as most liberal approach because a large number of underemployed get included in the definition of employed in this concept. Current Daily Status (CDS) approach includes underemployed in the number of unemployed. In the 10th Plan, gainful employment is considered as one of the primary objectives. CDS concept has been considered better because it not only captures the unemployed persons but also captures underemployed to some extent. CDS is closer to the real situation prevalent in the country on unemployment. It is also closer to the level of poverty in the country

Labour & Labour Welfare

9. Labour sector addresses multi-dimensional socio-economic aspects affecting Labour welfare, productivity, living standards of labour force and social security. To raise living standards of the workforce and achieve higher productivity, skill up-gradation through suitable training is of utmost importance. Manpower development to provide adequate labour force of appropriate skills and quality to different sectors is essential for rapid socio-economic development. Employment generation in all the productive sectors is one of the basic objectives. In this context, efforts are being made for providing the environment for self-employment both in urban and rural areas. Steering Committee on Labour & Employment has suggested the following important recommendations for the Tenth Plan.

Employment

- To bring about a qualitative change in the structure and pattern of employment in terms of promoting growth of good quality work opportunities.

Skill Development & Training

- Creation of adequate training facilities for organized sector and to develop skill requirement according to demand in industry of use
- Creation of more avenues and opportunities for training in respect of informal sector.
- Increase of Industry- Institute interaction for demand driven skill development
- Creation of skill development fund mainly funded and managed by industry for improvement and effectiveness of training programme.
- Multi-level skill training for sustainability of work force in job in the modern age of technological changes and globalization.

Occupational Safety & Health

- To bring a general legislation (Umbrella) on OSH with a view to provide a focus on OSH measures in Industry.

Social Security

- To provide social security to the organized as well as the unorganized sector workers on self-sustaining and self-financing basis without putting any additional pressure on the budget of the government.
- To provide social security to landless agricultural workers and to motivate the State governments to initiate the programme on economic up-liftment of landless agricultural workers.

Vulnerable Groups

- To create strong awareness generation amongst the migrant labourers and ensure effective implementation of the Inter-State Migrant Workmen Act, 1979.
- Creation of a strong awareness generation amongst the building and other construction workers regarding their protection of rights and provisions made in various labour laws and schemes for their welfare.

Plan outlay and its utilization

10. Ministry of Labour and Labour & Labour Welfare Departments at State level through various plan schemes aim at achievement of plan targets relating to labour and employment sector. Annual Plan 2001-02 outlay for last year of the 9th Plan for this sector was Rs. 145 crore for the Central Plan under Ministry of Labour and Rs. 291.11 crore in the State's Plan against which anticipated expenditure is Rs. 137.87 crore in Central Sector and Rs. 262.02 crore for State Sector Plans.

11. The major part of the plan budget of the Ministry of Labour relates to the scheme - Elimination of Child Labour through the National Child Labour projects scheme, Rehabilitation of Bonded Labour, schemes of DGE&T – programmes relating to

Employment Services, Vocational Training Schemes and Vocational Rehabilitation Centres for the Handicapped. Research and Statistics on labour related subjects, schemes for improving working conditions of Mines and Factories, social security and safety in work places are the other important plan schemes **(**For Labour and Labour Welfare Sector outlay refer to Annexure 5.14.1 for Central Sector and Annexure 5.14.2 for State Sector).

Rationalization of Plan schemes under Ministry of Labour.

12. As a follow up of the Finance Minister's Budget Speech for 2001-02 and in order to implement the decision of the National Development Council taken in its last meeting on 1.9.2001 which was chaired by the Prime Minister, the Planning Commission has undertaken a zero based budgeting exercise. With a view to optimizing and containing the growth of govt. expenditure and deploying scarce resources in a more cost effective manner, Zero Based Budgeting exercise was carried out for the schemes of the Ministry of Labour.

13. On the basis of the information supplied by Ministry of Labour and after taking into account the views of the Ministry regarding Centrally Sponsored Schemes and Central Sector Schemes, it has been decided that there will be 28 Central Schemes (i.e. 27 Central Sector Schemes and 1 Centrally Sponsored Scheme) ongoing 9th Plan Schemes to be continued during 10th Plan.

National Employment Service

14. National Employment Service covers all the States and Union Territories and functions within the framework of the Employment Exchanges (compulsory notification of vacancies) Act, 1959. Year-wise registration, placement, vacancies notified, submission made and live register for the period 1991 to 2001 (January to August) may be seen in the Annexure 5.14.3**.** Day to day administration of the Employment Exchanges is with the States/UT. Ever since its inception, the network of employment service has extended from 18 Employment Exchanges to 938 as on 31-8-2001. In selected 23 Employment Exchanges, special cells for promotion of self-employment have been working. To give vocational guidance to job seekers, 360 vocational guidance units and 82 University Employment Information Bureau continue to function. To maintain organized sector labour market information, Employment Market Information (EMI) programme is being implemented. A total of 2.82 lakh establishments (in Public Sector & non-agricultural establishments in the Private Sectors, employing 10 or more workers) have been covered under the EMI programme.

15. The employment service continues to pay special attention to the needs of the weaker sections of the society. To provide vocational training and guidance in confidence building to SCs/STs, 22 coaching cum guidance centers continued to function in different parts of the country. These centers were also engaged in arranging the pre-recruitment training programme to improve employability of SCs to STs in competitive examination conducted by Staff Selection Commission, Banking Service Recruitment Board, etc. for Group 'C' and equivalent posts.

