CHAPTER 4

HUMAN AND SOCIAL DEVELOPMENT

4.1 Elementary 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 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 increase of 13.16 since 1951. It 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 student's enrolment. 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 government. 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 Panchayat Raj Institutions will form on districts having low female literacy among Scheduled Castes and Scheduled Tribes and other children in difficult circumstances. A Constitutional Amendment Act, notified on 13th December 2002, makes elementary education a fundamental right.

Review of the year 2002-03

4. As against the approved outlay of Rs.4667 crore for Schemes of Elementary Education during 2002-03, the actual expenditure was Rs.4259.29 crore which represents 91.25% of approved outlay. The financial performance of two major schemes i.e. District Primary Education Programme (DPEP) and Mid-Day Meal (MDM) during the year 2002-03 has been

fairly good. For District Primary Education Programme, an amount of Rs.1287.05 crore was spent aginst the approved outlay of Rs.1380 crore. Similarly, for National Programme of Nutritional Support for Primary Education, the expenditure was Rs.1099.03 crore against the approved outlay of Rs.1175.00 crore. States like Haryana, Himachal Pradesh, Kerala, Manipur, Meghalaya, Nagaland, Sikkim, Uttar Pradesh and Pondicherry were able to lift more than 90% of the foodgrains allocated under Mid-Day Meal Scheme. However, some States such as Arunachal Pradesh, Goa, Jammu& Kashmir and Delhi lifted less than 25% of the allocated foodgrains.

5. The expenditure under Shiksha Karmi Scheme which is operational only in Rajasthan was Rs.15.02 crore against the plan provision of Rs.40.00 crore. The expenditure under the scheme "Janshala' was Rs.13.50 crore against the allocation of Rs.20 crore, which represents an expenditure of 67.5% only. Similarly, Mahila Samakhya reported an expenditure of Rs.7.52 crore against the allocation of Rs.20 crore which is just 39.55%. No expenditure could be made under the Scheme of Kasturba Gandhi Swatantrata Vidyalaya, as the scheme did not take off during the year under review.

Major Developments

The Tenth Plan focus on Education For All reflected in the monitorable targets set by the NDC-All children in school by 2003; All children to complete 5 years of schooling by 2007; Reduction in gender gap in literacy by at least 50% and attainment of functional literacy of 75%

The President's assent to the 86th constitutional amendment providing for free and compulsory education for all children in the age group of 6-14 a justiciable Fundamental Right.

Translation of the spirit of 73rd and 74th Constitutional Amendments for greater decentralization of power and enhanced role for local bodies, community organizations in the effort towards UEE. Primary education identified as one of the subjects to be transferred to Local Bodies/PRIs.

Planning Commission rationalizes the schemes for Elementary education based on ZBB exercise bringing all the schemes under four major programmes/schemes i.e. SSA, MDMS, Teachers Education and KGSV for girls.

Annual Plan 2003-04

6. An outlay of Rs.4667.00 crore has been approved for the Annual Plan 2003-04 for Elementary Education. This includes a provision of Rs.1415.00 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 Swatantrata 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 detail programme implementation at district level with all other departments. SSA also aims at systematic mobilization 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 everyone literate in the country. 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 600 districts in the country, 587 districts have been covered under literacy programmes. The continuing education programme has begun in 201 districts; post-literacy programmes are ongoing in 196 districts while total literacy campaigns are on in 190 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 of NGOs in the literacy movement, they are now allowed to receive funds from Zilla Saksharta Samitis and actually run continuing education centres.

REVIEW OF THE YEAR 2002-03

9. As against the approved outlay of Rs.233 crore for Adult Education for the year 2002-03, the actual expenditure was Rs.216.33 crore i.e.92.83% of the total outlay. The scheme of Continuing Education alone was allocated Rs.145.00 crore i.e.62.23% of total approved outlay against which the expenditure incurred was Rs.133.03 crore. The expenditure of Rs.22.03 crore under the scheme 'Voluntary Organisations' exceeded its allocation of Rs.20.00 crore. The scheme Special Project for Eradication of illiteracy, reported an expenditure of Rs.24.57 crore against the outlay of Rs. 25 crore. Similarly, Rs.23.32 crore was spent under the scheme Jan Shikshan Sansthan against the allocation of Rs.25 crore. 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 ration 4:1. Implementing agencies are now allowed to incur expenditure on basic literacy activities during the post-literacy phase.

Annual Plan 2003-04

10. The approved annual plan outlay for adult-education is Rs.233 crore for 2003-04. 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 for 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.

Externally Aided Projects

11. The Department of Elementary Education has been implementing a number of projects, which are externally funded. The financial performance of the EAPs are given below:

(Rs. Crores)

	EAPs	**Tenth Plan**	**Annual Plan 2002-03**			**Annual Plan 2003-04**
		App. Outlay	App. Outlay	Rev.Esti-mates	Expenditure	Outlay
1	Shiksha Karmi	47.0	40.0	15.02	15.02	10.00
2	Lok Jumbish	137.0	60.00	60.00	60.00	70.00
3	Mahila Samakhya	100.0	20.00	9.00	7.52	30.00
4	DPEP	4000.0	1380.0	1287	1287.05	1200.00
5	SSA	600.0				100.00
6	Joint GOI- UN programme for Primary Education	20.00	20.00	13.50	13.50	5.00
	Sub-Total(EAP)	**4904.0**	**1520.0**	**1384.52**	**1383.09**	**1415.00**
7	Kasturba Gandhi Swantrata Vidyalaya (New Scheme)	489.00	8.50	0.02	0	8.50

Releases to States/UTs Under Centrally Sponsored/ Central Sector Schemes during 2002-2003 (PLAN)

Annexure 4.1.1

(Rs. In lakhs)

	Name of the States/UT	SSA	O B	T.E	DPEP	Mahila Samakhya	Lok Jumbish	Shiksha Karmi	V.E	Sc. Ed.	Env. Ed.	I E D C	Class
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	Andhra Pradesh	8226.10	0.00	19.00	16500.00	190.00	0.00	0.00	0.00	2.27	1.61	89.98	0.00
2	Arunachal Pradesh	1412.00	0.00	62.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	Assam	10175.92	805.31	672.53	5401.00	0.00	0.00	0.00	0.00	592.76	4.02	23.08	0.00
4	Bihar	7914.97	0.00	319.50	6400.00	0.00	0.00	0.00	0.00	21.60	2.74	12.54	0.00
5	Chhattisgarh	3639.73	2778.59	0.00	2700.00	0.00	0.00	0.00	0.00	108.60	5.09	10.58	250.00
6	Goa	0.00	0.00	47.64	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.37	125.00
7	Gujarat	14004.30	0.00	1961.14	4668.00	130.00	0.00	0.00	467.58	35.81	34.37	798.15	0.00
8	Haryana	2735.87	0.00	961.88	3500.00	0.00	0.00	0.00	329.00	0.00	0.00	68.32	39.30
9	Himachal Pradesh	1717.62	0.00	797.48	1800.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
10	Jammu and Kashmir	1948.85	0.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11	Jharkhand	3244.32	0.00	0.00	4100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
12	Karnataka	8270.46	0.00	1437.34	4950.00	205.00	0.00	0.00	0.00	520.84	0.00	517.02	0.00
13	Kerala	2250.78	0.00	617.74	1250.00	0.00	0.00	0.00	0.00	0.00	0.00	379.78	0.00
14	Madhya Pradesh	11017.10	0.00	1157.05	13100.00	0.00	0.00	0.00	0.00	0.00	5.78	583.64	0.00
15	Maharashtra	11000.00	0.00	257.30	9148.00	0.00	0.00	0.00	0.00	0.00	5.83	160.66	0.00
16	Manipur	0.00	0.00	98.84	0.00	0.00	0.00	0.00	0.00	0.00	1.37	132.87	0.00
17	Meghalaya	711.37	0.00	193.49	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.73	0.00
18	Mizoram	903.29	833.06	166.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	33.58	0.00
19	Nagaland	973.28	0.00	243.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	22.61	0.00
20	Orissa	2214.15	11.38	584.02	7300.00	0.00	0.00	0.00	0.00	1.94	4.14	150.33	0.00
21	Punjab	4868.00	0.00	889.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
22	Rajasthan	9995.58	0.00	1259.39	11300.00	0.00	6000.00	1501.50	0.00	0.00	0.00	33.66	0.00
23	Sikkim	425.14	0.00	6.69	0.00	0.00	0.00	0.00	291.48	0.00	0.00	12.35	72.50
24	Tamil Nadu	13526.90	0.00	1734.18	2013.00	0.00	0.00	0.00	0.00	10.00	28.00	139.60	72.66
25	Tripura	1162.18	0.00	40.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.20	0.00
26	Uttar Pradesh	20245.40	0.00	1965.27	23900.00	160.00	0.00	0.00	375.00	270.00	3.66	16.94	0.00
27	Uttaranchal	2067.69	0.00	0.00	2000.00	50.00	0.00	0.00	0.00	0.00	61.00	0.00	0.00
28	West Bengal	10867.61	0.00	98.01	7850.00	0.00	0.00	0.00	0.00	20.93	2.18	103.24	469.84
29	A and N Islands	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	16.49	0.00
30	Chandigarh	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.34	0.00
31	D. & N. Haveli	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10.18	0.00	0.00	0.00
32	Daman & Diu	12.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.17	0.00
33	Delhi	161.27	0.00	468.57	0.00	0.00	0.00	0.00	0.00	17.78	14.74	57.77	0.00
34	Lakshdweep	19.98	0.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
35	Pondicherry	116.46	0.00	58.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.41	0.00
TOTAL(STATES/UTs)		**155828.32**	**4428.34**	**16216.03**	**127880.00**	**735.00**	**6000.00**	**1501.50**	**1463.06**	**1612.71**	**174.53**	**3384.41**	**1029.30**

Legend: SSA: Sarva Shiksha Abhiyan; OB : Operation Blackboard; TE: Teacher Education; DPEP: District Primary Education Programme; VE: Vocational Education; Sc. Ed.: Science Education; Ed.Tech.: Education Technology; Env. Ed.: Environmental Education; IEDC: Integrated Education for Disabled Children; Class: Computer Literacy & Studies in Schools

Releases to States/UTs Under Centrally Sponsored/ Central Sector Schemes during 2002-2003 (PLAN)

Annexure 4.1.2

(Rs. In lakhs)

	Name of the States/UTs	Yoga	Literacy campaigns & OR	Jan Shikshan Sansthan	Continuing Education	Support to NGO's for AE	AIMMP	App. of Lang. Tchrs.	Dev. of Skt.	National Schl	Schl. For Tal. Chlrn	Total CSS+CS
1	2	15	16	17	18	19	20	21	22	23	24	25
1	Andhra Pradesh	0.00	0.00	209.39	701.48	164.02	968.51	14.73	27.51	0.00	0.00	**27114.60**
2	Arunachal Pradesh	0.00	171.00	15.25	0.00	0.00	0.00	172.19	0.00	0.00	0.00	**1832.64**
3	Assam	1.31	48.65	37.05	0.00	25.00	0.00	276.20	2.70	0.00	0.00	**18065.53**
4	Bihar	0.00	808.24	56.06	0.00	97.23	0.00	0.00	0.00	0.00	0.00	**15632.88**
5	Chhattisgarh	0.00	252.98	21.78	10.00	0.00	0.00	0.00	0.00	0.00	0.00	**9777.35**
6	Goa	0.00	0.00	24.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**198.02**
7	Gujarat	2.65	0.00	130.26	1720.35	29.35	0.00	0.00	0.00	0.00	0.00	**23981.96**
8	Haryana	0.00	0.00	39.43	0.00	42.78	0.00	0.00	1.08	0.00	0.42	**7718.08**
9	Himachal Pradesh	0.00	0.00	0.00	0.00	26.40	0.00	0.00	155.42	0.00	0.00	**4496.92**
10	Jammu and Kashmir	0.00	0.00	21.42	0.00	39.99	0.00	0.00	2.03	0.00	0.00	**2062.29**
11	Jharkhand	0.00	307.54	54.14	12.50	0.00	0.00	0.00	0.00	0.00	0.00	**7718.50**
12	Karnataka	2.39	20.37	150.86	1810.79	34.50	0.00	167.04	23.71	0.00	0.00	**18110.32**
13	Kerala	0.00	0.00	117.31	119.40	32.92	0.00	95.46	5.96	0.00	0.00	**4869.35**
14	Madhya Pradesh	0.00	88.21	172.49	3475.80	89.25	205.98	0.00	757.97	0.00	0.00	**30653.27**
15	Maharashtra	6.42	10.00	193.84	10.00	80.00	0.00	0.00	14.52	0.00	0.00	**20886.57**
16	Manipur	1.67	0.00	15.25	0.00	0.00	0.00	248.44	0.00	0.00	0.00	**498.44**
17	Meghalaya	0.00	0.00	0.00	0.00	32.00	0.00	0.00	0.00	0.00	0.00	**938.59**
18	Mizoram	0.00	0.00	14.00	74.40	0.00	0.00	165.92	0.00	0.00	0.00	**2190.27**
19	Nagaland	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**1239.06**
20	Orissa	4.11	282.45	146.80	0.00	36.84	0.00	0.00	17.90	0.00	0.00	**10754.06**
21	Punjab	0.00	43.14	24.24	0.00	25.00	0.00	0.00	0.00	10.00	0.00	**5859.38**
22	Rajasthan	0.00	77.47	137.08	2328.30	48.61	0.00	0.00	10.53	12.39	0.00	**32704.51**
23	Sikkim	0.00	36.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**844.76**
24	Tamil Nadu	0.00	0.00	150.29	530.70	60.72	0.00	0.00	44.23	0.00	0.00	**18310.28**
25	Tripura	2.47	0.00	0.00	155.00	10.00	45.72	0.00	0.00	0.00	0.04	**1423.61**
26	Uttar Pradesh	0.00	247.97	441.89	2262.28	1168.27	1624.37	0.00	16.78	0.00	0.00	**52697.83**
27	Uttaranchal	0.00	11.63	12.00	0.00	37.00	0.00	0.00	0.00	0.00	0.00	**4239.32**
28	West Bengal	0.00	50.00	98.79	0.00	53.00	0.00	0.00	23.82	0.00	0.00	**19637.42**
29	A and N Islands	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**16.49**
30	Chandigarh	0.00	0.00	26.99	91.40	0.00	0.00	0.00	10.00	0.00	0.00	**131.73**
31	D. & N. Haveli	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**10.18**
32	Daman & Dui	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.08	0.15	**12.40**
33	Delhi	1.50	0.00	20.93	0.00	68.57	0.00	0.00	1.57	0.00	0.10	**812.80**
34	Lakshdweep	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**69.98**
35	Pondicherry	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.01	**181.96**
TOTAL(STATES/UTs)		**22.52**	**2456.25**	**2331.55**	**13302.40**	**2201.45**	**2844.58**	**1139.98**	**1115.73**	**22.97**	**0.72**	**345691.35**

Legend: OR: Operation Restoration
AE: Adult Education
AIMMP: Area Intensive and Madrasa Modernization Programme
Schl. for Tal. Chlrn: Scholarship for Talented Children

4.2 SECONDARY 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. The impact of recent initiatives undertaken for universalisation of elementary education is resulting in increased demand for expansion of secondary education. Out of the total eligible age group population (15-19 years) i.e. 9.7 crore, as high as about, 7.0 crore (72.16%) remain outside the school system, as only 2.8 crore are enrolled in secondary schools. Although, there has been a faster growth of High and Higher Secondary level Institutions in the country, about 23% population have to walk more than 5 kms. to reach the school. This means that we are far behind the target of having a Secondary School within five kms. In case of girls, in rural areas, only 32.33% are attending secondary schools and 29.76% are enrolled at higher secondary level. Apart from girls, there is a large number of children from SC/ST and minority communities whose educational needs are not being addressed by the main stream school system. Expansion of schooling facilities with equity in focus is the need of the hour.

The key issues during the Tenth Plan would be a greater focus on improving access and reducing disparities in the secondary education sector. The Plan will also focus on revision of curricula with emphasis on vocationalisation and employment oriented courses, expansion and diversification of open learning system, re-organisation of teacher training and greater use of new information and communication technologies.

Review of 2002-03

3. The year under review was the first year of the Tenth Plan. An outlay of Rs. 719 crore was approved for the secondary education sector under the Annual Plan 2002-03 in the central sector. This outlay was reduced to Rs. 525.03 crore at the RE stage. Against this an expenditure of Rs. 578.14 crore has been incurred in the above year.

4. Presently, central intervention in the Secondary Education Sector is at two levels, by creation and establishment of the apex national level institutions for school education and secondly through Centrally Sponsored Schemes. In the year 2002-03 the Planning Commission conducted a zero-based budgeting (ZBB) exercise for converging various centrally sponsored and central sector schemes of various Ministries/Departments including the MHRD for focused implementation/better targeting and efficient utilization of funds.

5. As a fall out of this exercise there would be only five centrally sponsored schemes to be implemented in the Tenth Plan under Secondary Education Sector: (i) Access and Equity (ii) Quality Improvement in Schools (iii) ICT in Schools (iv) Integrated Education for Disabled Children (IEDC) and (v) Vocationalisation of Secondary Education. (The details of Vocationalisation of Secondary Education is in Section 2 of the Chapter). Most of these schemes are currently in the process of being approved by the Cabinet and their EFC proposals are under examination. Till such time, the schemes are being implemented on the Ninth Plan pattern.

6. The five central sector apex level institutes - NCERT, National Open School, Navodaya Vidyalayas, Kendriya Vidyalayas and Central Tibetan School Administration (CTSA) – would continue to function in the Tenth Plan.

7. **The major Centrally-sponsored schemes in Secondary Education under implementation in 2002-03 were:**

(a) The scheme for strengthening of Boarding and Hostel facilities for girls, meant to increase girls enrolment in schools continued to be implemented in the year 2002-03. The MHRD has revised assistance to NGOs(in 2001-02) which are running these hostels. This component shall be merged in the new Centrally sponsored scheme "Access and Equity" from the year 2003-04.

(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) Under the scheme ICT in schools each State and U.T have been asked to prepare Computer Education Plans for IT education in schools. Based on the computer education plans received from the State Governments 19 States and Uts have been released funds under the scheme.

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

(e) 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.

(f) 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).

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

(h) 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. The scheme is presently being implemented in 27 States and 4 UTs through over 41,875 schools benefiting more than 1,33,000 disabled children.

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

8. 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 and provide support to teacher training programmes.

9. The **National Institute of Open Schooling (NIOS)** was established as an autonomous organization under the Department of Education in 1989 to provide opportunities to students to complete their school education. The NOS has network of ten regional centres and about 2000 study centres for programme delivery through open learning and distance education mode. The NOS has set up study centers in UAE, Quwait, Oman, Nepal, Canada and the USA.

10. The **Central Tibetan School Administration** continues to run 79 schools for Tibetan children in the country in which 9602 students are receiving education. The schools are affiliated to various all-India Boards.

11. **Kendriya Vidyalayas** have been set up with the aim of providing education to children of transferable central government employees. At present there are 843 vidyalayas in the country

12**.** **Jawahar Navodaya Vidyalayas** were set up to provide good quality education to talented children from rural areas. Under the scheme each district in the country will be provided with one Navodaya Vidyalaya. At present, there are 480 NVs in as many districts of 33 States and UTs.

ANNUAL PLAN 2003-04

13. An outlay of Rs. 669 crore is for the Secondary Education Sector under the Annual Plan 2003-04. The details of proposed activities under the Centrally sponsored schemes during the year 2003-04 are given in the following paras:

CENTRALLY SPONSORED SCHEMES

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. During the Tenth Plan, an outlay of Rs. 305 crore has been allocated for this scheme in the Central Sector of which Rs.20 crores has been allocated under the Annual Plan 2003-04. (An additional Rs. 300 crore in the State Sector has also been allocated by the Planning Commission for the scheme)

15. The EFC proposal for the scheme has been received and is under examination. The scheme will include two components : (i) The on-going scheme of Strengthening of Hostel and Boarding Facilities for Girls and (ii) Setting up of new schools in partnership with reputed NGOs, trusts, societies and State Governments. The State Government will conduct surveys in the educationally backward districts to identify places where to set up new

schools. The State Governments would also identify NGOs in these districts who are running schools upto middle level but due to financial constraints were not able to expand their activities. To these organizations the Government of India would provide a one time of grant/seed money to start new schools.

16. **Quality Improvement in Schools** In the Tenth Plan it has been decided to introduce a centrally sponsored scheme, namely, Quality Improvement in Schools which will comprise the Ninth Plan centrally sponsored/central sector schemes, namely, (i) Improvement of Science Education in Schools, (ii) International Science Olympiad, (iii) Environmental Orientation to School Education, (iv) Population Education and (v) Introduction of Yoga in Schools. A Plan provision of Rs. 110 crore has been made for QIS in the Tenth Plan. For the Annual Plan 2003-04, an outlay of Rs. 26 crore has been allocated. Children in about 50,000 schools will acquire knowledge in basic sciences and will be exposed to the various aspects of science education, environment education, yoga and the concept of population control. The teachers in these schools will be benefited through training imparted under the scheme. The QIS will be a 100% centrally sponsored scheme. State Governments, local bodies and panchayati raj institutions, NGOs, registered societies, public trusts would be eligible for support and partnership under this programme. Under the scheme, as per the prescribed pattern, assistance will be given for science laboratories, libraries, sport facilities, provision for yoga teachers etc. In addition, innovative projects in the areas of science, environment, population, art and craft, sports, yoga would be taken up. The proposals of the above mentioned implementation partners would be examined by the Grants-in-aid Committee of MHRD.

17**.** **Information and Communication Technologies in schools (ICT).** An outlay of Rs. 800 crore has been approved for the Tenth Plan for this Centrally sponsored scheme. An outlay of Rs. 111 crore has been earmarked for the scheme during the Annual Plan 2003-04. Each State/UT would submit Computer Education Plans (CEPs) to the Central Government. Under the scheme the schools, through the State Governments will be given financial assistance as per a prescribed pattern, for computer hardware, software, teacher training, internet connectivity, computer stationery and maintenance. The school has the flexibility of incurring expenditure on the items they desire upto a maximum limit of Rs. 6.70 lakh The Central Government assistance, however, will be limited to Rs. 5 lakh per school. Through the scheme children in Government/Government aided schools will acquire basic knowledge and skill in computer operations.

18. **Integrated Education for Disabled Children (IEDC)** An outlay of Rs.200 crore has been allocated for the above scheme under the Tenth Plan of which Rs. 35 crore is the allocation for 2003-04. 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.

Central Sector Institutions

19. The five central sector institutes will continue their on-going activities during the Annual Plan 2003-04. The **NCERT** has launched the Seventh All-India Educational Survey which is likely to be completed in 2004. The NCERT will continue publication of school text books, work books, readers, instructional material and undertake teacher training programme. NCERT has an outlay of Rs. 60 crore for the Tenth Plan of which Rs. 14 crore has been allocated during the year 2003-04 for completing construction activities in the

Regional Institutes of Education including the North Eastern Regional Institute of Education at Shillong. The **National Open School** is under-going major expansion in the Tenth Plan with an outlay of Rs. 65 crore. An outlay of Rs. 15 crore has been allocated for NOS during the current year. During the Tenth Plan a major initiative of open basic education (OBE) programme for neo-literates, school drop-outs and non-formal education completers has been launched. The number of **Kendriya Vidyalayas** as on 30th November 2002 is 843. An outlay of Rs. 420 crore in the Tenth Plan has been allocated for completing the construction work in 106 KVs which do not have their own buildings. This year's allocation for the Kendriya Vidyalaya Sangathan is Rs. 85 crore. During the Tenth Plan, the **Navodaya Vidyalaya Samiti** has a major outlay of Rs. 2000 crore to set up 100 new Jawahar Navodaya Vidyalayas (JNVs) in remaining districts and strengthen the facilities in the existing 491 JNVs. An outlay of Rs. 360 crore has been allocated during the year 2003-04 for completing of infrastructure facility like construction of school building, hostels, residential staff quarters etc. The **Central Tibetan School Administration** which runs schools for the children of Tibetan refugees has a Tenth Plan outlay of Rs. 15 crore of which Rs. 3 crore during the Annual Plan 2003-04 is for academic activities and construction work.

4.3 HIGHER & TECHNICAL EDUCATION

HIGHER EDUCATION

The Higher Education system has witnessed phenomenal expansion during the recent years. There are now 196 Universities, 76 Deemed Universities and nearly 13,150 colleges (including 1600 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 6% of the estimated population in the 18-24 age group. (As per the latest data available pertaining to the year 2000-01, out of a total estimated population of 1345 lakhs in the age group (18-24) 88.21 lakh were enrolled in colleges and universities). We have to increase 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.

3. The main objective is to raise the enrolment of the population in the age group (18-24) 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 and deemed universities.

Review of 2002-03

4. An outlay of Rs.615.00 crore was allocated for the University and Higher Education sector in the year 2002-03 which was reduced to Rs. 569.41 crore at the RE stage against which an expenditure of Rs.619.14 crore 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 18 Central Universities, 178 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. 225 orientation programmes and 9833 refresher courses were allocated to the ASCs and refresher course centers (RCCs). 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.

7. Under the Special Assistance Programme (SAP) the Computer Open System Improvement Programme (COSIP) and College Humanities and Social Science Improvement Programme (COHSSIP), the UGC strengthened the department of humanities, basic sciences and social sciences in selected universities which have potential for advanced academic work.

Annual Plan 2003-04

8. Under the Annual Plan 2003-04, an amount of Rs.615 crores has been allocated for University and Higher Education sector.

9. During the current year 2003-04 an outlay of Rs. 516.75 crore has been allocated for the **University Grants Commission**. In the current year the UGC will continue to provide development assistance to universities and colleges for improving infrastructure like laboratories, libraries and for campus development as well as construction of buildings in the University and college campuses. During the Plan period the UGC will, in a phased manner take steps for intranet and internet connectivity of colleges and universities. In addition, steps for setting up new Academic Staff Colleges will be taken up to improve the quality of teaching. For encouraging participation of women in higher education grants will be given to universities and colleges for establishing day care centers/creches, women hostels so as to facilitate continuing education for women. In pursuance of its objective of providing equity special development grants to universities and colleges in backward areas of the country will be provided by the Commission.

10. The **Indira Gandhi National Open University** is going-in for massive expansion during the Tenth Five Year Plan. An outlay of Rs. 67 crore has been allocated in the year 2003-04 is for IGNOU which proposes to establish 40 FM radio channels completely dedicated to education and development. During the year 2003-04 the seven Gyan Vani Centres established at : Allahabad, Coimbatore, Lucknow, Mumbai, Bangalore, Vishakhapatnam and Bhopal, will be strengthened. The tele-conferencing of IGNOU through INSAT-2A on the extended C-Band will also continue. Its on-going academic programmes in 21 countries including the middle east countries will also continue. To make distance education accessible to educationally backward groups of the North Eastern Region, down linking facility has been set up in all the NE States in their capitals. In addition, 82 study centers have been established in these States including Sikkim.

11. The Distance Education Council under the IGNOU Act will continue to discharge its responsibility of providing financial support to the 9 State Open Universities and 64 Correspondence Course Institutes.

12. The **Social Science Research Institutions** outside the university system, viz., Indian Council of Social Science Research (ICSSR), Indian Council of Philosophical Research (ICPR), Indian Council of Historical Research (ICHR) etc. continue to undertake research on current political, social and economic issues. These organisations sponsored research studies, by individual scholars and other subordinate institutes.

TECHNICAL EDUCATION

13. 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.

14. The key issues in technical and management education during the Tenth Plan would be a continuing focus on increased intake capacity; quality; faculty development; optimization of resources through networking; development of information technology

education; improving quality and quantity of research in technologies; modernization/development of curriculum; international benchmarking; developing capacity in new and emerging technology areas; Strategic planning and management of Technical Education System and informal sector development.

15. During the Tenth Plan, the MHRD has taken a number of initiatives for improving the quality of technical education and upgrading standards. Firstly, steps have been taken to integrate Information Technology in the technical education system so as to improve its efficiency and effectiveness. A new programme for Distance an Web based Learning has been launched. Under this initiative, IITs, IIMs, IIITs and IISc., Bangalore would jointly develop modular web enabled courses and offer them through distance mode/online with focus on faculty development and continuing education for working professionals. With the help of IT, in the form of web based learning, online learning, video conferencing, e-mail, CD-ROMS, multi-media, etc. technical education can be made accessible to a larger number of students.

16. In addition, the Technical Institutes will give thrust to new emerging technology areas like Bio-Technology, Earthquake Engineering, Nano Technology etc.

Review of 2002-03

17. An outlay of Rs.575.00 crores was allocated for the schemes of Technical Education in the year 2002-03 which was reduced to Rs. 537.88 crore at the RE Stage against which an expenditure of Rs.600.47 crores was incurred.

Annual Plan 2003-04

18. During the year 2003-04 an outlay of Rs. 700 crore has been allocated for the schemes of Technical Education.

19. On the 14th May, 2003 a notification was issued by the Ministry of HRD, Department of Secondary and Higher Education on taking over the control of 14 National Institutes of Technology and 3 Regional engineering Colleges in the country by the Central Government.

20. The Central Government has taken over the full administrative and financial control of these 17 institutions. The Plan and non-plan expenditure of these institutions would be borne entirely by the Central Government from the financial year 2003-04 onwards.

21. The AICTE covers programmes of technical Education including Training and Research in Engineering Technology, Architecture, Town Planning, Management, Pharmacy, Applied Arts and Crafts, Hotel Management and Catering Technology, etc. The AICTE initiated steps for providing Networking of Technical Institutions through the schemes of DELNET and ERNET. A Memorandum of Understanding has been signed with DELNET for the purpose of Modernisation and Networking of the libraries of Technical Institutions and with the ERNET for providing internet connectivity of AICTE approved Technical institutions.

22. As on 31st March, 2002, there were 1057 AICTE approved degree level Engineering and Technology (including Pharmacy Institutes) with a sanctioned intake capacity of 295796 and 1203 Diploma Engineering and Technology Institutes with a sanctioned intake of 235507. During the year under review the Council continued to operate a number of

schemes for quality upgradation of technical education. These included schemes for career development of teachers under the quality improvement programme. The faculty members can upgrade their academic qualifications undertake short-term training, avail of travel and seminar grants and fellowship awards. To encourage post-graduate education and research, a number of initiatives have been launched. Fifty National Fellowships have been introduced with a scholarship of 12,000/- per month and a contingency grant of Rs. 25,000/- per annum. These scholars will be given the best possible facilities and attached to leaders in R & D in respective fields. Accreditation of courses is being encouraged and strengthened as tool for quality management. Greater focus is being given to PG Programmes in new emerging technology areas.

23. In order to promote overall improvement of quality of technical education in the country, AICTE operated various schemes, viz., Modernisation and Removal of Obsolescence. Thrust Areas of Technical Education, Research and Development, Industry Institute Interaction Partnership Cells, Entrepreneurship Management Development, Staff Development Programmes including Continuing Education Programmes, Quality Improvement Progrmmme; Career Award for Young Teachers, Emeritus Fellowships, Grant to Professional Bodies, Networking of Technical Institutions, AICTE-INAE Distinguished Visiting Professorship, National Facility in Engineering Technology with Industrial Collaboration and Early Faculty Induction Programme, etc.

24. The new programmes “National Programme for Earthquake Engineering Education” and “National Programme for Support for Distance and Web-based Education in Technical Education” were launched in the current year.

25. As a follow-up of the NPE 1986 and the Programme of Action the All-India Combined Entrance Exams to Professional and Technical Institutes in the country is being held since 2002. The Common Entrance Exam- All-India Engineering Entrance Examination (AIEEE) organized by the MHRD on an all-India basis helps in maintenance of professional standards in these institutes.

26. The World Bank aided Technical Education Quality Improvement Programme of Government of India launched in 2002. During the current year the first phase of the project was operationalised. In the first cycle of the first phase of this programme, six States : Haryana, Himachal Pradesh, Kerala, Madhya Pradesh and Uttar Pradesh will be covered. The primary activities under the proposed Programme are : (i) Developing academic excellence, (ii) Net-working Engineering Institution (iii) Developing Management Capacity. During the first phase, the programme will provide financial support to 70 to 80 competitively selected engineering institutions comprising of 18 lead institutions and remaining Network Institutions.

Promotion of Languages

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

Annual Plan 2003-04

28. An outlay of Rs.114 crores was allocated for the schemes of Languages in the year 2002-03 which was reduced to Rs. 101.23 crore at the RE stage against which an expenditure of Rs. 103.57 crore was incurred.

29. The major Centrally Sponsored Schemes in this Sector are : (i) Appointment of Language Teachers (ii) Area Intensive and Madrasa Modernisation Programme and (iii) Education in Human Values.

30. Under the **Area Intensive and Madrasa Modernisation Programme** an outlay of Rs. 28.35 crore was allocated during the year 2002-03. There are two components of the scheme: (a) 100% financial assistance is given by the Central Government to State Governments and NGOs for establishing new primary/upper primary schools/residential higher secondary schools for girls in the educationally backward blocks and districts and (b) Under the second component of Madrasa Modernisation the Government of India funds salaries of two teachers per Madrasa selected. These teachers are for teaching modern subjects like Science, Mathematics, English and Social Studies; also a one-time grant of Rs. 7000/- is given for purchase of science and maths kits per Madrasa and another one-time grant of Rs. 7000/- is for the Book Bank and libraries.

31. Under the Centrally Sponsored Scheme of **Appointment of Language Teachers,** an outlay of Rs. 11.50 crore was allocated in the year 2002-03. The scheme has three parts – (a) salaries of Hindi teachers in non-Hindi speaking States; (b) salaries of Urdu teachers in educationally backward blocks/districts (as identified by the Ministry of Social Justice and Empowerment) and (c) salaries of Modern Indian language teachers will be funded by the Central Government in the respective States and UTs.

32. Under the third Centrally Sponsored Scheme **Education in Human Values** financial assistance is provided for projects to Government agencies, PRI registered societies, public trusts for taking up projects relating to culture and values in education in formal and non-formal schools and for training of in-service teachers in arts, crafts, music and dance. Religious/spiritual organizations like Sri Satya Sai Baba Institute of Higher Learning, Ramakrishana Mission Institute of Moral and Spiritual Education, Sri Aurobindo Education Society, Chinmaya Mission etc. have been identified as Resource Centres for teachers in Value Education.

33. 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.

34. 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.

35. The Rashtriya Sanskrit Sansthan, a deemed University under the MHRD is an apex body for the propagation and development of Sanskrit learning. The Sansthan imparts

Sanskrit Teaching upto the doctorate level through ten Kendtriya Sanskrit Vidyapeeths located in various places. The Sansthan provides financial assistance to voluntary organizations engaged in promotion of Sanskrit. It also pays honorariums to retired eminent Sanskrit scholars

Book Promotion and Copy Right

Review of 2002-03

36. An outlay of Rs. 12 crore was allocated for Book Promotion and Copyright Scheme under the Annual Plan 2003-03 against which an outlay of Rs. 6.80 crore was incurred.

37. In pursuance of the National Policy on Education, (NPE 1986) which envisages easy accessibility to books for children, the Government of India set up the National Book Trust, India (NBT) which is the nodal agency for book promotional activities. The trust organized a number of book fairs and exhibitions to encourage and inculcate reading habit among the people. The NBT receives grants from the MHRD. In addition, the Ministry gives grants-in-aid to voluntary organizations and associations of publishers for organizing seminars, workshops and training in connection with book promotional activities.

38. Under Copyrights there are basically two schemes :

(i) The Scheme for Intellectual Property Education, Research and Public Outreach. Under the Scheme expenditure is incurred by the MHRD directly or financial assistance is given to UGC recognized universities and colleges, copyright societies, voluntary organizations, recognized educational institutions with a view to carry out activities on Intellectual Property Rights Studies and Copyright and Related Matters. The MHRD and the CSIR has set up five IPR Chairs and Universities of Allahabad, Delhi, Pune, Chennai and the National Law College at Bangalore.

(ii) The "Scheme for Financial Assistance on WTO Studies" is being prepared to help institutes of higher education to undertake studies on WTO proposals. It may be recalled that Education is one of the 12 services which are to be negotiated under the GATS. The implication of various provision of GATS related to education need to be studies so as to assess our strength and weaknesses in various sectors of education so as to respond appropriately to offers coming from developed countries.

39. During the Tenth Plan Government is formulating a new Scheme for Educational Libraries under which one-time financial assistance of Rs. 1-2 lakhs for infrastructures support and Rs. 25,000 to Rs. 50,000 as annual grant for purchase of high quality generals and periodicals/children books will be given to schools. The Scheme is in a stage of formulation.

Annual Plan 2003-04

40. During the year 2003-04 an outlay of Rs. 12 crore has been allocated for the above mentioned schemes of Book Promotion and Copyright.

Scholarships

41. The MHRD had been implementing the National Scholarship Scheme and the Scheme of Scholarships at the secondary stage for talented children from rural areas since 1961-62 and 1971-72 respectively. During the Tenth Plan these two schemes have been merged into one Scheme namely the National Merit Scholarship Scheme fully financed by the Government of India. An outlay of Rs. 52 crore has been allocated for the National Merit Scholarship Scheme in the Tenth Plan.

42. In the Tenth Plan, the rates of scholarships applicable in the Ninth Plan, under these schemes are proposed to be revised as per the details given below:

((Rs. per month)

Sl. No.	Name of the course	Existing rates (Ninth Plan)		Rates of scholarships proposed during Tenth Plan
		Day Scholars	Hostellers	
1	XI and XII (i.e., +2 stage)/pre-university.1st year of 3 years BA/B.Sc.B.Com/etc. course	60	100	300
2	B.A./B.Sc./B.Com./B.Archaeology, etc. (2nd and 3rd year) courses	90	140	500
3	B.E./B.Tech.MBBS/LL.B./B.Ed./Diploma in Professional and Engineering Studises BDS/MA/MSc./LL.M./M.Ed./MBA etc	120	300	1,000
4	VI to X	30		250
5	XI to XII	60		300
6	Scholars residing in hostels	100		NA* *Categorisation between day scholars and hostelers removed in 10th Plan

Planning and Administration

43. An outlay of Rs.7 crore was allocated under Annual Plan 2002-03 against which an expenditure of Rs. 5.40 crore was incurred. In this sector, there are mainly Central Sector Schemes involving grants to UNESCO, NIEPA, and to the AUROVILLE management.

44. A Centrally sponsored scheme for Strengthening Of Statistical Machinery at State level is being launched with a Tenth Plan outlay of Rs.33.50 crore and an outlay of Rs.1 crore during the year 2003-04. As the existing system of educational statistics is deficient in terms of quality, comprehensiveness and timeliness. Under the scheme a computerized,

decentralized planning machinery would ensure collection and analysis of education data on the various indicators decided by MHRD. The scheme will replace the existing manual system of processing data.

45. The Annexure 4.3.1 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 2002-03 and 2003-04. (Approved earlier).

Annexure 4.3.1

OUTLAY AND EXPENDITURE OF THE SCHEME OF DEPARTMENTS OF EDUCATION, MHRD – CENTRAL SECTOR

(Rs. in crores)

Sl. No.	Scheme/Programme	Ninth Plan (1997-2002) Approved outlay	2000-2001 Actual Expendi-ture	2001-2002		2002-03 approved outlay
				Approved outlay	Funds certified as on 31-3-2002	
1	2	3	4	5	6	7
A 1	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) – ***Deptt. of Elementary Education and Literacy***	16999.98	322.55	4000.00	3743.16	4900.00
B 1	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**

4.4 YOUTH AFFAIRS AND SPORTS

In the context of our country, youth as a distinct group comprises those men and women who are in the age group of 13-35 years. According to 2001 census, there were approximately 400 million youth in this age group out of whom around 74% lived in rural areas. The number is expected to rise to a further 510 million by the year 2016. Youth constitutes a vibrant and vital segment of the society, who should be harnessed for overall development of the nation. There is a need to create opportunities for them to develop their personality and functional capabilities, which would make them not only economically productive but also socially useful. Such opportunities need to be created on a large scale to cover a wide spectrum. The Planning Commission has supported several programmes of the Ministry of Youth Affairs and Sports to harness the energy of youth into constructive work and to inculcate in them noble and patriotic values.

Review of the Annual Plan 2002-03

2. For the Tenth Five Year Plan an amount of Rs. 1825.00 crore has been provided by the Planning Commission of which Rs. 677.64 crore is for youth activities and Rs. 1145.36 crore for sports and Rs. 2.00 crore for modernization and computerization of office. Against an actual expenditure of Rs. 261.45 crore during the year 2001-02 an amount of Rs. 285.00 crore was provided for the Annual Plan 2002-03 of which an amount of Rs. 106.98 crore was allocated for the Youth bureau and Rs. 177.76 crore for sports, in addition to it Rs. 0.35 crore was provided for administration and secretariat services. For the Annual Plan 2003-04, an amount of Rs. 385.00 crore is provided of which Rs. 121.98 Crore is for youth welfare, Rs. 262.67 crore for sports and Rs. 0.35 crore for administration and secretariat services

3. Nehru Yuva Kendra Sangathan (NYKS), an autonomous organization of the Ministry of Youth Affairs and Sports, has its offices in 500 districts of the country. It has become one of the largest grass-root level organizations in the world, catering to the need of more than 8 million non student rural youth enrolled through 1.89 lakh village based youth clubs. NYKS organized 7687 vocational training programmes to update and improve vocational skills of the rural youth so that they may supplement their income from the existing occupations. From this programme 216281 youth were benefited. 1340 awareness generation programmes, 1235 work camps have been organized during 2002-03.

4. NYKS have implemented Swarna Jyanti Gram Swarojgar Yojana - a rural youth initiative in the selected 1400 villages of 14 districts of 9 states of the country. 14000 poor people who are below the poverty line are expected to benefit from this scheme. Deen Dayal Upadhyaya Swavalamban Yojana, village talk aids, National Reconstruction Corps, Tenzing Norgay Adventure Camp, National Youth Cooperative Society, Kashmiri Rural Youth Cultural Exchange Programme, North-Eastern Students and youth Cultural Exchange Programme, Tobacco Cessation Activities, were undertaken during the Annual plan 2002-03.

5. National Service Scheme (NSS), a centrally sponsored scheme, is being implemented with its primary focus on the development of the personality of the students through community services. Today NSS has over 20.82 lakh student volunteers spread over 176 universities and 22 senior secondary schools. From its inception, more than 2.51 crore students from universities, colleges and institutions of higher training have benefited from NSS activities. One of the most innovative programmes undertaken by the NSS

volunteers has been in the area of HIV/AIDS awareness. Through the Universities Talk AIDS (UTA) programme, the volunteers of NSS have succeeded in sensitizing millions of students and the general public about the dangers of HIV/AIDS.

6. In order to give a fillip to the participation of rural youth and development activities, the Youth Development Centres (YDCs) are proposed to serve as a nodal agency for information dissemination and as a kind of resource center for youth. In the current financial year, 500 YDCs are going to be upgraded so as to cater purposefully, as IT Centers, to the needs of the rural youth in the rural areas.

7. The thrust of the youth programmes lies in a major expansion of Nehru Yuva Kendra and National Service Scheme with emphasis on vocational training and employment promotion. The expansion of NYKS will be undertaken with a view to covering all the districts of the country and to mobilize and empower the youth by strengthening the youth club movement to cover at least 50% of the 6-lakh villages in the country. The youth Development Centres (YDCs) will be expanded in each of the 5000 blocks of the country. Various schemes of the Youth Bureau of the Ministry of Youth Affairs and Sports should be integrated in such a manner that the focus is on harnessing the energies of youth and on encouraging them to participate in development activities. As the adolescents need particular attention, some new intervention strategies will have to be thought of in the areas of career counseling, vocational guidance, emotional counseling, camps and workshops for the adolescents to educate them about problems of education health and nutrition etc. Efforts are being made to build a network of government and NGO sector for the development of youth.

8. There are certain sections of youth which suffer from various disabilities and handicaps both physical and mental. It is desirable that facilities and services for them are coordinated, publicized and monitored by the Youth Bureau of the Ministry of Youth Affairs and Sports as the nodal Bureau for all youth related activities.

SPORTS

9. As a result of the zero based budgeting exercise, all the plan schemes of the Sports Bureau of the Ministry of Youth Affairs and Sports were merged into six umbrella schemes.

10. The need and importance of physical education, games, sports and yoga are essential for health and physical fitness with a view to increasing individual productivity. The value of sports as a means to create potential for promoting social harmony and discipline is well recognized all over the globe. One of the basic issues in the field of education has been an acute realization of the fact that no education is complete without emphasis on sports and physical education. The new sports policy envisages broad-basing of sports, achievement of excellence in international sports events and provision of modern sports infrastructure, upgrading skills of our coaching fraternity, more efficient functioning of sports federations, enhanced participation of women, scheduled tribes and rural youth, and also involvement of the corporate sector in sports promotion. In Commonwealth Games which were held at Manchester, England from August 25 to September 4,2002, India secured the fourth position by winning 69 medals (30 gold, 22 silver & 17 bronze).

11. Sports Authority of India (SAI) is a field arm of the Ministry of Youth Affairs and Sports and implements a few schemes of the Ministry. The Tenth Plan allocation of Sports

Authority of India is Rs. 482.28 crore and the Annual Plan outlay for 2002-03 was Rs. 88.23 crore excluding the provision of North East Component which was Rs. 10.23 crore. During the Tenth Plan an enhanced budget was provided to SAI mainly on account of the fact that a large number of infrastructure projects were likely to be completed in the current financial year.

Review of Annual Plan 2002-03

12. There is an immediate need to create a network of basic sports infrastructure throughout the country. More than creation, access to the infrastructure is of prime importance. The role of the government is to create the infrastructure and promote capacity building for broad-basing sports as well as for creating enough opportunity for achieving excellence in various competitive events at national and international levels. For competitive sports, modern equipments and tools need to be provided to sportspersons.

13. Against an expenditure of Rs.178.46 crore in Annual Plan 2001-02 an outlay of Rs. 177.67 crore was provided for sports during 2002-03; for the Annual Plan 2003-04, Rs. 262.67 crore was allocated for the development of sports in the country.

Thrust Area

14. To make available adequate sports infrastructure to the public at large and in their vicinity, sports infrastructure in schools and colleges will be created. All urban bodies should earmark open space for playfields whenever new colonies are set up. A ban is required to be imposed on conversion of playfields into housing or for commercial complexes. Broad basing of sports from village to State-level should be undertaken by involving youth and by organizing planned sports programme in all the educational institutions. Particular attention for promoting sports activities in rural areas by involving Ministry of Rural Development should be undertaken. Talented boys and girls at various levels should be provided with standard quality sports equipments for day-to-day training and competitive opportunities to improve their performance.

4.5 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 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.

3. Health system consists of

- Primary, secondary and tertiary care institutions, manned by medical and paramedical personnel to provide health services
- 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
- HMIS - Two-way system of data collection, collation, analysis and response.

