CHAPTER 9

POINT 8 : HEALTH FOR ALL

9.1 Health is more than mere avoidance of disease. It is a positive state of physical and mental well-being. A person 92s capacity for intensive and sustained work, and to enjoy life, depends to a large extent, on the state of his health. Improvement in health of the population is, therefore, an essential element of human resource development and of a better quality of life. Government is taking multi-pronged approach in this vital sector through preventive, promotive and curative measures alongwith clean drinking water and proper sanitation. It is a hard fact that productivity has a direct link with health, it improves as the health care improves. Therefore, health care has been included as one of the points of the TPP 9286. This point aims at: (i) improving the quality of primary health care, (ii) fighting leprosy, tuberculosis, malaria, goitre, blindness and other major diseases, (iii) providing immunisation for all infants and children, (iv) improving sanitary facilities in rural areas, particularly for women, and (v) paying special attention to programmes for rehabilitation of the handicapped.

9.2 Primary Health Care:- Primary health care services are provided through a three-tier delivery system of Sub-Centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs). One sub-centre, for every 5000 population in general, and for every 3000 population in hill and tribal areas, is envisaged. PHC caters to 30,000 population, in general, and 20,000 population in hill and tribal areas. One CHC is established for every 80,000 to 1.20 lakh of population. The total numbers of Sub-Centres, PHCs and CHCs functioning in the country are 137311, 2432 and 3084 respectively. The statewise details of new centres setup during the period are in *Annexure-9.1 & 9.2*

(i) Sub-Centres: The Sub-Centre is the most peripheral contact point between the primary healthcare system and the community. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker. One Lady Health Worker (LHV) is entrusted with the task of supervision of six Sub-Centres. In most Southern States, as well as parts of Gujarat and Mahasashtra, the ANMs in charge of the health Sub-Centres are performing deliveries, and refer complicated cases to the primary health centers. In other States, the staff at Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioural charge in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoel control and control of communicable diseases programmes.

(ii) Primary Health Centres (PHCs): The Primary Health Centre is the first contact points benween the village community and a medical officer. These are established and maintaiined by the State Government under the Minimum Needs/Basic Minimum Services Programme. A PHC is manned by a medical officer and is supported by 14 paramedical and other staff. It acts as a referral unit for six Sub-Centres and has 4-6 beds. The activities of PHCs include curative, preventive and promotive health care as well as family welfare services.

(iii) Community Health Centres (CHCs): The Community Health Centres are established and maintained by the State Governments under the MNP/BMS Programme. It is manned by four medical specialists i.e. surgeon, physician, gynaecologist and paediatrician supported by 21 paramedical and other staff. It has 30 indoor beds with X-ray, labour room, operation theater and laboratory facilities. It serves as a referral center for the PHCs, and also provides facilities for obstetric care and specialist consultations.

9.3 Immunisation Programme: The Immunisation Programme aims at:- (i) Reduction of morbidity due to diphtheria, tetanus, polio myetities, tuberculosis, measles and typhoid, (ii) Self-sufficiency in vaccine production, and (iii) 100% coverage of two doses of TT to pregnant women and 100% coverage of DPT, Polio, BCG and Measles to infants. Pre-natal, natal and postnatal care of mother, and immunisation of mother and children are the main components of this programme. Under Universal Immunisation Programme infants are given 3 doses of DPT, OPV, and one dose each of BCG and measles. Two doses of PP for pregnant women are also offered. A brief table below gives the progress of Universal Immunisation Programme during April 2003- March 2004 at the national level. During 2003-2004, a total of 235.57 Lakh expectant pregnant mothers were covered under the Tetanus Immunisation Programme in the country achieving 77.8% of the proportionate assessed need for the year 2003-04. During the period, 233.67 lakh children were immunized against DPT, 237.08 lakh against Polio, 256.88 lakh against BCG, and 219.46 lakh against Measles achieving 91.0%, 92.3%, 100.0%, and 85.5% of the respective need assessed at the national level. In addition, DT (2nd Dose) Immunizations, TT (10 yrs), TT (16 yrs) stood at 105.68 lakh, 98.98 lakh and 84.95 lakh respectively during April-March 2004. Achieving 77.7%, 65.4% and 59.9% of their reaspective need assessed at National level. Based on the Monthly Progress Report (MPR) of Twenty Point Programme for the year April 2003- March 2004 against the target of 253.53 lakh infants to be immunised the achievement was 274.08 lakh, which was 108 % of targets. The State/UT-wise details regarding the immunisation programme are given at *Annexure 9.3.* The details of BCG, DPT, Polio and Measles are given separately in *Annexures 9.4 to 9.8.* During the year April, 2003-March 2004, the performance of the States of Andhra Pradesh, Chattisgarh, Goa, Gujarat, Haryana, Himachal Pradesh, J&K, Jharkhand, Karnataka, Kerela, M.P., Maharashtra, Mizoram, Orissa, Pondicherry, Punjab, Rajasthan, Tamil Nadu, Tripura, Uttaranchal, Uttar Pradesh, West Bengal and Union Territory of Andaman & Nicobar Islands, Chandigarh, Dadra & Nagar Haveli, Daman & Diu and Lakshadweep was 91*Very Good 92*, while the performance of the State of Sikkim was 91*Good* 92. Rest of the States/UTs had shown 91*Poor* 92 performance.