16. A comprehensive package of services is provided to the disabled by 17 Vocational Rehabilitation Centres (VRCs). Out of these, the VRC at Vadodara has been set up

exclusively for the disabled women. These centers evaluate the residual capacity of the disabled and provide them adjustment training and facilitating their early economic rehabilitation. Efforts are also made to assist them in obtaining other suitable rehabilitation services such as job placement and training for self-employment. Rehabilitation services are also extended to the disabled living in rural areas through mobile camps and rural rehabilitation extension centers set up in 11 Blocks under 5 VRCs at Chennai, Kanpur, Kolkata, Ludhiana and Mumbai.

Welfare of Labour

17. The improvement of labour welfare and increase in productivity with reasonable level of social security is one of the prime objectives concerning social and economic policies of the government. The resources have been directed through the Plan programmes towards skill formation and development, monitoring of working conditions, creation of industrial harmony through infrastructure for health, industrial relations and insurance against disease, accident and unemployment for the workers and their families. In the area of industrial relations, the enforcement and adjudication machinery has been strengthened to cope up with the increasing work. There are 17 Central Government Industrial Tribunal (CGIT)-cum-Labour Courts dealing with the industrial disputes in respect of which the Central Government is the appropriate government. State and UT governments have also set up Industrial Tribunal and Labour Courts for adjudicating industrial disputes. In order to reduce and tide over the pending cases, a Lok Adalat is being set up in CGITs.

18. To extend a measure of social assistance to workers in the unorganized sector, 5 Welfare Funds viz., Beedi, Cine, Mica Mines, Lime Stone and Dolomite Mines and Iron, Manganese ore and Chrome ore have been evolved and are being administered by the Ministry of Labour. These Welfare Funds continue to provide assistance for housing, medical care, educational facilities to workers employed in beedi industry, cine industry and in certain non-coal mines. Efforts are being made to substantially extend the welfare fund approach to cover more categories and sub-categories of workers in unorganized sector workers such as Tendu Patta pluckers, fish processing industry workers and salt industry workers.

19. The labour laws enforcement machinery in the States and at the Centre are working to amend the laws which require changes, revise rules, regulation orders and notifications. The Industrial Dispute Act, 1947 has been revised and approved by the Cabinet in 2002.

Vocational Training & Skill Development

20. Central Government and the State Governments share responsibilities for vocational training, being a concurrent subject. At the national level, Directorate General of Employment & Training (DGE&T), Ministry of Labour is the nodal Department for formulating policies laying down standards, conducting trade testing and certification, etc. in the field of vocational training. A number of training institutions are also run by the DGE&T. At the State level, the State Govt. Departments are responsible for vocational training programmes. National Commission advises the Central Govt. for Vocational Training (NCVT), a tripartite body, to have representatives from employees, workers and Central/ state Government. At State level also, the representative of the State Governments

constitutes similar Councils known as the State Councils for Vocational Training (SCVT)for the same purpose.

21. The Vocational Training System under the Ministry of Labour (DGE&T) is one of the most comprehensive training system in the country. Under the system, the Craftsmen Training Schemes (CTS) and Apprenticeship Training Schemes (ATS) are two important schemes. At present 17800 establishments are imparting apprenticeship training. The Craftsmen Training Scheme and Apprenticeship Training Scheme are adequately dovetailed and meant to bring maximum benefit to the youth. A number of other departments have also started training activities for their respective sectors e.g. Small Industry, KVIC, handlooms, tourism (hotel management & catering), electronics, medical technicians, agriculture and rural development. These training schemes are smaller but serve a very useful and essential purpose in the overall sphere of vocational training. In spite of difficulties and shortcomings, the Vocational Training Schemes have continued to make progress especially in terms of being the primary source of manpower for the industry.

22. Under craftsmen training, 191 new ITIs have come up during 2001-02. Starting from 54 ITIs in 1953, the number of training institutes functioning have gone upto 4465, out of which 1733 are in government sector and the remaining 2732 are in the private sector (Number of ITIs/ITCs with seating capacity in various States/UTs may be seen at Annexure 5.14.4). These institutes have a total seating capacity of 6.52 lakhs, out of which 54.8% are in government ITIs. To reduce unemployment among educated youth and equipping them with suitable skill for industrial employment, the Craftsmen Training is imparted in 43 Engineering and 24 Non-engineering trades.

23. To provide training facilities to women in employable skills and for taking up self-employment income generating activities, training facilities exclusively for women are continued to be imparted through a National Vocational Training Institute for Women (RVTI). The present training capacity of these institutes is 2068. In the State sector, skill training to the women are continued to be provided through a network of 244 women exclusive ITIs and Special Wings for women in 520 general ITIs with seating capacity of 46,070 (State-wise distribution of Women ITIs and Special Wings for Women in General ITIs may be seen at Annexure 5. 14.5**).**

24. To strengthen the Industrial Training Institutes in Jammu and Kashmir, a Study on modernization and strengthening of vocational training in the State has been conducted in Jan, 2001 by Nettur Technical Training Foundation (NTTF), Bangalore. The Study has recommended for discontinuation of unpopular trades and introduction of new need-based job-oriented training programmes which have local relevance. Based on the findings of the Study, Ministry of Labour has formulated and submitted a Centrally Sponsored Scheme for consideration of the Planning Commission. This will help to tackle the problem of unemployment amongst youth in the State of J&K.

25. In the North-Eastern States, a Centrally Sponsored Scheme has recently been launched to strengthen and sustain high quality infrastructure in the existing 35 ITIs and also to set up 22 new ones. The scheme aims for doubling the existing seating capacity in the North Eastern States and Sikkim and create infrastructure for the training of youth in the identified skill area as per the demand pattern.

Industrial Relations

26. Central Industrial Relation Machinery (CIRM) is an attached office of the MOL. The functions of CIRM broadly consist of settlement of industrial disputes, enforcement of labour laws in Central sphere and verification of membership of trade unions. During the yearn 2001-02, CIRM intervened in 630 threatened strikes and its conciliatory efforts succeeded in 622 strikes which represents a success rate of 98.7%.