4. These four components are not linked appropriately and do not function as cohesive parts of the system. The health care delivery system in govt., private and voluntary sectorsface paradoxical situation wherein there are:

- Plethora of hospitals but few located in areas with high morbidity.
- 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
- ♂ Availability and utilisation of services are poorest in the most needy remote rural areas in states/districts.
- ♂ Huge health manpower – many underemployed some unemployed - still unqualified persons practice
- ♂ Vast sums spent on drugs and diagnostics- unused piles of drugs in some places & lack of appropriate diagnostics and drugs in others
- ♂ Lack of defined norms for care at each level and referral
- ♂ Primary care workers are not given the responsibility of gatekeepers; their referrals are not honoured.
- ♂ Some hospitals overcrowded; many underutilised

5. Most secondary and tertiary care institutions have good facilities with skilled staff; but they face difficulty in running the institutions because of changing health care needs, rapid advances in technology, obsolescence of equipment and rapid turn over of staff. Conflicting imperatives of having to contain costs and be self sustaining versus shouldering social responsibility, and dealing with labour and consumer litigations as if they are an industry have very adverse consequences on delivery of services.

6. There is global recognition that Indian health care providers are highly skilled, competent and committed. But in view of the rapid advancement in the health care they all urgently require CME providing up dated information on rational use of drugs and protocols for management of illnesses. In order to function effectively and economically they need to follow a system of screening and referral of patients who require care for complicated ailments to institutions with adequate staff and infrastructure.

7. Data from all the health and demographic surveys suggest that people are responsible, rational, and increasingly aware of the importance of seeking appropriate health care ; they may be rather slow to respond to health education messages but their response is sustained. They are willing to invest for and in health and utilise available services inspite of the meagre information available on access and cost of health care. But they are increasingly concerned that diagnosis and management of illnesses are becoming increasing complex and costly; the family physicians who guided the family in accessing appropriate care is no longer available .With commercialisation of health care they are apprehensive of poor quality of care, problems due for overuse, abuse and misuse of technology and exploitation of vulnerable patients.

Who are the Stakeholders in Health System Reform

States - as Health is a state subject

Centre –as effective implementation of the CSS requires an efficient state health care infrastructure.

Health care Institutions – as they can function according to defined norms

Health care providers- as they will get their essential needs to provide required care

People – because they need access to good quality care health at affordable cost

HEALTH SYSTEM REFORM

8. Faced with the problems of a sub-optimally functioning health care system and inadequate investment for improving health status of the population, 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 health scenario;

- ☛ reorganising and restructuring health services so that they function as integral components of an efficient and effective multiprofessional health system
- ☛ 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.

9. The Tenth Plan reviewed the progress in the Ninth Plan period and recommended broadening and deepening of the ongoing reform processes, utilising the lessons learnt. There is a growing emphasis on the need to introduce quality control systems, which ensure that patients get appropriate care, cost of care is not prohibitive and at the same time physicians get protection against litigation.

10. 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 quality and bringing about transparency and accountability.

It was envisaged that the public sector would play the lead role in health systems reform.

Structural Reforms:

- ♂ 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.
- ♂ Mainstreaming of the ISM&H manpower and infrastructure so that they will improve access to health care by providing health care according to their system and they also help in counselling and follow up care to patients under the National Disease Control Programmes and Family Welfare programme.

Functional reforms

- ♂ Human resource development

→ to meet growing/changing health care needs – adequate in number, with appropriate skills and attitudes.

→ skill up gradation of health care providers through CME; 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.
- ♂ Building up efficient and effective logistic system for supply of drugs, vaccines and, consumables based on the need and utilisation.
- ♂ 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 levels within and as a part of existing health services

Governance Related

- Introduction of Quality Control System in India that will:
  - prevent over use, under use, abuse, and misuse of the facilities
  - improve effectiveness and efficiency
  - help to make positive outcomes more likely
  - help use of resources effectively and responsibly
  - minimise barriers to appropriate care at different levels, by matching levels of care to level of need
  - bring in accountability in the health system and ensure that optimum use is made of every rupee invested

- Introduction of a system for assessment of quality of care based on quantifiable determinants and ingredients such as infrastructure/manpower, processes for diagnosis and treatment, safety and timeliness of intervention, outcomes such as case fatality, disability and cost of care.
- Introduction of 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.
- Working out cost of diagnostics and therapeutic procedures for major and minor ailments in different levels of care and setting cost of care norms.
- 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.
- Better access to information about the types of services available, where and at what cost.

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 & not on 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.

Health System Reforms Reported in the Current Year

11. Planning Commission reviews the progress in health sector reforms as a part of Annual Plans and Quarterly Performance Reviews of Central Ministries/ States and enables them to share their experiences with others. Summary of the progress achieved have been reported in the Annual Plan documents every year. This year States/Centre reported progress in two major areas: use of IT in improving health system and experiments to introduce low cost health insurance to help the low and middle income group to meet hospitalisation costs. These two are described in some detail.

Use of IT in improving Health System

12. Efforts are being 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, and ensure that an effective two way management information system is built up through out the country. All data pertaining to health and family welfare programmes will be collected, collated and reported from all districts through this system. This would provide data on births, deaths, diseases, request for drugs, diagnostics and equipment, manpower and funding and status of ongoing programmes through service channels within existing infrastructure. Monitoring and evaluation of these reports and appropriate midcourse corrections will be done at district level. This will also facilitate decentralized district based planning, implementation and monitoring.

13. Available IT tools are being utilized by CME Programmes to ensure easy access to the materials for skill and knowledge up gradation. Online consultation services between paraprofessionals and doctors, and doctors with specialists aimed to improve quality of services and reduce the problem in transporting patients to hospitals for diagnosis and advice regarding management are being attempted in some states.

14. In Andhra Pradesh remote sensing has been used for identifying areas with high mosquitogenic conditions and initiating interventions to control mosquito breeding.

15. Efforts are underway to develop Telephonic linkages between PHCs and FRUs, between FRUs, district hospitals and tertiary care institutions. Telemedicine consultation between tertiary/super-specialty care institutions in different regions is also being implemented. Some of the major ongoing initiatives are:

- 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. A satellite-based tele-system is connected from SGPGIMS, Lucknow to three medical colleges in Orissa.
- The S&T Division NEC proposed video conferencing linkages among the health care institutions in the Northeast and with selected institutions within and outside the region. Professionals and Para-professionals from the region will receive training in telemedicine from SGPGIMS, Lucknow.
- Uttranchal is building up telephonic linkages among the primary health care centers; 10% of villages are already connected under the SIP project. SGPGIMS, Lucknow is assisting the state govt in developing “Uttaranchal Telehealth Network”, and in designing HMIS for the Dehra Dun hospital.

- Uttar Pradesh – SGPGI Lucknow, besides assisting the neighbouring states in developing their Telemedicine infrastructure, was connected to Pithoragarh Hospital, and provided telemedicine coverage to Kailash Manasarover pilgrims on an experimental basis. It also conducts telemedicine CME in various subjects.
- Tamil Nadu – all Block PHCs in Salem and Namakkal Districts are linked with computers; software has been developed for use by the department of Health and Family Welfare and is under pilot testing; and the state proposes to train all the PHC and FRU staff on HMIS and computer operations.
- 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.
- Andaman and Nicobar Islands has decided to link the villages to the nearest subcentre, subcentres to the nearest PHC, PHCs to the nearest CHC and CHCs to the District hospitals through telephonic linkages. The patient / ANM posted in subcentres can telephonically contact the doctor for advice regarding management of illnesses. Developing a proper referral system, and connecting the PHCs to the referral hospital through Tele-linkage to tackle the problem of overcrowding in the referral hospital, and under utilization of urban health care centers in Port Blair will also be taken up.
- Lakshdweep had developed Tele-medicine linkages with the mainland speciality hospitals for consultation in complicated medical problems. These linkages could also be used to hold periodical CMEs to update the knowledge and skill of the medical and para-medical staff, especially in problems that are endemic to the area.

Ongoing initiatives regarding health insurance

16. Tenth Plan envisages that the centre and the states will try to evolve, implement and evaluate an appropriate scheme for health care financing for different income groups. Health insurance has been suggested as a mechanism for reducing adverse economic consequences of hospitalization/ treatment of chronic illnesses. Some steps taken by the state Govts to formulate social insurance for meeting the essential hospitalization costs for people below poverty line are:

- Kerala has proposed a Health Insurance Scheme for meeting hospitalisation cost in BPL families with contribution from the individual, state and the PRI administered through the Kutumbashree self help groups .
- In Delhi a government funded health insurance scheme 'Arogya Nidhi' is being taken up. The state plans to initiate a pilot project on health insurance for people below the poverty line for secondary care in government institutions.
- In Andhra Pradesh a health insurance scheme is being implemented under which a cover of Rs 20,000 towards hospitalisation 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 and Himachal are in the process of launching a Community Health Insurance Scheme.

17. Union Finance Minister, in his budget speech this year, announced that in an effort to provide easy access to health facilities and services to the less advantaged citizens, the budget proposes to launch a new community based health insurance scheme during 2003-04. Public sector general insurance companies have been encouraged to pilot the programme. Under the

scheme, a premium equivalent to Re. 1 per day (or Rs. 365 per year) for an individual, Rs. 1.50 per day for a family of five, and Rs. 2 per day for a family of seven, will entitle eligibility to get reimbursement of medical expenses up to Rs. 30, 000 towards hospitalisation, a cover for death due to accident for Rs. 25,000, and compensation due to loss of earning at the rate of Rs. 50 per day up to a maximum of 15 days. To make the scheme affordable to below poverty line families, the Government has decided to contribute Rs. 100 per year towards their annual premium.

18. Some of the states have reported that the low income group families are hesitant to contribute to schemes where every citizen contributes a fixed amount as premium towards the insurance scheme, and only those who are hospitalized get financial assistance up to a fixed limit, as they feel that the scheme will provide benefit to only a small fraction of the total population who contribute. Currently there are no schemes where the individual who is healthy, contributes a relatively small amount which accumulates over years and will later provide cover for health care expenses including hospitalisation without individual facing acute financial crisis. None of the current insurance schemes have any incentive for people who remain healthy, such as "no claim bonus" built into the scheme if they pay and remain healthy and not claim any amount.

Review of Progress in Health System Reform

19. Review of progress achieved during the Ninth Plan and the first year of the Tenth Plan suggests that health system reforms have been accepted and institutionalized both in the Centre and in the State. But there is very little coordination of efforts between different agencies trying to implement the reforms, and substantial duplication of efforts between reform programmes funded by them. Almost all the states have started implementing one or more components of health system reforms. However, none of the states have really embarked on implementing all components of the reforms. Also, no component of the reforms has been implemented in all the states. As a result, even though substantial progress has been achieved in terms of implementing one or the other component in one or more states, the health system as a whole, or any component of the health system has not shown perceptible improvement in all states. The pace of the implementation of health systems reforms has been slow. So far none of the states have embarked on the massive task of comprehensive reforms of the entire health system; most have chosen to implement one or more of the components which they felt will have an immediate impact in terms of improving efficiency. It is expected that as the states experience the benefits of the reforms that they have implemented, the reforms movement aimed at improving efficiency, quality and equitable access will gather momentum.

20. One or more aspects of health sector reforms were incorporated into various Centrally Sponsored Schemes for disease control (improved electronic HMIS for RNTCP, delivery of leprosy services through the existing health infrastructure) and family welfare (decentralized, district based planning, implementation and monitoring). The external funding agencies including World Bank (user charges in district hospitals and hospital infection control and waste management as a part of the Secondary Health System Projects) and European Commission (health sector reforms as a part of their SIP) have incorporated components of health sector reforms as parts of ongoing projects funded by them.

21. It is expected that during the Tenth Five Year Plan the core set of reforms such as reorganisation and restructuring of the three tier health care infrastructure with appropriate

referral services, improving logistic of supplies, supply of good quality drugs at affordable cost, improving quality of services by establishing a system of quality assurance for institutions procedures, cost of care at various levels, introduction of user charges, ensuring that funds so generated are used locally for improving quality of services, and building up of a health management information system that provides access to information on all programmes on a real time basis would be institutionalised in all the states. The progress in these will be reviewed both during the Quarterly Performance Reviews and during the Annual Plan Reviews with the states and the Central Ministry of Health & Family Welfare.

IN PRINCIPLE AND EFC APPROVAL OF THE TENTH PLAN PROPOSALS OF CENTRAL SECTOR INSTITUTIONS

22. In order to improve autonomy and encourage decentralised planning, Tenth Plan recommended that a Technical Appraisal Committee should be constituted in all major government institutions to assess and prioritise the essential schemes for strengthening and up grading of facilities keeping in mind the funds available. AIIMS, New Delhi, PGI Chandigarh, JIPMER Pondicherry, RML Hospital New Delhi, Safdarjung Hospital and VM Medical College had their proposals for the Tenth Five Year plan appraised and prioritized by a Technical Appraisal Committee before they were sent to the Planning Commission for "in principle" approval. It is expected that other institutions will do this shortly. During the year, the following medical educational institutions have sought and obtained approval of the Planning Commission for the scheme- wise allocation and also `in principle' approval for the new schemes.

All India Institute of Medical Sciences

23. AIIMS was established in 1956 by an Act of Parliament as a Centre of Excellence in modern medicine for providing comprehensive under graduate and post graduate training by bring together educational facilities of highest order in all important branches of health activity under one roof. It awards its own degrees and is outside the purview of the MCI. The Institute is fully funded by the Government of India. In addition, it gets research grants from national and international sources. Most of the hospital services are highly subsidized but some categories of patients are charged for treatment and diagnosis.

24. The Institute has prepared a 25 years perspective plan and the Tenth Plan proposals of the Institute had been drawn up taking into account this long-term perspective. The Tenth Plan proposals of the Institute have been vetted by the Institute's Hospital Affairs Committee and Institute's administration. Planning Commission has approved the sub scheme wise outlays and given `in principle' approval to specific new initiatives. Under the ongoing activities spilling over to the Tenth Plan, a substantial proportion of Plan funds have been allocated to salaries and consumables that are being met from the Plan side because non-Plan funds are not available. As these are needed to ensure that the Institute continues to provide good quality services, Planning Commission has agreed Institute's request to meet part of the salaries and consumables from Plan funds.

Jawaharlal Institute of Postgraduate Medical Education and Research, (JIPMER)

25. JIPMER is a Central Government Institution affiliated to Pondicherry University providing under graduate, postgraduate and para medical training courses. The Institute has drawn up its

Tenth Plan priority scheme and has submitted the sub scheme-wise outlays for approval by the Planning Commission.

Post Graduate Institute of Medical Education and Research, Chandigarh

26. PGI Chandigarh is an Institute of national importance created by an Act of Parliament in 1967 with the objective of developing patterns of under graduate and post graduate medical education in all its branches, and bringing together educational facilities of highest order for training personnel in important branches of health activity. In addition, the hospital undertakes research studies funded by various national and international organizations. The PGI Chandigarh has submitted its sub scheme-wise outlays for Tenth Plan and the Planning Commission has approved these.

Indian Council of Medical Research(ICMR)

27. The ICMR is an apex body for planning, organization, implementation and coordination of medical research in the country and promotes biomedical research through a network of 21 permanent institutes and 6 regional medical research centres distributed throughout the country. The ICMR also provides grants-in-aid for projects. The research activities of ICMR are funded by the Department of Health (Rs.870 crores for the Tenth Plan) and by the Department of Family Welfare (Rs. 100 crores for the Tenth Plan). The Council undertakes basic, applied, clinical and operational research in communicable diseases, non-communicable diseases, maternal and child health and nutrition. ICMR has submitted sub scheme-wise outlays for the total allocation provided by the Ministry of Health & Family Welfare. Planning Commission has approved the sub scheme-wise outlays and also given in principle approval for new initiatives.

COMMUNICABLE DISEASES

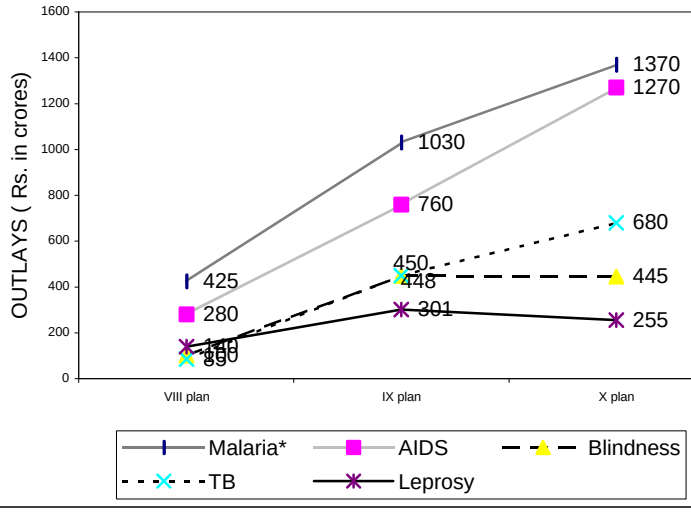
28. Control of communicable diseases continues to receive priority attention during the Tenth Plan because morbidity due to these diseases continues to be high. Deteriorating urban and rural sanitation, poor liquid and solid waste management and overcrowding have contributed to the increasing prevalence of communicable diseases. Treatment of infections has become more difficult and expensive because of the emergence of antibiotic resistance;therefore increasing attention is urgently needed for prevention through effective implementation of infection control measures. Even though health is a state subject, the Central Government continues to provide additional funds through Centrally Sponsored Schemes for disease control (Figure 1). The strategies and programmes initiated in the Ninth Plan for control of communicable diseases will continue in the Tenth Plan. Modalities to improve delivery of services pertaining to these programmes through the existing health services are being worked

Tenth 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.

out. Efforts are being made to improve states' ownership of the programmes, and participation of the community, private sector and NGOs. PRIs are being involved to improve local accountability and intersectoral co-ordination. Evaluation and operational research to rectify problems in implementation and to improve efficiency are receiving due attention.

Figure 1 : TOTAL OUTLAYS



National Vector Borne Disease Control Programme

29. The National Malaria Control Programme, the first centrally sponsored programme, was initiated in 1953. The National Anti Malaria Programme dealt with malaria, filaria, kala-azar, japanese encephalitis and dengue. As recommended by the Planning Commission, the Department of Health integrated the ongoing National Anti Malaria Programme, programme for control of kala azar, filariasis, Japanese encephalitis and other vector borne diseases into a single National Vector Borne Disease Control Programme (NVBDCP) during the Tenth Plan and provided an outlay of Rs. 1370 crores for it.

Malaria

30. The National Malaria Control Programme had spectacular success initially in bringing down the incidence of malaria from 75 million cases with 0.8 million deaths to 0.1 million cases with no death by 1965, even though there was no well-established health care infrastructure in the rural areas. However, there was a resurgence of malaria subsequently. In 1976, over 6.7 million cases were reported. From 1977, the National Malaria Eradication Programme started implementing a modified plan of operation for control of malaria. In spite of these efforts, the number of reported cases of malaria has remained around two million in the 1990s. Since 1994 the northeastern states received 100% plan funding for meeting operational costs and insecticide spraying. The Enhanced Malaria Control Project has been in operation in 1045 tribal PHCs in 100 districts in 8 states (Andhra Pradesh, Chhatisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Orissa, Rajasthan) and 19 cities.The project was approved for 5 years from September 1997 and an extension of 2 years has been negotiated with the World Bank. The Department of Health has obtained approval of the EFC to cover all

Tenth Plan strategy for control of malaria.

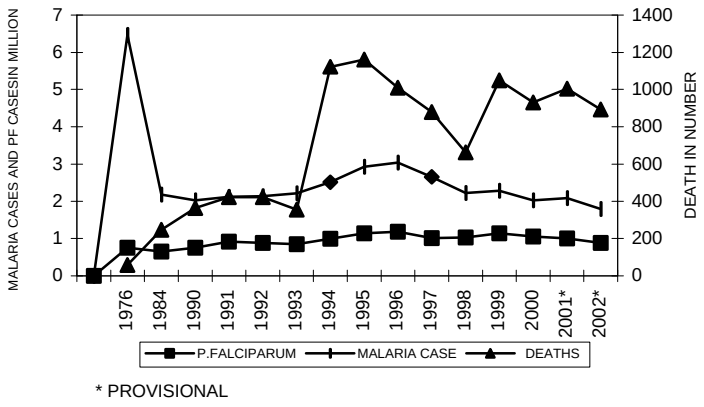
- early diagnosis and prompt treatment
- selective vector control and personal protection
- prediction, early detection and effective response to outbreaks
- IEC
- ensure timely, efficient implementation and effective monitoring

Goals for 2007

- ABER of over 10%
- API of less than 0.5%
- 25% reduction in morbidity and mortality due to malaria

the 8 KBK districts of Orissa in the pattern of funding similar to northeastern states and provide support for transportation cost of insecticides.

Figure 2 : TOTAL MALARIA CASES & DEATHS



* PROVISIONAL

Source - NAMP, DEPARTMENT OF HEALTH

31. Performance during the Ninth Plan period is shown in Figure-2. The decline in cases was not commensurate with the substantial increase in the funding for the activities of the programme. The rising proportion of P. falciparum malaria, increasing vector resistance to insecticides, and the growing parasite resistance to chloroquin will render malaria containment and control more difficult in the Tenth Plan period. The Ninth Plan goal for reduction in API and morbidity has not been achieved. The utilisation of funds under the programme has been sub-optimal (Table-1**).** However it is noteworthy that the reported number of cases of malaria in 2002 was below 2 million. If the decline is confirmed and the trend of decline in reported cases continues in 2003-04 even when the monsoon is normal, it is possible to hope that the Tenth Plan goals for malaria may be achieved.

Table-1:NAMP-OUTLAYS & EXPENDITURE (Rs in Lakhs)

YEAR	OUTLAY*	EXPD./ RE#
9th PLAN	103000.00	
1997-98	20000.00	12575.68
1998-99	29700.00	14404.16
1999-00	25000.00	15500.61
2000-01	25500.00	16914.12
2001-02	22500.00	19443.86
TOTAL	122700.00	78838.43
10th PLAN	137000.00	
2002-03	23500.00	21400.00
2003-04	24500.00	
Source:# EXPD/RE from Bureau of Planning		
* Outlays from Planning Commission		

Kala Azar

32. Kala azar is endemic in 33 districts of Bihar, 11 districts of West Bengal, and three districts in Jharkand and sporadic cases have been reported from Uttar Pradesh. After a reported increase in the number of cases and deaths due to kala-azar between 1989-91, an intensive programme for containment of kala azar was launched in 1992. The strategy for control of infection includes interruption of transmission through insectidical spraying with DDT and early diagnosis and treatment of kala azar cases. Central Government provides the insecticides and anti kala azar drugs, while the state governments meet the expenses involved in the diagnosis and treatment of cases and insecticide spraying operations. The number of reported cases and deaths (Table-2)

Table-2 : KALA AZAR CONTROL PROGRAMME

Year	Bihar		West Bengal		Country	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
1996	25056	674	NA	NA	27049	687
1997	15948	251	1450	3	17429	255
1998	12229	211	1113	6	13577	226
1999	11627	277	1091	6	12869	297
2000	12909	130	1244	11	14753	150
2001(P)	10327	204	1238	4	12239	213
2002(P)*	6364	84	920	3	7757	90
Source: NAMP, Department of Health P-Provisional						
* as per reports received by NAMP upto Aug 2002						

Goals for Tenth Plan

- 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)

have not shown significant decline during the Ninth Plan period. This is due to inadequate insecticide spraying operations and poor outreach of diagnostic and curative services. Increase in drug resistance to sodium stibogluconate has been reported in the Muzffarpur and Darbhanga districts of Bihar. Though sand fly is usually sensitive to DDT, pockets of insecticide resistance have been reported from Bihar. In view of the problems faced by Bihar in providing for operational costs for insecticide spraying, Planning Commission has agreed to the request of the Department of Health that the Department of Health will bear the cost of drugs, insecticides as well as operational cost of kala azar elimination efforts including spraying, wages, transportation and mobility cost. The programme will include not only the affected districts of Bihar but also affected districts of Uttar Pradesh, Jharkhand and West Bengal. This has been approved by the EFC.

Dengue/Japanese Encephalitis (JE)

33. Periodic dengue outbreaks occur in many parts of both rural and urban India. Mortality is usually low but may be high in cases of dengue shock syndrome and dengue haemorrhagic fever. Diagnostic tests for dengue are not readily available. Japanese encephalitis outbreaks have been reported mainly in Andhra Pradesh, Karnataka, Uttar Pradesh and West Bengal. Diagnostic tests and case management facilities for Japanese encephalitis are not readily available in many parts of the country. In endemic states, efforts are being made to improve early diagnosis, proper management and rehabilitation of those with residual disabilities. Innovative strategies for vector control are being investigated. The reported total cases and deaths due to dengue/Japanese encephalitis during the Ninth Plan are given in Table-3.

Table-3 : JAPANESE ENCEPHALITIS (JE) AND DENGUE CASES AND DEATHS

	JE		DENGUE	
Year	Cases	Deaths	Cases	Deaths
1997	2516	632	1177	36
1998	2120	507	707	18
1999	3428	680	944	17
2000	2593	556	622	7
2001	2061	479	3278	53
2002*	816	229	748	15

Source: Annual Report, Department of Health 2002-03

* JE cases upto Sept & Dengue cases upto Oct 2002

34. Currently, there is no organised programme for control of dengue/DHS in the country. Limited assistance in terms of insecticide is being provided for containment of outbreaks. Under the National Vector Borne Disease Control Programme there will be an organised dengue control component implementing the following strategies :

- enactment of municipal by laws/legislative measures to reduce peri-domestic mosquito breeding
- vector control through source reduction, larvicide or adulticide application, and bio environmental measures
- improved facilities for early diagnosis and prompt management in existing health care institutions through capacity building and manpower development.

Filariasis

35. Estimates based on surveys by the Filariasis Survey Units suggest that about 454 million people (120 million in urban areas) are living in known endemic areas; there are 29 million filariasis cases in the country and 22 million microfilaria carriers. Filariasis control programme is being implemented in 19 endemic states/union territories through filariasis control units, municipal bodies and PHCs in rural areas. Central assistance is provided for supply of antifilarial drugs and larvicides/ adulticides. Currently there are 206 Filaria Control Units; 199 Filaria Clinics; and 27 filaria survey units. A total of 48 million people in urban areas are being protected through anti-larval measures. The Indian Council for Medical Research (ICMR) is conducting a feasibility and efficacy study on a mass annual single dose administration of DEC and albendazole for the control of filariasis. Kerala has initiated a pilot project for monitoring and management of mosquitoes in three filariasis endemic districts (Kottayam, Alappuzha and Ernakulam) for the control of vector-borne diseases. The progress of such innovative initiatives will be evaluated and, if found feasible, they will be replicated. EFC has approved the proposal of the Dept of Health that the ongoing strategies for filariasis control will continue and by the end of Tenth Plan annual mass drug administration will be expanded in a phased manner to cover 60 districts.

36. The EFC considered the NVBDCP on 13th June 2003. The Deptt of Health indicated that World Bank assisted Enhanced Malaria Control Project credit arrangement may end next year and if so the project may have to be sustained during the remaining years of the Tenth Plan through domestic budgetary supports. The EFC approved the NVBDCP with an outlay of Rs 1370 crores with the following conditions. The programme should have built-in flexibility to reallocate need-based statewise/disease-wise provisions within the approved outlays. The evaluation of the ongoing programme should be undertaken during 2003-04. Based on the evaluation, fresh components should be considered to change the programme content and qualitatively upgrade the level of assistance. A high level committee should work this out with State representatives. After the evaluation, the Department may come back to EFC with a revised programme. 'In principle' approval of the CCEA may be obtained for the programme the year 2003-04. Guidelines regarding pricing and community involvement in distribution of bed nets should be evolved and circulated to all states. There would be no appointment of lab supervisor, lab technician and volunteers as proposed; performance based honoraria may be given to local volunteers with involvement of PRI, Mahila Samiti, Anganwadi workers during the active transmission period. Efforts need to be made to find out and involve private laboratories and also other testing facilities. Total freight charges be paid for supply of DDT to states not to exceed 3-5% of the total price of DDT supplied. There will be no construction of building for Directorate of National Anti Malaria Programme.

37. Surveillance for vector borne diseases should be an essential component of ongoing disease control programme, and should be carried out preferably with the existing primary, secondary and tertiary care infrastructure and manpower with assistance from specialists and laboratory research institutions as and when necessary. Once it is fully established and made effectively operational, the surveillance programme should provide feedback on a regular basis at various levels of programme implementation and ensure appropriate response. It is imperative that efforts should be made to improve :

- awareness that primary health care institutions are best suited for effective treatment of vector bone diseases through prompt diagnosis and treatment,

- monitoring, surveillance and response; continuous monitoring of vector densities, and emergence of vector and parasitic resistance are critical for success of the programme.

38. It is important to obtain cooperation from other agencies such as :

- civic authorities for prevention of mosquitogenic conditions
- Public Health Engineering Department for operationalization of bioenvironmental measures for control of mosquito breeding
- National remote sensing agency for early identification of mosquitogenic conditions in tribal areas.

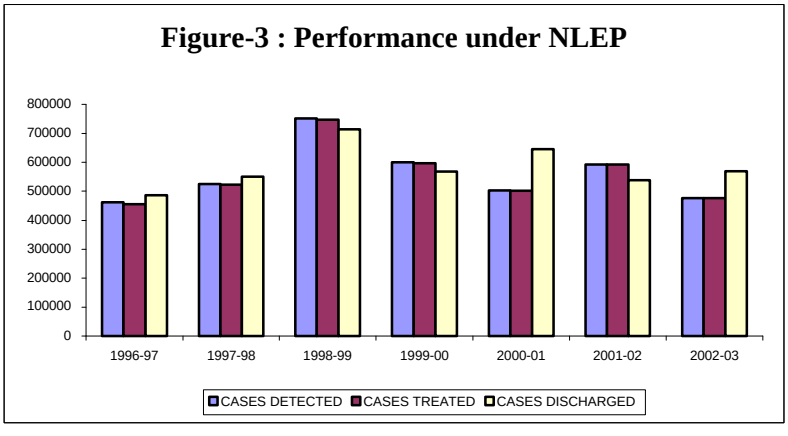
National Leprosy Eradication Programme (NLEP)

39. Leprosy has been a major public health problem in India. In 1984 it was estimated that there were nearly four million cases of leprosy in the country, 15 percent of whom were children. 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. The NLEP was launched in 1983 as a 100% Centrally 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. The strategy adopted to achieve this was:

- Early detection of leprosy cases through active community based case detection by trained health workers;
- Regular treatment of cases with MDT administered by leprosy workers in endemic districts and mobile leprosy treatment units and primary health care workers in moderate to low endemic areas/districts;
- Intensified health education and public awareness campaigns to remove the social stigma attached to the disease; and
- Appropriate medical rehabilitation and ulcer care services

40. Coverage under the programme in the eighties was low. Initiation of NLEP phase – I in 1993-94 with World Bank assistance (Rs.302 crores for a period of six years starting from 1993-94) resulted in rapid expansion of MDT services to cover all the districts in the country, and a steep increase in the number of leprosy patients detected and treated. Against the target of detection and treatment of two million new patients, a total of 3.8 million new cases were detected and 4.15 million leprosy patients were treated and cured till March, 2000. Encouraged by the progress in this period the NLEP Phase II (total project cost of Rs.249.8 crore , IDA to provide Rs.143.6 crores, Government of India to contribute Rs.58.2 crores and WHO to provide free anti-leprosy drugs worth Rs. 48 crores), aimed at reducing the prevalence of leprosy to 1/10, 000 was approved by the CCEA in May 2001.

Figure-3 : Performance under NLEP



41. The performance of the NLEP during the Ninth Plan is shown in Figure-3.

(The States wise data on prevalence of leprosy is given in Table-4. Outlays and utilisation of funds during the Ninth Plan period is shown in Table-5).

Table-4 : Prevalence of Leprosy

States	PR
Bihar	8.60
Orissa	7.32
Chattisgarh	7.20
Jharkhand	6.49
D&N Haveli	5.05
Lakshadweep	4.64
Delhi	4.17
Uttar Pradesh	4.12
Goa	3.10
Maharashtra	2.95
West Bengal	2.70
Andhra Pradesh	2.53
Chandigarh	2.48
Tamil Nadu	2.34
Madhya Pradesh	1.98
Karnataka	1.90
Uttaranchal	1.88
Gujarat	1.40
A & N Islands	1.31
Pondicherry	1.29
Arunachal Pradesh	0.90
Rajasthan	0.73
Kerala	0.67
Sikkim	0.61
J & K	0.60
Assam	0.56
Punjab	0.47
Himachal Pradesh	0.41
Daman & Diu	0.41
Manipur	0.37
Meghalaya	0.35
Tripura	0.31
Haryana	0.25
Nagaland	0.19
Mizoram	0.10
TOTAL	3.23

Source: Leprosy Div. DGHS

42. The Department of Health has initiated steps for the phased integration of this 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.

Table-5 : NLEP- OUTLAYS & EXPENDITURE

(Rs in lakhs)

YEAR	OUTLAY	EXPD. /RE
9TH PLAN	30100.00	
1997-98	7500.00	7679.72
1998-99	7900.00	7188.99
1999-2000	8500.00	7001.98
2000-2001	7400.00	6509.56
2001-2002	7500.00	4704.92
TOTAL	38800.00	33085.17
10th PLAN	25500.00	
2002-2003	7500.00	7500.00
2003-2004	7400.00	

Source:

OUTLAYS: Planning commission

EXP/ RE: BOP, Dept of Health

43. During 1997-98, the duration of treatment with MDT was reduced from 24 months to 12 months for multi-bacillary patients and from 12 months to six months for pauci-bacillary patients. Single dose rifampicin, ofloxocin and minocycline (ROM) treatment for single lesion patients was introduced. Prior to the initiation of the fixed dose treatment, treatment was continued until clinical inactivity. With fixed dose treatment, patients are released from treatment once the duration of treatment is completed. Under the programme, smear examination is optional, it is, therefore, difficult to determine cure rates and relapse rates. It is important that surveillance is strengthened so that relapses are detected early.

44. The NLEP has been successful in reducing the number of leprosy cases. However, this will not result in any immediate decline in the number of patients who have deformities. There is a need to give a major thrust to surgical correction of deformities so that the functional status of individuals can improve. So far 210 district leprosy societies were 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.

45. The major thrust of activities under NLEP in the Tenth Plan is to:

- Ensure reduction in prevalence of cases in the high prevalence states

- Consolidate the gains achieved so far in other states, so that there is no resurgence of the disease
- Effectively integrate leprosy services into general health care so that leprosy care becomes part of health care services at primary, secondary and tertiary level.

46. The Tenth Plan goal is to eliminate leprosy as a public health problem and bring prevalence to less than 1/10,000. The strategy to achieve this will focus on:

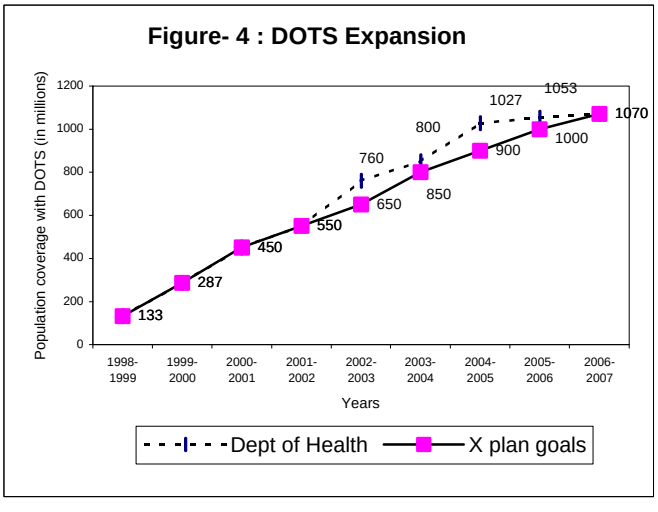
- Training of the existing personnel in primary health care institutions in the early detection and management of leprosy patient; identification and referral of those with complications;
- Re-constructive surgery to improve functional status of individuals;
- Inter-sectoral collaboration for rehabilitation of leprosy patients
- Completing horizontal integration of the programme into the general health care system by 2007. The personnel employed under the NLEP will be transferred to the states during the Tenth Plan. Skill upgradation and redeployment of the over 30,000 leprosy workers and laboratory technicians will go a long way in filling existing gaps in male multi-purpose workers and laboratory technicians in PHC/CHC, and can result in improved performance of all health programmes, including the leprosy programme.

47. Outlay for NLEP the Tenth Plan is Rs.255 crores. It is expected that at the completion of this project NLEP will become the first Centrally Sponsored Scheme in Health Sector to have achieved its goal and to be integrated into the general health services. Orderly transfer of the function is essential to ensure that the disease does not reemerge after a few years.

Revised National Tuberculosis Control Programme

48. Tuberculosis is a major public health problem in India. It accounts for about 1/3rd global cases of TB. National Tuberculosis Control Programme was initiated in 1962 as a Centrally Sponsored Programme. In spite of availability of effective chemotherapy under this programme for nearly three decades, there was no decline in morbidity and mortality due to TB because of low case detection, case holding and cure rates. It is estimated that prevalence of TB is 1.4% and about a third of cases are sputum positive. Over the last two decades, there has been progressive increase in primary and acquired multi drug resistant cases of TB. With HIV epidemic the number cases of TB and of drug resistant TB may increase.

Figure- 4 : DOTS Expansion



49. Following a major review of TB control activities in 1992, the country revised its strategy to ensure improved performance. The Revised National Tuberculosis Control Programme (RNTCP) was taken up as a pilot project and then expanded during the Ninth Plan with

World Bank assistance (Figure-4). RNTCP aimed at improving cure rate through emphasis on:

- Diagnosis through sputum microscopy.
- Uninterrupted supply of drugs for short course chemotherapy.
- Direct observation of treatment with short course chemotherapy (DOTS) to improve compliance and
- Systematic monitoring, evaluation and supervision at all levels.

50. There were substantial delays in operationalization of RNTCP during the Ninth Plan. However, rapid scaling up of the programme began in late 1998. There has been progressive increase in coverage under RNTCP. The performance under the programme is shown in Table-6.

Table-6 : Performance during the Ninth Plan

Year	Sputum exam.		Sputum +ve	NEW CASES			NEW CASES	
	TAR.	ACH.	TAR.	Sputum+ve	Others	TOTAL	RNTCP	NTCP
1997-98	14189175	4518068	472980	351921	957744	1309665	-	-
1998-99	14189175	3893213	472980	321920	927526	1249446	-	-
1999-2000	4884840	4009727	488480	373055	862611	1235666	137615	1098051
2000-01	4985720	3768539	498590	356522	784848	1141370	245135	896235
2001-02	5135100	3889007	513510	402743	718685	1121428	471658	649770
2002-03	4316220	4327176	431622	448381	679157	1127538	623876	503662
SOURCE: DGHS, Central TB Div.								

Utilisation of the funds during the initial period of the Ninth Plan was low; subsequently utilization improved(Table-7) .

51. Review of the programme by Government of India and World Bank team in 2000 shows that :

There has been a progressive improvement in the quality of sputum examination and treatment completion rates. In the RNTCP districts more than 240,000 patients have been placed on RNTCP treatment, with 80% treatment success. But RNTCP covers less than 10% of TB patients in the country.

In non RNTCP districts there has been some improvement in the quality of diagnosis in some areas, with a gradual decrease in over-diagnosis of smear-negative patients and a gradual increase in the number of smear-positive patients diagnosed. In non RNTCP area sputum positive case detection rates are low and treatment completion rates are less than 30%.

Non-standard drug regimens and self-administered regimens which contain rifampicin in the continuation phase are still used in

Table-7 : RNTCP- Outlays/Expenditure

Rs in Lakhs

YEAR	OUTLAY	Expn./RE
9TH PLAN	45000.00	
1997-98	9000.00	3083.50
1998-99	12500.00	6777.76
1999-2000	10500.00	8654.15
2000-2001	12500.00	10626.00
2001-02	13600.00	10129.73
TOTAL	58100.00	39271.14
10th PLAN	68000.00	
2002-03	11500.00	9700.00
2003-04	11500.00	

Source:

OUTLAYS from Planning Commission

EXP/ RE from BOP, Dept of Health

some states despite policy and recommendations to the contrary; this practice is associated with significant risk of further increase in multidrug resistance.

In the non RNTCP areas, some states have sufficient drug stocks but many do not, and treatment completion rates remain very low.

52. The high treatment completion under RNTCP has been attributed to the availability of sufficient funds , sound technical and training policies, and intensive monitoring and supervision, use of patient-wise boxes containing the entire course of treatment and establishment of sub-district level tuberculosis units (TUs) with mobile and dedicated supervisory staff. The main problems faced are that :

- Not all health care providers are involved (government, private, and non-government organization (NGO) and therefore not all patients receive the benefits of the RNTCP.
- It is difficult to co-ordinate care, particularly in urban areas, some of which lack primary health care systems, TB control infrastructure, or both.
- Observation of treatment is often not convenient.
- Lack of awareness of RNTCP.

53. The review group recommended that :.

- The Central Government should work with state governments to develop a Plan for decentralizing the RNTCP.
- Capacity at the state level should be increased to accelerate preparations for implementation of RNTCP and improve supervision and monitoring.
- For states with sufficient capacity, the Central Government should shift its focus from the state to the district level. For states without sufficient capacity, the Central Government should assist the states in developing this capacity on a priority basis. It should be ensured that states have a reasonable likelihood of succeeding in critical tasks prior to decentralizing these tasks.
- There should be increased intra-and inter-sectoral coordination so that patients presenting to public and private health facilities have access to RNTCP
- All governmental health services should adopt the RNTCP at least for their patients.
- In the areas preparing for RNTCP implementation, key challenges are to increase local commitment, ensure microscopy services, train staff according to guidelines and contract or deploy supervisory staff, ensure quality and diagnostic services, use of standard treatment protocols by all case providers.
- There should be regular drug supply, and in SCC areas, where possible, use of direct observation of treatment during the intensive phase, at least for hospitalized patients.
- State and district TB programmes should promote observation of treatment by community volunteers to accommodate patient preference and ensure that observation occurs as per policy.
- NGOs should be encouraged to implement the programme in accordance with recently published guidelines.
- The revised recording and reporting system should be implemented to improve monitoring .

54. The Tenth Plan envisaged that the entire country will be covered under RNTCP by 2007. The Dept of Health sought and obtained the Planning Commission's "in principle" approval for

accelerated coverage of the entire country under the RNTCP by 2005 within the outlay provided for the programme (Table-8) by utilizing the external assistance provided by different agencies.

Table 8 : Outlay for RNTCP during Tenth Plan (Rs. in crore)

Schemes	Ninth Plan			Yearwise outlay for Tenth Plan				
	IX Plan Exp.	Spill Over to X plan	X plan Outlays	2002-03	2003-04	2004-05	2005-06	2006-07
World Bank assisted RNTCP*	266.89	442.44	222.65	71.98	84.31	66.36	-	-
New (or GOI funding)			163.41	-	-	13.52	71.00	78.89
DANIDA Assisted RNTCP in Orissa *	12.84	19.11	12.64	7.49	5.15	-	-	-
New			31.00	-	3.00	9.00	9.00	10.00
DFID Assisted RNTCP in Andhra*	34.37	75.56	54.73	15.73	6.00	15.00	18.00	
New			20.00	-	-	-	-	20.00
Other ongoing Projects (NTP)	84.36	Nil	3.09	1.74	1.35	Nil.	Nil.	Nil.
GDF			30.00	-	11.00	10.00	9.00	-
RNTCP in 3 new states (GFATM)			56.22	-	9.39	17.06	14.77	15.00
RNTCP inHaryana(USAID)			25.23	-	6.91	5.91	6.10	6.31
New Initiative to be started under GFATM in later years			61.03	-	2.00	8.00	25.28	25.75
Total			680.00	96.94	129.11	144.85	153.15	155.95

***** Ongoing schemes

55. While approving the proposal Planning Commission suggested that the Deptt should:

Ensure that quality of diagnosis, treatment and follow up are not adversely affected by rapid expansion of the programme

Undertake a mid term evaluation of RNTCP to assess the impact of the programme of diagnosis through sputum microscopy, completion of treatment under DOTS as well as problems encountered in implementation of RNTCP and

Assess modalities by which the programme can be sustained after externally assisted projects are completed.

National AIDS Control Programme

56. 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. The apparent differences between and within states in the prevalence of HIV infection may, to a large extent, be due to differences in the type and number of persons screened. Available data suggest that over the last two decades, there has been a slow but progressive rise in the prevalence of infection in all groups in all states. 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 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. As infection exists in all the states, it is essential that steps be taken to gear up the health infrastructure and manpower, so that the capability to deal with HIV/AIDS at primary, secondary and tertiary care level is built up in all the states.

56. In 1992 National AIDS Control Programme Phase-I (NACP-I) was initiated with the assistance of World Bank with the objective of containing the spread of HIV infection in the country and strengthening the country's capacity to respond to HIV/AIDS on a long-term basis. Initially the programme was for a period of five years, but was extended up to March 1999. It was implemented through the National AIDS Control Organization at the National level, and the state AIDS Cells at the state /union territory level. NACP-II was initiated from April 1 1999 with assistance of World Bank and two bilateral agencies, namely USAID and DFID. AIDS Phase II programme focuses on:

- reducing HIV transmission among the poor and marginalized high risk group population by targeted intervention, STD control and condom promotion;
- 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 linkages between public, private and voluntary sectors.

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 centers,
- 320 sentinel sites for monitoring the time trends in prevalence of HIV infection
- 570 targeted intervention for prevention and management of HIV infection in high risk groups
- low cost community based care for people living with HIV/AIDS

58. In the earlier years, the focus was on awareness building and bringing a behavioural change in specific vulnerable groups for prevention of HIV/AIDS, but in the later years the approach broadened to address target populations most at risk of acquiring and transmitting the infection. The outlays and expenditure under NACP is given in Table-9.

59. During the Tenth Plan, the programme will be continued with emphasis on:

- prevention of mother-to-child transmission;
- reduction in blood-borne transmission and accidental infection in health care settings;
- care of HIV-infected persons/AIDS cases;
- prevention and management of STD; and
- improved efforts to obtain epidemiological data on time trends in HIV infection.