Target and Achievement of Immunisation Programme during the year 2003-04 (in lakh)

Sl. No.	Immunisation	Target	Achievement *	% Achievement
(1)	(2)	(3)	(4)	(5)
1	TT (EM)	302.83	235.57	77.8
2	DPT	256.80	233.67	91.0
3	OPV (Polio)	256.80	237.08	92.3
4	BCG	256.80	256.88	100.0
5	Measles	256.80	219.46	85.5

** Figures are Provisional*

9.4 Disease Prevention

(i) Leprosy

9.4.1 The National Leprosy Eradication Programme (NLEP) in India is being implemented as a centrally sponsored programme. The main activities of the programme are; to detect cases in the community, to bring all the cases detected under treatment, to release from treatment after completion of the treatment and other supportive activities. The programme is monitored at the national level for case detection, treatment and cases discharged from treatment.

9.4.2 The prevalence rate of Leprosy for the country as whole has declined from 24 per 10,000 population in 1992 to 2.38 per 10,000 population in March 2004 (Provisional). The second phase of the World Bank assisted National Leprosy Eradication Programme (NLEP) has been approved with the objective of elimination of leprosy for the country as a whole. In order to achieve integration of leprosy with general health care in 27 states as also in the high endemic states, the guidelines for information systems for leprosy have been simplified. Tenth Plan goal is to eliminate leprosy as a public health problem by bringing the prevalence rate to less than 1 per 10,000 of population.

9.4.3 The Registered Caseload (Provisional) as on 31st March 2004 was 0.26 million with PR 2.38/10,000 population in India. Seventeen states have achieved elimination of leprosy (PR<1/10,000). These states are: Arunanchal Pradesh, Assam, Haryana, Himachal Pradesh, Jammu & Kashmir, Kerala, Manipur, Meghalaya, Mizoram, Nagaland, Punjab, Rajasthan, Sikkim, Tripura, Andaman & Nicobar Islands, Pondicherry and Daman & Diu. Further, seven states having PR between 1 and 2 per 10,000 are close to achieve elimination. These states are Goa, Gujarat, Karnataka, Madhya Pradesh, Tamilnadu, Uttaranchal and Lakshadweep.

9.4.4 The country has six major endemic states, namely Bihar, Chhattisgarh, Jharkhand, Orissa, Uttar Pradesh and West Bengal.

9.4.5 Achievements in 2003-04: During the year 2003-04, 334596 new leprosy cases were detected and 419125 cases were cured (discharged).

9.4.6 The *Multi Drug Therapy* (MDT) coverage has been extended to all the PHCs of all the districts in India and 11.24 million patients have been cured by MDT till March 2004 in the country.

9.4.7 The epidemiological situation of Leprosy in Six major endemic states as on 31st March 2004 is as under:

S.No.	States	Population in million	Leprosy cases on record	PR/10,000	Total % of Districts
(1)	(2)	(3)	(4)	(5)	(6)
1	Jharkhand	28.63	12409	4.33	22
2	Bihar	89.25	44351	4.97	37
3	Chhattisgarh	21.85	11582	5.30	16
4	Orissa	38.36	13382	3.49	30
5	Uttar Pradesh	177.77	53695	3.02	70
6	West Bengal	84.23	26199	3.11	18

(ii) Tuberculosis

9.4.8 The National TB Control Programme was launched in 1962 on 50:50 sharing basis between the Centre and the State Governments with regard to supply of anti-TB drugs. The programme is implemented through District TB Centres, as nodal agency and is integrated with primary health care facilities. The pattern of Central assistance for anti-TB drugs was changed from 50% to 100% from March 1997 and since then, 100% requirement of anti-TB drugs of the States is met by the Centre. Under the Programme, all diagnostic and treatment facilities including supply of anti-TB drugs are provided to the patients free of cost.