27. Another important function of CIRM is enforcement of labour laws in the establishments for which Central Govt. is the appropriate Government. These are approximately 1.5 lakh establishments in the Central spheres. The inspecting officers of CIRM inspect these establishments under different labour enactments. During the year 2001-02, CIRM officers carried out 344682 inspections, rectified 360712 irregularities and launched 16040 prosecutions.

Indian Labour Conference

28. The 37th Session of Indian Labour Conference was held on 18-19 May, 2001 under the Chairmanship of Union Labour Minister, Hon'ble Prime Minister inaugurated the Conference. The following agenda items were discussed in the Conference:-

- Impact of Globalization on Indian Industry, Labour & Employment.
- Social Security of Workers.
- Consultation by Central Government with Social partners on Labour Policy.

29. During the Conference Central Trade Unions were quite vocal about their apprehensions on the impact of globalization on the Indian economy. They were also critical of the announcement regarding some labour reforms made in Union Budget. Prime Minister made it clear in his address that process of economic reforms would not be reversed. However, the genuine interests of workers would be protected.

National Commission on Labour

30. The Second National Commission on Labour, which was set up on 15.10.1999, has submitted its report in July, 2002. The terms of reference of the Commission were – i) to suggest rationalization of the existing laws relating to labour in the organized sector; and ii) to suggest umbrella legislation for ensuring a minimum level of protection to the workers in the unorganized sector. The Commission has also dealt with the emerging economic environment involving rapid technological changes, globalization of economy, liberalization of trade and industry, basic institutional framework for ensuring minimum level of labour protection & welfare measures, improving the effectiveness of measures relating to social security, occupational safety and health, minimum wages, etc. The report is under examination in the Ministry of Labour.

Labour Statistics

31. The importance of accurate, timely and detailed statistics and research relating to various aspects of labour activities for taking policy decisions need not be emphasized.

Labour Bureau (MOL) is premier agency in the collection, analysis and dissemination of labour statistics at all India level on different facets of labour. Labour Bureau has two wings, four Regional Offices and one sub-regional office at Chandigarh, Shimla (wings), Ahmedabad, Kolkata, Chennai, Kanpur (Regional Office) & Mumbai (Sub-Regional Office).

32. Labour Bureau compiles and maintain following three price indices on monthly basis.

a) Consumer Price Index for Industrial Workers (Base 1982-83=100)

b) Consumer Price Index for Rural Labourers as well as for its subset, Agricultural Labourers (Base 1986-87=100)

c) Retail price Index for selected 31 Essential Commodities in urban areas. (Base 1982=100).

33. Labour Bureau also collects, compiles and disseminates labour statistics on different facets of labour based on annual statutory returns received by Labour Bureau from various States and U.T. authorities under the provisions of various labour enactments and voluntary statistics relating to industrial disputes, closure, lay off and retrenchment furnished every month by State and Central Labour Departments to Labour Bureau.

34. The consumer Price Index for Industrial Workers which determines the dearness allowance of workers, Government employees, etc. is presently being compiled with a two decade old base 1982 to up-date the base year main survey for collection of income and expenditure data from all the 78 selected Centres has been completed and tabulation data is under progress. The new series is expected to be available by mid 2003. During the year 2001-02, Labour Bureau released 28 publications on Labour Statistics, Labour Laws, evaluation of implementation of minimum wages and occupation wage survey, etc.

Elimination of the problem of Child Labour

35. According to the 1991 census, the estimated figure of working children in our country was 11.28 million as against the 13.4 million in 1981 census. As per the 55th Round of NSSO Survey, the number of working children is 10.5 million. Although Government's interventions have been able to tackle the problem of child labour significantly, particularly, the organized sector, efforts are needed to address the problem in the unorganized sectors. The State with the highest child labour population in the country is Andhra Pradesh, which according to the 1991 census had 1.66 million working children. Other States where the child labour population is more than one million are Madhya Pradesh, Maharashtra and Uttar Pradesh. More than 90% of child labour is engaged in rural areas, in agriculture and allied activities.

36. To assess the number of working children in the district, including children working in hazardous occupation and children working for a wage, and impact of development effort on problem of child labour, a concurrent survey needs to be carried out in the Tenth Plan.

37. The existence of child labour in hazardous industry is a big problem. Non-availability of accurate, authentic and up-to-date information on child labour has been the major handicap in planned intervention for eradication of the social evil. Among the existing Plan schemes designed to make effective intervention to prevent the abuse of child labour are

the National Child Labour Projects (NCLP) initiated in the areas of concentration of child labour to rehabilitate the children withdrawn from work. At present, 100 NCLPs are under implementation covering about 2.11 lakh children in 13 child labour endemic states engaged in glass, brassware, locks, carpets, slates, tiles, match and fire work, gems, agro-chemicals, beedi industries, etc. (State-wise coverage under NCLP is given in Annexure 5.14.6). One of the important components of the project is establishment of special schools to cater to the basic needs of children withdrawn from work, such as non-formal education, vocational training and supplementary nutrition. A National Authority for Elimination of Child Labour, which was set up earlier, is working towards convergence of services under various Central Ministries and Departments of the State Governments, which implement child related programmes.

38. In addition to above initiatives, India has been participating in the ILO's International Programme for the Elimination of Child Labour (IPEC). IPEC is a global programme launched by the ILO in December, 1991. India was the first country to join it in 1992 when it signed a MOU with ILO. The budget committed under IPEC for programmes in this country from 1992-2002 is US $ 5.1 million. Altogether 165 action programmes were taken up for implementation under IPEC during 1992-2001 while the programme initially focussed on small initiatives through NGOs and other social partners, it is now attempting an area based approach through the Government's NCLPs in 6 districts in the country. A total of 11 projects (including 6 area based projects) are currently under implementation in the country under IPEC.