Table-9 : NACP-Outlays& Expenditure (Rs in crore)		
YEAR	OUTLAY	EXPD.
NINTH PLAN	760 .00	
1997-98	100.00	59.58
1998-99	111.00	62.49
1999-2000	140.00	105.13
2000-2001	145.00	91.11
2001-2002	210.00	154.49
Total	706.00	472.80
10th PLAN	270/127.00	
2002-03	225.00	242.00
2003-04	225.00	
Source:		
OUTLAYS from Planning Commission		
EXP/ RE from BOP, Dept of Health		

60. Department of Health has proposed to implement a comprehensive HIV /AIDS control programme during the Tenth Plan including all the components indicated in the Tenth Plan. An Action Plan for coordinated management of blood transfusion services through out the country is being taken up. Blood storage facilities are being created at First Referral Units in collaboration with the Department of Family Welfare. Activities for prevention of mother-to-child transmission are proposed to be scaled up to district level hospitals as well as medical colleges, both private and public sector, in Maharashtra, AP, Karnataka, Manipur, Nagaland and Tamil Nadu. Subsequently, medical college hospitals of other states will be covered in a phased manner. Voluntary Counselling and Testing (VCT) services have been established up to district level in some states initially, and will be expanded in a phased manner. Post exposure prophylaxis (PEP) for health care providers in the event of accidental needle stick injury while treating HIV positive patients will be made available in all public sector hospitals up to district level. Provision of drugs for treatment of opportunistic infections in HIV/AIDS patients has been made available. Collaboration with Revised National Tuberculosis Control Programme for early diagnosis and treatment of HIV-TB co-infection has been established. Efforts are under way to improve utilization of STD clinics in public sector hospitals by improving privacy and confidentiality. Linkages with sub-district STD/RTI programmes of the Department of Family Welfare are being strengthened. Community Care Centres have been established to provide care and support services to AIDS patients. Facilities are provided for management of opportunistic infections among these patients at all levels of health care system. Targeted intervention among high-risk group by providing counselling high quality services will be continued in the Tenth Plan period. A comprehensive programme for infrastructure development and training of health care providers at primary, secondary and tertiary levels is under implementation. Till January 1, 2003, 81650 doctors, 78122 nurses, 190944 Para-medical workers have been trained. A computerized information system has been developed for effective monitoring of the implementation of NACP-II at National and state levels. Officers from State AIDS Control Societies are being trained to operate the system, and all information from states is being transferred to NACO electronically from January 2002.

Tenth Plan Goals

- 80% coverage of high risk groups through targeted interventions;
- 90% coverage of schools and colleges through education programmes;
- 80%awareness in general population in rural areas;
- Reducing blood-borne transmission to less than 1%;
- Establishing at least one voluntary counselling and testing centre in each district;
- Scaling up prevention of mother-to-child transmission activities up to the district level; and,
- Achieving zero level increase of HIV/AIDS prevalence by 2007.
- Improving utilization of STD clinics; and,
- Improving treatment and care of HIV infected persons and AIDS cases.

NACP – External funding for on-going and new programmes

EAP Funding agency	(Rs in crore)
WB assisted AIDS Phase II Project	1155.00
DFID Project (in 5 states)	487.40
AVERT project (Maharashtra)	166.00
APAC Project (TN & Pondicherry)	64.58
CIDA Project (Rajasthan & Karnataka)	37.81
UNDP	6.47
Aus AID (4 states)	24.65
Total	1941.91

61. The Deptt of Health obtained approval of the Planning Commission for a comprehensive multi agency funded programme for AIDs control during the Tenth Plan within the Tenth Plan outlay. During the Ninth Plan, expenditure on the various components of NACP was Rs 515.97 crores . The outlay for NACP-II for the Tenth Five-year plan is Rs.1270 crore. To ensure that expenditure is limited to the allocation provided, expenditure on the DFID project will spill over to the next plan period.

62. The EFC approved the proposal of NACO with a total outlay of Rs. 1941.91 crore subject to the following:

- The total outlay should not exceed that provided by the Planning Commission, i.e. Rs.1270 crore;
- Certain percentage of the funds should be earmarked for creation of infrastructure. This may be decided by NACO in consultation with the Planning Commission,
- Load of recurring liabilities should be ascertained and economized, since this will have implications for future strategy and sustainability,
- Component-wise details of allocation of funds should be worked out before the proposal is submitted for CCEA approval;
- Unit cost as well as cost effectiveness of interventions should be looked into by NACB;
- Component proposed to be directly funded by donor agencies should be looked into by NACO and should be in consonance with the aims, objectives and priorities of the programme.

63. HIV is a multifaceted problem affecting all segments of society. Until now the Department of Health has been the nodal point of interventions not only for the traditional activities of the health sector such as prevention, detection, counselling and management, but also other areas such as legislation, rehabilitation of infected persons and their families. During the Tenth Plan it is expected that each Department will handle HIV infection related issues in their respective sectors. For instance, the Ministry of Labour will look after area of 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 to take care of children who have lost their parents due to AIDS. If each sector takes up the tasks pertaining to its sector, the country will be able to look after the needs of HIV infected persons and their families without any adverse effect on other programmes.

Horizontal Integration of Vertical Programmes

64. 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 will 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.

65. 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 improve data collection, and reporting, strengthen HMIS, improve the supply of essential drugs and devices at PHCs/CHCs and enable the operationalisation of 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. During the Tenth Plan, efforts will be mainly directed to improving the pace and coverage of this convergence. The NHP 2002 envisages manpower in rural /urban health sytsem should be available for the entire gamut of public health activities at the decentralised level, irrespective of whether these activities relate to national programmes or public health activities initiated by state /PRI.

CONTROL OF NON-COMMUNICABLE DISEASES (NCD)

66. Non-communicable diseases cover a wide range of heterogeneous conditions affecting different organs and systems in different age and socio-economic groups. Over the last two decades, morbidity and mortality due to cardio-vascular diseases, mental disorders, cancers and trauma have been rising due to an increase in:

- the number of senior citizens with higher prevalence of non-communicable diseases;
- prevalence of non-communicable diseases in younger people due to life-style changes, obesity and stress; and
- exposure to environmental risk factors and use of tobacco. .

67. 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.

68. The Ninth Plan envisaged the provision of integrated non-communicable diseases prevention and control services through the existing infrastructure. However, the progress on this front has been very slow. In some states like Kerala efforts are being made to implement

an integrated non-communicable disease control program at the primary and secondary care level with emphasis on prevention, early diagnosis, management and building up of a suitable referral system. Tertiary care centres are being strengthened to provide treatment facilities for the management of complications.

69. During the Tenth Plan, efforts will be made to improve preventive, promotive, curative and rehabilitative services for non-communicable diseases throughout the country at all levels of care so as to reduce morbidity and mortality. The major thrust will be on:

- a well-structured IEC&M for primary and secondary prevention of non-communicable diseases;
- re-orientation and skill upgradation of health care providers in diagnosis and management of non-communicable diseases at different levels of care;
- establishment of referral linkages between primary, secondary and tertiary institutions;
- production and provision of drugs for treatment of non-communicable diseases at affordable costs;
- development of institutions for rehabilitation of disabled persons, teaching persons to live with their disability;
- development of hospices for care of terminally ill people who cannot have home-based care; and
- creation of an epidemiological database on non-communicable diseases especially CVDs, stroke and diabetes

National Cancer Control Programme (NCCP)

70. India has one of the lowest rates of cancer in the world, but because of the billion plus population 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 350,00 cancer patients die each year. Current projections suggest that the total cancer burden in India for all sites will double by 2026 because of increasing longevity, greater exposure to environmental carcinogens due to industrialisation, use of fossil fuels, use of a wide variety of chemical agents in industry and agriculture, and the continued use of tobacco.

71 Cancers of mouth/oropharynx, oesophagus are common in both sexes, cancer of the stomach and the lower respiratory tract are more common in men; cancer cervix, breast are common in women . About one-third of cancers are easy to detect and can readily be cured it diagnosed easily. Tobacco-related cancers (especially cancers of oral cavity, and lung) form more than 50 per cent of the overall cancer burden in the country. An increase in tobacco smoking instead of chewing might lead to a rise in the incidence of lung cancer, which is more difficult to detect and treat. Changing dietary patterns (high calorie, high fat intake) and lower parity may result in increasing incidence of breast cancer.

72. 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) for diagnosis, treatment and follow up of cancer patients. RCCs undertake research studies, surveys of mortality and morbidity due to cancer, train medical and paramedical personnel in cancer care and health education. NCCP provides funds for the purchase of equipment (cobalt unit, mammography unit), and

development of oncology wings in Government Medical Colleges/voluntary organisations. The District Cancer Control Programme initiated in 1990-91 is aimed at promoting health education, early detection of cancer and pain relief. ICMR established a National Cancer Registry Programme (NCRP) in 1981–82 with five population-based urban cancer registries in Mumbai, Bangalore, Chennai, Bhopal, Delhi and a rural registry at Barsi in Maharashtra and six hospital-based registries at Chandigarh, Dibrugarh, Thiruvananthapuram, Bangalore, Mumbai and Chennai. The NCRP provides data on regional difference and time trends in cancer prevalence so that appropriate modifications in the ongoing programmes could be made.

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.

73. Progress in ongoing efforts for cancer prevention, early detection and management has been very slow.The evaluation of the NCCP showed that :

- The cancer treatment facilities are not equitably distributed. There are fewer radiotherapy units in states like Bihar, Orissa, Rajasthan and Uttar Pradesh and in poorer districts in better performing states.
- Because of the absence of a well established referral system , cancer treatment facilities are over crowded.
- District cancer Control Programme is functioning very poorly.
- the Voluntary organistaions providing IEC are functioning poorly.
- There is a need for better coordination

74. The major focus of cancer control programme should not be to provide continuous support to existing units, but utilization of available plan funds to fill gaps in the availability of cancer treatment facilities in under served states/ districts, and improve functional status of existing cancer treatment centres throughout the country. There is a need to train existing health care providers at primary, secondary and tertiary care level in early detection of cancers. During ZBB exercise 2000 it was agreed that the programme will continue during the Tenth Plan period and will be re-classified as a Centrally Sponsored Scheme. During the Tenth Plan, a major effort will be to made 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 to appropriate levels of care at the right time

75. Department of Health came up with an EFC proposal for the NCCP in the Tenth Plan for continuation of the programme as in the Ninth Plan with augmentation of assistance for the various components. Expenditure Finance Committee considered the EFC proposal in its meeting held on 11th February, 2003. The EFC suggested that the Dept may recast the EFC memo taking into account the evaluation findings. While recasting the proposal the

following comments may considered. The existing RCCs as well as cancer treatment centers should become increasingly self-reliant so that funds available from cancer control programme can be provided to centers where no treatment facilities exist. It is important to network existing centres and build up appropriate referral services. All medical colleges should be provided with at least one cobalt machine on priority. Existing cancer treatment centres and regional cancer centers have to be integrated with existing health care system in the states. Clear norms should be evolved and implemented regarding user charges for diagnostic and therapeutic services for people above poverty line while providing free/subsidized treatment for those below poverty line. Until the new proposal is approved existing schemes under NCCP may continue as per the Ninth Plan parameters.

National Mental Health Programme

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 - 1 .0% of children have mental retardation.

76. Mental health care has three major aspects –restoration of health in mentally ill patients, early identification of those who are at risk, and appropriate protection and promotion of mental health in normal persons. Prior to 1950, mental health services consisted mainly of large, centralized mental hospitals, providing custody and care of persons with mental disorders. At the time of independence, there were 17 mental hospitals accommodating over 8, 000 patients. Soon after independence efforts were made to improve access to mental health services by increasing the number of mental hospitals, and opening psychiatric units in general hospitals. Providing psychiatric care through general hospitals and bringing mental health care out of the confines of mental hospitals reduced the stigma associated the treatment of mental illness, removed legal restrictions on admission and treatment, and facilitated the early detection of associated physical problems.

77. In 2001, there are 37 specialized government mental hospitals in the country (small: <250-bedded, medium: 250–500 bedded, and large: >500 bedded) with total bed strength of 18,024 beds. In addition, various medical colleges and general hospitals in the country have about 200 psychiatry units of varying sizes with total of 3000 beds. The National Human Rights Commission (NHRC) conducted a review of the functioning of all the state-run mental health institutions through the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, and found that:

- Only 16 states have govt. mental hospitals.
- The average age of psychiatric hospital in India is 85.7 years, with quite a few being over 100 years old.
- About 40% of these Mental Health Institutions are structured like jails, and are poorly maintained.
- There are a large number of vacancies amongst doctors and nursing staff.
- The budget for these hospitals is also limited.

78. Facilities for treatment of mentally ill patients existing in general hospitals and medical colleges is inadequate; in many of these neither the full team of trained functionaries, nor adequate resources were available. The NHRC suggested that all these hospitals would need strengthening if they have to play a substantive role in care of mentally ill patients.

79. According to the norms laid down by the Medical Council of India, every medical college should have a department of psychiatry with a minimum of three faculty members and inpatient facilities for 30 beds. They should also have outdoor facilities and facilities for providing various forms of therapy. About a third of the medical colleges do not have these essential facilities . The country currently has about 40 PG teaching centres, 3000 qualified psychiatrists, 500 clinical psychologists, 300 psychiatric social workers and 600 trained psychiatric nurses. The training curriculum at the undergraduate level in medical colleges has not been upgraded. There are very few centres in the country to train specialist non-medical mental health professionals (clinical psychologists, psychiatric social workers) and psychiatric nurses. For up gradation of training in psychiatry in medical colleges, following strategies have been proposed :

- Creation of psychiatry department in medical colleges where it does not exist.
- Up gradation of the existing psychiatry services (including provision of inpatient services), with necessary equipment, and trained manpower.
- Departments of psychiatry to be responsible for implementing and providing support for execution of National Mental Health Programme/DMHP.
- Provide facilities for training psychiatric social workers and nurses, and providing accreditation and licensing for them.
- Enhancing capacity for training manpower in the existing Central/State government institutes/colleges.

80. The National Mental Health Programme (NMHP) was initiated in 1982

- to ensure availability and accessibility of minimum mental health care for all in the foreseeable future (particularly the most vulnerable and underprivileged sections).
- to encourage application of mental health knowledge in general health care.
- to promote community participation in developing mental health services, and to stimulate efforts towards self-help in the community.

81. Attempts were made to :

- Integrate basic mental health care into general health services, and improve diffusion of mental health skills to al levels of the health service system.
- Appropriate allotment of tasks in mental health care for different levels of health personnel.
- Equitable and balanced distribution of resources.
- Improve linkages to other community development programmes.

The progress under this programme was slow during the Sixth and the Seventh Plan periods.

82. During the Eighth Plan, NIMHANS developed and implemented a district mental health care model in the Bellary district of Karnataka taking into account that :

- Majority of mentally ill individuals do not reach the existing psychiatric services
- A large proportion of patients with mental disorders are ambulatory and can be provided with care at home .

- Early detection and prompt treatment of mental disorders holds the key for rapid improvement

83. The main objectives of the programme were

- to develop a domiciliary care, to be delivered by non-specialist medical and non-medical personnel, using simple, inexpensive and effective intervention techniques.
- community education to reduce the stigma attached to mental illness; and
- treatment and rehabilitation of patients within their family setting.

84. The services covered a population of 1.5 million distributed in 7 talukas. A program officer for mental health was appointed in the District Health & Family Welfare Office to organize a mental health clinic in the premises and also tour the entire district. A simple recording and reporting system was developed. Five essential drugs were made available for distribution in all the health centres in the district. After 1990, DMHP` in Bellary was taken over by the Department of Health and Family Welfare, Karnataka. Based on these encouraging experiences during the Ninth Plan the programme was extended to cover 22 districts in 20 states.

85. Tenth Plan envisaged that the centre and the states will progressively improve access to mental health care services at the primary and secondary care levels to cover all the districts in a phased manner. Psychiatry departments in medical colleges will play a pivotal role in the operationalisation and monitoring of the programme in the district in which they are located and synergistic links will be formed with other ongoing related programmes. An outlay of Rs 190 crores was provided for the CSS National Mental Health Programme.

86. The Dept of Health has formulated the following intervention under the NMHP during the Tenth Plan period:

- Improving the infrastructure and functioning of existing government mental hospitals and psychiatric wings of general hospitals (Rs 72.00 crores) and psychiatric wings in medical colleges (Rs 37.50 crores);
- Expansion of District Mental Health Programme to 100 districts (Rs 89.43 crores);
- Increased thrust on IEC and awareness creation so as to dispel myths and prejudices related to mental health (Rs 10 crores);
- Promoting relevant research, with emphasis on community based research, which would facilitate more effective public health interventions (Rs 5 crores) ;
- Strengthening the State and Central Mental Health Authorities, in order to make their monitoring role more effective.

87. The EFC approved the above proposal with the proviso that the total cost of the Programme being restricted to the Tenth Plan outlay of Rs 190.00 crore. The EFC supported the following steps for of expansion and strengthening of Medical colleges, streamlining and modernising the existing mental hospitals, and implementing the Mental Health Act:

- Within the total outlay of Rs 72 crores, a provision upto Rs.3.00 crore made for hospitals with bed strength of more than 500, and for those with bed strength of less than 500, a provision upto Rs. 1.50 crore may be made. This would be released to the

hospitals on submission of a concrete proposal from the institution through the state government. The grant would cover construction/repair of existing buildings, purchase of equipment/furniture, and provision of infrastructure (water tanks, toilets etc). It would not cover expenses such as salaries, and recurring expenses towards running the mental hospitals, or expenses on drugs and consumables.

- This is a one-time grant linked not to bed strength but to the requirement and preparedness to absorb the funds provided and provide the needed services
- Each proposal should be considered and sanctioned by the Committee under the chairmanship of Secretary (Health) within the projected funds for these components.

88. EFC recommended the strengthening of the psychiatric wings of general hospitals and medical colleges in the government sector by providing them a one-time grant of Rs. 50 lakhs for up gradation of infrastructure and equipment to colleges after the proposals routed through the state is considered and sanctioned by the Committee under the chairmanship of Secretary (Health). The grant would not be used for recurring costs and running expenses. Based on an estimate that at least 75 proposals can be considered during the Plan period, and at least 15 proposals for up gradation of hospitals/ medical colleges every year, the estimated requirement per year for this purpose would be about Rs.7.5 crore/year, and Rs. 37.5 crore for the Tenth Plan.

89. The EFC recommended that evaluation of District Mental Health Programme in districts covered under the pilot project should be taken up forth with. Districts that have not been given assistance for complete five years during the Ninth Plan may be given assistance for the balance period on existing basis. Expansion of the District Mental Health Programme should be undertaken only after evaluation of the pilot programme. A Committee under the Chairmanship of Secretary (Health) will decide on the issue of expansion of the District Mental Health Programme after evaluation of the pilot project. The EFC also suggested that the IEC and the research strategies may be revised .

National Programme for Control of Blindness

90. Of the total estimated 45 million blind persons (visual acuity less than 3/60) in the world, 7 million are in India. Two major surveys were conducted to find out the prevalence of blindness in the country. The first undertaken by the Indian Council of Medical Research (ICMR) in 1974 indicated a prevalence rate of 1.38% in general population (visual acuity <6/60). National Programme for Control of Blindness (NPCB) was launched in 1976 as a 100% centrally sponsored programme with the goal of reducing the prevalence of blindness. The second survey sponsored by the Government of India/WHO (1986-89) showed that in the intervening 15 years, there had not been any decline in the prevalence of blindness in the country. Both these surveys indicated that cataract was the single largest cause of blindness in India. Correcting cataract blindness was therefore given highest priority. The NPCB aims at improving eye care facilities with a focus on improved access to cataract surgery. The target was to reduce the prevalence of blindness to 0.3% by 2002. Assistance was obtained from the World Bank to improve the facilities for cataract surgery in the 7 states estimated to be contributing 70% of the country's cataract blind. The programme was in operation between 1994-2003. The remaining states received funds from the domestic budget. Under the National Programme for control of blindness:

- 307 dedicated eye operation theatres and eye wards have been constructed in district level hospitals;
- ophthalmic equipments for diagnosis and treatment of common eye disorders, and for IOL have been supplied to all district hospitals;
- more than 800 eye surgeons have been trained in IOL surgery;
- 30 NGOs assisted for setting up/expanding eye care facilities;

91. Performance under the programme, and utilization of funds are given in the Figure-5 and Table-10.

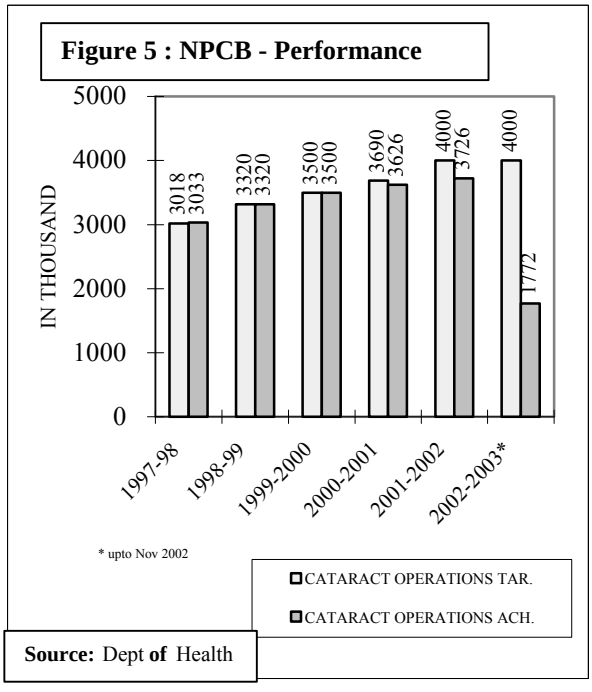


Table-10 : FINANCIAL SCENARIO-Blindness Control Programme (Rs inlakhs)

YEAR	OUTLAY	EXPD. /RE
9TH PLAN	44800.00	
1997-98	7000.00	6799.46
1998-99	7500.00	7542.75
1999-2000	8500.00	8990.14
2000-2001	11000.00	10144.33
2001-2002	14000.00	8564.99
TOTAL	48000.00	42041.67
10th PLAN	44500.00	
2002-03	8600.00	8600.00
2003-04	8600.00	

OUTLAYS from Planning Commission

EXP/ RE from BOP, Dept of Health

Volume of cataract surgery has increased steadily since 1993; the current rate is 3700 per million population. Cataract surgery with IOL implantation has increased from 5% in 1994 to 65% in 2001-02, and there has been an increase in coverage of eye care services. Rapid assessment survey carried out in 12 districts has indicated that 70% of cataract blind persons utilized eye care services. Recent survey (1999-2001) in 15 districts of the country indicated that prevalence of blindness (VA <6/60) has come down to 1.08%

92. Mid-term evaluation of World Bank assisted Cataract Blindness Control Project carried out in 1997-98 shows that:

- There is an increase in the number of cataract operations performed in all the project states
- Utilization of services by women has increased.
- There is evidence of reduction in the prevalence of blindness in the project states (except in Uttar Pradesh).
- Gradual reduction in proportion of operations performed in eye camps.
- Quality of care, as assessed by reduction in failure rate, has improved significantly.

- Sight restoration after IOL surgery is far superior as compared to conventional surgery; the latter also required intensive follow up, and outcome was dependent upon provision of corrective glasses.
- The coverage of services has now been enhanced to about 50% persons and 70% eyes.

93. The WB/GOI evaluation of the programme in 2001 showed that inspite of the impressive progress the programme faced some problem such as :

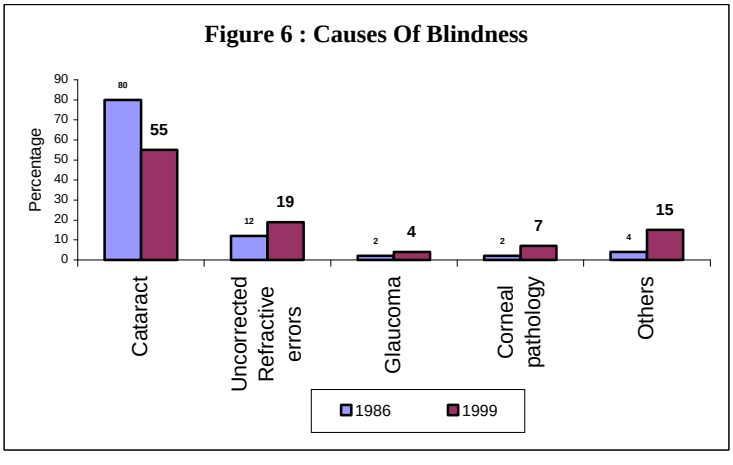
Inequitable distribution of eye surgeons: though there are 11,000 eye surgeons in India for a population of 1 billion (average ratio of 1 eye surgeon for 1,00,000 population), there is a wide disparity between rural and urban areas;
Sub-optimal utilization of human resources: it is estimated that about 50% of eye surgeons are "non-operating" surgeons, practising medical ophthalmology, refractive services, or providing general medical care;
Inadequate number of para-medical eye care personnel, leading to eye surgeon – paramedic ratio far below the norm of 1:3 or 1:4: there are less number of qualified paramedic than eye surgeons;
Variation in quality: absence of mandatory protocols and mechanisms for accreditation have led to wide variation in quality of services and outcome;
Sub-optimal coverage of remote and socially backward population;
Overemphasis on cataract and low priority for other problems such as corneal opacities, glaucoma, diabetic retinopathy, and problems in children causing blindness. These sub-specialties are available only at a few tertiary level institutions, and training of eye surgeons in these sub-specialties has been inadequate;
Lack of public awareness: rural, illiterate and under privileged population is not aware of the various possible interventions available to restore vision. Since integration with primary health care is limited, rural health workers are not motivating potential beneficiaries.

94. As a part of end-line evaluation of the World Bank Assisted Cataract Blindness Control Project several studies were carried out. Results of some of these studies are summarized below:

- National Survey on Blindness (2001-02) showed that there has been a shift in the causes of blindness over the last decade (Figure-6).

95. Survey undertaken in 2001-02 in 9 randomly selected districts of states covered under World Bank Project showed that:

Figure 6 : Causes Of Blindness



- Dependence on eye camps has now reduced, except in remote and tribal areas.
- Involvement of PHC/CHC doctor in NPCB programme has increased.
- Higher proportion of Cataract Operated Persons consulted doctors at early stage.
- There is increasing demand for modern techniques like IOLs and suture-less surgeries;

- 84% of Cataract Operated Persons received free spectacles.
- The unit cost of providing a cataract surgery is highest in private hospitals (Rs.5331), followed by NGO hospitals (Rs.4977) and government camps (Rs.2143). the cheapest option was NGO-organised screening camps supplemented by surgery of screened persons at base hospital (Rs.1128). The patients spent a substantial amount out of their pockets to pay for direct (medicines, spectacles, diagnostics, etc.) and indirect (travel, food, wage loss, etc.) costs.

Blindness control programme in the Tenth Plan period

96. During the Tenth plan, the focus will be to improve access to good quality eye care for majority of ophthalmological problems. Dept has proposed that they will perform 211-lakh-cataract operation during the period 2002-07, of which minimum of 50% operations will be by IOL implantation. In addition, about 3 lakh school children with refractive errors will be provided free glasses. Network of eye care infrastructure including vision centers in rural areas, pediatric units, low vision centers and eye banks will be established to increase capacity of the state in providing comprehensive eye care services to the community. This would require training of adequate number of eye care personnel and commodity assistance in the form of equipments, consumables and drugs.

97. District Blindness Control Societies (DBCS) will act as nodal agencies in 563 districts and will be responsible for decentralized planning and preparation, implementation through utilization of government facilities, monitoring and quality control, social mobilization and public awareness, procurement of drugs, equipment, consumables etc, financial and material management, orientation of health functionaries and identifying the blind, arranging transportation of patients and ensuring follow up after surgery.

98. Micro planning at the district level will include listing of all blind persons, particularly those blind in both eyes, and those above 50 years of age; mapping of eye care infrastructure – plotting of fixed facilities (government, voluntary, private sector) and mapping as per the norms, e.g. 1 eye surgeon for 700 cataract surgeries per year, bed for 50 surgeries per year.

99. The target set would ensure :
Cataract surgery rate up to 600/100,000 population over 3 years;
To ensure more than 50% coverage of women;
To ensure equal coverage of all villages and 60% coverage of persons living below the poverty line for free cataract surgery;

In order to improve the quality, DBCS will ensure that:
Surgeries are conducted in dust free, sterile operation theatres;
IOL surgery is performed only in fixed facility where requisite equipments and trained eye surgeon are available;
In the absence of a trained surgeon, conventional surgery should be performed.

100. DBCS will assess progress in each block through periodic review, Concurrent monitoring of individuals and organisations to assess the validity of data. Software has been developed to facilitate data compilation and analysis of various activities under NPCB. It has been installed in 25 Sentinel Surveillance Units (SSUs) located in Medical Colleges to facilitate monitoring and evaluation.

Objective	Goals for the Tenth Plan
To improve the quantity and quality of cataract surgery	*To increase cataract surgery rate to 4500 per lakh population per year by 2007. *To improve visual outcome of cataract surgery (>80% to have visual outcome of >6/18 after surgery). *To increase the proportion of IOL surgery to >80% by 2007.
Development of paediatric ophthalmology units	*Pediatric ophthalmology units established in 50 institutions
Early diagnosis and treatment of glaucoma and diabetic retinopathy	*To screen all known diabetics for retinopathy, and provide laser treatment to those who need it. *To screen for glaucoma all patients above the age of 35 years who attend eye clinics.
Low vision services to be initiated at tertiary level with adequate linkages with secondary level and with primary care in a phased manner.	*Basic refraction services to be available at CHC level in all districts of the country *4000 vision centres manned by trained personnel to be established in rural areas. *Establish low vision centres at 50 institutions in a phased manner.
Development of safe eye banks and networking of eye donation and training centres.	* Setting up 25 fully functional and accredited safe eye banks, each with a capacity to collect and utilize 1000 or more eyes per year and linked with network of eye donation centres.
Integration of primary eye care with primary health care	*Treatment of simple eye diseases including refraction services at PHC level. *measles vaccine in primary immunization, ensuring 100% coverage under (RCH programme) *75% coverage of all under 3 children by regular Vitamin A supplementation (Integrated RCH programme)
Develop human resources and institutional capacity for eye care.	*Training of eye surgeons in IOL surgery, corneal transplantation, vitreo-retinal surgery, pediatric ophthalmology and other sub-specialties. *Training of middle level eye care personnel for primary eye care and supportive services. *Training in eye care management. *Capital grants for infrastructure *Commodity Assistance: ophthalmic equipments and consumables.

101. The EFC approved the National Programme for Control of Blindness in the Tenth Plan with an outlay of Rs.445 crore. (Rs. 433.65 crore from Plan Budget, and Rs.11.35 crore from DANIDA Project Phase III). The EFC recommended that:

A committee consisting of Additional Secretary (Health), Joint Secretary, Health & FA would decide on the norms for financial assistance for various components.

Non-recurring grants should be only for purchase of new equipment and not for replacement of equipment.

Mid-term evaluation should be undertaken during the year 2004-05 and further modification could be considered thereafter.

There should be a special focus in this programme on illiterate women in rural areas, school children in underserved areas and states where the incidence of blindness is relatively high.

LOGISTICS OF SUPPLY OF ESSENTIAL DRUGS AND DIAGNOSTICS

102. About one third of the expenditure on health is on procurement, storage and distribution of drugs. Most patients complain that Government hospitals do not provide drugs and there is shortage of even essential drugs. Health professionals are concerned about the overuse, abuse and wastage of drugs in government, private and voluntary sector which not only results in increased health care costs but in the long run could have adverse health consequences. Currently there are several efforts to evolve and implement appropriate strategy for effective and efficient use of funds available for purchase of drugs. Some of the ongoing initiatives include, listing of essential drugs, advocacy for rational drug use among doctors and community, evolving standard protocols for treatment of common ailments and informing the doctors about these through appropriate CME programmes. Efforts will be made to reduce the cost of drugs and diagnostics through pooled procurement and improving logistics of supply. Strengthening the drug control organization and drug/ biological agents testing laboratories is essential for ensuring quality of drugs and diagnostics. During the Tenth Plan efforts will be made to provide adequate investment predominantly from public sector in R&D to develop low cost, effective and safe drugs/ diagnostics for use in public health programmes.

CAPACITY BUILDING IN FOOD SAFETY AND DRUG QUALITY CONTROL

103. Central Acts regulate quality and safety of both Drugs and Food. Policy making, imports and new drugs are the responsibility of the Central Government, and enforcement of these Acts is the responsibility of the State. The Central Drug Standard Control Organization (CDSCO), Directorate of Health Services along with Drug control organization of the State are responsible for ensuring safety, efficacy and quality of drugs, their import, manufacture, distribution, sale and standards. These are regulated under the Drug and Cosmetic Act and Rules (1940&1945). The main function of CDSCO includes control of quality of drugs imported into the country and coordination of activities of State/UT. Drug Control Authority approves new drugs proposed to be imported or manufactured in the country, lays down standards and regulatory measures and acts as Central License Approving Authority for drugs (including blood and blood products and large volume parenterals, syringe and vaccine) and cosmetics manufactured in the country and regulated under Drugs and Cosmetic Act.

104. Over the years, there has been deterioration in the regulatory mechanism for quality control of drugs and food because of lack of priority, fiscal constraints and poor regulatory infrastructure both in the Centre and the States. India's competence in drug sector is globally recognized but the absence of efficient and effective regulatory system has come in the way of the sector realising its full potential. In view of the increasing international trade it has become essential to ensure proper quality control of foodstuffs and food products both for

internal consumption and for export. Simultaneously, there is need for ensuring quality of food imported into the country.

105. Department of Health had sought and obtained the approval of the Planning Commission for a composite scheme for capacity building of Centre and State for quality control of food and drugs with World Bank Assistance, with total outlay of Rs 291.25 crores. The Department has indicated the activity under each component and scheme will be kept separate through out the Tenth Plan period and subsequently handed over to appropriate Central and State agencies so that they could internalise it on the Non-plan side during Eleventh Plan.

Name of the Sub-component	Central Sector	State Sector (CSS)	TOTAL
Food Safety	75.88	95.39	171.27
Quality Control of Drugs	53.07	61.84	114.91
Project Management Unit	5.07	0	5.07
TOTAL	**134.02**	**157.23**	**291.25**

106. The scheme aims at

Strengthening of food and drug laboratories in the State and Centre through provision of appropriate infrastructure, equipment and training
Setting up new laboratories in the Central Sector and in the States where food testing laboratories do not exist.
Strengthening of CDSCO at Central and regional level
Setting up a management information system linking up all the laboratories and the administrative set up.
Adoption of GMP and HACCP by food processing industries.
Setting up of small food monitoring units at state head quarters.

107. Currently there are 70 laboratories in the food sector in the states. They perform routine analysis and are not in a position to test for newer additives and contaminants. It is proposed to supply equipment and train the personnel so that at least one laboratory in each state can undertake all the essential tests. Currently there is no infrastructure to monitor the quality of imported food products, or to maintain a database of such products. Additional laboratories will be set up in areas where food is being imported but facilities for testing them are not available. Staff at all level in food regulatory authorities and food industry will be trained in all aspects of food safety especially in HACCP. Food products for testing in each laboratory will be defined clearly. It is envisaged that training of industry personnel, particularly from small scale-sector would be taken up, so that they are able to up grade their manufacturing capabilities in line with the new upgraded GMP. The feasibility of generating funds within the organization by charging appropriately for training and certification is to be explored so that these vital activities become self sustaining.

108. In the drug sector, there are 19 drug testing laboratories covering in 27 states and union territories. Of these, only 7 have the capacity to test all varieties of drugs. The proposal aims at strengthening these laboratories with equipment and training the staff to carry out essential chemical and microbiological tests, so that delays are avoided. All the regulatory staff would be trained to effectively administer and monitor implementation of the Drugs and Cosmetics Act and Rules and ensure uniform implementation of GMP and GLP. Strengthening of laboratories/setting up of new laboratories will take into consideration the quantum of drugs

manufactured in the state for testing, the import and export potential, and the number of drugs/ formulations that require testing.

109. The Expenditure Finance Committee while approving the Capacity Building Project on Food Safety and Quality Control of Drugs in August 2002 recommended that the Dept of Health should explore the feasibility of providing the staff requirements for these labs from the surplus staff in health system after suitable training. It is essential to take an undertaking from the state governments that once the facilities are created, they will be taken over in the subsequent plan period, and the state government will meet their functional cost. The Deptt of Health must take into account the present level of capacity utilization of existing laboratories, details of the gaps to be filled, and the extent to which the new labs will fill these gaps, as well as the extent to which the present level of user charges and licensing fees are able to meet the recurring costs of these laboratories while implementing the programme.

HEALTH SECTOR OUTLAY

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

Externally assisted projects

111. 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). 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

112. 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. The state-wise outlay and expenditure in the Ninth Plan and 2002-03 is shown in Annexure I.

Central Sector

113. 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.

114. Department of Health has been provided an outlay of Rs.1550 crores in the Annual Plan 2003-04. The outlay was the same as the outlay provided for 2002-03. The Dept of Health stated that the outlays provided would be insufficient to carry out the programmes proposed in the Tenth Plan. During the Annual Plan discussions for year 2003-04 Dept of Health had raised the issue that the Dept is able to attract funds coming as grants from External agencies such as Global Funds for AIDS, TB and Malaria for strengthening the disease control programme, which could not be accommodated within the Tenth Plan outlay for the Dept of Health. The Deptt requested that that these grants should be provided to the Deptt as additionalities to the existing Tenth Plan outlay. Secretary Planning Commission suggested that the Deptt should prepare a position paper on this and have discussions with the Deptt of Economic Affairs, Ministry of Finance and Planning Commission so that appropriate solution for this problem could be evolved. The Dept of Health had brought out a position paper which is currently under discussion.

115. During the Ninth Plan the Deptt of Health had classified only seven programmes as CSS (National anti malaria programme, National leprosy eradication programme, National Tuberculosis control programme, National AIDS control programme, National guinea worm eradication programme, National Blindness control programme and Strengthening of the drug control and food standards administration in the states). Some of these schemes such as food and drug control had multiple components which were distinct. At the time of ZBB 2001, Planning Commission identified a total of 22 schemes which ought to be classified as Centrally Sponsored Schemes because they were funded by the Centre and carried out through State Government infrastructure and reclassified them as Centrally Sponsored Schemes. There were 69 central sector schemes. The Ninth Plan and the yearly outlays and expenditure for all these 91 schemes have been given in Annexure 4.5.2 A .

116. ZBB 2001 under took a rationalisation , merger and weeding out exercise and recommended that only twelve CSS and 47 CS schemes should be continued in the Tenth Plan. Subsequently during the Annual Plan 2002-03 Deptt of Health sought and obtained approval to retain two CSS (Drug de addiction and Hospital waste management) during the Tenth Plan and this was agreed to by the Planning Commission. Planning Commission has given in principle approval for a new CSS on Assistance to States for Capacity Building for Trauma Care. All the ongoing schemes were reviewed again during the QPR in 2003. None of the ongoing and new schemes required any modification, merger or deletion. Scheme wise outlays for Tenth Plan, outlay for 2002-03 and 2003-04 is given in Annexure 4.5.2 B. Department of Health had provided statewise allocation/ expenditure for six major CSS during the Ninth Plan and 2002-03 and allocation for 2003-04; these are given in Annexure 4.5.3 – 4.5.8.

Annexure 4.5.1

Health -State Plan Outlays & Expenditure

	1997-98		1998-99		1999-2000		2000-01		2001-02		IX Plan Total		X Plan	2002-03	2002-03
	Outlay	Expenditure	Outlay	Expenditure	Outlay	Expenditure	Outlay	Expenditure	Outlay	Expenditure	Outlay	Expenditure	Outlay	Outlay	R.E.
Andhra Pradesh	13937.00	12366.00	20046.00	19865.00	28033.00	25294.00	27750.00	20450.00	33223.02	26695.00	122989.02	104670.00	133024.00	24309.00	25302.00
Arunachal Pradesh	3149.00	1782.00	3520.00	1814.00	2947.00	1741.00	2069.00	1731.00	2476.01	1995.00	14161.01	9063.00	23129.00	2181.00	2460.00
Assam	6561.00	6223.00	7191.00	6887.00	7741.00	7536.00	7439.00	9725.00	12580.00	11526.00	41512.00	41897.00	57069.00	8648.00	8648.00
Bihar	7245.00	4950.00	12177.00	6902.00	12768.00	8615.00	9891.00	7466.00	10078.21	7293.00	52159.21	35226.00	107920.00	13703.00	13181.00
Chattisgarh								1949.00	6025.00	2919.00	6025.00	4868.00	43418.00	6935.00	6935.00
Goa	1082.00	1032.00	772.00	1069.00	1646.00	1401.00	1423.00	1433.00	1649.00	1480.00	6572.00	6415.00	13135.00	1895.00	1895.00
Gujarat	22093.00	17180.00	23550.00	17179.00	25100.00	20650.00	26000.00	21805.00	21000.00	14319.00	117743.00	91133.00	116616.00	21387.00	21387.00
Haryana	3882.00	4493.00	5946.00	4126.00	5327.00	3840.00	5648.00	4148.00	6595.00	5146.00	27398.00	21753.00	96062.00	6280.00	6907.00
Himachal Pradesh	5544.00	6535.00	8966.00	8164.00	10555.00	11458.00	9685.00	14260.00	12014.86	11550.00	46764.86	51967.00	78772.00	13414.00	13112.00
J & K	7450.00	6989.00	11386.00	8244.00	11974.00	12836.00	10595.00	10444.00	11628.32	12532.00	53033.32	51045.00	79666.00	13000.00	13000.00
Jharkhand										6498.00		6498.00	65000.00	11575.00	11575.00
Karnataka	18359.00	21914.00	19544.00	22909.00	22774.00	22111.00	22558.00	20528.00	26879.60	25638.00	110114.60	113100.00	153052.00	19247.00	19948.00
Kerala	6096.00	5828.00	6200.00	7343.00	6400.00	4808.00	6335.00	6192.00	5553.00	5102.00	30584.00	29273.00	40840.00	7135.00	7000.00
Madhya Pradesh	9331.00	7031.00	17351.00	14524.00	13524.00	12269.00	11218.00	11702.00	13462.62	11210.00	64886.62	56736.00	71533.00	14016.00	14370.00
Maharashtra	17391.00	13811.00	22993.00	16224.00	27798.00	17082.00	30486.00	21023.00	39128.91	20174.00	137796.91	88314.00	110666.00	40740.00	40740.00
Manipur	630.00	540.00	810.00	809.00	1080.00	617.00	1250.00	1016.00	1486.00	789.00	5256.00	3771.00	8173.00	1415.00	1415.00
Meghalaya	2430.00	1790.00	2430.00	2360.00	3079.00	3000.00	3300.00	3028.00	3200.00	3458.00	14439.00	13636.00	18000.00	3020.00	3323.00
Mizoram	1651.00	1651.00	1816.00	1785.00	2286.00	2546.00	2562.00	2321.00	2542.00	2513.00	10857.00	10816.00	12370.00	2860.00	4062.00
Nagaland	2506.00	2480.00	2128.00	2022.00	2128.00	2180.00	1577.00	1577.00	1283.00	1292.00	9622.00	9551.00	7965.00	1548.00	1549.00
Orissa	4104.00	5198.00	7526.00	7042.00	13208.00	7546.00	8405.00	8808.00	14915.16	11018.00	48158.16	39612.00	52139.00	12777.00	8347.00
Punjab	9938.00	3187.00	16352.00	8374.00	18319.00	8889.00	19187.00	10727.00	17465.57	12752.00	81261.57	43929.00	53081.00	9298.00	9298.00
Rajasthan	13919.00	12339.00	15289.00	10991.00	17262.00	9962.00	9915.00	10852.00	12366.30	11217.00	68751.30	55361.00	56892.00	12778.00	5831.00
Sikkim	857.00	757.00	814.00	1914.00	1559.00	1062.00	1200.00	988.00	1373.50	1383.00	5803.50	6104.00	8000.00	1600.00	1611.00
Tamil Nadu	8909.00	11005.00	11651.00	12843.00	12426.00	13686.00	12724.00	10238.00	18084.16	10552.00	63794.16	58324.00	70000.00	10440.00	16911.00
Tripura	1371.00	1091.00	1408.00	1448.00	1355.00	1677.00	1443.00	1622.00	1879.18	1513.00	7456.18	7351.00	25072.00	1480.00	1480.00
Uttar Pradesh	17312.00	15609.00	40401.00	10862.00	42816.00	11934.00	30200.00	15372.00	37278.00	17116.00	168007.00	70893.00	240543.00	27826.00	18893.00
Uttaranchal								553.00	5972.00	4240.00	5972.00	4793.00	38767.00	4286.00	4336.00
West Bengal	20633.00	3322.00	19286.00	7811.00	23502.00	15527.00	32176.00	24901.00	42931.24	20066.00	138528.24	71627.00	103618.00	27898.00	26604.00
A & N Islands	1559.00	1831.59	1895.00	2055.29	2000.00	2008.73	1900.00	1962.59	1900.00	2223.36	9254.00	10081.56	11400.00	2050.00	2050.00
Chandigarh	3617.00	3748.90	3548.30	3297.61	3483.00	3465.02	3717.00	3404.57	3947.25	3777.31	18312.55	17693.41	22426.00	3803.65	3803.65
D & N Haveli	219.00	148.87	252.70	189.82	280.00	319.93	217.80	195.48	234.80	198.15	1204.30	1052.25	1225.00	238.00	238.00
Daman & Diu	133.00	165.96	173.00	186.91	136.00	135.50	150.10	211.74	165.00	197.62	757.10	897.73	1750.00	194.15	194.15
Delhi	15240.50	12684.15	19700.00	13994.62	27345.00	19789.12	26642.00	25852.03	34121.00	30291.00	123048.50	102610.92	238150.00	38970.00	35635.00
Lakshadweep	233.85	267.78	333.00	323.61	229.03	226.92	281.45	213.56	211.46	221.44	1288.79	1253.31	901.30	275.20	275.20
Pondicherry	1630.00	1546.97	2370.00	1921.30	2720.00	2802.20	2720.00	3096.17	3160.54	2921.08	12600.54	12287.72	16360.00	3272.09	3019.39
	229012.35	**189497.22**	**307825.00**	**225480.16**	**351800.03**	**257014.42**	**330664.35**	**279795.14**	**406809.71**	**301815.96**	**1626111.44**	**1253602.90**	**2176734.30**	**370494.09**	**355335.39**

Annexure 4.5.2-A

Health Schemewise 9th Plan outlays & Expenditure (Rs in crores)