9.4.9 India accounts for nearly 1/3rd of the global TB burden. Every year there are approximately 18 lakh new cases in the country of which approximately 8 lakh are new smear positive highly infectious cases. One person dies from TB in India every minute-more than 1 thousand people every day and nearly 4,17 lakh every year.

9.4.10 Revised National TB Control Programme (RNTCP) based on WHO recommended DOTS strategy (Directly Observed Treatment Short Course Chemotherapy) was launched in the country in March 1997 and is being implementing in the country in a phased manner with the assistance of international agencies i.e. World Bank, DFID, DANIDA, USAID and GFATM. Presently, more than 870 million population has been covered under the revised strategy. The entire country is to be brought under RNTCP at the earliest and latest by 2005 in order to control TB and meet the global targets.

9.4.11 Programme is constantly monitored and reviewed. National Tuberculosis Institute, Bangalore, consolidates the quarterly reports of Non-RNTCP districts, analyzes and sends regular feedback to districts. The States also send information on sputum examination and new sputum positive case detection under 20 Point Programme directly to Central TB Division. Quarterly reports of RNTCP Project Areas are regularly sent to the CTBD. Detailed feedback is given to the District and State authorities. In addition to this for *Revised National TB Control Programme* (RNTCP) districts, State Govt. has also started its own feedback after detailed analysis.

9.4.12 The performance under the National TB Control Programme is monitored against the two types of physical target-number of chest symptomatics undergoing sputum examination for diagnosis and number of new sputum positive case detected. During that year 2003-04 target and achievements are shown below:

Years	Target	Achievement	% Achievement
(1)	(2)	(3)	(4)
1999-2000	488480	371521	76
2000-2001	498590	347273	70
2001-2002	513510	402743	78
2002-2003	431622	451658	105
2003-2004	448829	397106	88

9.4.13 Overall achievement for treatment & cure of sputum positive cases for the year 2003-04 was 397106 against the target of 448829 which works out to 88.48%.

9.4.14 Achievement of RNTCP has also been very high. Against a target of 135 cases per 1,00,000 population for case detection, achievement has been 132 per 1,00,000 population. Against targeted success rate of 85% actual achievement is more than 86%. Under RNTCP, more than 30 lakh patients have been started on treatment, more than 5 lakh lives saved. In 2003 alone more than 9 lakh patients were put on DOTS.

Thrust Involvement of NGOs & Private Practitioners.

9.4.15 An NGO policy has been formulated and widely disseminated. Five different schemes for involvement of NGOs have been envisaged. Depending on the capacity of the NGOs they are being involved in various aspects of service delivery and till date more than 750 NGO 92s are actively participating in RNTCP. Policy for involvement of Private Practitioners in RNTCP has also been finalized and circulated widely. Actions have been initiated to involve Private Practitioners through professional organizations like Indian Medical Association/State Branches of Medical Associations. For sensitization of Private Practitioners, workshops have been organized in many cities. 3000 Private Practitioners and 80 Corporate establishments are involved in the provision of RNTCP services. Government of India has now initiated a Public-Private Mix (PPM) Project in 14 urban sites across the country. Involvement of Medical College has been identified as a key area to ensure standardized diagnosis and treatment of TB patients as per RNTCP guidelines. Presently, about 70% (131/186) of medical colleges in RNTCP implementing areas are participating in the programme.

(iii) Blindness

9.4.16 National Programme for Control of Blindness was first launched in the year 1976 as a 100% centrally sponsored programme with the goal to reduce the prevalence of Blindness fro 1.4% to 0.3%. A special thrust is given to reduce the Cataract Blindness, which now constitutes nearly 63% of blindness in the country, of the total estimated 45 million blind persons (Visual Acuity (VA) <3/60) in the world, 7 million are in India. Due to the large population base and increased life expectancy, the number of cataract cases is expected to increase in the coming years. India is committed to reduce the burden of avoidable blindness by the year 2020 by adopting strategies advocated for Vision 2020: The Right to Sight initiative.