Women Labour

39. Programmes for women labour include action oriented projects and studies, organization of Child Care Centres and welfare projects for women engaged in construction activities, etc. Important amongst schemes for workers education are the programmes for the education of rural workers for creating awareness about their socio-economic environment, need for developing their own organization and about the benefits available under various welfare and credit scheme.

Rehabilitation of Bonded Labour

40. To deal with the rehabilitation of the bonded labourers, the Govt. of India launched Centrally Sponsored Scheme since May, 1978 for rehabilitation of bonded labourers. Under the scheme rehabilitation assistance of Rs. 20000 per freed bonded labour is provided which is shared by the Central and State Govt. on 50:50 basis, in case of the seven North Eastern States, 100% Central Assistance if they express their inability to provide their share. Under the modified scheme, 100% subsidy for conducting district wise surveys of bonded labourers, awareness generation activities, evaluation studies are provided to the State Govts. / U.T.s. Since operation of the Centrally Sponsored Scheme from May, 1978 up to 30.12.2001 as many as 2,82,204 bonded labourers have been identified out of which 2,60,783 have been rehabilitated and a sum of Rs. 6293 lakhs provided as Central assistance to various Governments / UTs for their rehabilitation . Details of Bonded Labourers identified and rehabilitated may be seen at Annexure 5.14.7.

Occupational Safety & Health

41. The Constitution of India contains specific provisions for the occupational safety and health of workers. Director General of Mines Safety (DGMS) and Director General Factory Advice Service & Labour Institutes (DGFASLI) strive to achieve occupational safety and health in mines, factories and ports. The schemes relating to Occupational Safety and Health concentrates on improvement of work environment, man machinery interface, control and prevention of chemical hazards, development of protective gear and equipment, training in safety measures and development of safety and health information system.

Directorate General of Factory Advice, Service and Labour Institute (DGFASLI)

42. This organization functions as the technical area of the Ministry in matters concerning with safety, health and welfare of workers in factories and ports/docks. In keeping with DGFASLI's pioneering role in the field of industrial safety and health, seventy eight Seminars/Workshops and longer duration Training Programmes were conducted for 1574 participants from 660 organizations during 2001-02. Labour Institutes in Mumbai, Kanpur, Kolkata and Chennai conducted 201 appreciation programmes for 3630 beneficiaries on safety, health and welfare. Mobile safety exhibitions were set up at 16 factories benefiting 15000 factory workers. DGFASLI completed 38 consultancy studies in the areas of hazardous assessment, environment assessment, safety audit, assessment of occupational health status at the request of various organizations.

Directorate General of Mines Safety (DGMS)

43. The Directorate General of Mines Safety is a subordinate office under the Ministry of Labour with its Head Quarter at Dhanbad (Jharkhand) and is headed by the Director-General who is assisted by specialist staff-officers of Mining, Electrical and Mechanical Engineering, Occupational Health, Law, Survey, Statistics, Administration and Accounts discipline. The Head Quarter also has a Technical Library and S&T Laboratory as a back-up support to the organization.

44. DGMS completed the first 100 years of its existence on 7th January, 2002. Beginning as the Bureau of Mines Inspection in 1902, the DGMS gradually expanded its role and functions. From inspections and enquiries it moved on to development of safety standards, enquiries into occupational health, permissions and approval of equipment, and ensuring appointment of competent persons in the mining industry. A solid body of technical know-how on mine safety was built up through in-house S&T efforts, observations during inspections and enquiries and interaction with CMRI and other institutes. Through a many-pronged approach of enforcement, legislative change, emergency responses and promotion of safety awareness, a sustained thrust on strengthening of mines safety was maintained. As a result of this thrust, the manifold growth of the mining industry in the last century was accompanied by a steady decline in fatality rates, especially since the 1950's. Much, however, still remains to be done. Committees which have studied the functioning of DGMS have recommended its strengthening by sanction of additional manpower. Occupational health surveillance has still a long way to go. The goal of zero accidents is also yet to be reached.

45. During the year following activities were undertaken at DGMS.

i) A project for "Training of DGMS officials in mines safety" is being executed in collaboration of Govt. of Australia since June 1997. The project was granted an one year extension during which period it was planned to be used as industry examples in India in October,2000. The Indian project management team visited Australia for review of the results of DGMS training officer for exposing him to Australian mining and mine safety practices under the project.

ii) Two days seminars on Mines Safety were organized in each Zone of the DGMS; namely at Ajmer in North Zone, Bhubaneshwar in South Eastern Zone, Sitarampur in Eastern Zone, Chennai in Southern Zone, Nagpur in Western Zone and at Dhanbad in Central Zone.

iii) Compendium on Mines Safety was published.

iv) Number of technical manuals on DGMS were prepared and released on 7.1.2002.

Social Security

46. In India, social security measures draw their strength from the Directive Principles of State Policy, which inter-alia, enjoins upon the State, to strive to promote the welfare of the people by securing and protecting, as effectively as it may, a just economic and social order.

47. To provide social security measures to the workers, the Government has enacted and established schemes (by the Central/State) providing for social security and welfare of specific categories of working people. The principal social security law enacted centrally, are the following:

- The Workmen's Compensation Act, 1923
- The Employees State Insurance Act, 1948
- The Employees Provident Funds and Miscellaneous Provisions Act, 1953
- The Maternity Benefit Act, 1961
- The Payment of Gratuity Act 1972

Initiatives to Accord Larger Benefits to Workers Under EPF & MP Act and ESI Act

Several initiatives have recently been taken up to accord larger benefits to workers under EPF & MP Act and ESI Act as detailed below:

EPFO

- Arrangements have been made for the first time for disbursement of pension through 26,000 Post Offices across the country under the Employees' Pension Scheme.
- Special drive launched and 54,983 establishments brought under the compliance fold and 54,51,436 deprived workers extended the Provident Fund benefits.