9th Plan No. *	Name of the Schemes / Institution	9th Plan Approved Outlay	1997-98		1998-99		1999-2000		2000-01		2001-02		9th Plan Sum of Yearly Outlays	9th Plan Sum of Yearly Exp.
			Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure		
	CENTRALLY SPONSORED SCHEMES													
	Control of communicable Diseases:													
1 & 2	National Anti Malaria Programme(includingKala-Azar, Filaria, Dengue and J.E. Control Programmes)	1030.00	200.00	142.76	297.00	163.71	250.00	176.01	220.00	188.32	225.00	219.97	1192.00	890.77
3	National Leprosy Eradication Programme.	301.00	75.00	79.56	79.00	78.03	85.00	82.05	74.00	73.86	75.00	70.70	388.00	384.20
4	National Tuberculosis Control Programme.	450.00	90.00	31.31	125.00	68.88	105.00	87.54	130.00	108.75	136.00	103.62	586.00	400.10
5	National AIDS Control Programme including Blood Safety Measures and National S.T.D. Control Programme	760.00	100.00	121.00	111.00	99.36	140.00	135.25	175.00	173.30	210.00	226.60	736.00	755.51
6	National Guinea Worm Eradication Prog.	2.00	0.50	0.38	0.50	0.40	0.25	0.17	0.17	0.14	0.10	0.10	1.52	1.19
7	Disease Surveillance Programme	25.00	3.00	2.90	4.85	3.75	5.82	2.72	7.50	4.31	6.64	0.14	27.81	13.82
8	Hospital Waste Management	2.00	0.40	0.11	0.40	0.09	1.00	0.59	2.00	0.00	1.00	0.18	4.80	0.97
	Strengthening of Drug & Food Administration & Control													0.00
	Capacity Building													0.00
9	Assistance to States for Capacity Building (drug Quality)	20.00			6.00		6.00	3.00	3.00	6.00	20.00	24.62	35.00	33.62
10	Capacity Building for drug & PFA	20.00									1.00	0.00	1.00	0.00
11	Strengthening of State Drug Analytical Laboratories	5.00	2.20		1.50		1.60	1.48	3.50	1.48			8.80	2.96
12	Strengthening of State Drug Control organisations including improvement of their information system and strengthening of enforcement and supporting staff	5.00	1.31	0.00	1.50	0.00	1.60	0.00	2.50	0.00			6.91	0.00
13	Financial Assistance to the States for Strenghening their food testing laboratories	5.00	4.08	0.80	1.50	18.00	1.50	1.50	1.50	0.45			8.58	20.75
14	Setting up of District Food Inspection Units in the States/UTs including Management Information System													
	Control/Containment of Non-communicable Diseases:													
15	National Programme for Control of Blindness	448.00	70.00	58.06	75.00	72.85	85.00	83.73	110.00	109.41	140.00	126.61	480.00	450.66
16 & 17	National Cancer Control Programme	190.00	20.00	19.87	30.00	29.53	35.00	40.74	51.00	48.70	61.00	60.96	197.00	199.80
18 & 19	National Iodine Deficiency Disorders Control Programme & Micronutrient Malnutrition.	18.00	2.91	2.80	3.70	2.65	3.80	3.20	5.88	1.95	5.00	3.69	21.29	14.29
20	National Mental Health Programme	28.00	3.00	2.85	4.00	2.00	5.00	4.97	6.00	4.57	6.00	3.80	24.00	18.19
21	Drug De-addiction Programme including assistance to States	20.00	4.00	3.11	4.00	4.66	4.50	4.91	7.00	6.90	6.93	5.90	26.43	25.48
	Other Programmes												0.00	0.00
22	UNDP Pilot Initiatives for Community Health								2.50	0.00	2.50	0.00	5.00	0.00
	TOTAL	**3329.00**	**576.40**	**465.51**	**744.95**	**543.91**	**731.07**	**627.86**	**801.55**	**728.14**	**896.17**	**846.89**	**3750.14**	**3212.31**
	Central Sector Schemes:													
	Control of Communicable Diseases:													
1	National Institute of Communicable Diseases, Delhi (ongoing activities including Guineaworm & Yaws Eradication)	23.00	6.50	3.91	4.60	3.10	4.70	3.63	5.00	5.19	6.57	6.35	27.37	22.18
2	Strengthening of Institute	3.70											3.70	0.00

Annexure 4.5.2-A

Health Schemewise 9th Plan outlays & Expenditure (Rs in crores)

9th Plan No. *	Name of the Schemes / Institution	9th Plan Approved Outlay	1997-98		1998-99		1999-2000		2000-01		2001-02		9th Plan Sum of Yearly Outlays	9th Plan Sum of Yearly Exp.
			Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure		
3	National Institute of Tuberculosis, Bangalore	1.50	0.26	0.22	0.38	0.28	0.88	0.31	1.05	0.66	2.31	1.22	4.88	2.69
4	Lala Ram Sarup Institute of T.B. and allied diseases, Mehrauli, Delhi	30.00	6.00	6.30	6.50	1.00	6.00	4.30	7.00	7.00	9.00	10.30	34.50	28.90
5	Central Leprosy Training & Research Institute Chengalpattu (Tamil Nadu)	5.00	1.00	0.60	0.90	0.66	1.00	0.61	0.74	0.71	0.99	0.86	4.63	3.44
	Regional Institute of Training, Research & Treatment under Leprosy Control Programme:													
6	(a) R.L.T.R.I., Aska (Orissa)	2.00	0.40	0.00	0.40	0.01	0.45	0.01	0.45	0.09	0.45	0.03	2.15	0.14
7	(b) R.L.T.R.I., Raipur (M.P.)	2.50	0.50	0.17	0.50	0.17	0.38	0.19	0.50	0.08	0.10	0.10	1.98	0.71
8	(c) R.L.T.R.I., Gauripur (W.B.)	5.00	0.90	0.76	1.29	0.99	1.42	0.94	1.54	0.86	1.10	0.97	6.25	4.52
9	B.C.G. Vaccine Laboratory, Guindy, Chennai	5.00	1.00		1.90	1.50	2.00	1.80	2.00	0.50	2.00	1.00	8.90	4.80
10	Pasteur Institute of India, Coonoor	5.00	2.00	1.10	2.50	1.50	2.75	2.00	2.50	2.50	6.00	6.00	15.75	13.10
11	Central Research Institute, Kasauli	20.00	5.60		9.40		3.21		6.61		6.20		31.02	
		102.70	**24.16**	**13.06**	**28.37**	**9.21**	**22.79**	**13.79**	**27.39**	**17.59**	**34.72**	**26.83**	**141.13**	**80.48**
	Hospitals and Dispensaries:													
12	Central Government Health Scheme	40.00	11.00	5.47	11.00	7.31	11.00	7.92	12.00	9.96	17.00	11.53	62.00	42.19
13	Central Institute of Psychiatry, Ranchi	16.00	3.00	1.62	4.00	2.51	5.00	1.97	5.00	3.90	7.00	4.19	24.00	14.19
14 & 15	All India Institute of Speech & Hearing Mysore, Mysore	8.00	1.50	1.18	2.07	1.50	2.30	3.03	3.40	3.50	6.00	6.00	15.27	15.21
16 & 17	All India Institute of Physical Medicine & Rehabilitation, Mumbai	15.00	3.00	0.66	2.57	0.56	2.00	1.55	2.66	1.66	2.28	2.06	12.51	6.49
18	Health Sector Disaster preparedness and Management	3.00	0.50	0.00	0.50	0.00	0.50	0.00	1.00	0.00	3.00	0.00	5.50	0.00
19	Safdarjung Hospital, New Delhi	103.00	17.00	13.45	20.00	17.60	28.93	19.59	32.00	20.72	25.00	25.76	122.93	97.12
20	Dr. R.M.L. Hospital, New Delhi	45.00	9.50	9.05	11.50	10.32	16.47	14.01	25.00	14.69	22.00	22.19	84.47	70.26
21	Institute for Human Behaviour & Allied Sciences, Shahdara, Delhi	10.00	5.00	3.00	3.00		3.00						11.00	3.00
		240.00	**50.50**	**34.43**	**54.64**	**39.80**	**69.20**	**48.07**	**81.06**	**54.43**	**82.28**	**71.73**	**337.68**	**248.46**
	Medical Education, Training & Research:													
	(a) Medical Education:													
22 to 25	All India Institute of Medical Sciences & Its Allied Departments, New Delhi	340.00	54.00	57.01	69.96	70.46	81.00	70.00	91.30	85.00	100.00	95.00	396.26	377.47
26	P.G.I.M.E.R., Chandigarh	175.00	30.00	30.00	40.00	40.00	47.00	25.00	44.00	22.00	45.00	29.00	206.00	146.00
27	J.I.P.M.E.R., Pondicherry	70.00	14.50	7.23	14.76	7.87	16.50	9.43	17.00	12.52	15.00	11.31	77.76	48.36
28	Lady Harding Medical College & Smt. S.K. Hospital, New Delhi	65.00	10.00	5.11	10.50	5.39	10.75	5.82	10.65	6.47	7.80	7.26	49.70	30.05
29	Kalawati Saran Childrens Hospital, New Delhi	56.00	24.00	13.55	20.80	17.49	12.24	8.83	7.08	4.35	5.70	5.23	69.82	49.45
30	Indira Gandhi Institute of Health & Medical Sciences for North East Region at Shilong.	85.00	10.00	7.00	7.00	0.00	8.00	8.50	15.00	15.00	29.00	29.00	69.00	59.50
31	Kasturba Health Society, Wardha	25.00	4.25	4.68	6.00	6.60	8.00	8.00	9.00	9.00	10.00	10.00	37.25	38.28
32	V.P. Chest Institute, Delhi	5.00	0.30	0.30	0.64	0.64	4.00	4.00	1.34	1.34	5.00	5.00	11.28	11.28
33 & 34	i) All India Institute of Hygiene & Public Health, Calcutta	15.00	4.00	0.93	4.20	1.08	4.25	0.57	4.75	0.30	3.94	0.31	21.14	3.19
35	Serologist & Chemical Examiner to the Government of India, Calcutta	1.25	0.25	0.18	0.25	0.15	0.30	0.27	0.30	0.28	0.35	0.19	1.45	1.07

Annexure 4.5.2-A

Health Schemewise 9th Plan outlays & Expenditure (Rs in crores)

9th Plan No. *	Name of the Schemes / Institution	9th Plan Approved Outlay	1997-98		1998-99		1999-2000		2000-01		2001-02		9th Plan Sum of Yearly Outlays	9th Plan Sum of Yearly Exp.
			Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure	Approved outlay	Actual Expenditure		
36	National Medical Library, New Delhi	15.00	1.80	2.02	5.40	4.77	6.00	5.04	6.00	5.29	8.00	6.71	27.20	23.83
37	National Academy of Medical Sciences, New Delhi	1.60	0.26	0.23	0.50	0.15	0.67	0.20	0.64	0.30	0.67	0.30	2.74	1.18
38	National Board of Examinations, New Delhi	0.50	0.15	0.15	0.10	0.07	0.15	0.15	0.20	0.20	0.20	0.20	0.80	0.77
39	Medical Council of India, New Delhi	3.90	0.85	0.25	0.85	0.45	0.73	0.73	0.80	0.55	0.80	0.00	4.03	1.98
40	Education Commission of Health Sciences	2.00	1.00		1.00								2.00	0.00
41	N.I.M.H.A.N.S., Bangalore	60.00	7.00	7.90	13.00	13.00	15.50	15.50	20.00	20.00	24.00	24.00	79.50	80.40
	(b) Nursing Education:													
42	Indian Nursing Councils								0.2	0.2	0.3	0.3	0.50	0.50
43 to 47	Strengthening/adding seats to existing schools of Nursing	4.50	0.75	0.81	1.75	1.68	2.00		2.00	2.25	2.00	4.02	8.50	8.76
48	R.A.K. College of Nursing, New Delhi	3.50	0.70	0.16	0.70	0.04	0.80	0.58	0.40	0.34	0.41	0.35	3.01	1.47
49	Lady Reading Health School										0.25	0.25	0.25	0.25
	(c) Research:													
50 to 55	Indian Council of Medical Research, New Delhi	263.00	36.12	37.76	54.00	48.36	60.00	59.25	86.00	86.00	102.00	102.00	338.12	333.37
		1191.25	**199.93**	**175.27**	**251.41**	**218.20**	**277.89**	**221.87**	**316.66**	**271.39**	**360.42**	**330.43**	**1406.31**	**1217.16**
	Other Programmes:													
56	National Institute of Biological, NOIDA (U.P.)	70.00	27.00	14.07	35.00	3.00	20.00	12.00	30.00	11.32	23.15	3.85	135.15	44.24
57	Health Education	6.00	1.50	0.02	1.50	0.02	1.70	1.44	1.70	0.79	1.70	0.65	8.10	2.92
58	Health Intelligence (& Health Accounts)	1.25	0.31	0.27	0.30	0.02	0.30	0.35	0.45	0.35	0.45	0.37	1.81	1.36
59	Port Health Authority (Including setting up of offices at 8 newly created international airport)	2.00	0.40	0.08	0.43	0.17	0.50	0.16	1.72	0.13	1.58	0.15	4.63	0.69
60	Strengthening of D.G.H.S.	3.99	0.80	0.06	0.70		0.80	0.40	0.80	0.38	0.70	0.50	3.80	1.34
61	Strengthening of (Deptt. under) Ministry		0.75	1.14	0.75	0.69	1.00	1.12	1.00	1.38	2.00	2.02	5.50	6.35
62	Prevention of Food Adulteration	20.00	4.00	0.87	2.00	0.94	2.00	1.35	3.30	2.47	7.00	3.95	18.30	9.58
63 & 64	Central Drug Standard & Control Orgn.	40.00	9.00	1.64	3.80	2.06	4.20	2.49	8.47	7.49	10.00	4.68	35.47	18.36
		143.24	**43.01**	**17.01**	**43.73**	**6.21**	**29.50**	**18.19**	**46.44**	**22.93**	**44.58**	**14.15**	**207.26**	**78.49**
	NEW INITIATIVES DURING 10TH PLAN													
	Centrally Sponsered Schemes													
	Central Sector Schemes													
SCHEMES THAT ARE EITHER TRANSFERRED OR DROPPED														
65	Rural Health Training Centre, Najafgarh	4.00	0.80	0.20	0.80	0.17	0.80	0.21	1.20	0.20	1.00	0.23	4.60	1.01
66	Tejpur Mental Hospital						0.50						0.50	0.00
67	Assistance to Voluntary Organisations													
	(a) Improvement of Medical Services	10.00	1.35	0.18	3.00	0.10	4.00	0.18	2.50	0.12	0.50	0.07	11.35	0.65
	(b) Special Health Scheme for rural areas													
68	Continuing Education of Model Teachers	1.00	0.25	0.08	0.25	0.12	0.30	0.23	0.30	0.25	0.25	0.15	1.35	0.83
69	Training of Medical Officers of C.H.S. Cadre	0.50	0.20	0.08	0.10	0.06	0.10	0.06	0.15	0.12	0.10	0.00	0.65	0.32
		15.50	**2.60**	**0.54**	**4.15**	**0.45**	**5.70**	**0.68**	**4.15**	**0.69**	**1.85**	**0.45**	**18.45**	**2.81**
	TOTAL	**1692.69**	**320.20**	**240.31**	**382.30**	**273.87**	**404.58**	**302.60**	**475.50**	**366.83**	**523.30**	**443.04**	**2109.58**	**1626.65**
	GRAND TOTAL	**5118.69**	**896.60**	**705.82**	**1127.25**	**817.78**	**1135.65**	**930.46**	**1277.05**	**1094.97**	**1419.47**	**1289.93**	**5859.72**	**4838.96**

Note: Grand Total of the outlays in a particular year can be different from the actual sum total of each scheme in that year.

			Annexure 4.5.2 B Concld.		
Health Schemewise 10th Plan outlays & Expenditure				**(Rs in crores)**	
10th Plan No.	**Name of the Schemes / Institution**	**10th Plan Outlay**	**2002-03**	**2002-03**	**2003-04**
			Outlay	**RE**	**BE**
	CENTRALLY SPONSORED SCHEMES				
	Control of communicable Diseases:				
1	National Vector Borne Diseases Control Programme (Malaria, Kala-Azar, Filaria, Dengue and J.E.)	1370.00	235.00	214.00	245.00
2	National Leprosy Eradication Programme.	255.00	75.00	75.00	74.00
3	National Tuberculosis Control Programme.	680.00	115.00	97.00	115.00
4	National AIDS Control Programme including Blood Safety Measures and National S.T.D. Control Programme	1270.00	225.00	242.00	225.00
5	Disease Surveillance Programme	190.00	10.00	4.69	
6	Hospital Waste Management	10.00	5.00		5.00
	Strengthening of Drug & Food Administration & Control				
	Capacity Building				
7	Assistance to States for Capacity Building (drug Quality)	60.00	20.00		
8	Capacity Building for drug & PFA	97.00	1.30		30.00
	Control/Containment of Non-communicable Diseases:				
9	National Programme for Control of Blindness	445.00	86.00	86.00	86.00
10	National Cancer Control Programme	285.00	61.00	61.20	55.00
11	National Iodine Deficiency Disorders Control Programme.	35.00	7.00	10.00	7.00
12	National Mental Health Programme	190.00	30.00	4.50	30.00
13	Drug De-addiction Programme including assistance to States	33.00	7.00	11.00	6.50
	Other Programmes				
14	UNDP Pilot Initiatives for Community Health	4.80	4.80	4.80	4.10
		4924.80	**882.10**	**810.19**	**882.60**
	Central Sector Schemes:				
	Control of Communicable Diseases:				
1	i) National Institute of Communicable Diseases, Delhi (ongoing activities including Guineaworm & Yaws Eradication)	65.00	12.00	10.00	11.75
2	National Institute of Tuberculosis, Bangalore	10.30	2.00	1.35	2.00
3	Lala Ram Sarup Institute of T.B. and allied diseases, Mehrauli, Delhi	54.50	10.00	10.00	10.00
4	Central Leprosy Training & Research Institute Chengalpattu (Tamil Nadu)	5.50	1.00	1.00	1.00
5	(a) R.L.T.R.I., Aska (Orissa)	2.00	0.40	0.40	0.40
6	(b) R.L.T.R.I., Raipur (M.P.)	1.00	0.20	0.20	0.20
7	(c) R.L.T.R.I., Gauripur (W.B.)	7.00	1.50	1.50	1.50

			Annexure 4.5.2 B Concld.		
Health Schemewise 10th Plan outlays & Expenditure (Rs in crores)					
10th Plan No.	Name of the Schemes / Institution	10th Plan Outlay	2002-03 Outlay	2002-03 RE	2003-04 BE
8	B.C.G. Vaccine Laboratory, Guindy, Chennai	19.50	5.00	1.70	5.00
9	Pasteur Institute of India, Coonoor	35.00	7.00	5.25	7.50
10	Central Research Institute, Kasauli	50.00	5.00	5.00	5.00
		249.80	**44.10**	**36.40**	**44.35**
	Hospitals and Dispansaries:				
11	Central Government Health Scheme	80.00	20.00	17.13	20.00
12	Central Institute of Psychiatry, Ranchi	50.00	8.00	5.00	8.00
13	All India Institute of Speech & Hearing Mysore, Mysore	30.00	7.00	7.00	7.00
14	All India Institute of Physical Medicine & Rehabilitation, Mumbai	20.00	2.70	2.00	2.70
15	Health Sector Disaster preparedness and Management	30.00	6.00	0.10	6.00
16	Safdarjung Hospital, New Delhi	230.00	65.00	38.00	65.00
17	Dr. R.M.L. Hospital, New Delhi	150.00	25.00	17.77	25.00
18	Institute for Human Behaviour & Allied Sciences, Shahdara, Delhi	7.00	1.00		1.00
		597.00	**134.70**	**87.00**	**134.70**
	Medical Education, Training & Research:				
	(a) Medical Education:				
19	All India Institute of Medical Sciences & Its Allied Departments, New Delhi	675.00	105.00	105.00	105.00
20	P.G.I.M.E.R., Chandigarh	200.00	25.00	40.00	25.00
21	J.I.P.M.E.R., Pondicherry	150.00	15.00	12.50	15.00
22	Lady Harding Medical College & Smt. S.K. Hospital, New Delhi	200.00	10.00	9.44	10.00
23	Kalawati Saran Childrens Hospital, New Delhi	140.00	6.00	5.70	6.00
24	Indira Gandhi Institute of Health & Medical Sciences for North East Region at Shilong.	380.00	60.00	40.00	65.00
25	Kasturba Health Society, Wardha	50.00	10.00	10.00	10.00
26	V.P. Chest Institute, Delhi	23.00	8.00	6.00	4.80
27	i) All India Institute of Hygiene & Public Health, Calcutta	20.00	3.00	1.00	1.40
28	ii) Serologist & Chemical Examiner to the Government of India, Calcutta	2.50	0.50	0.25	
29	National Medical Library, New Delhi	35.00	8.00	7.50	0.05
30	National Academy of Medical Sciences, New Delhi	2.50	0.50	0.50	8.00
31	National Board of Examinations, New Delhi	1.00	0.20	0.20	0.50
32	Medical Council of India, New Delhi	5.00	1.00	1.00	0.20
33	Education Commission of Health Sciences	10.00	5.00	0.10	1.00
34	N.I.M.H.A.N.S., Bangalore	120.00	24.00	29.00	1.00
	(b) Nursing Education:				24.00
35	Indian Nursing Councils	2.10	0.40	0.40	0.40
36	Strengthening/adding seats to existing schools of Nursing	100.00	20.00	10.00	20.00
37	R.A.K. College of Nursing, New Delhi	11.00	3.00	1.00	0.85

			Annexure 4.5.2 B Concld.		
Health Schemewise 10th Plan outlays & Expenditure (Rs in crores)					
10th Plan No.	Name of the Schemes / Institution	10th Plan Outlay	2002-03 Outlay	2002-03 RE	2003-04 BE
38	Lady Reading Health School	2.00	0.30	0.20	0.30
	(c) Research:				
39	Indian Council of Medical Research, New Delhi	870.00	110.00	114.00	110.00
		2999.10	**414.90**	**393.79**	**408.50**
	Other Programmes:				
40	National Institute of Biological, NOIDA (U.P.)	170.90	20.00	15.00	25.10
41	Health Education	12.60	2.20	1.20	1.50
42	Health Intelligence (& Health Accounts)	8.80	1.90	1.00	1.90
43	Port Health Authority (Including setting up of offices at 8 newly created international airport)	9.00	1.60	0.60	1.35
44	Strengthening of D.G.H.S.	8.00	2.00	1.26	2.00
45	Strengthening of (Deptt. under) Ministry	12.00	3.00	3.00	3.00
46	Prevention of Food Adulteration	83.00	8.00	2.50	8.00
47	Central Drug Standard & Control Orgn.	57.00	15.00	5.79	12.00
		361.30	**53.70**	**30.35**	**54.85**
	NEW INITIATIVES DURING 10TH PLAN				
48	**Centrally Sponsered Schemes**	110.00	20.00	22.00	20.00
49	**Central Sector Schemes**	11.00	0.50		5.00
		0.00	**0.00**	**0.00**	**0.00**
	TOTAL	**4328.20**	**667.90**	**569.54**	**667.40**
	GRAND TOTAL	**9253.00**	**1550.00**	**1379.73**	**1550.00**
Note: Grand Total of the outlays in a particular year can be different from the actual sum total of each scheme in that year.					

Annexure 4.5.3

STATE-WISE RELEASES & EXPENDITURE ** OF FUNDS UNDER DEPARTMENT OF HEALTH

Scheme Included: Pre ZBB (1997-98 -- 2001-02)- National AIDS Control Programme (5)

Post ZBB (2002-03 onwards)- National AIDS Control Programme (4)

Rs in Lakhs

STATE	1997- 98		1998 - 99		1999 - 2000		2000 - 01		2001- 02		Total(1997-2002)		2002-03#	2003-04
	Released	Expenditure	Released	Expenditure	Released	Expenditure	Released	Expenditure	Released	Expenditure	Released	Expenditure	Allo/ Rel	Alloc
Andaman & Nicobar	31.09	6.05	20.00	13.38	50.00	52.27	66.44	53.89	95.50	79.43	263.03	205.02	89.50	138.27
Andhra Pradesh	425.00	425.39	650.00	843.51	1219.67	1003.93	1074.50	1097.80	1875.00	1927.31	5244.17	5297.94	2090.00	1508.26
Arunachal Pradesh	25.00	50.86	30.00	4.78	159.00	103.07	111.00	140.83	214.88	72.51	539.88	372.05	130.50	225.91
Assam	100.00	103.60	100.00	155.60	322.00	314.78	375.00	346.27	653.80	568.04	1550.80	1488.29	614.50	811.43
Bihar	50.00	1.21	110.00	60.37	55.00	124.03	196.00	105.84	809.50	1017.85	1220.50	1309.30	600.50	821.65
Chandigarh	28.00	39.97	60.00	48.90	115.00	123.38	93.11	106.32	152.65	134.60	448.76	453.17	156.50	222.10
Chattisgarh									150.50	101.09	150.50	101.09	243.50	381.66
D & N Haveli	16.00	7.92	0.00	5.25	25.00	6.16	9.00	14.80	26.00	12.09	76.00	46.22	17.00	72.30
Daman & Diu	24.22	17.82	15.00	14.98	95.00	26.02	9.00	72.76	31.00	25.16	174.22	156.74	36.00	105.50
Delhi	25.00	135.15	110.00	144.12	283.00	383.39	239.00	168.15	334.00	329.46	991.00	1160.27	431.00	521.58
Goa	50.00	17.20	35.00	28.00	98.00	69.12	72.73	92.78	99.00	97.32	354.73	304.42	170.50	312.88
Gujarat	250.00	271.06	235.00	443.78	796.00	622.17	681.78	528.96	1188.30	878.95	3151.08	2744.92	1280.19	814.88
Haryana	75.00	65.79	160.00	73.62	270.00	167.57	246.50	321.05	266.00	207.76	1017.50	835.79	315.00	567.67
Himachal Pradesh	225.00	196.77	115.00	58.24	318.00	227.02	262.50	266.68	308.50	276.80	1229.00	1025.51	236.50	395.52
Jammu & Kashmir	25.00	0.00	25.00	0.00	25.00	16.40	152.00	69.03	244.50	215.63	471.50	301.06	295.50	393.30
Jharkhand									156.00	0.00	156.00	0.00	162.00	293.69
Karnataka	175.00	218.42	335.00	391.94	801.67	555.03	398.65	533.57	785.15	783.35	2495.47	2482.31	975.00	1224.37
Kerala	100.00	229.37	65.00	233.97	280.00	301.65	600.63	437.88	835.00	608.90	1880.63	1811.77	855.00	700.28
Lakshadweep	15.42		0.00	0.00	25.00	1.04	9.16	18.84	29.50	22.62	79.08	42.50	25.50	98.07
Madhya Pradesh	150.00	185.40	315.00	147.28	352.31	455.43	542.00	361.49	780.50	471.12	2139.81	1620.72	481.50	1175.21
Maharasthra	950.00	844.67	1150.00	439.15	1668.35	1856.95	1296.58	1241.73	1598.65	669.66	6663.58	5052.16	2293.21	2433.12
Manipur	150.00	42.17	245.00	212.84	352.38	561.89	415.30	145.94	708.15	656.03	1870.83	1618.87	787.50	947.30
Meghalaya	25.00	34.76	30.00	17.35	70.14	43.88	87.50	50.50	224.93	64.18	437.57	210.67	90.50	178.55
Mizoram	100.00	67.98	100.00	115.99	168.00	170.55	179.00	177.46	246.70	266.85	793.70	798.83	311.50	414.75
Nagaland	155.00	176.59	227.00	251.96	380.00	455.23	250.50	187.39	635.50	568.54	1648.00	1639.71	626.50	748.59
Orissa	75.00	59.80	100.00	0.00	200.00	34.47	408.50	236.20	565.00	313.04	1348.50	643.51	448.00	582.69
Pondicherry	0.00	34.11	40.00	14.14	25.00	35.78	21.50	26.81	54.00	48.98	140.50	159.82	74.00	155.96
Punjab	75.00	324.54	150.00	150.91	312.39	173.29	321.50	177.55	266.50	185.62	1125.39	1011.91	403.50	603.11
Rajasthan	225.00	186.57	100.00	133.85	150.00	136.26	380.00	232.68	317.50	297.01	1172.50	986.37	358.50	713.52
Sikkim	50.00	26.76	50.00	36.71	25.00	44.16	66.00	45.50	120.02	73.95	311.02	227.08	64.00	134.98
Tamilnadu	2000.00	1681.71	800.00	1642.37	1596.58	1445.92	1870.92	783.27	2139.26	1415.82	8406.76	6969.09	2207.03	2163.27
Tripura	50.00	40.00	20.00	20.09	50.00	36.60	92.00	76.73	196.67	108.85	408.67	282.27	71.00	194.14
Uttar Pradesh	495.00	307.96	200.00	192.47	851.00	343.77	1175.00	448.53	1465.65	1729.25	4186.65	3021.98	1674.50	2268.95
Uttaranchal									98.00	0.00	98.00	0.00	162.00	375.36
West bengal	100.00	158.58	350.00	354.20	425.00	621.80	643.15	544.60	1059.50	1221.56	2577.65	2900.74	1503.00	1681.47
Total	**6239.73**	**5958.18**	**5942.00**	**6249.75**	**11563.49**	**10513.01**	**12346.45**	**9111.83**	**18731.31**	**15449.33**	**54822.98**	**47282.10**	**20280.43**	**24380.29**
TOTAL OUTLAYS*	**10000.00**		**11100.00**		**14000.00**		**14500.00**		**21000.00**		**70600.00**		**22500.00**	**22500.00**

SOURCE: *Planing Commission ** Bureau of Planning, Dept of Health # Provisional

Annexure 4.5.4

STATE-WISE RELEASES & EXPENDITURE ** OF FUNDS UNDER DEPARTMENT OF HEALTH

Scheme Included: Pre ZBB (1997-98 -- 2001-02)- National Tuberculosis Control Programme (4**)**

Post ZBB (2002-03 onwards)- National Tuberculosis Control Programme (3)

(Rs. in lakhs)

State / UT	1997-1998		1998-1999		1999-2000		2000-2001		2001-2002		Total (1997-2002)		2002-03#	2003-04
	Alloc.	Exp.	Alloc.	Exp.	Alloc.	Exp.	Alloc.	Exp.	Alloc.	Exp.	Alloc.	Exp.	Allo/ Rel	Alloc
Andhra pradesh	588.00	189.20	834.24	573.66	478.16	375.20	442.13	888.93	1200.00	1509.35	3542.52	3536.34	1050.00	1.84
Andman & Nicobar	20.76	13.52	13.65	10.93	1.24	1.17	2.54	0.96	1.53	0.58	39.73	27.16	2.23	600.00
Arunachal Pradesh	12.69	1.37	19.21	11.79	2.52	18.41	94.10	83.13	119.42	87.87	247.93	202.57	15.00	30.19
Assam	309.74	58.46	251.15	109.62	113.04	211.01	294.32	162.29	212.38	191.32	1180.63	732.69	391.77	411.91
Bihar	757.43	274.10	1413.83	652.24	1044.68	647.22	1015.06	405.19	700.05	401.60	4931.05	2380.36	697.27	608.38
Chandigarh	76.13	37.57	19.19	12.41	3.44	3.53	7.27	19.03	12.84	8.38	118.87	80.92	9.54	9.00
Chattisgarh							0.00	18.36	36.54	35.60	36.54	53.97	183.56	333.00
D & N Haveli	10.38	7.29	1.86	0.00	0.66	0.63	0.07	0.68	0.04	0.30	13.01	8.91	1.48	1.23
Daman & Diu	8.07	5.22	1.36	0.00	0.49	0.45	1.46	0.54	0.88	0.30	12.26	6.52	1.48	1.23
Delhi	250.62	216.86	139.71	72.43	0.00	294.70	192.23	352.06	228.75	159.51	811.31	1095.55	146.24	138.08
Goa	15.00	1.70	13.28	3.39	3.14	2.88	12.72	12.70	15.55	9.69	59.69	30.36	13.78	13.00
Gujarat	474.06	215.19	894.83	641.25	1192.41	419.34	867.72	704.86	810.07	457.64	4239.10	2438.27	536.22	506.28
Haryana	140.73	42.49	208.46	66.12	78.38	205.45	233.31	108.03	195.23	155.09	856.11	577.18	179.75	619.00
Himachal Pradesh	87.55	48.06	153.78	143.61	132.37	105.88	114.84	324.13	183.57	142.12	672.11	763.80	64.64	61.03
Jammu & Kashmir	69.21	20.03	101.70	28.41	36.94	63.26	79.64	111.47	73.42	76.26	360.91	299.43	95.28	86.71
Jharkhand							0.00	17.40	55.13	53.71	55.13	71.11	233.91	431.00
Karnataka	433.17	154.82	716.81	430.68	694.67	349.61	661.83	478.92	632.73	519.29	3139.21	1933.33	534.01	497.42
Kerala	350.56	151.91	542.79	465.11	877.25	170.59	599.18	391.29	687.23	441.73	3057.01	1620.63	337.00	318.17
Lakshadweep	4.61	2.70	0.68	0.00	0.25	0.23	5.45	2.04	3.28	0.00	14.27	4.97	1.06	1.00
Madhya Pradesh	601.94	200.01	859.90	269.27	414.19	622.91	754.83	272.40	658.38	412.31	3289.23	1776.89	592.09	545.77
Maharashtra	678.57	210.30	1075.59	582.45	844.72	1049.55	1257.08	1557.36	1683.61	1144.82	5539.56	4544.46	1025.81	968.53
Manipur	29.43	11.17	37.11	33.79	31.36	29.53	29.66	154.24	100.47	86.19	228.02	314.92	30.77	65.88
Meghalaya	24.22	4.62	25.05	7.30	8.52	15.49	19.46	9.37	19.59	12.69	96.84	49.46	31.74	45.92
Mizoram	8.07	1.87	19.49	12.45	3.45	5.16	7.47	7.72	14.17	15.50	52.66	42.71	11.82	22.56
Nagaland	16.15	1.49	21.81	11.94	2.74	15.83	13.64	61.69	99.36	95.44	153.71	186.39	25.64	54.90
Orissa	274.53	69.80	366.48	230.50	322.28	330.27	449.33	923.79	600.00	528.04	2012.63	2082.40	450.00	515.00
Pondicherry	114.20	3.14	19.20	11.95	2.75	3.12	15.38	3.24	11.67	3.89	163.20	25.33	9.96	9.23
Punjab	175.33	51.53	251.31	99.12	95.07	64.37	226.14	92.23	281.74	234.87	1029.59	542.12	227.65	206.68
Rajasthan	422.53	141.05	615.68	253.59	393.62	808.40	973.83	952.45	1072.53	730.57	3478.18	2886.06	598.74	565.31
Sikkim	6.92	1.02	15.36	11.64	1.88	8.15	4.37	48.52	31.82	30.72	60.35	100.05	6.41	13.72
Tamilnadu	533.18	187.01	861.91	485.94	654.19	598.95	1117.60	856.46	999.81	666.27	4166.70	2794.64	658.09	621.34
Tripura	39.22	7.17	38.25	10.19	13.23	21.24	29.81	23.38	30.52	36.09	151.03	98.07	33.57	68.49
Uttar Pradesh	1249.97	390.21	1813.60	801.23	889.02	1342.46	1670.68	586.99	1402.20	1222.44	7025.47	4343.32	1586.38	1449.76
Uttranchal							0.00	9.67	15.56	15.23	15.56	24.89	67.21	136.00
West Bengal	817.01	362.62	1052.71	734.77	2063.34	869.16	1126.85	984.51	1109.92	644.29	6169.83	3595.34	849.90	802.44
Grand Total	**8600.00**	**3083.50**	**12399.99**	**6777.76**	**10400.00**	**8654.15**	**12320.00**	**10626.00**	**13299.97**	**10129.73**	**57019.96**	**39271.14**	**10700.00**	**10760.00**
TOTAL OUTLAY *	**9000.00**		**12500.00**		**10500.00**		**12500.00**		**13600.00**		**58100.00**		**11500.00**	**11500.00**

SOURCE:* Planning Commission ** Bureau of Planning, Deptt. Of Health # Provisional

Annexure 4.5.5

STATE-WISE RELEASES & EXPENDITURE ** OF FUNDS UNDER DEPARTMENT OF HEALTH

Schemes Included: Pre ZBB (1997-98--2001-02)- National Anti Malaria Control Programme (including Kala Azar, Filaria and JE Control Programmes), National Dengue Control Programme (1&2)

Post ZBB (2002-03 onwards)- National Vector Borne Disease Control Programme (1)

(Rs. in Lakhs)

STATE	1997-98		1998-99		1999-00		2000-01		2001-02		Total(1997-2002)		2002-03##	2003-04 #
	Allo./Rel.	Exp.	Allo./Rel.	Exp.	Allo./Rel.	Exp.	Allo./Rel.	Exp.	Allo./Rel.	Exp.	Allo./Rel.	Exp.	Allo/ Rel	Alloc
Andaman & Nicobar	126.19	24.75	99.44	155.68	116.46	111.28	208.13	231.75	226.84	220.78	777.06	744.24	217.85	236.75
Andhra Pradesh	817.15	655.12	704.79	722.81	1047.91	1388.55	2418.88	2523.34	794.77	954.65	5783.50	6244.47	529.2	154.13
Arunachal Pradesh	258.74	297.50	270.42	186.61	303.27	229.22	343.91	293.79	486.93	364.67	1663.27	1371.79	280.72	277.52
Assam	2207.29	2618.00	2435.18	2170.42	2267.03	2616.75	5514.11	2657.86	1983.27	2377.47	14406.88	12440.50	1626.56	2010.25
Bihar	600.02	360.48	614.70	508.85	562.36	659.67	538.69	238.82	377.44	546.01	2693.21	2313.83	77.71	100.38
Chandigarh	23.81	12.37	43.15	44.30	47.25	34.55	50.00	44.81	41.06	34.87	205.27	170.90	36.00	34.25
Chattisgarh							271.65	271.65	826.39	876.30	1098.04	1147.95	2460.92	486.02
D & N Haveli	76.42	66.04	24.93	24.90	25.94	34.85	40.03	18.12	40.67	40.67	207.99	184.58	34.33	40.02
Daman & Diu	34.15	3.48	15.80	10.08	16.42	12.97	18.86	9.90	16.08	18.64	101.31	55.07	11.72	15.15
Delhi	49.16	93.93	69.56	37.21	75.40	20.10	90.97	100.45	97.57	89.57	382.66	341.26	97.39	88.83
Goa	10.26	5.18	21.72	7.72	10.93	4.54	8.71	0.98	6.08	6.17	57.70	24.59	8.85	8.55
Gujarat	691.75	733.67	1295.28	907.77	1464.01	1324.92	1669.02	1480.92	1330.96	1353.89	6451.02	5801.17	754.40	113.75
Haryana	448.17	291.08	316.94	284.20	259.03	160.95	197.22	78.35	18.43	18.42	1239.79	833.00	72.30	48.01
Himachal Pradesh	112.06	90.84	62.33	51.77	46.11	92.45	90.30	89.06	2.20	36.78	313.00	360.90	3.06	0.00
Jammu & Kashmir	92.78	78.62	48.55	72.57	52.73	103.40	86.96	84.28	22.96	69.62	303.98	408.49	11.94	52.65
Jharkhand							90.00	90.00	759.92	784.26	849.92	874.26	1159.63	594.11
Karnataka	542.97	568.62	545.30	315.27	602.66	229.29	352.68	233.36	308.24	386.45	2351.85	1732.99	176.28	229.21
Kerala	86.30	63.60	122.58	102.73	126.42	58.33	84.35	75.92	64.22	67.76	483.87	368.34	12.63	4.58
Lakshadweep	12.55	12.48	4.96	5.24	5.81	5.82	10.98	5.57	6.35	5.92	40.65	35.03	6.10	6.47
Madhya Pradesh	1167.47	1124.77	721.98	840.66	2012.59	1562.47	1976.66	2154.36	2238.77	2540.77	8117.47	8223.03	2063.16	317.47
Maharasthra	929.17	1044.56	2091.24	1671.03	2234.35	2132.89	1481.06	1478.39	2239.20	2289.20	8975.02	8616.07	976.91	170.18
Manipur	324.52	273.91	435.75	377.34	403.05	219.53	520.37	235.72	358.91	275.28	2042.60	1381.78	121.36	101.70
Meghalaya	239.15	196.96	261.44	231.55	306.70	212.27	337.64	303.58	384.02	292.98	1528.95	1237.34	167.63	282.86
Mizoram	195.47	132.00	286.17	172.53	309.56	190.05	385.11	235.26	433.94	345.85	1610.25	1075.69	118.51	158.01
Nagaland	193.37	212.62	192.53	183.34	240.83	308.33	290.38	278.91	346.91	368.08	1264.02	1351.28	212.48	307.41
Orissa	501.34	312.93	845.65	838.32	788.17	894.67	1173.68	1440.89	1478.23	1745.01	4787.07	5231.82	1953.62	914.94
Pondicherry	7.72	48.53	11.08	6.15	10.32	11.28	22.03	13.56	13.43	8.30	64.58	87.82	22.61	22.12
Punjab	356.58	183.26	437.50	290.67	288.96	148.45	230.77	148.31	49.38	94.09	1363.19	864.78	70.79	34.89
Rajasthan	1467.88	1818.24	2115.38	2094.15	1244.91	1174.46	967.35	468.09	534.04	924.93	6329.56	6479.87	303.37	769.00
Sikkim	0.94	1.77	10.15	8.56	11.65	7.90	10.65	0.12	0.11	0.14	33.50	18.49	4.37	3.82
Tamilnadu	427.25	204.88	276.02	248.45	400.36	122.24	174.92	133.90	303.11	289.06	1581.66	998.53	242.30	132.92
Tripura	322.71	414.05	413.64	356.97	375.89	379.31	599.05	480.94	542.45	505.76	2253.74	2137.03	302.79	390.09
Uttar Pradesh	881.62	505.73	842.79	1139.70	641.51	547.13	605.75	558.72	548.62	645.62	3520.29	3396.90	200.48	460.06
Uttaranchal									23.64	39.19	23.64	39.19	7.84	1.60
West Bengal	465.28	125.71	460.63	336.61	296.26	501.99	354.86	454.44	589.86	826.70	2166.89	2245.45	198.68	268.77
Total	**13670.24**	**12575.68**	**16097.58**	**14404.16**	**16594.85**	**15500.61**	**21215.73**	**16914.12**	**17495.00**	**19443.86**	**85073.40**	**78838.43**	**14544.49**	**8836.47**
TOTAL OUTLAY *	**20000.00**		**29700.00**		**25000.00**		**25500.00**		**22500.00**		**122700.00**		**23500.00**	**24500.00**

SOURCE:* Planning Commission ** Bureau of Planning, Deptt of Health

Excluding commodity grant ## Provisional

NOTE: The centre purchases & supplies states drugs & insecticides required.

