**=following reservation roster**

**Chapter 7**

**Facilities for Scheduled Castes and Scheduled Tribes**

**7.1.1 The Scheduled Castes and Scheduled Tribes Cell in**

**the Ministry continued to look after the service-interests**

**of these categories of employees during 2002-2003. The**

**Cell assisted the Liaison Officer in the Ministry to ensure**

**that representations from Scheduled Castes/Scheduled**

**Tribes, OBCs and Physically Handicapped Persons in the**

**establishment/services under this Ministry received proper**

**consideration.**

**7.1.2 The Cell circulated various instructions/orders**

**received from the Department of Personnel and Training**

**on the subject to the peripheral units of the ministry for**

**guidance and necessary compliance. It also collected**

**various types of statistical data on the representation of**

**Scheduled Castes/Scheduled Tribes/OBCs/Physically**

**Handicapped persons from the subordinate Offices/**

**Autonomous/Statutory bodies of this ministry as required**

**by the Department of personnel and Training, National**

**commission for Scheduled Castes and Scheduled Tribes etc.**

**The Cell also rendered advice on reservation procedures**

**and maintenance of reservation particularly post based**

**rosters.**

**7.1.3 During 2002-2003 inspection of rosters was carried**

**out in respect of four offices, namely, (1) AIIMS, New Delhi**

**(2) LHMC & Smt. S.K.Hospital, New Delhi (3) Lady Reading**

**Health School, New Delhi and (4) Kalawati Saran Children**

**Hospital, New Delhi which are under the administrative**

**control of this Ministry. Apart from these 6 institution of**

**the Ministry namely All India Institute of Hygiedne and**

**Public Health, Central Drugs Standard Control Organization**

**(East Zone), Institute of Serology, Airport Health**

**Organization, National Institute of Homoeopathy and**

**Central Food Laboratory at Kolkata were also inspected.**

**The salient aspects of the scheme of reservation were**

**emphasised to the participating units/offices. Suggestions**

**were made to streamline the maintenance and operation**

**of rosters in these Institutes/Organisations. The defects**

**and procedural lapses noticed were brought to the attention**

**of the concerned authorities.**

**7.1.4 The representation of Scheduled Castes and**

**Scheduled Tribes in (i) the Central Health Services Cadre**

**(administered by this Ministry) and (ii) the Ministry- its Attached and Subordinate Offices as on 01.01.2003 is as**

**follows:**

**Name of Total SC ST**

**Cadre Employees**

**(i) Central Health 3,678 650 246**

**Service :**

**(All Group**

**A posts)**

**(ii) Ministry-its 24,520 7,266 1,439**

**Attached and**

**Subordinate**

**Offices**

**Note: This statement relates to persons and not to posts.**

**Posts vacant etc. have not, therefore, been taken into**

**account.**

**7.2. TRIBAL DEVELOPMENT PLANNING**

**CELL**

**7.2.1. A separate Tribal Development Planning Cell has**

**been functioning under the Ministry of Health and Family**

**Welfare, Directorate General of Health Services since 1981**

**to co ordinate the policy, planning, monitoring, evaluation**

**etc. of the Health Care Schemes for welfare and**

**development of Scheduled Tribes and Scheduled Castes.**

**7.2.2. Various Public Health Programmes are being**

**implemented in the country and SCs/STs are deriving full**

**benefit of the same. However, Programme Officers have**

**been directed to ensure that plan funds to the extent of**

**8.1% for Tribal Sub Plan & 16.5% for Special Component**

**Plan are allocated in proportion to the total population as**

**per 1991 Census.**

**7.3. PRIMARY HEALTH CARE**

**INFRASTRUCTURE**

**7.3.1. Keeping in view that most of the tribal habitation**

**is concentrated in far flung areas, forest land, hills and**

**remote villages, the population coverage norms have been**

**relaxed as under:** **Centre Population Norms**

**Plain Area Hilly/Tribal Area**

**Sub- Centre 5,000 3,000**

**Primary Health 30,000 20,000**

**Centre**

**Community 1, 20,000 80,000**

**Health Centre**

**Multipurpose 5,000 3,000**

**Workers**

**7.3.2 Under the Minimum Needs Programme, 21,513 Sub**

**Centres, 3,610 Primary Health Centres and 604 Community**

**Health Centres have been established in tribal areas as on**

**31.03.2003.