- Additionally, 23,639 new establishments have been brought under the fold of the Act and 44.39 lakh workers enrolled to the Provident Fund membership.
- The number of subscribers has increased to 2.59 crore. EPFO is targeting to substantially increase the number of subscribers under the Scheme in the near future.
- EPFO has also launched a Website for the beneficiaries.

ESIC

- Employees State Insurance (ESI) Scheme has been implemented in 125 new geographical areas in 9 States benefiting about 2.40 lakh additional employees.
- ESIC has exempted insured persons earning up to Rs. 40/- a day from the payment of employees contribution w.e.f. 1st April, 2001. Over six lakh workers would benefit from this.
- Dependent and disability benefits under ESI scheme have been increased ranging from 14% to 23.59%.
- ESIC has decided to upgrade one hospital into a model hospital in each State with state-of-the art medical facilities.
- ESIC has introduced family photo Identity cards in respect of insured persons from April 2001.

48. At present, to provide social security to some of the unorganized sector workers, welfare funds for various target groups have been set up by the government without burden on the budget. The Central Government through the Ministry of Labour, also operates at present Five Welfare Funds for Beedi workers, Limestone & Dolomite Mine workers, Iron ore, Chrome ore & Manganese Ore Mine workers, Mica Mine workers, Cine workers. These welfare funds have been developed by way of collecting Cess from the persons who are selling the finished products. To provide social security to fish processing workers, salt workers etc. this type of Welfare Fund is under consideration.

49. To extend social security to the rickshaw pullers in Jaipur, an experiment has been carried out by ESIC and if it gets successful, throughout the country this group can get benefit. In addition to the Central Govt., a number of State Govts. have also taken several initiatives to extend social security for unorganized sectors. Recently, the Government of West Bengal introduced State Assisted Scheme of Provident Fund for Unorganized Workers (SASPFUW). The scheme covers all wage employed and self-employed workers between the age of 18 to 55 years in the unorganized sector having an average family income of not more than Rs. 6500 per month. Each subscriber worker contribute a sum of Rs. 20 per month and equal matching amount contributed by the State Government. Similarly, the Govt. of Punjab has been implementing a Social Security scheme for farmers and labourers in case of death or injury on duty. To extend social security cover to manual worker, auto-rickshaws, washermen, tailoring workers, handcraft workers etc. the Govt. of Tamil Nadu has introduced a new Social Security and Welfare Scheme-2001. In addition to Governmental efforts, several public institutions and agencies are also providing various kinds of social security benefits to the selected groups of workers.

Welfare of Agricultural Labour

50. In order to meet the social security needs of the agricultural workers, a social security scheme viz. "Krishi Shramik Samajik Suraksha Yojana – 2001" formulated by the Ministry of Labour in consultation with the Insurance Division of Ministry of Finance was launched on 1.7.2001. The agricultural workers between the age of 18 to 50 years would be eligible under the Scheme. The workers will contribute Rs. 365/- per year (Rupee one per day) and the Government of India will contribute Rs. 730/- per annum per worker. A total of 10 lakh agricultural workers has been proposed to be covered in 50 districts of the country. Though the scheme is yet to be placed before the EFC, presently, the scheme is being funded through Social Security Fund of India.

Workers Education

51. The Central Board for Workers Education (CBWE), Nagpur, sponsored by the Ministry of Labour, Government of India was established in 1958 to implement workers education scheme at National, Regional, Unit and Village Levels. The primary objective of workers education scheme is not only to make the workers more knowledgeable but also to tackle the issues connected with industrial relation to mould their thinking.

52. To suggest ways and means to enrich and redefine the concept of Workers' Education, possibility of widening its scope and to meet the challenges of the country on account of globalization, a Committee was constituted to study the up-gradation / restructuring of CBWE in May, 2001. The Committee is expected to submit the report very soon.

53. The Central Board of Workers Education through its Regional Offices is striving to educate the workers to help to avoid wasteful expenditure, adopting cost effectiveness and enhancing production of qualitative nature. They have been conducting the following programmes:

- Rural Awareness Programme
- Functional Adult Literacy Classes
- Short-term programmes for the unorganized sector to educate them on their rights, ethics and hygiene
- Participative Management
- Orientation Courses for Rural Educators
- Leadership Development Programme for Rural Workers.

Labour Research and Training

54. V.V. Giri National Labour Institute a fully funded autonomous body of the Ministry of Labour conducts action-oriented research and provides training to grass root level workers

in the trade union movement, both in the urban and rural areas, and also to officers dealing with industrial relations personal management, labour welfare, etc.

55. V.V. Giri National labour Institute completed 32 research projects in the areas of labour market, employment and regulations, agrarian relations and rural labour, integrated labour history, child labour and prevention of HIV/AIDS in the work place. There are as many as 33 projects under various stages of progress. The Institute also organized 50 training programmes covering 1107 participants. Besides 4 regular publications, the Institute also brought out occasional papers including 8 research studies. The Institute proposes to undertake on an average 25 research projects and 75 training programmes every year during 10th Five Year Plan.

Institute of Applied Manpower Research (IAMR)

56. The Institute of Applied Manpower Research (IAMR) was established in 1962 as an autonomous organization under the Societies Registration Act of 1860. The main mandate of IAMR is to evolve an institutional framework capable of sustaining and steering of systematic manpower planning process. The Labour, Employment and Manpower of the Planning Commission is the nodal Division for the activities relating to the Institute. The Chief Executive of IAMR for its day-to-day management is the Director and the academic activities of the institute are being carried out through various technical units, dealing with research on various sectors – training national and international, education, etc.