9.4.17 Three major surveys were conducted to find out the prevalence of blindness in the country. The first survey undertaken by the Indian Council of Medical Research (ICMR) in 1974 indicated 1.38 percent prevalence rate for the economically blind (VA<6/60). In the Government of India/WHO survey (1986-89), the prevalence rate increased to 1.49 per cent (VA<6/60). Recent survey (1999-2001) in 15 districts of the country indicated that prevalence of blindness (Visual Acuity <6/60) has come down to 1.1%. Prevalence of blindness in 50+ population was estimated to be 8.5%. Cataract continues to be the main cause of blindness (62.6%). Uncorrected refractive errors were responsible for 19.7% of blindness. Other important causes of blindness include glaucoma (5.8%), posterior segment pathology (4.7%), corneal opacities (0.9%) and others (6.2%). Surgical coverage of cataract-affected population was 65.7%. With best correction, successful visual outcome after cataract surgery was 93.5% (Post-operative vision >3/60).

9.4.18 Among the emerging causes of blindness, diabetic retinopathy and glaucoma need special mention. 2% of India 92s population is expected to be diabetic. 20% of diabetics have diabetic retinopathy and this number is likely to grow in future. Prevalence of glaucoma is estimated to be 4% in population aged 30 years and above.

9.4.19 The programme has witnessed better performance in cataract operations, which have gone up over the years, as may be seen from the following table:

Year	Targets	Achievement	% Achievement
(1)	(2)	(3)	(4)
1992-93	2,00,000	16,04,926	80
1993-94	24,30,000	19,13,683	79
1994-95	24,50,000	21,66,524	88
1995-96	25,50,000	24,70,499	97
1996-97	26,20,000	27,25,426	104
1997-98	30,17,952	30,32,309	101
1998-99	33,20,330	33,20,305	101
1999-2000	35,00,000	34,57,113	99
2000-2001	40,00,000	36,26,000	91
2001-2002	40,00,000	37,25,579	93
2002-2003	40,00,000	38,57,112	96
2003-2004(*)	40,00,000	32,64,356	82

(*) Provisional upto Jan 04

9.4.20 Collection and Utilization of donated eyes: Currently, nearly twenty thousand donated eyes are collected per annum in India. Hospital retrieval programme is the main strategy for collection of donated eyes which envisages motivation of relatives of terminally ill patients, accident victims and other grave diseases to donate eyes. Eye donation fortnight is organised from 25th August to 8th September every year to promote eye donation/eye banking. Gujarat, Tamilnadu, Maharashtra and Andhra Pradesh are leading States in this activity. Overall achievement of donated eyes collected during the year 2002-2003 was 19640. In terms of percentage, the achievement was 79% against the target of 25,000 in respect of donated eyes collected. The programme in close coordination with the Eye Bank Association of India has launched awareness campaign to enhance motivation for eye donation after death.

9.4.21 Government of India has committed to adopt strategies of 93Global Elimination of Avoidable Blindness: Vision 2020: The Right to Sight Initiative 94 advocated by WHO. This aims at eliminating all causes of blindness that can be prevented or cured by the year 2020.

(iv) Acquired Immune Deficiency Syndrome (AIDS)

9.4.22 India has launched the National AIDS Control Programme (NACP) in 1987 aimed at containing the spread of HIV in order to reduce the future morbidity and mortality. An agreement with the World Bank for the project was signed on 24/4/1992. Phase-I of National AIDS Control Programme was launched on 23/9/1992 for a period of 5 years (1992-97), but was extended up to March, 1999. The Phase-II of the programme with the assistance of World Bank and two bilateral agencies, namely United States Agency for International Development (USAID) and Department for International Development (DFID) was initiated with effect from 1st April, 1999 for a period of 5 years (1999-2004). The Phase-II has two key objectives, namely: (i) to reduce the spread of HIV infection; and (ii) to strengthen the capacity of Central/State Govt. to respond to HIV/AIDS on a long-term basis.

9.4.23 During 2003-04, the entire programme on the prevention and control of HIV/AIDS was repositioned into a more holistic and balanced combination of focused initiatives.