Annexure 4.5.6

STATE-WISE RELEASES & EXPENDITURE ** OF FUNDS UNDER DEPARTMENT OF HEALTH

Scheme Included: Pre ZBB (1997-98 -- 2001-02)- National Leprosy Eradication Programme (3**)**
Post ZBB (2002-03 onwards)- National Leprosy Eradication Programme (2)

(Rs. in Lakhs)

STATES	1997-98		1998-99		1999-2000		2000-2001		2001-2002		Total(1997-2002)		2002-03#	2003-04
	Rel.	Exp.	Rel.	Exp.	Rel.	Exp.	Rel.	Exp.	Rel.	Exp.	Rel.	Exp.	Allo/ Rel	Alloc
A & N Islands	7.50	6.50	6.50	6.50	5.63	5.63	1.00	1.00	18.30	4.59	38.93	24.22	20.22	0.89
Andhra Pradesh	635.24	640.07	322.50	322.50	442.21	402.41	508.75	508.75	223.83	143.79	2132.53	2017.52	179.22	111.25
Arunachal Pradesh	47.42	47.42	168.26	132.77	60.36	60.36	136.00	136.00	62.09	52.11	474.13	428.66	115.96	4.88
Assam	334.65	334.65	299.00	287.96	235.93	230.11	112.00	112.00	153.85	152.24	1135.43	1116.96	97.48	14.39
Bihar	804.23	826.66	1004.45	1004.45	1323.77	1323.77	869.80	869.80	663.94	432.53	4666.19	4457.21	855.85	341.27
Chandigarh	1.50	0.50	6.00	6.00	13.29	13.29	3.50	3.50	5.50	5.83	29.79	29.12	10.13	0.91
Chhatisgarh									378.34	185.65	378.34	185.65	354.41	17.58
D & N Haveli	8.46	6.46	1.00	1.00	1.17	1.17	8.79	8.79	6.00	5.30	25.42	22.72	6.00	5.07
Daman & Diu	5.50	4.50	9.50	9.50	9.50	9.50	14.50	14.50	18.40	4.56	57.40	42.56	14.50	2.34
Delhi	1.50	0.50	53.15	53.15	14.38	14.38	41.50	41.50	48.36	51.11	158.89	160.64	93.42	35.06
Goa	9.28	9.28	10.48	2.42	1.51	1.51	1.50	1.50	11.52	5.50	34.29	20.21	8.10	0.76
Gujarat	438.43	438.43	247.16	247.16	230.37	230.37	230.00	211.66	61.97	42.27	1207.93	1169.89	99.65	63.88
Haryana	22.65	23.37	25.08	25.08	43.24	41.75	23.00	23.00	61.94	31.94	175.91	145.14	43.89	12.63
Himachal Pradesh	24.76	24.76	108.03	97.48	54.53	54.53	61.00	52.00	49.69	49.99	298.01	278.76	30.45	5.75
Jammu & Kashmir	67.34	102.72	150.89	105.40	63.61	56.07	87.00	60.61	100.55	63.33	469.39	388.13	96.39	11.13
Jharkhand									356.23	174.88	356.23	174.88	257.46	285.53
Karnataka	419.16	412.16	348.48	348.48	247.98	172.99	302.75	300.73	196.05	286.74	1514.42	1521.10	122.66	37.75
Kerala	208.74	209.24	232.00	232.00	147.30	139.50	237.00	230.87	74.61	57.19	899.65	868.80	69.36	38.67
Lakshadweep	3.00	2.00	11.53	11.53	1.36	1.36	3.00	3.00	6.00	4.59	24.89	22.48	7.26	0.51
Madhya Pradesh	968.10	968.10	756.83	756.83	794.35	677.96	645.36	645.36	395.32	372.63	3559.96	3420.88	676.61	50.16
Maharashtra	454.59	465.58	525.56	411.33	391.04	378.60	398.60	398.60	435.99	281.32	2205.78	1935.43	263.14	60.79
Manipur	37.15	38.27	132.91	132.91	95.71	95.71	125.00	103.68	71.02	48.02	461.79	418.59	101.25	4.01
Meghalaya	21.50	21.59	78.81	65.43	45.26	45.26	47.00	44.43	46.94	28.00	239.51	204.71	46.24	3.78
Mizoram	61.34	61.34	75.77	75.77	51.22	19.26	61.00	61.00	60.51	61.22	309.84	278.59	76.50	1.26
Nagaland	129.69	129.69	52.20	52.20	106.09	78.53	109.00	109.00	89.22	95.61	486.20	465.03	112.44	3.22
Orissa	698.59	695.59	569.94	569.94	581.09	401.59	628.00	393.55	540.77	241.55	3018.39	2302.22	478.63	63.68
Pondicherry	26.95	16.45	2.00	2.00	2.00	2.00	7.00	7.00	2.00	6.97	39.95	34.42	6.00	1.95
Punjab	34.96	40.96	134.96	121.28	100.39	100.39	36.00	36.00	32.30	40.74	338.61	339.37	40.27	22.43
Rajasthan	57.00	57.00	508.51	285.37	148.37	116.88	105.00	105.00	123.07	69.81	941.95	634.06	52.32	29.57
Sikkim	49.40	49.40	65.00	65.00	71.36	22.82	41.71	41.10	34.87	18.59	262.34	196.91	39.36	1.63
Tamil Nadu	253.56	253.56	349.43	349.43	385.79	269.42	422.74	282.32	413.04	181.58	1824.56	1336.31	240.63	56.94
Tripura	21.50	21.50	75.85	40.91	47.18	18.23	34.00	19.53	46.47	7.85	225.00	108.02	33.60	2.19
Uttar Pradesh	1084.56	1130.81	914.36	914.36	1417.10	1175.10	1093.51	1002.97	129.01	856.62	4638.54	5079.86	1508.04	248.10
Uttaranchal									1282.50	65.13	1282.50	65.13	120.01	22.55
West Bengal	640.66	640.66	452.85	452.85	841.53	841.53	784.00	680.81	574.66	575.14	3293.70	3190.99	599.55	83.82
Total	**7578.91**	**7679.72**	**7698.99**	**7188.99**	**7974.62**	**7001.98**	**7179.01**	**6509.56**	**6774.86**	**4704.92**	**37206.39**	**33085.17**	**6877.00**	**1646.33**
TOTAL OUTLAY*	**7500.00**		**7900.00**		**8500.00**		**7400.00**		**7500.00**		**38800.00**		**7500.00**	**7400.00**

SOURCE: *Planning Commission ** Bureau of Planning, Deptt of Health # Provisional

Annexure 4.5.7

STATE-WISE RELEASES & EXPENDITURE ** OF FUNDS UNDER DEPARTMENT OF HEALTH

Scheme Included: Pre ZBB (1997-98--2001-02)- National Programme for Control of Blindness (15)

Post ZBB (2002-03 onwards)- National Programme for Control of Blindness (9)

(Rs. in Lakhs)

STATES	(1997-1998)		(1998-1999)		(1999-2000)		(2000-2001)		(2001-2002)		Total (1997-2002)		2002-03 # #	2003-04 #
	Released	Exp.	Released	Exp.	Released	Exp.	Released	Exp.	Released	Exp.	Released	Exp.	Rel	Alloc
Andaman & Nicobar	7.00	4.28	7.80	3.70	10.67	9.54	3.75	4.74	16.80	11.68	46.02	33.94	1.59	8.00
Andhra Pradesh	616.16	637.56	578.97	696.24	638.54	797.00	689.05	904.70	1,063.81	1,078.60	3586.53	4114.11	834.82	400.00
Arunachal Pradesh	7.04	13.65	8.50	11.88	15.00	8.27	48.82	47.91	43.81	11.26	123.17	92.97	16.22	15.00
Assam	91.04	91.77	107.15	105.95	81.50	63.01	207.09	74.34	62.67	49.53	549.45	384.60	35.70	100.00
Bihar	162.94	283.36	204.00	298.70	108.58	114.91	306.30	119.12	72.50	36.96	854.32	853.05	157.97	250.00
Chandigarh	7.00	9.35	10.60	11.45	11.44	8.43	11.00	8.51	20.15	19.96	60.19	57.70	10.07	13.00
Chhatisgarh					140.00	95.27	126.98	125.63	302.74	188.48	569.72	630.79	165.23	150.00
D&N Haveli	7.00	2.01	6.70	0.91	2.50	0.50	105.64	103.00	16.92	2.44	138.76	108.86	4.16	7.00
Daman & Diu	8.00	4.86	7.70	8.69	9.40	9.38	12.60	9.62	12.86	63.11	50.56	95.66	4.97	7.00
Delhi	12.75	25.38	24.70	34.10	42.40	29.44	61.29	49.53	22.15	62.01	163.29	200.46	22.30	45.00
Goa	8.75	10.06	63.15	8.37	14.50	9.29	41.20	7.75	33.95	105.48	161.55	140.95	10.52	20.00
Gujarat	123.51	197.50	157.49	265.84	404.50	442.69	384.00	160.95	245.85	164.33	1315.35	1231.31	231.45	250.00
Haryana	58.47	91.68	101.00	112.75	169.27	50.97	178.00	62.68	104.63	31.01	611.37	349.09	45.36	100.00
Himachal Pradesh	32.47	57.07	83.53	77.49	86.25	67.78	131.00	141.18	64.03	78.29	397.28	421.81	54.11	70.00
Jammu & Kashmir	39.16	48.87	92.00	42.53	40.75	62.89	106.50	74.41	110.04	16.62	388.45	245.32	66.79	70.00
Jharkhand					46.00	38.06	54.00	42.69	29.30	36.02	129.30	116.77	118.57	150.00
Karnataka	170.78	151.72	258.01	201.43	352.20	227.51	305.89	346.53	454.43	412.21	1541.31	1339.41	368.30	300.00
Kerala	56.34	214.97	91.57	214.22	263.39	254.61	294.20	167.64	184.85	171.26	890.35	1022.70	153.22	150.00
Lakshadeep	7.04	1.17	17.70	0.18	5.72	3.03	229.59	226.17	5.02	0.31	265.07	230.86	1.56	7.00
Madhya Pradesh	935.97	1,204.10	1,370.11	1,076.52	969.51	1,294.92	832.39	758.51	908.02	908.48	5016.00	5021.11	667.29	325.00
Maharashtra	548.63	586.06	540.65	670.02	998.85	1,481.01	766.38	758.62	1,251.09	924.73	4105.60	4420.44	627.15	325.00
Manipur	10.27	16.15	25.91	12.62	9.00	15.54	55.94	26.16	50.73	4.95	151.85	75.42	20.13	20.00
Meghalaya	22.06	26.52	23.75	37.78	21.00	26.31	153.84	119.10	78.28	44.20	298.93	253.91	25.12	20.00
Mizoram	7.04	20.11	25.75	33.41	26.50	25.90	79.57	68.39	35.56	45.95	174.42	193.76	31.72	20.00
Nagaland	6.35	16.73	64.10	15.24	14.00	2.26	40.58	3.06	51.10	39.12	176.13	76.41	23.22	15.00
Orissa	671.84	362.99	711.81	542.91	535.73	892.40	1,187.45	1,165.50	468.35	446.81	3575.19	3410.62	324.80	250.00
Pondicherry	4.00	0.95	5.30	0.55	20.82	14.39	14.50	9.10	15.50	2.65	60.12	27.64	2.04	13.00
Punjab	54.65	69.49	56.60	83.27	199.61	59.47	117.60	51.14	65.05	28.47	493.51	291.84	189.25	100.00
Rajasthan	455.72	450.31	389.04	615.18	428.41	471.73	946.45	1,107.21	1,128.85	694.38	3348.47	3338.82	526.93	300.00
Sikkim	7.92	11.61	26.30	4.82	15.25	6.35	103.39	81.66	6.61	39.10	159.47	143.54	20.56	10.00
Tamilnadu	785.50	975.10	1,065.68	1,132.77	1,196.44	1,051.40	1,111.05	1,383.39	1,972.99	1,589.69	6131.66	6132.35	1653.03	1000.00
Tripura	20.27	38.46	50.89	48.66	35.39	35.70	68.80	43.97	397.74	192.92	573.09	359.71	39.88	50.00
Uttar Pradesh	1,045.60	971.69	1,099.19	878.81	1,042.55	1,075.48	940.39	1,621.29	2,166.92	721.20	6294.66	5180.12	1063.20	700.00
Uttaranchal					50.00	43.72	80.34	95.37	175.03	189.31	305.37	416.77	115.02	100.00
West Bengal	56.75	203.93	141.70	295.74	194.10	200.98	275.00	174.77	180.76	153.46	848.31	1028.88	305.12	275.00
Grand Total	**6048.02**	**6,799.46**	**7417.36**	**7542.75**	**8,199.79**	**8,990.14**	**10,070.57**	**10,144.33**	**11,819.09**	**8,564.99**	**43554.82**	**42041.68**	**7937.37**	**5635.00**
TOTAL OUTLAY*	**7000.00**		**7500.00**		**8500.00**		**11000.00**		**14000.00**		**48000.00**		**8600.00**	**8600.00**

* The releases as well as expenditure figures include cash equivalent of commodity assistance.

Excluding commodity grant ## Provisional

SOURCE:* Planning Commission ** Bureau of Planning, Deptt of Health

Annexure 4.5.8

NATIONAL CANCER CONTROL PROGRAMME

STATE-WISE RELEASES DURING THE NINTH FIVE YEAR PLAN (199702002) AND 2002-03

(Rs. In Lakhs)

STATE/UTs	Grand Total						
	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	Total
	Releases	Releases	Releases	Releases	Releases	Releases	(1997- 2003)
Andaman & Nicobar	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Andhra Pradesh	205.00	286.00	403.50	0.00	276.00	154.00	1324.50
Arunachal Pradesh	0.00	0.00	0.00	0.00	45.00	0.00	45.00
Assam	47.00	0.00	6.24	0.00	0.00	0.00	53.24
Bihar	100.00	30.00	75.00	83.00	299.00	77.50	664.50
Chandigarh	0.00	0.00	0.00	0.00	200.00	0.00	200.00
Chattisgarh	0.00	0.00	0.00	0.00	225.00	35.00	260.00
D & N Haveli	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Daman & Diu	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Delhi	320.00	770.00	470.00	1829.28	1406.54	1595.95	6391.77
Goa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Gujarat	175.00	78.30	175.00	75.00	375.00	75.00	953.30
Haryana	105.00	0.00	0.00	325.00	175.00	2.50	607.50
Himachal Pradesh	0.00	0.00	73.00	75.00	75.00	0.00	223.00
Jammu & Kashmir	0.00	150.00	36.00	0.00	0.00	0.00	186.00
Jharkhand	0.00	0.00	0.00	0.00	329.00	0.00	329.00
Karnataka	77.00	82.50	175.00	475.00	275.00	275.00	1359.50
Kerala	225.00	251.65	558.50	82.50	75.00	78.00	1270.65
Lakshadweep	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Madhya Pradesh	77.00	67.50	170.00	395.00	75.00	157.00	941.50
Maharasthra	0.00	75.00	175.00	325.00	75.00	80.50	730.50
Manipur	0.00	0.00	30.00	0.00	0.00	0.00	30.00
Meghalaya	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Mizoram	0.00	0.00	0.00	0.00	101.00	75.00	176.00
Nagaland	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Orissa	272.50	81.20	75.00	75.00	78.00	77.00	658.70
Pondicherry	0.00	0.00	0.00	0.00	75.00	75.00	150.00
Punjab	0.00	149.00	51.00	0.00	0.00	0.00	200.00
Rajasthan	100.00	300.00	225.00	75.00	82.50	185.00	967.50
Sikkim	0.00	0.00	0.00	30.00	0.00	0.00	30.00
Tamilnadu	83.89	86.00	194.00	401.00	259.55	412.00	1436.44
Tripura	0.00	0.00	30.00	0.00	0.00	0.00	30.00
Uttar Pradesh	50.00	82.50	160.50	85.50	551.71	282.50	1212.71
Uttaranchal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
West bengal	150.00	463.50	316.50	468.71	946.70	1077.00	3422.41
Total	**1987.39**	**2953.15**	**3399.24**	**4799.99**	**6000.00**	**4713.95**	**23853.72**

4.6 INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

Introduction

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. Ayurveda is popular in Kerala, Himachal Pradesh, Gujarat, Karnataka, Madhya Pradesh, Rajathan, Uttar Pradesh and Orissa. The Unani System widely used in Andhra Pradesh, Karnataka, Tamil Nadu, Bihar, Maharashtra, Madhya Pradesh, Uttar Pradesh, Delhi & Rajasthan. Homoeopahty is in vogue in Uttar Pradesh, Kerala, West Bengal, Orissa, Andhra Pradesh, Maharashtra, Punjab, Tamil Nadu, Bihar Gujarat and North Eastern States.

2. India also has a vast network of governmental ISM&H healthcare institutions. There are separate Directorates of ISM&H in 18 States. There are 3,841 hospitals with over 65753 beds and over 23,597 dispensaries providing primary healthcare in the Govt sector. Over 19,196 ISM&H practitioners qualify every year from 409 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.

Approach during the Tenth Plan

4. The Tenth Plan aims at addressing these shortcomings through:

- ♂ 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 to meet 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)

Table 1

Summary of Infrastructural Facilities Available under Indian System of Medicine & Homeopathy as on 1.4.2001

S. No.	Facilities	Ayurveda	Unani	Siddha	Yoga	Naturopathy	Homeopathy	TOTAL
1	Hospitals	2955	312	237	7	22	307	3841@
2	Beds	43973	5128	1986	200	757	13694	65753@
3	Dispensaries	14721	958	352	65	56	7411	23597*
4	Registered Practioners$	430890	43108	17097	-	455	197252	688802
5	(i) Under Graduate College	196	39	2	-	6$$	166	409
	(ii) Admission Capacity	7145	1410	150	-	170	9330	18205
6	(i) Post Graduate Colleges#	53	5	2	-	-	17	77
	(ii) Admission Capacity	651	54	76	-	-	210	991
7	Licensed Pharmacies	8386	453	384	-	-	609	9832

Source: Dept. of ISM&H, 2001
Figures are Provisional
Note:
- = Nil Information
@ = Includes one hospital of Amchi with 15 Beds
** = Includes 34 Amchi Dispensaries*
$ = Information as on 1.1.2001
$$ = These colleges conduct 51/2 years BNYS degree course
 # = All these colleges are part of U.G. colleges mentioned at Sno. 5(I) except two colleges under Ayurveda one each in West Bengal & Gujarat where only P.G. courses are conducted. As such total no. of colleges under Ayurveda comes

Mainstreaming of ISM&H services

5. Over the last five decades a vast infrastructure of dispensaries and hospitals have been built up to provide ISM&H care to the population (Table 1) Most of these institutions are in the primary care settings. In addition there are secondary and speciality hospitals

Vast infrastructure has been created in Govt, voluntary and private sectors , but

- Each centre is isolated. They are not linked with other institutions in the area
- There is 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.

some of which are attached to ISM&H colleges. Many of them lack infrastructural facilities, diagnostics and drugs and are not functioning optimally. The Ninth Plan aimed at improving the quality of primary, secondary and tertiary care in ISM&H. Departments of ISM&H in the Centre and the states took up several initiatives to improve the quality and coverage of these services at each level. Every effort is being made to mainstream ISM&H services. The Central Department of ISM&H has posted ISM&H doctors in major tertiary care institutions in the Central Sector, for example, in Safdarjung and RML hospitals. All states are being encouraged to follow a similar strategy both at the tertiary care level and in district hospitals. Some states like Kerala are already posting ISM&H practitioners in PHCs along with modern medicine practitioners, so that patients coming to PHC for care can choose the system of care that they would like to utilize. Other states like Gujarat and Himachal Pradesh are giving training to ISM&H doctors in national programmes and then posting them in primary health centres (especially in remote primary health centres) even where there is no doctor trained in modern system of medicine so that there is improved access to health care.

Development of Human Resources for ISM&H

6. 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 409 under graduate and 77 post graduate colleges in ISM&H (Table- 1). But the quality of training these colleges impart is poor. All colleges have a student/bed ratio, which is higher than the prescribed ratio of 1:3. 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.

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.

7. Some of the Tenth Plan recommendations for improving the situation are to :

- 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

8. 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.

9. 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. Department of ISM&H is taking steps to reduce the proliferation of substandard medical colleges and check the deterioration in standards of teaching Indian Medicine Central Council Act 1970 and Homoeopathy Central Council Act 1973 have been amended in order to curtail the growth of sub standard ISM&H hospitals.

10. 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 got in principle and the EFC approval for the Centrally sponsored scheme of development of UG/PG educational institutions under which selected UG/PG colleges will be appropriately strengthened so that quality of care and teaching improve.

National Institutes in ISM&H

11. 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' and EFC approval for the Central sector 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

12. Most of the Registered Practitioners of ISM&H (Table- 1), 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 practices and in yoga. The response to this course was poor because most practitioners felt that they cannot leave their practice for an extended period.

Table -1 - Registered Medical Practitioners In ISM&H

Ayurveda	4,30,890
Unani	43,108
Siddha	17,097
Naturopathy	455
Homoeopathy	1,97,252
Total	**6,88,802**

Source: Department of ISM&H, 2002

13. 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 national institutes and the state ISM&H colleges with the help of experts will produce the training material. 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.

Traditional Knowledge Digital Library(TKDL)

14. 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. The traditional knowledge digital library for ayurveda is almost completed. The TKDL, Siddha, Unani and Yoga has also been taken up.

Medicinal Plant Board (MPB)

15. India has 16 Agro-climatic zones, 45000 different plant species and 15000 medicinal plants that include 7000 plants used in Ayurveda, 700 in Unani medicine, 600 in Siddha medicine and 30 in modern medicine. This makes India one among 12 mega bio-diverse

countries of the world. The Deptt of ISM&H have identified 1500 medicinal plants, of which 500 species are used in preparation of drugs. More than 150 plant species have been categorized as endangered. India, with its vast bio-diversity has tremendous potential and advantage in the emerging herbal products market both in India and abroad

16. Over 90 % of the drugs used in ISM are plant based. The effectiveness of these systems mainly depends upon the sustained availability of genuine plant material which get processed appropriately into drugs and formulation according to the classical methods. Keeping in view the need for availability of authentic raw drugs and the vast potential of herbal product/herbal drugs and the role India could play in global market, the Government of India has constituted a "Medicinal Plants Board" for an integrated development of medicinal plants sector, organize medicinal plants marketing and, coordinate efforts of all the stakeholders of the sector. The Medicinal Plants Board was set up under a Government Resolution notified on 24th November, 2000 under the Chairmanship of Union Health & Family Welfare Minister. The MPB is a national level nodal body, which has been established to formulate a policy for medicinal plants, and help develop the potential of this sector through diverse schemes and projects.

17. The MPB is responsible for coordination of all matters related to medicinal plants, including drawing up policies and strategies for conservation, proper harvesting, cost-effective cultivation, research and development, processing, marketing of raw material in order to protect, sustain and develop this sector. The work will continue to be carried out by the respective Departments/ Organizations but the Board will provide a focus and direction to the activities. MPB will work in co-ordination with Ministries/Departments/ Organizations/ State/UT Governments for development of medicinal plants in general and specifically in the following fields:

- Assessment of demand/supply position relating to medicinal plants both within the country and abroad.
- Advise concerned Ministries/Departments/Organisations/State/UT Governments on policy matters relating to schemes and programmes for development of medicinal plants.
- Provide guidance in the formulation of proposals, schemes and programmes etc. to be taken-up by agencies having access to land for cultivation and infrastructure for collection, storage and transportation of medicinal plants.
- Identification, inventorisation and quantification of medicinal plants.
- Promotion of ex-situ/in-situ cultivation and conservation of medicinal plants.
- Promotion of co-operative efforts among collectors and growers and assisting them to store, transport and market their produce effectively.
- Setting up of database system for inventorisation, dissemination of information and facilitating the prevention of Patents being obtained for medicinal use of plants, which is in the public domain.
- Matters relating to import/export of raw material, as well as value added products either as medicine, food supplements or as herbal cosmetics including adoption of better techniques for marketing of product to increase their reputation for quality and reliability in the country and abroad.
- Undertaking and awarding scientific, technological research and cost-effectiveness studies.
- Development of protocols for cultivation and quality control.
- Encouraging the protection of patent rights and IPR.

18. National Medicinal Plant Board is fully operationalized under the Department of ISM&H; 26 Medicinal Plant Boards have been set up in different states. 32 medicinal plants which are in demand both in domestic and international market have been identified and prioritised for correlation, cultivation, value addition and marketing. During the year 2002-03, the Medicinal Plant Board has sanctioned 219 projects including 103 promotional schemes and 116 commercial schemes. The funds provided for the Medicinal Plant Board at RE stage was Rs. 15 core and this was fully utilized. Under the Medicinal Plant Board, the Department has established export promotion zones in Uttaranchal and Karnataka and are planning to establish one in the northeast. In the North East one of the major problems is the transport and processing bottlenecks. The Board is exploring methods by which this could be resolved.

Supply of ISM&H drugs

19. The Department of ISM&H is supplying drugs in the Centrally Sponsored Scheme of Supply of Essential Drugs to rural areas. The Department is simultaneously strengthening ISM&H pharmacies in the states. The Department of ISM&H is releasing the funds under the Supply of Drugs Scheme of the State Government with the request that they should purchase the drugs only from the state ISM&H pharmacies which are being strengthened by the Department of ISM&H. This system has the dual advantage of ensuring with ISM&H pharmacies which are being strengthened by the Department become functional, and viable and good quality drugs are available in Government ISM&H hospitals and dispensaries. In an effort to reduce the gap between replacement and availability of ISM&H drugs in ISM&H hospitals, the Department is making efforts to reappropriate the unspent balance in other schemes so that this amount could be utilized for providing drugs in ISM&H dispensaries and hospitals.

Quality Control of Drugs

20. There are a large number of ISM&H pharmacies in the country (Table -2) 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.

Table -2 - Licensed Pharmacies in India

♂ Ayurveda	8,386
♂ Unani	453
♂ Siddha	384
♂ Homoeopathy	609
♂ **Total**	**9,832**

Source: Department of ISM&H,2002

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.

21. 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 obtained the approval of the EFC for the 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 safety, efficacy and quality of the drugs persists, and 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.

22. 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.

Medical Tourism

23. 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

24. 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

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.

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.

25. 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.

26. 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

27. 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. During the Ninth Plan funds had been provided by Department of Family Welfare for inclusion of Ayurvedic and Unani drugs in the drug kit of ANM. Involvement of ISM&H practitioners in all other Central and State Health Sector Programmes including disease control programmes for Malaria, Tuberculosis, diarrhoeal diseases will have to be taken up in a phased manner.

National ISM&H Policy

28. 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. The National ISM&H Policy approved by the Cabinet in

October 2002 outlines measures that will enable ISM&H system achieve its full potential in providing healthcare.

Review of the ZBB exercise

29. The ZBB 2001 reviewed all the ongoing schemes in the Department of ISM&H. There were that time 45 schemes. These schemes were merged and restructured into four Centrally Sponsored Schemes and nine Central Sector Schemes. At the time of QPR, Member (Health) reviewed the ZBB exercise of 2001 and 2002. He agreed to the Department's request that CSS of IEC could be merged with the Central Sector Schemes of IEC bringing down the Centrally Sponsored Schemes under the Department of ISM&H to three. The Central Sector schemes are satisfactory performing and no alteration in the parameters of the schemes were required.

In principle approval/EFC/SFC approval.

30. In view of the massive changes in parameters of implementation of the schemes between Ninth Plan and Tenth Five-Year Plan period, the Department had to seek `in principle' approval as well as EFC/SFC approval for almost all the schemes. By end of 2002-03, the Department of ISM&H has completed the exercise of obtaining `in principle' approval for all the new schemes, SFC/ EFC approval for all the Centrally Sponsored Scheme, and almost all Central Sector Schemes. As the Department has completed the process of getting proposals approved in the very first year of the Tenth Plan, they can concentrate on implementation of the schemes and monitoring their progress over the next four years.

Annual Action Plan/Quarterly Performance Review

31. In order to monitor the timely implementation of the programmes during the Tenth Plan, Planning Commission has taken two new initiatives. The Annual Action Plans will focus on implementing the strategies, and monitoring the progress through yearly processes and impact indicators in the state and Central Sectors. Quarterly Performance Reviews (QPR) is aimed at monitoring of timely release of funds , their utilisation and progress in implementation of the programme. The major strategies for ISM&H in the Tenth Plan are to:

- ♂ Mainstream of ISM&H institutions/personnel with existing primary, secondary health care institutions
- ♂ Improve quality control of drugs and formulation.

32. Member (Health) under takes QPR for Central Deptt of ISM&H and the State Plan Principal Advisers/Adviser in course of the QPR of their respective states review the performance in ISM&H sector also.

Outlays and expenditure

33. In the Ninth Plan period the Deptt of ISM&H had total 44 schemes; none of the schemes were classified as CSS in the Ninth Plan. At the time of ZBB 2001, Planning Commission identified 10 schemes, funded by the Centre and carried out through State Government/other agencies. ZBB 2001 recommended that these 10 schemes should be reclassified as Centrally Sponsored Schemes. The Ninth Plan and the yearly outlays and expenditure for all the 44 (CS & CSS) is given Annexure I A .

34. During the ZBB an exercise to merge weed out schemes was taken up and 4 CSS and 9 CS were identified for continuation in the Tenth Plan. During QPR & ZBB 2002-03 the Deptt sought the approval of the Planning Commission for the merger of the CSS on IEC with the Central sector scheme on IEC and Planning Commission agreed to this. Therefore, there were only 3 CSS. The Tenth Plan outlays were scheme-wise revised taking the change into account. The scheme-wise outlays for Tenth Plan, Annual Plan outlay and RE for 2002-03, Revised Tenth Plan outlay and BE for 2003-04 is given Annexure 4.6.1B.

35. The Department has sent the information on state wise release under CSS during the Ninth and Tenth Plan. There were no releases to states under 6 CSS during the Ninth Plan. Department of ISM&H had provided statewise allocation/ expenditure for the remaining 4 CSS. The Department has also sent the information on release to the States under all the three CSS in the Tenth Plan. These are given in Annexure 4.6.2.

SCHEMEWISE NINTH PLAN OUTLAYS & EXPENDITURE (Rs in Lakhs)

9th Plan No.	NAME	9th Plan Outlay	1997-98		1998-99		1999-00		2000-01		2001-02		9TH Plan	9TH Plan
			OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	Sum of yearly outlays	Sum of yearly expenditure
A	**INFORMATION, EDUCATION AND COMMUNIATION (IEC)**	**51.00**	**1.00**	**0.00**	**10.00**	**0.00**	**10.00**	**0.00**	**30.00**	**0.00**	**0.00**	**0.00**	**51.00**	**0.00**
1	Health for all through preventive and promotive programmes of ISM&H	51.00	1.00	0.00	10.00	0.00	10.00	0.00	30.00	0.00	0.00	0.00	51.00	0.00
B	**DEVELOPMENT OF INSTITUTIONS**	**2920.00**	**600.00**	**626.00**	**585.00**	**789.00**	**840.00**	**822.00**	**970.00**	**1056.00**	**1025.00**	**986.48**	**4020.00**	**4279.48**
2	Development of ISM&H UG. Colleges	1725.00	375.00	326.00	465.00	450.00	690.00	550.00	650.00	815.00	650.00	686.46	2830.00	2827.46
3	Assistance to P.G. Medical Education in ISM	650.00	75.00	150.00	0.00	190.00	0.00	209.00	195.00	205.00	250.00	256.07	520.00	1010.07
4	Re-orientation of in-service training Programme	545.00	150.00	150.00	120.00	149.00	150.00	63.00	125.00	36.00	125.00	43.95	670.00	441.95
C	**HOSPITALS AND DISPENSARIES**	**490.00**	**0.00**	**0.00**	**80.00**	**0.00**	**110.00**	**0.00**	**200.00**	**0.00**	**12.00**	**73.72**	**402.00**	**73.72**
5	ISM Polyclinic with Regimental therapy,panchkarma,Yoga & Naturopathy	100.00	0.00	0.00	15.00	0.00	35.00	0.00	50.00	0.00	10.00	0.00	110.00	0.00
6	Speciality Clinic on ISM&H	190.00	0.00	0.00	65.00	0.00	75.00	0.00	50.00	0.00	1.00	0.00	191.00	0.00
7	Ayurveda Park/Panchkarma in Hotels (Medical Tourism)	200.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00		1.00	73.72	101.00	73.72
D	**DRUGS QUALITY CONTROL**	**2582.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**1850.00**	**2047.00**	**1850.00**	**1099.55**	**3700.00**	**3146.55**
8	Assistance toState Drug Testing Lab & Pharmacies	2582.00	0.00	0.00	0.00	0.00	0.00	0.00	1850.00	2047.00	1850.00	1099.55	3700.00	3146.55
9	Essential Drugs for Ayurveda, Siddha, Unani and Homoeopathy (ISM&H) Dispansaries for Rural and Backward Areas in various States													
10	NEW SCHEME - 'HOME REMEDIES KIT'*	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	TOTAL	**6043.00**	**601.00**	**626.00**	**675.00**	**789.00**	**960.00**	**822.00**	**3050.00**	**3103.00**	**2887.00**	**2159.75**	**8173.00**	**7499.75**
	CENTRAL SECTOR													
A	**STRENGTHENING OF DEPTT. OF ISM&H**	**1650.00**	**427.00**	**384.00**	**427.00**	**333.00**	**367.00**	**348.00**	**429.00**	**503.00**	**479.00**	**396.61**	**2129.00**	**1964.61**
1	Secretariat Social Services	956.00	227.00	246.00	227.00	250.00	227.00	271.00	275.00	338.00	325.00	310.02	1281.00	1415.02
2	Strengthening of Pharmacopeal Committee on ISM	694.00	200.00	138.00	200.00	83.00	140.00	77.00	154.00	165.00	154.00	86.59	848.00	549.59
B	**EDUCATIONAL INSTITUTIONS**	**5282.00**	**656.00**	**637.00**	**905.00**	**924.00**	**1186.00**	**965.00**	**2015.00**	**1243.00**	**1931.00**	**1221.65**	**6693.00**	**4990.65**
3	IPGTR, Jamnagar	200.00	25.00		25.00	50.00	75.00	75.00	75.00	75.00	75.00	60.00	275.00	260.00
4	NIA, Jaipur	1035.00	200.00	163.00	160.00	396.00	250.00	348.00	425.00	316.00	357.00	357.00	1392.00	1580.00
5	RAV, New Delhi	139.00	30.00	26.00	25.00	34.00	40.00	44.00	44.00	41.00	50.00	46.65	189.00	191.65
6	NIS Chennai	676.00	1.00	0.00	25.00	4.00	50.00	27.00	300.00		300.00		676.00	31.00

9th Plan No.	NAME	9th Plan Outlay	1997-98		1998-99		1999-00		2000-01		2001-02		9TH Plan	9TH Plan
			OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	Sum of yearly outlays	Sum of yearly expenditure
7	NIH, Calcutta	946.00	150.00	253.00	200.00	210.00	225.00	300.00	371.00	464.00	400.00	400.00	1346.00	1627.00
8	NIUM, Bangalore	821.00	150.00	150.00	200.00		121.00	133.00	350.00	200.00	350.00	150.00	1171.00	633.00
9	MDNIY, New Delhii	1135.00	55.00	5.00	170.00	170.00	325.00	0.00	350.00	53.00	300.00	109.00	1200.00	337.00
10	Vishwayatan Yogashram, New Delhi.	75.00	15.00	5.00	20.00	19.00	20.00	10.00	20.00	17.00	19.00	19.00	94.00	70.00
11	NIN, Pune.	255.00	25.00	14.00	75.00	46.00	75.00	28.00	80.00	77.00	80.00	80.00	335.00	245.00
C	**STATUTORY INSTITUTIONS**	**176.00**	**31.00**	**44.00**	**42.00**	**62.00**	**42.00**	**17.00**	**21.00**	**14.00**	**11.00**	**10.00**	**147.00**	**147.00**
12	CCIM ,New Delhi	130.00	30.00	44.00	40.00	60.00	40.00	17.00	20.00	14.00	10.00	10.00	140.00	145.00
13	CCH, New Delhi.	6.00	1.00	0.00	2.00	2.00	2.00		1.00		1.00		7.00	2.00
14	Indian Homoeopathy Pharmacy Council	20.00												
15	ISM Pharmacy Council	20.00												
D	**RESEARCH COUNCILS (INTRA AND EXTRA MURAL RESEARCH)**	**8391.00**	**1445.00**	**1341.00**	**2149.00**	**2321.00**	**2393.00**	**2439.00**	**2364.00**	**2206.00**	**2386.00**	**2354.94**	**10737.00**	**10661.94**
16	CCRAS, New Delhi.	2774.00	450.00	495.00	744.00	947.00	824.00	967.00	756.00	689.00	788.00	772.60	3562.00	3870.60
17	CCRUM, New Delhi.	2429.00	350.00	404.00	650.00	692.00	729.00	798.00	700.00	849.00	734.00	807.00	3163.00	3550.00
18	CCRYN, New Delhi	575.00	75.00	80.00	130.00	132.00	200.00	139.00	170.00	164.00	200.00	175.00	775.00	690.00
19	CCRH, New Delhi.	1294.00	210.00	250.00	325.00	360.00	360.00	364.00	399.00	330.00	400.00	370.71	1694.00	1674.71
20	Central Councils combined building complex	404.00	110.00	90.00	110.00	80.00	80.00	75.00	104.00	88.00	108.00	82.55	512.00	415.55
21	Extra Mural research projects through Research Institutions(Pvt/Semi-Govt./Govt./Universties/GOs)etc.	840.00	250.00	22.00	190.00	110.00	200.00	73.00	200.00	63.00	150.00	147.08	990.00	415.08
22	Survey on Usage & acceptability of ISM&H systems.	75.00						23.00	35.00	23.00	6.00		41.00	46.00
E	**HOSPITALS AND DISPENSARIES**	**71.00**	**1.00**	**25.00**	**20.00**	**20.00**	**20.00**	**0.00**	**25.00**	**26.00**	**226.00**	**243.80**	**292.00**	**314.80**
23	Advanced Ayurvedic Centre for Mental Health in NIMHANS	61.00	1.00	25.00	20.00	20.00	20.00	0.00	20.00	26.00	26.00	26.00	87.00	97.00
24	National Ayurvedic Hospital in Delhi	10.00							5.00		200.00	217.80	205.00	217.80
	Expansion of CGHS dispensaries													
	Ayurveda Hospital, Lodhi Road													
F	**MEDICINAL PLANTS**	**1765.00**	**160.00**	**174.00**	**160.00**	**200.00**	**335.00**	**113.00**	**610.00**	**353.00**	**2135.00**	**1365.56**	**3400.00**	**2205.56**
25	Setting up of National Board for Medicinal Plants	650.00					100.00		150.00	88.00	1610.00	1175.17	1860.00	1263.17
26	Information Technology	200.00					0.00		100.00	110.00	100.00	40.00	200.00	150.00
27	Innovative Scheme for development of Medicinal Plants	875.00	150.00	165.00	150.00	200.00	225.00	112.00	350.00	144.00	350.00	75.39	1225.00	696.39

9th Plan No.	NAME	9th Plan Outlay	1997-98		1998-99		1999-00		2000-01		2001-02		9TH Plan	9TH Plan
			OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	OUTLAY	EXPD	Sum of yearly outlays	Sum of yearly expenditure
28	Patent cell for ISM intellectual property rights(in TKDL)	40.00	10.00	9.00	10.00	0.00	10.00	1.00	10.00	11.00	75.00	75.00	115.00	96.00
G	**Strengthening of Pharmacopoeial Laboratories**	**1082.00**	**150.00**	**48.00**	**215.00**	**165.00**	**73.00**	**28.00**	**191.00**	**75.00**	**468.00**	**49.50**	**1097.00**	**365.50**
29	PLIM Ghaziabad	139.00	75.00	7.00	15.00	4.00	8.00	7.00	41.00	7.00	42.00	7.31	181.00	32.31
30	HPL, Ghaziabad	314.00	75.00	41.00	150.00	139.00	40.00	21.00	49.00	17.00	26.00	22.19	340.00	240.19
31	Strengthening of PLIM/HPL	575.00			50.00	22.00	25.00		100.00		300.00	20.00	475.00	42.00
32	Publiic Sector Undertaking (IMPCL, Mohan, U.P.)	54.00							1.00	51.00	100.00		101.00	51.00
H	**INFORMATION, EDUCATION AND COMMUNIATION (IEC)**	**480.00**	**20.00**	**10.00**	**110.00**	**146.00**	**150.00**	**133.00**	**200.00**	**357.00**	**200.00**	**193.28**	**680.00**	**839.28**
33	Information, Education & Communication(IEC)	480.00												
													0.00	0.00
I	**Other Programmes and Schemes**	**1595.00**	**9.00**		**257.00**		**337.00**		**1020.00**				**1623.00**	**0.00**
34	International Exchange Programmes/Seminars/Workshops on ISM&H and Scholarship scheme for foreign students in ISM&H	195.00	30.00	15.00	40.00	32.00	50.00	40.00	75.00	66.00	75.00	73.52	270.00	226.52
	Programme for training/ fellowship/ exposure visit/ upgradation of skills etc. for ISM&H personnel.													
	Incentives to ISM&H industry for participation in fairs/ conducting market study for creating & developing market opportunity													
	Publication of text book													
	Manuscript, publication and acquisition													
	Lumpsum Provision for North Eastern States & Sikkim	1400.00												
	NEW INITIATIVES DURING THE 10TH PLAN													
	North Eastern Institute of ISM&H													
	TOTAL	**20492.00**	**2899.00**	**2663.00**	**4285.00**	**4171.00**	**4903.00**	**4043.00**	**6875.00**	**4777.00**	**7836.00**	**5835.34**	**26798.00**	**21489.34**
	GRAND TOTAL	**26635.00**	**3530.00**	**3289.00**	**5000.00**	**4960.00**	**5913.00**	**4865.00**	**10000.00**	**7880.00**	**12000.00**	**7995.09**	**36443.00**	**28989.09**

Note: Grand Total of the outlays & Expd. in a particular year can be different from the actual sum total of each scheme in that year.

^ As per decision taken at ZBB 2002-03

				Annexure 4.6.1 B Concld.		
SCHEMEWISE TENTH PLAN OUTLAYS & EXPENDITURE						
						Rs. in Lakhs
S.No.IN X PLAN	NAME	10th Plan Outlay as per 10th	Revised 10th Plan outlays	2002-03		2003-04
				Outlay	RE	Outlay
	IEC	1200.00	Merged	Merged	Merged	Merged
A	Development of Institutions	11750.00	12000.00	2000.00	1170.00	2195.00
B	Hospitals and Dispensaries	4900.00	5900.00	1050.00	228.00	1281.00
C	Drugs Quality Control	4540.00	4540.00	875.00	548.00	678.00
	Total	22390.00	22440.00	3925.00	1946.00	4154.00
	CENTRAL SECTOR					
A	**STRENGTHENING OF DEPTT. OF ISM&H**	2250.00	2250.00	515.00	531.00	574.00
	Secretariat Social Services	1750.00	1750.00	350.00	481.00	474.00
	Strengthening of Pharmacopeal Committee on ISM	500.00	500.00	165.00	50.00	100.00
B	**EDUCATIONAL**	11650.00	11650.00	2615.00	2439.40	2430.00
	IPGTR, Jamnagar	550.00	550.00	100.00	60.00	100.00
	NIA, Jaipur	2500.00	2500.00	600.00	600.00	460.00
	RAV, New Delhi	300.00	300.00	55.00	55.00	60.00
	NIS Chennai	2500.00	2500.00	400.00	400.00	700.00
	NIH, Calcutta	2500.00	2500.00	600.00	600.00	500.00
	NIUM, Bangalore	1500.00	1500.00	300.00	300.00	300.00
	MDNIY, New Delhi	1100.00	1100.00	450.00	317.40	200.00
	Vishwayatan Yogashram, New Delhi.	100.00	100.00	20.00	17.00	20.00
	NIN, Pune.		600.00	90.00	90.00	90.00
C	**STATUTORY INSTITUTIONS**	265.00	265.00	15.00	13.00	32.00
	CCIM ,New Delhi	60.00	60.00	12.00	12.00	12.00
	CCH, New Delhi.	5.00	5.00	1.00	1.00	1.00
	Indian Homoeopathy Pharmacy Council	100.00	100.00	1.00	0.00	0.00
	ISM Pharmacy Council	100.00	100.00	1.00	0.00	0.00
	Central Pharmacy Council					19.00
D	**RESEARCH COUNCILS (INTRA AND EXTRA MURAL RESEARCH)**	13600.00	13600.00	2520.00	2441.60	2586.00
	CCRAS, New Delhi.	4500.00	4500.00	800.00	741.00	800.00
	CCRUM, New Delhi.	4200.00	4200.00	750.00	825.00	800.00
	CCRYN, New Delhi	1000.00	1000.00	200.00	175.00	200.00
	CCRH, New Delhi.	2200.00	2200.00	400.00	400.00	400.00
	Central Councils combined building complex	600.00	600.00	110.00	110.00	120.00

				Annexure 4.6.1 B Concld.		
SCHEMEWISE TENTH PLAN OUTLAYS & EXPENDITURE						
						Rs. in Lakhs
S.No.IN X PLAN	**NAME**	**10th Plan Outlay as per 10th**	**Revised 10th Plan outlays**	**2002-03**		**2003-04**
				Outlay	**RE**	**Outlay**
	Extra Mural research projects through Research Institutions(Pvt/Semi-Govt./Govt./Universties/GOs)etc.	1000.00	1000.00	200.00	68.00	104.00
	Survey on Usage & acceptability of ISM&H systems	100.00	100.00	60.00	7.60	12.00
E	**HOSPITALS AND DISPENSARIES**	**2244.00**	**2894.00**	**276.00**	**91.00**	**262.00**
	Advanced Ayurvedic Centre for Mental Health in NIMHANS	44.00	44.00	26.00	26.00	26.00
	National Ayurvedic Hospital in Delhi	1500.00	1500.00	200.00	15.00	100.00
	Expansion of CGHS	700.00	700.00	50.00	50.00	86.00
	Ayurveda Hospital, Lodhi Road	650.00	650.00	-	0.00	50.00
F	**MEDICINAL PLANTS**	**10700.00**	**9800.00**	**2466.00**	**1500.00**	**2000.00**
	Setting up of National Board for Medicinal Plants	9350.00	9350.00	2316.00	1500.00	2000.00
	Information Technology					
	Innovative Scheme for development of Medicinal Plants	300.00	300.00	100.00	Merged with Medicinal Plant Board	
	Patent cell for ISM intellectual property rights(in TKDL)	150.00	150.00	50.00		
G	**Strengthening of Pharmacopoeial Laboratories**	**2650.00**	**2650.00**	**567.00**	**40.00**	**736.00**
	PLIM Ghaziabad	50.00	50.00	46.00	19.00	20.00
	HPL, Ghaziabad	100.00	100.00	20.00	20.00	16.00
	Strengthening of PLIM/HPL	2000.00	2000.00	500.00	0.00	500.00
	Publiic Sector Undertaking (IMPCL, Mohan, U.P.)	500.00	500.00	1.00	1.00	200.00
H	**INFORMATION, EDUCATION AND COMMUNIATION (IEC)**	**1700.00**	**1900.00**	**300.00**	**315.00**	**425.00**
	Information, Education & Communication(IEC)	1700.00	1900.00	300.00	315.00	425.00
I	**Other Programmes and Schemes**	**8550.00**	**10046.00**	**1801.00**	**1182.00**	**1800.00**
	International Exchange Programmes/Seminars/Workshops on ISM&H and Scholarship scheme for foreign students in ISM&H	800.00	800.00	100.00	75.00	100.00

				Annexure 4.6.1 B Concld.		
SCHEMEWISE TENTH PLAN OUTLAYS & EXPENDITURE						
						Rs. in Lakhs
S.No.IN X PLAN	**NAME**	**10th Plan Outlay as per 10th**	**Revised 10th Plan outlays**	**2002-03**		**2003-04**
				Outlay	**RE**	**Outlay**
	Programme for training/ fellowship/ exposure visit/ upgradation of skills etc. for ISM&H personnel.	300.00	300.00	50.00	20.00	50.00
	Incentives to ISM&H industry for participation in fairs/ conducting market study for creating & developing market opportunity	500.00	500.00	50.00	35.00	50.00
	Publication of text book	500.00	500.00	50.00	1.00	50.00
	Manuscript, publication and acquisition	200.00	200.00	50.00	1.00	50.00
	Lumpsum Provision for North Eastern States & Sikkim	7746.00	7746.00	1501.00	1050.00	1500.00
J	**NEW INITIATIVES DURING THE 10TH PLAN**	**1501.00**	**5.00**	**1.00**	**1.00**	**1.00**
	North Eastern Institute of ISM&H	1501.00	5.00	1.00	1.00	1.00
	Total	**55110.00**	**55060.00**	**11075.00**	**8554.00**	**10846.00**
	GRAND TOTAL	**77500.00**	**77500.00**	**15000.00**	**10500.00**	**15000.00**
Note: Grand Total of the outlays & Expd. in a particular year can be different from the actual sum total of each scheme in that year.						
Revised Tenth Plan, 2002-03 BE, RE & 2003-04 BE as per Annual Plan.						

Annexure 4.6.2

STATEWISE RELEASE OF FUNDS UNDER DEPARTMENT OF ISM&H

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Development of ISM&H UG. Colleges (2)^, Assistance to P.G. Medical Education in ISM$ (3), Re-orientation of in-service training Programme # (4), State Drug Testing Laboratory & Pharmacies *(8)

Post ZBB (2002-03 onwards) - Drugs Quality Control *(3), Development of Institutions (1)^ $ #, Hospital and dispensaries(2)

(Rs in Lakhs)

Sno.	Name of the state/ UT	Ninth Plan								Tenth Plan		
		Development of ISM&H UG Colleges ^		Assistance to P.G. Medical Education in ISM $		Re-orientation of in-service training programme #		Drugs *		Development of Institutions	Hospitals & Dispensaries	Drugs *
		2000-01	2001-02	2000-01	2001-02	2000-01	2001-02	2000-01	2001-02	2002-03	2002-03	2002-03
1	Andhra Pradesh	62.00		28.65	92.00	3.94	3.02	105.00	115.00	15.56	20.57	85.00
2	Arunachal Pradesh							-	-	10.00	6.05	-
3	Assam		2.00					-	-	7.20	5.30	110.00
4	Bihar	70.00				1.16	1.16	75.00	-	-	5.57	-
5	Chattisgarh						2.55	75.00	95.00	-	5.57	-
6	Delhi	22.00	15.00			6.61	1.86	-	95.00	-	0.00	-
7	Goa							-	-	-	0.00	-
8	Gujarat	27.00	68.00	11.85	34.22			133.00	90.00	54.00	5.57	-
9	Haryana		27.00					-	-	-	20.57	-
10	Himachal Pradesh	14.71				2.78		131.24	114.55	13.59	29.82	106.02
11	J & K	14.00	4.00						170.00	-	0.00	-
12	Jharkhand							-	-	-	5.57	-
13	Karnataka	87.40	56.80	19.76	33.90	4.78	4.03	112.88	-	122.25	20.57	-
14	Kerala	49.00	49.00		14.64	4.87	2.80	75.00	-	79.53	5.00	90.00
15	Madhya Pradesh	27.00	44.00		26.46	2.23		150.00	95.00	35.42	5.57	-
16	Maharashtra	266.69	161.00		5.90		8.12	131.69	-	163.60	5.57	-
17	Manipur						2.92	-	-	-	5.30	-
18	Meghalaya							-	-	-	5.30	-
19	Mizoram							-	-	-	0.00	-
20	Nagaland							-	-	-	0.00	-
21	Orissa		10.00	56.52		2.32	6.05	170.63	-	22.93	5.57	-
22	Punjab	12.00	44.00			1.16	1.16	70.39	95.00	-	20.57	90.00
23	Rajasthan	27.00	5.37			3.94	2.80	230.00	-	5.37	20.57	-
24	Sikkim							-	-	-	0.00	45.00
25	Tamil Nadu	27.00		83.81	37.21	2.32		170.00	-	-	4.02	-
26	Tripura							-	85.00	-	0.00	20.00
27	Uttar Pradesh	97.20	108.29	4.34	11.74		4.00	260.00	-	36.04	5.57	-
28	Uttaranchal		92.00					157.05	145.00	10.00	20.57	-
29	West Bengal	12.00						-	-	34.61	5.30	-
30	A & N Islands							-	-	-	0.00	-
31	Chandigarh							-	-	-	0.00	-
32	D & N Haveli							-	-	-	0.00	-
33	Daman & Diu							-	-	-	0.00	-
34	Lakshadweep							-	-	-	0.00	-
35	Pondicherry							-	-	-	0.00	-
	TOTAL	**815.00**	**686.46**	**204.93**	**256.07**	**36.11**	**40.47**	**2046.88**	**1099.55**	**610.10**	**234.03**	**546.02**

Source: Dept. of ISM&H

4.7 FAMILY WELFARE

Right from the time of independence health services focused on efforts to improve access to health care for women and children and provision of contraceptive care. Successive Five- Year Plans have been providing the policy framework and funding for the planned development of nation wide health care infrastructure and manpower for delivering these services. The centrally sponsored and 100 per cent centrally funded Family Welfare Programme provides the states the additional infrastructure, manpower and consumables needed for improving the health status of women and children and to meet all the felt needs for fertility regulation.