Field of Academic & Research Activities

57. Besides research, technical manpower planning, IAMR also conducts a 9-month diploma course and one-year master's degree course in Human Resource, Planning & Development with affiliation from Guru Gobind Singh Indraprastha University. The Institute envisioned, conceptualized and developed a range of academic activities in the field of human resource planning and development, including research, consultancy, information system, training and workshops, seminars and conferences.

58. Research activities of IAMR mainly lay stress on rural and urban employment and unemployment, establishment of computerized labour market information systems, relevance of technical and vocational education (in service and continuing education) to upgrade knowledge and skill component, development of skill among women, self-employment generation, human resource development (HRD), issues of decentralized governance and development, emerging areas of science and technology, rural industrialization, manpower dynamics in agriculture and rural development and impact assessment of social sector development programmes. These activities are carried out by various Units/Cells to achieve continued thrust in direction on major research areas, viz. Employment and Unemployment; Science, Technology and Industry; Human Resource Development; Social Concerns and Manpower Information Systems.

The Plan Outlay & Expenditure for IAMR

(Rs. lakh)

Outlay	Year (2000-01)			Year (2001-02)
	BE	**RE**	**Expenditure**	**BE**
Plan Capital	1500	500	432.09	750
Plan Revenue	50	2	Nil	50

Development of New Campus at Narela

59. A new Campus for the Institute is coming up at Narela (35 km from Central Delhi) on a 15.12 acre plot. Cost of the building project is Rs. 16 crore (approx.). The inauguration of Computer Management Block at Narela Campus was done by Hon'ble Deputy Chairman, Planning Commission on 5th October, 2001. The Campus is expected to be fully functional this year.

RESEARCH & TRAINING ACTIVITIES

Continuing programmes

60. Manpower Profile India Year Book: A compiled information on various aspects of manpower related to different sectors is brought out annually. The Year Book 2001 was brought out during the year.

61. National Technical Manpower Information System (NTMIS) continued compilation of information on technical manpower is done with the aid of All India Council of Technical Education (AICTE), Ministry of Human Resource Development (HRD) and Government of India.

Spillover Studies

62. An amount of Rs. 50 lakh was sanctioned in March, 2001 to the Institute of Applied Manpower Research (IAMR) as a grant-in-aid under Plan (capital account) with the purpose of conducting special studies in the thrust area "Impact of Economic Reforms and Employment" with an objective to promote research competence by (1) taking up a set of studies in house of IAMR and by commissioning papers in consultation with the LEM Division of Planning Commission and (2) developing IAMR research personnel in the thrust area "Impact of Economic Reforms and Employment".

63. The output of the scheme will be a set of research reports, which are useful to Planning Commission, State Govt., and Ministry of Labour and the ministries in charge of Programme and Planning in various sectors leading to employment creation.

Annexure 5.14.1 contd.

Ministry of Labour (Annual Plan 2002-2003)

(Rs. Lakh)

Sl. No.	Division/ Scheme	Approved Outlay Ninth Plan (1997-02)*	Actual Exp (1997-2000)	Approved Outlay (2000-01)	Actual Exp (2000-01)	Approved Outlay (2001-02)	Anticipated Exp. (2001-02)	Approved Outlay (2002-03)
1	2	3	4	5	6	7	8	9
1	Employment Directorate	3700.00 (cw2200)	1551.18 (cw1340)	1600.00 (cw900)	1011.73 (cw900)	351.00 (cw1)	195.77	1273.00 (CW 1200.00)
2	Training Directorate							3281.00 (CW 541.00)
	(a) World Bank Projects	18700.00 (FA9000)	9914.79 (cw170)	1532.00 (cw500)	486.93 (cw500)	715.00	1475.01	
	(b) Women Training Schemes	1820.00	1666.76 (cw260)	480.00 (cw280)	801.68 (cw260)	959.00 (cw544)	762.86	
	c) Other Training Schemes	9620.00 (FA1746)	2865.22 (FA 122.66)	1510.00 (FA 75) (cw260)	861.79 (FA 65)	2312.00 (FA 47) (cw189)	935.03	
3	Child Labour	24960.00	7858.53	3600.00	3798.69	6700.00	6760.00	7010.00
4	Women Labour	100.00	35.98	20.00	14.09	20.00	20.00	46.00
5	Industrial Relations	3856.00	1010.57 (cw150)	550.00 (cw160)	710.98 (cw160)	600.00 (cw202)	594.81	241.00
6	Workers Education (CBWE)	1500.00	670.00	468.00	422.00	425.00	425.00	700.00
7	Labour Statistics (Labour Bureau)	3000.00	1765.54	800.00	668.42	750.00	860.82	
8	Mines Safety (DGMS)	4000.00	616.60	497.00 (cw300)	137.33	200.00	322.00	300.00
9	Industrial Safety (DGFASLI)	2500.00	551.67	298.00 (cw100)	139.47	270.00 (cw100)	262.5	450.00 (CW 200.00)
10	Labour Research (NLI)	1075.00	550.00	265.00	241.00	250.00	250.00	265.00
11	Grant-in-aid To Research & Acadimic Instts./ NGOs	100.00	33.03	30.00	17.83	20.00	20.00	20.00
12	Rehabilitation of bonded Labour	3581.00	981.00	575.00	920.64	603.00	603.00	200.00
13	Housing Scheme for Hamals	200.00	0.00	0.00	0.00	0.00	0.00	
14	Information Technology (New)	250.00	66.11	75.00	48.00	100.00	100.00	100.00
15	Training to the Personnel of the Ministry	50.00	0.00	0.00	0.00	25.00	0.00	10.00
16	Modernisation of Sections	50.00	0.00	0.00	0.00	50.00	50.00	50.00
17	Awareness Generation on Labour Welfare and Development	50.00	0.00	0.00	0.00	50.00	50.00	150.00
18	Welfare Scheme for Agricultural workers.	100.00	0.00	0.00	0.00	100.00	100.00	300.00

Annexure 5.14.1 contd.