The programme has the following five components:

B7 Preventive interventions for high-risk populations through targeted interventions adopting a multi-pronged strategy including peer counselling and behaviour change communication.

B7 Preventive interventions for the general population through programmes for blood safety, voluntary counselling and testing services, information education and communication (IEC) and awareness building among adolescents.

B7 Provision of low cost care and support services by providing community care services, treatment of opportunistic infections and prevention of occupational exposure.

B7 Collaborative efforts to promote inter-sectoral programme activities including interventions and public-private partnerships.

B7 Build technical and managerial capacities for programme implementation through surveillance, training, monitoring & evaluation, technical resource groups, operational research and programme management.

9.4.24 Based on the sentinel surveillance data estimates of magnitude of HIV infection reveal that these have increased from 3.51 million in 1998 to 3.71 million in 1999, 3.86 million in 2000, 3.97 million in 2001 and 4.58 million in 2002. These estimates indicate that there has been no dramatic upsurge in the spread of HIV. However, these figures are a cause of increasing concern to Government.

9.4.25 Under the programme, the number of condoms procured in 2003-04 has increased by 50 million over the previous year and the sites at which the condoms are made available to vulnerable populations have also increased to 882. Centres for voluntary counseling and testing have increased from 140 in 2002 to 628 in 2003 and three model VCTCs have been set up which provide the continuum between prevention and care, support and treatment. Sites for Prevention of Parent to Child Transmission in antenatal clinics have been up scaled to 225 centres across the country. Clinics for treatment of STD have increased to 678. 915 Blood Banks have been established in Government Hospitals and 80 Blood Component Separation facilities across the country. 10 State of the art model blood banks are being set up in the under-served states. A meticulous Action Plan has been put in place to operationalise the National Blood Policy 2002.

9.4.26 The agenda on Care and Support of People Living with HIV/AIDS (PLHAs) has been expanded to include the provisioning of Anti Retroviral Treatment across the six high prevalence states (Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Manipur, and Nagaland) and NCT Delhi. Priority will be given to :

B7 HIV positive mothers in the interest of child survival, and for saving families and communities;

B7 Children with AIDS below 15 years of age and

B7 People with full blown AIDS seeking treatment in government hospitals.

National AIDS Control Organisation (NACO) has initiated detailed planning for installing delivery mechanisms, appropriate logistics, training and procurement of ARV drugs.

9.4.27 During 2003, the agenda to promote and develop an appropriate AIDS vaccine for India has surged ahead on several fronts, since its formal beginning in a tripartite Memorandum of Understanding between NACO, the Indian Council of Medical Research and the not-for-profit International AIDS Vaccine Initiative (IAVI).

9.4.28 To control AIDS, the Government of India is conducting family health awareness campaign for both male and female population. Mass media, such as, electronic media, press and all India radio are fully utilised in IEC campaigns for dissemination of HIV/AIDS messages. NACO has extended coverage of 55,000 schools through the School AIDS education programme and reached out to 8000 institutions associated with 176 universities to cover 7 million young people in the country through the Universities Talk AIDS (UTA) project. NACO has also addressed out-of-school youth through the Villages Talk AIDS (VTA) programme conducted by the Nehru Yuvak Kendra Sangathan (NYKS) network. NACO supports 700 NYKS units spread over 410 districts in the country. NACO facilitates the involvement of various public sectors such as education, defence, labour, youth affairs, steel, railways, industry, transport, and social justice and empowerment to address HIV/AIDS in their respective sectors.

National Vector Borne Disease Control Programme

(v) Malaria

9.4.29 Malaria has been one of, the major public health problems in India. Before the launch of National Malaria Control Programme in 1953, malaria was the single most important disease, cases estimated at 75 million, and 0.8 million deaths yearly, and these figures used to multiply during epidemic years. DDT spraying under the National Malaria Eradication Programme (MNEP) nearly eradicated malaria from the country and by the early 1960s there were only about 0.1 million cases. Problems of malaria started to return and its resurgence was widespread in the late, sixties. By 1976, incidence went up to 6.47 million cases annually. In 1977 the Modified Plan of Operation (MPO) was launched successfully and the cases were brought down to 2.18 million cases in the' year 1984. Since 1984, malaria incidence has declined to around 2 million cases; it has been brought down to 1.84 million cases during 2002 and 1.65 million during 2003.