2. Technological advances and the improved quality and coverage of health care resulted in a rapid fall in the crude death rate (CDR) from 25.1 in 1951 to 8.4 in 2001. In contrast, the reduction in crude birth rate (CBR) has been less steep, from 40.8 in 1951 to 25.4 in 2001. The pace of demographic transition in India has been relatively slow but steady. The 1991 and 2001 Census showed that the population growth rate fell below 2 per cent and continues to decline.

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 coverage under the family welfare services has not improved, 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 based on community need assessment, implementation of programmes aimed to meet all the needs is yet to be fully operationalised
- monitoring and mid-course correction utilising the locally generated service data and Civil Registration has not yet been operationalised .

Approach During The Tenth Plan

4. During the Tenth Plan, the paradigm shift, which began in the Ninth Plan, will be fully operationalised. The shift was from:

- demographic targets to *focussing on enabling couples to achieve their reproductive goals;*
- method specific contraceptive targets to *meeting all the unmet needs for contraception to reduce unwanted pregnancies;*
- numerous vertical programmes for family planning and maternal and child health to *integrated health care for women and children;*
- centrally defined targets to *community need assessment and decentralised area specific microplanning* and implementation of program for health care for women and children, to reduce infant mortality and reduce high desired fertility;
- quantitative coverage to *emphasis on quality and content of care*;
- predominantly women centred programmes to *meeting the health care needs of the family with emphasis on involvement of men in planned parenthood;*
- supply driven service delivery to *need and demand driven service; improved logistics for ensuring adequate and timely supplies to meet the needs;*
- service provision based on providers' perception to *addressing choices and conveniences of the couples.*

5. The population growth rate continues to be high due to:

- the large size of the population in the reproductive age-group (accounting for an estimated 60 per cent of the total population growth);
- higher fertility due to the unmet need for contraception (contributing to around 20 per cent of population growth); and
- high wanted fertility due to the prevailing high Infant Mortality Rate (IMR) and other socio-economic reasons (estimated contribution of about 20 per cent to population growth).

6. The Tenth Plan will fully operationalise efforts to:

- assess and meet the unmet needs for contraception;
- achieve reduction in the high desired level of fertility through programmes for reduction in IMR and maternal mortality ratio (MMR); and
- enable families to achieve their reproductive goals.

7. If the reproductive goals of families are fully met the country will be able to achieve the National Population Policy goal of replacement level of fertility by 2010. The medium and long term goals will be to continue this process to accelerate the pace of demographic transition and achieve population stabilisation by 2045. Early population stabilisation will enable the country to achieve its developmental goal of improving the economic status and quality of life of the citizens.

8. Reductions in fertility, mortality and population growth rate will be major objectives during the Tenth Plan. Three of the eleven monitorable targets for the Tenth Plan and beyond are:

- reduction in IMR to 45 per 1,000 live births by 2007 and 28 per 1,000 live births by 2012;

- reduction in maternal mortality ratio to 2 per 1,000 live births by 2007 and 1 per 1,000 live births by 2012; and
- reduction in decadal growth rate of the population between 2001-2011 to 16.2

9. The focus during the Tenth Plan will be on improving access to services to meet the health care needs of women and children by:

- a decentralised area-specific approach to planning, implementation and monitoring of the performance and effecting mid-course corrections;
- differential strategy to achieve incremental improvement in performance in all states/districts;
- special efforts to improve access to and utilisation of the services in states/districts with high mortality and/or fertility rates;
- filling the critical gaps in existing infrastructure especially in CHCs through appropriate reorganisation and restructuring of the primary health care infrastructure;
- ensuring that posts of specialists in CHCs do not remain vacant; upgrading skills and redeploying existing manpower to fill other critical gaps;
- streamlining the functioning of primary health care system in urban and rural areas; providing good quality integrated RCH services at the primary, secondary and tertiary care levels and improving referral services;
- providing adequate supply of essential drugs, diagnostics and vaccines; improving the logistics of supply;
- ensuring well coordinated activities for delivery of services by public, private and voluntary sectors to improve coverage;
- involvement of PRIs in planning, monitoring and mid-course correction of the programme at the local level;
- involvement of industry in the organised and unorganised sectors, agriculture workers and labour representatives in improving access to RCH services;
- effective use of social marketing to improve access to simple over the counter (OTC) products such as ORT and condoms;
- effective IEC and motivation programmes; and
- effective inter-sectoral coordination.

10. The steep reduction in mortality and fertility envisaged in the tenth plan are technically feasible within the existing infrastructure and manpower as has been demonstrated in several states/districts. In view of the massive differences in the availability and utilsation of health services and health indices of the population, a differential strategy is envisaged so that there is incremental improvement in all districts. This, in turn, is expected to result in substantial improvement in state and national indices and enable the country to achieve the goals set for the Tenth Plan.

Performance of the Family Welfare Programme

11. Data on the goals set in the Ninth Plan, current status and the goals set in the Tenth Plan and NPP 2000 are given in Annexure I. 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 for ambulatory care for management of minor ailments. 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 has

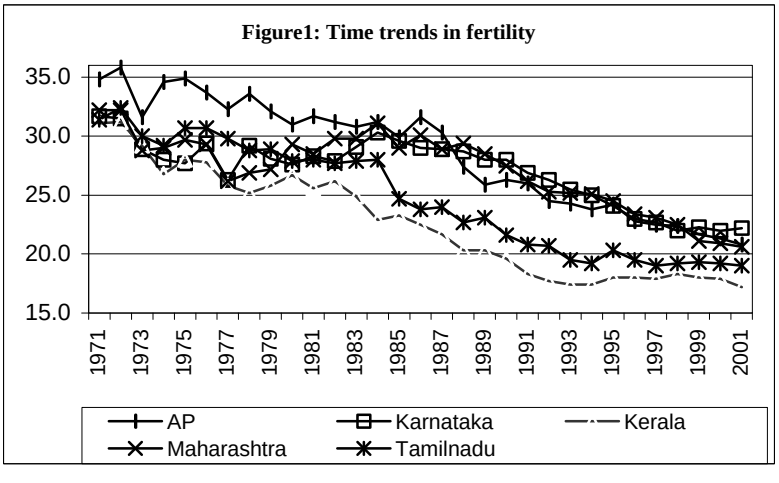
embarked on decentralized, district based, area specific need assessment and programmes for fulfilling the needs (CNA approach). RCH programme was aimed at providing integrated good quality maternal health, child health and contraceptive care. It was expected that these initiatives would lead to substantial improvement in the coverage and quality of services. Goals for the Ninth Plan were projected on the basis of these assumptions.

12. 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 and also delivery of services under all components under RCH programme. Comparison of current data with the goals set for the terminal year of the Ninth Plan indicate that the goals for Crude Birth rate are likely to be achieved; goals for institutional delivery will be achieved well ahead of the terminal yea of the plan. However, goals set for other parameters are unlikely to be achieved by 2002. 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 higher couple protection rates and use of spacing methods compared to 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.

13. The Tenth Plan has set an ambitious goal of meeting all the unmet needs for contraception and maternal and child health and achieving steep decline in IMR, CBR and MMR in five years. As these goals for five year period are comparable to what was achieved over the last three decades, there has been a debate whether the goals set can be achieved.

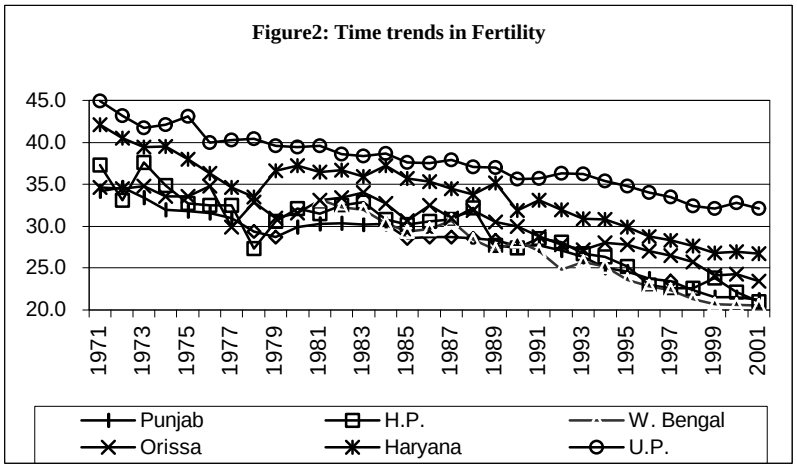
Figure1: Time trends in fertility

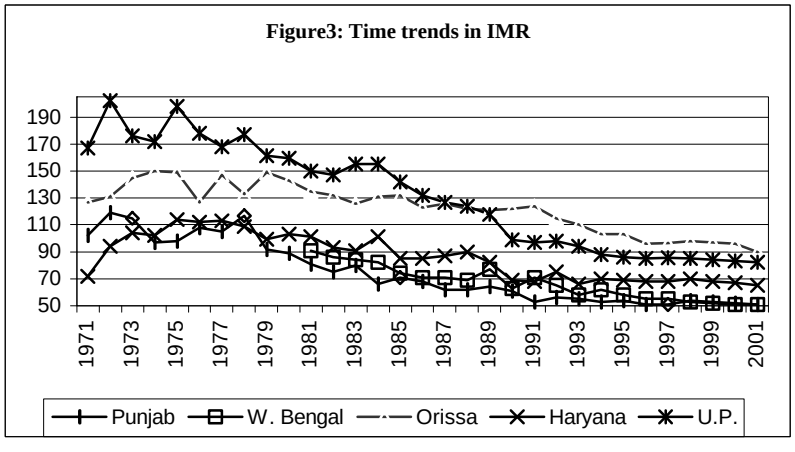


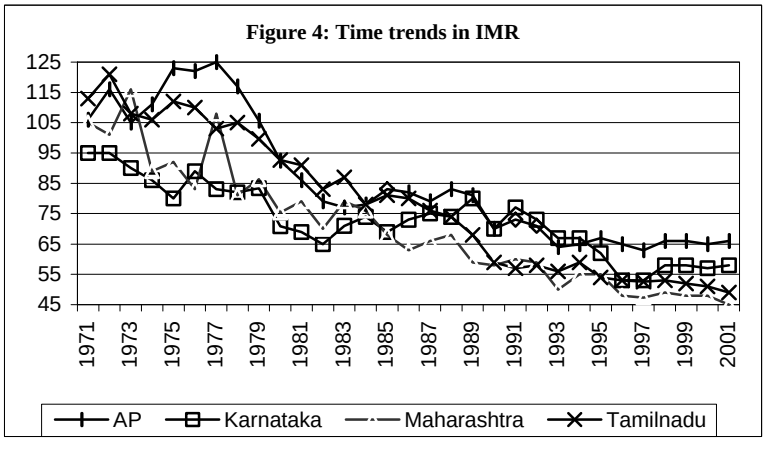
14. Sample Registration System provides information on state specific infant mortality and crude birth rate (CBR) since 1971. All the states have shown a decline in CBR and IMR through out the period; but the pace and time of decline varied. Analysis of data from SRS clearly shows that several states have achieved massive decline in CBR and IMR within a decade even though in the preceding years the decline was

slow. Time trends in CBR for Andhra Pradesh, Mahrashtra, Karnataka, Kerala and Tamil Nadu is indicated in Figure-1. The steep fall in CBR in Kerala occurred between 1981 and 1991, and after that it has remained essentially unaltered. The steep fall in CBR in Tamil Nadu occurred between 1984 and 1994 (from 28 in 1984 to 19 in 1994); Andhra Pradesh reported a fall from 31 in 1986 to 21 in 2001. In Mahrashtra birth rate remained essentially unaltered till 1989 and then started declining but the fall is less steep than that of Andhra Pradesh. More rapid decline in birth rate in Karnataka began in 1990 but the rate of decline is the slowest among all the southern and western states. These data indicate that a steep fall in birth rate can occur within a relatively short period until replacement level of fertility is attained, if there is political will, effective administration and access to health services to meet the unmet need for contraception.

15. The changes in CBR over the years 1971 to 2001 in Punjab, Orissa, Himachal Pradesh, West Bengal, Haryana and Uttar Pradesh are shown in Figure-2. All these states except Punjab and Orissa had higher CBR in seventies than the southern states. The decline in birth rate in all these states during eighties has been very slow. In Orissa, in spite of very high infant mortality, birth rate declined from 32 to 23 between 1988 and 2001. In West Bengal the decline began in 1987 and by 2001 birth rate is 20.5, in Punjab the decline began in nineties and currently the CBR is 21/1000. In Uttar Pradesh a steep decline in CBR is yet to begin. If simultaneous efforts are made to improve access to health and contraceptive care, especially access to sterilization service to meet the unmet needs for terminal methods of contraception, it is possible to expect a very steep fall in CBR in Uttar Pradesh during the first decade of current century.





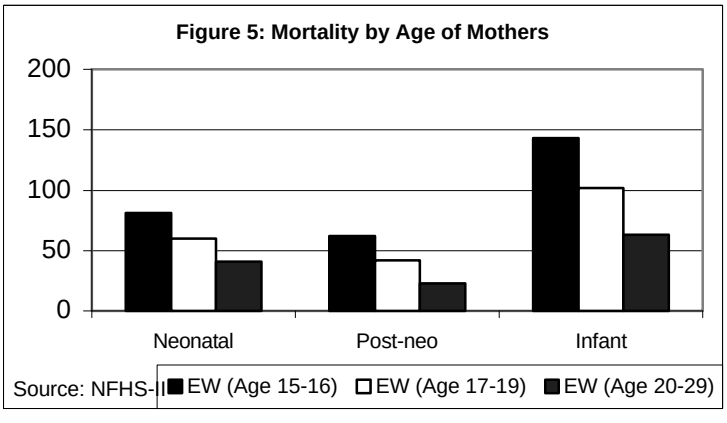


16. Time trend in IMR in

the northern and eastern states and southern and western states are shown in Figures 3 & 4. The southern and western states had lower IMR in the seventies. There was a steep decline in IMR in all the states during the seventies. However, by mid eighties the decline slowed down and during the nineties the decline in IMR in southern and western states has plateaued. In Orissa, there has been very slow decline in IMR from 130 in 1972 to 90 in 2001. The pace of decline in IMR in Uttar Pradesh in eighties was relative steeper; subsequently decline has been slow. The Tenth Plan advocates differential strategy for achieving rapid reduction in IMR. Focus will be to improve access to ORT and ARI treatment in states with relatively high IMR and high post neonatal mortality. This approach is likely to bring about relatively steep decline in infant mortality in Orissa, Uttar Pradesh, Madhya Pradesh and Rajasthan. Improving antenatal, delivery and new born care would be essential for achieving reduction in IMR in states such as Tamil Nadu, Maharashtra, Punjab, Haryana and West Bengal. This differential strategy will enable all states/ districts to achieve incremental improvement from the current status, enabling the country to progress towards the goals set in the Tenth Plan.

Adolescent Pregnancy

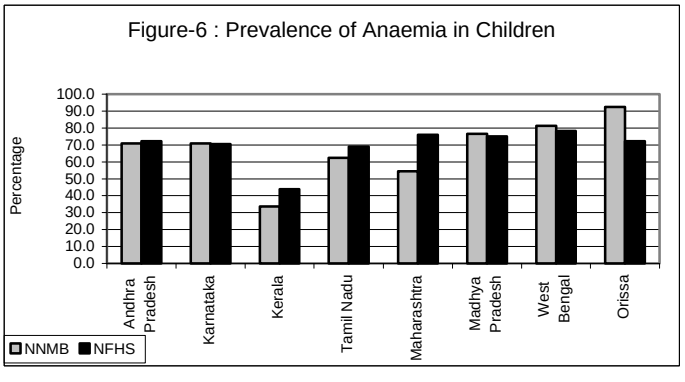
17. Data from NFHS – II indicates that mean age of marriage of girls in India is 16 years and mean age at first birth is 19.2 years. Analysis of data on the effect of maternal age on mortality during infancy shows that mortality rate in infancy were highest, if the girl delivers when she is 15 or 16, mortality rate were lowest when birth occur in women in the 20's (Figure-5). Nutritional requirement of pregnancy coming immediately after needs for adolescent growth spurt, high prevalence of anaemia and pregnancy induced, hypertension and poor utilization of health services are likely to be same of the major factors responsible for high neo-natal mortality rates. The poor child caring/ child rearing practices of very young girls and poor access to health services especially in rural areas might be responsible for higher infant mortality rate. There is an urgent need to improve awareness regarding adverse consequences of early teenage pregnancy and mobilize social support for strict implementation of lowest regarding aged marriage. As and when pregnancy occur in teenagers, they and their infants have to be treated as "high risk" individuals and provided adequate nutrition and health care.



Anaemia

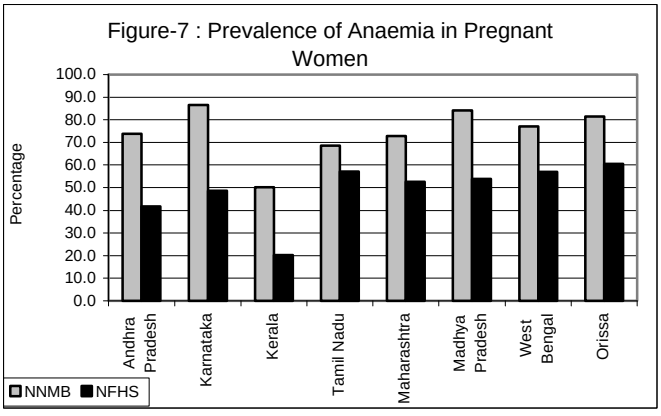
18. In India prevalence of anaemia is high because of

- low dietary intake, poor iron and folic acid intake
- poor bio-availability of iron in phytate, fibre-rich Indian diet.



- Infection such as malaria and hook worm infestations

19. Studies carried out by Indian Council of Medical Research (ICMR) and National Nutrition Monitoring Bureau (NNMB) have shown that while anaemia exists in all segments of population in all age groups, prevalence of anaemia is higher among pregnant women and pre-school children. India was the first developing country to take up National Nutritional Anaemia Prophylaxis Programme to prevent anaemia. Screening for anaemia and appropriate management of anaemic persons had been components of ante-natal and paediatric practice. In spite of all these efforts, anaemia continues to be a major problem affecting all segments of population. The National Family Health Survey-2 undertook haemolglobin estimation in 1998-99 and provided statewise information on prevalence of anaemia in children in the age group 0-3 years and pregnant women (Figures 6 & 7). Prevalence of anaemia in pre-school children reported by NFHS-2 was similar to the reported data from earlier ICMR and NNMB surveys; however the reported prevalence of anaemia in pregnancy was substantially lower.



20. NNMB in eight states in 2002 collected information on haemoglobin status in pre-school children, adolescent girls, pregnant and lactating women (Table-1). Comparison of

Table-1: Mean SE of Haemoglobin levels by Age/ Sex/ Physiological status

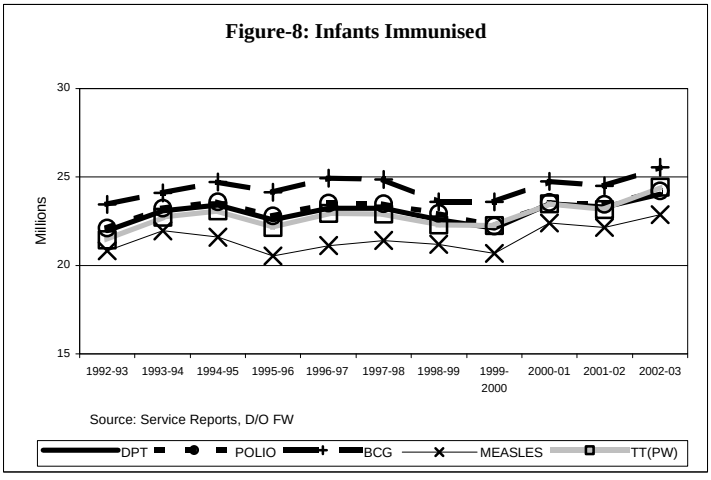
States	1-4 Years (Boys+Girls)	12-17 Years (Girls)	Pregnant Women	Lactating Women
Kerala	11.4 ± 1.43 (369)	11.8 ± 1.39 (706)	10.9 ± 1.39 (279)	11.7 ± 1.33 (338)
Tamil Nadu	10.3 ± 1.67 (387)	11.6 ± 1.73 (773)	9.9 ± 1.81 (365)	10.8 ± 2.06 (380)
Karnataka	10.0 ± 1.67 (344)	11.1 ± 1.72 (682)	9.2 ± 1.50 (319)	10.4 ± 1.82 (320)
Andhra Pradesh	10.1 ± 1.63 (448)	10.8 ± 1.82 (889)	9.9 ± 1.63 (416)	10.7 ± 1.85 (439)
Maharashtra	10.6 ± 1.68 (250)	11.5 ± 1.74 (522)	9.9 ± 1.67 (239)	10.8 ± 1.91 (250)
Madhya Pradesh	9.7 ± 1.68 (235)	10.5 ± 1.80 (461)	9.4 ± 1.61 (208)	10.1 ± 1.90 (227)
Orissa	9.6 ± 0.94 (407)	10.7 ± 1.46 (869)	9.7 ± 1.57 (356)	10.0 ± 1.60 (408)
West Bengal	10.1 ± 0.96 (437)	10.9 ± 1.00 (872)	10.2 ± 0.97 (436)	10.3 ± 0.94 (437)
Pooled	10.2 ± 1.55 (2877)	11.1 ± 1.63 (5774)	9.9 ± 1.58 (2618)	10.6 ± 1.75 (2799)
Figures in parenthesis indicate numbers				
Source: Assessment of Micronutrient Def. NNMB 2003				

data on prevalence of anaemia in pregnant women and pre-school children in NFHS-2 and NNMB is shown in Figures 6 & 7. In both the surveys prevalence of anaemia in pre-school children is comparable except in Orissa and Maharashtra. NNMB reported substantially higher prevalence of anaemia in pregnant women for all states. Studies carried out by NIN, AIIMS and others centers have shown that haemocne method used for estimating haemoglobin in NFHS-2 tends to over estimate haemoglobin levels; but there is no linear correlation between

haemoglobin level reported by cyanmethhaemoglobin and haemecene method. This might account for substantially lower prevalence of anaemia reported in NFHS-2 in pregnant women. In view of the continued high prevalence of anaemia in pregnancy and its adverse consequences to the mother and the foetus, it is imperative that the anaemia screening, detection and management programme is effectively implemented as a part of antenatal care.

Progress in performance under the FW programme

Figure-8: Infants Immunised



21. Department of Family Welfare has been reporting performance under family planning and immunization programmes every month. Information on process indicators are also compiled and reviewed periodically. Available data from service reports regarding performance during the 90's and the first two years of the new decade for immunization and contraception are shown in Figures 8 & 9. Service reports indicated substantially higher couple protection rates under spacing method as compared to coverage evaluation (Figure-10). Reported coverage under immunization at national level ranged from 100% for BCG to 90% for

Figure-9: Acceptors of Family Planning Methods- All India

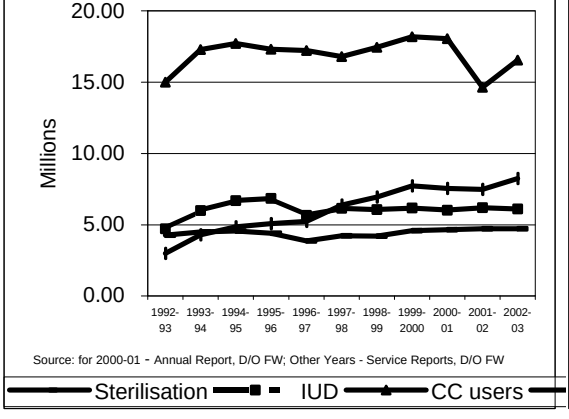
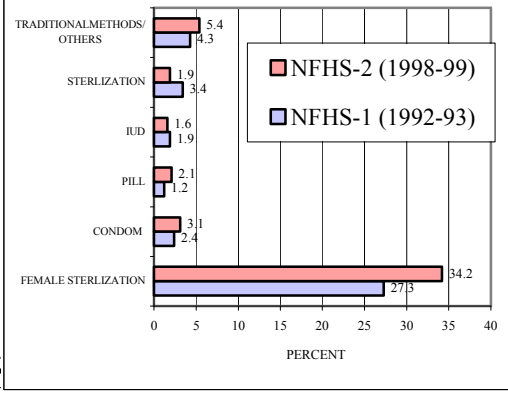


Figure-10: CONTRACEPTIVE USE BY METHOD (MARRIED WOMEN AGES 15-49)

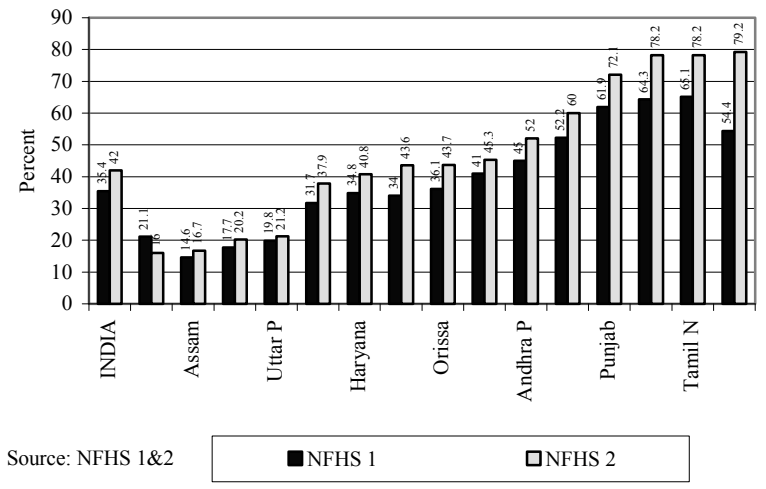


measles while evaluations have shown substantially lower coverage (Figure-11). The massive difference in coverage reported by service channels and evaluation surveys has to be corrected so that service reports provide reliable indication of progress achieved in the programme. The narrowing of gap in coverage figures between service and evaluation reports can be used as an important indicator for improvement in the quality of reporting.

22. Data from service reports suggests that during the Ninth Plan period there had not been any increase in the acceptance of family planning methods or coverage under immunisation (Figure-11). However, there has been some improvement in the coverage in the first year of the Tenth Plan. Concern has been expressed that this apparent lack of improvement, and in

some states actual decline in coverage which might be due to the introduction of decentralised district planning, based on the community needs assessment for these vital programmes, focus on campaign mode service delivery for some components of RCH programme and massive pulse polio initiative. The National Family Health Survey 1 and 2 provided evaluated coverage under the immunisation programme and acceptance for various contraceptive methods in 1992-93 and 1998-99; Rapid Household Survey 1 and 2 (currently underway) provides similar data for 1998-99 and 2002-03. Data from NFHS 1 and 2 clearly indicated that between 1992-93 and 1998-99 there was some improvement in performance both for contraception and routine immunisation. Preliminary analysis of data from the first phase of Rapid Household Survey has shown a similar trend with respect to antenatal care, institutional delivery and contraceptive acceptance. It is reassuring to note that evaluation studies have shown that coverage, content and quality of services have shown steady but slow improvement over the years. During the Tenth Plan efforts have to be made to accelerate the pace of improvement so that the goals set are achieved.

Figure-11: Children Fully Immunised (%)



Polio elimination

23. In 2002 only 7 countries in the world have reported polio cases. India (84%), Nigeria and Pakistan account for 99% of polio cases worldwide; 78% of India's cases are in UP. Number of polio cases reported state-wise between 1998-2003 is shown in Annexure II. Endemic transmission of both Type I and Type III polio virus is ongoing in western Uttar Pradesh. Major outbreak of Type-I polio virus occurred in central and eastern Uttar Pradesh and spread to western Bihar and adjoining districts in other states. Focal outbreak of Type I polio have occurred after reintroduction of polio virus in West Bengal and Gujarat. More than 80% of cases in 2002 occurred in children under 2 years of age.

24. Based on the data available from the coverage evaluation surveys and the polio surveillance data broadly the states can be classified into four categories:

- Not reporting polio cases for two or more years and have high coverage both under routine immunization and under NID (eg Kerala, Tamil Nadu) - in these states high coverage has to be sustained to prevent reemergence of the infection.
- Not reporting polio cases for the two or more years but have low routine immunization coverage (eg. smaller Northeastern states) – steps have to be taken urgently to improve coverage both under routine and pulse polio to prevent outbreaks if infection enters the state.

- Reporting some polio cases with low to moderate routine immunization coverage and uncovered pockets in pulse immunization (West Bengal , Haryana)- steps have to be taken to improve coverage both under routine and pulse polio to eliminate polio cases.
- Large number of polio cases with low coverage under routine immunization and uncovered pockets in pulse immunization (UP, Bihar)- energetic steps are required to improve coverage both under routine and pulse polio to achieve substantial reduction and then elimination of polio cases.

25. Available data suggest that in states /districts where routine immunization levels are high, outbreaks of polio do not occur. However if the routine immunization levels are low the state/district is vulnerable; as and when wild polio virus gets introduced outbreaks of polio occur in the unimmunised children. Thus, along with pulse polio campaigns, improvement in routine immunization coverage is essential not only to hasten the elimination of polio but to sustain elimination and prevent reemergence of polio.

26. The India Expert Advisory Group on Polio (IEAG) reviewed the polio situation in the country in Nov 2002 and Feb 2003; IEAG noted that unimmunized susceptible cohort of children in Uttar Pradesh and Bihar increased because of poor routine immunization coverage and poor coverage during SNIDs leading to the outbreak. Polio free states in India face risk of reintroduction of poliovirus from endemic areas in northern India. After considering all the epidemiological data, the IEAG recommended that in 2003 – 04 the following activities should be carried out:

- two rounds of SN ID in Uttar Pradesh, Bihar, Delhi, Haryana and Gujarat and high risk districts in West Bengal (all districts south of South Dinajpur) , MP(16), Jharkhand (13), Rajasthan (29) and Uttarnchal (4) on 6th April and 1st June- already completed.
- Two rounds of SNID in these areas between September and November, 2003
- Two rounds of NID in January-February 2004
- House to house campaigning after booth immunization will be done over 7days in Uttar Pradesh, 5days in Bihar, Delhi and two days in other states.
- mop up rounds will not be done in areas that are included under SNID; they will be carried out in other areas following detection of wild polio virus after February 2003.

27. The Expenditure Finance Committee has approved the above strategy and the Pulse Polio Programme will be taken up in the country at the total cost of Rs. 605 crores during 2003-04. The Committee emphasized that every effort should be made to ensure rapid elimination of polio and get the polio free certification through up commitment at all levels both for high routine immunization and also high coverage during pulse polio immunization.

28. Because of immunity following the outbreak there may be a steep reduction in number of reported cases especially in UP and Bihar in the next two years; this should however not lead to any complacency. Last year's outbreak should be considered as an opportunity rather than a set back in polio elimination. Because of the outbreak susceptible children who were not earlier immunized either by routine immunization or by pulse immunization have become immune. If during the next few years, coverage under routine and pulse polio is good in all these areas, the country may perhaps achieve the goals of elimination of both polio and neonatal tetanus by 2007 as envisaged in the Tenth Plan.

29. As the country progresses towards polio elimination the expert groups have to consider what is the appropriate time for any change in polio immunization strategy (eg change from OPV to IPV) in states, which have remained polio free for three or more years. India has built up a good polio surveillance system. So far the focus has been on identification of polio cases due to wild polio virus (as indicated by wild polio virus in stool culture). It is seven years since the country embarked on NID and SNIDs for pulse polio administration . As the number of polio cases due to wild polio virus comes down , it might be appropriate to assess the magnitude of the vaccine associated paralytic polio and also keep a vigil for the emergence of mutant neuro virulent strains of vaccine virus (polio outbreaks due to these have been reported in other countries) in different states in a systematic fashion .

Reorganisation Of Family Welfare Infrastructure

30. 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 posts, 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.

31. 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 taken over the responsibility of funding post partum centres and rural family welfare centres from 1 April 2002.

32. Since ANMs are crucial for improving 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, about 40,000 were funded by the state (mostly 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 and contraceptive care.

33. The Expenditure Finance Committee considered the proposal of the Dept of Family Welfare for funding of all the ANMs in subcentre in its meeting on 4.8.2003 and approved the same with the following conditions

- The norms for Central funding of Sub-centres may be based on benchmark with reference to 1991 Census population for all States/UTs, as jointly determined by the Planning Commission and Department of Family Welfare. Expenditure on sub-centres established in excess of these benchmark in some States should be borne by them from their own budget. Additional sub-centres beyond the benchmark may be supported only if they are justified on exceptional grounds.
- A system of performance review of Sub-centres, including Block and Sub-centre level performance indicators, may be put in place after evaluation through an external agency by the end of this financial year;
- A Committee of officers of Departments of Rural Development, Women and Child Development, Family Welfare and the Planning Commission may work out guidelines for convergence of services. Based on their recommendations, guidelines may be issued by Department of Family Welfare for convergence of services. Draft guidelines may be included in the note for CCEA.
- The mandate of the existing Committee of the EAG may be broadened to include review of performance of sub-centres on the basis of Block and Sub-centre level performance indicators and to take corrective measures, in case of shortfall in attainment levels.

Empowered Action Group

34. The health and demographic indices of Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Orissa, Uttaranchal, Jharkhand and Chhattisgarh are indicated in Table2. There is an urgent need to improve access to health care in these states if the ambitious goals for decline in fertility and mortality set in the National Population Policy and the Tenth Plan are to be achieved because these states contribute to over 50 per cent of the country's mortality and fertility. The Tenth Plan envisaged that special efforts will be made to upgrade the capacity of the health system in these states/districts so that there is rapid decline in both fertility and mortality. In order to address these concerns Empowered Action Group (EAG) has

Table 2: Family welfare Indicators of EAG States

Sno.	States	% of girls marrying below the age of 18	Contribution of higher order birth 3+	% of women with any ANC	% of women who had full ANC	Safe Deliveries	% of children fully immunised	% of children with no immunisation	CPR any method
1	Bihar	58.2	57.1	26.4	8.0	18.8	20.1	53.2	23.4
2	Jharkhand	50.8	54.2	42.8	18.9	19.9	30.8	34.1	27.8
3	Madhya Pradesh	58.6	53.6	53.9	20.2	29.5	47.3	13.3	47.1
4	Chattisgarh	41.9	47.0	52.2	27.1	22.4	59.1	7.8	40.1
5	Uttar Pradesh	49.3	59.4	48.0	12.1	21.9	44.5	27.3	29.1
6	Uttaranchal	12.4	50.8	40.6	17.5	22.3	62.8	19.4	39.9
7	Orissa	32.2	45.3	72.9	32.4	32.9	57.4	10.0	49.4
8	Rajasthan	57.1	51.9	62.0	14.7	33.5	36.9	33.8	40.5

Source: Dept of FW

been set up in the Ministry of Health and Family Welfare to ensure that all required assistance is provided to these eight states with poor health and demographic indices. The EAG is chaired by the Union Minister of Health and Family Welfare and consists of Secretaries of related departments, Planning Commission, NGOs and experts. The EAG has the mandate:

- To formulate programmes aimed at achieving the socio-demographic goals enumerated in National Population Policy 2000 in the areas/states that have been lagging behind in containing population growth. Action will be taken:
  To introduce information technologies and management information systems, at district and sub-district levels in these States, to monitor availability and access to contraceptives, drugs and vaccines, as well as to services, in the near and far flung areas within these states;
  To improve the existing systems for logistics in these states, to ensure proper cold chain arrangements, timely delivery of supplies and equipment, adequate inventory control and timely reporting of stock positions;
  To implement the paradigm shift in the management of programmes for population stabilization by incorporating diverse health care providers:
  To position appropriate health care providers at every CHC/PHC/Sub-Centres in these states, to target 24 hour service delivery at the primary health centers in these states;
  To pilot convergence of service delivery at village levels, through self help groups, with the help of the voluntary sector and the non-government organizations;
  To finalize a targeted campaign for information, education and communication in these states that will involve the community, civil society, opinion leaders and political representatives; from village levels upwards, for dissemination of advocacy, information and communication, in these states;
  To energize the existing systems of referral transportation, training of dais, and quality of reproductive health care through a public private partnership;
  To put in place intensive monitoring systems, inclusive of concurrent evaluations and reliable, detailed household and facility surveys, through professional agencies.
  To ensure implementation of district planning through the community needs assessment reporting from each of the districts, in these states;
  To align program and project delivery with advances in current technologies in reproductive research;
  To pioneer projects for extending wider coverage and outreach of basic health care services through the active participation of non-government organizations, the voluntary sector and the private corporate sector, particularly in the area of referral transportation and improving quality of care.
- To assist the concerned State Governments in achieving the goals set in their State Population Policy.
- To devise ways for meaningful involvement of voluntary associations, community organizations and Panchayati Raj Institutions.
- To explore the possibility of expanding the scope of social marketing of contraceptives in a manner that makes them easily accessible even while raising awareness levels.

35. The EAG has also envisaged a single high powered one window clearance mechanism for undertaking schemes to address the gaps in on-going programmes and facilitate inter-sectoral convergence. In order to enable EAG to implement its mandate of strengthening delivery mechanism, or support innovative interventions suggested by the states for filling critical gap, specific funds have been earmarked for taking up need based specific initiatives as

100% Centrally Sponsored Schemes. An outlay of Rs.250 crores has been provided for this scheme in the Tenth Plan. The Department of Family Welfare has requested all the states to submit Annual Action Plan incorporating on-going schemes as well as new initiatives to fulfill unmet needs for contraception and maternal and child care in these states through bridging gaps in infrastructure, supplies and services. The norms for ongoing schemes will be adhered to. A comprehensive review of on-going and proposed initiatives are to be taken to ensure that there is no duplication of efforts.

36. The EFC in its meeting on 4.3.2003 approved the EAG schemes with the following recommendations:

- A sub-committee of EAG consisting of representatives of Ministry of Finance and Planning Commission and JS (FA) of the Department of Health and Family Welfare should make appropriate recommendations in laying down targets for performance review and recommending investment needed under various schemes to EAG, which would then consider the same for final approval.
- The existing infrastructure in the state (Family Welfare Training Centre and Medical Colleges) will be utilized for in service training programmes.
- New construction would be undertaken only when hiring option is not available. In no case expenditure on civil work should exceed 50% of the project outlays.
- Proposal for further support for improving mobility of an ANM will be considered only after evaluating the success of the scheme in other states and identifying areas where there is an urgent need to augment mobility.
- For creation of posts in the Department of Family Welfare prescribed procedure is to be followed.
- Funds available for construction of warehouses under other schemes are to be utilized before seeking additional assistance under the EAG schemes. The funds will be routed through budget of respective state Governments.

Funding of Family Welfare Programme

37. Prior to the Ninth Plan, Family Welfare Programme has been considered as a single centrally sponsored scheme. As a result, sub schemes under this CSS for funding were functional viz. Personnel, Services, Supplies, Transport, Area Development etc. Funds from these functional heads were given to all ongoing programmes including maternal and child health and immunisation. In the Ninth Plan, major schemes such as RCH, pulse polio immunisation and strengthening of routine immunisation were added as individual schemes with large outlays to these functional sub schemes. In 2001 the Planning Commission and the Department of Family Welfare carried out the ZBB and at that time an attempt was made to rationalize the schemes under the Deptt of Family welfare under different programmes. 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 and listed as specific schemes. A total of 94 schemes were thus identified . Scheme wise outlays and expenditure in these 94 schemes during the Ninth Plan period is given in Annexure 4.7.3 A .

38. On these 94 schemes, a zero based budgeting effort was taken up to identify schemes for continuation in the Tenth Plan as such, those for convergence, weeding out or transfer to the

states. At the end of this exercise there were 54 schemes which were to continue into the Tenth Plan . The Tenth Plan, Annual Plan outlay –2002 - 03 for these schemes is indicated in Annexure 4.7.3B. In 2003-04 the National Population Stabilisation Fund was transferred from National Commission on Population to Deptt of Family Welfare and this became scheme No 55 of the Deptt of Family Welfare. While working out statewise outlays for these CSS it was realized that some of the schemes which were classified as CSS are in fact implemented through the Centre / or institutions funded by the Centre (ICMR, IIPS , NIHFW); hence these were reclassified as CS. These are indicated in Annexure 4.7.3.B with * . They will be indicated as central sector schemes in the Annual Plan 2004-05.

39. In view of the local outbreak of polio in three states in 2002-03 the Deptt had to modify the ongoing pulse polio programme. It was estimated that the Deptt will need additional Rs. 1660 crores for this effort over and above the outlays of Rs 1450 provided for this programme in the Tenth Plan. In addition the Deptt required additional Rs 30 crores for Health melas over and above the outlay of Rs 20 crores provided to this in the Tenth Plan. The Dept of Family Welfare worked out revised scheme wise outlays for the Tenth Plan taking into account provisional expenditure in the year 2002-03 so that the additional needs for these two programmes could be accommodated within the existing Tenth Plan outlays of the Deptt of Family Welfare and obtained the approval of the Planning Commission for the revision. These revised Tenth Plan scheme wise outlays are indicated in Annexure 4.7.3B

40. The statewise release of funds under the major Centrally sponsored schemes in the Dept of FW grouped in nine broad areas is given in Annexure 4.7.4 - 4.7.11. There were several small schemes for which statewise releases were not made during the Ninth Plan . The list of such schemes is indicated in Annexure 4.7.12.

Annexure 4.7.1

Current status and the Tenth Plan Goals

Indicator	Present Status	Goals			
		NHP-1983	Ninth Plan	Tenth Plan	NPP 2000
Target Year		**2000**	**2002**	**2007**	**2010**
Crude Birth Rate	25.4 SRS(2001)	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	66 SRS(2001)	Below 60	56	45	below 30
Under Five Mortality Rate	94.9*	-	-	-	-
% immunised 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	-	-	-

* NFHS -2

					Annexure 4.7.2			
POLIO CASES FOR 1998 to 2003**								
							(upto 31st May, 2003)	
Sl.No.	**Name of the State/UT**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**% Fully immunised**
1	ANDHRA PRADESH	96	21	0	0	0	0	*58.7
2	A&N ISLANDS	0	0	0	0	0	0	#77.4
3	ARUNACHAL PRADESH	0	0	0	0	0	0	*20.5
4	ASSAM	1	0	0	1	0	0	*17.0
5	BIHAR	158	123	50	27	121	8	*11.0
6	CHANDIGARH	1	2	1	0	1	0	#61.6
7	CHHATISGARH	-	-	-	0	1	0	*40.0
8	D&N HAVELI	1	0	0	0	0	0	#77.5
9	DAMAN & DIU	5	0	0	0	0	0	#68.7
10	DELHI	47	73	3	3	24	3	*69.8
11	GOA	2	0	0	0	0	0	*82.6
12	GUJARAT	164	9	2	1	24	3	*53.0
13	HARAYANA	39	19	4	5	37	2	*62.7
14	HIMACHAL PRADESH	0	0	0	0	0	0	*83.4
15	JAMMU&KASHMIR	0	0	0	0	1	0	*56.7
16	JHARKHAND	-	-	-	2	12	0	*18.2
17	KARNATAKA	71	21	8	0	0	0	*60.0
18	KERALA	0	0	1	0	0	0	*79.7
19	LAKSHADWEEP	0	0	0	0	0	0	#94.5
20	MADHYA PRADESH	107	17	2	0	21	7	*22.4
21	MAHARASHTRA	121	18	7	4	6	1	*78.4
22	MANIPUR	0	0	0	0	0	0	*42.3
23	MEGHALAYA	0	0	0	0	0	0	*14.3
24	MIZORAM	0	0	0	0	0	0	*59.6
25	NAGALAND	0	0	0	0	0	0	*14.1
26	ORISSA	49	0	0	0	4	2	*43.7
27	PONDICHERRY	2	0	0	0	0	0	#95.3
28	PUNJAB	9	4	0	5	2	0	*72.1
29	RAJASTHAN	63	18	0	0	41	4	*17.3
30	SIKKIM	0	0	0	0	0	0	*47.4
31	TAMIL NADU	91	7	0	0	0	0	*88.8
32	TRIPURA	0	0	0	0	0	0	#46.3
33	UTTARANCHAL	-	-	-	3	14	0	*56.0
34	UTTAR PRADESH	881	773	179	216	1242	28	*21.2
35	WEST BENGAL	26	21	8	1	49	23	*43.8
	TOTAL	1934	1126	265	268	1600	81	
	Source : * * Dept of FW ; *NFHS -2; #RHS							

Annexure 4.7.3 A Concld.