Ministry of Labour (Annual Plan 2002-2003)

(Rs. Lakh)

Sl. No.	Division/ Scheme	Approved Outlay Ninth Plan (1997-02)*	Actual Exp (1997-2000)	Approved Outlay (2000-01)	Actual Exp (2000-01)	Approved Outlay (2001-02)	Anticipated Exp. (2001-02)	Approved Outlay (2002-03)
1	2	3	4	5	6	7	8	9
19	Overall Direction & Administration							418.00 (CW 200.00)
20	New Initiative in the 10th Plan - CS							285.00
21	New Initiative in the 10th Plan - CSS							100.00
22	Schemes to be transferred under Non - Plan							1803.00
	Total	**79212.00 (FA 10746)**	**30136.98 (FA 122.66) (cw 1920)**	**12300.00 (cw 2500) (FA 75)**	**10280.58**	**14500.00 (cw 1036) (FA 47)**	**13786.80**	**17000.00 (CW 2141.00)**

* Ministry of Labour reallocated its intitial 9th Plan Outlay to meet more fund requirements in some schemes
FA. :- Foreign Aid Component
CW :- Civil Works Component

Annexure 5.14.2

Labour & Labour Welfare Outlay

(Rs. Lakhs)

Sl. No.	State/U.T.	Annual Plan 2001- 02 Approved Outlay	Revised Outlay
1	**2**	**3**	**4**
1	Andhra Pradesh	888.00	888.00
2	Arunachal Pradesh	126.00	136.00
3	Assam	2869.00	2869.00
4	Bihar	248.00	248.00
5	Chattisgarh	1045.00	1045.00
6	Goa	469.00	469.00
7	Gujarat	5500.00	4919.00
8	Haryana	2043.00	2092.00
9	H.P.	154.00	154.00
10	Jammu & Kashmir	1045.00	1045.00
11	Jharkhand	-	-
12	Karnataka	1880.00	1815.00
13	Kerala	720.00	500.00
14	Madhya Pradesh	1015.00	874.00
15	Maharashtra	4503.00	3924.00
16	Manipur	91.00	91.00
17	Meghalaya	120.00	88.00
18	Mizoram	75.00	74.00
19	Nagaland	168.00	128.00
20	Orissa	208.00	240.00
21	Punjab	573.00	573.00
22	Rajasthan	1013.00	886.00
23	Sikkim	30.00	24.00
24	Tamil Nadu	314.00	270.00
25	Tripura	40.00	40.00
26	Uttar Pradesh	1253.00	331.00
27	Uttaranchal	299.00	299.00
28	West Bengal	1080.00	877.00
	Total (States)	**27769.00**	**24899.00**
	UTs		
29	A & N Islands	67.00	67.00
30	Chandigarh	32.00	32.00
31	D & N Haveli	26.00	26.00
32	Daman & Diu	27.00	27.00
33	Delhi	821.00	821.00
34	Lakshadweep	29.16	29.16
35	Pondicherry	340.00	301.00
	Total (UTs)	**1342.16**	**1303.16**
	All India	**29111.16**	**26202.16**

Source: Figures obtained from State Plans Division

Annexure 5.14.3

Year Wise Registration, Placement, Vacancies Notified, Submission Made and Live Register for The Period 1991 To 2001(Jan. to Aug.)

(in thousands)

Year	Employment Exchanges ($)	Registration	Placement	Vacancies Notified	Submission Made	Live Register
1	2	3	4	5	6	7
1991	854	6235.9	253.0	458.6	4531.2	36299.7
1992	860	5300.6	238.7	419.6	3652.1	36758.4
1993	887	5532.2	231.4	384.7	3317.8	36275.5
1994	891	5927.3	204.9	396.4	3723.4	36691.5
1995	895	5858.1	214.9	385.7	3569.9	36742.3
1996	914	5872.4	233.0	423.9	3605.9	37429.6
1997	934	6321.9	275.0	393.0	3767.8	39139.9
1998	945	5851.8	233.3	358.8	3076.6	40089.6
1999	955	5966.0	221.3	328.9	2653.2	40371.4
2000	958	6041.9	177.7	284.5	2322.8	41343.6
2001 (Jan-Aug.)	938	3961.7	110.2	218.1	1288.6	42272.1

$:- At the end of the year

Annexure 5.14.4

Statement showing number of ITI/ITCs with seating capacity in various States / Union Territories as on 31.11.2001