9.4.30 The annual physical targets for surveillance have been achieved for the country as around 95 million population is screened annually and all detected cases are given suitable treatment including radical treatment. Further under the technical target for spray around 50-60 million population annually has been protected with appropriate insecticide spray in the country.

Targets in the 10th plan for malaria control are:

(i) Annual Blood Examination Rate (ABER) above 10.

(ii) 25% reduction in mortality and morbidity due to malaria by 2007 and Annual Parasite incidence of 1.3% or less.

9.4.31 Under the centrally sponsored scheme or NVBDCP, Government or India provides technical support as well as logistics as per the approved pattern. The State governments ensure the programme implementation. The Centre as well as states monitors the programme closely and high-risk areas are identified for focused attention. Based on this process of monitoring, North-Eastern states that contribute about 11 percent of total malaria though have only about 4 percent population, have been identified for enhanced support since December 1994. Government of India has been providing 100 per cent assistance to these States. Similarly, 1045 tribal PHCs in 100 hard-core malarious districts in 8 states namely Andhra Pradesh, Chattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Orissa and Rajasthan have been identified as high-risk to provide enhanced central support under Enhanced Malaria Control Project (EMCP) with World Bank assistance to intensify malaria control. 19 urban areas have also been identified for this support. Training, IEC and MIS is for the entire country under EMCP. The goal is to bring about 50 percent reductions in mortality due to malaria by 2010 according to NHP-2002.

9.4.32 The measures adopted by the Government in the rural areas are insecticide spray, fortnight surveillance of cases and radical treatment. In the urban areas weekly recurrent antilarval measures as source reduction method and radical treatment at Health Centres are being adopted.

(vi) Goitre

9.4.33 Iodine is an essential micronutrient with an average daily requirement of 100-150 micrograms for normal human growth and development. There is an increasing evidence of distribution of environmental Iodine deficiency in various parts of the country. On the basis of surveys conducted by the Directorate General of Health Services, Indian Council of Medical Research and the State Health Directorates, it has been found that out of 316 districts surveyed in all the 28 States and 7 UTs, 256 districts were endemic i.e. where the prevalence of IDDs is more than 10%. It is also estimated that more than 71 million persons are suffering from goitre and other Iodine Deficiency Disorders. These disorders include abortions, stillbirth, mental retardation, deaf mutism, squint, goitre and neuromotor defects.

9.4.34 Realising the magnitude of the problem, the Govt of India have launched a 100 percent centrally assisted National Iodine Deficiency Disorders Control Programme to bring down the incidence of Iodine deficiency disorders to below 10 percent in the entire country. For this purpose the Govt of India has adopted the policy of universalization of iodated salt in the country. Most of the states have launched the use of iodated salt. The state Govts have been advised to introduce it in Public Distribution System (PDS). For ensuring the quality of iodated salt at the consumption level, testing kits for on the spot qualitative testing have been developed and distributed to all the district health officers in endemic states for awareness

9.4.35 There is complete ban on the sale of non-iodated salt in 26 States and all the 7 UTs There is partial ban in the state of Maharashtra. There is no ban in the states of. Gujarat and Kerala. For effective monitoring and proper implementation of National Iodine Deficiency Disorders Control Programme (NIDDCP) at the state level 30 States/UTs have established IDD Control Cells. A total of 14600 samples of iodinated salt were analyzed out of which 12086 (82.10%) samples were found to conform to the PFA standards.

9.4.36 The spots on Iodine Deficiency and benefits of Iodated salt consumption were telecast through the National Network of Doordarshan at prime time The IDD spots about the consequences of iodine deficiency and the benefits of consuming iodated salt, were broadcast through All India Radio. Besides this posters and pamphlets on consequences of IDD and the benefits of Iodized salt consumption have been distributed to all States/UTs. for Health Mela. Besides IEC Activities in various states/UTs were conducted with participation of various agencies such as Song & Drama Division, Directorate of Field Publicity, and DAVP through the publication of messages appealing to the masses for consumption of iodated salt in the leading national and regional dailies on the occasion of Global IDD Prevention Day.