SCHEMEWISE NINTH PLAN OUTLAYS & EXPENDITURE

(Rs. in Crore)

Ninth Plan No. *	Name of Scheme	9th Plan approved Outlay	1997-98		1998-99		1999-2000		2000-01		2001-02		Sum of Yearly Outlays	Sum of Yearly Expenditure
			BE	Exp.	BE	Exp.	BE	Exp.	BE	Exp.	BE	Exp.		
	INFRASTRUCTURE MAINTENANCE	**5281.90**	**643.35**	**644.97**	**866.50**	**861.78**	**1263.00**	**1172.47**	**1236.00**	**1212.27**	**1437.00**	**1395.82**	**5445.85**	**5287.31**
1	**Rural Family Welfare Centres**	1500.00	200.00	199.92	265.00	264.90	350.00	350.84	355.00	354.70	430.00	429.00	1600.00	1599.36
2	**Sub-Centres**	2200.00	260.00	261.27	340.00	340.19	525.00	524.30	566.00	565.30	655.00	632.42	2346.00	2323.48
3	**Urban FW Services**	250.00	50.00	49.68	64.00	63.64	58.00	57.77	60.00	59.60	75.00	70.20	307.00	300.89
4	**Direction & Administration**	671.90	52.00	52.75	87.00	83.37	180.00	110.03	110.00	108.15	112.00	109.68	541.00	463.98
5	**Post Partum Centres**	530.00	70.00	69.14	100.00	99.74	120.00	119.60	120.00	119.55	150.00	148.59	560.00	556.62
6	**Village Health Guides Scheme**	50.00	10.00	9.87	10.00	9.94	10.00	9.93	5.00	4.97	5.00	4.74	40.00	39.45
7	**Logistics Improvement**	80.00	1.35	2.34	0.50	0.00	20.00	0.00	20.00	0.00	10.00	1.19	51.85	3.53
	Contractual Services/ Consultancies	**Included in RCH**												
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	79.00	266.11	250.00	450.00	200.00	641.68	300.00	300.00	380.00	380.00	1209.00	2037.79
	INFRASTRUCTURE DEVELOPMENT	**1050.00**	**190.00**	**84.40**	**180.00**	**120.92**	**212.35**	**169.89**	**280.00**	**246.02**	**340.00**	**220.25**	**1202.35**	**841.48**
14	**Area Projects (IPP Projects)**	800.00	150.00	43.72	120.00	74.49	100.00	100.01	200.00	200.04	250.00	186.98	820.00	605.24
15	**Social Marketing Area Projects**						42.35		20.00	1.42	20.00	4.14	82.35	5.56
16	**USAID Assisted Area Project**	250.00	40.00	40.68	60.00	46.43	70.00	69.88	60.00	44.56	70.00	29.13	300.00	230.68
17	**Other Externally Aided Infrastructure Development Projects**	**Included in RCH**												
18	**EC Assisted SIP Project**													
	TRANSPORT	**150.00**	**32.00**	**32.74**	**27.50**	**27.87**	**43.00**	**42.97**	**78.00**	**77.13**	**70.00**	**69.47**	**250.50**	**250.18**
19	Maintainence of vehicle already available													
20	Supply of Mopeds to ANMs													
	TRAINING	**257.35**	**32.05**	**31.13**	**45.20**	**41.68**	**64.43**	**61.74**	**67.90**	**63.22**	**91.70**	**85.72**	**301.28**	**283.49**
21	**Basic Training for ANM/LHVs**	150.00	15.00	15.98	25.00	24.81	39.40	39.58	42.00	41.87	60.00	59.07	181.40	181.31
22	**Maintenance & Strengthening of HFWTCs**	40.00	6.15	6.20	7.00	7.20	10.91	10.97	11.00	9.57	13.00	11.76	48.06	45.70
23	**Basic Training for MPWs Worker (Male)**	35.00	4.50	4.35	6.00	5.87	8.40	8.37	9.00	7.17	10.00	9.24	37.90	35.00
24	**Strenthening of Basic Training schools**	5.00	1.00	0.60	1.00	0.32	1.00	0.38	1.00	0.24	1.00	0.31	5.00	1.85
25	**F.W. Training and Res. Centre, Bombay**													
26	**NIHFW, New Delhi**	21.00	4.45	3.02	5.00	2.24	3.65	1.47	3.75	3.29	4.50	3.04	21.35	13.06
27	**IIPS, Mumbai**	5.70	0.85	0.90	1.10	1.10	0.95	0.85	1.00	0.98	3.00	2.30	6.90	6.13
28	**Assistance to I.M.A.**	0.65	0.10	0.08	0.10	0.14	0.12	0.12	0.15	0.10	0.20		0.67	0.44
	RESEARCH	**96.00**	**13.10**	**13.13**	**20.50**	**16.14**	**20.70**	**16.77**	**23.70**	**21.54**	**29.00**	**25.94**	**107.00**	**93.52**
29	**Population Research Centres**	35.00	3.00	3.03	8.00	3.55	8.00	4.05	7.00	4.84	7.00	6.28	33.00	21.75
30	**CDRI, Lucknow**	8.00	1.10	1.10	1.50	1.50	1.70	1.70	1.70	1.70	2.00	1.66	8.00	7.66
31	**ICMR and IRR**	53.00	9.00	9.00	11.00	11.09	11.00	11.02	15.00	15.00	20.00	18.00	66.00	64.11
32	**Other Research Projects**													
	CONTRACEPTION	**1541.50**	**257.35**	**241.53**	**274.10**	**245.42**	**347.55**	**299.47**	**333.70**	**306.35**	**366.00**	**336.39**	**1578.70**	**1429.16**
	Free distribution of contraceptives	460.00	106.80		82.00		87.50		100.00		115.00		491.30	
33	Conventional Contraceptives	265.00	65.00	47.39	50.00	42.15	50.00	50.92	65.00	65.74	80.00	73.92	310.00	280.12
34	Oral Contraceptives	80.00	18.40	10.33	15.00	12.80	15.00	14.03	15.00	13.50	15.00	19.09	78.40	69.75
35	IUD	115.00	23.40	16.83	17.00	11.79	22.50	23.41	20.00	12.94	20.00	19.07	102.90	84.04
36	New Methods													
	Social marketing of contraceptives	400.00	54.05	65.20	80.00	60.08	97.65	89.04	90.00	86.08	107.00	90.07	428.70	390.47
37	Conventional Contraceptives		45.00	53.20	70.00	50.97	81.85	73.77	74.00	71.10	90.00	75.29	360.85	324.33
38	Oral Contraceptives		9.05	12.00	10.00	9.11	15.80	15.27	16.00	14.98	17.00	14.78	67.85	66.14
	Sterilization	680.20	95.50	101.29	111.90	118.47	162.20	122.00	142.20	126.92	142.00	132.45	653.80	601.13
39	Sterilization Beds	8.60	2.00	2.98	1.70	1.43	1.70	1.43	1.70	1.45	1.50	1.36	8.60	8.65
40	Sterilisation and IUD insertion	600.00	90.00	90.17	100.00	99.34	140.00	101.18	120.00	118.56	125.00	123.34	575.00	532.59
41	Supply /Procurement of Laparascopes	70.00	3.00	8.14	10.00	17.70	20.00	19.39	20.00	6.91	15.00	7.75	68.00	59.89
42	Recanalization	1.60	0.50		0.20		0.50		0.50		0.50		2.20	0.00
43	**Testing Facilities**	1.30	0.50	0.14	0.20	0.13	0.20	0.07	0.50	0.40	0.50	0.30	1.90	1.04
	Role of Men in Planned Parenthood	**Included in RCH**												
44	No Scalpel Vasectomy		0.50	0.35	0.00	0.00	0.00	0.00	1.00	0.77	1.50	1.49	3.00	2.61
45	Other Innovative Schemes *(Male Participation)*													

Annexure 4.7.3 A Concld.

SCHEMEWISE NINTH PLAN OUTLAYS & EXPENDITURE

(Rs. in Crore)

Ninth Plan No. *	Name of Scheme	9th Plan approved Outlay	1997-98		1998-99		1999-2000		2000-01		2001-02		Sum of Yearly Outlays	Sum of Yearly Expenditure
			BE	Exp.	BE	Exp.	BE	Exp.	BE	Exp.	BE	Exp.		
	REPRODUCTIVE & CHILD HEALTH	**5150.00**	**458.50**	**451.24**	**764.00**	**545.16**	**726.80**	**657.66**	**1162.00**	**785.87**	**1312.00**	**943.34**	**4423.30**	**3383.27**
	Immunisation													
46	Procurement of Vacccines for Routine Immunisation													
47	Cold Chain													
	(a) Cold Chain Maintenance													
	(b) Cold Chain Equipment													
48	Surveillence against VPDs													
49	Other Vaccines *(Hepatitis B)*													
50	**Routine Immunisation Strengthening**													
51	**Pulse Polio**													
	(a) OPV													
	(b) Operating cost													
	Child Health													
52	Essential New Born care *(Home based neonatal care)*													
53	Diarheal Diseases - Prevention/Treatment													
54	ARI-Prevention/Treatment													
	NUTRITION													
55	Vitamin-A Programme													
56	Adolscent Health													
	Maternal Health													
57	Ante-natal care													
58	Nutitional Anaemia *(Anaemia Control & De-worming)*													
59	Home Delivery Care													
	(a) Community based midwives													
	(b) Dais Training													
60	Dais Kits *(Drugs, Kits & Equipments)*													
	(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													
62	MTP Services (Manual Vac. Aspirator for safe abortion)													
63	RTI/ STI prevention and management													
	Other RCH Interventions and services													
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	NGOs and SCOVA													
	Training													
72	RCH Training													
73	Training of ISM&H													
74	Training of AWW													
75	Tribal Projects													
76	Urban Slums Projects													
77	District Projects													
78	Other Projects under RCH													

Included in RCH

Annexure 4.7.3 A Concld.

SCHEMEWISE NINTH PLAN OUTLAYS & EXPENDITURE

(Rs. in Crore)

Ninth Plan No. *	Name of Scheme	9th Plan approved Outlay	1997-98		1998-99		1999-2000		2000-01		2001-02		Sum of Yearly Outlays	Sum of Yearly Expenditure
			BE	Exp.	BE	Exp.	BE	Exp.	BE	Exp.	BE	Exp.		
	OTHER FAMILY WELFARE PROGRAMMES	**643.25**	**124.00**	**56.91**	**61.55**	**33.78**	**42.17**	**36.44**	**38.70**	**35.50**	**164.26**	**149.30**	**430.68**	**311.93**
79	Maternity Benefit Scheme	Transferred from Rural development	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	80.00	75.87	80.00	75.87
80	Information, Education and Communication	170.00	60.60	49.87	28.00	26.54	31.20	29.37	30.00	28.35	35.00	31.23	184.80	165.36
81	Travel of Experts/Conferences /Meetings etc.	16.10	10.10	0.64	1.50	0.04	1.50	0.07	1.00	0.15	1.25	0.45	15.35	1.35
82	International Contribution	6.30	1.10	1.13	1.30	1.13	1.30	1.27	1.60	1.11	1.69	1.01	6.99	5.65
83	Empowered Action Group	265.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	30.00	26.76	30.00	26.76
84	Community Incentive Scheme		0.00	0.00	25.00	0.00	0.00	0.00	0.00	0.00	5.00	5.00	30.00	5.00
85	Family Welfare Link Health Insurance Plan		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
86	Policy Seminars		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00	2.81	3.00	2.81
87	Other Initiatives		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
88	Strengthening of Rural Family Welfare Centres under National Human Development Initiative	**Included in Sub- Centres (scheme2)**												
89	Other Offices under Direction & Administration	28.10	5.00	4.21	5.00	5.20	5.50	5.73	6.10	5.89	8.00	6.17	29.60	27.20
90	ISM Institutions	7.00	3.00	0.50	0.50	0.79	1.42	0.00	0.00	0.00	0.10	0.00	5.02	1.29
91	Regional Institute of MCH	0.75	0.10	0.11	0.15	0.00	0.15	0.00	0.00	0.00	0.20	0.00	0.60	0.11
92	Hindustan Latex Limited	1.90	1.50	0.05	0.10	0.08	0.10	0.00	0.00	0.00	0.02	0.00	1.72	0.13
93	Family Welfare Counsellor Scheme	1.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00
94	School Health Scheme	147.10	42.60	0.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	42.60	0.40
	Additional RCH activities in the Tenth Plan													
	Other New Initiatives													
	GRAND TOTAL	**15120.00**	**1829.35**	**1822.16**	**2489.35**	**2342.75**	**2920.00**	**3099.09**	**3520.00**	**3090.00**	**4210.00**	**3614.00**	**14969.00**	**13969.00**

Note: Grand Total of the outlays & expd. in a particular year can be different from the actual sum total of each scheme in that year.

Annexure 4.7.3 B Concld.

SCHEMEWISE TENTH PLAN OUTLAYS & EXPENDITURE

(Rs. in crore)

Tenth Plan No.	Name of Scheme	Approved Tenth plan Outlay	2002-03 outlay	2002-03 Expd. (Prov.)	Revised Tenth plan alloc.	2003-04 BE
A						
1	Sub-Centres	9663.00	1809.00	1848.78	9663.00	1758.50
2	Urban FW Services	580.00	122.00	103.39	580.00	132.80
3	Direction & Administration	1100.00	200.00	188.24	1100.00	220.20
4	Logistics Improvement	90.00	10.00		50.00	1.00
5	Contractual Services/ Consultancies	1212.64	162.00	53.57	742.64	66.80
B	INFRASTRUCTURE DEVELOPMENT	2412.00	364.20	144.48	2370.00	322.90
6	Area Projects (IPP Projects)	987.00	74.80	60.85	950.00	62.90
7	Social Marketing Area Projects	25.00	10.00		20.00	4.00
8	USAID Assisted Area Project	400.00	59.40	40.24	400.00	40.00
9	Other Externally Aided Infrastructure Development Projects	Included in RCH				
10	EC Assisted SIP Project	1000.00	220.00	43.39	1000.00	216.00
C	TRANSPORT	378.00	113.00	113.07	313.00	55.00
11	Maintainence of vehicle already available	303.00	98.00	98.00	303.00	50.00
12	Supply of Mopeds to ANMs	75.00	15.00	15.00	10.00	5.00
D	TRAINING	521.00	99.60	90.51	521.00	117.07
13	Basic Training for ANM/LHVs	350.00	67.00	63.33	350.00	73.45
14	Maintenance & Strengthening of HFWTCs	70.00	14.00	12.52	70.00	16.00
15	Basic Training for MPWs Worker (Male)	50.00	10.00	9.16	50.00	10.00
16	Strenthening of Basic Training schools	10.00	2.00	0.22	10.00	10.00
17	F.W. Training and Res. Centre, Bombay *	10.00	1.50	0.98	10.00	1.50
18	NIHFW, New Delhi *	20.00	3.15	2.60	20.00	4.15
19	IIPS, Mumbai *	10.00	1.70	1.70	10.00	1.72
20	Assistance to I.M.A. *	1.00	0.25		1.00	0.25
E	RESEARCH	159.50	30.30	28.01	159.50	40.80
21	Population Research Centres	45.00	8.00	5.71	45.00	8.50
22	CDRI, Lucknow *	12.00	2.30	2.30	12.00	2.30
23	ICMR and IRR *	100.00	20.00	20.00	100.00	30.00
24	Other Research Projects	2.50	0.00	0.00	2.50	
F	CONTRACEPTION	2727.50	483.50	407.11	2532.50	531.15
25	Free distribution of contraceptives	1045.00	184.00	153.96	850.00	170.00
		800.00				
		130.00				
		115.00				
26	Social marketing of contraceptives	660.00	115.00	98.87	660.00	132.00
		550.00				
		110.00				
27	Sterilization	1002.00	180.50	152.49	1002.00	226.15
		12.00		1.94		
		900.00		171.37		

Annexure 4.7.3 B Concld.

SCHEMEWISE TENTH PLAN OUTLAYS & EXPENDITURE

(Rs. in crore)

Tenth Plan No.	Name of Scheme	Approved Tenth plan Outlay	2002-03 outlay	2002-03 Expd. (Prov.)	Revised Tenth plan alloc.	2003-04 BE
		90.00		18.00		
28	**Testing Facilities**	2.50	0.50	0.37	2.50	0.50
29	**Role of Men in Planned Parenthood**	18.00	3.50	1.42	18.00	2.50
		8.00				
		10.00				
G	**REPRODUCTIVE & CHILD HEALTH**	6333.86	1174.20	798.08	7287.86	1293.20
30	**Immunisation**	1410.00	226.00	183.50	1410.00	222.00
		850.00				
		35.00				
		200.00				
		325.00				
31	**Routine Immunisation Strengthening**	17.86	10.00	8.00	17.86	8.00
32	**Pulse Polio**	1450.00	400.00	483.18	3110.00	550.00
		870.00	240.00	169.00		362.00
		580.00	160.00	152.00		188.00
33	Child Health	20.00	1.00		20.00	1.00
		20.00				
34	NUTRITION	**Included in RCH**				
35	Adolscent Health	50.00	3.00		50.00	5.00
36	Maternal Health	1384.00	254.00		1300.00	285.60
		30.00				
		30.00				
		40.00				
		704.00				
		350.00				
		10.00				
		125.00				
		20.00				
				76.58		
		25.00				
		50.00				
37	MTP Services (Manual Vac. Aspirator for safe abortion)	4.00	1.20		4.00	5.00
38	RTI/ STI prevention and management	35.00	2.00		35.00	4.50
39	Other RCH Interventions and services	730.00	122.00		560.00	96.60
		15.00				
		130.00				
		95.00				
		350.00				
		40.00				
		90.00				

Annexure 4.7.3 B Concld.

SCHEMEWISE TENTH PLAN OUTLAYS & EXPENDITURE

(Rs. in crore)

Tenth Plan No.	Name of Scheme	Approved Tenth plan Outlay	2002-03 outlay	2002-03 Expd. (Prov.)	Revised Tenth plan alloc.	2003-04 BE
		10.00				
40	NGOs and SCOVA	130.00	22.00	17.79	130.00	40.00
41	Training	328.00	53.00	6.58	250.00	20.50
		265.00				
		15.00				
		48.00				
42	Tribal Projects					
43	Urban Slums Projects	700.00	5.00	1.50	350.00	25.00
44	District Projects	75.00	75.00	20.95	51.00	30.00
45	Other Projects under RCH	25.00			25.00	
H.	OTHER FAMILY WELFARE PROGRAMMES	1900.50	355.90	141.55	1780.50	385.28
46	Maternity Benefit Scheme	500.00	90.00	52.20	500.00	75.00
47	Information, Education and Communication	489.50	84.70	79.15	489.50	101.38
48	Travel of Experts/Conferences /Meetings etc. *	7.00	1.50	0.47	7.00	1.00
49	International Contribution *	9.00	1.70	1.34	9.00	1.70
50	Empowered Action Group	250.00	50.00	3.28	250.00	100.00
51	Community Incentive Scheme	300.00	60.00		200.00	1.00
52	Family Welfare Link Health Insurance Plan	250.00	50.00		150.00	1.00
53	Policy Seminars *	20.00	3.00	2.95	50.00	3.00
54	Other Initiatives	75.00	15.00	2.16	25.00	1.20
55	National Population Stabilization Fund				100.00	100.00
		25.00	0.30			0.30
		22.00	6.00			5.00
		27125.00	**4930.00**	**3916.79**	**27125.00**	**4930.00**

Note: Grand Total of the outlays & expd. in a particular year can be different from the actual sum total of each scheme in that year.

Annexure 4.7.4

STATEWISE RELEASE OF FUNDS UNDER DEPARTMENT OF FAMILY WELFARE (1997-98 -- 2003-04)

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Rural Family welfare Centres (1), Sub Centres (2), Direction & Administration (4), Urban Family welfare Services (3), Post Partum Centres (5), Village Health Guide Scheme (6), Maintainence of Vehicle already available (19), Supply of Mopeds to ANM's (20), Basic Training of ANM's/ LHV's (21), Maintainence & Stengthening of HFWTC's (22), Basic Training of MPWs Worker (male) (23), Sterilization Beds (39), Strengthening of Rural Family welfare Centres under National Human development Initiative (88)

Post ZBB (2002-03 onwards)- Sub Centres (1), Direction & Administration (3), Urban Family welfare Services (2), Maintainence of Vehicle already available (11), Supply of Mopeds to ANM's (12), Basic Training of ANM's/ LHV's (13), Maintainence & Stengthening of HFWTC's (14), Basic Training of MPWs Worker (male) (15), Sterilization Beds (27)

(Rs. in Lakhs)

Sl. No.	Name of State/UT	1997-98	1998-99	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004 (Allocation)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1	Andhra Pradesh	4300.36	5955.46	7599.69	7737.28	8975.15	11814.11	11563.04
2	Arunachal Pradesh	102.93	127.06	211.21	246.42	388.10	385.16	216.60
3	Assam	2334.79	3163.97	6199.13	5649.93	8785.47	10385.72	6603.32
4	Bihar	5899.91	8548.83	11625.42	11975.26	8412.47	11087.26	9741.22
5	Chhatisgarh					3392.06	4074.86	4267.52
6	Goa	140.34	160.86	216.39	238.04	260.11	81.48	208.48
7	Gujarat	3477.88	4695.84	6202.09	6401.86	7418.92	8627.99	8303.92
8	Haryana	1275.24	1700.17	2288.04	2375.03	2728.41	2965.68	2892.96
9	Himachal Pradesh	987.30	1377.87	1845.13	1903.93	2199.94	2581.13	2547.24
10	Jammu & Kashmir	906.26	1250.62	1756.55	1888.32	2099.81	2186.38	2142.08
11	Jharkhand					5340.31	4946.11	4996.50
12	Karnataka	3612.35	5365.48	6817.64	6366.02	8015.10	11797.17	8699.76
13	Kerala	2582.59	3464.53	4779.22	4873.03	5760.68	5461.99	5504.92
14	Madhya Pradesh	5759.63	7562.77	10123.99	10336.45	7487.15	6312.21	8444.68
15	Maharashtra	6099.62	7963.88	10258.52	10257.09	12054.89	13487.55	12704.20
16	Manipur	404.41	599.12	878.67	945.80	1406.14	1339.57	1080.22
17	Meghalaya	263.67	310.46	584.19	617.48	936.65	953.62	701.88
18	Mizoram	184.24	214.36	332.26	427.16	700.90	718.45	592.46
19	Nagaland	159.36	227.22	379.64	431.27	616.10	826.00	576.40
20	Orissa	3160.69	4326.69	5603.05	5755.50	6698.64	6278.63	6286.44
21	Punjab	1551.64	2191.81	2553.53	2652.59	2991.27	926.52	3345.52
22	Rajasthan	4272.19	5601.81	7534.45	8483.18	9096.07	11942.51	11146.40
23	Sikkim	190.35	214.37	335.45	396.94	633.07	441.75	347.16
24	Tamil Nadu	4754.66	6192.47	8235.98	8397.36	9828.93	11258.20	10105.60
25	Tripura	360.67	461.16	785.15	844.14	1387.80	1215.50	813.68
26	Uttar Pradesh	10365.15	13428.93	17797.83	18811.81	17110.12	21023.64	20612.52
27	Uttranchal					2430.77	1617.32	1635.80
28	West Bengal	4378.32	5811.37	7768.97	8252.88	9164.11	9164.17	9444.20
	Total - All States	**67524.55**	**90917.11**	**122712.19**	**126264.77**	**146319.14**	**163900.68**	**155524.72**
	UTs with Legislature							
1	Delhi *	605.42	681.38	756.89	1040.57	1264.20		1598.32
2	Pondicherry	104.65	108.04	119.24	377.99	418.06	368.16	544.48
	UTs without Legislature							
1	A&N Islands	92.59	84.60	143.60	191.40	209.40	295.25	305.15
2	Chandigarh	77.25	92.33	156.30	173.55	192.50	129.00	129.00
3	D&N Haveli	30.66	43.31	56.55	53.70	47.55	52.30	52.30
4	Daman & Diu	31.50	28.50	58.00	73.50	81.00	81.00	81.00
5	Lakshdweep	11.50	17.05	27.10	37.25	42.25	49.28	49.28
	Total (UTs)	**953.57**	**1055.21**	**1317.68**	**1947.96**	**2254.96**	**974.99**	**2759.53**
	GRAND TOTAL	**68478.12**	**91972.32**	**124029.87**	**128212.73**	**148574.10**	**164875.67**	**158284.25**

***** No releasese were made to NCT of Delhi during 2002-03 on account of unspent balances lying with them.

Annexure 4.7.5

STATEWISE RELEASE OF FUNDS UNDER DEPARTMENT OF FAMILY WELFARE (1997-98 -- 2003-04)

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Arrears (13)

(Rs. in Lakhs)

Sl. No.	Name of State/UT	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04 *
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1	Andhra Pradesh	2373.40	3200.00	6587.17	7953.63	6510.81	6868.48	
2	Arunachal Pradesh						64.39	
3	Assam	795.45		800.66	591.01		501.76	
4	Bihar	3525.17		16571.00	981.00		6042.12	
5	Chhatisgarh							
6	Goa							
7	Gujarat	3817.69	4450.00	7407.09			5999.72	
8	Haryana	1306.85	686.76	754.71	1132.82		448.05	
9	Himachal Pradesh		497.26	112.41	816.00		1043.18	
10	Jammu & Kashmir	871.43	310.51				144.53	
11	Jharkhand							
12	Karnataka		1000.00	8304.82			3840.40	
13	Kerala		380.19			15997.87	3094.32	
14	Madhya Pradesh						5083.05	
15	Maharashtra		1286.60	302.54	1641.00	6365.83	4112.84	
16	Manipur		5.15					
17	Meghalaya						92.97	
18	Mizoram						37.63	
19	Nagaland							
20	Orissa	1107.99			736.89		6406.98	
21	Punjab							
22	Rajasthan	997.96	1450.00	5794.97	4953.43	2765.69	3282.68	
23	Sikkim	2.33	78.07	66.38	242.04	132.05		
24	Tamil Nadu	4255.62	2072.33	9613.40	7449.09	410.51	2856.82	
25	Tripura		1283.13		784.52		1490.76	
26	Uttar Pradesh	7457.73	27500.00	7240.20	2718.56	503.12	14473.85	
27	Uttranchal							
28	West Bengal	99.38	800.00	612.35		5314.12		
	Total - All States	**26611.00**	**45000.00**	**64167.70**	**29999.99**	**38000.00**	**65884.53**	
	UTs with Legislature							
1	Delhi							
2	Pondicherry							
	UTs without Legislature							
1	A&N Islands							
2	Chandigarh							
3	D&N Haveli							
4	Daman & Diu							
5	Lakshdweep							
	Total (UTs)	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	
	GRAND TOTAL	**26611.00**	**45000.00**	**64167.70**	**29999.99**	**38000.00**	**65884.53**	

***** No allocation is made for the Arrears as it is released after the States/UTs claim it.

Annexure 4.7.6

STATEWISE RELEASE OF FUNDS UNDER DEPARTMENT OF FAMILY WELFARE (1997-98 -- 2003-04)

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Sterilisation & IUD insertion (40)

Post ZBB (2002-03 onwards)- Sterilisation (27)

(Rs. in Lakhs)

Sl. No.	Name of State/UT	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04 (Allocation)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1	Andhra Pradesh	1253.41	1599.49	1756.37	1595.96	1776.00	1864.43	2922.00
2	Arunachal Pradesh	2.32	4.69	4.79	2.03	29.90	25.18	26.00
3	Assam	31.06	35.95	49.68	225.48	934.00	1262.00	1759.00
4	Bihar	228.56	172.37	198.22	91.53	505.00	630.79	750.00
5	Chhatisgarh					269.00	317.39	582.00
6	Goa	8.40	9.76	21.02	22.18	13.00	4.80	8.00
7	Gujarat	502.57	587.54	590.52	742.73	615.00	604.84	950.00
8	Haryana	219.44	230.92	275.77	320.55	223.30	215.59	320.00
9	Himachal Pradesh	66.74	70.27	75.70	31.08	71.40	72.86	96.00
10	Jammu & Kashmir	30.85	20.40	36.49	20.66	24.50	17.97	40.00
11	Jharkhand					238.00	279.47	374.00
12	Karnataka	812.45	925.58	884.28	1576.43	987.00	1038.01	1392.00
13	Kerala	245.39	289.67	372.19	546.37	355.00	418.20	572.00
14	Madhya Pradesh	713.79	906.51	836.95	484.41	759.00	633.67	1156.00
15	Maharashtra	1127.13	1128.48	1111.49	1569.76	1246.00	1542.05	1932.00
16	Manipur	9.96	6.32	9.53	22.76	18.68	8.35	9.00
17	Meghalaya	3.00	2.90	6.32	6.88	46.72	55.79	65.00
18	Mizoram	4.32	6.07	8.19	7.94	93.40	69.77	132.00
19	Nagaland	4.44	0.88	3.37	8.87	24.28	29.00	29.00
20	Orissa	285.52	309.26	261.62	196.39	223.30	314.40	304.00
21	Punjab	297.14	298.17	323.62	425.55	316.30	105.24	140.00
22	Rajasthan	647.53	536.78	563.32	512.64	493.50	503.04	816.00
23	Sikkim	3.43	3.51	4.08	9.90	32.70	39.24	28.00
24	Tamil Nadu	679.54	797.24	923.35	1510.90	916.70	1119.86	1552.00
25	Tripura	16.11	17.15	17.93	27.23	70.32	86.92	52.00
26	Uttar Pradesh	1095.11	1125.96	1039.10	1053.92	992.40	1307.50	2000.00
27	Uttranchal					184.30	223.57	410.00
28	West Bengal	560.69	681.62	529.95	687.82	641.30	958.17	980.00
	Total - All States	**8848.90**	**9767.49**	**9903.85**	**11699.97**	**12100.00**	**13748.10**	**19396.00**
	UTs with Legislature							
1	Delhi *	68.88	70.71	99.06	75.40	174.80		636.00
2	Pondicherry	19.00	20.31	23.64	44.60	25.20	48.00	94.00
	UTs without Legislature							
1	A&N Islands	5.00	5.00	7.00	7.00	30.36	90.78	8.00
2	Chandigarh	12.00	12.00	12.00	12.00	51.32	153.96	10.00
3	D&N Haveli	5.00	5.00	5.00	5.00	6.58	19.74	5.00
4	Daman & Diu	2.00	2.00	2.00	2.50	11.18	33.54	2.00
5	Lakshdweep	1.00	1.00	1.00	0.15	0.66	1.98	0.25
	Total (UTs)	**112.88**	**116.02**	**149.70**	**146.65**	**300.10**	**348.00**	**755.25**
	GRAND TOTAL	**8961.78**	**9883.51**	**10053.55**	**11846.62**	**12400.10**	**14096.10**	**20151.25**

***** No releasese were made to NCT of Delhi during 2002-03 on account of unspent balances lying with them.

Annexure 4.7.7

STATEWISE RELEASE OF FUNDS UNDER DEPARTMENT OF FAMILY WELFARE (1997-98 -- 2003-04)

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Free distribution of Conventional Contraceptives (33-36), Supply/ Procurement of Laparoscopes (41), Dais Kits (Drugs, Kits & Equipments) (60)

Post ZBB (2002-03 onwards)- Free distribution of Conventional Contraceptives (25), Supply/ Procurement of Laparoscopes (27), Dais Kits (Drugs, Kits & Equipments) (36)

(Rs. in Lakhs)

Sl. No.	Name of State/UT	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04 * (Allocation)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1	Andhra Pradesh	2387.25	2961.41	3023.31	3458.96	3329.24	3216.50	
2	Arunachal Pradesh	89.65	75.75	103.35	130.72	160.67	77.10	
3	Assam	1165.61	1177.35	1421.68	1817.62	1458.50	1796.43	
4	Bihar	2727.31	4025.28	4868.39	5957.71	4959.26	6624.79	
5	Chhatisgarh					1432.44	1874.57	
6	Goa	38.70	58.94	82.50	125.61	68.21	67.07	
7	Gujarat	1877.12	2108.13	2600.21	3335.35	3032.43	3341.21	
8	Haryana	722.46	906.66	1019.59	1420.10	1269.71	1375.14	
9	Himachal Pradesh	307.30	399.57	338.33	470.20	386.99	548.70	
10	Jammu & Kashmir	264.16	455.77	458.21	539.43	537.45	608.59	
11	Jharkhand					1392.54	2150.38	
12	Karnataka	1275.84	2111.95	2107.70	2640.17	2439.98	2579.99	
13	Kerala	973.70	1313.51	1376.24	1575.88	1060.67	1497.60	
14	Madhya Pradesh	3227.78	4587.46	4988.02	5477.07	4130.38	3948.99	
15	Maharashtra	2388.04	3872.20	3924.85	4423.30	4243.32	5279.34	
16	Manipur	132.90	108.80	147.96	118.94	211.66	127.24	
17	Meghalaya	96.13	140.78	152.50	139.93	202.41	166.29	
18	Mizoram	74.68	68.77	75.80	70.32	79.50	87.02	
19	Nagaland	59.19	90.31	97.73	90.13	155.96	99.24	
20	Orissa	1337.46	1773.73	1765.56	1630.78	2013.89	2212.87	
21	Punjab	1117.79	1125.51	1246.95	1284.46	1303.63	1426.32	
22	Rajasthan	2176.96	2688.55	3238.37	4039.05	3624.75	3674.05	
23	Sikkim	46.00	41.68	68.33	38.73	73.45	67.32	
24	Tamil Nadu	1924.08	2582.39	1833.16	1708.95	2330.52	2325.59	
25	Tripura	161.28	193.98	177.00	211.06	219.87	157.41	
26	Uttar Pradesh	5797.10	8773.56	10356.72	11338.42	12322.12	13621.11	
27	Uttranchal					1163.12	970.67	
28	West Bengal	2505.16	3172.95	2944.78	3140.07	3499.66	4080.46	
	Total - All States	**32873.65**	**44814.99**	**48417.24**	**55182.96**	**57102.33**	**64001.99**	**0.00**
	UTs with Legislature							
1	Delhi	435.59	473.35	698.88	686.84	651.42	1103.78	
2	Pondicherry	35.49	54.55	38.19	41.17	44.31	36.00	
	UTs without Legislature							
1	A&N Islands	22.06	19.00	28.19	22.21	21.28	24.20	
2	Chandigarh	17.08	57.72	55.44	52.16	42.17	86.20	
3	D&N Haveli	5.55	9.98	10.43	12.15	15.34	9.95	
4	Daman & Diu	12.15	8.55	11.07	5.54	9.71	9.73	
5	Lakshdweep	5.91	5.01	6.87	5.80	13.05	6.81	
	Total (UTs)	**533.83**	**628.16**	**849.07**	**825.87**	**797.28**	**1276.67**	**0.00**
	Ministry of Railways					14.86		
	Total - Other Min.				**0.00**	**14.86**		**0.00**
	GRAND TOTAL	**33407.48**	**45443.15**	**49266.31**	**56008.83**	**57914.47**	**65278.66**	**0.00**
*	No allocation is made for the year 2003-04 as the supply is demand driven and is also based on the requirement.							

Annexure 4.7.8

STATE-WISE RELEASES & EXPENDITURE OF FUNDS UNDER DEPARTMENT OF FAMILY WELFARE (1997-98 -- 2003-04)

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Logistics Improvement (7), Contractual services/ Consultancies (8-12), EC Assisted SIP Project (18), Strengthening of Basic Training schools (24), Immunisation (46-49), Routine Imunisation Strengthening (50), Pulse Polio (51), Child Health (52-54), Nutrition (55), Adolescent Health (56), Maternal Health (57-59) (61), MTP Services (62), RTI/ STI Prevention & Management (63), Other RCH Interventions (64-70), NGOs & SCOVA (71), Training (72-74), Tribal Projects (75), Urban slum Projects (76), District Projects (77), Othr projects under RCH (78), ISM Institutions (90), Regional Institute of MCH (91),

Post ZBB (2002-03 onwards) - Logistics Improvement (4)**,** Contractual services/ Consultancies (5), EC Assisted SIP Project (10), Strengthening of Basic Training schools (16), Immunisation (30), Routine Immunisation Strengthening (31), Pulse Polio (32), Child Health (33), Nutrition (34), Adolescent Health (35), Maternal Health (36), MTP Services (37), RTI/ STI Prevention & Management (38), Other RCH Interventions (39), NGOs & SCOVA (40), Training (41), Tribal Projects (42), Urban slum Projects (43), District Projects (44), Othr projects under RCH (45)

(Rs. in Lakhs)

Sl. No.	Name of State/UT	1997-98		1998-99		1999-2000		2000-2001		2001-2002		2002-2003		2003-2004 **	
		Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Allocation	Releases
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
1	Andhra Pradesh	945.92	143.81	737.14	355.23	1961.98	1447.00	1662.15	1501.72	2021.72	1704.42	1527.89	739.86		
2	Arunachal Pradesh	237.38	93.62	334.95	121.86	155.24	246.90	175.72	144.81	153.26	168.92	306.67	102.03		
3	Assam	556.06	160.38	299.63	256.84	727.83	561.78	474.86	415.52	1244.53	865.09	727.97	872.82		
4	Bihar	958.59	105.05	728.49	480.88	1385.88	1128.92	2711.64	1868.03	1676.45	628.69	4119.99	83.81		
5	Chhatisgarh	0.00	0.00	0.00	0.00	0.00	0.00	314.10	0.00	880.07	102.17	462.72	46.1		
6	Goa	54.87	9.88	35.28	15.92	41.11	44.04	13.40	33.10	22.08	17.36	14.93	26.93		
7	Gujarat	748.48	95.18	917.92	159.58	726.28	631.33	983.39	935.66	7776.26	1398.64	1121.49	696.17		
8	Haryana	801.34	91.93	613.85	295.87	895.38	603.46	1664.30	1128.95	1236.25	951.35	1230.54	776.64		
9	Himachal Pradesh	253.59	62.23	475.35	126.71	312.48	256.41	427.02	469.43	249.07	250.33	410.41	214		
10	Jammu & Kashmir	306.29	45.70	125.68	43.87	346.54	205.68	555.39	202.44	297.90	549.08	345.53	12.04		
11	Jharkhand	0.00	0.00	0.00	0.00	0.00	0.00	37.00	0.00	515.35	0.00	881.84			
12	Karnataka	751.42	145.95	429.28	181.92	537.58	489.41	1671.15	1033.75	1782.66	1460.17	2065.63	1022.99		
13	Kerala	489.18	89.98	775.10	175.08	747.39	599.83	1165.32	800.81	768.03	961.07	709.15	747.45		
14	Madhya Pradesh	1285.20	312.03	1370.30	648.33	1836.42	2111.75	3553.34	2105.66	1377.96	1223.90	1897.92	952.1		
15	Maharashtra	939.47	256.26	585.97	745.58	1403.87	1120.56	1256.71	1728.11	3195.03	52.37	1067.61	551.69		
16	Manipur	188.06	139.17	90.69	128.81	500.98	297.11	421.71	265.14	860.86	993.14	203.03	194.29		
17	Meghalaya	177.07	46.85	103.81	49.05	107.84	90.43	67.61	69.04	146.28	127.04	68.77	79.47		
18	Mizoram	91.76	38.50	467.11	373.59	563.80	480.10	729.58	638.15	747.62	684.82	666.17	349.04		
19	Nagaland	144.90	56.04	80.52	66.53	145.78	175.68	146.96	97.57	116.51	172.48	217.88	10.58		
20	Orissa	716.56	195.58	599.58	293.71	1132.50	819.58	1524.79	601.80	1930.77	358.43	596.51	1120.96		
21	Punjab	601.48	97.68	187.12	138.77	426.26	332.98	686.25	546.37	621.10	668.49	263.96	419.08		
22	Rajasthan	1103.10	151.97	762.32	346.28	1255.65	818.96	2313.58	1417.52	3954.41	1393.63	2026.58	1257.32		
23	Sikkim	91.38	31.90	91.31	90.52	51.60	56.37	43.07	33.51	69.30	28.54	92.90	38.38		
24	Tamil Nadu	1127.12	171.80	377.13	588.25	1475.36	1120.88	2373.39	894.20	541.25	536.57	1059.48	412		
25	Tripura	97.38	74.52	263.72	104.84	255.43	325.44	166.18	229.43	446.87	140.04	175.58	4.09		
26	Uttar Pradesh	1647.06	396.64	3425.05	618.98	3990.12	2923.38	4654.45	5474.78	7567.00	5106.69	9880.12	3068.88		
27	Uttranchal	0.00	0.00	0.00	0.00	0.00	0.00	208.59	0.00	440.98	137.78	362.24	191.72		
28	West Bengal	478.00	127.13	638.38	293.00	1455.89	1242.03	2073.46	1317.01	1949.32	1403.79	1270.90	933.19		
	Total - All States	**14791.66**	**3139.78**	**14515.68**	**6700.00**	**22439.19**	**18130.01**	**32075.11**	**23952.51**	**42588.89**	**22085.00**	**33774.41**	**14923.63**	**0.00**	**0.00**
	UTs with Legislature														
1	Delhi	129.33	47.36	167.95	54.70	127.31	107.17	311.22	290.35	297.60	315.57	342.37	77.61		
2	Pondicherry	92.26	25.26	48.16	32.21	49.28	48.62	21.79	28.51	21.58	39.35	16.53	41.96		
	UTs without Legislature														
1	A&N Islands	24.62	13.97	46.47	13.88	33.57	46.41	31.04	9.07	134.89	38.34	12.99	3.81		
2	Chandigarh	40.22	18.62	28.22	22.33	43.07	22.09	117.61	19.69	23.20	18.23	14.89	15.05		
3	D&N Haveli	17.97	11.37	32.24	12.86	26.43	13.86	3.88	14.33	14.02	6.69	5.96	7.13		
4	Daman & Diu	44.76	16.92	27.49	14.07	32.05	23.83	4.87	1.88	8.66	3.22	25.41	8.71		
5	Lakshdweep	17.56	3.23	32.47	5.03	28.72	11.69	21.44	18.60	11.42	7.07	14.87	7.14		
	Total (UTs)	**237.39**	**89.37**	**215.05**	**100.38**	**213.12**	**166.50**	**200.63**	**92.08**	**213.77**	**112.90**	**90.65**	**83.80**	**0.00**	**0.00**
	GRAND TOTAL	**15029.05**	**3229.15**	**14730.73**	**6800.38**	**22652.31**	**18296.51**	**32275.74**	**24044.59**	**42802.66**	**22197.90**	**33865.06**	**15007.43**	**0.00**	**0.00**

Figures are provisional.

***** The expenditure figures are as reported by the States/UTs but they do not reflect the extent of funds utilised.

****** No allocation is made for the year as it is demand driven and also on the submission of utilisation certificates of the earlier releases.

Annexure 4.7.9

STATE-WISE RELEASES & EXPENDITURE OF FUNDS UNDER DEPARTMENT OF FAMILY WELFARE (1997-98 -- 2003-04)

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Area Projects (IPP) (14), Social Marketing Area Projects (15), USAID Assissted Area Projects (16), Other Externally Aided Infrastructure Development Projects (17)

Post ZBB (2002-03 onwards) - Area Projects (IPP) (6), Social Marketing Area Projects (7), USAID Assissted Area Projects (8), Other Externally Aided Infrastructure Development Projects (9)

(Rs. in Lakhs)

Sl. No.	Name of State/UT	1997-98		1998-99		1999-2000		2000-2001		2001-2002		2002-2003		2003-2004 **	
		Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Allocation	Releases
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
1	Andhra Pradesh	1998.00		112.00	766.00	400.00	1147.00	4000.00	2149.00	1400.00	2201.00		1378.00		
2	Arunachal Pradesh														
3	Assam	857.00		2000.00	2437.00	2500.00	2139.00	2300.00	239.00	1643.00	3621.00				
4	Bihar	490.00		100.00	788.00		224.00		30.00						
5	Chhatisgarh											300.00			
6	Goa														
7	Gujarat	-126.00			584.00	500.00	193.00	300.00	381.00	300.00	399.00	400.00	431.00		
8	Haryana	117.00			741.00										
9	Himachal Pradesh			100.00	1.00	100.00	93.00		19.00						
10	Jammu & Kashmir	1369.00			1451.00		736.00								
11	Jharkhand														
12	Karnataka	4856.00		99.00	2928.00	841.00	2814.00	3900.00	2912.00	4959.00	5732.00	378.00	563.00		
13	Kerala	27.00			1.00	250.00	18.00		205.00	400.00	266.00	143.00	265.00		
14	Madhya Pradesh					648.00	13.00	92.00	79.00	1067.00	582.00	700.00	1332.00		
15	Maharashtra	1072.00	35.00	500.00	169.00		596.00		389.00	1000.00	416.00	2350.00	1527.00		
16	Manipur														
17	Meghalaya														
18	Mizoram														
19	Nagaland														
20	Orissa	152.00		200.00	61.00	811.00	160.00	260.00	371.00	697.00	603.00	63.00	346.00		
21	Punjab	296.00			854.00										
22	Rajasthan	2036.00		500.00	1153.00	500.00	871.00	2500.00	1617.00	2400.00	3559.00	700.00	1014.00		
23	Sikkim														
24	Tamil Nadu	500.00	215.00		1599.00	2100.00	2120.00	1800.00	211.00	1381.00	808.00	400.00	1050.00		
25	Tripura														
26	Uttar Pradesh					100.00		1000.00	227.00	800.00	369.00				
27	Uttranchal														
28	West Bengal	3342.00		3534.00	1695.00		2280.00	1800.00	2189.00	1664.00	2649.00		1454.00		
	Total (States)	**16986.00**	**250.00**	**7145.00**	**15228.00**	**8750.00**	**13404.00**	**17952.00**	**11018.00**	**17711.00**	**21205.00**	**5434.00**	**9360.00**	**0.00**	**0.00**
	UTs with Legislature														
1	Delhi	1432.00		250.00	727.00	1200.00	1292.00	1990.00	1859.00	943.00	2150.00	360.00	108.00		
	GRAND TOTAL	**18418.00**	**250.00**	**7395.00**	**15955.00**	**9950.00**	**14696.00**	**19942.00**	**12877.00**	**18654.00**	**23355.00**	**5794.00**	**9468.00**	**0.00**	**0.00**
	STATE-WISE RELEASES & EXPENDITURE ON SIFPSA FOR THE PERIOD 1997-98 TO 2003-04														
	Uttar Pradesh	4068.50	3685.61	4643.12	2748.54	6987.50	4090.69	4455.60	4119.58	2913.01	7809.06	4024.24	4024.24		

Figures are provisional.

Pondicherry and other UTs donot have any Area Project. SIFPSA is for UP only

* The expenditure figures are as reported by the States/UTs but they do not reflect the extent of funds utilised.

** No allocation is made for the year as it is demand driven and also on the submission of utilisation certificates of the earlier releases.