Sl. No.	Name of State/Uts	No. of Govt. ITI	Seating Capacity Govt.	No. of Pvt.ITCs	Seating Capacity (Pvt.)	Total ITI/ITCs (3+5)	Total Seating Capacity (4+6)
1	2	3	4	5	6	7	8
	NORTHERN REGION						
1	Haryana	78	13173	24	1428	102	14601
2	HP	44	4593	4	276	48	4869
3	J&K	37	4076	0	0	37	4076
4	Punjab	106	13999	32	1852	138	15851
5	Rajasthan	83	8512	16	1180	99	9692
6	UP	179	38148	100	8724	279	46872
7	Chandigarh	2	936	0	0	2	936
8	Delhi	14	8948	36	1572	50	10520
9	Uttaranchal	34	5080	14	1480	48	6560
	Sub-Total	**577**	**97465**	**226**	**16512**	**803**	**113977**
	SOUTHERN REGION						
1	Andhra Pradesh	84	22811	474	85082	558	107893
2	Karnataka	102	17348	355	25024	457	42372
3	Kerala	68	13848	461	43305	529	57153
4	Tamil Nadu	53	17200	604	60048	657	77248
5	Lakshadweep	1	96	0	0	1	96
6	Pondicherry	7	1256	7	424	14	1680
	Sub-Total	**315**	**72559**	**1901**	**213883**	**2216**	**286442**
	EASTERN REGION						
1	Arunachal Pradesh	2	368	0	0	2	368
2	Assam	24	4536	3	84	27	4620
3	Bihar	28	10256	12	2504	40	12760
4	Jharkhand	14	2564	11	1616	25	4180
5	Manipur	7	540	0	0	7	540
6	Meghalaya	5	622	2	304	7	926
7	Mizoram	1	294	0	0	1	294
8	Nagaland	3	404	0	0	3	404
9	Orissa	24	5744	122	11092	146	16836
10	Sikkim	1	140	0	0	1	140
11	Tripura	4	400	0	0	4	400
12	West Bengal	48	11564	13	740	61	12304
13	A&N Island	1	204	0	0	1	204
	Sub-Total	**162**	**37636**	**163**	**16340**	**325**	**53976**
	WESTERN REGION						
1	Goa	11	2492	4	420	15	2912
2	Gujarat	129	54416	98	12114	227	66530
3	Madhya Pradesh	130	19186	20	1884	150	21070
4	Chattishgarh	59	7920	54	5976	113	13896
5	Maharashtra	347	63476	266	28908	613	92384
6	Dadra & Nagar Haveli	1	228	0	0	1	228
7	Daman & Diu	2	388	0	0	2	388
	Sub-Total	**679**	**148106**	**442**	**49302**	**1121**	**197408**
	Grand-Total	**1733**	**355766**	**2732**	**296037**	**4465**	**651803**

Annexure 5.14.5

State-wise distribution of women Industrial Training Institutes & wings for women in General I.T.I.s/Private WITIs.

(Data as in Nov. 2001)

Sl. No.	Name of State/UTs & Region	WITIs WITIs	W.Wings/pvt. WITIs / Wings	Total.	Total Seats
1	**2**	**3**	**4**	**5**	**6**
	Northern Region				
1	Haryana (P)	7	34	41	2452
2	HP	16	0	16	784
3	J&K	1	30	31	672
4	Punjab	43	33	76	6018
5	Rajasthan	8	8	16	736
6	UP (P)	11	66	77	4188
7	Chandigarh	1	0	1	320
8	Delhi (P)	3	36	39	2712
9	Uttaranchal (P)	3	5	8	608
10	Bihar	11	0	11	976
11	Madhya Pradesh	15	5	20	2480
	Sub-Total	**119**	**217**	**336**	**21946**
	Southern Region				
1	Andhra Pradesh (P)	23	15	38	3880
2	Karnataka	17	6	23	1932
3	Kerala	8	3	11	1552
4	Tamil Nadu	10	13	23	2182
5	Pondicherry	2	1	3	280
	Sub-Total	**60**	**38**	**98**	**9826**
	Eastern Region				
1	Assam (P)	5	3	8	336
2	Manipur	1	0	1	48
3	Meghalaya	1	0	1	32
4	Nagaland	1	2	3	96
5	Orissa	10	20	30	1872
6	Tripura	1	0	1	84
7	West Bengal	4	6	10	496
	Sub-Total	**23**	**31**	**54**	**2964**
	Western Region				
1	Gujarat	27	8	35	2262
2	Maharashtra	15	226	241	9072
	Sub-Total	**42**	**234**	**276**	**11334**
	Grand-Total	**244**	**520**	**764**	**46070**

(P) :- Provisional data

Annexure 5.14.6

Coverage Under National Child Labour Project During 2001

Sl. No.	Name of States	No. of districts covered	Sanctioned coverage		Actual coverage	
			No. of schools	No. of children	No. of schools	No. of children
1	**2**	**3**	**4**	**5**	**6**	**7**
1	Andhra Pradesh	22	1008	51650	965	50921
2	Bihar	3	85	6500	85	6316
3	Chattisgarh	5	139	9900	98	5128
4	Jharkhand	5	114	5700	114	5700
5	Karnataka	5	190	9500	105	5222
6	M.P.	3	88	4600	44	2334
7	Maharashtra	2	74	3700	69	3570
8	Orissa	18	696	39550	628	35002
9	Rajasthan	6	180	9000	154	7700
10	Tamil Nadu	9	425	21900	417	22029
11	UP	11	514	26500	365	21574
12	West Bengal	8	347	17350	298	14950
13	Punjab	3	107	5350	27	1350
	Total	**100**	**3967**	**211200**	**3369**	**181796**

Annexure 5.14.7

Statement showing details of Bonded Labourers Identified and Rehabilitated upto 30.12.2001

Sl. No.	State	Number of Bonded Labourers		
		Identified and Released	Rehabilitated	Central assistance provided (Rs.in lakhs)
1	**2**	**3**	**4**	**5**
1	Andhra Pradesh	36289	29552	680.10
2	Bihar & Jharkhand	13092	12368	314.48
3	Karnataka	62763	55269	1386.38
4	Madhya Pradesh & Chhattisgarh	12822	11897	146.35
5	Orissa	49971	46843	898.13
6	Rajasthan	7478	6321	71.42
7	Maharashtra	1393	1309	8.70
8	UP & Uttranchal	27797	27797	533.22
9	Kerala	823	710	15.56
10	Haryana	544	21	0.42
11	Gujarat	64	64	1.01
12	Arunachal Pradesh	3526	2992	568.48
13	Tamil Nadu	65573	65573	1661.94
14	Other	69	67	6.81
	Total	**282204**	**260783**	**6293.00**