9.5 Rehabilitation of Handicapped

The Ministry of Social Justice & Empowerment is the nodal Ministry for formulation of policies and programmes for the handicapped persons in the country covering the entire range of activities from prevention of the disability to the rehabilitation of the disabled. The Ministry also provides facilities like education, vocational training, economic and social rehabilitation and provision of aid and appliances to the handicapped persons through voluntary organisations by giving them assistance upto 90% of their expenditure. It also provides services like education, manpower development, vocational guidance, counselling and rehabilitation through National Institutes. Further, 3% job reservation (1% each for blind, deaf and orthopaedically handicapped) in Group C & D posts under the Central Government and Public Sector Undertakings is provided for. To assist the employable handicapped, 35 special employment exchanges and 55 special cells are functioning throughout the country. For comprehensive rural rehabilitation services, Rehabilitation Centres are also functioning. In line with the commitment of the Tenth Plan to empower as many disabled as possible to become active self reliant and productive contributors to the national economy, the Annual Plan 2002-03 has relied upon the strength and support of the provisions of Persons and Disabilities(Equal Opportunities, Protection of Rights and Full Participation)Act 1995. To ensure adequate fund availability, steps are being taken to introduce a component plan for the disabled in the Budget of Ministries/Departments to ensure that the funds/benefits flow to the disabled. Over 133 districts have been identified for providing comprehensive rehabilitation services at the doorsteps of disabled persons. 107 District Disability Rehabilitation Centres (DDRCs) have started functioning. The Expert Committee has identified 120 jobs at the supervisory, executive and managerial levels and 945 jobs at the level of skilled/semi-skilled for persons with disabilities, in the private sector. A new scheme of scholarships for the disabled students had been launched for pursuing higher and technical education. A one-time contribution of Rs.100 crore from the Central Government is envisaged towards the corpus of the National Trust set up under the National Trust Act for affirmative action in favour of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple disabilities. A scheme of Assistance to the Disabled for Purchase/Fitting of Aids and Appliances was also being operated for rehabilitation of handicapped. The Scheme to promote Voluntary Action for Persons with Disabilities (Umbrala, Scheme) is aimed at providing education, training and rehabilitation services through Non Governmental Organizations.

9.6 Rural Sanitation Programme

The rural sanitation programme is implemented to improve the sanitary facilities through construction of sanitary latrines in rural areas and to supplement the efforts made under different Central and State Programmes for improving the quality of life in rural areas and to provide privacy and dignity to the women. This programme was restructured in 1999 and Total Sanitation Campaign (TSC) introduced. The TSC envisages a synergised interaction between the Government, people and active NGO participation, besides intensive IEC campaigns, provision of an alternative delivery system and more flexible, demand oriented construction norms. The revised Tenth Five Year Plan strategy envisages a shift from allocation based programme to a demand based project mode. Besides, the paradigm shift envisages a greater household involvement, intensive IEC campaigns, and stress on software and emphasis on school sanitation. In India, sanitation coverage in rural areas is only 22%, as a result, a large number of people practice open defecation. This is the root-cause for various water-borne diseases and incidence of diarrheal cases. In addition to the health hazard, lack of sanitation facilities causes a great inconvenience to the people particularly women in the rural areas. Realising this as a major problem, Government of India had launched *Central Rural Sanitation Programme*(CRSP) in 1986.The programme was restructured with effect from 1.4.1999 and people oriented, demand-driven, *Total Sanitation Campaign* (TSC) was launched. These projects are being implemented in a campaign approach giving emphasis on social mobilisation involving Panchayat Raj Institution (PRI), NGOs and people from all walks of life. The Total Sanitation Campaign (TSC) focuses on awareness generation to create demand for sanitation facilities. Financial support is given for construction of individual household toilets by the below poverty line (BPL), school toilets for all government schools in the rural areas with emphasis on separate toilets for girls in all co-educational schools, toilets for Anganwadi and Balwadi centres, Community Sanitary Complexes for women in villages where land availability with individuals is a problem and people are ready to own, operate and maintain such complexes. In addition to meet the demand generated for sanitation facilities alternative delivery mechanism in the form of Production Centres and Rural Sanitary Marts are being set up. Total Sanitation Campaign (TSC) is being implemented in 398 districts of the country. It is targeted to sanction up to 500 districts in the current financial year and cover all the districts by the end of 10th Plan. The physical progress during the year as per latest information was construction of 45.14 lakh Individual Household Toilets for BPL families, 52,268 School toilets, 1751 women community complexes and 8,881 Aganwadi toilets. In addition, 1,593 Rural Sanitary Marts (RSM) were set-up in different TSC project districts.