**

**7.3.3 The State Governments have been advised to**

**introduce schemes for compulsory annual medical**

**examination of Scheduled Castes/Scheduled Tribes**

**population in rural areas. Under the schemes, it is**

**envisaged that Mobile Health checkup teams would be**

**deputed to villages according to a schedule drawn up**

**annually and in case of need for further investigation/**

**treatment, they would be entitled to free facilities in**

**Government/Referral hospitals.**

**7.3.4 Access to and benefits from the public health**

**system have been very uneven between the better endowed**

**and the more vulnerable sections of society. This aspect**

**has been adequately recognized in the National Health**

**Policy-2002.**

**7.4. CENTRALLY SPONSORED SCHEMES**

**IMPLEMENTED BY STATES/UTs**

**7.4.1. The National Vector Disease Control Programme**

**approved in 2003-04 by convergence of three ongoing**

**programmes of malaria, filarial, Kala-azar and inclusion**

**of Japanese Encephalitis & Dengue/DHF is proposed to be**

**implemented by States/UTs with 50% Central Assistance**

**for spraying insecticides, supply of Anti Malaria drugs etc.**

**in the country including tribal and SC areas under TSP and**

**SCP. Cent percent Central Assistance is being provided to**

**North Eastern states dominated by tribal population from**

**the year 1994 95 onwards. 100 hard core identified tribal**

**districts in the States of Andhra Pradesh, Gujarat, Madhya**

**Pradesh, Maharashtra, Orissa, Jharkhand, Chattisgarh and**

**Rajasthan and 19 identified urban areas are also covered**

**under the Enhanced Malaria Control Project with World Bank**

**support. This Project at a cost of Rs. 891.04 Crores started**

**in September, 1997 for a period till March, 2003. It has**

**received one year extension upto March, 2004.** **7.4.2. National Leprosy Eradication Programme is being**

**implemented with 100% assistance in all the districts of**

**the country and thus covers the entire tribal population**

**for detection and treatment of leprosy cases. The North-**

**Eastern States of Nagaland, Meghalaya, Tripura, Sikkim,**

**Mizoram, Assam, Manipur and Arunachal Pradesh (mostly**

**inhabitated by the tribal population) have all achieved the**

**target of elimination (Prevalence rate of less than 1/10,000**

**population).**

**7.4.3. National Tuberculosis Control Programme is**

**implemented with 100% Central Assistance for supply of**

**anti TB drugs, equipment etc. in tribal and SC areas under**

**TSP and SCP. Under the programme, all diagnostic and**

**treatment facilities including supply of anti TB drugs are**

**provided free of cost to all for full course of treatment.**

**Further, norms are being relaxed and following steps are**

**being taken for facilitating service delivery in rural tribal**

**areas:-**

**ª Norms for establishment of TB unit and Microscopy**

**centers**

**Population Norms**

**Normal Difficult/Hilly/**

**Areas Areas**

**TB unit 5.0 lakh 2.5 lakh**

**Microscopy 1.0 lakh 0.5 lakh**

**centre**

**ª Providing Senior Treatment Supervisor (STS) and**

**Senior Tuberculosis Laboratory Supervisor (STLS) for**

**every 2.5 lakh population against the established norms**

**of 5 lakh;**

**ª Opening of more DOT centres; and**

**ª Provision to reimburse the travel claims of patients**

**and attendants visiting the Microscopy Centre for**

**diagnosis and DOTs center for treatment.**

**414 districts with a population of approximately 740 million**

**including tribals have been covered with the support of**

**WB, DFID and DANIDA till October, 2003. The population**

**coverage under RNTCP is expected to increase to about**

**850 million by the end of 2004 and the entire country by**

**2005.**

**DANIDA assistance was obtained to implement the revised**

**strategy of RNTCP in the State of Orissa. Service delivery**

**has already started in 19 tribal districts. DANIDA has agreed to cover the entire State of Orissa under RNTCP. Accordingly,**