Annexure 4.7.10

STATE-WISE RELEASES & EXPENDITURE OF FUNDS UNDER DEPARTMENT OF FAMILY WELFARE (1997-98 -- 2003-04)

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - Information, Education & Communication (80)

Post ZBB (2002-03 onwards) - Information, Education & Communication (47)

(Rs. in Lakhs)

Sl. No.	Name of State/UT	1997-98		1998-99		1999-2000		2000-2001		2001-2002		2002-2003		2003-2004 **	
		Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Allocation	Releases
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
1	Andhra Pradesh	59.24	17.62	53.22	29.01	40.53	56.12	85.74	30.19	79.09	78.90	117.61	117.61		
2	Arunachal Pradesh	19.76	8.37	12.31	5.94	14.38	7.25	16.68	6.47	20.22	6.50	18.28	29.73		
3	Assam	50.52	18.42	60.53		43.52		60.53		75.12					
4	Bihar	90.52	33.20	71.42		82.49		86.42	52.75	60.91					
5	Chhatisgarh									35.21			9.29		
6	Goa	12.05	1.92	9.80	2.22	12.05	2.99	14.05	4.65	11.63	3.06	12.64	6.74		
7	Gujarat	77.93	41.67	71.33	46.75	78.33	43.37	91.42	32.41	86.78	86.46	119.82	119.35		
8	Haryana	63.16	8.23	56.16	38.56	58.16	45.72	62.84	43.05	58.81	64.94	89.78	89.78		
9	Himachal Pradesh	32.41	25.70	28.57	24.53	30.56	26.06	32.26	28.83	29.25	10.69	47.86	3.26		
10	Jammu & Kashmir	25.69		19.20		21.19	0.00	24.20	0.00	21.17	21.15	33.13	32.80		
11	Jharkhand									17.46					
12	Karnataka	91.36	75.01	90.86	62.48	89.86	35.27	90.86	79.24	85.82	88.75	105.78	74.13		
13	Kerala	56.14		56.04	56.04	57.64	51.34	65.04	47.55	60.20	57.73	76.89	65.37		
14	Madhya Pradesh	106.50	107.72	96.80	76.69	155.41	8.97	146.44	8.25	97.07		193.22	82.30		
15	Maharashtra	86.54	70.52	80.54	48.50	89.54	73.03	104.64	82.87	96.98	94.55	140.11	134.01		
16	Manipur	15.17	4.85	11.67		11.67	5.30	16.68	0.00	20.66					
17	Meghalaya	15.82	1.94	15.39	13.35	16.41	12.50	21.34	18.40	26.00	17.40	33.40	39.57		
18	Mizoram	19.50	19.58	18.68	18.68	18.93	18.68	21.28	21.28	25.98	25.98	42.00	42.00		
19	Nagaland	22.85	22.85	19.86	12.48	19.85	19.68	21.85	21.85	29.43	29.43	42.00	42.00		
20	Orissa	87.08	21.78	74.94	43.41	80.34	48.81	85.09	85.09	80.10	36.55	106.31	91.46		
21	Punjab	75.66	31.36	68.67	17.77	69.66	40.79	73.66	64.29	69.63	64.44	97.57	92.29		
22	Rajasthan	99.32	73.69	87.84	3.76	96.07	47.97	105.40	44.24	100.56	50.00	180.06	141.80		
23	Sikkim	13.05	5.94	11.77	5.93	11.82	3.46	13.76	3.73	16.34	11.01	16.67	16.99		
24	Tamil Nadu	56.39	55.20	59.76	59.76	45.77	45.77	65.17	52.62	59.33	30.00	71.19	69.07		
25	Tripura	21.33	22.89	20.17	21.94	21.86	28.10	27.84	27.84	35.37	26.86	36.18	33.98		
26	Uttar Pradesh	93.62	87.00	67.63	44.20	94.62	77.04	102.62	0.00	81.42	46.76	166.76	3.27		
27	Uttranchal									9.11	3.10	51.01			
28	West Bengal	61.30	9.70	61.86	44.37	73.12	68.00	78.24	0.00	71.39	12.90	40.05			
	Total - All States	**1352.91**	**765.16**	**1225.02**	**676.37**	**1333.78**	**766.22**	**1514.05**	**755.60**	**1461.04**	**867.16**	**1838.32**	**1336.80**	**0.00**	**0.00**
	UTs with Legislature														
1	Delhi	40.68	29.95	25.00	23.38	25.24	25.24	31.24	25.98	24.99	7.36	64.70	65.68		
2	Pondicherry	9.50	0.59	10.51	2.12	10.50	5.72	12.50	7.25	10.08	8.59	14.68	2.74		
	UTs without Legislature														
1	A&N Islands	8.07	3.50	10.11	3.57	10.12	5.56	12.12	8.24	9.70	3.40	12.98	15.72		
2	Chandigarh	7.73	8.61	10.23	8.99	5.23	5.08	6.82	5.99	5.50	2.51	12.78	9.49		
3	D&N Haveli	6.76	0.56	3.00	2.00	10.43	0.00	10.43	2.31	8.41	3.60	11.60	6.32		
4	Daman & Diu	7.46	2.00	10.28	2.72	5.28	7.56	6.28	11.35	5.08	6.72	14.80	5.07		
5	Lakshdweep	7.81	1.30	10.32	2.62	5.31	0.00	7.70	0.00	6.23	3.03				
	Total (UTs)	**47.33**	**16.56**	**54.45**	**22.02**	**46.87**	**23.92**	**55.85**	**35.14**	**45.00**	**27.85**	**66.84**	**39.34**	**0.00**	**0.00**
	GRAND TOTAL	**1400.24**	**781.72**	**1279.47**	**698.39**	**1380.65**	**790.14**	**1569.90**	**790.74**	**1506.04**	**895.01**	**1905.16**	**1376.14**	**0.00**	**0.00**

Figures are provisional.

***** The expenditure figures are as reported by the States/UTs but they do not reflect the extent of funds utilised.

****** No allocation is made for the year as it is demand driven and also on the submission of utilisation certificates of the earlier releases.

Annexure 4.7.11

State-wise and Year-wise Releases & Expenditure of Funds under Department of Family Welfare

Schemes Included: Pre ZBB (1997-98 -- 2001-02) - National Maternity Benefit Scheme (79) ^, Empowered Action Group (83) #

Post ZBB (2002-03 onwards) - National Maternity Benefit Scheme (46) ^, Empowered Action Group (50) #

(Rs. in Lakhs)

Sl. No.	Name of State/UT	National Maternity Benefit scheme ^				EAG Scheme#			
		2001-2002		2002-2003		2001-2002		2002-2003	
		Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*	Releases	Expdt.*
(1)	(2)	(11)	(12)	(13)	(14)	(11)	(12)	(13)	(14)
1	Andhra Pradesh	1882.12		1217.83					
2	Arunachal Pradesh	21.39		10.70					
3	Assam	241.33		169.32					
4	Bihar	302.73		269.62		367.50		2.50	
5	Chhatisgarh	83.15		57.30		147.50	147.50	3.00	
6	Goa	6.00		3.00					
7	Gujarat	69.42		112.71					
8	Haryana	32.61		28.56					
9	Himachal Pradesh	8.40		5.77					
10	Jammu & Kashmir	34.59		21.14					
11	Jharkhand	152.62		130.72		229.50		2.50	
12	Karnataka	425.11		336.14					
13	Kerala	96.90		78.38					
14	Madhya Pradesh	543.84		363.09		413.50		13.00	
15	Maharashtra	327.56		204.18					
16	Manipur	38.61		30.08					
17	Meghalaya	31.92		16.41					
18	Mizoram	16.87		28.10					
19	Nagaland	31.51		25.23					
20	Orissa	601.92		410.27		284.50		9.00	
21	Punjab	52.52		26.26					
22	Rajasthan	95.86		89.44		294.50	294.50	280.00	
23	Sikkim	8.84		4.42					
24	Tamil Nadu	843.90		615.20					
25	Tripura	57.35		39.40					
26	Uttar Pradesh	1075.35		592.82		643.50	4.17	10.00	
27	Uttranchal	63.29		38.96		119.50	71.02	5.00	
28	West Bengal	364.75		281.85					
	Total - All States	**7510.46**	**0.00**	**5206.90**	**0.00**	**2500.00**	**517.19**	**325.00**	**0.00**
	UTs with Legislature								
1	Delhi	3.00		1.50					
2	Pondicherry	2.69		2.33					
	UTs without Legislature								
1	A&N Islands	3.00		1.50					
2	Chandigarh	3.00		1.50					
3	D&N Haveli	3.00		1.50					
4	Daman & Diu	6.00		3.00					
5	Lakshdweep	2.95		1.48					
	Total (UTs)	**20.64**	**0.00**	**12.81**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	GRAND TOTAL	**7531.10**	**0.00**	**5219.71**	**0.00**	**2500.00**	**517.19**	**325.00**	**0.00**
	Figures are provisional.								
*	The expenditure figures are as reported by the States/UTs but they do not reflect the extent of funds utilised.								
**	No allocation is made for the year 2003-04 as it is demand driven and also on the submission of utilisation certificates of the earlier releases.								

Annexure 4.7.12

List of Schemes of Dept of Family welfare for which no releaes was made to the States/ Societies

SNO.	Name of the Scheme	Ninth Plan No.	Tenth Plan No.
1	F.W. Training and Res. Centre, Bombay	25	17
2	National institute of Health & Family Welfare, New Delhi	26	18
3	International Institute for Population Sciences, Mumbai	27	19
4	Assistance to IMA	28	20
5	Population Research Centres	29	21
6	CDRI, Lucknow	30	22
7	ICMR	31	23
8	Other Research Projects	32	24
9	Social Marketing of Conventional Contraceptives	37	26
10	Social Marketing of Oral Pills	38	
11	Recanalisation	42	27
12	Testing Facilities	43	28
13	No Scalpel Vasectomy	44	29
14	Other Innovative Schemes (Male Participation)	45	
15	Travel of Experts/ Conferences/ Meetings etc	81	48
16	International Contribution	82	49
17	Community Incentive Scheme	84	51
18	Family Welfare Linked Health Insuance Plan	85	52
19	Policy/ Seminars	86	53
20	Other Initiatives	87	54
21	Other Offices under Direction & Administration	89	
22	Hindustan Latex Ltd.	92	
23	Family Welfare Counsellor Scheme	93	
24	School Health scheme	94	

4.8 WOMEN AND CHILDREN

INTRODUCTION

Women as an independent target group, account for 495.74 million as per the 2001 Census and represent 48.3 per cent of the country's total population. The child population (0-14 years) as projected for 2001, accounts for 347.54 million (33.8 per cent) of the total population in the country. Thus women and children not only constitute vital human resource of the country but also are critical determinants to the overall human development. The Tenth Five Year Plan (2002-07) is, therefore, committed to 'Empowerment of Women and Development of Children'. In pursuance of the approach, strategies and priorities of the Tenth Five Year Plan towards empowerment of women, while the concerned women-related line Ministries/Departments continued to implement various schemes/programmes related to women and children in 2002-03, the nodal Department of Women and Child Development continued implementing specific programmes for the empowerment of women and development of children with the support of its exclusive institutional mechanisms at various levels.

2. The various strategies and mechanisms that were put into action for the empowerment of women and development of children include – i) the nation-wide scheme of Integrated Child Development Services (ICDS) launched in 1975, as a major intervention for the over-all development of children, especially the Girl child and the mothers all over the country; ii) setting up of a National Commission for Women (NCW) in 1992 to safeguard the interests of women; iii) setting up of Rashtriya Mahila Kosh (RMK) in 1993 for women to meet the credit needs of poor and assetless women; iv) adoption of the National Nutrition Policy (NNP) in 1993 to fulfil the constitutional commitment to ensure adequate nutritional standard to the people especially to women and children; v) setting up of National Creche Fund (NCF) in 1994 so as to meet the growing demand for crèche services; vi) launching of Swayamsidha formerly known as Indira Mahila Yojana (IMY) in 1995-96 on pilot basis (Recast and ratified in 2000 as Integrated Women's Empowerment Programme (IWEP); vii) launching of Swa-Shakti Project in 1999 which was earlier known as Rural Women's Development and Empowerment Project (RWDEP); viii) Launching of Balika Samriddhi Yojana in 1997 which was recast in 1999; ix) Distance Education Programme for Women's Self Help Groups launched in 1998; and x) Swadhar in 2001-02 for the benefit of women in difficult circumstances. Efforts will be made towards effective implementation of these programmes/ schemes during 2003-04.

REVIEW OF THE ANNUAL PLAN 2002-03 AND ANNUAL PLAN 2003-04

3. Through the application of Zero Based Budgeting (ZBB), out of the 46 on-going schemes of the Department of Women and Child Development (D/WCD) at the end of the Ninth Five Year Plan (1997-02) as many as 25 schemes were either weeded out, merged or transferred. Therefore, only 21 schemes including 15 Central Sector (CS) and 6 Centrally Sponsored Schemes (CCS) existed at the beginning of the Tenth Plan. Reduction in the number of schemes in the Tenth Plan could be achieved through effective scrutiny of the same while adhering to the directives of the Core Committee of ZBB. The Department of Women and Child Development proposed 5 new schemes (2 CS and 3 CSS) in the Tenth Five Year Plan. Out of these 5 new schemes proposed, only one Centrally Sponsored Scheme has been approved during 2002-03. In the Annual Plan 2003-04, a total of 22 schemes (15 CS and 7 CSS) including the new CSS introduced in 2002-03 will continue to be implemented by D/WCD.

4. As against an outlay of Rs.2,200.00 crore provided to the D/WCD during 2002-03, an expenditure of Rs.2,085.00 crore has been anticipated by the Department indicating nearly 95 per cent utilisation of funds. The expenditure incurred during 2002-03 also indicate

increase by 56 per cent over the same of the previous year - 2001-02 (Rs.1,396.07 crore). Therefore, in the Annual Plan 2003-04, a total outlay of Rs.2,600.00 crore has been provided for Women and Child Development under the Central Sector, which is around 18 per cent increase over the previous year. The major achievements during 2002-03 include Universalisation of ICDS in a phased manner during Tenth Five Year Plan, Enhancement of Honorarium for Anganwadi Workers (AWWs) and Anganwadi Helpers (AWHs) and expansion of the Swayamsidha scheme to cover 412 additional blocks in the country. As against the target of operationlisation of 100 Blocks each for ICDS and Swayamsidha fixed for the year 2002-03 as many as 152 ICDS Blocks and 301 Swayamsidha blocks have been operationalised. As Women and Child Development is included as part of 'Social Services and Welfare Sector' of the State Plan, the outlays for the same are included in the outlays of the Social Welfare as furnished at Annexure-7.3.4 of the Chapter on 'Other Special Groups'. While details of the programme-wise and year-wise outlays and expenditure earmarked under the Women and Child Development at central level are furnished at Annexure-4.8.1(i) and Physical Target and Achievements at Annexure 4.8.1(ii), summary of the same is given in Table below.

Table 1
Outlays and Expenditure under Women and Child Development Sector during Annual Plan 2002-03 and Annual Plan 2003-04

(Rs. In Crores)

S. No	Schemes	Annual Plans			
		2001-02	2002-03		2003-04
		Actuals	B.E.	R.E.	**B.E.**
1.	2.	3.	4.	5.	6.
I.	**Women and Child Development**	**1640.41**	**2197.00**	**2083.01**	**2597.97**
i)	Central Sector Schemes	161.15	156.07	123.82	162.00
ii)	Centrally Sponsored Schemes	1479.26	2040.93	1959.19	2435.97
II.	**Food and Nutrition Board**	**2.78**	**3.00**	**1.99**	**2.03**
i)	Central Sector Schemes	2.78	2.00	1.98	2.00
ii)	Centrally Sponsored Schemes	0.00	1.00	0.01	0.03
		1643.19	**2200.00**	**2085.00**	**2600.00**

Empowerment of Women

5. In view of the recently adopted National Policy for Empowerment of Women 2001, there can be no better approach for empowering women in the Tenth Plan than translating the Policy in to Action. In the Annual Plan 2003-04 the process of empowerment of women will, therefore, be pursued to accomplish Social Empowerment and Economic Empowerment with a special thrust on Gender Justice. To improve the socio-economic status of women and girl 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. As a follow up and also recognizing the gender sensitisation as a pre-requisite for empowerment of women, the Cabinet Secretary has already requested all Ministries / Departments in January, 2003 to introduce a Chapter on Gender Issues in their Annual Reports which should include new initiatives taken by them on women and gender related issues, resource available and their utilisation.

6. During the Ninth Plan (1997-02) the process of organising women into Self-Help Groups (SHGs) was initiated with a view to provide permanent aid for articulating their needs and contributing their perspectives to development. The SHGs which are in action under the programme of Swayamsiddha have been implementing various income-generating activities. The Socio-Economic Programme (SEP) launched in 1996 aims to encourage women to take up wide variety of income-generating activities which include production of industrial components in ancilliary units, handlooms, handicrafts, agro-based activities such as animal husbandry, sericulture and fishery and self-employment ventures like vegetable or fish vending, etc. While taking note of the deficiencies in the implementation of the on-going programmes, efforts will be made in the Annual Plan 2003-04 not only to sensitise the implementing agencies but also to ensure effective implementation of the same especially through overcoming the drawbacks.

7. The Annual Plan 2003-04 will pursue the 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, welfare services, Science and Technology, small and medium industrial sectors/industries, micro-credit etc. to optimise the impact.

8. The Annual Plan 2002-03 was started keeping in view the recently adopted National Policy for Empowerment of Women which envisages a three-fold strategy for empowering women through - i) Social Empowerment, ii) Economic Empowerment, and iii) Gender Justice. These strategies will also continue during 2003-04.

Social Empowerment

Condensed Courses of Education and Vocational Training (CCE&VT)

9. Recognising education being the basic and fundamental requirement for Social Development, the Tenth Plan is committed to increase the literacy rate to 75 per cent within the Plan period. Therefore, 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, concerted efforts will be made to reach the un-reached Girl Child and to ensure that SSA achieves its commitment as scheduled. The progress made under female education by the end of previous year 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 Condensed Courses of Education and Vocational Training (CCE&VT) run by Central Social Welfare Board (CSWB) is one of the schemes which aims to help the women complete their schooling and also to upgrade their skills in order to meet the demands of changing work environment. Also, the women are trained in the various trades so as to make them self confident and self-reliant. An outlay of Rs. 2.00 crore was provided for 2002-03. As against this, a sum of Rs. 1.40 crore has been spent by the end of 31 December,2002 for organising 89 courses benefiting 2250 candidates. For the Annual Plan 2003-04 an outlay of Rs. 4.00 crore has been earmarked to conduct 400 courses.

Information and Mass Media and Information Technology

10. The Plan directs media to foster women and the Girl Child, especially through bringing about change in the mind-set of the people with an aim to promote balanced portrayals of women and men. For the scheme of Information and Mass Media as against an outlay of Rs. 6.00 crore during 2002-03 an expenditure of Rs. 1.10 crore has been

incurred on production of 18 films and 52 Radio Programmes both for general and North-Eastern Region (NER) by the end of 31.12.2002. Similarly as against the outlay of Rs. 0.50 crore for Information Technology an expenditure of Rs. 0.26 crore has been incurred by the same period i.e. by December, 2002. For the Annual Plan 2003-04 an outlay of Rs. 5.00 crore has been provided for the scheme of Information and Mass Media earmarked for the production of 17 video films / spots. The outlay provided for the Scheme of Information Technology for the Annual Plan 2003-04 is Rs. 0.50 crore.

Short Stay Homes (SSHs)

11. The scheme of Short Stay Homes which was launched in 1969 is now being implemented by Central Social Welfare Board (CSWB) to provide temporary shelter, counselling or psychiatric treatment to women and girls who are the victims of mental maladjustment, emotional disturbances and social ostracism and have either escaped or been made to leave their homes due to family problems, mental or physical torture or who have been sexually assaulted or have been forced into prostitution. The objective of the SSHs is to rehabilitate and reintegrate such women into society. In the Annual Plan 2002-03 an outlay of Rs. 15.00 crore was earmarked for construction of 90 SSHs. The expenditure for the period ending 31.12.2002, however, stands at Rs. 8.25 crore for the construction of only 39 SSHs. Keeping in view the necessity for more and more SSHs, the outlay for the year 2003-04 has been retained at Rs. 15.00 crore.

Economic Empowerment

Swa-Shakti Project

12. The ultimate objective of the Plan is to make all women economically independent and self-reliant through training and upgradation of skills and provision of employment and income-generation activities with both 'forward' and 'backward' linkages. To this effect, Self Help Groups (SHGs), which act as the agents of social change, development and empowerment of women, are being encouraged. The on-going Integrated Women's Empowerment Programme - Swa-Shakti which is jointly supported by the World Bank (WB) and International Fund for Agricultural Development (IFAD) is being implemented with an aim to enhance women's access to resources for better quality of life through use of drudgery and time reduction devices improvement health and literacy and confidence enhancement and increasing their control over income generating activities. As against an outlay of Rs.25.00 crore during 2002-03 an expenditure at Rs.17.83 crore has been incurred under the scheme upto 2002. However, the Department could achieve the fixed physical Target of 650 new SHGs for the year 2002-03 in December, 2002 itself. An outlay of Rs.40.00 crore has been provided for the year 2003-04 .

Swayamsiddha

13. The programme of Swayamsiddha aims at the all round empowerment of women by ensuring their direct access to and control over, resources through a sustained process of mobilisation and convergence of all the on-going sectoral programmes. The process of expanding the scheme has already started in the year 2002-03 but the progress has been very slow. Despite having achieved the best results being yielded through effective income generation and awareness generation activities of SHGs under Swayamsiddha, there lies a big gap in understanding the actual concept of the scheme. As per the concept of Swayamsiddha, activities of both income and awareness generation are only the medium to raise the status of SHGs into registered societies and at a later stage, the same to get upgraded into independent Financial Institutions/Banks, while the members of these groups are expected to become entrepreneurs, either individually or as a group. The SHGs which are in action under the programme have been under taking various income generating activities very effectively with the support of both 'backward and forward linkages'. To strengthen the programme, Government

has approved the expansion of Swayamsiddha into 650 blocks throughout the country during the Tenth Five Year Plan. As against an outlay of Rs.20.00 crore in 2002-03, only Rs.5.86 crore was spent by the end of December, 2002 itself. The physical achievements in terms of operationalisation of blocks has been very good. A target of 650 blocks including 238 Indira Mahila Yojana (IMY) blocks was fixed for operationalisation during the Tenth Five Year Plan (2002-07). The Department has achieved a target of 574 Blocks by December, 2002. Keeping in view the performance, an outlay of Rs. 20.00 crore has been earmarked for the Annual Plan 2003-04 with an ultimate objective of universalising the same through the already available grass-root level networking of SHGs.

Support for Training and Employment Programme (STEP)

14. Support for Training and Employment Programme (STEP) started in 1987 seeks to provide updated skills and new knowledge to poor and assetless women through training besides employment, credit and marketing linkages in the traditional sectors of animal husbandry, dairying, fisheries, handlooms, handicrafts, khadi and village industries, sericulture, social forestry and wasteland development for enhancing their productivity and income generation. As against an outlay of Rs. 25.00 crore in the Annual Plan 2002-03, only Rs.2.81 crore could be spent benefiting 25,000 women beneficiaries against a target of 35,000 by the end of December, 2002 indicating short fall in achieving both financial and physical targets. An outlay of Rs. 25.00 crore has been provided during the year 2003-04 towards much needed skill upgradation and entrepreneurship leading to economic empowerment of women especially engaged in rural / traditional sectors.

Employment-cum-Income Generation-cum Production Units (NORAD)

15. The scheme of Employment-cum-Income Generation-cum Production Units now known as `Swawlamban' was launched in 1982-83 with the assistance from the Norwegian Agency for Development Cooperation (NORAD) to provide training and skills to women to facilitate them to obtain employment or self-employment on a sustained basis. The target groups under the scheme are the poor and needy women especially belonging to weaker sections of society, viz. Scheduled Castes and Scheduled Tribes, etc. In the Annual Plan 2002-03 an outlay of Rs. 25.00 crore was provided for this programme. By the end of December, 2002 an expenditure of Rs. 10.79 crore benefiting 21,000 women beneficiaries against the target of 65,000 beneficiaries has been reported. The success of the programme has demonstrated the efficacy of informal and low-cost training modules in imparting skills to disadvantaged women at the grassroots level. Various evaluation studies, including independent study commissioned by NORAD, have shown that nearly 50 – 60 per cent of the women trained under the programme have been able to get employment or self employment. Keeping this in view, the outlay for 2003-04 has been retained at Rs. 25.00 crore.

Hostels for Working Women

16. The Department of WCD is implementing the scheme of Hostels for Working Women with a view to encouraging women's participation in the employment market. Under the scheme, cheap and safe hostel accommodation is being provided to Working Women living out of their homes. The beneficiaries include single working women, widows, divorces, separated and working women whose husbands are out of town. Women undergoing training for employment and girl students studying in post school professional courses are also eligible to stay in the hostels. The progress for construction of Hostels for working women has been far below the target fixed both financially and physically during the year 2002-03. Only 15 per cent of expenditure which works out to Rs. 2.25 crore by the end of 31.12.2002 was incurred as against the outlay of Rs. 15.00 crore for the construction of Working Women Hostels. As against a target of 40 hostels to be constructed during the

year 2002-03 only 9 hostels could be added benefiting 741 women as against the target of 4000 women beneficiaries. Due to slow progress, the outlay for Working Women's Hostels has been reduced to Rs. 10.00 crore in 2003-04.

Rashtriya Mahila Kosh (RMK)

17. The Annual Plan 2003-04 will further help in linking the micro-credit programme of RMK 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. All States/UTs with Women's Development Corporations will be persuaded to provide both 'forward' and `backward' linkages of credit and marketing facilities to women entrepreneurs, besides rendering the role of catalysts. As on 31.3.2003, RMK could disburse Rs. 93.44 crore benefiting as many as 4.63 lakh poor and assetless women through 1,044 voluntary organisations. An outlay of Rs. 1.00 crore has been provided for RMK in the Annual Plan 2003-04.

Grant-in-Aid and Other Schemes

18. To provide adequate employment opportunities to remove inequalities in employment – both in work and accessibility and thereby ensure women's work more visible and their contribution recorded in the National Accounts, a proper strategy will be worked out in the Annual Plan 2003-04. 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 sensitisation in administrative and enforcement machinery will be given priority attention towards ensuring that the rights and interests of women are taken care of, besides involving them in planning, implementation and monitoring processes. An outlay of Rs.5.00 crore was provided under Awareness Generation Projects for Rural and Poor Women (AGPRPW) run by D/WCD but the progress has not been satisfactory as the Department could spend only Rs.0.44 crore by the end of December, 2002. Similarly as against the target of 30 new studies during 2002-03 only 8 studies could be conducted and 4 workshop/seminars etc were arranged against the target of 40 Seminars/Workshops. An outlay of Rs.1.50 crore for the Annual Plan 2003-04 has been provided for AGPRPW.

19. Government has already introduced a Bill in the Lok Sabha to legislate reservation of not less than one-third 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. The Bill is pending for a final decision of the Lok Sabha.

Swadhar

20. Despite a number of legislations, there has been no change in the trend of violence against women and the girl-child, both domestic and at work-place, which is progressively increasing. As per the latest data (2000) published by the National Crime Records Bureau, New Delhi, the total number of crimes committed against women has risen from 1.31 lakh in 1998 to 1.41 lakh in 2000. Of the total 1.41 lakh crimes committed against women in 2000, torture claims the highest share of 32.38 per cent followed by molestation (23.30 per cent), kidnapping and abduction (10.62 per cent), rape (11.66 per cent), sexual harassment (7.80 per cent), dowry death (4.95 per cent), immoral traffic (6.74 per cent) and others (2.55 per cent). Therefore, to arrest the ever increasing violence against women and the Girl Child including the Adolescent girls, efforts will be made towards stringent administration of the existing legislation especially through involvement of the voluntary agencies in supplementing efforts of the enforcement authorities. The scheme – Swadhar was recently

launched in 2001-02 for the benefit of women in difficult circumstances, like destitute widows deserted by their families in religious places like Vrindavan, Kashi, etc.; women prisoners released from jail and without family support; women survivors of natural disasters who have been rendered homeless and are without any social and economic support; trafficked women/girls rescued or runaway from brothels or other places or women/girls victims of sexual crimes who are disowned by family or do not want to go back to their respective families for various reasons; women victims of terrorist violence who are without any family support and without any economic means for survival; mentally disordered women who are without any support of family or relatives etc. Since the scheme has been recently launched, the progress in its implementation is slow. As against the outlay of Rs. 15.00 crore in 2002-03 the expenditure incurred by the end of 31.12.2002 was Rs. 2.07 crore. Accordingly, as against the target of setting up of 35 Centres, only 20 Centres have been set up during the above period. As the scheme is expected to pick up during 2003-04, an outlay of Rs. 15.00 crore has been provided for extending shelter, food, clothing and care to the marginalized women living in difficult circumstances.

Gender Justice

21. Various policies and programmes introduced by the Government for the empowerment of women and development of children show that the gender responsive policies can contribute to achieving the objectives of gender equality, human development and economic efficiency. Therefore, gender mainstreaming requires gender responsive policy. To achieve this objective, Government has adopted a 'National Policy for Empowerment of Women' in March, 2001. The main objective of this policy is to bring about the advancement, development and empowerment of women and to eliminate all forms of discrimination against women and to ensure their active participation in all spheres of life and activities. The themes and issues covered by the Policy include: 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 male counterparts. To ensure that the policy prescriptions get implemented, the Department of WCD has drafted a Plan of Action (POA) with achievable goals by the year 2010. The POA will also identify commitment of resources and responsibilities for implementation and strengthen institutional mechanisms and structures for monitoring. The operational strategy also mentions the need to develop Gender Development Index as a method of gender auditing and stresses the importance of collecting gender-disaggregated data, which will be useful for planning, implementation and monitoring. The POA is being finalised in consultation with all the stakeholders. Besides, the Annual Plan 2003-04 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.

National Commission for Women (NCW)

22. The National Commission for Women (NCW) - a statutory body constituted on 31.1.1992 in-charge of safeguarding rights and interest of women, has been in the forefront of the national endeavour to improve the status of women in the society and work for their overall empowerment. An outlay of Rs. 6.00 crore during 2002-03 was provided for NCW. However, an expenditure of Rs. 2.85 crore would be achieved by the end of December, 2002. An outlay of Rs. 4.50 crore has been provided to NCW in the Annual Plan 2003-04.

Development of Children

23. Development of Children - as an investment in the country's human resource development, has been the major strategy in the earlier Plans which is now being pursued with a Rights-based Approach as proposed by the National Policy for Children (2002) and the two existing National Plans of Action for Children/Girl Child (1992) in the Tenth Plan (2002-07). Thus, in pursuance of the Tenth Plan objectives, the Annual Plan 2003-04 will further strengthen and ensure the following Right-based Approach to the development of children:

- '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 Reproductive Child Health, Integrated Child Development Services, Sarv-Shiksha Abhiyan and other related programmes.

Integrated Child Development Services (ICDS) Scheme

24. The Nation-wide programme of Integrated Child Development Services (ICDS) Scheme which has completed more than 25 years continues to be the major intervention for the over-all development of the young children especially the Girl Child and the mothers all over the country. The Plan recognises that 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 especially the children below 3 years. Efforts will also be made to further expand/widen the scope of the development of children along 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 under Kishore Shakti Yojana (KSY), counselling facilities will be added and vocational training and entrepreneurial skills will be strengthened.

25. 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 (SNP) will be made to achieve universal coverage under the Universal Immunisation Programme. The Plan will operationalise universal screening of children through locating them in the identified families living below the poverty line. The programme will be operationalised for assuring 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 focussing the girl children.

26. So far, it has been a challenge, to achieve community participation and community contribution in the field of child development 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. The corporate sector will be persuaded to adopt the ICDS projects and thus fulfil their societal obligations. The principles enunciated above, and the envisaged role of PRIs/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.

27. All types of mass media will be used to re-orient the mind-set of people to perceive Girl Child as an asset. Currently, services under ICDS are being provided to 395 lakhs beneficiaries, comprising of about 332 lakhs children (0 – 6 Years) and about 62 lakhs pregnant and lactating mothers through a network of 5.8 lakhs Anganwadi Centres. There has been a significant increase in the Central Government spending on implementation of ICDS. During Annual Plan 2002-03 an outlay of Rs.1635.44 crore for ICDS (General) was provided. Although the expenditure at the end of 31.12.2002 was Rs. 737.62 crore, the Department anticipates full-utilisation of Rs. 1477.40 crore agreed at RE stage on the basis fund released to the tune of Rs. 1335.85 crore by 25.2.2003. Similarly, as against the target of 4947 ICDS block to remain operational, as many as 4761 ICDS block have been made operationationed by the end of 30.9.2002. In view of the above, an outlay of Rs. 1675.97 crore has been provided for the Annual Plan 2003-04.

28. Out of the total 5,652 ICDS Projects, 922 World Bank-assisted (ICDS) Projects are in operation in 10 States viz. Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. The World Bank-assisted Projects are scheduled to end on 30.9.2004. Thereafter, these Projects will be covered under ICDS (General). During 2001-02, a sum of Rs. 219.94 crore was spent on these Projects. As against the outlay of Rs. 288.48 crore in the Annual Plan 2002-03, the likely expenditure is Rs. 378.31 crore. An outlay of Rs. 600.00 crore has been provided in the Annual Plan 2003-04 for the scheme.

ICDS – Training Programme - UDISHA

29. The spectrum of ICDS services has been broadened with interventions related to the empowerment of women and communities and convergence of sectoral services. The thrust areas under ICDS include - addressing to the needs of urban poor; direct intervention to fight rampant under nutrition and mal-nutrition 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 Kishore Shakti Yojana (KSY) - (Adolescent Girls' Scheme) as a component of ICDS; 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 and strengthening of basic infrastructural facility. For the Scheme of Training of ICDS functionaries an outlay of Rs. 72.00 crore was provided in the Annual Plan 2002-03. By the end of 31.12.2002 a sum of Rs. 44.33 crore reported spent on the training of CDPOs, Supervisors and Anganwadi Workers. As against the fixed target for 325 Job training courses for CDPOs only 104 courses could be achieved by 31.12.2002. Similarly, as against the target of 2025 Job Training Courses for Supervisors only 985 courses were organised for the same period. In the case of AWWs Training, as against the target of 97,000 AWWs beneficiaries only 44,000 AWWs could be trained. To fulfil the targets during 2003-04, an increased outlay of Rs.85.00 crore has been provided towards effective implementation of the programme and to ensure that targets thus fixed are met.

30. The Pradhan Mantri Gramodaya Yojana (PMGY) envisages an Additional Central Assistance (ACA) to extend the basic minimum services of primary health, primary education, rural shelter and nutrition. The allocation under nutrition component of PMGY is

essentially meant as an additionality for providing enhanced nutrition requirement to children in 0-3 years, etc. To this effect, added thrust will be given to implementation of PMGY 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 pose threat to their development potentials. Steps will be taken especially 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 terms of 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 vital supplementation towards rectifying the existing inequalities and discriminatory feeding practices.

National Nutrition Mission (NNM) and Food and Nutrition Board (NNB)

31. Although prevalence of under Nutrition among Children (1-5 year old) has declined, there has been no significant difference in the number of malnourished children among boys and girls. In the age group 0-3 years, there has been improvement in the nutritional status of children in 1998 as compared to 1992. Under -nutrition is lowest among children less than six months old, and most widespread among children 12-35 months.

32. At the state level, half the children below three years of age in Madhya Pradesh, Bihar, Orissa, Uttar Pradesh and Rajasthan are underweight and at least 20 per cent children are underweight in the rest of the states. About 20 per cent children in Orissa, Maharashtra, Bihar, Karnataka, Tamil Nadu and Madhya Pradesh are excessively thin. There is not much improvement in the incidence of low birth weight which continues to be nearly 30 per cent. Micronutrient deficiencies among children though still prevalent, are on the decline. Among these, anaemia is still wide spread among children and women. It is estimated that about 52 per cent women and 74 per cent children in the age group 6 – 35 months are anaemic. In the major states, the highest incidence of anaemia among children was reported in Gujarat (83.9 per cent) followed by Punjab (82.3), Bihar (80.01 per cent) and Orissa (80 per cent). In other states like Andhra Pradesh, Goa, Kerala, Madhya Pradesh, Nagaland, Rajasthan, Tripura and Uttar Pradesh, anaemia among children was between 70-80 per cent. NNM has been introduced as a CSS in 2002-03 as a follow up of the announcement made by the Prime Minister in his Independence Day Speech, 2001. Under this scheme, subsidized food would be made available to adolescent girls and expectant/nursing mothers – belonging to Below Poverty Line (BPL) families. The focus of the Mission is to promote synergy between the various programmes and activities carried out by different Ministries/ Departments of the Government in the field of nutrition and to implement those programmes in a holistic and integrated manner and the new programmes that become necessary are put in place and that States are fully brought into the picture so that the nation as a whole may address the silent crisis of mal-nutrition. A provision of Rs. 1.00 crore has been earmarked for NNM. Special Central Assistance is extended to the States/UTs implementing NNM. During 2003 a sum of Rs. 103.33 crore has been sanctioned for all the States when a pilot project in 51 districts of the country was started. Efforts will be made by taking necessary measures towards achieving objectives set for the proposed NNM. In view of slow progress during 2002-03, only a token provision of Rs. 0.03 crore has been earmarked for the Annual Plan 2003-04. Food and Nutrition Board attached to the nodal Department of Women and Child Development is working towards generating nutritional awareness through its National Nutrition Policy and Nutrition Education (NNP&NE) 1993. During 2002-03 an outlay of Rs. 2.00 crore was provided for NNP & NE and the same amount has also been earmarked for the Annual Plan 2003-04.

Creches / Day-Care Centres

33. Demand for support services like Crèches/Day Care Centres for the children of Working/Ailing Mothers is increasing every year especially in the present day context where more and more women are joining the workforce both in the organised and unorganised sectors. Therefore, efforts will have to be made to expand Support Services of Crèche/Day-Care during the year 2003-04 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. An outlay of Rs.12.00 crore was made in the Annual Plan 2002-03. The expenditure incurred by end of December, 2002 was Rs. 6.75 crore. To meet the growing demand for Crèches/Day Care Centres for Children of Working/Ailing Mothers, an allocation of Rs.20.00 crore has been made in the Annual Plan 2003-04.

34. The National Plans of Action both for 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; socially economically weak including those belonging to broken families. 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, efforts will be initiated to get the necessary in-depth studies conducted on priority basis to assess the size and magnitude of the problem and to streamline and expand the on-going efforts both in the government and non-government sectors during the year 2003-04.

National Institute of Public Cooperation & Child Development (NIPCCD)

35. In addition to Training of ICDS functionaries, the 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. An outlay of Rs.6.00 crore was provided to NIPCCD in the Annual Plan 2002-03. However, only a sum of Rs.0.50 crore has been utilised by the end of December, 2002. An outlay of Rs. 5.00 crore has been made in the Annual Plan 2003-04 for the same.

Balika Samridhi Yojana (BSY)

36. With a view to extending financial assistance to Below Poverty Line (BPL) families when a girl-child is born, the scheme of Balika Samriddhi Yojana (BSY) has launched in 1997, as a strategy to enhance the Social Status of GM Child. The scheme is under implementation providing post-delivery grants, annual scholarships and text books-uniforms etc. As the scheme was slated to be transferred to the States/UTs during 2002-03 and no outlay was provided in the Annual Plan 2002-03. However, a provision of Rs.2.00 crore was made at R.E. stage. Pending final decision of NDC the scheme is still continuing as Centrally Sponsored Scheme during 2003-04. An outlay of Rs. 15.00 crore has been earmarked for Annual Plan 2003-04.

The National Commission for Children (NCC)

37. 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 already been initiated. Setting up of a National Commission for Children has been approved by the Cabinet in April, 2003 inter-alia to oversee the proper implementation of the existing legislations and thus safeguard the interests of Children. Introduction of a Bill to this effect in Parliament is awaited. A token provision of Rs. 1.00 crore has been made in the Annual Plan 2003-04.

Externally-Aided Projects

38. In addition to the Government funding, external aid is also received from the outside agencies to support certain women and child development projects like - i) Setting up of Training-cum-Production Centres for Women (NORAD), ii) World Bank (WB) ICDS programme (Multi-State ICDS Project), iii) Training of ICDS Functionaries – UDISHA and iv) Rural Women's Development & Empowerment Project (RWD&EP). For the Annual Plan 2002-03, an enhanced allocation of Rs. 390.49 crore (NORAD - Rs.5.00 crore, WB-ICDS – Rs.288.48 crore, Training of ICDS Functionaries - Rs.72.00 crore, Rural Women Development and Empowerment Project (RWD&EP) – Rs.25.00 crore, and Canadian International Development Agency (CIDA) assisted Programme for Himachal Pradesh - Rs.0.01 crore) was made under EAP against the total aid of Rs. 236.50 crore received during previous year 2001-02. By the end of December, 2002 an amount of Rs.305.78 crore has been spent. The allocation under EAP has further increased to Rs. 518.50 crore in the Annual Plan 2003-04. A statement showing year-wise external aid spent during the Annual Plan (2002-03) is given in Annexure–4.8.2. A summary of the external aid budget for the Tenth Plan (2002-07) and for Annual Plan 2002-03 and 2003-04 is given in the following Table 2.

Table–2
Outlays under Externally-Aided Project (EAP) for Women and Child Development Sector during Tenth Plan (2002-07) and Annual Plan (2003-04)

(Rs. in Crore)

Sl. No.	Name of the Schemes	Tenth Plan Outlay (2002-07)		Annual Plan (BE) (2002-03)		Annual Plan (BE) (2003-04)	
		Total	EAP	Total	EAP	Total	EAP
	1	2	3	4	5	6	7
I.	**Women and Child Development**	13670.00	1683.02	2198.00	279.28	2597.97	518.50
i)	**Central Sector Schemes**	1148.11	37.01	156.18	5.02	162.00	4.00
ii)	**Centrally-Sponsored Schemes**	12521.89	1646.01	2041.82	274.26	2435.97	514.50
II.	**Food and Nutrition Board**	110.00	-	2.00	-	2.03	-
i)	**Central Sector Schemes**	10.00	-	1.00	-	2.00	-
ii)	**Centrally Sponsored Schemes**	100.00	-	1.00	-	0.03	-
	Total	**13780.00**	**1683.02**	**2200.00**	**279.28**	**2600.00**	**518.50**

Centrally-Sponsored Schemes

39. There are 7 Centrally Sponsored Schemes (CSS) fully funded under the Central Plan. These include – i) Integrated Child Development Services (ICDS -General); ii) World

Bank-assisted ICDS; iii) Training of ICDS Functionaries – UDISHA; iv) Integrated Women's Empowerment Programme – Swayamsidha; v) Rural Women's Development and Empowerment Project – Swashakti; vi) Balika Samridhi Yojana; and vii) National Nutrition Mission (NNM) being implemented by the Department of Women and Child Development. While 6 schemes are continuing from Ninth Five Year Plan, 1 scheme viz. National Nutrition Mission has been introduced from the Tenth Five Year Plan and is being funded with Additional Central Assistance (ACA). As the CSS scheme of Balika Samridhi Yojana was slated to be transferred to the States, no outlay was provided in 2002-03. The State-wise release of funds under remaining 5 CSS has been shown in the Annexure – 4.8.3.

Role of Voluntary Organisations

40. The voluntary organisations have been contributing significantly for the empowerment of women and development of children by creating awareness and gender sensitisation to change the mindset of people in favour of both women and girl child and also for combating violence/atrocities against the women and the girl child. They also help in formulating alternative models in the areas of credit, organising women into SHGs, self-employment, participatory rural appraisal etc. The voluntary organisations will, therefore, be encouraged to act as catalytic agents in the process of `Empowerment of Women and Development of Children'.

4.9 Art and Culture

The functions of the Department of Culture range from creating cultural awareness at the grass-root level to international cultural exchanges. The Department encourages and disseminates a variety of contemporary creative arts. Broadly speaking there are three dimensions of culture: National Identity, Mass Media and Tangible and Intangible heritage. Tangible and intangible heritage have several strands, and among other things include monuments, sites of Archaeology; Anthropology and Ethnology; Folk and Tribal art; Literature; Handicrafts; Archives; Libraries; Performing Arts including Music, Dance and Drama; and Visual Arts in the form of Painting, Sculpture, and Graphics.

2. An attempt has been made by the Department of Culture to build up linkages through a network of institutions and schemes between the past and the present in terms of their bearing on future development. The Department of Culture has a network of subordinate and attached offices beside a number of other autonomous institutions/organizations, such as Archaeological Survey of India, Anthropological Survey of India, National Archives, Museums, Libraries Academies etc. During the Annual Plan 2002-03, stress was laid on improving literacy through libraries and associate activities. Concentrated efforts were made on inculcating reading habits among the people covering rural, urban and inaccessible areas. There are various central schemes through which Department of Culture is providing grants of fellowship to outstanding artists, scholarships to young artists and persons distinguished in letters and arts and in such other walks of life. Financial assistance has been provided to professional, groups and individuals for specific performing art projects. In addition, Voluntary Cultural Organisations are supported financially towards construction of building and purchase of equipments in order to promote and disseminate tribal/folk art and culture. Support is also extended for scientific development of Buddhist/Tibetan culture and their tradition.

3. Against an actual expenditure of Rs. 1720.00 crore in the Annual Plan 2001-02 an amount of Rs. 250.00 crore was allocated for Annual Plan 2002-03. For the Annual Plan 2003-04 an amount of Rs. 250.00 crore is provided to the Department by the Planning Commission.

Action Plan 2003-04

4. During the period under report, support for necessary infrastructure activities both administrative and technical is to be provided to cope with enhanced activities of Archaeological excavation and for effective implementation and coordination of activities. Stress will be given on modernization and preservation facilities to accelerate the pace of repair and rehabilitation of records of archives of India.

5. Besides continuing its ongoing programme on promotion and preservation of various arts and cultural forms, cultural heritage, strengthening of inter-governmental network and introducing management oriented approach in administration of cultural institutions, emphasis will be placed on computerization of records of the National Archives of India during the current financial year. Networking among central museums will be strengthened for enabling these institutions to share their experiences and resources. During the period under report, the Department will undertake computerization work with the assistance of NIC which could include LAN and WAN and digitalization of various art forms, reprography/microfilming of manuscript and introduction of equipment for audio tour.

6. The Department is fully involved in creating assets for the development of libraries. Department has proposed to establish a Regional Language Library (Bhasha Pustakalaya). Computerization of administrative block of Delhi Public Library. Thanjauvur Maharaja Serfoji Saraswathi Mahal Library (construction of six-storey building. Various buildings under different stages of construction are to be completed during the year.

7. Recently, norms/guidelines have been approved by the Cabinet for funding of Science cities projects in the country; the salient features of the norms for setting up of Science Cities are as under;

- The total cost of a Science City should be between Rs. 65-70 crores;
- The equity shares the Central Government and the concerned State Government should be 13% each. The balance equity of 74% should be raised through private entrepreneur or any other agency by the State Government;
- The concerned State Govt. must provide at least 50 acres of developed land for setting up of a Science City and its cost (even notional cost) should not be included in the equity contribution of the State Government;
- The location of the Science City should be either the State capital or any town of the State having a sizable population of say 50 lakhs inclusive of its vicinity;
- Before a project for setting up a Science City is posed to Central Govt. by any State Govt., a detailed feasibility report should be prepared and submitted beforehand;
- Recurring cost for the operations and maintenance of Science City to be provided by State Govt. or the Society of State Govt. especially constituted, or any other agency or private entrepreneur so chosen by State Govt.;
- The central Government shall not be responsible for the maintenance of the Science City nor would it provide any funds or manpower for the project;
- The State Govt. shall make suitable provision for water, electricity, local taxes, etc. at concessional rates as is available to educational institutions.