**preparatory activities have started in remaining 11 districts**

**for adoption of the revised strategy.**

**7.4.4 National Programme for Control of Blindness was**

**launched in the year 1976 with 100% assistance for**

**strengthening of ophthalmic infrastructure, training of**

**personnel, etc. in tribal areas for treatment of eye ailments**

**and control of blindness under TSP. In addition, schemes**

**for non-recurring grant-in-aid to NGOs, for setting up or**

**expansion of eye care units in tribal/remote areas, is being**

**implemented to develop infrastructure for eye care in such**

**areas. Special campaigns for identification and treatment**

**of bilaterally blind persons due to cataract is undertaken**

**in remote and underserved areas during mega eye camps.**

**National survey was conducted during the period 1986-89**

**to evaluate the programme. The prevalence of blindness**

**revealed by the survey was 1.49%. During the year 2002-**

**2003, 38.4 lakh cataract operations have been done against**

**a target of 40 lakh. IOL implantation surgery has increased**

**from 65% in 2001-02 to 77% in 2002-03. Under the revised**

**strategy, coverage of eye care service in tribal and other**

**underserved areas has been enhanced.**

**7.4.5 National AIDS Control Programme is implemented**

**all over the country including tribal areas, though no**

**separate provision is made for TSP. Central assistance is**

**provided as per pattern of assistance. The National AIDS**

**Control Programme II was launched in November, 1999 at**

**a total cost of Rs.1425 crore. AIDS is also 100% Centrally**

**Sponsored Programme. However, this programme is now**

**fully decentralized with total financial and administrative**

**delegation of power and responsibilities to the State AIDS**

**Control Societies. These societies allocate money based**

**on the needs of the population including tribals in various**

**districts. The major aim of this Programme is to reduce**

**the spread of HIV infection in the country and strengthen**

**India's capacity to respond to HIV/AIDS on a long term**

**basis. This is to be done through**

**ª Targeted intervention for communities with high risk**

**behaviour by providing peer counseling, condom**

**promotion, and treatment of sexually transmitted**

**infections.**

**ª Preventive intervention for the general population by**

**Information, Education and Communication (IEC) and**

**awareness campaign, provision of voluntary testing**

**and counselling, safe blood transfusion services and**

**prevention of occupational exposure.**

**ª Providing financial assistance for opportunistic**

**infections, home and community based care ª Strengthening effectiveness and technical, managerial**

**and financial sustainability at National, State and**

**Municipal levels.**

**ª Promoting collaboration amongst public, private and**

**voluntary sectors.**

**7.5. PURELY CENTRAL SCHEMES**

**7.5.1. In order to overcome the difficulties, book banks**

**for medical SC/ST students have been set up in Institutions**

**like PGIMER, Chandigarh; JIPMER, Pondicherry; AIIMS, New**

**Delhi; Lady Hardinge Medical College, New Delhi; UCMS,**

**Delhi; Maulana Azad Medical College, New Delhi.**

**Similarly, under graduate colleges of ISM&H run by voluntary**

**organisations have also set up book banks for SC/ST**

**students with Central assistance. Many SC/ST students**

**are benefiting by this scheme.**

**7.5.2 The Central Institute of Psychiatry, Ranchi is**

**providing health care facilities to the neighbouring areas**

**of Ranchi pre dominantly inhabited by tribal people in the**

**Chhota Nagpur belt of Jharkhand. During the Tenth Plan**

**Period on amount of Rs. 50 Crore was allocated to the**

**Institute while during 2003-2004 an amount of Rs. 8 crore**

**has been allocated to meet expenses on medical services**

**and strengthening of the Institute.**

**7.5.3 In order to provide specialised medical care to the**

**people of the entire North Eastern Region, primarly**

**inhabited by tribal, the North Eastern Indira Gandhi**

**Regional Institute of Health and Medical Sciences**

**(NEIGRIHMS) a 500 bedded super speciality referral hospital**

**with PG teaching in 35 specialities/super specialities at**

**an estimated cost of Rs. 422 cores in being set up.**

**7.5.4 The Indian Council of Medical Research, (ICMR)**

**New Delhi have set up 5 Regional Medical Research Centres**

**(RMRC) in the tribal areas in the country one each at**

**Jabalpur, Bhubaneswar, Jodhpur, Dibrugarh and Port Blair**

**to carry out research on health related problems of**

**Scheduled Tribes.**

**One of the reasons cited for tardy improvement in health**

**status of the tribal population is poor and incomplete**

**understanding about their health problems, both general**

**and specific to certain tribes. In order to bridge this gap,**

**the Indian Council of Medical Research, through its network**

**of disease oriented National Institutes and Regional Medical**

**Research Centers has conducted several surveys and**

**studies.**

**Among the research areas covered with specific reference**

**to tribals and SC/ST communities is thalassemia and sickle cell anemia where capacity building is being undertaken**

**as also counseling of parents who are carriers of the gene.**

**In addition, there are also research programmes on**

**leptospriosis and malaria in tribal and other under privileged**

**communities. Council is also coordinating a study on**

**capacity building of primitive tribes for health systems in**

**States.**

**7.5.5 Yaws Eradication Programme (YEP)as a Central**

**Sector Scheme implemenated through National Institute**

**of Communicable diseases (NICD) is an initiative which**

**started in the year 1996-97 from health sector exclusively**

**for tribal and remote areas. Yaws is a disease of primarily**

**the poor tribals in remote areas of Madhya Pradesh, Orissa,**

**Andhra Pradesh and Maharashtra. It is a disfiguring and**

**disability disease transmitted by (person - to - person)**

**contact with the infectious Yaws lesion.**

**YEP is now operational in ten yaws affected states viz.,**

**Orissa, Andhra Pradesh, Gujarat, Madhya Pradesh,**

**Maharashtra, Uttar Pradesh , Tamil Nadu, Assam,**

**Jharkhand and Chhatisgarh.**

**During 2001-02, only two states, i.e., Orissa and Andhra Pradesh have reported new cases of yaws. It is expected**

**that, there will be no yaws case by the year 2005, the**

**target date set for yaws eradication in the National Health**

**Policy-2002, thereby giving a boost to much needed tribal**

**health of the country.**

**7.5.6 The Ministry of Health & Family Welfare is**

**assigned with the responsibility of providing treatment**

**services to the drug addicts. The efforts include**

**prevention, health education, detoxification, after care**

**and follow up and is supplementary to the activities of**

**Ministry of Social Justice & Empowerment. 43 out of**

**118(36.44%) Drug De-addiction Centres have been**

**established upto 31.3.2003 in North Eastern States, which**

**are primarily inhabited by tribals.**

**7.6 ALLOCATION**

**Under the major Central Health Sector Disease Control**

**Programmes like malaria, TB, leprosy and blindness, out**

**of the total allocation of Rs. 520.00 crore, an allocation of**

**Rs. 118.52 crore and Rs. 77.34 crore has been made under**

**TSP and SCP respectively during 2003-2004**